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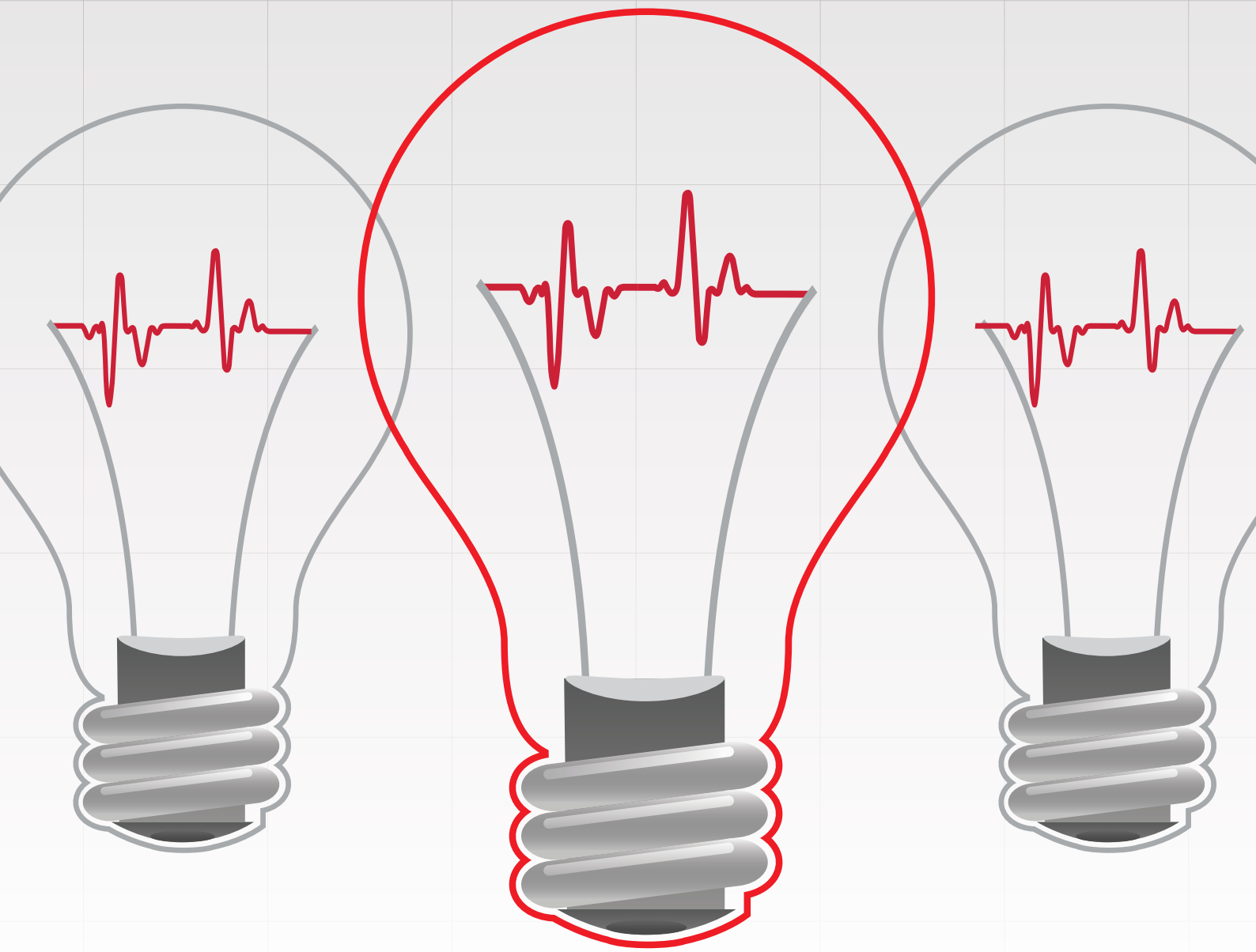

2010 AWARDS

BEST PRACTICE REPORT

Delivering best practice

The NHS remains an inspiration for health systems across the world. In the toughest year for the NHS for over a decade, the HSJ Awards prove once again that the service remains a centre of excellence. Quality, innovation and productivity are not just government buzzwords, they are enshrined in the work recognised by the awards.

However, we appreciate that times are getting tougher and that — along with the rest of you — the HSJ Awards must work even harder to spread best practice.

As a result, we have produced detailed examinations of the entries from both winners and shortlisted organisations.

Each of these "best practice reports" explore what our finalists set out to achieve and the methods they choose to deliver those benefits.

Reflecting the shift from targets to outcome measures, the reports show what worked, what did not and the unexpected pros and cons which accompany most interventions affecting anything as complex as a nationalised healthcare system.

The reports also set out how our finalists are developing their ideas and the applicability of the projects to other services and organisations. Crucially, in an era of efficiency, the reports set out any savings achieved by the projects.

We hope these best practice reports prove a practical guide to delivering similar initiatives across the health service. We equally hope that they will provide enough inspiration to help other teams and individuals to become HSJ awards finalist themselves.

Alastair McLellan
Editor, *HSJ*

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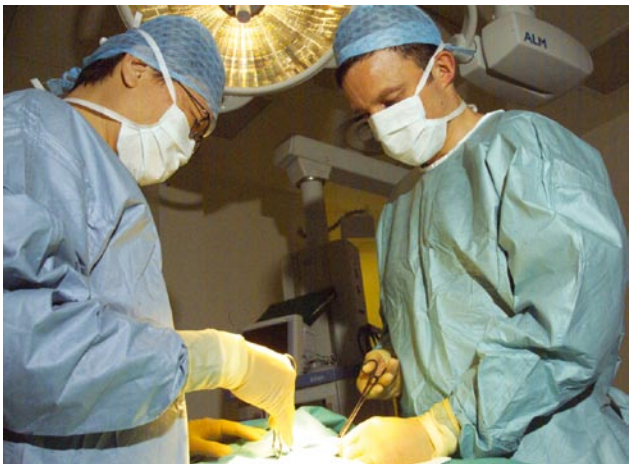
WINNER
Calderdale and Huddersfield FT



Aims and objectives

Calderdale and Huddersfield Foundation Trust's unifying vision — Your Care, Our Concern — is driven by four themes:

- Transforming care and improving the patient experience;
- Attracting, retaining and developing the best people;
- Creating a sustainable future and developing effective partnerships;
- Taking pride in and being recognised for its achievements.

The trust has clear strategies for clinical and quality improvements. The clinical strategy details work we plan to undertake at service level over the next 10 years. This is tied with activity forecasts based on public health and demographic data. This strategy is linked to the estate strategy to ensure we have the facilities required to deliver this plan. The plan includes:

- More community based multidisciplinary teams to ensure people are kept fit and well in their homes;
- A reduction in beds per 1,000 population even though the elderly population will grow by over 40%;
- A more streamlined approach to acute care;
- More services delivered in local communities through our joined up approach with PCTs, local authorities and the 3rd sector;

The third quality improvement strategy has three work streams:

- Safety;
- Effectiveness;
- Experience.

Each stream incorporates a number of collaboratives. Dedicated resources have been provided to ensure implementation.

Our organisational development approach puts clinicians as key leaders and promotes patient centred care. We are a clinical led organisation with a focus on delivery of appropriate, effective, and safe care, in an environment of continuous improvement.

The trust has been involved in national projects such as: Co-Creating Health; the Exemplar Ward Programme; the Enhanced Recovery Programme; the Showcase Hospital programme and the Safer Patients initiative.

Outcomes

Performance and effectiveness are continually monitored. At board level this is done through the integrated performance report. This is replicated at divisional and directorate level. The quality improvement strategy is monitored by the board and the quality improvement board.

The trust has set challenging targets for the next three years around turnaround time in A&E and length of stay for medical patients and is currently testing various changes in practice.

In A&E the concept of senior clinical assessment at the front door for minor injuries has been tested as a way of minimising patients' waiting time. It has allowed increased efficiency as the consultants are able to confidently manage patients without having to order unnecessary diagnostics.

Work with acute short stay medical patients is focusing on development of a robust system for hour by hour operational management, in particular discharges ensuring they start early and happen evenly during the day. To help with this we are testing the visual hospital concept, which tells us at a glance what is going on in every bed, which is improving patient flow. In addition we are working closely with primary care and social services to ensure patients' discharge and social care needs are identified and met before discharge. This avoids delay and ensures a smooth transition for patients from hospital back home or into intermediate care settings.

Financial implications

Calderdale and Huddersfield Foundation Trust has produced a surplus of:

- 2008–09 — £5.6m — excluding exceptional items
- 2009–10 — £3.8m
- 2010–11 — £400,000

We have an annual cash releasing efficiency saving programme which is always delivered. In 2010–11 this is 4%, saved through a mixture of small tactical schemes and large strategic schemes including:

- Reduction of hospital standardised mortality ratio;
- Reduction of harm;
- Achieving patient satisfaction in the top 20%;
- Being in the top 20% of comparable trusts for length of stay and readmission rates;
- Vertically integrating PCTs and local authority provider services;
- Establishing property investments partnerships.

The Co-Creating Health Programme (CCH) is producing savings of approximately £1,000 per patient from the sample taken so far. We have already committed approximately £70,000 for phase 2 of the programme as we believe we can further embed self management support for patients with long term conditions.

At our clinical leaders' request we now have a commissioning for quality and innovation incentive scheme; each division will receive payment for demonstrable quality improvements.

Contact

For more information on this initiative please contact Helen Bennett: *helen.bennett@wcheshirepct.nhs.uk*

Judges

Paul Robinson, *head of market intelligence, CHKS*

Mark Jennings, *director of health care improvement, The King's Fund*

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

Ian Dalton, *chief executive, North East Strategic Health Authority*

Tony Spotswood, *chief executive, Royal Bournemouth and Christchurch Hospitals FT*

Mark Goldman, *The Goldman Partnership*

Acute healthcare organisation of the year

FINALIST

Derby Hospitals FT

This organisation received a *Judges' Commendation* for the high quality of its entry

The initiative

This year has been one of elation and challenge for staff and patients at Derby Hospitals, marking a truly special event as we celebrated the biggest investment in healthcare Derby has ever seen with the opening of the new Royal Derby Hospital.

The day to day challenges of running an acute hospital and the unprecedented demand during winter were a constant challenge to staff who were both responsible for the move of all acute services including a busy emergency department, 450 inpatient beds and over 1,000 outpatient clinics, across the city while maintaining patient safety and quality of service.

From the outset, the new hospital project was an extensive exercise in staff and patient engagement. The need for all staff and patients to own these designs was crucial to the success of the project. The staff contribution throughout the 10 year journey was vital to understand service requirements and clinical adjacencies. Clinical and patient involvement was at the very heart of the design process.

Our long term strategic direction is creative and memorable to staff. Our objectives of PRIDE (Putting patients first, Right first time, Investing our resources wisely, Developing our people, and Ensuring value from partnerships) together with our values CARE (Compassion, Attitude, Respect and Equality) underpinned by our commitment to deliver best care and best value ensures we achieve our vision, Quality and value for money are threads that run throughout the activities of the trust and are reflected in individuals' objectives and through our annual plan clinical visions and trust strategies.

Benefits

In a local patient survey 95% of patients asked said that Derby Hospitals has achieved its objective with a strong patient focus that shows we '"take pride in caring". National and local patient survey results consistently support this as we are among the top 20% of trusts in the country for patient satisfaction. Our operational and financial performance also remains consistently high.

Staff absence is at its lowest for seven years; compared with 2008 this equates to 43 more staff at work every day, helping to provide quality patient care. Job satisfaction is the highest since 2005 and we are in the top 20% of trusts where staff feel there are good opportunities to develop themselves at work.

Financial implications

The new hospital development required an investment of £334m, the biggest investment in healthcare Derby has ever seen. However, moving all acute services onto one site will make these services much more efficient providing best care and best value.

Over the past two years, we have delivered savings of £17.5m. This was achieved through identifying a number of projects across all aspects of the trust's infrastructure, and working with staff to make efficiency savings. One example of this is the clinical redesign of the emergency department. This involved working with PCTs on demand management to optimise department processes, improve the patient experience and reduce non value added activities.

Contact

For more information on this initiative please contact Paul Widdowfield: *paul.widdowfield@derbyhospitals.nhs.uk*

FINALIST

Northumbria Healthcare FT

This organisation received a *Judges' Commendation* for the high quality of its entry

The initiative

The initiative is part of a refresh of the trust strategy, 2010–2015 that was approved by the board of directors and the governors' body in July 2010.

Our first five year strategy was approved in 2006 and during this time our knowledge about the strategic approach to patient safety and quality and demonstrating this via measured outcomes on safer care, effectiveness and patient experience has grown exponentially.

Much of this has been stimulated by the Institute of Healthcare Improvement and the best practice evidence published. This alerted us to the need to change culture and become more open and transparent as an organisation.

The first step was to be more open about our serious incidents. Over 150 staff were trained in the right tools and every serious incident was investigated and the learning reported to the clinical policy group. From this our priorities emerged:

- Hospital acquired infection;
- Responding to the deteriorating patient;
- Reducing errors for high risk medicines.

This sent a strong message to everyone in the organisation that the board of directors were determined to reach better understanding of the causes of serious incidents.

The second step was to identify clinical leaders to be briefed on the Institute for Healthcare Improvement framework; this took place in July 2008. Following on from this the clinical team has adopted the Patient Safety First best practice models. These include:

- The plan, do, study, act approach;
- Safety walk rounds;
- Measurement tools;
- Safety culture assessment tools;
- The Lean methodology approach.

Benefits

Safer care benefits include:

- Annual incidence of MRSA reduced from 59 cases to 11 in three years (79% reduction);
- Annual incidence of *Clostridium difficile* infections reduced from 232 to 129 in two years (44% reduction);
- Surgical site infections from the bottom quartile to national average in two years;
- 90% of patients who are deteriorating have the necessary observations taken, recorded and the appropriate action taken. Two years ago the rate was 10%;
- Clinical correspondence following an outpatient appointment to the GP within one week, 40% to 89% within one year;
- Clinical correspondence following an inpatient admission to the GP within one week, 25% to 69% within one year.

Effective care benefits include:

- The mortality rate is now in the top quartile — two years ago it was in the top 30%;
- The harm rate halved from 90 to 50 events per 1,000 bed days in one year.
- Our orthopaedic elective length of stay for primary hips and knees reduced from seven days to three in two years.
- Our admission on the day of surgery has increased from 30% to 92% in two years.

In addition our patient and staff experience results have gone from average to the top 20% as a result of the initiative.

Financial implications

The financial resources required to improve Northumbria's performance was £5m a year for the last three years. The majority of this has been invested in beds and people to ensure we have the right capacity, skills and knowledge.

As described earlier, the strategy was an emphasis on patient safety and the clinical leaders prioritised the improvements. The necessary cost improvement programmes put in place were approved by the clinical leaders in order to release the savings for reinvestment in the service priorities. Some of the resources were a direct result of increased activity.

An emphasis has been placed on training to ensure staff on the front line are clear about the expected standard and are required to audit at weekly intervals to ensure the standards are being maintained, the results are reported on the trust website for teams to learn from each other.

Most of the opportunities for savings have involved staff being redirected to other tasks. For example, digital dictation by medical staff resulted in the need for fewer medical secretaries. However, there was a need for administrative support to ward managers to allow them more time for direct patient care. This meant that the medical secretaries were redeployed to the ward teams.

Contact

For more information on this initiative please contact Ann Farrar: *ann.farrar@nhct.nhs.uk*

FINALIST

Salford Royal FT

This organisation received a *Judges' Commendation* for the high quality of its entry

The initiative

Salford Royal Foundation Trust (SRFT) has set itself the target of being the safest hospital in the NHS. To do this it has initiated a quality improvement programme that aims to reduce mortality by eliminating avoidable harm within three years.

The trust recently launched "the Salford Royal Way" a strategic plan aligning the quality improvement programme with a plan to safely reduce costs. The overall aim is safeguarding services and standards.

The strategy is based on deep staff engagements. It is delivered through a series of projects designed to contribute to the aim to provide "safe, clean and personal" care to every patient.

Over 850 staff members have been involved in quality improvement learning via participation in courses during the financial year 2009–10.

Staff also take part in numerous quality improvement events through the clinical quality academy, leadership of system change for quality programmes and the Lean capability and facilitator training. We will continue to work on developing a culture of safety that will underpin the success of all the project work.

The board and its senior leadership are highly visible and accessible in support of quality improvement. Underpinning effective leadership is a sophisticated framework and machinery for governance, assurance and delivery.

Benefits

Our quality improvement projects have reduced our mortality rate to 68.8 (June 2010) enabling us to report a total of 527 lives saved. The acutely unwell adult project has enabled a 59% reduction in cardiac arrests. The falls reduction programme has resulted in a 25% reduction in falls across seven wards. Most importantly, our patients have given us one of the highest satisfaction scores of any hospital in the NHS.

As a result of the initiative the trust is developing a more performance oriented culture. Staff's personal contribution to trust goals will be assessed as well as their behaviour relative to the Trust's values. The assessment of contribution and behaviours is likely to enable local pay progression and other discretionary payments, and also inform a future talent management strategy.

Financial implications

The board invested £1m of its surplus to support the delivery of the QI strategy. This enabled the creation of the QI directorate. Most projects have not required additional financial resources apart from staff time.

Patients who are harmed in hospital have a longer length of stay. Reducing harm has a financial benefit in liberated bed days. This has enabled the trust to accommodate additional service developments and patient activity without the need for additional beds — and this year it is enabling bed reductions. In 2009–10 the trust has admitted 5% more patients than in the previous year without the need for an increase in beds.

The trust is also on track to deliver a £200m private funding initiative to redevelop the hospital. The £12m additional revenue charge associated with this development is largely being found through the liberated beds associated with improvement activity.

It is also is participating as a national pilot to determine a tool that can distinguish hard cash reduction as a direct consequence of harm reduction.

Pilot "perfect care" wards are implementing all improvement/change packages simultaneously and recording cost consequences capable of comparison with other wards in this and other hospitals. This will allow a clearer understanding of the association of harm reduction with cost reduction and the return on investment of quality improvement.

Contact

For more information on this initiative please contact Jane Burns: *jane.burns@srft.nhs.uk*

FINALIST

University College London Hospital FT

This organisation received a *Judges' Commendation* for the high quality of its entry

The initiative

University College London Hospital (UCLH) was one of the first trusts to produce quality accounts in 2009, as part of the preparation for introducing them across the NHS in 2010. Performance was reviewed against four priorities:

- Improving overall patient satisfaction;
- Reducing hospital standardised mortality;
- Reducing in harm from falls;
- Developing quality scorecards in all divisions.

The emphasis on measuring quality improvement is the backbone of our work and informs our priorities.

We are ensuring we link improving quality to reducing cost to embed sustainable services for the future. To deliver this we have embarked upon a trustwide, quality, efficiency and productivity programme that shares innovation and accelerates improvements in quality and efficiency.

We delivered improvements by implementing the following:

- Executive safety walk rounds facilitated by human factors expert;
- Patient safety and quality sub-committee of the board, attended by the Chair and CEO;
- Training a cohort in LEAN and Six Sigma who are moving on to develop an ongoing improvement network with 50 improvement leaders;
- Presenting actions and learning from complaints and serious untoward incidents across the organisation to share learning and prevent similar issues in other areas.

To customise improvement efforts, we introduced patient surveying via handheld electronic devices in June 2009. This is monitored centrally, but more importantly, staff are now able to obtain weekly feedback on a range of issues from cleanliness to quality of interactions with doctors and nurses.

Wide engagement including corporate support and director leadership has raised the profile of this important aspect of service delivery. In many instances it is the frontline staff who determine the type and rate of improvement strategies.

Benefits

The most significant benefit has been a reduced hospital standardised mortality ratio (HSMR) from 0.8 to 0.62 in June 2010. In addition, there have been the following improvements:

- Reducing harm from falls — the percentage of falls with harm has decreased from 11.63% of all falls to 2.67%;
- Implementing the World Health Organization safety checklist;
- Improving overall patient satisfaction — average score for patient satisfaction rose from 80 in 2008 to 84 in 2009;
- Developing quality scorecards in all divisions;
- Improvement in clinical support services — for example the turnaround time for pathology specimens fell from 149 minutes to 54 minutes.

Financial implications

Improvement in the four priority areas was achieved with a very small financial investment. Three senior members of staff were added to lead the quality and patient safety agenda. Work to support reducing HSMR and falls, and to develop the scorecards was managed within the existing divisional and corporate teams. Handheld devices used to conduct patient satisfaction surveys were purchased with charitable funds, with UCLH volunteers carrying out the surveys.

Reducing falls and improving infections has ensured a low length of stay for our non elective patients. Our average length of stay is four days for general medical patients, where our peers have a value of 6.4 days. This saves 19,155 bed days, 52 beds, or £2.6m a year.

Contact

For more information on this initiative please contact
Donna Elliott-Rotgans: *donna.elliott-rotgans@uclh.nhs.uk*

FINALIST

Aintree University Hospitals FT

The initiative

In 2008–09 the trust began an initiative to reduce infection rates for *Clostridium difficile* following a significant outbreak. Our staff successfully delivered a year on year reduction in our infection rates. The experience left the board and staff clear that patient safety would be the key to how we exceed the expectations of patients, GPs and commissioners.

The trust decided to create a safety culture, improving the quality of services and reducing patients' chances of being harmed.

The trust board reviewed the strategic framework and infection prevention and control (IPC) improvement became the main priority. The board agenda was reorganised to have quality and patient safety lead each meeting, a position it retains. Directors provided leadership, support to staff and approved £2.2m investment to improve IPC standards. Visible ownership by all directors, including safety walkabouts, ensured all staff knew this was the trust's priority. A significant education programme and communications strategy engaged staff, patients and visitors.

With *Clostridium difficile* rates successfully reduced and maintained the momentum was used to broaden the safety focus. The quality board adopted specific workstreams. Clinical and managerial staff who had visited Johns Hopkins Hospital in Baltimore formed the "Baltimore Group", using their spare time to develop new safety initiatives owned at ward level.

IT developments included dashboards to give board assurance and multidisciplinary teams helped develop other systems to support patient safety and quality. An electronic appraisal system was introduced to support positive behaviours and ensure links between personal objectives and our vision.

The trust did not lose sight of other key priorities, and successfully delivered ambitious capital developments while meeting quality, performance and financial targets.

The trust's elective care centre (ECC) was opened in June 2010, having been constructed on time and to budget. The ECC is key to our clinical and quality strategies, as it enables us to become a single site trust by moving day surgery and outpatients services from the Walton Hospital to the main University Hospital Aintree site. Being single site and the improved clinical linkages will enable us to increase day case procedures from 8,000 to 10,000. Having the full support services from the acute hospital enables increases in the range of procedures offered as day case.

A £9m programme to invest in radiology services was progressed, installing state of the art equipment while creating separate areas for inpatients and outpatients. This is improving clinical standards along with the patient pathway and experience.

Benefits

The major benefit of the initiative is that the trust is safer now than it was before. Our excellent hospital standardised mortality ratio rates continued improving to 77.9 for 2009–10, meaning 320 fewer deaths than benchmarked predictions.

Clostridium difficile cases were cut by 70% from 341 in 2008–09 to 103 in 2009–10, against a trajectory of 201 cases. MRSA cases were reduced by a third from 28 in 2008–09 to 18 in 2009–10, against a trajectory of 24. CQC and the DH visits gave positive reports. The medical emergency team responded to 600 call outs by July 2010, with a year on year one third reduction in cardiac arrest calls.

Financial implications

The trust board invested £2.2m to support the improvement in infection prevention and control standards. This paid for the opening of an isolation ward, an enhanced deep cleaning programme, the creation of a fast cleaning unit and supported IPC nursing recruitment.

Contact

For more information on this initiative please contact
Fin McNicol: *fin.mcnicol@aintree.nhs.uk*

Acute healthcare organisation of the year

FINALIST

Countess of Chester Hospital FT

The initiative

The Countess of Chester Hospital Foundation Trust has embarked on an initiative that is transforming our culture, fundamentally changing our working practices, 'leaning' our pathways and processes, and developing our leadership to motivate and inspire staff. This programme focuses on cultural change — the new "Countess Way" of doing things will be radically different from the way we have traditionally worked.

The initiative began in January 2009, supported at first by Unipart Expert Practices. After early stages of visioning, assessing our readiness for change, and creating the conditions for change, the key workstreams have:

- Created an accredited leadership and management development programme to motivate and drive cultural and process improvements and promote innovation;
- Developed a new performance management framework;
- Redesigned human resources structure and processes;
- Redesigned communication and staff engagement;
- Restructured management teams;
- Introduced new standardised working practices;
- Developed a comprehensive quality improvement programme to ensure best practice and reduction of harm;
- Redesigned emergency and elective patient pathways.

The initiative has given frontline staff, managers and clinicians the time and facilities to redesign key areas.

Benefits

Wards that have been subject to the initiative are able to demonstrate significant reductions in lengths of stay, for example:

- Respiratory ward, baseline 14.30 days, current 11.77 days (18% reduction);
- Stroke/neurology ward, baseline 11.43 days, current 9.92 days (10% reduction);

We have achieved a 62% reduction in *Clostridium difficile* rates and 55% reduction in MRSA over 12 months, and a reduction in falls per 1,000 bed days of 27%. Standard mortality rates (SMR) have continued to reduce and for the past three months have averaged just below an SMR of 60.

The staff absence rate has been reduced by 1% to an average of 3.47% sustained over the last six months, equating to a recurrent productivity saving of £500,000 in the past 10 months;

Overall staff numbers have been reduced by 80 through organisational redesign and improved efficiency. This equates to recurrent savings of £1.4m

The numbers of delayed discharges has been reduced from 5.3% to 1.8% through process redesign and the number of cancelled operations by 25%. In addition, staff and patient satisfaction surveys show sustained improvement over a range of indicators.

Financial implications

An initial one off investment of around £1m was made to support the programme; the return on that investment currently equates to £2.4m of recurrent savings and cost avoidance. The current and next few years' investment is anticipated to be approximately £250,000 a year, required to accelerate the speed of change. The initiative is expected to achieve annual savings of £6.5m over the next three years.

Contact

For more information on this initiative please contact Peter Herring: *peter.herring@coch.nhs.uk*

FINALIST

King's College Hospital FT

The initiative

King's College Hospital is both a leading teaching hospital and a local hospital embedded in a diverse inner city local community. Our world class specialties are largely driven by the health problems of the local population — and its diversity helps us in our research and development work as our local clinical trials can involve patients of many different ethnic origins.

Being able to deliver a first class service for patients also entails constant improvement and monitoring our performance. King's has an ongoing programme of improvement that covers a wide range of topics. Each separate work stream is made up of multidisciplinary teams facilitated by an inhouse change manager. These are fed by a performance management system across the trust. Our current management priorities are to:

- Improve patient experience, length of stay and patient flows;
- Redesign outpatients;
- Redesign our workforce;
- Improve medical productivity;
- Improve our business intelligence.

We have established an information and performance analysis team to provide a comprehensive reporting and information analysis service. Data is collected by a sophisticated reporting database, which includes an electronic patient status board system and Galaxy (Theatre) system.

We produce 72 performance scorecards at trust, division and specialty/team level. These are used at regular meetings to inform decision making, right down to ward level. Scorecards include key performance indicators measuring clinical effectiveness, patient safety, patient experience, operation and finance efficiency and staff capability.

Benefits

Satisfaction with patient care has risen steadily year on year. Our *How Are We Doing?* survey, which forms a key part of our performance management system, regularly achieves a response rate of more than 1,300 patient responses a month. Between November 2006 and March 2010 King's has improved its overall patient satisfaction score by 10%.

As wards now have specific information about their own areas, rather than general trustwide information, they can act on this to effect changes to benefit their patients. The detailed performance framework helps us use information intelligently. We can monitor activity and results across a wide range of measures, from infection control to average length of stay or same sex accommodation to progress on national targets.

The availability of detailed activity based costing systems has also been invaluable for the joint clinical/management teams of divisions to understand the differences in each element of the unit cost and the impact by volume of activity.

Financial implications

Our performance scorecard system was developed in house at no cost to other than the time and effort of the staff involved.

We estimate that by automating the access to information, we have saved around four analyst posts — an annual saving of around £100,000. We anticipate improvements in length of stay, infection rates, patient experience and safety and these will result in improvements in waiting times and throughput of patients — all of which have the potential to add value.

Contact

For more information on this initiative please contact Chris Rolfe: *chris.rolfe@nhs.net*

Primary care organisation of the year

WINNER
NHS Western Cheshire

Background
When it was formed in 2006, NHS Western Cheshire was the poorest performing PCT in the North West. We decided that in order to fulfil our core purpose of enabling our population to live longer, healthier lives we needed need to target services to those who need them most. At the same time we would not compromise on the following commitments:

- The safety of patients and the experience of care received is our highest priority;
- We always seek to reduce health inequalities;
- We always work to increase life expectancy;
- We always operate in financial balance.

The process
Early focus on governance has secured processes with patient safety and quality at the heart of the organisation. The desire to ensure services reach those who need them and will benefit most has led us to become an intelligence driven organisation able to operate in a complex strategic environment. The use of intelligence to drive decision making and the local quality innovation productivity and prevention agenda is exemplified through our approach to GP quality profile and peer review processes, clinical risk stratification and practice based commissioning (PbC).

With this on mind we have formed partnerships with providers such as Map of Medicine and Bupa HealthDialog to support intelligence driven commissioning.

Quality improvement has been strengthened by embedding clinical leadership and engagement, aligned to a mature PbC consortium and wider clinical networks. Practice based commissioning has allowed us to manage unwarranted variations and make financial savings. Our partnership with the consortium is supported with management resources and board commitment. We are established as local leaders across strategic partnerships and are committed to integrated health and social care including joint posts.

Advice to other organisations
Our approach to transformation has included:

- Clinical risk stratification and predictive modelling;
- Map of medicine;
- Partnership working;
- Management of unwarranted variation;
- A programme of quality improvement.

Each of these is applicable to other organisations. We are actively sharing our work with neighbouring PCTs.

Benefits of the initiative
Benefits for clinical and non clinical staff from our intelligence led approach are considerable. Commissioning staff have improved access to information and can quickly draw on evidence. GPs report benefits of only having to deal with relevant information that quickly converts into improved outcomes for patients.

The GP peer review process resulted in prevalence of detected hypertension increasing from 13.7% in 2008–09 to 14.1% in 2009–10. We expect detection and treatment of hypertensive patients over the next five years to prevent 15 early deaths.

Award sponsored by

Boehringer Ingelheim

Clinical risk stratification and predictive modelling allowed us to actively case find patients whose care is less than optimum. The community matron caseload could then be targeted on those people most at risk of hospital admission. As a result emergency admissions were reduced by 400 a year. Early discharge with supporting care outside of hospital led to a 9% reduction in emergency bed days.

In addition partnership working has delivered measurable health improvement benefits for local people, including:

- 11% more four week smoking quitters in the first three quarters of last year compared with 2008–09
- An increase in infants breastfed at six to eight weeks old from 26.7% to 39.1% over the past year;
- A fall in teenage conceptions of 20% in 2008.

Our allocative efficiency service review programme ensures that we know what we spend our money on and what value we get. This has identified opportunities for £7.5m of savings within our current investments in the first wave of reviews.

Financial implications
As an organisation without the reserves needed to invest significant amounts of new money we have focused on achieving maximum value from existing investment. This has been done by developing and embedding systematic, repeatable processes. This approach has led to savings of:

- £700,000–£900,000 a year from 2010–11 onwards from caseload review and early supported discharge by community matrons;
- £7.5m from within our current investments identified by the service review programme. These are currently being implemented through a business case process;
- £3m from a reduction in acute demand in 2009–10 from an outpatient referral management pathway;
- £600,000 from a prescribing underspend in 2009–10.

As a result, within three and a half years of our formation, we have moved from a £42m deficit to achieving a year on year balanced control total.

Contact
For more information on this initiative please contact Helen Bennett: *helen.bennett@wcheshirepct.nhs.uk*

Judges
Andy McKeon, *managing director health,* Audit Commission

Drew Owenson, *sales director, Boehringer Ingelheim*

David Stout, *director, Primary Care Trust Network, NHS Confederation*

Steve Field, *chairman of council, Royal College of General Practitioners*

David Colin-Thome, *national clinical director for primary care, Department of Health*

Greg Quinn, *health policy manager, Boehringer Ingelheim*

HIGHLY COMMENDED

NHS Leicester City

Background

Leicester has one of the most diverse and disadvantaged populations in Britain. When NHS Leicester City was formed four years ago our approach was to embed national healthcare objectives in an programme aimed at tackling the two clinical conditions which lead to high local premature death rates: cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD).

We created a clinical cabinet with prominent roles for clinical consultants, and a commissioning executive built around the leads of new GP clusters, which cover the whole city. This has put us in a strong position to achieve our aims in the face of a challenging financial climate and to transfer key commissioning roles to GP consortia by 2013.

We are addressing CVD and COPD with initiatives that simultaneously tackle many underlying causes of premature death including:

- Smoking cessation;
- Healthier eating and increased physical activity;
- Reduced alcohol related harm;
- NHS health checks;
- Patient risk stratification;
- Personalised care plans;
- Better coordinated care for those suffering diabetes, stroke and major trauma.

We are also re-organising unscheduled care, addressing inappropriate use of A&E and avoidable emergency admissions. We are refocusing primary medical care onto prevention, greater patient choice, and care closer to home. The redesign of unscheduled care is improving patient experience, safety and outcomes.

We have invested in better public facing communications with a free citywide health newspaper and a public patient membership of more than 5,000.

Benefits

Our revised contract with Leicester hospitals achieved significant savings. We are delivering safer services, with continued reductions in healthcare acquired infections. Recorded outcomes include better patient experience, with new health centres increasing choice and extended hours. We have also continued to reduce the maximum waiting times for treatment. Hundreds of patients, carers, voluntary groups and clinicians worked together to develop our new integrated community diabetes service, which has successfully moved care from hospitals into community settings and improved patients' self management of their conditions.

Data from the annual survey of 1,500 residents showed public satisfaction with the city's NHS rose by 5% in the last year. Last year's survey showed public concern with access to dentistry, which led to our commissioning more appointment slots. Afterwards public satisfaction with dentistry rose 7%, while 13% more people accessed an NHS dentist than in the previous year.

We ironed out historic funding differentials across our 66 GP surgeries through a local agreement which saw GPs cooperate in a shift of funds from the wealthier to the poorer, increasing cost effectiveness, quality of care, and improving GP relations. We opened a 24 hour urgent care centre alongside A&E, a walk in centre, and three new GP surgeries. Smoking cessation campaigns show record high rates of achievement, and our social marketing work to tackle teenage pregnancy has contributed to unplanned conceptions falling substantially.

Financial implications

Our funding has risen from £410.5m of net operating costs in 2006–07 to over £550m this year. Early in 2009 we analysed the impact of the economic climate and predicted that year on year funding would level out, while cost pressures and demand for NHS services would increase. We formally embedded this in renegotiating contracts with healthcare providers.

We are progressing towards saving £15.9m, using a programme based on enhanced quality, productivity, demand management, prevention and strategic initiatives, while redesigning unscheduled care. These measures include a reduction in management costs this year by 30%, which we can reinvest into frontline services. The programme is projected to deliver cumulative recurrent return on investment savings of £109.7m over the four years to March 2014.

Contact

For more information on this initiative please contact Geoffrey White: *Geoffrey.White@LeicesterCity.nhs.uk*

FINALIST

Horizon Health Commissioning

This organisation received a *Judges' Commendation* for the high quality of its entry

Background

Horizon Health Commissioning Ltd was established by 26 GP practices in 2006 supporting a population of 169,000 and a budget of £115m.

The basis of our commissioning approach is that we will:

- Commission on the basis of hard evidence;
- Commission services in direct relation to their clinical effectiveness;
- Decommission services where outcomes cannot be achieved within acceptable timescales;
- Explicitly commission services that reduce local health inequalities and preventable causes of death;
- Commission services which increase measurable patient satisfaction;
- Encourage residents (armed with appropriate information and support) to take more responsibility for managing their own health;
- Target public health campaigns to reduce smoking, obesity and misuse of drugs and alcohol, and improve sexual and mental health;
- Set measurable standards for provision of primary care;
- Build patient confidence in primary care as an alternative to hospital care;
- Involve the local population in the setting and delivery of healthcare strategy.

We have defined PBC strategies in urgent care, long term conditions and planned care using best practice applied to local service performance and health needs. We are implementing each strategy in a number of ways. In addition, we define and deliver care closer to home through implementation of numerous innovative local enhanced services (LES). We work with the prescribing team to drive improvement in prescribing practice and deliver targeted reductions in expenditure on medicines.

One recent example of how the PBC uses local feedback and data to drive commissioning decisions is in the high level and cost of emergency activity from local care homes where £2.7m was spent on emergency admission in 2009–10. The PBC commissioned an innovative multidisciplinary complex care team to address this issue and deliver savings while improving care.

Benefits

As a PBC, we have sustained lower levels of growth in emergency activity than seen elsewhere. A&E attendances at Bedford Hospital have risen by 0.58% a year since 2006 compared with 13% across England. Emergency admissions have been reducing by on average 0.9% a year since 2006 against a national trend of increasing admissions.

Following public consultation we are planning to reduce pressure on acute services through our urgent care strategy. The interim findings of our innovative complex care team pilot shows a 25% reduction in A&E use and 38% reduction in emergency admissions from participating residential and nursing homes.

We have been able to commission key services including:

- Musculoskeletal triage and treatment service;
- Community chronic pain service;
- Community gynaecology service;
- Hearing and audiology support services.

We have also been able to design and contract an evidence based community pulmonary rehabilitation service and home oxygen service.

Financial implications

Horizon Health Commissioning receives income from the PCT based on a per head of population basis. Projects and initiatives led by the organisation have varying scopes and timescales for achieving return on any investment.

The complex care team pilot is saving £31,000 a year in medication alone. The home oxygen service has resulted in more than £125,000 in savings since March 2008. Implementation of our urgent care strategy will potentially generate net savings of £11m over five years with a return on our initial investment in two years.

Contact

For more information on this initiative please contact Nisha Patel: *Nisha.Patel@horizonhealth.co.uk*

FINALIST

NHS South Gloucestershire

Background

This initiative was prompted by benchmarks that showed that NHS South Gloucestershire was spending more than average in the South West on hospital care. Shifting care closer to home is a strategic priority so to improve care and treat more patients in the community, the NHS South Gloucestershire, the practice based commissioning consortium (PBC) and North Bristol trust (NBT) worked together to reverse a trend of year on year increases in the number of patients being admitted to hospital.

Partners examined national evidence to agree thresholds for care and the list of interventions not normally funded. The PBC consortium took ownership of and redesigned 10 care pathways where there had been the biggest increases in referrals with hospital clinicians.

In partnership we developed a range of community alternatives to hospital care, for example: extended scope physiotherapy service for peripheral joint problems, community DVT, urology and IV antibiotic services.

To ensure all parties had an equal interest in success, this partnership shared targets, incentives and objectives with a formal contract schedule. The PCT and the PBC consortium undertook to improve demand management while NBT agreed to a marginal rate for elective over performance. This provided powerful incentives for all parties to work together on delivering shared targets.

Benefits

The most important benefit of working in this way has been that more patients are treated in the community. Referrals to hospital in the final quarter of 2009–10 were 6.6% down on the same period in 2008–09. Our standardised activity ratio for GP referrals to hospital is 75. There has been no growth in non elective activity. GP with special interest services reduced referrals in their specialties by up to 40% and over 1,000 individual care plans were completed in six months.

In addition we have improved our World Class Commissioning performance from average score of 1.6 in 2008 to 2.4 in 2010 over the same 10 competencies. The Healthcare Commission ratings improved from "fair" for quality of services and managing resources in 2008 to "good" for both in 2009.

Financial implications

NHS South Gloucestershire has the fifth lowest budget allocation in England and a higher than expected reliance on secondary care. This gives us the opportunity to drive change in spending patterns to achieve our strategic objective of providing care closer to home.

Overall we have regenerated over £22m in three years. Of this we have invested £12m in community services for older people, learning disabilities, mental health, physical and sensory impairment and primary care services and facilities.

We are investing £31m in a capital programme that will deliver community facilities that will enable 37,000 outpatient appointments a year, including 12,000 diagnostic tests, into local communities.

We have delivered our savings programmes and either broken even or achieved a small surplus in line with SHA expectations while improving services. We use contestability to:

- Develop partnerships — for example a £2.3m children's service delivered by a partnership between the NHS and Barnardo's;
- Achieve a price advantage — for example alternative provider medical services contracts;
- Achieve quality improvements — for example new contracts in prisons;
- Promote market entry— for example end of life and urology services.

Contact

For more information on this initiative please contact Fiona Reid: *fiona.reid@sglos-pct.nhs.uk*

FINALIST

StHealth PBC

The initiative

The annual direct cost of chronic obstructive pulmonary disease (COPD) to the UK healthcare system is between £810m and £930m and is set to grow. Of those admitted to hospital with the condition 15% die within three months and around 25% die within a year.

This initiative was a joint working project with GlaxoSmithKline (GSK) to improve treatment and care of people with COPD by training healthcare providers to manage patients in the community. In this way it should be possible to slow the progress of the condition and reduce the number of unplanned hospital attendances.

The initiative began by taking baseline measurements

of the quality of primary care COPD reviews, GSK provided participating practices with POINTS software to record this.

At baseline only 33% were to National Institute for Health and Clinical Excellence (NICE) standard. We then changed the clinical data recording template. The QOF recording template was replaced with a NICE standard review template that would prompt nurses to comply with NICE. Nurse confidence and skill levels were assessed.

A 12 month educational programme was commissioned including differential diagnosis and accredited spirometry assessment. We met several times with stakeholders including respiratory consultants, pulmonary rehab, smoking support, the PCT, and community COPD nurses, to agree a pathway of care which all would work towards.

Eastern Region Public Health Observatory (EPHO) figures suggested StHealth PBC should have an additional 4,000 COPD patients by 2020. We agreed that we would proactively seek these out to improve outcomes. This was done by initial screening with a COPD6 FEV1 monitor. Abnormal results were followed up with full spirometry and further treatment as per agreed pathway. Initial results suggest that the EPHO figure is an underestimate.

Benefits

Practice nurses are now educated to a high level enabling them to treat patients to a higher standard and to manage patients in general practice where possible and appropriate. There has also been a reduced variability of care across StHealth practices. To start with only 32% of patients were receiving NICE standard reviews, data shows this has increased to 85%.

Patients are being diagnosed earlier due to the early detection aspect of the project. So far 1,737 at risk of COPD have been screened, of whom 243 have been diagnosed with COPD. This early diagnosis reduces the risk of disease progression, improving outcomes for patients and reducing future NHS costs.

Patients have been educated and are being provided with care plans so they are better able to manage their own condition. Smoking cessation advice is reinforced at all points of care.

Financial implications

The total cost of the initiative was £294,000. This was split 50:50 with GSK as part of the Department of Health defined joint working agreement. This figure includes human resource costs, education, software, equipment and a local enhanced scheme to fund some nurse time and to screen those at risk of COPD.

Secondary user service data from Dr Foster shows that emergency admissions with a primary diagnosis of COPD during the period April 2009 to March 2010 have reduced by 34% when compared with the same period in 2008–09. This equates to a potential saving of £487,000. If funds could be redirected from secondary care the project would have made a full return on its investment in year.

Contact

For more information on this initiative please contact
Andrea Gupta: *andrea.gupta@hsthpct.nhs.uk*

FINALIST

Torbay Care Trust

Background

Torbay Care Trust was established in 2005 with the intention to improve the quality and accessibility of care for the local population by reducing the bureaucracy that traditionally exists between health and adult social care.

We have reduced anxiety, delays and duplication for the most vulnerable within the communities of Torquay, Paignton and Brixham by having one point of contact for all our services. We have established multidisciplinary teams in each town and specialist roles, such as the health and social care coordinator designed to eradicate any unnecessary complexity from the care system.

Our strong relationships with other organisations also mean we can realise the benefits of shared skills, information and learning across boundaries. The partnership with South Devon Healthcare Foundation Trust (Torbay Hospital) continues to deliver benefits for the population, with very low maximum waiting times — less than 11 weeks across almost all specialties — and quicker and easier discharge back home or into community beds after treatment.

Our local zone teams make decisions that, while within the parameters of the NHS and care trust vision and methodology, are in the best interests of that particular community.

The formal partnerships which the zone teams have with local GP surgeries means that the full breadth of clinical and management/commissioning expertise can be drawn together to create a community focused approach to providing and commissioning care.

Benefits

Despite one of the worst winters on record, the accessibility of primary care and the success of preventive healthcare meant A&E attendance in Torbay actually dropped by nearly 1,000 between 2008–09 and 2009–10

Incidents of *Clostridium difficile* for the care trust as a commissioner have fallen from 89 to 63, thanks to a comprehensive programme of infection control, which was also rolled out into the independent sector.

On discharge it may be appropriate for patients to receive intermediate care; a recent but well established service means people are able to return home with safe, enabling support. Such services and the success of the joint discharge team helped to reduce excess elective care beds days from 1,731 to 948 (45%) and excess non elective beds fell from 3,086 to 2,808 (9%), between 2008–09 and 2009–10.

Financial implications

The care trust manages a joint budget from both health streams and the local authority as part of the delegated social care responsibility. The joint gross operating costs in 2009–10 were £310m.

Last financial year the care trust again met its three key financial targets:

- Achieving a surplus;
- Recovering costs in relation to its provider function;
- Maintaining capital expenditure within the resource limit.

This is despite absorbing challenging budgetary constraints from both health and social care.

The success of the joint discharge team in reducing excess elective and non elective care beds days, between 2008–09 and 2009–10, represented a cost reduction of £287,217.

Investment has been required in order to develop a community health and social care provider arm but this has occurred in parallel with a drive to realise benefits from working with social enterprises and other independent providers. The result is a reduction of £1m in the provider arm costs between 2008–09 and 2009–10.

Contact

For more information on this initiative please contact
Simon Blackburn: *simon.blackburn@nhs.net*

WINNER

Primary care chest pain clinic

Kosta Manis, David Brennand-Roper and Clare Ross

Bexley Medical Group

Background

More than 80% of chest pain has no cardiac origin. National and local data shows a clear need for more accurate, less invasive diagnostic tests for heart patients. The Bexley Community Cardiology Service fulfils this need. Our scheme, with a cardiologist at the "front care" and improved triaging, ensures we only deal with genuine cardiac pain, providing a better service for all patients — at a far lower price.

The initiative is GP driven, offering top quality, low cost service close to patients' homes by applying practice based commissioning principles. We set out to prove that GPs can offer their patients NHS healthcare that is better than any private medical scheme.

The process

Bexley's primary care chest pain clinic provides world class cardiology care to patients in some of the country's most deprived areas; the service cuts waiting times and offers more accurate diagnosis, which takes a fraction of the time of traditional diagnostic methods, is safer and prevents unnecessary intervention.

The first cardiology diagnostics clinic started in 2007 at a GP's surgery in Bexley, with state of the art equipment. It included standard ECG, 24 hour ECG, 24 hour blood pressure monitoring and echocardiograms.

Soon afterwards, four local GP surgeries offered a weekly specialist cardiology clinic with diagnostic tests and consultant appointments, as well as services from heart failure nurses. A rehabilitation scheme is also provided in the community. Patients are seen within a week of being referred, rather than having to wait for at least eight weeks.

Combining all these services into the clinics provides a one stop shop for residents and reduces pressure on local hospitals. The clinic is safe, effective and at the patient's doorstep (our cardiology bus literally picks patients up from their front door), providing 100% accuracy and no risk.

Advice to other organisations

Our initiative is an example of services being driven by those most in need, rather than imposed from above, with an approach that is starting to be echoed in other schemes and initiatives. The Department of Health has recognised Bexley primary care chest pain clinic as the leading example of GP commissioning and the first initiative of its kind to put patients at the heart of healthcare, and to achieve 100% positive results, while reducing costs.

Benefits of the initiative

The clinic produces 100% accurate test results, saving lives while preventing unnecessary suffering, at less cost than traditional care pathways. Patient evaluation shows 100% satisfaction.

The best example of how the primary care chest pain clinic has transformed care is the introduction of a groundbreaking piece of technology. The Aquilion ONE scanner took 10 years to develop, at a cost of $500m. There are two in Europe and only one in London. It is the world's first dynamic volume CT (computerised tomography) scanner, which can scan a heart in a single heartbeat while administering a fifth of the radiation dose of conventional scanners.

The time taken to treat patients is dramatically reduced. They are taken to Harley Street in transport provided by Bexley Care Trust. The scanner's findings are checked by a highly specialised consultant from King's College Hospital. Those with normal results return home and those in need of intervention are treated promptly and can even be added onto the intervention list the next day if necessary at either King's or St Thomas's Hospital.

Financial implications

Using the CT scanner is far more cost effective than traditional, often inaccurate and potentially risky stress tests and angiograms. As well as taking a fraction of the time (a few seconds, compared with weeks) the CT scan costs less.

The scheme was funded by Bexley Care Trust, which showed remarkable foresight in giving GPs the power to design services. It has delivered savings of £300,000 against traditional outpatient angiogram pathways each year since it started in 2008. More accurate diagnosis means £1,000 is saved every time a patient is prevented from having an unnecessary angiogram, not to mention the hidden costs of misdiagnosis. Accurate results also mean a further £500 is saved each time a patient is prevented from further consultant visits.

Future plans

Following presentations by our team to GPs and commissioners in the neighbouring boroughs of Greenwich and Bromley, a formal process has started to create a cardiology company covering the GPs of all three primary care trusts.

This entry was also winner of the **Patient centred care award and a finalist in the **Quality and productivity** category*

Contact

For more information on this initiative please contact Jon Hanlon: *jon.hanlon@bexley.nhs.uk*

Award sponsored by

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Judges

Ian Dodge, *director, Policy Support Unit, Department of Health*

Bernard Crump, *chief executive officer, NHS Institute for Innovation and Improvement*

Mike Sadler, *medical director, Serco Health*

HIGHLY COMMENDED

Lighten Up weight loss programme

Jane Beach and John Denley;
NHS South Birmingham

The initiative

Several studies have shown that weight loss improves the entire risk factor profile. NICE recommends that first line treatment for obesity is a supported weight loss programme aiming to achieve a weight loss of over 5%. Lighten Up was established as a public health intervention as part a broader local obesity strategy. Following consultation with local GP groups, it was decided to develop a population approach to delivering weight management services to patients with a BMI over 30.

A business case was developed and local delivery plan (LDP) funding obtained. Using this, a client management system and call centre was set up. The primary care trust (PCT) negotiated a standardised reporting process with seven local providers.

The delivery pathway starts by GPs writing to patients with a recorded BMI of 30+ inviting them to contact the call centre, When they do this they are offered a choice of seven different 12 week weight management programmes. Once the patient has chosen a service, staff at the call centre:

- Log a call reminder for first appointment, and follow this up after the first visit offering the chance to change programme;
- Liaise with the service provider to make sure attendance and weekly weights are recorded;

At 12 weeks clients are provided with a 12 months maintenance pack and an agreed follow up schedule.

In the nearly two years since the programme began 5,240 patients (average BMI of 34) have accessed the service. For these people average weight loss at three months is 5.6% of body weight (n=4,837), 5.1% (n=3,143) at 12 months. Eighty three percent of patients who access the service live in PCT deprivation quintiles 1 and 2, and call centre staff are now linking callers to other lifestyle services. The total cost per patient for a year is £68.

Benefits

Immediate benefits are that:

- Referrals to specialist weight management services for patients with a BMI between 30 and 40 have reduced by 45%;
- Prescribing for weight management has slowed;
- The service is a preferred option for patients.

In addition Lighten Up has helped the PCT to redesign the obesity treatment pathway, and demonstrated the potential impact of public health initiatives on service costs.

Financial implications

The project was given an LDP allocation of £198,000 for a one year pilot. The decrease (n=140 patients) in referrals directly to specialist weight management services produced an immediate saving to the PCT of £168,000 in one year. In addition, the PCT prescribing of obesity medication increased at a slower rate compared with the UK average, resulting in an estimated saving of £61,000. This means that the project has resulted in a saving of £229,000 for an initial investment of £198,000.

The partnership with the private commercial organisations has also proved significant. We have decommissioned one of the NHS services originally offered because it cost three times as much as commercial organisations and was not as effective.

Contact

For more information on this initiative please contact Jonathan Hill: *jonnie.hill@nhs.net*

FINALIST

Driving improvements in tertiary neuro-rehabilitation

Lynne Turner-Stokes and Kellie Blane;
The London Specialised Commissioning Group

The initiative

The London Specialised Neuro-rehabilitation Consortium (LSNRC) was set up in April 2007, as a result of a 2001 neurosciences review. The LSNRC's remit is to commission complex, intensive specialised inpatient neuro-rehabilitation. Treatment is provided by nine NHS and independent specialist centres.

The 2001 review found excessively long waiting times were leading to patients missing the critical window of opportunity for rehabilitation. In addition, patients were having abnormally long stays in inappropriate settings with high cost to the NHS. The review recommended:

- Tackling service fragmentation by moving away from primary care trust level spot purchasing;
- Building a more consistent, outcomes driven service;
- Pooling resources and expertise in a collaborative network, creating opportunities for peer support.

In order to accomplish this the LSNRC obtained agreement from all the PCTs across London to contribute funding into the consortium.

Having done this the consortium:

- Synthesised a single service commissioning specification;
- Constructed a universal dependency and capability measurement scale and assessment process;
- Reviewed the care pathways to find inconsistencies;
- Established the consortium itself with its constitution, management protocol and recruited members;
- Introduced market management arrangements including a pricing policy to remove any perverse incentives.

Benefits

The consortium has brought several benefits to the key stakeholders, including; equitable access, focus on quality and outcomes, clinical and patient/carer involvement,

It has also resulted in the elimination of excessive delayed discharges through the trim point charging mechanism which, by transferring the cost of overstaying patients to PCTs at day 15 of the agreed discharge date, incentivises PCTs and their local authority partners to work together to discharge patients.

Before the consortium was set up waiting times were up to six months; in 2009–10 they averaged eight weeks. The consortium negotiated reduced OBD rates across the nine centres, on average a 20% discount on the standard unit price. In addition the was a reduction in delayed discharges.

Financial implications

The initiative required no additional resources. There were substantial savings made, capped tariffs across all providers saved of in excess of £750. Cumulative savings since the consortium came into operation in 2007–08 include; incorporated 1:1 specialing into the OBD tariff £182,000; reduced length of stay from an average of 16 months to six months, saving of over £1.2m

Contact

For more information on this initiative please contact Kellie Blane: *kellie.blane@londonscg.nhs.uk*

FINALIST

New model of community eye care provision

Julian De Silva and Tim Jollyman
Moorfields Eye Hospital FT

The initiative

Moorfields Eye Hospital Foundation Trust was approached by Direct Local Health (DLH), a local practice based commissioning group, to assist with the development of a clinical assessment and treatment service (CATS) for local patients in a branch of Boots located in the centre of Watford's main shopping precinct.

This pilot project has been running since December 2009. It is a three way partnership between Moorfields Eye Hospital NHS Foundation Trust, Boots Opticians and DLH. The aim is to:

- Enhance the management of patients within primary care;
- Actively manage the demand for secondary care services;
- Ensure that patients have timely advice and treatment.

Initial patient feedback and clinical audit have confirmed that the service meets patient expectations and is compliant with national guidance. As a result, it is being expanded to play a larger role in the management of common conditions.

Moorfields provided DLH and Boots with sub-specialty trained senior medical staff. Initially, these staff set up referral and triage arrangements with the local primary care trust and general practitioners. They then trained Boots' customer service staff and opticians to work as part of a consultant led multidisciplinary clinical team. State of the art ophthalmic imaging equipment facilitates this clinical assessment in one visit. The senior medical staff also provide telephone advice for local GPs.

Half day clinics are run four times a week, during which clinicians see patients with minor eye problems referred from the community triage scheme. Patients are subsequently managed within the clinic itself or referred for specialist care.

Benefits

Patients rate the new service highly with an average satisfaction score of 97% compared with 88% elsewhere. Clinical outcomes and adverse events have been evaluated using a modified global trigger tool combined with the Royal College of Ophthalmologists' definition of critical risk incidents. The results showed that 87% of patients had optimal management.

Financial implications

This initiative has come at no additional cost to Moorfields. We were fortunate in securing the support of a Darzi fellow, funded by NHS London. Income from the primary care trust pays for the staff costs of the multidisciplinary team, the accommodation and the equipment. The service also provides savings for the local health economy as it is delivered at significantly less cost than in a conventional hospital clinic setting.

Contact

For more information on this initiative please contact Kate Jeffreys: *kate.jeffreys@moorfields.nhs.uk*

FINALIST

Primary care ECG service

Caroline Westley
North East Essex Practice Based Commissioning

The initiative

North East Essex Practice Based Commissioning identified a need for patients to be able to access ECG services close to home. Eight GPs with interest in cardiac conditions were selected as providers with their practices as locations for the service. The GP providers meet PBC and PCT commissioners on a quarterly basis to review the service. ECG monitors were allocated to practices depending on practice population.

The service is provided to all patients from North East Essex Monday to Friday, with patients aimed to be seen within two weeks, and a full report including outcome and recommendations returned to the referring GP within four weeks.

Benefits

The primary care ECG service allows better management of patients within primary care. In the last two years the eight providers of this service have seen over 1,000 patients within North East Essex, with around 70% of patients receiving normal ECG results and therefore being discharged without having to enter secondary care. This reduction in secondary care referrals will assist in improving waiting times for diagnosis and meeting the referral to treatment 18 week target.

Financial implications

With the initial purchase of ECG machines being a one off, the only on going costs is £105 per patient to the ECG service providers. This sum includes the amount that must be paid for analysis by Express Diagnostics or ERT. In the 18 months that the service has been running 683 patients have been seen at a total cost of £71,715

If these patients had been referred onto secondary care at a cardiology outpatient cost of £189 first appointment, and £91 follow up appointment, costs would have been at least £129,087. Therefore savings for the 18 months the scheme has been running are at least £51,372

Contact

For more information on this initiative please contact Caroline Westley: *caroline.westley@northeastessex.nhs.uk*

FINALIST

Crisis intervention community support service (CICSS)

Hazel Buchanan and Sheila Price
Nottingham North and East Consortium PBC

The initiative

Our PBC cluster recognised that sometimes patients were admitted to hospital because their moderate illness had made them particularly vulnerable and they did not have a support network in the community. We did not have "step up" interventions and wanted to develop a simple solution to deliver care in the home and work closely with GP practices.

Our objectives in setting up the initiative were:

- To provide rapid response and intensive support over a four week crisis period;
- To support individuals and carers in their own homes;
- To provide efficiencies and deliver a good quality service;
- To reduce unplanned hospital admissions.

Initially CICSS was set up as a 12 month pilot. The criteria for the service was a rapid response within a minimum of one hour of referral and intensive care over a four week period.

The British Red Cross put forward a proposal for the pilot and were able to go live with the service in six weeks. The pilot has proven a success for the consortium and we are planning on implementing it as an ongoing service.

Benefits

The service contributed to a reduction in hospital admissions; the current position is that it has avoided a hospital admission in 18% of referrals. Patient surveys have demonstrated that the pilot improves quality of life for patients and carers. It has also improved patient care by integrating the input of other agencies and services in the community.

Financial implications

The pilot cost £151,000 for one year, coming from innovation funds. Return on investment was achieved within the first year due to efficiency and hospital admissions savings: it is estimated that in 18% of referrals a hospital admission was avoided. An average cost of £2,650 per admission this means that savings on admissions are £228,960.

In addition the service can save an average of £30,864 in practice and community resource costs based on 480 referrals. As such, total gross savings in one year are £259,824.

Contact

For more information on this initiative please contact
Hazel Buchanan: *hazel.buchanan@nottspct.nhs.uk*

FINALIST

Emergency care practitioner scheme

Gareth Bennett and Rob Gorringe
SSAFA Hallam Care

The initiative

Following the national publications of *The NHS Plan* (2000) and *Reforming Emergency* Care (2001), and *Our Health, Our Care, Our Say: a new direction for community services* (2006), Doncaster PCT identified that a new unscheduled care service was required for the population of Doncaster.

The Doncaster emergency care practitioner scheme provides a new, ambitious model of care that delivers first line patient assessment and treatment for minor and moderate illness and minor injuries to the population of Doncaster.

The service has been created from scratch. The first step was to incorporate a company (SSAFA Hallam Care LLP) with a management structure and board of directors. This company recruited a team of experienced ECPs, and sourced equipment. It then marketed the service to all community healthcare providers via local publications, leaflets and presentations. The next steps were to:

- Gain admission rights into secondary care for ECPs;
- Develop patient group directives (PGDs) with the PCT;
- Become members of the patients' panel;
- Become members of the unplanned care board.

An team of 12 emergency care practitioners of nursing or paramedic background deliver enhanced patient care in the unscheduled care setting 24/7. The team receives patient referrals from; ambulance service, care homes, community teams, district nurses, GPs, minor injury units, nurseries, pharmacies and schools.

These multiple referral pathways contribute towards a reduction in avoidable hospital admissions by providing safe and effective patient assessment, diagnosis, treatment, referral, review or discharge as appropriate at initial point of contact.

Benefits

The main aim of the ECP service is to provide a patient with the right skill, at the right time, at the right place. In the majority of cases this means the patients will be treated in their own home. The patients receive the appropriate medications at the point of contact and referral to other community/social teams if needed. Patient evaluations have found no negative findings and that every patient or carer who has received care from an ECP has been very happy with the service.

Financial implications

A significant amount of money was required to set up the service and pay initial rental requirements, however a break even point should be reached by the end of year 2.

The ECP service has created significant cost savings for the PCT; by the end of year 1 Doncaster NHS should make a saving of £1m. This will continue to increase over the remaining term of the contract as more patients will be seen at home instead of being transported to hospital.

Contact

For more information on this initiative please contact
Alex Munro: *alexmunro@hallammedical.com*

FINALIST

KingMark calibration marker that calculates the radiological magnification of the hip

Richard King
University Hospitals Coventry and Warwickshire Trust

The initiative

More than 55,000 hip replacement operations are performed each year in the UK. Current estimates suggest that replacement hip size is correct in only 30% of cases, costing the NHS thousands of pounds every year.

Orthopaedic surgeon Richard King developed an innovative medical device, KingMark, which is the first licensed tool to measure patients for hip replacements accurately.

The invention includes a simple kit for measurement and comprises a pad with an incorporated measurement system. The kit has been developed so that it is easy for radiographers to use. The device is making a global impact in the orthopaedic world and was launched in the US market in March with great success.

Benefits

A more accurately determined hip size means improved positioning of the implant and this reduces wear, which reduces the revision rate. The new system is less intrusive for patients, is more accurate and also particularly useful in measuring larger patients. More reliable measurement also leads to efficiency and time savings from orthopaedic surgeons and reduced risk of complications.

Financial implications

The main development cost was staff time, estimated to be around 300 hours in total. KingMark was licensed to Voyant Health Ltd, which has paid the patent costs and spent significant amounts on further project development and marketing. The trust received an upfront payment for a licence fee and will receive a percentage of the net sales.

Typical costs to the NHS of revision are £1,800 per joint, plus surgery and aftercare costs of about £2,000. Reducing the revision rate by 10% would save the NHS around £1.9m per year.

Contact

For more information on this initiative please contact
Sally Gillespie: *sgillespie@bell-pottinger.co.uk*

WINNER

Increasing the uptake of breast screening

Paul Collins and Esther Trenchard-Mabere

NHS Tower Hamlets

Background

The national breast screening programme has a screening target rate of 80%. The London borough of Tower Hamlets had among the lowest screening rates in the country at 51%, compared with 75% nationally.

As part of a whole systems approach to increase uptake of breast screening, NHS Tower Hamlets commissioned a social marketing intervention to increase breast cancer screening rates among white and Bangladeshi women aged 50 –70 in the area.

Breast cancer is the second most common cause of death from cancer among women in Tower Hamlets and, contrary to England overall, the area has not seen any increase in the registrations of breast cancer since the introduction of the NHS mammographic screening programme 19 years ago.

While recognising that this is partly due to reduced prevalence of breast cancer among Bangladeshi women, NHS Tower Hamlets also needed to respond to lower survival rates for women with breast cancer, which may be as a result of them presenting themselves at more advanced stages of the disease.

The process

Two forms of research were conducted to inform the initiative:

- Primary — interviews with key stakeholders and desk research;
- Secondary — focus groups with women from the target audiences.

The research showed that while Bangladeshi women were not opposed to screening, they did not know about it or think it was relevant to them. White women did know about screening, but their fear of finding cancer was so strong that in their minds it outweighed the benefits of screening.

Following the research we worked collaboratively to develop a number of social marketing interventions including:

- Working with the community group, Social Action for Health, to support Bangladeshi women to attend screening appointments;
- Two marketing campaigns. One, aimed at white women led by two local women from Tower Hamlet, the other aimed at Bangladeshi women led by a local GP. The campaigns gave positive messages about attending breast screening as part of taking care of their health;
- Events at bingo halls, local supermarkets and community centres;
- Breast screening health page and cartoon strip in a local free paper delivered to 98,000 homes in Tower Hamlet.

A service review had highlighted a number of areas where we could improve the supply side of the service, so alongside these intervention we also:

- Appointed a GP cancer screening lead;
- Introduced text messages from practices to remind women to attend appointments;
- Piloted in scheme in two GP practices to call women before they receive their invitations to encourage them to attend;
- Organised support and translations by health advocates at the screening unit.

Advice to other organisations

The initiative used research techniques that could be useful for any social marketing project, UK wide. The use made of the research was specifically to our local target audiences, but there is no doubt that areas in the UK with a similar demographic could replicate the work.

Benefits of the initiative

The initiative is contributing to a continuing increase in the uptake of screening Tower Hamlets: breast cancer screening coverage was 63.5% in March 2009 (an increase in 10% from the previous year) compared with 64.5% in London and 76.5% in England.

An independent survey into the effectiveness of the media campaign was undertaken with the target audience in June 2008. This reported:

- 30% awareness of the campaign was achieved in the target audience;
- 94% believed it was important women attend screening;
- 40% in the target area had seen materials promoting screening.

Financial implications

The initiative cost £106,000 for the research and implementation. It resulted in an increase in the number of women screened, which would have a cost saving to the NHS. However this has not been quantified as a cost benefit analysis was not undertaken for this project.

Future plans

We are developing talking invitations for women who cannot read or who use a spoken only dialect such as Sylheti for the 2010 screening round. We are also intending to introduce a helpline.

Contact

For more information on this initiative please contact Jacqueline Katz: *jacqueline.katz@thpct.nhs.uk*

Award sponsored by

nsmc leading behaviour change

Judges

Ray Jones, *head of marketing and communications, The Chartered Institute of Marketing*

Sheila Mitchell, *marketing director, The Department of Health*

Dame Yve Buckland, *chair, NHS Institute for Innovation and Improvement*

John Bromley, *director, National Social Marketing Centre*

HIGHLY COMMENDED

Sub21: reducing underage street drinking

Jan Thompson and Louise Pinkney; NHS North of Tyne

The initiative

Heavy and harmful drinking patterns have increased among young people in the UK, who experience the highest levels of binge drinking and lifetime drunkenness in Europe.

Youth drinking trends in North Tyneside reflect the national picture — a survey found that about two thirds of young people drink alcohol and more than half drink at least once a week.

Primary research identified three main drivers for underage street drinking;

- A lack of attractive, affordable activities for young people;
- Easy availability of alcohol;
- Low cost of alcohol.

Three pilot areas of Wallsend, Howdon and Battle Hill were chosen for the project, because they had particular problems with antisocial behaviour and alcohol related incidents.

A two pronged approach was developed under the campaign brand, Sub21. The aim was to support off-licencees and help them tackle illegal and proxy purchasing of alcohol, alongside a programme of youth led activities and events. Retailers were asked to place a voluntary ban on selling alcohol to under 21s during peak times. In addition, a 10 week rolling programme of out of hours activities took place on Thursday, Friday and Saturday evenings designed by and for local young people including graffiti, skateboarding, street dance, cookery, bodyfit, bike workshops and nail art.

Benefits

By running the two strands in tandem, the project has achieved an overall reduction in street drinking in under 18s and a 30% decrease in antisocial behaviour and alcohol related incidents. Evaluation streams pre and post initiative have found the project has achieved the following:

- Reached more than 3000 young people with over 400 of those taking part in activities on a regular basis;
- Recruited more than 25 local retailers;
- A third of young people surveyed attended Sub21 activities;
- 50% of young people surveyed reported "more to do around here now";
- Reduced binge drinking reported by young people, especially among females.

The Safe Durham Partnership has decided to roll out the Sub21 model in County Durham. Discussions are underway to do likewise in North Shields.

Financial implications

The initiative received funding from NSMC and Department of Health of £64,000. This was made up of £20,000 for research, £39,000 to implement both intervention strands and £5,000 to fund a programme coordinator.

The Pfizer UK Foundation awarded £42,750 to continue the project from the end of the pilot phase to March 2010. Since then it has received further funding within the region and a grant from Extended Schools to continue for the foreseeable future.

Contact

For more information on this initiative please contact Jan Thompson : *suzanne@sociallysound.co.uk*

FINALIST

House campaign to reduce risky behaviours

Debbie Smith and Mark Lemon; Kent County Council

The initiative

The House project's aim was to deliver the "Towards 2010 Target 50" by introducing a hard hitting campaign for young people that promoted public health messages on smoking, alcohol, drug misuse and sexual health.

In February 2008 service providers and commissioners across Kent who had a vested interest in changing risky behaviours among vulnerable young people convened a steering group to set out a strategy to deliver a campaign to effect positive behaviour change.

The campaign was to be undertaken in conjunction with other Kent initiatives to reduce alcohol related crime, reduce teenage pregnancies, and reduce smoking and drug use.

M&C Saatchi were awarded the contract for their innovative campaign idea and young people were brought together in focus groups.

These focus groups reported that young people did not want more health related messages. They were more concerned about peer pressure, self confidence, bullying and relationships and all they wanted was somewhere cool and fun to go, somewhere to hang out with friends. The result of this is House.

House turns an empty shop into a friend's house. The set looks like four rooms in a house. There are also added extras, an arcade dance, an Xbox, Wii and large screen TV as well as computers with free internet access. The Beat Project held music workshops once a week and these plus the other extras are a particular draw to young people and create the right environment for delivering appropriate lifestyle messages. 13,000 young people came through the House door in 12 months.

Benefits

Qualitative feedback from the 13,000 young people who attended House in the first year established that although young people enjoyed visiting House because of its environment, many felt inspired to make positive behaviour changes, such as giving up smoking, looking after themselves, learning respect and "staying out of trouble".

House has enabled partners to reach a wider group of young people, particularly those that are traditionally considered "hard to reach" and who would not normally access services and who are hard to reach with health messages.

Financial implications

The initiative cost £150,000 per year for three years, which covered 12 town centre shops across Kent. Once the House set and equipment was built most of the costs were to do with moving from town to town. This involved removal costs and reinstallation along with tenancy and legal costs. Following the success of the pilot it is our aim to set up separate and more permanent Houses in town centres. After the initial set up the costs will be the lease of shop premises and minimal staff to manage the day to day running of House. The participating agencies provide their service provision on an outreach basis and find it a highly cost effective way to expand their service delivery to new groups of young people

Contact

For more information on this initiative please contact Barbara Fairway: *barbara.fairway@kent.gov.uk*

FINALIST

Access and Connect: changing children's health

Marcel Berenblut;
NHS Barking and Dagenham

The initiative

In 2007, the national support team for health inequalities highlighted that the fact that given the growth in the under 19 population of Barking and Dagenham and the challenging health outcomes meant there was a need for major change in the approach to young people's health behaviours. In response, a three phase approach to changing to children's health was developed jointly by NHS Barking and Dagenham and the London Borough of Barking and Dagenham. The joint project group set out to improve the lives of the borough's 43,000 children by:

- Providing incentives for physical activity and healthy eating;
- Reinforcing healthy positive choices through reward;
- Promoting choice and autonomy.

In addition the group wished to destigmatise and reduce access barriers to free school meals and drive an uplift in take up of school meals, particularly in families with low incomes. In order to achieve this we devised Access and Connect, an integrated access card offered in three forms:

- Family Card, for children aged under five and their families;
- MyCard, for children aged 5–11 years;
- Connect Card, a youth card for 11–19 year olds.

Phase 1 of the Access and Connect initiative began in July 2008 with a contract between NHS Barking and Dagenham, London Borough of Barking and Dagenham and London Swimming, for the provision of "Get Wet, Swim For Free" as a two year pilot, externally evaluated by Sheffield Hallam University. This was a £1m joint investment.

Phase 2 established the first significant Section 75 agreement between the two lead organisations. Pooling a budget of £2m over two years, Access and Connect is an ambitious partnership initiative which fundamentally changes the relationship between partners and children and young people.

By linking the card to the rollout of cashless catering in schools, it has been seen as a school based intervention. The administration of the card through the school roll has enabled accuracy and validation of identity in a way that maintains the confidence and confidentiality of the young people. By linking across the public sector, there has also been an ability to establish a core data set for the demographics of the youth population and develop service utilisation information as well as highly targeted social marketing campaigns.

We are now able to engage with young people through email and with both them and their parents through the portal. We have the ability to provide incentives for a wide range of behaviours and track the impact of promotional work in real time.

Benefits

In phase 1 there was a 295% increase adult and toddler swims to average of 310 adult each month. In addition there was a sustained 32% increase in under 19 swimming activity outside of school and a 23% increase in school swimming.

Phase 2 saw a 10% uptake in free school meals among entitled children. The initiative allowed real-time changes in school menus based on catering uptake and the development of recipe cards of top five meals based on children's choices.

Phase 3 went live in the first site in April 2010. In the first six weeks it delivered a 10% increase in free school meal uptake and an overall uptake of school meals of around 14%. More than 75% of parents accessed the online portal for payment

Financial implications

In addition to the investment detailed above the project is sustainable because recurrent costs can be mainstreamed at around £150,000 per annum, with substantial cost savings from removing cash operations and payroll from schools.

Contact

For more information on this initiative please contact
Marcel Berenblut : *marcel.berenblut@barkingdagenham.nhs.uk*

FINALIST

Fight Back smoking cessation campaign

John Ashworth and Catherine Tomaney;
NHS Birmingham East and North

The initiative

The leading causes of death in Birmingham are cardiovascular disease (CVD), lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD). All of these can be linked to smoking. The Fight Back campaign arose from a desire to increase the number of people from particularly at risk groups giving up smoking. The group most resistant to giving up smoking, with the highest prevalence and biggest likelihood of developing complications was identified as white men aged between 35 and 55 in routine and manual occupations. Therefore, a campaign and intervention was designed to increase their uptake of stop smoking services among this group.

Research with the target audience identified they were unlikely to access GPs or community based clinics, so a new campaign was created urging them to seek support in pharmacies. The campaign focused on the belief in this group that they are "in control" and challenged that by equating smoking with allowing someone to beat you up. It urged them to fight back against the harm smoking does.

This message was taken to specifically targeted areas through posters, billboards and advans. There was also on street activity, with staff engaging with the public, talking to them about stopping smoking and a hard hitting film showing a smoker being beaten up by an invisible assailant. The campaign was organised in partnership with pharmacies, who were then in a position to provide services.

The film, created by well known photographer Rankin, was also released virally online and prompted a great deal of public discussion, both in the media and online. Following the success of the campaign, a second phase was run during spring 2010.

Benefits

Positive outcomes from the campaign included:

- A 53% increase, year on year, in smoking quits through pharmacy during the campaign period (Oct–Nov 2009);
- A 68% increase, year on year, in those setting a four week quit date through the Quit Pharmacy Service during the campaign period (Oct–Nov 2009);
- A fresh smoker contact database of 1,303 names;
- A threefold increase in people citing 'advertising' as their motivation for using the Quit Pharmacy Service;
- Heightened awareness of smoking as an issue and heightened pressure on smokers to move from consideration to action — prompted awareness of the campaign was 50%, two and a half times the industry average;
- A real increase in uptake in those most resistant to and most in need of stop smoking messages — reaching those that have previously not accessed services.

Financial implications

The marketing spend for the entire campaign was £227,000. For 183 additional quit dates set this gives a spend of £1,240 per quit date.

Contact

For more information on this initiative please contact Dawn Rayson: *Dawn.Rayson@benpct.nhs.uk*

FINALIST

Teenage Kicks: reducing teenage pregnancies

Richard Morris and Melanie Shilton; NHS Leicester City

The initiative

In 2007, the under 19 conception rate for Leicester was 50.1 out of 1,000 females aged 15–17 — 51% higher than the national average. This campaign was developed to help reduce teenage pregnancies in line with the national average of 40 per 1,000.

NHS Leicester City joined forces with Leicester City Council to tackle the problem. This included an innovative communications approach, using social marketing theory, to highlight the realities of being a teenage parent.

It also needed to normalise condom use and provide young people with the confidence to delay sexual activity. The objectives were to:

- Reduce incidence of teenage pregnancy in Leicester City;
- Improve sexual health;
- Highlight the realities and difficulties of teenage pregnancy and parenthood;
- Encourage condom use as normal behaviour;
- Prevent sexually transmitted infections.

The campaign followed National Social Marketing Centre principles. This meant it was based on insight gained from young people in the target audience through thorough research — including focus groups, paired depth interviews and polling of more than 200 young people living in the city. Exploring and testing these insights with the target audience at every stage led to us co-creating an extensive campaign.

A video shows a teenage girl giving birth on a school field in Leicester. The desired perception was that it was real, filmed on a teenager's mobile to generate debate about the girl's identity and its authenticity. The video was placed on YouTube and as expected was soon removed. Reports that YouTube had 'banned' an NHS teenage pregnancy video, sparked significant interest from the media at home and abroad.

A media campaign was immediately launched taking ownership of the video. Worldwide press coverage resulted, discussing the content of the video, and raising awareness of the wider campaign.

A fun and discreet website was launched giving local teenagers easy access to all the information they need in one place. They can interact with the site by asking questions and leaving comments anonymously.

Alongside the website a drama series was created to deliver campaign messages in a appealing way for the target audience. The drama used real teenagers from Leicester to perform and shape the content based on their own experiences.

The video resources from the campaign have been produced into a DVD for schools and groups working with young people, to further embed the campaign messages. A number of other NHS organisations have made approaches to use the campaign in their own work.

Benefits

Data published in February 2010 by the Office of National Statistics shows that the rate of under 18 conceptions in the city has already reduced by 24.8%. This is compared to a national reduction of 13.3% since 1998. Other key results from the campaign are:

- 2.7 million views of the viral video worldwide;
- 15,000 people watching each episode of the drama — many of whom are local;
- 75,000 hits to the campaign website;
- More than 250 pieces of media coverage with an AVE of over £3m.

Research with local young people revealed that 66% had seen or heard about the campaign the campaign, with more than 80% saying they would now consider acting differently

Financial implications

The total cost of the campaign was £100,000. By preventing teenage pregnancies, the campaign will have contributed to a reduction in health and social care costs.

Contact

For more information on this initiative please contact Melanie Shilton: *melanie.shilton@leicestercity.nhs.uk*

FINALIST

NHS Southwark supermarket clinics (Stop while you Shop)

Kevin McCarthy and Emily Davis; onedeepbreath

The initiative

The longer term objective of this initiative was to reduce health inequalities in Southwark so it focused on deprived areas like Peckham and Old Kent Road, where rates of smoking prevalence were higher. The smokefree legislation encouraged many to quit and the remainder tend to be smokers with addiction ingrained into their lifestyle, who require a lot of support to permanently change their behaviour.

The initiative's focus was on recruiting these smokers into NHS Southwark's stop smoking service and helping them to quit. Although many smokers (70%) wanted to stop they did not want to access traditional NHS stop smoking services. By engaging people who wanted to stop smoking and offering them the right therapy and support on the spot we were able to increase their success rate.

In partnership with supermarket and pharmacy managers the "Stop while you Shop" clinics ran in supermarket foyers at 4–8pm twice a week for nine weeks. The initiative was based on idea that smokers would take the opportunity to quit providing the process was accessible, immediate and convenient.

The branding emphasised accessibility and convenience and was used for local press, service leaflets and instore advertising. Advisors consulted with smokers with empathy about their smoking habits, worked through preferred therapies and prescribed nicotine replacement therapy vouchers, which the patient could collect from instore pharmacies free of charge.

All smokers were encouraged to sign up to a minimum four week programme. A comprehensive follow up service was established with SMS message appointment reminders and weekly callback consultations. At the end of the programme successful quitters were given a certificate to acknowledge their achievement. The model was piloted in ASDA in July 2009 and expanded to Sainsbury's, Tesco and Morrisons.

Benefits

In terms of improved patient care, it proved invaluable to build personal relationships with smokers; understanding was key in ensuring they returned each week. It was also vital not to be judgemental towards smokers and keep consultations informal and not too clinical. Regular follow up calls were an essential part of the service to keep smokers motivated and supported throughout their quit attempt. Word of mouth advocacy was also a fantastic way to recruit new smokers wanting to quit.

Overall, the initiative reached 125,000 residents through press, instore advertising and PR coverage, which helped to raise awareness of stop smoking services. In total, over 2,000 smokers were engaged by the service, 659 joined the supermarket clinics and set a quit date and 225 of these successfully quit smoking (35%). Patient feedback included:

- "They called me at least twice a week to check on me. Now in just four weeks I have quit a 13 year habit."
- "It's thanks to you guys I've quit. The day I signed up I was going to ASDA to get my 100 fags for the week. You've saved me over £200."

Financial implications

The financial resources required were:

- Design and production of materials, £586;
- Planning and implementation, £37,560;

Follow up and evaluation, £2,032;

- Management, administration and expenses, £4,200.

Therefore, the total project budget was £44,378. The cost per quit for 225 quits is £197.24 per quit.

In terms of return on investment the number of quits (225) multiplied by the cost saving to NHS per person per quit (£3,115) divided by the project budget (£44,378) equates to 1:16. So every £1 spent on the initiative saved £16 on future NHS treatments for smoking related illnesses.

Contact

For more information on this initiative please contact Steven Jamieson : *steve@onedeepbreath.co.uk*

FINALIST

More than "Just another Lunch Club"!

Pat Kendal and Jackie Doe;
Perth and Kinross Healthy Communities Collaborative

The initiative

This community engagement project seeks to give older people the skills and capacity to promote the importance of good physical and mental wellbeing, using social marketing techniques to significantly impact on the lives of their peers in their local communities.

Teams of older volunteers were recruited and working alongside professionals used the five issues identified in the *Mental Health and Wellbeing in Later Life* report as a steer. They established the "Alyth Lunch Club" which led to the following interventions:

- Physical health — structured exercise groups;
- Relationships — providing socialising opportunities;
- Poverty — agencies providing advice locally on benefits and energy efficiency;
- Participation in meaningful activity — empowering volunteers to organise local information events;
- Discrimination — offering 1:1 mobile phone training and access to remote broadband.

Two older people were recruited from Alyth as part of the Blairgowrie area team. Along with other team members they attended a residential learning workshop, learning the "Plan, do, study, act" methodology and gaining the knowledge to take the work forward.

They initially decided to consult with local older people to identify any unmet need within Alyth. Two main areas highlighted were:

- A need for an exercise class as there are no leisure facilities;
- A lunch club as there are limited socialising opportunities.

Initially identifying a qualified exercise instructor was difficult so they piloted the lunch club, which proved extremely successful and popular. As many older people avoid contact with health and statutory services the club is an excellent opportunity to disseminate relevant health and social information through stalls and informal discussions with service providers. The group now runs monthly in summer and twice monthly in winter.

Many rarely exercised and when a suitably qualified exercise instructor was identified the pilot was so well attended that they now run two different ability groups on alternate weeks to the lunch club.

Benefits

The regular numbers attending the lunch club and satisfaction questionnaires demonstrate the success of the initiative. The register is checked by the volunteers and non attendees contacted in case their absence is due to physical illness or deteriorating memory with appropriate action taken. As the lunch club (costing £2) or exercise groups (costing £1.50) occur on alternate Mondays, this provides social interaction and reduces isolation on a weekly basis.

The volunteers also identify carers and the cared for and encourage them to attend together or offer informal respite in a caring, friendly, familiar setting within their own community. Social prescribing is also encouraged with social care officers bringing more vulnerable clients to the events which assists them to integrate into the community.

A variety of stalls has enabled people to have assistance with digital switch over; replacement of inefficient central heating boilers and benefits reviews. The dementia advisor has given 1:1 support, there has been falls prevention information and advice for those suffering from a lung condition.

Both these self sustaining groups encourage older local residents to adopt healthier active lifestyles with trained volunteers and are an inexpensive way to disseminate health promotion message to local older people.

Financial implications

The project funded the first four lunch clubs. This included a £5 donation for the church hall, the purchase, preparation and serving of home made soup, buttered roll, tea and coffee by a member of staff — about £25 for food. The overall cost was £120 (not including staff time). The community development officer assisted the volunteers to successfully apply for local community funding and statutory funding was no longer required. Those attending elected to hire a cook and pay an annual membership of £1 and £2 for each lunch club. They are now self sufficient.

Perth and Kinross Healthy Communities Collaborative (P&KHCC) funding was used for a four week pilot at a cost of £25 per session (£100). P&KHCC continued to pay the instructor for 12 sessions (£30x12=£360) then the exercise group too became self sufficient. The overall cost was £460.

Contact

For more information on this initiative please contact Jackie Doe: *jackie.doe@nhs.net*

WINNER

Acute stroke services reconfiguration

Ruth Carnall and Tony Rudd

The NHS in London

Background

Stroke is the second highest cause of death and most common cause of adult disability in London. More than 11,000 people having a stroke are admitted to London hospitals each year and around one in six of these died. In London, big differences existed in the quality of stroke care and rates of death in different hospitals varied considerably. Stroke patients need fast access to high quality scanning facilities and specialist care. Studies show that much higher rates of thrombolysis are achieved when patients are taken to a 24/7 specialist centre. Units in London with a critical mass of expert staff were achieving far higher thrombolysis rates than units without.

The process

In July 2008 a joint committee of PCTs (JCPCT) decided to work up proposals for world class stroke services in London. A recommendation was made by the clinical expert panel to provide high quality specialised stroke care, delivered in dedicated hyper acute stroke units (HASU) supported by a network of local stroke units (SU) and transient ischaemic attack (TIA) units.

The model of care developed aims to treat patients within three hours of having a stroke. On arrival at a HASU patients are assessed by a specialist and have access to a brain scan and thrombolysis within 30 minutes. Once stable, they are transferred to an SU closer to home to receive continued specialist treatment and intensive rehabilitation.

TIA patients are seen by an expert who will do further investigations and start treatment within 24 hours, greatly reducing their chances of going on to have a full stroke.

All acute hospitals in London were invited to submit bids for HASUs, SUs and TIA services against a set of specific criteria. Bids were evaluated by an independent team of leading stroke experts. For full HASU and SU accreditation trusts had to demonstrate that they would be able to meet tough new quality standards. Many successful trusts undertook major reorganisations of staffing and bed configuration to ensure their services were consistent with the model of care.

It was also agreed that those delivering stroke services that were not formally designated as HASUs or SUs would cease doing so after implementation of the new London stroke model.

A comparative analysis of all possible configuration options of acute stroke services were evaluated against clinically developed criteria including travel times; health inequalities and cost/efficiency. Pan London consultation then ran for three months outlining the preferred option.

London's JCPCT met in public in July 09 and recommended the preferred option be implemented.

Advice to other organisations

The model of care developed for London is based on best practice, is relevant to all acute providers and could be adopted elsewhere. The configuration of services could be adapted to meet variations in population size and density.

Award sponsored by:

NHS Institute for Innovation and Improvement

Benefits of the initiative

Clinical evidence shows that patients are 25% more likely to survive or recover from a stroke if treated in a specialist centre. As a result of the reconfiguration of stroke services and the improved model of care in London it is estimated that over 400 lives will be saved each year.

In the five months from February 2010 to June 2010 compared with the same period last year, the number of patients in London being thrombolysed has more than tripled. This rate of thrombolysis, of approximately 12%, is higher than that reported for any large city elsewhere in the world.

For patients who have a TIA and who are assessed as high risk, evidence shows that investigating their symptoms within 24 hours and providing specialist treatment can reduce the likelihood of a full stroke by 80%. Improved TIA services co-located with all stroke units has meant the number of patients' treatment initiated within 24 hours has risen by over 70% (from 48.57% in Q1 2008–09 to 84.04% in Q4 2009–10).

Financial implications

The JCPCT supported the additional financial commitment required by all PCTs — an extra £20.4m for acute stroke care and £0.7m for thrombolytic drugs per annum.

To incorporate the new model of care and the additional funding the London Stroke Tariffs were created. An analysis is currently being scoped to understand the complex economic impact of these stroke improvements.

Future plans

Following full implementation a robust audit is planned and these findings will be published. Furthermore, three academic HASUs have recently been designated by the Stroke Research Network The network is providing three year funding for a dedicated research nurse at each academic HASU.

Contact

For more information on this initiative please contact Patrice Donnelly: *patrice.donnelly@london.nhs.uk*

Judges:

Stephen Smith, *chief executive, Imperial College Healthcare Trust*

Gillian Leng, *deputy chief executive and chief operating officer for NHS Evidence*

Lynne Maher, *interim director for innovation and design, NHS Institute for Innovation and Improvement*

Alan Maynard, *professor of health policy, University of York*

HIGHLY COMMENDED

Finger on the pulse: day case service redesign at Alder Hey

Paul Hetherington, Moya Sutton and Carol Platt; Alder Hey Children's Foundation Trust

The initiative

Alder Hey needed to radically change ways of working if it was going to meet increasing financial and service delivery pressures. Day case service was the first breakthrough transformation of our lean programme with the vision to deliver the most efficient and effective patient journey, reducing non value added steps as seen through the eyes of the patient.

Traditionally our patients arrived at the same time of day and were located in the same ward with no clear division between stages of treatment. Workflow was not obvious for staff and mixing pre and postoperative patients was often confusing or distressing for the children and families. Our day case wards were unable to cope with increasing demand.

The key objectives where to:

- Meet increasing demand within current resources;
- Increase day case rate from 63%;
- Relieve pressure on inpatient beds;
- Improve patient experience.

When developing solutions a junior nurse on the team drew her vision in a simple picture which provided the spark for the wider team to radically change how patients were to be treated in the hospital.

The patient pathway was fundamentally changed by physically separating the various stages of patient flow into the appropriate parts (admission, pre-op, theatre, first stage recovery, second stage recovery and discharge).

An experiment was arranged to test the new system so that patient arrivals were then pulsed through in a steady rhythm in line with the Takt time. Patients progressed steadily through the process smoothly and efficiently with minimal delays.

The experiment proved that the process worked and has been implemented over the subsequent improvement events.

We are currently implementing a physical layout change to the day case service to further improve flow, which will enable an increase of patients by a further 5% to ensure the trust achieves its growth target within the current financial constraints.

It is expected that this will also further reduce the patient length of stay so that 90% of all short stay patients are treated and discharged in under four hours.

Benefits

The outcomes of the work to date are set out in the table below:

	Before	After
Day case rate	62%	73%
Activity, per annum,	12,196	15,092
Ward capacity	26	35+
Average length of stay	7+hours	4 to 5 hours

Financial implications

No increase in staffing was required. There were minor refurbishments to deliver the first phase of the project. There was a cost avoidance from not having to build a day case unit of approximately £3m.

The transformation of the day case services across surgical, medical, MRI and cardiac catheter increased capacity by 6,600 bed days. Emergency bed days over the improvement period used 4,000 of these and the remainder contributed to a further reduction of 3,385 bed days through bed rationalisation.

Over this period the demand for bed days would have equated to an additional 18 inpatient beds which would have been needed to cope if this day case transformation had not occurred.

In addition, it changed the original output specification for the new hospital build from a 44 bedded surgical day case unit to a unit.

Contact

For more information on this initiative please contact Carol Platt: *carol.platt@alderhey.nhs.uk*

FINALIST

The Somerset COPD Service

Richard More and Jill Allen; Avanaula and Bupa Home Healthcare

The initiative

Nationally COPD accounts for one in eight hospital admissions (one in 10 in Somerset). The Somerset Community COPD service was set up to reduce this rate by preventing, where possible, people with COPD from becoming so unwell as to require hospital admission. It does this by offering the most up to date evidence based care for COPD, and maximising opportunities for support and education, while minimising inappropriate variations in care.

In the summer of 2007 the county practice based commissioning group (Wyvernhealth.com) produced a document *The challenge of reducing avoidable admissions* which set out the procurement process for a new COPD service on the basis that admissions could be reduced by more than 25% if all suitable patients were offered:

- Pulmonary rehabilitation;
- Medication optimisation;
- Education on self management;
- Oxygen assessments and therapy.

Best care has been clearly set out by both NICE and the British Thoracic Society. The challenge was to deliver this care.

To do this a brand new partnership of a small GP owned organisation (Avanaula) and a large provider of home healthcare (Bupa Home Healthcare) was set up. This was the only way that we could devise of making the organisational form and structure suit the patient needs, rather than the other way round.

The partnership developed a patient pathway which includes:

- Discussing with the patient which of the 12 locally placed clinics they wish to attend;
- A 90 minute community based nurse assessment with plenty of opportunity for patient education;
- A recommendation on any medication changes;
- Provision of a written management plan, with emphasis on self treatment of exacerbations;
- Booking for further assessment for oxygen therapy, pulmonary rehabilitation or nebuliser assessment as indicated;
- Onward referral to other providers such as the hospice or social services;
- Provision of telephone support for patients 24/7.

Benefits

Starting with the first month the service went fully live we have analysed finished consultant episodes (FCE), (used as a proxy marker for admissions). This has been compared with the FCE rate 12 months earlier. A trend line analysis shows that when the service was launched monthly admissions were running at more than 120% of the previous year. After 23 months admissions are running at less than 80% of the previous year.

In addition patient feedback has been very positive, with over 90% of patients considering the care they received as excellent or nearly excellent.

Financial implications

Due to the inherent delays involved in commissioning it is still too early to calculate the retrospective net positive values. However if the reduction in admission rates identified in the previous section continues then the savings using payment by results tariff will exceed the costs of the service. Further savings will be gained by more effective use of the oxygen contract.

The use of financially strong third party providers meant that the upfront investment in pathway design, IT, tendering and servicing implementation was not carried by the NHS. When linked with a contract where financial flows are linked with outcome markers this produces a risk profile which is far more beneficial to commissioners than the more common NHS payment by process.

However, being a commercial contract the precise sums involved are confidential.

Contact

For more information on this initiative please contact Richard More: *richard.more@avanaula.com*

FINALIST

Excellence in gynaecology within the community

Kalpesh Shah, Rasik Shah and P Shah;

Croydon Intermediate Gynaecology Service working in partnership with PBC Croydon

The initiative

The 2006 white paper *Our Health, Our Care, Our Say* highlighted gynaecology as one of the services that would benefit by moving from secondary care into the community. The modernisation agency nominated North Croydon Practices to develop a gynaecology service redesign model. We commissioned a patient satisfaction survey in which women from different practices in Croydon were asked for feedback on their experiences of gynaecological services. Women said they were frustrated with:

- Lack of easy access to a consultant;
- Delays in diagnostics and management plans;
- Lack of continuity.

It would take a minimum of three visits weeks between seeing different doctors and getting a diagnosis and management plan. In addition it was difficult to get results by phone from the hospital.

There was a clear preference for an accessible service within the community. Referral and patient pathway analysis confirmed that diagnostics remained a block in the patient journey. Clearly there was room for improvement by integrating the care pathway and designing a woman centred service.

Our objectives were:

- To reduce the new follow up ratio from 1:1.5 to 1:0.5;
- To reduce the did not attend (DNA) rates to less than 10%;
- To reduce the referrals to secondary care below 30%.

To achieve this we combined diagnostics, consultant input and treatment options at the first visit in a "woman friendly" community setting. A clinic letter is given to the patient 10 minutes after being seen with the results of the consultation, diagnostics and management plan. Reminders about appointments are sent by secure text; this has reduced DNA rates to less than 5% compared with secondary care rates of approximately over 10%.

Benefits

All women were offered an appointment within two weeks, and 80% of these needed only one visit to have their condition diagnosed and the treatment plan initiated. Continuity of care was maintained in 90% of women. Follow up rates are significantly lower than secondary care.

Monthly audits of management plans have confirmed adherence to NICE guidance in 95% of cases, a clear reflection of evidence based clinically effective care. A surrogate marker has been the low conversion rate from outpatients to surgery compared to data from secondary care. In addition the service has been provided at a 40% reduction in tariff with a significantly improved level of service

Patient satisfaction surveys have been consistently high. Their appreciation of the service is clear from their responses to the questionnaire. Over 98% report that they are "absolutely happy with the service".

Financial implications

The PCT commissioned the service as a pilot in December 2007 to run for six months for 14 practices in North Croydon. We were given £26,000 to cover the cost of service including staffing plus an additional £25,000 to purchase an ultrasound scanner. Within six months we demonstrated success by making savings and providing high quality care. Following this the service was tendered out for whole of Croydon in November 2008 — a population of 360,000.

The service has been provided at 60% of tariff — a recent evaluation of the 2,344 patients seen between November 2008 and March 2010 confirms that we have managed to save £275,000. Our first appointment to follow up ratio is 3.5:1 as compared with local secondary care provider, where the ratio is 1:1.3. There have also been as savings by a reduction in inappropriate interventions which at this stage is difficult to quantify.

Contact

For more information on this initiative please contact Kalpesh Shah: *kalpeshshah@nhs.net*

FINALIST

Community ReStart within a stepped care mental health service

Keith Isherwood, Barry Heys, Jill Jackson and Andy Wild;

Lancashire Care Foundation Trust

The initiative

Community Restart is a social inclusion, employment and housing service; and the model for transforming day services which has been adopted in East Lancashire. The model operates within a stepped care approach.

The redesign and restructuring of the day service provision

in East Lancashire was the opportunity to improve access to the right support, by the right person at the right time for those identified as having a need for additional support. The initiative was undertaken as part of a larger scale clinical service redesign achieved through consultation and collaboration with service users, carers, the workforce, local health and government agencies, third sector parties and the general public.

The design of the Community ReStart service was based on a hub and spoke model. The hub includes an integrated team manager, two managers with specific responsibilities around housing and employment and a lead for user/carer development. Each have small specialists teams. There are also specialist support time and recovery workers (Str workers) for black and minority ethnic groups, rural work and community farms.

There are four fully functioning spokes, each covering a specific geographical area, with one senior Str worker and four or five Str workers in each. Each member of staff has received training from the National Development Team for Social Inclusion.

Benefits

The Health and Social Care Advisory Service has evaluated the early development of the service. The Burnley Team scored top marks for socially inclusive and integrated services for adults with a mental illness.

In the year following the implementation of the model the number of referrals managed had risen by 25% across all of the sites, demonstrating an increase in productivity. Between February and June 2010 there have been 342 referrals, less than 10% of these being inappropriate or choosing not to engage following initial contact. Of 112 discharges 92% have been successfully assisted in accessing housing or employment services, supported to use community groups and facilities or signposted to use alternative and appropriate community resources.

Financial implications

The initiative will be funded in the coming year by:

- Lancashire County Council, £628,516;
- Lancashire Care Foundation Trust, £123,835;
- Pendle, Rossendale, Hyndburn, Burnley and Ribble Valley Councils, £15,000;
- Lancashire County Council Mental Health Grant (permanent), £54,484;
- Lancashire County Council Mental Health grant (temporary) two years, £31.405;
- Primary Care trust, for training and equipment £33,000.

In the year before to the implementation services provided cost £1.27m. In the year after the implementation of the model, running costs reduced to below £1m and the number of referrals managed had risen by 25% across all of the sites, demonstrating an increase in productivity with associated cost savings.

Contact

For more information on this initiative please contact
Gill Pope: *gill.pope@lancashirecare.nhs.uk*

FINALIST

Emergency Medical Admission Pathway Redesign (EMAP)

Michelle Gallagher and Jane Shipp;
Royal Surrey County Hospital NHS Foundation Trust

The initiative

The Emergency Medical Admission Pathway (EMAP) project is an initiative to reduce average length of stay (ALoS) for all our emergency medical patients (over 5,500 patients each year) from 20% above national average to 5% below national average.

The project was undertaken in order to address a local issue. In July 2008 we were faced with a substantial challenge: over the previous two years the ALoS for medical emergencies had increased from eight to 10 days. This was not caused by increased patient numbers or patient complexity as throughout this period, the level of activity and case mix had remained constant.

To address this challenge, we started the EMAP project to first understand where significant changes in length of stay had occurred and why, and second to target key areas for improvement throughout the pathway.

The first phase of the initiative involved the project team mapping out the current pathway of an example patient, conducting data analysis on the different patient groups, carrying out waste analyses to identify improvement opportunities and referring to established clinical evidence.

The work revealed that the increasing ALoS was being driven by the longest staying patients. For these patients there were extended periods between being declared medically fit and being discharged.

The team developed a range of solutions to be implemented across seven medical wards between January and July 2009:

- All medical wards now make ward performance highly visible using a red/amber/green tracking system;
- An estimated date of discharge is implemented and monitored across all wards;
- A database was built to speed up the HNA health needs assessment completion process;
- Guidelines were developed for successful consultant led multidisciplinary team meetings;
- A fast-track system was set up within the pharmacy and more ward rounds added enabling quicker dispensing and delivery of prescription medicines to take home;
- Each ward receives LoS charts each month which highlight variations and benchmark against peer groups.

Benefits

The first phase of the initiative has been evaluated and has generated significant results. It has brought:

- Improved service for over 5,500 patients;
- A fall in readmission rate from 9% in 2008–09 to 3% in 2009–10;
- A reduction in length of stay releasing over 11,000 bed days;
- Sustained reduction in medical outliers of over 50%.

In addition he initiative has improved teamwork across departments within the trust, and improved transparency of performance at a ward level and this has been developed into a balanced scorecard covering safety, patient experience, outcomes and efficiency.

Financial implications

The initiative cost £80,000 and approximately 300 person hours were dedicated to it. The team used lunchtime meetings in order to maximise their effectiveness and prevent clinicians from being taken away from frontline care.

The reduction in length of stay has saved over £1m in one year (based on a seven month reference period), and a conservative marginal cost of £90 per medical bed day. This means that the costs were significantly less than 10% of the savings realised.

Contact

For more information on this initiative please contact
Lisa Ward: *via adele.carter1@nhs.net*

FINALIST

Auckland Park assessment and treatment services, mental health services for older people

Jill Jefferson and Malcolm Allen;
Tees, Esk and Wear Valleys NHS Foundation Trust

The initiative

In April 2007 a review of pressures in the locality identified that wards were overspent, largely due to overtime and agency spend, waiting lists were in operation, working relationships between the wards and community teams were strained and staff were generally stressed.

Work to redress these issues began. Through a process of consistent and sustained team building, review of communication, meeting structures, capacity and demand, changes began to take place. Our trust adult services were using a standard model to tackle long stays and reduce readmission and we adopted this hugely successful model, involving using visual control boards and daily ward rounds.

The team used the PARIS electronic clinical record system from day one of roll out and were keen to ensure that the CPA/PARIS processes were key to any development. Work was undertaken with staff to ensure that the principles and processes being applied were understood and accepted.

In November 2008 we applied this model and developed it further with outstanding results. Staffing issues, budgets and waiting lists became manageable and we reduced the beds from 36 to 30 (15 on each ward) with no adverse effects.

Benefits

A major change in our service model was to agree that one consultant psychiatrist would work into the wards and team members could admit into beds directly. The daily ward rounds are structured to allow a 20 minute report per ward which released time for individual meetings with patients and carers as well as time for quality interventions.

An electronic task board ensures that interventions are dealt with on a daily basis. The electronic record (PARIS) allows real time access to information by the wider team. Members of the wider team are encouraged to attend the daily ward round and we have recently developed an electronic visual display board.

As a result of the reduced length of stay and occupied bed days we have been able to pilot an intensive treatment and support service which aims to prevent admission and support discharge from hospital from within existing resources. This development continues the use of the visual control board and daily ward round to monitor interventions and manage risk for complex patients who might otherwise require an inpatient stay.

Financial implications

Work was undertaken from existing resources. Savings were achieved by reducing length of stay and managing beds efficiently, with almost no use of overtime, bank or agency. The cost of two flat screen televisions to broadcast the electronic visual display board was met from end of year underspend.

Savings in terms of improving staff morale meant a reduction in staff sickness, currently at 1.4%.

Contact

For more information on this initiative please contact Jayne Lamplugh: *jayne.lamplugh@tewv.nhs.uk*

FINALIST

Joint Care Programme

Willem Schenk and Matthew Porteous;
West Suffolk Hospital

The initiative

The Joint Care Programme was developed to create a comprehensive programme of quality care for patients requiring total hip and total knee replacements, a key element being the improved education of patients throughout the process. All aspects of the patient journey have been overhauled, and they now have greater involvement in their own treatment, working with the close cooperation of a multidisciplinary team.

The initiative began after a visit to hospital in Holland where the orthopaedic department had implemented a programme to change radically the care of hip and knee joint replacement patients, Participants involved in the visit returned as enthusiastic ambassadors of the programme.

Initially a multidisciplinary team was put together to provide the broadest possible base involving staff from all departments connected to the patient journey. There was a pilot study involving two consultants, after which the programme was rolled out to the whole department. The initiative encouraged a change of patients' mind set focusing on the idea that they are not ill, their hospital stay is short, and they are part of the team.

A six bed bay on the orthopaedic ward was converted into a day room for rehabilitation. The preadmission assessment process was streamlined and a preoperative educational joint group was set up. We also introduced orthopaedic tea parties to get feedback from patients in a structured informal session. We now hold monthly multidisciplinary meetings to identify concerns and seek resolutions, reporting back to departmental clinical governance meeting, for further feedback and support.

Benefits

This programme has changed how we work beyond recognition, with staff at all levels feeling valued, working together towards the same goal, challenging the way they were working to find ways to improve and develop working patterns to optimise the quality and standard of care of patient services.

Patients take part ownership in their treatment. Through extensive education they are happier during their stay in hospital, are discharged earlier and better prepared for their return home. Increased efficiency and productivity has significantly reduced waiting lists, length of stay, hospital costs.

An important part of rehabilitation is the day room with recliner chairs where patients can exercise but also relax and talk to each other and healthcare workers as part of the group process. Many patients stay in touch after discharge,

Streamlining an anaesthetist led preadmission assessment process condensed the time taken from over six hours to 2–3 hours. Any medical problems are investigated and resolved thus reducing day of surgery cancellations.

Financial implications

Minimal financial resources were required as the programme restructured the system already in place; each department examined and fine tuned its individual contribution.

Charitable funds from WRVS enabled the purchase of the eight recliner chairs in the day room, a necessary and important part of the rehabilitation process.

Contact

For more information on this initiative please contact Willem Schenk: *via marion.gladwell@wsh.nhs.uk*

WINNER

The GCHS virtual admissions avoidance team — a template for the future?

Giselle Broomes and Anita Koelmel

Greenwich Community Health Services

Background

The Greenwich Community Health Services virtual admissions avoidance team (GCHS VAAT) was established in response to a need to relieve congestion at the Queen Elizabeth Hospital in Woolwich. The primary objective of this multiprofessional team is to work collaboratively with London Ambulance Service (LAS) and other health and social care professionals to prevent unnecessary A&E attendances and avoidable hospital attendances.

The team incorporates primary care, community services, secondary care, the ambulance service and social services and demonstrates how acute care can indeed be delivered closer to home. It is committed to providing appropriate and clinically beneficial care to patients at a time when they are most vulnerable and are more likely to be channelled through an emergency care pathway needlessly.

The process

Patients with long term conditions are the highest consumers of emergency and urgent care. However if their urgent care needs is met with rapid, early, consistent and expert assessments in their own environments, they can be prevented from being admitted to hospital unnecessarily.

Many boroughs across London employ emergency care practitioners (ECPs) who work alongside ambulance crews to prevent unnecessary admissions. Without the funding to employ ECPs we had to think about how we could achieve the same outcomes without further investment. We therefore decided to employ a 'virtual team' concept.

We have adopted a fresh approach to partnership working. The team is made up of professionals who actively contribute to every aspect of the patients journey; LAS, primary care, community care, secondary care and social care and our shared objective is to improve patient outcomes and experience while making better use of available resources.

The team developed a portfolio of clinical pathways that will be used by LAS as an agreed alternative to automatic hospital attendance. These are based on the most common reasons for A&E attendance particularly for older people, and include:

- Falls;
- Cellulitis
- Blocked catheter;
- UTI;
- Heart failure;
- Poorly controlled diabetes;
- Exacerbation of COPD;
- Rapid response (including social crisis).

Advice to other organisations

This initiative is based on two important concepts; the virtual model and the whole systems approach. The two together are underpinned by openness, a spirit of camaraderie, good inter professional dynamics and a shared desire and determination

to succeed. This can definitely be replicated elsewhere and used to improve practices in both health and social care. The virtual model can be especially useful in instances where disparate teams are working towards the same strategic or operational goals particularly where the services are not colocated.

Benefits of the initiative

The benefits have been that a previously disparate group now function as a team meeting objectives that they set for themselves. The team has achieved the following;

- Patients receive safe and appropriate care in their own homes;
- Carers and relatives feel supported and part of the caring process;
- Gaps highlighted within the services as part of this journey have been addressed;
- Efficiency and value for money have increased.

Financial implications

The initiative avoided 1,123 admissions between January and June 2010. Using an average tariff of £2,500 per medical admission, this equates to a saving of £2,807,500. The expected savings for the year will be a minimum of £6,470,000. This has been achieved without any additional financial resources.

Future plans

Our goal for the next three months is to focus on the following:

- Data collection and analysis, including patient related outcome measures;
- Strengthening our links with patient groups and GPs;
- Developing and piloting a single point of access;
- Benchmarking and information sharing with other;
- Continually advertising our service in the borough .

This entry was also a finalist in the **Managing long term conditions category*

Contact

For more information on this initiative please contact Giselle Broomes: *giselle.broomes@greenwichpct.nhs.uk*

Award sponsored by

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Judges

David Flory, *deputy NHS chief executive, Department of Health*

Stephen Dorrell MP, *chair, Health Select Committee*

Joe McEvoy, *deputy director of partnership commissioning, NHS Cornwall and the Isles of Scilly*

Tom Watson, *product manager — psychiatry, Servier*

HIGHLY COMMENDED

P2: daring to be different

Tricia McGregor and Karen Cornish; Central Surrey Health

The initiative

In 2009 the UK was in financial crisis: public sector funding cuts were imminent and, nationally, inefficiencies in community services were widely acknowledged. Locally, we were facing an immediate 10% reduction in income as part of the PCT's financial recovery programme.

We chose to respond in a new way by implementing an organisation wide transformation and efficiency programme. If setting up Central Surrey Health was phase 1, then the enormity of the task ahead was certainly phase 2 (P2). We launched P2 in April 2009. Our objectives were to manage the immediate 10% reduction in income by reducing waste and delivering the same or improved clinical services for less money. We also wanted to build capability to deliver year on year improvements in quality and efficiency.

Through P2 we committed to:

- Base decisions on evidence (historically not readily available in community services);
- Fully involve our co-owners in designing and driving through service improvements;
- Develop our own capabilities so we would not be dependent on external consultants in future.

To do this a four phase process was developed:

- Define — clarifying aims and outcomes;
- Diagnose — 17 organisation wide analyses provided baseline data on areas of inefficiency. We identified 40 change projects, each was scoped to quantify costs and benefits before approval to progress;
- Deliver — we took a whole system approach, encompassing policy development, culture change, IT enablement, local waste removal and organisation wide redesign projects;
- Sustain — embedding change into "business as usual".

Numerous communications methods were used to involve and engage clinicians, managers and stakeholders with P2. After we presented the diagnostic results to co-owners in September 2009, 91% understood the importance of P2 and 83% supported it.

Benefits

The initiative allowed us to remove £800,000 worth of wasteful processes in one year without redundancies. It also identified 236 "quick fixes" to improve efficiency and 78 capacity release projects. The result is that service delivery is more efficient, streamlined and standardised. For example there has been a 13% reduction in waiting times for musculoskeletal physiotherapy services. We anticipate that patient numbers will increase by 20% by the end of 2010.

District nursing teams removed 10% waste in 12 weeks . This is equivalent to releasing 53 minutes per day per nurse. Eight "Lean" projects have enabled the teams to maintain service levels despite a 10% reduction in headcount.

Financial implications

P2 has been funded entirely from Central Surrey Health resources. We chose to work initially with a specialist partner. Our aim was to build our in house capability so we could become self sufficient. The consultancy's involvement with P2 has now ended, meeting our August 2010 deadline to continue our efficiency drive using the skills and knowledge we've acquired.

Our strategy to develop co-owners rather than rely on outside experts will pay for itself many times over in the longer term. We expect an estimated return on investment of 5:1 by 2013–14, and are on track to deliver this.

We expect that the majority of cost savings during 2009–10 to come from Lean and Workout (74% and 26% respectively), with greater efficiency savings from the bigger redesign projects over time. By 2013–14, the service redesign projects should contribute 53% of our cost savings, Lean 35% and Workout 12%.

Contact

For more information on this initiative please contact Emma Harewood: via *rebecca.jones@centralsurreyhealth.nhs.uk*

FINALIST

Getting better for less : Alder Hey rapid improvement and service transformation programme

Louise Shepherd, Carol Platt and Paul Hetherington; Alder Hey Children's FT

The initiative

In 2007 Alder Hey faced a number of key challenges:

- A projected financial deficit of £13.5m from the impact of payment by results (PBR);
- Pressures arising from the 18 week referral to treatment service delivery rules;
- The need to resolve financial and governance performance to achieve foundation trust status while improving the quality and safety of patient care.

Alder Hey's vision is to "provide world class health care to children and young people". We needed to develop a service innovation capability that matched our internationally recognised clinical reputation. We decided that in order to achieve our objectives an innovative whole organisation approach using lean methodology was required so that service transformation should touch and affect every service and every person.

The rapid improvement and service transformation (RIST) programme is led by the board but is delivered by front line staff. The initial trust wide review in 2007 involved 60 people and in one week undertook analysis and identified the levels of waste to be eliminated.

Over 100 week long RIST improvement events have taken place, with 1,000 attendees actively improving the services they provide. They are supported in identifying solutions and implementing changes by the RIST team of Lean facilitators and our external consulting partners.

These events give people the opportunity to develop new leadership skills and work with people who may or may not be from their workplace or area of expertise. Teams are usually made up from people in the workplace as well as "customers" and "suppliers" of their process.

Benefits

The RIST approach is demonstrating that a trust wide involvement in change is leading to greater levels of performance, ownership and an improved sustainable behaviour. Initial feedback from staff and patients included the following:

- "Runs smoothly and efficiently with minimal delays";
- "It wasn't hard work, no waiting";
- "Excellent care, good explanations about the process";

Benefits of the initiative	Initial	End 2009	Improvement
Referral to treatment target	48%	90%	88%
Waiting times for diagnostics (weeks)	13	4	69%
Day case rate	62%	73%	18%
Average length of stay (days)	3.3	2.7	18%
Bed occupancy	72%	81%	13%
Theatre utilisation	86%	91%	6%
Complaints	132	107	19%
Serious medication errors (per annum)	6	0	100%
Blood science waiting time (mins)	100	20	80%
Near patient pharmacy	120	10	92%

Financial implications

Through redeployment and secondment an internal team of four Lean facilitators were identified and external support is currently provided by a Lean healthcare consulting company. It is intended that this support should not be needed by 2012.

One significant transformation of our day case services across surgical, medical, MRI and cardiac catheter created an additional capacity of 6,600 bed days. Emergency bed days over the improvement period used 4,000 of these and the remainder contributed to a further reduction of 3,385 bed days through bed rationalisation.

This has been achieved as well as financial benefits such as:

- Productivity — 5% year on year;
- Cash savings — £3.5m per annum;
- Additional income — £1.5m per annum.

Contact

For more information on this initiative please contact Carol Platt: *carol.platt@alderhey.nhs.uk*

FINALIST

The Prudence Project: closing the gap between income and expenditure

Alex Whitfield and Fiona Kenyon; Basingstoke and North Hampshire FT

The initiative

Basingstoke and North Hampshire Foundation Trust (BNHFT) has seen a 6–9 % rise in income and expenditure each year for the last five years in cash terms. For 2010–11 onwards the expectation is that the trust will receive a flat cash income. However, the drivers that have increased costs are still there. All Agenda for Change staff received a pay rise on 1 April 2010, and emergency admissions are continuing to increase at 6–10% each year. The result of this was anticipated to be a gap between income and expenditure for 2010–11 and beyond. The Prudence Project was launched to close this gap.

There are a number of aspects to the Prudence Project. The character of "Prudence" was developed and has become a familiar one around the trust. She has featured in CEO briefings, in presentations to medics, matrons, the public and the board. She has an email address and an office. Data has been shared in such a way as to change behaviour. For example, sickness rates of 4% are uninteresting — spending £1.9m a year on paying sick people is interesting. People say they can't cut 20% from their admin and clerical numbers until you demonstrate that this is only a return to levels they operated at quite happily two years ago. We stopped relying on better quality care to save money, and started looking for the cash releasing initiatives as well, for example 12 hour shift patterns in nursing and better control of drugs.

All levels of staff and all professional groups have been recruited to the Prudence bandwagon. We have technicians studying for an NVQ in Lean techniques and reducing what is spent on rental equipment. We have medical secretaries working to email correspondence instead of using paper. We have domestic supervisors thinking about how to reduce the laundry bill. This is about organisational commitment to saving money without compromising care.

Benefits

The trust paybill has been flat for the last eight months, even with a pay rise in April for all Agenda for Change staff. The non pay bill has been flat for the last eight months. The headcount has come down by 100 staff since October 2009 with no mass redundancies, a reduction in bank use and no overtime or agency. Sickness rates have reduced from 4.0% to 2.5%.

These reductions in cost have come about while patient activity is increasing and patient and staff satisfaction are as high as ever. All targets are being met.

Financial implications

The resources used by the initiative were to second a senior manager from operational delivery into productivity and cost improvement. It is on track to save £12m per annum for the trust within a year.

Contact

For more information on this initiative please contact Alex Whitfield: *alex.whitfield@bnhft.nhs.uk*

FINALIST

NHS Nottingham and Nottinghamshire carbon reduction project

Laura Mayhew-Manchon and Jenny Cawkwell; NHS Nottinghamshire County and NHS Nottingham City

The initiative

This initiative has the short term aim of reducing the carbon footprint and natural resource costs of two NHS trusts. The long term aim has been to integrate processes into the two large NHS organisations to drive a lasting ethos of carbon management and sustainability throughout their own operations, commissioned services and supply chains.

The initiative has affected how both participating trusts deliver services, manage their buildings, travel to deal with their waste, undertake and monitor contracts and work with staff. It has helped the trusts achieve significant carbon, energy and financial savings to meet the government's targets in improving efficiency and cutting public sector expenditure.

We followed a process of baseline, prioritise, act. First an accurate scope 1, 2 and 3 carbon footprint for each trust, covering travel, buildings, waste, water and sewage, procurement and commissioning was calculated. Then the footprint and the quality of the data to produce the footprint were assessed to provide a data source hierarchy to guide future years and other trusts. The baseline has informed policies and strategies and has provided a launch pad for action in all areas.

The approach to accurate baselining, ensuring quality data sources, and cooperatively finding solutions has created a cross organisational approach. An accurate fine-grain baseline has generated confidence at board level in tracking and steering progress and the capacity to delegate to individual staff manageable chunks of the challenge.

The trusts have introduced:

- Major behaviour change programmes;
- Smart metering across all health centres;
- Car sharing designated parking spaces;
- Energy saving refurbishment of all buildings;
- Massive increases in waste recycling;
- Turning down of thermostats.

Sixty green champions have been trained across both organisations, all actively looking for ways to cut costs, carbon and improve efficiency.

Benefits

NHS Nottingham City is now on course to achieve level 3 in the Audit Commission's KLOE "Use of Natural Resources". Both trusts manage HQ and provider site waste contracts and now achieve over 80% domestic waste recycling rates. The county NHS clinical waste treatment is now 20% incineration and 80% alternative treatment (autoclave) then recycling.

Financial implications

The entire two year project cost was £352,000. All the elements detailed in the previous section would have cost more in total to deliver individually. For example one local trust was quoted £20,000 for a procurement carbon footprint. Nottingham Energy Partnership (NEP) worked with the regional Re:Source, sourcing this for free for our trusts, This work has now been replicated for 24 other local trusts.

Another local trust paid £5,400 for 20 smart meters and was considering 80 more sites. NEP worked with Southern Electric to install 23 meters in Nottinghamshire health centres for a small increase in standing charges. Again, all 24 local trusts have been informed how to replicate the process.

From the 20007–08 baseline the NHS Nottingham City reduced their estates carbon footprint by 14% saving £34,000 per annum from investments identified by the initiative. The investments all pay back within 10 years or under.

Contact

For more information on this initiative please contact Jerome Baddley: *jerome.b@nottenergy.com*

FINALIST

The Rotherham InterQual initiative — transforming patient care

Jackie Bird and Carole Lavelle; The Rotherham FT

The initiative

Since 2008, the NHS in Rotherham has been working with McKesson to implement InterQual, its utilisation management and appropriate level of care solution.

A social care economy partnership was established between The Rotherham Foundation Trust, NHS Rotherham (PCT) and Rotherham Social Services to deliver this initiative. It arose in response to both national requirements and a local need for people to have rapid and equitable access to comprehensive, high quality, patient centred care that is provided close to their homes.

The aim of the project was to provide appropriate levels of care for individuals with defined needs. Specifically, the project objectives were to:

- Develop a service model as an outcome of the analysis of the InterQual data;
- Promote safety and optimise outcomes for individuals
- Exceed patients' expectations where InterQual has been used to determine appropriate level of care;
- Provide value for the tax payer and safeguard public resources by ensuring right care, right place, right time and having the right level of staff in each care setting.

The social care economy partnership wanted to ensure care and discharge processes were seamless and to provide a positive experience (in terms of safety and quality) for patients while improving resource utilisation.

The system was initially implemented in four pilot areas. Using a range of clinical criteria, the system identified patients who did not meet the criteria for acute levels of medical care and could have been cared for elsewhere. These included patients who were waiting for outpatient procedures, did not meet the threshold for medically managed acute beds and could have been discharged home.

During the first 16 weeks, 3,631 reviews were undertaken on 892 patients. Of those reviewed against the acute criteria, 558 were admission reviews, 2,872 were against the continued stay criteria and 83 reviews were undertaken against discharge screens.

Only 49% of the admission reviews met the criteria for an acute admission; 45% did not meet the criteria. The remaining reviews were either redirected off the project or referred for a secondary review.

Fifteen per cent of the continued stay reviews met the acute criteria and 77% did not. Again, the remaining reviews were either redirected off the project due to transfer to other wards or were sent for secondary review.

The reviews that did not meet the criteria resulted inpatients occupying an acute bed for a total of 1,574 variance days.

The largest cohort of patients identified were those who did not need acute medical care, but could not be discharged to an alternative facility because the level of skilled nursing and/or therapy input was not provided within the Rotherham community setting.

The outcome has been for the trust to develop a solid business case for a skilled nursing facility. This will accept patients who have been discharged from acute medical care where there is currently no suitable facility within current commissioned provision.

Benefits

Once fully implemented, the system will result in a reduction in unnecessary bed occupancy, a reduced risk of hospital complications by moving patients along the care pathway in an appropriate and timely manner. It will also make the most efficient use of healthcare services; thus providing a better health service for patients.

Financial implications

Rotherham has procured software licences from its technology partner McKesson. In order to undertake the project, band 7 case managers were appointed to case manage patients through the system with the support of the InterQual criteria. Each case manager has a case load of 30–35 patients at any one time.

InterQual will undoubtedly deliver a return on investment, however at the moment this is difficult to quantify. To date, the main focus has been on service reconfiguration both inside and outside the hospital and informing future commissioning decisions.

Contact

For more information on this initiative please contact Carole Lavelle: *carole.lavelle@rothgen.nhs.uk*

Efficiency initiative of the year

FINALIST

Excellent Health programme

Steve Bloomar and Val Doyle; Royal Orthopaedic Hospital FT

The initiative

The Royal Orthopaedic Hospital NHS Foundation Trust is a specialist orthopaedic hospital that provides a range of elective services in Birmingham. In 2009 the trust developed a long term strategy to be the first choice for orthopaedic services for patients, carers and commissioners.

The aim of this strategy and in particular the excellent health programme was to improve efficiency and liberate capacity to deliver an increase in services in locations closer to home. We also wanted to build on our marketability, improve quality and safety and maintain the ratings in an economic climate where there is no planned financial growth.

The Excellent Health programme was developed locally and follows the principles of Lean methodology. This provides a mechanism for fostering leadership and innovation by adopting new ways of working and changing the culture and behaviours to ensure that our services are first class and fit for purpose and to enable us to react to the ever changing environment.

There was executive sponsorship by the chief executive officer and to ensure the change process was supported at the clinic level our medical staff engaged in the process and drove the change. Commitment was given to establishing an academy of individuals with dedicated time to work on the project so that the learning could be spread throughout the workforce in all service areas.

The project approach concentrated initially in theatres and achieving efficiency. However, it has now been rolled out to encompass the entire patient pathway.

Benefits

The major benefit has been clinical engagement and involvement which has brought many rewards that were not anticipated. It has enabled staff regardless of professional status to become involved in a programme built around improving the patient experience.

Some other benefits are:

- Reduced waiting times for first appointments;
- Improved quality in patient information;
- Reduced rework — removed need for an external theatre saving £1,750,000;
- Single theatre operating and increasing throughput — financial benefit £350,000;
- Twin theatre operating model — financial benefit £60,000;
- Less reliance on agency staff and improved pay budget;
- Improved start times in theatre;
- Improved safety for the patient.

Financial implications

Stage 1 of the programme cost £299,000 and was planned to produce savings of £2,791,000. The overall programme has signed off potential savings of £3,140,000, which represents a return on investment of 10.5:1.

The other associated financial implications of this development is a cost of £60,000 to establish and run a Lean academy and an investment of £200,000 for programme support and the implementation of stage 2 and roll out in the organisation.

Contact

For more information on this initiative please contact Valerie Doyle: *valerie.doyle@roh.nhs.uk*

FINALIST

Streamlining patient pathways, increasing theatre capacity and reducing wasted resources through theatre timetable optimisation and utilisation improvement at RWHT

Adrian Simons and Tim Powell; The Royal Wolverhampton Hospitals Trust

The initiative

The Royal Wolverhampton Hospitals Trust (RWHT) outsourced six orthopaedic theatre sessions per week to another acute provider during 2008–10 due to in house capacity constraints. In June 2009, a project was initiated with the aim of repatriating all outsourced theatre sessions before the end of that financial year by identifying and delivering sufficient in house capacity. Anticipated benefits included:

- Reduced infection rates — infection rates of those patients whose surgery was undertaken at RWHT were lower than at the external provider;
- A more efficient patient pathway— patients would complete their entire pathway within RWHT, rather than being transferred between providers mid pathway;
- Improved patient choice — if a patient required surgery, the trust could guarantee that the procedure would be carried out in house;
- Increased theatre utilisation — it would be possible to book more patients to each list, as historically patients had been asking not to be operated on at the external provider, resulting in underbooked lists;
- Reduced waiting times resulting from the increased theatre utilisation and capacity;
- Valuable medical resource would no longer be wasted travelling between sites;
- Anticipated net savings to the trust of just under £1m per annum.

Benefits

The ultimate measure of success of this project is that all six outsourced sessions were successfully repatriated and being carried out in house by the start of the 2010–11 financial year, which equates to a 14% increase in the number of orthopaedic theatre sessions being run in house. This comes with all the benefits targeted: reduced infection risk, streamlined patient pathways, greater patient choice, increased theatre utilisation, reduced waiting times, improved use of valuable resource and reduced cost.

In addition, improvements made in day case theatres led to a 15% increase in orthopaedic utilisation in Q3 2009–10 compared with the same period in the previous year (equivalent to running an extra two sessions per week). Finally, improvements to the visibility of cancelled sessions plus process improvements led to 2.4 additional sessions being available every week.

The work on improving visibility of cancelled sessions has also enabled us to consider flexible consultant timetables as a future option, to make the most of available resources and minimise the need for additional theatres to be built.

Financial implications

No capital expenditure was required to deliver this project. The net benefits totalled £1.24m per annum net of additional recurrent costs incurred.

Contact

For more information on this initiative please contact Lewis Grant: *Lewis.Grant@nhs.net*

WINNER

Children's acute nursing initiative

Jocelyn Thompson

Newcastle upon Tyne Hospitals FT

Background

In January 2008 a new pilot initiative was launched entitled the Children's Acute Nursing Initiative (CANI) — part of the children's community nursing service. The aim of this service improvement is to provide a high quality, flexible and responsive nursing service in order to facilitate much earlier hospital discharge for children and young people resident within (or nearby) the Newcastle area with acute illnesses, and exacerbations of chronic conditions.

The main objectives of the initiative are to:

- Facilitate early discharge from the inpatient wards;
- Reduce the need for, and inappropriate use of, acute care inpatient beds;
- Reduce the level of A&E and ward reattendances;
- Alleviate additional pressures placed on inpatient beds;
- Reduce anxiety about hospitalisation, reduce disruption to family life and provide choices;
- Facilitate health education and empowerment of parents/carers in order that services are more effectively used.

The process

The initial proposal was prompted by identified gaps in service provision between community and hospital based services. The aim was to facilitate earlier discharge for children and young people. It was developed to meet winter pressures and to facilitate a working model to highlight true costs and potential. It was initially funded as a six month pilot and is now funded substantially.

Work on paediatric medical wards, and an audit from an earlier pilot in 1999 identified that medically stabilised children were remaining as inpatients to finish their course of treatment or for further clinical monitoring, often causing severe disruption to family life.

The CANI team, in collaboration with the children's directorate team, including the children's wards and assessment/day unit staff, promptly identified admitted patients who had been medically stabilised, but continued to have acute nursing needs as well as a number who could have been referred via A&E had there been a pathway to classify them as an admission to the CANI team and retain the Payment by Results tariff.

Although we initially predicted that "winter typical illness" would be the main focus of the CANI service, in fact that the majority of referrals have involved children with "non seasonal specific general illness", with a number also coming from specialist teams.

Advice to other organisations

Where an extended community nursing service is provided many paediatric patients with acute illnesses and exacerbations of chronic conditions can be discharged early and managed in the community.

Benefits of the initiative

The provision of a CANI team, creating a virtual ward in the community has, since its launch in January 2008, cared for a total of 620 patients, and reduced the hospital admission period/treatment in hospital by a minimum of 1,490 bed days, Most importantly from a child and family perspective nursing children at home when stabilised is less stressful and reduces their risk of hospital acquired infection.

An analysis of the bed and cubicle data collected by paediatric bed information services, in relation to number of children on the caseload, demonstrates evidence that this service has impacted on the trust's target in reducing the number of breeches and deflections.

Financial implications

The initiative has saved at least 1,490 bed days, thereby allowing more activity through the beds and enhancing our ability to use funds in the most appropriate and cost effective manner, particularly, during peak "crisis" pressure periods.

	January 08 to March 08	April 08 to March 09	April 09 to March 10
Bed days saved	266	746	484
Cubicle days saved	211	1,250	778

Future plans

Feedback from across the children's services multidisciplinary team has been extremely positive and highly supportive of this initiative. Other areas of the trust where children are nursed have expressed interest in accessing the CANI service if capacity allowed. This interest is replicated by local regional nursing services whose children are treated or admitted to this trust.

Contact

For more information on this initiative please contact Jocelyn Thompson : *jocelyn.thompson@nuth.nhs.uk*

Award sponsored by

DH Department of Health

Judges

Sheila Shribman, *national clinical director for children, young people and maternity services, Department of Health*

Paul Ennals, *chief executive, National Children's Bureau*

Fiona Smith, *children and young people adviser, Royal College of Nursing*

HIGHLY COMMENDED

Delivering universal child health services creatively

Stephanie Wardle and Rachel Rispin; Northumberland Care Trust

The initiative

The Healthy Child Programme is the Department of Health framework for delivering the universal service to all families with children under five. This initiative aimed at creative delivery of the programme, focused on the first year development review.

The first year development review assesses childrens' growth, physical development and speech and language capabilities and includes a thorough review of previous medical and developmental history identifying. Any particular issues that are identified are tackled by offering an early intervention plan as required.

A new creative model was developed for the initiative in partnership with Blyth children's centre which offered a quality contact capitalising on all the services in the community. This improved the quality of service is offered to families and streamlined service delivery. As a result health visitors were able to target those families who had additional and more complex needs for home visits.

A multiagency team came together to develop the implementation plan, this included:

- Blyth health visitors;
- The Sure Start children's centre team;
- A language development worker;
- The oral health promotion team;
- Food and health workers;
- The families information service.

In order to market the initiative we developed attractive birthday invitations to be sent out to all those babies who became one in January 2010; individual services developed the delivery of the key areas of the session; we also produced a voucher offering a free child's meal at the cafes in Blyth Central and Blyth West children's centres;

Materials such as safety equipment were gathered for display with access to the low cost safety scheme. There was also information for parents and carers to take away; registration forms for the children's centre activities; oral health displays; and food displays.

The multiagency approach ensured the delivery of key messages in a creative and interactive way that engaged parents and carers. It also introduced families to a Sure Start children's centre approach which can lead to engagement in groups for toddlers, parent and carers groups, opportunities to comment on services and become volunteers or peer supporters. This can also be a stepping stone to future employment.

Benefits

The initial feedback from parents has been extremely positive, with increasing numbers attending subsequent sessions. The professionals involved have also expressed satisfaction at being able to offer a quality service at a time of pressure within the service.

In the second event 57 families were invited and 29 attended. This is higher than would normally attend a first year development review at the health centre. As a result of the efficient use of the health visitors' time they have been able to offer individual tailored home visits to complete this assessment and health promotion contact for those families who most need them.

Financial implications

The biggest potential cost is the staff involved in delivering the service, however in this case we were able to do this by reengineering the current service. As a result the only costs incurred have been food and activity costs (approximately £30).

Contact

For more information on this initiative please contact Joanne Brett : *Joanne.Brett@nct.nhs.uk*

FINALIST

College health development practitioners

Lisa Hartley and Sheridan Townsend; NHS East Lancashire Community Services

The initiative

Three colleges in East Lancashire have supported joint commissioning of a college health development practitioner (HDP) in partnership with NHS East Lancashire.

The HDPs are nurses who:

- Coordinate health activity delivered through the further education (FE) setting, integrating approaches from the statutory and voluntary sectors;
- Support health improvement and achieve quality outcomes focused on national and local health priorities for young people;
- Contribute to the health needs assessment of the college population to inform targeted interventions;
- Support the college to establish systems, training and protocols to protect vulnerable young people.

The HDPs also ensure that services meet the "You're Welcome" criteria and support transition from childhood to adulthood, promoting responsibility for health and wellbeing including managing risk to self and others and making a positive contribution via volunteering and enrichment programmes.

The initial trailblazer post was established in 2007 and two further posts have developed over the last 18 months. The HDPs are therefore at different stages of development and work flexibly and differently to meet the needs of the college population.

The initiative has involved working towards the "Healthy FE" criteria in partnership with each college, via an annual plan that spans the academic year. This is formulated at a healthy college steering group, with representation from NHS East Lancashire, the HDPs, college senior managers and student services.

The HDPs also train tutors to be effective health mentors, enabling them to provide appropriate brief interventions and signposting. They also provide health activity and tutorials linked to the college volunteering and enrichment programmes.

Benefits

Traditional health services often fail to meet the needs of young people. The HDPs are a single point of contact, providing a bridge into mainstream services while young people are still learning essential life skills such as managing their own time, and addressing health needs, complex relationships and problems. The nurse element of the HDP provides safe passage into a health service they find confusing and unwelcoming.

The initiative has been extremely well received in the colleges, who have quickly appreciated the added value the HDPs bring to the setting. Each quarter the HDPs are averaging 250 individual face to face contacts including: general health advice; healthy lifestyles; emotional health and wellbeing; sexual health; complex health needs; anger management;

substance abuse; smoking and relationship difficulties. As they walk around the college they interact informally with an average of 7–8 students every 15 minutes, providing reassurance, receiving brief feedback about a clinical appointment attended or supporting tutors working with troubled young people.

Financial implications

The cost of the service for three the HDPs is £120,000. Each college provides £20,000, with the remaining £60,000 provided by the PCT.

The savings produced by the service are hard to quantify but the presence of the HDP enables students who may otherwise have been excluded, dropped out or disappeared to sustain college attendance. It can only be assumed that completion of education by hard to engage young people provides long term cost saving for society as whole. Equally the ability of the nurse to provide basic health care on site has reduced attendance at GPs and mainstream clinical services.

Contact

For more information on this initiative please contact Judith Mace: *judith.mace@eastlancspct.nhs.uk*

FINALIST

Focus On: Children and Young People Emergency and Urgent Care

Sarbjit Purewal, Venkat Reddy, Kath Evans and Christine McDermott;

NHS Institute for Innovation and Improvement and partners

The initiative

Focus On: Children and Young People Emergency and Urgent Care was published by the NHS Institute to demonstrate that high quality emergency and urgent care for children and young people is achievable for all healthcare organisations. It features 20 characteristics found to be key to delivering high quality and care in this area.

The NHS Institute also designed a lesson plan for schools with the intention of promoting the involvement of children and young people; raising their level of awareness and knowledge about the variety of emergency and urgent care options; and encouraging their involvement in the planning, design and delivery of NHS services.

A rapid improvement programme was then designed to test how the recommendations in the *Focus On* document and lesson plan could be rolled out to local systems across NHS England. The aims of the programme are focused on:

- Improving experience and outcomes for children, young people and families utilising emergency care;
- Transforming emergency and urgent care processes for children and young people by ensuring a system approach is adopted across primary and secondary care.

The NHS Institute supported 10 systems, one from each SHA in NHS England. The initiative involved bringing together services in all of the participating sites that had not previously met as a whole system to focus on integrated working by adopting a pathway approach.

Children and young people account for 20% of the population, and more than 25% of all patients seen in emergency departments are children. There are five common conditions that account for 85% of all emergency activity in children (fever, diarrhoea and vomiting, accidental injuries including head injuries, bronchiolitis and asthma).

At each of the sites professionals from NHS Direct, emergency departments, paediatricians, GPs, out of hours services, community children's nursing teams, walk in centres, ambulance crew, children's centres, clinical and managerial leaders and commissioners collaborated to develop a whole system pathway for these common childhood conditions.

Working in partnership with the 10 NHS health systems, 10 secondary schools were asked to test the lesson plan through the existing curriculum. Each participating school hosted workshops with groups of Key Stage 3 pupils (11–14 years); these were cofacilitated by local healthcare professionals.

Sites also developed signposting tools so that the local community is aware of services available to children and young people

Benefits

Currently children and young people are not taught about appropriate use of emergency and urgent care services and they are not consistently engaged in the planning and delivery of these services. The lesson plan codeveloped by children, young people, teachers and health professionals, has helped health professionals to build their confidence and competence in engaging with children and young people, while organisations are changing the methods used to communicate with children and young people as a result of the initiative. The lesson plan has acted as a catalyst for ongoing engagement between schools and local healthcare services.

Financial implications

Present figures suggest that the current total national spend on children and young people admissions per annum is £765.3m, of which £149.9m could potentially be saved if admissions relating to high volume conditions were reduced by 25%. The potential savings from only reducing these admissions by 10% are estimated to be £52.3m for NHS England. This includes an implementation cost of £85,000 per system including project management support and investment to implement new ways of working.

We know this figure is an underestimate as it does not include any savings from reducing/avoiding emergency department attendances or reductions in readmissions. We are now seeking to provide evidence that these financial savings are achievable through continuing work with our test sites participating in the Rapid Improvement Programme.

Contact

For more information on this initiative please contact Kath Evans: *kath.evans@institute.nhs.uk*

FINALIST

An out of hospital integrated children's asthma service

Alison Davies and Julie Wallis;

NHS South East Essex

The initiative

Over the last 20 years the incidence of allergic disease has trebled and the UK has one of the highest rates in the world. Despite improvements in hospital environments and unrestricted parent participation, hospitalisation remains a stressful experience for many children. Their rate of recovery is on average 30–40% quicker at home than in hospital.

Redesigning the asthma service offered the opportunity to reduce hospital attendance and costs while improving quality of

care. By integrating the 9–5 asthma service with the community children's nursing service it became possible to offer specialist home nursing for children with acute asthma. Algorithms, protocols and patient group directives were developed to facilitate treatment and monitoring of children in their own homes with the aim of preventing the need to transfer them to hospital.

The initiative development was led by a specialist asthma nurse. It provides an individually tailored service where children and young people with asthma are assessed and treated in their homes by paediatric community nurses who use the algorithms and patient group directives to supply and administer medication and care.

The delivery of care is clinically innovative and has been developed collaboratively with a local paediatrician in the acute trust to ensure the coordinated delivery of safe effective personalised services.

Benefits

Using telephone triage and home visiting, qualified nurses empower children, young people and their families to manage their asthma at home, in turn preventing unnecessary attendance at hospital. With improved and timely access to support, advice and treatment the children and young people are supported in preventive management, leading to a reduction in acute exacerbations.

Outcomes at six months:

- 234 children and young people used the out of hours on call service;
- 63 of the 234 children and young people were managed at home through telephone advice;
- 172 of the 234 children and young people received treatment in their own home, this included assessment and treatment with oxygen, nebulisers and/or oral steroids;
- 35% of children and young people came from 20% lowest middle layer super output areas;
- 193 (84%) avoided hospital attendance.

Financial implications

The Transforming Community Service Innovation Fund gave £42,000 awarded to set up the one year pilot service. The PCTs committed to continue this funding for a further year based on the success of the pilot. One band 6 community paediatric nurse was employed to increase the teams capacity. Funding was also spent on medical consumables, emergency equipment and drugs.

Contact

For more information on this initiative please contact Alison Davis: *alison.davis@see-pct.nhs.uk*

FINALIST

Confident parenting groups

Annette Hames, Rebecca Peel and Jen Taylor; Northumberland Tyne and Wear FT

The initiative

Research shows that children with learning disabilities have more behavioural difficulties than children without disabilities, with up to 50% requiring mental health intervention and some being excluded from school. Parents of children with severe learning disabilities and behavioural difficulties have frequently told us that they find mainstream parenting groups inaccessible and unable to meet their needs.

With the help of parents and carers, our aim has been to develop an early intervention, innovative and cost effective parenting course that increases parents' confidence in their parenting skills and improves their children's behaviour. We also developed a group facilitator's training course. Most recently we have started to train parents so that they can facilitate these courses themselves.

Our groups are run by health workers (a clinical psychologist and a community nurse) and teachers. After training, we expect that similar groups will be run by any health professionals and other workers who already have knowledge and experience of working with children with learning disabilities and their parents/carers. Over the last year we have trained almost 100 health, educational and other workers.

We have run parenting groups for 11 years in Hadrian School (for 3–11 year olds with severe and complex learning difficulties). The groups have developed in response to parental feedback: they have become more reflective, concentrating more on parents' feelings, especially lack of confidence. Four years ago we also ran the first group specifically for parents with learning disabilities.

Two years ago we completed a thematic analysis, identifying the recurring themes that arise in groups. These were written up into a facilitator's handbook. We also raised £14,000 in order to produce a DVD to accompany the handbook.

Benefits

Most parents who attend our groups have lost confidence in their parenting skills and as a consequence, their children's behaviour has deteriorated. Our groups help parents to recognise their parenting skills; their confidence increases, and consequently their children's behaviour improves.

Three years ago we carried out a postal evaluation with over 100 carers who had attended. Sixty four per cent of respondents said that the groups had made a difference to their children's behaviour and over 90% said they had made a difference to them. The common responses from parents were that the groups had helped them to feel less isolated and that they no longer felt like "bad" parents.

Financial implications

All groupwork and the development of the facilitator's handbook and DVD has been carried out within working hours. The £14,000 for the DVD was raised through grants. Money raised through sale of the handbook and DVD and through training goes back to a charity run by Hadrian School, which provides extended services for the children.

Up to 50% of children with learning disabilities require mental health care at some time in their lives. Only 31% of parents who have attended groups subsequently required any further individual help with their children's behaviour from clinical psychology health services. While running the groups, the clinical psychologist can see up to eight families at a time (two hours a week) for a period of six weeks. By contrast, individual work with families would involve one hour a week for up to 12 weeks.

Many children with learning disabilities presenting with behavioural difficulties are excluded from school and require expensive residential education, with health support, which is often provided far from home. No children have been excluded from Hadrian School while the groups have been running.

Contact

For more information on this initiative please contact Annette Hames : *five@hamesinglis.plus.com*

FINALIST

Ashfield's Prison Health Performance Quality Indicators

Bob Jones and Jenny Arder;
Serco Health

The initiative

HM Prison Ashfield is the largest juvenile establishment in Britain, dealing with over 120 courts. It provides accommodation for 400 young people aged 15–18 who present with an array of challenging and chaotic behaviours. The healthcare team at HMP Ashfield has been growing since the establishment first opened in 1999. In what is a relatively short time in the prison service, the team has become recognised as one of the best, if not the best, within the service. The current team has been together for three years and have won several prestigious awards for their work.

The aim of the initiative was to was to achieve and maintain a 100% score in the national audit tool, the Prison Health Performance Quality Indicators (PHPQIs). The indicators were developed by the offender health team in conjunction with the key stakeholders with the objective of achieving NHS equivalent standards.

The 40 indicators are an amalgam of existing requirements from the NHS and prison service, including patient safety, governance, care and mental and public health. They were developed to measure the quality of service rather than the specific performance of any one organisation, and some indicators were specifically selected to demonstrate the efficiency of partnership working. Each indicator has a red, amber or green status, which identifies at what level the service is being provided. Our target was to achieve and maintain 100%. We have succeeded in doing this for the last two years.

Benefits

The PHPQI initiative encompasses all areas of health in prison life, therefore our other audits have reflected this:

- A recent score of 98% in our infection control audit;
- Very positive comments from a recent HMCIP inspection;
- The first prison to achieve National Healthy Schools status.

All these achievements are directly as a result of maintaining high standards governed by the PHPQIs.

The initiative has an impact on release into the community because if the team educates the young people to look after their own health and wellbeing it has benefits in being less time consuming for the public health services. There is also the benefit of keeping young people drug free and educating them about the damage drugs can do, which has an impact on release both on health services and crime.

Ashfield is only the second prison to implement a no smoking policy, in line with the "Acquitted" programme, which is best practice, the establishment now promotes a healthier lifestyle, which young people can benefit from when their sentence ends. Along with having the self esteem that comes from being a successful "quitter" is the knowledge that this will reduce the burden on the NHS for future treatment.

Financial implications

There were no direct finances involved. The initiative has simply highlighted the fact that prisoners are entitled to receive healthcare equivalent to that in the community.

Contact

For more information on this initiative please contact Bob Jones: *bob.jones@serco.com*

FINALIST

Working with teenagers to create "teen friendly" maternity services

Fiona New and Lesley Tones;
Tameside Hospital FT

The initiative

Tameside Hospital Foundation Trust lies east of Manchester in an area of socioeconomic deprivation. It has high teenage pregnancy rates, reduced clinic attendances and poor health outcomes. In accordance with Department of Health Teenage Pregnancy Strategy: Beyond 2010, We recognised that we needed to consult teenagers and redesign services if they were to reduce conception rates and improve uptake of breast feeding.

The hospital wanted to ensure we met the needs of very young mothers and fathers as part of a longer term multiagency effort to narrow social and health inequalities while tackling child poverty. With this in mind we decided to set up a new flexible bespoke teenage service to ensure easier access to ante/postnatal care and provide a friendly approach to avoiding unplanned pregnancy and sexually transmitted disease.

This involved:

- Consulting teenage pregnant girls/young partners and engage them in the service redesign;
- Creating multidisciplinary working to explore how ante/postnatal services could be reconfigured to ensure a "teen friendly" environment;
- Developing and implementing a teenage champion midwife post aimed at preventing further pregnancies and improving teenage parents' health outcomes;
- Involving a psychologist working with a midwife to address maternal emotional health and wellbeing, build resilience and raise aspirations;
- Using multiagency resources to create teenage information, support and standardised advice;
- Securing resources to test new ways of working and then move to a sustainable model;
- Planning and delivering a teenage parenting programme to improve parenting skills for girls/partners and to remove the stigma teenagers felt when mixing with "older" pregnant women.

Benefits

Previous audits had found that 20% of teenage mothers were pregnant again within 12 months. After the initiative this has now reduced to 12.6%. Breast feeding rates are now at 37%, which is up by 7% since beginning of initiative and 12% higher than the national figure.

Accurate, factual information is now consistently provided to teenage girls and their partners. It also benefits boys and young men as they can get contraceptive advice, access to Chlamydia testing and are positively encouraged in their parental role.

Having a clinical psychologist as part of multidisciplinary team ensures support during ante/postnatal appointments and allows us to address of issues of bonding with babies and general maternal mental health issues.

Financial implications

Most of the work within this initiative has been funded through existing resources that have been reconfigured to improve the quality of care for teenage girls.

Contact

For more information on this initiative please contact Christine Greenough: *Christine.greenough@nhs.net*

WINNER

Good corporate citizenship and carbon management

Dene Stevens and Shaukat Ali

Sandwell PCT

Background

The NHS Sustainable Development Unit Good Corporate Citizenship model supports NHS organisations in understanding and embracing sustainable development. The model was complementary to PCT core values to be socially and environmentally responsible and so presented an ideal opportunity to demonstrate the value practically.

The implementation of sustainability and corporate citizenship is slightly advanced in the acute sector, but it is relatively new in PCTs. Over the last two years Sandwell PCT has shown commitment at the highest level. For example a Good Corporate Citizenship working group was established with membership from different departments and functions of the PCT. The group is chaired by the PCT's chairman and has met on a monthly basis to drive forward the agenda.

The process

Wide ranging initiatives were implemented after discussion by the working group including:

- Introducing cycle training for staff and public;
- Using hot desking to maximise building utilisation;
- Introducing mixed and mobile phone recycling schemes
- Conducting a staff travel survey and introducing salary sacrifice schemes for bus and Cycle2work, "dump the car" days, car sharing, and implementing a hybrid fuel vehicle lease policy;
- Providing cycle lockers and showers and increasing the cycle mileage rate to 24p per mile;
- Developing a sustainable procurement policy;

We also set up a staff energy saving suggestions box on the trust intranet and introduced a Good Corporate Citizenship Award.

Advice to other organisations

The work we have carried out in implementing Good Corporate Citizenship and carbon management within the PCT is highly relevant to other healthcare providers, and can easily be replicated and adapted.

Benefits of the initiative

The initiatives that have been implemented have shown real benefits including:

- Reducing the PCT's carbon footprint from 4,552 tonnes of CO_2 at our 2008–09 baseline to 3,754 (21% reduction) tonnes in 2009–10;
- Creating 42 apprenticeships in 2009–10 including four for young people (14–19), 30 work experience placements and recruitment of 20 individuals from the local community;
- Server virtualisation enabled replacement of 11 physical servers with three physical and 40 virtual servers increasing storage and reducing energy consumption;
- Staff energy saving ideas/suggestions has generated 85 suggestions since its launch;
- "Dump the car" days achieved on average 73 staff leaving their car at home on each occasion;
- We have advertised tenders worth £1.3m using www.FinditinSandwell.co.uk as part of our local procurement initiative.

Financial implications

The introduction of hot desking at the PCT has resulted in financial savings and a reduction in carbon emissions and achieved increased utilisation of the PCT headquarters.

Preliminary results also show a total reduction of 111.36 tonnes of CO_2. For gas 507,030 KWhs were saved equating to £14,921 and 93.51 tonnes of CO_2. For electricity £2,776 was saved and 17.85 tonnes of CO_2. It is anticipated that 445 tonnes of CO_2 will be saved over the coming years with a five year payback.

Other savings include terminating a number of building leases equivalent to approximately £150,000 saving for investment in patient care, increased utilisation by 25% (294 desks to 400 staff) and achieving 18.5% reduction in annual energy costs per person. Replacing one printer for every 2.7 staff with one multifunctional device per wing has reduced paper and energy usage. Health of staff in PCT headquarters has improved by 1.95 days less sick leave compared with other PCT sites.

Server virtualisation achieved increased storage from 2TB to 24TB and a 920% improvement in power consumption to storage ratio. The implementation of the carbon management plan will lead to potential financial savings of around £300,000 per year by 2014.

Future plans

The PCT has set itself a challenging target to reduce our carbon footprint by 25% from its 2008–09 baseline over the next 4–5 years. This will bring about significant financial savings as well as improvements to the environment

Contact

For more information on this initiative please contact Shaukat Ali: *shaukat.ali@sandwell-pct.nhs.uk*

Award sponsored by

Sustainable Development Commission

NHS Sustainable Development Unit

Judges

Sir Muir Gray, *director, NHS National Knowledge Service*

Jake Reynolds, *head of education and young people, Sustainable Development Commission*

Sonia Roschnik, *operational director, NHS Sustainable Development Unit*

HIGHLY COMMENDED

Healthcare Careers and Skills Academy initiative

Natasha Mill and Ian Carruthers;
University Hospital of North Staffordshire

The initiative

Stoke on Trent is diverse area of deprivation (ranked 16th highest in England) with average household income some 30% below the national average. Approximately one in four adults receive state benefits and 15% of 16–18 year olds are not in education, employment or training (NEET).

Recruiting and retaining the "right" staff for current and future vacancies is a challenge familiar to all healthcare organisations, the situation at the University Hospital of North Staffordshire (UHNS) is no different. As the largest employer in the area, the trust recognised that in order to meet its staffing requirements in the future not only would it need to raise the skill levels of existing staff, it would also need to support the community to gain and retain employment.

For this reason we decided to develop a broad careers advisory service (Healthcare Careers and Skills Academy). An existing careers service was expanded to support NEETS, A level students, young carers and unemployed people.

Work experience opportunities are offered to local students, schools and the long term unemployed. In addition local teachers are encouraged to take up work experience placements to support their curricular development. Lesson resources were developed and delivered to NEETS to support their understanding the range of careers available in the NHS.

We have an active young apprenticeship programme in Health And Social Care in which 14–16 year old local students spend one day a week at the academy studying a BTEC and one day on placement in a local health and social care placement. An Aspiring Health Professionals programme has been developed to support student choices at GCSE, A level and degree level.

Benefits

Since the project began it has provided support to 2,137 people including 127 who started work at the trust and 77 who started work with other organisations. Over 100 students participated in the young apprenticeship programme with a 97% pass rate, while more than 600 students attended events at the Aspiring Health Professionals project. There have been a number of other benefits to the trust and community including:

- The quality of applications has improved;
- Trust staff are now more focused on young people as a potential future workforce;
- Local schools/community organisations more aware of the careers available in the NHS.

Financial implications

The Healthcare Careers and Skills Academy now has eight training rooms. Funding came from the Grampian Regional Development Fund, Advantage West Midlands, the Department for Education and Skills and the trust. Skills for Health, West Midlands SHA and the former SHA have pump primed projects within the academy. In terms of cost savings, taking over 200 people off the unemployment register will have resulted in savings in benefits and the outputs required by funding partners have been achieved.

Contact

For more information on this initiative please contact Ian Carruthers: *ian.carruthers@uhns.nhs.uk*

FINALIST

Embedding good corporate citizenship into a trust's day to day business

Joop Tanis and Eleanor Cappell;
NHS Birmingham East and North

The initiative

Birmingham and Solihull Mental Health Foundation Trust has a 15 year sustainable development and environmental strategy through which it seeks to develop and discharge its good corporate citizenship (GCC) responsibilities. The principal aims of this strategy are to:

- Deliver the trust's service development and business plans;
- Enhance the patient experience;
- Manage resources effectively;
- Fulfill the trust's GCC responsibilities.

In 2009–10 the focus was shifted to a recognised need to embed GCC into the day to day management of resources. This involved progressing a large number initiatives simultaneously. These include:

- Facilities: energy, procurement, transport, waste and food;
- Plans to deliver local and national policies and objectives;
- Awareness raising, learning and development.

Focusing specifically on a review of food and its direct relationship with patients' health resulted in a multidisciplinary dietary and nutrition review. This led to healthier menus being designed and prepared. Tertiary benefits include progress on a range of GCC objectives including:

- Sourcing and procurement of local / fresh produce;
- Production efficiency;
- Developing community/local partnerships;
- Reduced transportation — reduced carbon footprint;
- Reduced waste;
- Cost reduction and efficiency savings.

Benefits

The GCC initiative has improved the total care experience, while staff are more aware of the impact, cost and utilisation of resources. The following reductions have also been achieved:

- A 5.5% reduction in electricity consumption;
- A 3.4% reduction in gas consumption;
- Saving over 300 tonnes CO_2;
- Avoiding £10,000 of landfill tax;
- Reducing trust fleet vehicles by 20%;
- Recycling 70% of all waste.

Financial implications

To date the trust has committed approximately £1.5m (capital expenditure) in new plant, equipment and technology in developing and implementing its GCC responsibilities. Savings achieved to date are summarised below

Year	Energy	Procurement	Facilities	Transport	Capital	Total
2006/09	£110,000	£48,000	£62,000	£24,000	*£310,000	£554,000
2009/10	£100,000	£21,100	£18,000	£15,200	*£82,000	£236,300
Total	£210,000	£69,100	£80,000	£39,200	*£392,000	£790,300

(*capital savings include costs avoided)

In terms of return on investment (this broadly equates to £1.5m + £75,000 = £1.575m / £790,000 (2 year payback).

Contact

For more information on this initiative please contact Neil Cross: *neil.cross@bsmhft.nhs.uk*

FINALIST

Blue Bell Lane Primary Care Resource Centre

Ian Davies and Roger Burton; Knowsley Health and Wellbeing

The initiative

The Blue Bell Centre is a new primary care resource centre at the heart of Huyton, Merseyside. It will provide accommodation for four GP practices, a community pharmacy and a wide range of multidisciplinary and multiprovider services including out of hospital services. The building has been designed to show how the NHS can reduce its carbon footprint and deliver an affordable landmark building. The location at a main arterial gateway into the town meant that positive visual impact could not be sacrificed to deliver the sustainable vision.

Design workshops with stakeholders provided an opportunity to bring forward new ideas to shape the final design. The building includes: reduced water consumption and recycling; air source heat pumps to provide all heating and hot water; solar panels and a wind turbine to deliver 10% onsite renewable power; no requirement for onsite fossil fuel; a high thermal mass construction, including a ballast/green roof that provides a comfortable working environment.

Benefits

The Blue Bell Lane Centre is a landmark public building with a predicted annual energy requirement of only 7Gj/100m^3 and a BREEAM Healthcare "Excellent" rating.The building provides a focus for delivering wider health and wellbeing services in a significantly deprived community. Evidence from earlier schemes demonstrates that such facilities encourage public demand for services.

Financial implications

The Blue Bell building, which is just over 2,500m^2, cost £5.7m to construct with a final leaseplus cost of £286.68m^2 at financial close in March 2009. This cost is less in real terms than other NHS Local Improvement Finance Trust schemes that closed in August 2008 at £274m^2 and £287.49 in November 2008, neither of which include the innovative approach to design, construction and operation. The savings in lease plus costs are mirrored by the modelled savings in running costs for a building that requires no traditional heating or ventilation systems.

Contact

For more information on this initiative please contact Ian Davies: *ian.davies@knowsley.nhs.uk*

FINALIST

Local food onto patients' plates — improving quality and sustainability

Kirsty Edmondson-Jones and Dave Elsom; Northern Lincolnshire and Goole Hospitals FT

The initiative

The NHS spends over £300m on food and £500m on catering overall each year. The UK food chain employs 12.5% of the UK workforce and accounts for 8% of the economy. The NHS accounts for 5% of all road traffic in England and 3.2% of total carbon emissions in England.

With these facts in mind, the initiative sought to increase the amount of local produce served while investing in the local economy and reducing carbon emissions.

The main impediment was the lack of local suppliers on NHS Purchasing and Supply Agency framework agreements., which meant we could not procure sustainable local food. Getting authorisation is prohibitively complex and costly for smaller suppliers so we developed our own innovative systems and processes to give us access to local suppliers while observing limits, procurement policy, trust standing orders and transparent audit trail. A multi-quote IT solution has been integral to the transparency of creating our own, more accessible system for smaller local suppliers and our sustainable procurement strategy.

Benefits

As a result of the initiative, 50% of the food on our menu now contains sustainable local ingredients. Patient satisfaction with food services has increased since the new menus were introduced in December. Our Patient Environment Action Team results were "Excellent" for food services this year. Wastage has been reduced as patients eat more food and this improves their outcomes.

Our tender process means we now tender more regularly and get better deals. This has released funding to introduce premium ingredients onto the patient menu. Many of our suppliers are now within a 50 mile radius of the trust, most with 10–15 miles, saving transport costs and reducing carbon emissions. A significant proportion of the trust's food budget of circa £1.5m is now spent locally, supporting local businesses and communities.

Financial implications

No resource was available to fund this. We saved money on food costs for poor quality ingredients and now can afford higher quality local ingredients.

This entry was also a finalist in the **Procurement initiative of the year category*

Contact

For more information on this initiative please contact Kirsty Edmondson-Jones: *kirsty.edmondson-jones@nlg.nhs.uk*

FINALIST

Sustainable Health South West — supporting sustainability in the South West

Kate Burton and Lynn Gibbons; South West SHA

The initiative

The aim of the Sustainable Health project is to support effective sustainability policy and practice within all NHS trusts in the South West, to improve service delivery, combat and adapt to climate change and encourage healthy, sustainable communities across the region. The project works to support the policies and targets laid out in the NHS Carbon Reduction Strategy.

The project's first step was to convene a regional network for sustainability leads of all South West trusts, along with select partners and trust colleagues. The network meets quarterly to discuss a particular topic and is also supported through e-updates and the Sustainable Health SW website, which contains best practice information, case studies and information resources.

The website also contains downloadable templates for plans and policies, including a sustainable development management plan. Support is also provided to trusts on other actions plans, including carbon reduction and green travel. A series of training and expert tuition events is arranged for network members and relevant colleagues, examples from 2009–10 include carbon management, sustainable procurement and travel planning.

Benefits

The project has allowed for better coordination of information and good practice, as well as the dissemination of information and feedback. It helped the region to achieve the highest percentage of trusts with a board approved sustainable development management plan. Benefits to the individual trusts include:

- Helping to meet legislative requirements linked to sustainability, including the Carbon Reduction Committee's Energy Efficiency Scheme and elements of the Climate Change Act;
- Reducing energy use, cost and associated carbon, through training and best practice sharing;
- Support for best practice and carbon reduction.

Financial implications

The project was funded by NHS South West, and delivered by Sustainability South West. The funding paid for a project manager on a four day per week contract and for project costs, including website development.

Individual trusts should show savings and efficiencies as a result of involvement and support from the project manager. This could be in the form of energy savings, procurement efficiencies and waste and water reduction.

Many savings linked to sustainable development are not realised immediately. Actual cost savings will be seen in the coming years, particularly when the predicted rise in costs of fuel and other goods is taken into account.

Contact

For more information on this initiative please contact Kate Burton: *kate.burton@southwest.nhs.uk*

FINALIST

More than a Hospital

Judith Morris and Jan Sinclair;
Stockport FT

The initiative

After gaining foundation status in 2004, Stockport Foundation Trust has developed a strong local community focus through good corporate citizenship. In the last three years this has developed into its More than a Hospital initiative. The purpose is to implement the corporate social responsibility of the trust in a way that helps the local community.

The initiative covers a wide range of different areas:

- The lifestyles service — our lifestyles coordinator works with nursing staff to screen patients for smoking, alcohol and obesity and then provide brief health promotion interventions or referrals to specialist key workers;
- Extending employment opportunities — our volunteer learning scheme encourages those with a barrier to employment to develop the skills and confidence to gain employment with the trust or other local employers;
- Corporate citizenship — we use local suppliers wherever possible, whether for the supply of meat for our kitchens or awarding building contracts within the north west;
- Improving our green credentials — this includes active energy management and recycling initiatives;
- Overseas work — we link with Ahmadu Bello University Teaching Hospital in Zaria, Nigeria, working together to reduce maternal and infant mortality rates;
- Membership development and engagement — we have over 17,000 members who all receive a quarterly newsletter and are invited to specific trust events.

Benefits

The benefits are many and various and include:

- 70% of patients the referred to key workers by the lifestyles service reported a positive change in behaviour;
- Work placements have been provided for 105 individuals with a barrier to employment, with more than 40 of these gaining employment as a result;
- Neonatal deaths in Zaria have been reduced.

Financial implications

This is an ongoing programme with many strands some of which have been provided through more efficient working (corporate citizenship, green credentials), while others been funded through trust investment (energy reduction schemes), innovative use of existing budgets (lifestyles service, membership development) and some through external grants (volunteer learning scheme, Zaria).

Contact

For more information on this initiative please contact Judith Morris: *judith.morris@stockport.nhs.uk*

FINALIST

Patient transport optimisation project

Trevor Payne, Joanne Wilson and Brian McKenzie;
University College London Hospitals FT

The initiative

This project reduces costs and improves services by using vehicles and service providers suited to each demand. It optimises vehicle activity by ensuring good journey planning and is currently extended to all University College London Partner (UCLP) organisations as early implementers. We aimed to:

- Surpass the minimum service delivery expectation of 95%;
- Ensure the patient experience is positive;
- Provide a single call centre for all transport requirements;
- Optimise vehicle use and reduce out of contract activity;
- Reduce costs.

The project began by developing a scope covering all activity at the UCLP participants. Before tendering we developed a specification and met potential service providers. The most suitable tender was chosen based on sustainability, quality, and cost. We then we worked with the selected service provider to develop a change management process to reduce complexity and selected pilot areas for each of the early implementers.

Benefits

The project will benefit patients by improving air quality resulting in fewer respiratory cases. It will also result in faster patient to ward and ward to home transfer. There will also be improved non patient services. Consolidating demand through one service centre improve productivity and cost effectiveness through better vehicle use and fewer transactions.

Financial implications

The initiative did not require any additional resources other than an initial exercise to scope the opportunities. Savings already identified amount to more than £100,000 for UCLH alone.

Contact

For more information on this initiative please contact Joanne Wilson: *joanne.wilson@uclh.nhs.uk*

WINNER

Recognising and responding to the deteriorating patient

Sarah Ingleby and Steve Jones

Central Manchester University Hospitals FT

Background

The recording, recognition and response to the acutely deteriorating hospital patient has been a longstanding patient safety concern and "track and trigger" systems have been recommended by the National Institute for Health and Clinical Excellence (NICE) to assist in the early detection and referral of these patients.

Numerous strategies have been used to try and implement these recommendations, often without success. We developed and conducted a historically controlled trial of an IT application (Patientrack) that accurately calculates our early warning score (EWS) and alerts the appropriate responder. This alerting continues until the patient improves. This work has demonstrated improved patient safety gains and reduced risks to patients.

The process

When using the system ward nurses conduct patient observation rounds as normal but instead of recording them on paper charts they input them onto a wirelessly connected personal digital assistant. The remote software automatically calculates the EWS and advises the nurse of a raised score.

There are some products that do this already but the difference here is that the system will automatically alert the appropriate clinician — doctor or nurse — according to the significance. This alert will persist, and escalate, until the patient's condition improves. If a patient has abnormal observations the system automatically schedules the correct timings of observations to drive further clinical reviews.

This system does not aim to replace clinical judgement, instead it supports nursing staff seeking reviews of their patients without wasting time trying to locate and discuss the patient with the doctor. It also allows staff to quickly identify at risk patients by having a ward view of the patients' track and trigger scores. This, and the ability of the system to track all EWS, response times and trigger duration means that close audit and monitoring of care is possible, which can assist in calculating staffing numbers for individual areas.

Advice to other organisations

This IT patient safety intervention is easily transferable to other hospitals. The alerting structure can be adopted in its current form or the system can be configured to reflect any local track and trigger policy as recommended by NICE. The IT infrastructure required is within the easy reach of most, if not all, trusts and the software is written in Java and runs in Flash. We are making our business case and purchasing details available to other trusts via NHS Supplies to avoid duplication of effort.

Benefits of the initiative

During the 14 month trial of this initiative:

- Recording was improved by visibly showing the nursing staff when to do observation sets and alerting the ward manager to any delays;
- Recognition was improved as the track and trigger scores were correctly calculated (typically there is a 20% calculation error);
- Response was improved by alerting doctors directly and escalating this alert if the patients did not improve.

All of these improvements added up to proven patient safety gains: patients were "sicker" for a shorter period of time and there was a 20% reduction in hospital length of stay. Fewer patients ended up on intensive care and half of the usual number of bed days were used. No patient had a cardiac arrest in the intervention phase and we observed a mortality reduction of 2%.

Financial implications

The trust and Patientrack met their own costs during the trial. Trustech, the innovation hub for NHS North West, recognising the potential importance of the innovation also made a contribution. After the successful trial, the trust procured the system under normal commercial terms. The business case for the procurement demonstrated the savings which would be achieved from reduced length of stay, fewer unscheduled admissions to ICU and fewer adverse events. The trial gave the trust confidence in the Patientrack product. The business case showed the value of the product but most importantly how it could be used to underpin a comprehensive, trust wide focus on patient safety.

Future plans

We are continuing to develop both the Patientrack product and newer patient safety additions such as venous thromboembolism prophylaxis recording. After presenting at the NHS NorthWest Innovation Expo 2009 we have spoken to many colleagues in different trusts who all have similar issues, and several are interested in adopting our initiative. We successfully applied for NHS North West funding to spread this learning and good practice to other trusts including our business case and implementation "lessons learned" document.

Contact

For more information on this initiative please contact Barry Murphy: *barrymurphyhome@hotmail.co.uk*

Award sponsored by

system C
connected care

Judges

Bob Ricketts, *Director of System Management and New Enterprise, Department of Health*

Ian Denley, *Chief Executive, System C*

Geraint Lewis, *Senior Fellow, The Nuffield Trust*

HIGHLY COMMENDED

Ward based automation: a new approach to medicines management

Lee Knowles and Jeannette Green; Mersey Care Trust

The initiative

The purpose of this initiative undertaken by Mersey Care Trust pharmacy services has been the development of a novel system for medicines management at a ward level. Ward based automation uses vending machine hardware with newly developed software that creates an individual medication profile for each patient linked to an electronic "patient's own medication" cupboard/drawer.

Following a successful small pilot of a standard ward based stock MEDI-365 unit a pharmacy led project team worked with a private company (Mediwell) in order to develop the ward based system with an individual dispensed patient drug (IDPD) approach. This involved developing new software in order to produce an individual patient approach to pharmaceutical care at the ward level.

The team used the plan, do, study, act method because it is an interactive process base around an expected output. The software programmes were built up bit by bit and gradually introduced to the ward based systems. It has taken two years to develop this system, which now offers:

- Biometric access;
- Complete live record of all "active medications";
- Remote viewing of activity related to medicines administration;
- Complete drug history;
- Patient specific ordering direct to the dispensary;
- Remote access of live information by pharmacy staff;
- Fully labelled medications complete with directions for use available at a ward level.

Two IDPD systems were introduced in the trust in October 2008. Since then 80 trust staff have regularly used them and 40,000 doses have been administered.

Benefits

When compared with baseline data from 2007 and 2008 impact on delayed and omitted medications have been significant. Since the introduction of the IDPD automated approach on the STAR unit the rate of omitted medicines has fallen from 3.59% to 0.30%.

There has been a positive effect on time savings for both pharmacy and ward staff. The average medicines administration round has been reduced by 15 minutes, saving of one hour of nursing time per ward per day. In addition the ward staff are no longer required to keep a manual register for recorded drugs, as the IDPD system keeps an electronic record.

Unwanted medications/returns fell from £3,036 in a three month period before implementation to £9.60 in a three month period after implementation. In addition to this, stock holding on the STAR unit has been decreased by 80% compared to before implementation.

The feedback from ward based staff has been overwhelmingly positive, with all staff describing the service as excellent or good.

Financial implications

An investment of approximately £30000 was made for the procurement of the hardware involved in the two ward pilot. (Two double frame MEDI-365 storage units, finger print and barcode scanners and hard drive).

There has been an opportunity cost for the development of the system — £12,000 per annum of staff time has been used on the project. The project team has consisted of one pharmacist and three pharmacy technicians along with colleagues from Mediwell. However the initiative has resulted in savings in several areas including:

- Reduced stock holding per ward;
- Reduction in expired stock;
- Minimal need for pharmaceutical returns;
- Reduction in staff travel time and associated costs.

These cost savings have led to a return on investment within 15 months starting the project. Further work is needed to examine whether the reduction in delayed/omitted medication and administration errors has produced significant savings.

Contact

For more information on this initiative please contact Lee Knowles: *lee.knowles@merseycare.nhs.uk*

FINALIST

Systemic biofeedback: hearts on their sleeves

Anthony Scrafton and Brenda McHugh; CNWL FT

The initiative

Violence and antisocial behaviour are the most common reasons cited for exclusion from schools. These types of behaviours are also labour intensive and financially expensive for schools managing children with problematic behaviours. Inexplicable, out of control states of mind and the resulting 'unprovoked' and seemingly intractable behaviours are often taken to mean that a child represents too great a risk and must be excluded.

In this initiative children and their families use bespoke biofeedback devices to monitor their own personal triggers for stress, emotional and physical arousal. The use of the biofeedback devices was prompted by the realisation that some children, particularly adolescents, find the more traditional talking cures or therapies difficult to put into practice.

This project was influenced by several factors including knowledge of various biofeedback techniques, the field of sports science (where audible biofeedback devices are currently used to arousal levels) and in the area of psychophysiology. Biofeedback techniques have been used in a wide range of conditions such as headaches, disorders of the digestive system, cardiac arrhythmias and epilepsy.

In relation to the onset of mental health difficulties, this framework of understanding sees mental disorders as an adapted response to stress with depression, anxiety, poor control of emotions and behaviour. Children and families use these biofeedback devices to monitor changes to their emotional and physical arousal levels. Detecting these changes at an earlier stage allows more time to put into practice defusing strategies and thus learn to control their behaviour.

The application of the biofeedback device as a therapeutic aid to children at risk of social exclusion is unique to the Marlborough Family Education Centre.

Benefits

Over the past two years 43 children at risk of exclusion have been helped using this method. Children wearing the biofeedback devices can practise self calming methods and explore interactions while wearing the monitors at the Marlborough Family Education Centre, at home or in school. Parents and teachers have commented on the beneficial effects and increased

self control and anger management of many of the pupils.

We have found that the biofeedback device a highly effective way of capturing the interest of children and it provides a focus, as well as a fun way of addressing specific issues. It offers the opportunity to do something practical about difficulties that may have appeared entrenched and immutable. The use of the devices in highlighting mutually escalatory interactive processes, particularly between children and their parents, appears to be very powerful. Several parents have said that the monitors helped them to realise that, for their child to change, they themselves would need to change.

Financial implications

We have secured a research and clinical development grant of approximately £60,000 from NHS Innovations London to develop the concept of systemic biofeedback as a treatment programme. The funding includes costs for the concept design, development and implantation.

We are currently entering the product and technical development phase of the service evaluation for this concept. We intend to carry out our service evaluation once we have designed and trialled our bespoke biofeedback device. The forecast financial return for CNWL NHS in year 1 is estimated at £279,013.

Contact

For more information on this initiative please contact Anthony Scrafton: *anthony.scrafton@nhs.net*

FINALIST

DATIX and ICIS: the missing risk management link

Deborah Smith and Dave Pilsbury; Greater Manchester West Mental Health FT

The initiative

Before 2007, patient incidents were reported directly into the electronic clinical patient records (ICIS), which although invaluable to clinicians:

- Created duplication of administrative processes for recording incidents;
- Did not easily meet external reporting requirements for the National Patient Safety Agency (NPSA);
- Proved difficult to report lessons learnt, demonstrating safer working practices.

In 2007, Greater Manchester West Mental Health Foundation Trust (GMW) procured Datix integrated risk management system to provide a robust repository for the recording and analysis of risk and performance data. It used a web based system accessible to all staff across the trust. The intention was to ensure the full integrity of the patient record by developing a solution that would automatically populate ICIS to inform staff of patient incidents that had been recorded via Datix.

GMW spans 50 sites across six boroughs and has 3500 employees. For this reason staff engagement with the project required an intense level of communication and consultation.

A series of technical meetings were held between the Datix project team and the ICIS developers to link the two systems. A number of fields were identified in the Datix incident record that needed to be populated within the ICIS patient record.

The Datix team developed XML messages to be created every time an incident was recorded on the system, indicating whether it is a client related incident or not. Only client related incidents are processed.

If the content of the XML message passes all validation rules, then an incident event is created within ICIS as an event and as a nursing note in chronological date order. If the XML message content does not pass validation rules then no incident event is created, instead an error message and description of the error is managed by the Datix Administrator.

A qualified member of staff would review the incident in Datix and click "yes" if it needed to go in the patient record, and then check that the correct patient ICIS numbers were entered on the form and click "ICIS confirmation". The incident date, time, location, category, description, and reporter details would then populate the relevant patient ICIS record within 60 seconds.

Benefits

The Datix/ICIS integration has vastly reduced administrative time spent duplicating information for internal and external reporting requirements. The reduction in administrative work updating patient records has led to staff being able to spend more time both on wards and with patients.

The trust now has the ability to support the reporting requirements of an intelligent board to record, report and monitor all risk and performance issues both internally and externally across Greater Manchester West. In addition the quality of the incident reports has greatly increased and all direct facing staff are aware of patients incidents in a timely manner.

Incident reporting has increased as a result of easier reporting. The number of incidents reported trust wide between April 2008 and March 2009 totalled 4,932, whereas between April 2009 and March 2010 they increased to 10,200.

Financial implications

Phase 1 incurred technical consultancy costs of about £3,500. Future costs for phase 2 are in the region of £6,000 for the recording of multiple patient incidents within ICIS. However, the costs incurred are minimal compared with the benefits in terms of staff time saved.

Contact

For more information on this initiative please contact Deborah Smith: *deborah.smith@gmw.nhs.uk*

FINALIST

BT mobile health worker programme

Robert Flack and Elaine Gomersall; Kirklees Community Health Services

The initiative

Providing community based healthcare across a large geographical area can be a challenge. Large amounts of travelling can be a large drain on staff time. Not only does this impact on serving the needs of patients, it is also costly in terms of travel, infrastructure and productivity. The BT mobile health worker programme improves patient care by giving staff access to patient records at the point of care delivery (typically a patient's home).

Kirklees has deployed 600 Panasonic Toughbook laptops to frontline staff in order to enable them to access records remotely. These lightweight and semirugged laptops, which are supplied by BT, have built in, high speed mobile broadband and 3G capabilities, enabling innovative mobile working in the community.

In order to ensure that the system was secure robust information governance arrangements were set up and information sharing protocols were established. Standard operating procedures were developed to ensure security issues were in order from the outset.

A rigorous approach to training was implemented. It was regarded as important that this approach incorporated the very latest thinking and reflected lessons learnt from previous projects. A change management approach was implemented and the team focused on breaking down barriers and working on people's fears of the new technology.

Training sessions were practical and focused on problem solving. Clinicians were heavily involved in the process, which provided credibility as the trainers were also users and could talk about how they overcame issues themselves.

Benefits

The project delivers better local care while enabling significant long term cost savings and productivity gains. It enables increased efficiency and improved clinical outcomes. Benefits include improved communication, increased productivity and delivering a more convenient service for the patient. Being better informed leads to better clinical decision making, meaning resources are used more effectively. By cutting travelling time, staff are able to increase the number of patients they see.

The system avoids duplication of information and improves access to information at the point of care. Record keeping is contemporaneous, reducing errors and improving data quality. It brings a safer, quicker, more efficient service.

It enables the organisation to work towards becoming paper free. Staff's work/life balance is improved as they have increased flexibility around when and where they work. It has brought recruitment cost savings as a result of productivity gains, allowing the organisation to disestablish vacant posts without impacting on the level or quality of service provided.

Financial implications

The initiative required financial resources of £650,000 from July 2009 to July 2010. Reduced travelling has led to cost savings of £600,000 a year through travel expenses alone. The time saved will have resulted in increased productivity.

Contact

For more information on this initiative please contact Camilla Cross: *camilla.cross@yorksandhumber.nhs.uk*

FINALIST

GPO: GP online

Tim Coker, Nigel Brook and Tara Ritchie; NHS Warwickshire

The initiative

Information on Warwickshire GP websites was inconsistent and there was no way of amalgamating national and local content. Extensive research, revealed that:

- Online directories often contained out of date information and incorrect contact details;
- GP led sites were often limited by the skills and time that the GP had to devote to supporting the site;
- Some existing sites incorporated third party advertising with links to companies, services and professions beyond the control of the GP;
- Commercial websites would cost a practice up to £500 per year and many charged for content refreshes;
- There was no standardised methodology for provision of information and very little support or guidance for site upkeep;

In response to this situation NHS Warwickshire developed GPO, a tool providing a stable, uniform platform for websites that allows patients to order repeat prescriptions, update their records and, where GP systems allow, make appointments online.

GPO is a free service expected to empower patients and improve access to services that is already proving popular with GPs. It seamlessly integrates up to date NHS Choices data with locally derived information, using its sophisticated synchronisation process.

GPO launched in May 2010 and we are working with 39 interested GP practices, 19 of which have already gone live.

Benefits

GPO was built in response to an existing service that was spasmodic and in need of improvement and the benefits will reach GPs, their patients and the general public. Many of the benefits for GPs, patients and the public overlap, for example, time saved in updating content, ease of use and appointment bookings.

Financial implications

Following a successful business case submission to the strategic health authority, £25,000 was awarded to fund the project. When all the original 35 practices go live, GPs will save approximately £8,750 a year — the cost of buying and running their own sites. If all GPs practices in Warwickshire implemented GPO, it would result in annual savings to the local health economy of approximately £20,000. With the opportunity to implement GPO across the Coventry and Warwickshire health economy, there is the potential for further, huge savings.

As patients are able to order repeat prescriptions and book and cancel appointments online, a significant time savings for receptionists and nurses are also expected to be made as a result of this project.

Contact

For more information on this initiative please contact Tara Ritchie: *tara.ritchie@warwickshire.nhs.uk*

FINALIST

Perfect patient care: improving nursing standards and the patient experience

Mark Irving and Sandy Brown; North Cumbria University Hospitals Trust

The initiative

The purpose of this initiative was to develop a web based application that would facilitate real time data entry and reporting of patient satisfaction, staff satisfaction and nursing clinical indicators data all within the same system.

We engaged with a team of external software developers with previous experience of developing applications for clinical staff. They worked closely with staff to develop a sustainable system that was fast, secure, accessible and user friendly.

The information is collected on handheld devices and desktop computers by nursing staff. It is then available in realtime and viewable on ward computers immediately.

The system triangulates information from patient satisfaction, staff satisfaction and nursing clinical indicators in order to demonstrate excellent practice and share the lessons of this practice across the trust in an effective and efficient way. It also identifies areas where clinical practice requires improvement and acts as an early warning in identifying situations where corrective action may be required to protect patients.

The system is designed to produce a 360 degree report on the quality of care a ward is providing by measuring a series

of nursing standards against a framework linked to the Care Quality Commission's Standards for Better Health.

The patient and staff experience has been developed from NHS Institute for Innovation and Improvement questions and works from the premise that in the Mid Staffordshire Trust report the early signs were present in complaints from patients.

Benefits

Since the initiative began there has been an improvement in clinical practice across ward areas, a 30% improvement in staff satisfaction and maintenance of the excellent patient satisfaction results already received over the past two years.

The clinical indicators assessment provides evidence on the level of care the patient receives within each clinical area and examines 15 areas, many relating to the high impact interventions published in 2010. The assessment allows the senior nursing team to prioritise their resources in supporting some clinical areas. The information is shared across the trust and has lead to professional completion on delivering the "best care".

Financial implications

The application now costs the organisation £7,000 a year. This is a small fraction of the cost of purchasing multiple applications that would not provide us with the same level of information. Our research estimated that the cost of these applications would have been £30,000–40,000. This meant that savings resulted immediately.

The application developers were responsible for the development costs and provided the organisation with the software at minimal cost during the development stages. This was with the agreement that they intended to develop a system that could be marketed to other organisations following completion.

An important factor highlighted during development was the potentially significant labour costs of data collection. Our strategies to minimise this included integrating the application at the point of care, and using volunteers to collect patient/staff satisfaction data. This has led to significant resource savings in this aspect.

We estimate that the time saved by our clinical teams by not having to visit wards for results or input data themselves covers the annual cost of the application. More importantly, this allows these senior staff to focus their activity on any areas that are found to be of concern.

Contact

For more information on this initiative please contact
Sandy Brown: *sandy.brown@ncuh.nhs.uk*

FINALIST

Hospital wide patient surveillance

Gary Smith and Simon Freathy;
Portsmouth Hospitals Trust

The initiative

Together with our industry partners, The Learning Clinic, we used existing knowledge, research data and national recommendations to design a wireless, handheld computer based system, which permits clinical staff to record patient vital signs at the bedside on general wards (VitalPAC). The system calculates patients' early warning scores, transmits data wirelessly to the hospital computer system, creating an accurate, legible, electronic vital signs chart and a fully auditable trail of patient physiological data.

Demographic and laboratory data are automatically integrated and decision support provided directly to bedside staff. The system includes PC tablets for accessing data on ward rounds and gives staff elsewhere in the hospital instant access to the charts and data via the intranet. There is a real time operational clinical dashboard and a clinical performance dashboard for governance, which together provide measures of workload and compliance with monitoring protocols.

We ensured that VitalPAC was a clinical project, which happened to involve computers, rather than an imposed IT solution. We adopted a bottom up approach to developing the system, ensuring that it fitted into, and enhanced, current nursing/medical working practices. All staff were encouraged to provide critical appraisal, the results of which, more often than not, resulted in changes to the system.

The purpose was to improve patient safety by reducing levels of harm in three high risk patient safety areas: the early recognition and response to patient deterioration; healthcare associated infection (HCAI); and venous thromboembolism (VTE). Numerous publications from the Department of Health and other bodies identify these as critical safety issues.

The project, was originally limited to hospital wide physiological surveillance. This component of VitalPAC is installed hospital wide in Portsmouth and four other NHS hospitals. It is about to be installed hospital wide in a further three and is implemented part site in a further twelve.

The HCAI component includes: screening of MRSA; surveillance of *Clostridium difficile* associated diarrhoea; and surveillance of peripheral intravenous catheter related infections. These were developed in Portsmouth Hospitals and are being rolled out in other VitalPAC sites. The final component of "hospital wide patient surveillance" — VTE — is being implemented in five hospitals.

Benefits

Published research shows that VitalPAC facilitates and speeds clinical processes for staff. It simplifies clinical protocols and guides staff through their completion using direct questioning and prompts at specified times, ensuring that no essential steps are missed; provides local decision support regarding specific patient management; provides improved accessibility to clear and legible charts, facilitates access to laboratory results and provides instantaneous alerts about laboratory results.

There has been a 22% reduction in hospital standardised mortality ratio (from 106.1 to 84.4) during the time that VitalPAC has been in use. Compliance with MRSA screening has increased from 40% to 99%, MRSA carriage has reduced to less than 2% and there has been an 80% reduction in MRSA bacteraemias.

Monthly data has already shown improved compliance for VTE risk assessment on different wards ranging between 68–96% (mean = 77%). For the main medical, surgical and orthopaedic admission areas, compliance exceeds 90%.

Financial implications

Human resources were provided to the project by Portsmouth Hospitals in the form of time and intellectual property on clinical processes and data analysis. All other costs were met by the The Learning Clinic and are confidential to them. There is a royalty agreement resulting in payments to Portsmouth Hospitals on the basis of sales of VitalPAC to third parties. The timeframe for return on investment is unknown to us, as it depends upon uptake of the innovation by other sites.

Contact

For more information on this initiative please contact
Gary Smith: *gary.smith@porthosp.nhs.uk*

WINNER

The acute hospital RAID mental health project

George Tadros and Kerry Webb
Birmingham and Solihull Mental Health FT

Background

Birmingham and Solihull Mental Health Foundation Trust has developed an new approach to acute hospital mental health liaison services. The traditional model has been rewritten and the Rapid Assessment, Interface and Discharge (RAID) service is now in operation at City Hospital, Birmingham. The service is firmly embedded in the acute hospital (integration, not liaison) and incorporates three key domains of mental wellbeing:

- Adults of working age mental health;
- Substance misuse disorders;
- Older adult mental health.

Our key aims have been:

- A single point of contact for all referrals;
- A 24/7 service for continuity and consistency;
- Close partnership working with third sector organisations;
- Evaluation of the impact of the service.

The process

The initial scoping of Birmingham liaison psychiatry services began in the summer of 2008. The mental health trust chief executive convened the first project meeting in September 2008. A few weeks of prioritisation scoping led to the vision of the RAID model and its presentation with a business proposal to the acute trust management board.

The RAID team was inducted by autumn 2009. The service went live by December 2009 and was 24 hour by March 2010. As well recruiting new staff to increase staff numbers, there was a need for new accommodation within the front of the acute hospital, in keeping with the principles of integration and profile. Staff and patient leaflets were created and an official launch date helped put RAID on the map. Formal and informal training sessions to clinicians have helped to establish a level of clinical attainment and educate staff on all aspects of mental health input.

Advice to other organisations

There is much undiagnosed or under-managed mental health pathology within the acute hospital setting. If problems like depression, dementia and substance misuse can be identified earlier and more effectively then a number of things can occur including the following:

- Avoidance of unnecessary hospital admissions
- Reduced length of hospital stay;
- Improved engagement with treatment;
- Reduced hospital costs.

Most acute hospitals will have some form of mental health liaison service. Such services could embrace the RAID model.

Benefits of the initiative

RAID has been able to deal well with the targets of responding to A&E referrals within one hour and ward referrals within 24 hours. It has improved referral pathways through and out of the acute setting and as a result also assists community mental health colleagues through early and effective referral with comprehensive clinical information.

The initiative is an ongoing clinical delivery project, yet even after only six months we found:

- Significantly increased patient referrals and assessments;
- Improved pathways to community;
- Improved clinical coding of inpatient episodes;
- Earlier referral and identification of problems;
- Positive patient and staff experiences;
- Improved targeting and management of cases that might previously have resulted in serious untoward incidents.

RAID has worked closely with informatics and clinical coders to allow us to better diagnose mental health and substance use disorders, which allows better coding and identification of cases in the acute setting.

Partnership working with third sector providers within the hospital, through innovations such as hospital alcohol clinics has been an immense success for all parties.

Financial implications

RAID has been introduced to reduce costs at the acute hospital while improving patient and staff experience. Up to 40% of peak A&E presentations can be alcohol related; if RAID can identify an alcohol use disorder at presentation and offer a brief intervention unnecessary admission may be avoided.

Initially, average time from admission to referral to RAID for patients aged over 65 was 14.6 days. RAID addressed this through targeting admissions earlier. Early evaluation data suggests that length of stay is reducing as a result and patient pathways back to community settings are improving upon discharge.

Future plans

The service has developed collaborative links with other departments and institutions and so there will be a number of ways to feedback benefits.

Contact

For more information on this initiative please contact Kerry Webb: *kerry.webb@uhb.nhs.uk*

Judges

Hugh Griffiths, *acting national director for mental health, Department of Health*

Ian McPherson, *director, National Mental Health Development Unit*

Kathryn Hill, *director of mental health programmes, Mental Health Foundation*

Steve Shrubb, *network director, Mental Health Network*

Award sponsored by

DH Department of Health

HIGHLY COMMENDED

Nottingham City Asperger service

Jackie Dziewanowska;
Nottinghamshire Healthcare Trust

The initiative

Asperger syndrome is characterised by difficulties in social interaction, communication, imagination and developing relationships. It is difficult to meet the needs of people with Asperger syndrome either in mental health or learning disability services. Until recently commissioners did not understand the need to prioritise funding for this vulnerable group.

The Nottingham City Asperger service was set up to make formal diagnostic assessments for people with Asperger syndrome, and develop and deliver short term coordinated packages of support and enablement.

In the first year, the service received 116 referrals, the majority of which were initially for diagnostic assessment, with post diagnostic support, and specialist support packages provided.

Clinical problems encountered by adults who access the service have included anxiety, depression, obsessive compulsive disorder, psychosis, current and historical offending behaviour, and addictions. A range of clinical interventions specific or tailored to adults with Asperger syndrome have been provided by the multidisciplinary team including:

- Psychological therapy;
- Sensory integration;
- Speech and language therapy;
- Occupational therapy;
- Psychopharmacotherapy.

Service developments have included setting up specialist groups such as parenting skills, partner support and social skills training. We intend to develop a training programme for carers and support staff of adults with Asperger syndrome.

Benefits

People are now being diagnosed and receiving treatment. They are being helped to live independently, to attend college and university, and to gain employment or to sustain employment which previously they might have because of the symptoms of their illness.

Within its first 12 months, the service has received 116 referrals, with 74 adults initially seeking diagnostic assessment for Asperger syndrome, and the remainder (42) already diagnosed and seeking local specialist support.

Financial implications

The service is funded by Nottingham City PCT, the team consists of:

- Asperger Nurse Specialist (clinical lead) 1.0 whole time equivalent (wte);
- Asperger liaison nurse 1.0 wte;
- Consultant psychiatrist 0.4 wte;
- Clinical psychologist 1.0 wte;
- Speech and language therapist 0.6 wte;
- Occupational therapist 0.5 wte;
- Inclusion support worker 1.0 wte;
- Team secretary 1.0 wte.

The initiative is currently being evaluated and we anticipate it will demonstrate cost benefits across the health and social care budgets and benefits to the criminal justice system.

Contact
For more information on this initiative please contact Debbie Abrams OBE: *debbie.abrams@nottshc.nhs.uk*

FINALIST

Mental health gateway workers: promoting positive mental health

Louise Poley and Geraldine Jones;
Cardiff and Vale University Health Board

The initiative

The aim of the gateway workers (GWW) is to bridge the gap between primary and secondary care utilising a stepped care approach. The GWWs ease access to and choice of effective psychological interventions with referral into specialist services if needed. Before the initiative was set up in 2008 primary care professionals felt their patients were getting a poor service from secondary care, and the community mental health teams (CMHT) felt referrals were sometimes inappropriate. Funding was secured to extend the existing primary care liaison worker post into a dedicated service with three fulltime GWWs and a clinical nurse lead. The new service offers:

- Triage assessments for routine mental health concerns;
- Stepped care interventions;
- Stress management courses'
- Solution focused interventions.

The gateway workers needed a range of specialist skills to be able to undertake comprehensive assessment of mental health, recognise serious mental illness and ensure that people needing highly specialised care can access the appropriate service. A training programme was devised that included:

- Motivational interviewing;
- Solution focused work;
- Bibliotherapy prescribing;
- Accredited mental health first aid training;
- Stress management training.

The client group is the combined adult population of 14 GP surgeries. Treatments are offered to adults and 16–18 year olds not in full time education who have been identified as experiencing mild to moderate mental health problems.

Benefits

GPs were asked to give feedback on the introduction of the GWWs, comments included:

- "The gateway service is easily accessible to both GP and patients. For patients it is a lot less daunting to attend a familiar place with staff known to them in their local area. As a result some patients who have always declined referrals to CMHT have been able to engage with the service";
- "The services are timely and save the wait for an appointment with the CMHT".

Patient feedback included:

- "It was good knowing that I had a full hour's consultation. It gave plenty of time to explore some very difficult issues";
- "I attended an evening class run by a GWW, which I found very helpful, explaining ways to relax and prioritise everyday occurrences".
- "The GWW had different ideas for me to try. I would not have got better without the support of the GWW"

Financial implications

Cost savings are difficult to measure over the short period that the pilot has been in operation. However, there is anecdotal evidence that GPs now only refer the most serious cases to the secondary services.

Contact
For more information on this initiative please contact Peryn Morgan: *peryn.morgan@wales.nhs.uk*

FINALIST

Young Foundation Social Entrepreneur in residence

Eleanor Cappell and Mark Peters; NHS Birmingham East and North

The initiative

The Young Foundation has spent the past two years conceiving, refining and delivering the concept of the social entrepreneur in residence (SEiR). The role of brings the skills and support to foster communities into meaningful partnership with health care providers. It enables communities to transform ideas to reduce health inequalities into sustainable social ventures.

Start Again is one of these social ventures. It is registered as a community interest company and empowers young people with or at risk of mental health issues to access a customised football coaching programme to increase physical activity, community reintegration and employment opportunities.

Our SEiR intensively supported Start Again, which underwent an internal NHS Birmingham East and North (BEN) two stage process called Gateway. Stage 1 is the approval of the project proposal and stage 2 is the in depth operational plan. The Gateway process involved Start Again:

- Defining the project scope, start/end date, inclusion/exclusion criteria and number of beneficiaries;
- Identifying patient conditions, characteristics and prevalence levels;
- Demonstrating scalability and plans to share best practice;
- Managing key stakeholder relationships;
- Exploring linkages with local, regional and national standards, strategic policies and best practice;
- Identifying improvements to the patient experience;
- Demonstrating statistical relevance of the planned pilot;
- Analysing resource requirements and return of investment;
- Agreeing the key performance indicators;
- Outlining data and patient satisfaction systems and processes for collection, analysis and reporting;
- Undertaking milestone planning;
- Managing risk;
- Assessing the impact on diversity and equality.

The pilot will support a total of 180 young people who will have access to customised support in the form of exercise, community reintegration and employment opportunities. The aim is to encourage them to regain control of their lives and re-ignite a sense of purpose and wellbeing.

Benefits

In clinical terms the key annual performance indicators for Start Again are:

- 162 clients participating in health assessments;
- 18 clients reporting a reduction in smoking;
- 2% reduction in Body Mass Index (BMI);
- 3% reduction in systolic blood pressure;
- 4% reduction in cholesterol levels (mmol/l);
- 135 clients engaging with support and advice on nutrition and healthy eating;
- 135 clients receiving awareness and support for alcohol, drug, and substance abuse;
- 135 clients receiving information and support for emotional needs such as anger management.

Turning to the beneficiaries we intend that each year 114 clients not in education, employment or training (NEETs) will become economically active, 135 clients will gain accredited personal and professional development and 90 will gain a juniors level 1 award.

Financial implications

In 2009–10 NHS BEN invested £128,326 in Start Again, with a projected return on investment of £400,930. This calculation is made up of the following elements:

- Holistic support to increase wellbeing, £8,685;
- Resilience to manage mental health, £3,885;
- Individual support in secure mental health units, £5,010;
- Less reliance on prescription drugs, £5,370;
- Weight reduction, £45,000;
- Smoking cessation, £4,212,
- Destigmatisation of mental health, £288,000;
- Tackling social exclusion associated with mental health, £18,684;
- Creation of employment opportunities, £3,264;
- Creation of volunteering opportunities, £18,824.

Looking at the wider picture, in 2010 the Department of Health report *Economic Benefits of Self Care* analysed savings to the NHS from patients who engaged in self care interventions as follows:

- Visits to doctors reduced by 0.2 per patient per year (pppy);
- Visits to nurses reduced 0.2 pppy;
- Hospital inpatient bed days reduced by 1.6 pppy;
- A&E attendance reduced by 0.2 pppy;
- Outpatient appointments reduced by 0.4 pppy;
- Mediation costs reduced by £48 pppy .

These savings led to savings to primary care of £56.69 pppy and savings to secondary care services of £395.04 pppy.

Contact

For more information on this initiative please contact Dawn Rayson: *Dawn.Rayson@benpct.nhs.uk*

FINALIST

Advice on Prescription: a partnership approach to improving mental health and wellbeing

Erica Crisp and Hitesh Patel; NHS Halton and St Helens

The initiative

Advice on Prescription is a joint initiative run by NHS Halton and St Helens, Halton and St Helens Health Improvement Team (HIT) and the Citizens Advice Bureau (CAB).

Many people when feeling a change in their mood go to see their GP seeking a medical approach when a problem solving approach may be more appropriate. The aim of the initiative is to fasttrack people visiting their GP who have mental health problems due to social welfare issues into more appropriate support services than psychological therapies. Upon identifying a suitable patient, the GP refers into CAB services. Within 24 hours of referral a debt advisor rings the patient to assess which CAB intervention is required.

The initiative was undertaken to improve patients' experience of service delivery when experiencing distress. It is often this distress that a clinician identifies with and may refer to secondary care mental health services. These services often have assessment and treatment waiting times, which can result in the patient's condition deteriorating into a more severe state along with their social welfare issue.

The health improvement team's mental health improvement specialist worked alongside the CAB to produce the necessary materials and to promote the pilot project to selected GP practices, single point of access staff and psychological therapies to ensure their participation.

Benefits

The initiative is ongoing in a number of selected GP practices but an interim evaluation has been undertaken between February and April 2010. Within this period 35 referrals for debt advice were made. Significantly, two people referred had been under the care of the crisis team due to suicidal intent. Through receiving debt advice and support their risk was eliminated. The key benefits of the initiative are in:

- Reducing patients' anxiety/depression by offering a service that is responsive to their needs;
- Supporting primary care professionals during highly emotive consultations with a social prescribing problem solving, rather than a medical pharmaceutical, approach;
- Making full use of PCT funded debt advisors within the CAB to reduce mental health services costs.

After the 12 week period ended we gathered qualitative feedback from staff who referred to the scheme. The general theme was about the time it saved practitioners and the appropriateness of it as an intervention:

- "Saves time, gives people the opportunity to speak to experts within that field";
- "Will make my work a lot easier — reduces time spent, chasing round researching what's available";
- "Knowing I could speedily refer my patient into CAB and then onto a depression group made me feel confident I had done my best as the main problems will be addressed and then the mental health work will probably have a bigger impact";
- "by accessing the scheme and support so quickly my gentleman went from being a suicide risk and needing crisis support to having no suicidal intent".

Financial implications

The PCT provided funding to the CAB for six debt counsellors for three years and resources for referral materials at a total cost of £300,000. The HIT team performed an analysis to determine whether the project had an impact on the level/step of mental health intervention their patients received (as a proxy for cash releasing savings). They found that within a 12 week period, 38% of referrals resulted in a step down of mental health intervention and that 50% of these were discharged from mental health services completely.

Contact

For more information on this initiative please contact Eugene Lavan: *Eugene.Lavan@hsthpct.nhs.uk*

FINALIST

Online wellbeing service in partnership with Big White Wall

Richard Graham and Jenny Hyatt; The Tavistock and Portman FT

The initiative

Big White Wall (BWW): www.bigwhitewall.com, is an online early intervention service for people in psychological distress. It combines social networking principles with a choice of clinically informed interventions to improve mental wellbeing. It can be accessed 24/7 and has staff who ensure the full engagement, safety and anonymity of all members. BWW is a community of people who are experiencing common mental health problems who are supported to self manage their wellbeing.

BWW views mental wellbeing as a systemic interplay of factors in individuals' engagement with themselves, their networks/ communities and the society where they live. Hence, It reflects emergent policies that place mental health within the broader agenda of public health. Further, it supports moves to encourage people to self manage their physical and mental health, and does this within the context of stimulating community and connectedness as integral features of wellbeing.

As a digital service BWW extends accessibility and control to users, particularly those who may be isolated by physical, social or other circumstances. There are no waiting lists, there are no eligibility criteria and there are no opening hours.

The service was founded in 2007 by Jenny Hyatt; a social entrepreneur who had sat on the board of International Samaritans and had experience in counselling and other therapeutic interventions. Over a six month period a team of people who had experienced emotional health crises or worked in the mental health field tested the concept to ensure the community would provide support.

Big White Wall went live in October 2007 as an 18 month public pilot. The service was extensively refined through discussions with the community. In 2009, an independent evaluation highlighted the need for the service to improve its clinical integrity. This led to a partnership with the Tavistock and Portman Foundation Trust which has a long history in innovation and employs a senior clinical staff who have special interests within the digital environment.

The trust embraced the partnership and has set up internal processes to manage the development. This includes NHS best practice joint risk assessments of the service and joint working practices from clinical expertise through to business development. Since the partnership was formed the service has been widely commissioned.

Benefits

An independent review of 598 users of the pilot found that BWW was used most commonly to relieve stress and loneliness (each cited by nearly two thirds of respondents), anxiety (cited by a half), and depression (one third). One quarter of users were experiencing suicidal feelings and one fifth were self harming.

Three factors appeared to be critical in deciding to use the service: connection with others experiencing psychological distress, lack of alternative safe and anonymous places, and ease of access. Three quarters of respondents had never previously shared the issue they raised on BWW.

Overall, over three quarters of respondents found BWW more helpful than any other source of support in their lives, including family, friends, doctors, therapists and employers. Nine out of ten reported improved mental wellbeing as a result of their experience on Big White Wall, including enhanced self understanding and reduced isolation, as well as lower levels of stress and depression.

The majority of respondents said they were able to self manage their mental wellbeing without recourse to further help.

Financial implications

This initiative was privately financed with an initial investment of £236, 000. Beyond this there was a significant investment of staff time by BWW and the trust. The initiative became self financing through revenues within 12 months of the partnership being formed. BWW has already generated £400,000 in revenues in 2010–11 and is likely to double this figure before year end. The initiative will therefore be self financing and generate profit for reinvestment in service development.

Contact

For more information on this initiative please contact Emily Buttrum: *ebuttrum@tavi-port.nhs.uk*

FINALIST

A community mental health service for armed forces veterans

Simon Day;
Tees, Esk and Wear Valleys FT

The initiative

The service aimed to make it easier for armed forces veterans with mental health concerns to seek and get help with the particular issues that affect this group. Although only a minority of veterans experience mental health problems, they constitute a significant number of people. In the UK there has been no specialist mental health care provision for veterans from the NHS and local authorities, who have responsibility for veterans's health after they leave the armed forces.

In 2005 the Ministry of Defence funded a review to ensure the treatment offered by the NHS was appropriate. This report led to the Department of Health and Ministry of Defence announcing a pilot programme to develop and trial new models of community based mental health care for veterans. Our trust was one of six to take part.

Our model was to establish a network of services. We decided not to have dedicated centres for veterans, but to integrate the veterans' service into the services we already provided. This made better use of staff and financial resources and, as it does not rely on keeping separate centres or units open, was more sustainable.

We worked in partnership with veteran organisations like the Soldiers, Sailors, Airmen and Families Association the Royal British Legion, Combat Stress, Service Personnel Veterans' Association and the National Gulf Veteran and Families Association to establish what services would be required.

Because of the size of the trust, generic mental health workers and trauma leads were identified and the infrastructure was set up. In partnership with Catterick CMH, Military Mental Health CIC and the Hull Trauma Centre, 145 generic mental health staff were trained in military culture and mental health awareness. A further 62 staff with a specialist interest in trauma underwent additional training.

We considered the full mental health spectrum rather than just posttraumatic stress disorder and included depression and other mood problems, anxiety, alcohol and drug misuse, adjustment difficulties and psychosis.

The integrated network model ensures that our full range of mental health services is delivered locally to veterans. Support from veteran organisations aids the smooth transition from military service when appropriate. We also work closely with housing, welfare and local authority social services.

Benefits

Armed forces veterans have historically been reluctant to ask for mental health support when they leave the services, partly because they feel medical staff do not understand their military background. This new service addresses that and encourages veterans to identify the symptoms of mental ill health and ask for help.

We have formally counted over 70 veterans presenting to our service since its launch and the rate of referral is beginning to increase. We have received a number of complimentary statements from service users who have recommended us to others. Treating veterans within normal NHS services also aids their transition back into civilian society.

Financial implications

The sum of £35,000 was provided by the Ministry of Defence for each of the two years of the pilot. This paid for a project lead for three days a week to build and sustain the network of staff and the service model. Because we chose not to have dedicated centres for veterans, but to integrate the veterans' service into existing services, this made better use of staff and monetary resources.

Our integrated model has meant the trust has been able to continue to support the project lead after completion of the pilot, and also to support ongoing staff training.

Contact

For more information on this initiative please contact Jayne Lamplugh: *jayne.lamplugh@tewv.nhs.uk*

FINALIST

Ignite Your Life! A community resilience project

Paula Gamester, Mark Swift and Laura Pogue;
The Wellbeing Project

The initiative

The Wellbeing Project worked in association with NHS Halton and St Helens to develop a scheme to support the implementation of its early detection of depression programme.

The initiative was set up because there was a locally identified need to raise awareness of the signs and symptoms of common mental health problems so that people are able to seek support at an early stage. We believed that this would have the effect of reducing the number of people presenting with severe symptoms and requiring specialist interventions.

The Ignite Your Life! community resilience project aimed to provide communities with simple practical skills to stay resilient during difficult times. This was done through half day sessions (three hours) with interactive workshops focusing on:

- How to improve mental wellbeing;
- How to stay resilient;
- How to spot the signs of depression;
- How to get help.

During the events, participants were invited to make pledges to carry out the five ways to wellbeing. We used the pledge card system to track participants over several months to determine outcomes and impact of the scheme.

There were also seven day follow up telephone interviews with clients using semi structured questionnaires and a three month follow up questionnaire

The initial project was delivered to 192 people. Since then it has been delivered to 472 people over 7.5 months.

Benefits

The scheme proved a cost effective means of engaging large numbers of people in public mental health awareness activities. From the initial project:

- 178 out of 192 rated it as very satisfied/satisfied;
- 179 out of 192 rated it as very worthwhile/worthwhile.

Financial implications

NHS Halton and St Helens funded the initial project to deliver the scheme to 192 people with full evaluation. This cost £20,000.

Contact

For more information on this initiative please contact Mark Swift: *m.swift@wellbeingproject.co.uk*

WINNER

Care without walls case and care management

Niti Pall, David Morris and Dee Kyne

Pathfinder Healthcare Developments Community Interest Company

Background

Care Without Walls is a programme aiming to help a high risk group of patients to better manage their long term conditions (LTCs) and so reduce urgent care admissions. It focused on redesigning services using:

- Risk stratification of the registered list;
- Proactive patient outreach;
- Care designed to meet the needs of each specific patient demographic.

The service is intended to ensure efficient streamlined access to the right person at the right time in the right place. This will help to deliver better clinical care, tackle health inequalities and improve patient satisfaction.

The process

Working with Aetna UK as a strategic partner we have implemented a programme to deliver telephone support focused on promoting patient engagement and optimising health behaviours, to reduce hospital use and acute episodes of deterioration. This is connected to other key interventions such as group consultations and community health volunteers and has had an unusually high impact on our patients with LTCs. The scope of the work included:

- Targeting 400 high risk patients;
- Screening (including mental health considerations) through use of analytic tools and discussions with GPs;
- Providing incentives to promote behaviour change;
- Coordinating GPs and other community health resources;
- Monitoring patients' activities and outcomes for six months.

Smethwick medical centre (SMC) has reengineered the way primary care services are delivered. We introduced sign-posting resources; self assessment tools; a responsive access (triage) process and group consultations for specific long term conditions.

SMC worked with Aetna to commission a behavioural motivational programme for specific at risk patients; the programme improves the patient's confidence, compliance and self care.

Advice to other organisations

Our model has been a partnership between public, private and social sectors and has achieved significant reductions in secondary care usage. The work could be easily replicated and adapted for use in other areas. Others are now asking us for a blueprint of the programme.

Benefits of the initiative

Early audits demonstrate a change in patient behaviour, the achievement of personal health goals and reduced reliance on medical care. The "case and care" management programme has produced a reduction in use of secondary care — there is a 40+% differential between those in the managed group compared with the unmanaged group. We have engaged the

patient population, as demonstrated by our active force of 45 volunteers working as health champions and surveys showing patient satisfaction. These interventions have already started to reduce use of secondary care services.

Financial implications

Pathfinder Healthcare Developments CIC raised £200,000 to support this work from a social investment loan made by Big Issue Invest — its first in health. This loan was underwritten by the GPs with the mortgage on their building, enabling Sandwell PCT to invest in a number of ways and through a number of initiatives. Aetna UK, though paid for some of its work, did so at huge reductions in cost. Total investment has been just over £500,000 cash with much more in kind.

We expect this initiative to take five years from inception to realise a full return on investment. Early savings are calculated at £400,000 and financial modelling over the next five years indicates savings. We expect net benefits of just over £6m with roll out costs of £3m. These numbers reflect the early stages of rolling out only a portion of the work: case/care management and group consultations.

Future plans

The future of this work leads to population health management, cost reduction and value for money, and, ultimately, greater patient involvement in their care. We are embedding a "whole system" at a local level, with patients at its centre, who will inform and challenge practice.

Early indicators are that group consultations are creating a different way of interacting with clinicians and enabling patients to take back control of their healthcare in a supported environment. We are rolling the programme out within Sandwell to a population potentially of 55,000, and are negotiating to take on GP commissioning.

Contact

For more information on this initiative please contact Dee Kyne: *dee.kyne@nhs.net*

Judges

John Oldham, *national clinical lead — quality and productivity, Department of Health*

Mashkur Khan, *consultant physician and geriatrician, Epsom and St Helier Hospital*

Jeremy Taylor, *chief executive, National Voices*

Carole Nossiter, *regional business director, Sanofi-aventis*

HIGHLY COMMENDED

An integrated COPD service in Salford

Anna Thomson, Nawar Bakerly, June Roberts; NHS Salford and Salford Royal FT

The initiative

Diagnosed prevalence of chronic obstructive pulmonary disease (COPD) in Salford is twice the national average and places a large burden on health services. The city's primary and secondary care trusts instigated a joint initiative to tackle COPD by investing jointly in developing an integrated service that aims to:

- Reduce the number of unscheduled COPD admissions to secondary care and reduce length of stay (LoS);
- Improve access to COPD services by bringing services together and making them available in the community;
- Improve the patient journey by making the transition between primary and secondary care seamless;
- Empower patients by promoting self management;
- Empower primary care to manage COPD based on best evidence by introducing an educational and mentorship programme;
- Develop links with other services to improve COPD care;
- Produce cost savings by improving efficiency and reducing waste.

The first step in achieving these objectives was to jointly appoint a consultant respiratory physician and a nurse consultant. This was followed by stakeholder and public consultation to define priorities and a health needs analysis to establish population baseline. We also undertook an education needs analysis to establish a COPD management skills baseline in primary care.

At the end of this process we published Salford's COPD strategy. Implementing the strategy involved:

- Redesigning current services to become more responsive to patients' needs;
- Adding new staff roles and moving many services into the community;
- Creating new services based on established need (for example home oxygen service).

We conducted an annual of review of services and a further stakeholder and public consultation at 24 months.

Benefits

Measured outcomes include the following:

- Community clinics gave patients access to specialist service nearer to home (250 a year);
- More patients were offered specialist smoking cessation interventions (extra 100 a year);
- More patients completed a pulmonary rehabilitation programme nearer to home or at home (extra 100 a year);
- Only patients who met the criteria according to the best available evidence for home oxygen therapy were prescribed oxygen. Assessments were carried out in the community or at home (282 patients during the first year);
- More patients with severe and endstage COPD were offered end of life palliative care (200% increase);
- An additional 1,300 patients were added to primary care COPD registers, the majority having mild disease;
- Hospital admissions dropped from 955 to 695 and LoS from 8.1 to 5.9 for admissions with COPD exacerbations;
- The national COPD audit rated COPD services in Salford among the best in the country.

Financial implications

Primary and secondary care made a joint investment in appointing a consultant respiratory physician and respiratory nurse consultant. NHS Salford has also invested in developing a home oxygen team, and in expanding the pulmonary rehabilitation service. Total investment was:

- Consultant respiratory physician, £80,533;
- Respiratory nurse consultant, £48,794
- New home oxygen service, £89,000;
- Expansion in pulmonary rehabilitation, £82,000.

Savings were measured independently for primary and secondary care.

Primary care:

- Savings from reduction in admissions and LoS, £307,000 (between 2006–07 and 2008–09)
- Savings from reduction in oxygen prescribing, £113,000 (between 2008–09 and 2009–10)
- Savings from moving COPD outpatient activity from secondary to primary care, £51,000 in 2008–09

Secondary care:

The reduction in admissions and LoS within the respiratory department had contributed to the closure of four acute respiratory beds in the hospital. The reduction in COPD outpatient activity has reduced waiting times to see new patients.

Contact

For more information on this initiative please contact Nawar Diar Bakerly: *nawar.bakerly@srft.nhs.uk*

FINALIST

An innovative approach to improving urinary continence in older people: chronic disease management meets intermediate care

Rhian Morse and Paula Wilce; Cardiff and Vale University Health Board

The initiative

The prevalence and severity of urinary incontinence (UI) increases with increasing age. 30% of community dwelling women over 70 years old may be affected. Associated adverse health outcomes include:

- Low mood;
- Social isolation;
- Impairment of mobility;
- Poor functional recovery after acute illness;
- Urinary tract and skin infections;
- Falls and fractures;
- Requirement for long term care.

UI is highlighted in the National Service Framework for Older People, the subject of a NICE Guideline and currently the topic of a major national audit by the Royal College Physicians. It is poorly managed in older people with comorbidity — other conditions take precedence and there is an assumption little can be done.

The aim of this initiative was to improve the management of UI in frail older people via a dedicated community based facility and establish a hub of expertise for teaching, training and information. This would involve setting up:

- A community based continence clinic specifically designed to meet the needs of frail older people;
- A teaching and training base for medical and nursing staff. The service would have to be embedded within other community/intermediate care services in order to maximise clinical links and minimise costs since the majority of change had to be delivered within current resource.

A simple audit of patients attending the day hospital demonstrated 40–50% of attendees had UI. It was clear that solutions for this patient group could only be delivered via a multidisciplinary team within an appropriate setting. We identified two clinical rooms and refurbished them using charitable funds and purchased a portable bladder scanner.

A consultant geriatrician with an interest in continence worked with the existing day hospital multidisciplinary team to develop a system for comprehensive continence assessment (medical, nursing and functional). Existing qualified nursing staff were encouraged to undertake additional training in continence care. Qualified and unqualified nursing staff rotated through the service — to raise awareness, receive training and disseminate good practice. A lead nurse from within the day hospital was identified and released to the project for two sessions a week.

Benefits

Audits of outcomes have demonstrated that UI can be improved in 75% of this patient group (average age 83 years). Follow up of recommendations and an effective communications strategy with GPs, community nursing staff and carers is essential. Pad usage is halved and quality of life demonstrably improved. Through our weekly clinic coupled with our and nurse led support service we assess approximately 500 patients a year.

Training of nursing staff working within our elderly care services has significantly improved and this has had a knock on effect on our other services. Training existing elderly care nurses has proven a more effective approach for this patient group than referred to a standalone continence advisor. The existing community continence advisors now work much more closely with us, with one advisor due to start working within the clinic later this year

Financial implications

The financial resources required by this initiative were small. All staff initially involved in the project were already working within the service, while refurbishment of clinical rooms was undertaken using charitable funds. The purchase of a portable bladder scanner at a cost of £5,000 required a business case. This scanner is a shared resource and available to the entire department. Pad usage has fallen by over 50%, providing indirect savings to the wider health community.

Following the success of the clinic we have increased the input of our nurse lead. This has been achieved via a pump priming grant from a pharmaceutical company and equates to 16 hours of a band 6 Nurse per week (approximately £16,400). The survival of the clinic is not dependent on this but it has allowed further development of the educational initiatives.

Contact

For more information on this initiative please contact
Rhian Morse: *Rhian.Morse@btinternet.com*

FINALIST

Chronic obstructive pulmonary disease local enhanced service

Mark Hopkin and Joanne Hamilton; Dudley PCT

The initiative

With a population of 315,000 residents, the Dudley borough had seen a year on year increase in the number of people suffering from respiratory problems since 2008, with an increase of almost 500 patients in this category over the three years. The Chronic obstructive pulmonary disease local enhanced service (COPD LES) was designed to help patients to manage their own care with the support of their GP to avoid admission to hospital.

The initiative is delivered by GP practices supported by community nurses/case managers, hospital consultants and pharmacists. Leads from GP practices were invited to sign up' for the LES. This required them to have a named GP and nurse from each practice who had a COPD diploma or equivalent or agreed to attend a course.

The identified leads are the main channels for ongoing communication. The workshop included updates from pulmonary rehabilitation (offered across four sites in Dudley), exercise programmes, smoking cessation and the new oxygen service that was launched alongside the LES. All information and documentation is also available on the intranet.

The COPD pathway is accessible to all staff across the health economy. All practices signed up and each was provided with a pulse oximeter. Each patient is graded for severity. Other requirements include treatment review, oxygen saturation levels and if required, pulmonary rehabilitation referral, personal management plan and prescription for standby antibiotics and/or steroids. Practices were required to identify patients at high risk of admission and given a list of patients who had been admitted in the previous 12 months with a COPD exacerbation.

Benefits

The initiative proved successful. Patients feel empowered to manage their COPD with guidance from their management plans and standby medication. When a patient is having an exacerbation they increase inhaled bronchodilators, start antibiotics and/or steroids and then contact the surgery to inform staff they have COPD and have started their emergency medication.

COPD in house training has been provided to reception staff, who are the first point of contact. This will initiate a contact with the practice and an appropriate follow up. As well as the evidence based success of the LES, the feedback from health professionals across the borough has been excellent. Relationships have been strengthened and communication improved, resulting in better outcomes for those being treated. So far 45 staff have completed the COPD diploma and 18 started it in June 2010. A one day training course is offered to health professionals with 80 staff having attended. Twenty staff completed the asthma diploma in March 2010.

Financial implications

The enhanced service was initially pump primed by a PCT annual operating plan based on an invest to save business case. The case projected a saving of up to £316,000 by the end of the third year, calculating an annual reduction in hospital admissions of 250 spells and also a £40,000 reduction in oxygen prescribing.

As of the end of 2009–10, 67% of COPD registered patients had been reviewed by practices, at a cost of £172,000. The returns in this period have far exceeded expectations of the original case. Admissions have reduced by 345 spells, and the new oxygen assessment service had identified 170 patients who did not need oxygen therapy. In total this saved the PCT approximately £900,000. In addition more appropriate prescribing and improved self management plans, leading to better patient education, led to a further cost reduction of £115,000.

Contact

For more information on this initiative please contact
Rebecca Marsden: *rebecca.marsden@dudley.nhs.uk*

FINALIST

The GCHS virtual admissions avoidance team: a template for the future?

Giselle Broomes and Anita Koelmel; Greenwich Community Health Services

The initiative

Patients with long term conditions are the highest consumers of emergency and urgent care. If these needs are met with rapid, early, consistent and expert assessments in their own environments, they can be prevented from being admitted to hospital unnecessarily.

We have adopted a fresh approach to partnership working;. The team is made up of professionals who actively contribute to every aspect of the patients' journey; local ambulance services (LAS), primary care, community care, secondary care and social care and our shared objective is to improve patient outcomes and experience while making better use of available resources.

The team developed a portfolio of clinical pathways that will be used by ambulance services as an agreed alternative to automatic hospital attendance. These are based on the most common reasons for A&E attendance particularly for older people, and include:

- Falls;
- Cellulitis
- Blocked catheter;
- UTI;
- Heart failure;
- Poorly controlled diabetes;
- Exacerbation of COPD;
- Rapid response (including social crisis).

Benefits

The benefits have been that a previously disparate group now function as a team, meeting objectives that they set for themselves. The team has achieved the following:

- Patients receive safe care in their own homes;
- Carers and relatives feel part of the caring process;
- Efficiency and value for money have increased.

Financial implications

The initiative avoided 1,123 admissions between January and June 2010. Using an average tariff of £2,500 per medical admission, this equates to a saving of £2,807,500. The expected savings for the year will be a minimum of £6.47m. This has been achieved without any additional financial resources.

This entry was also the winner of the **Efficiency Initiative of the Year award*

Contact

For more information on this initiative please contact
Giselle Broomes : *giselle.broomes@greenwichpct.nhs.uk*

FINALIST

A unique holistic service to improve the patient pathway and reduce amputations in diabetic patients

Mike Edmonds and Melanie Doxford; King's College Hospital FT

The initiative

Diabetic foot disease is a national problem in the UK — 100 people a week have a lower limb amputation as a result of this condition. The purpose of the initiative was to develop an intensive evidenced based holistic service for patients with diabetic foot problems, providing a one stop shop for people in London and the South East with this disabling condition.

The initiative was born out of a recognition that patients with diabetic foot problems are highly vulnerable and extremely prone to ulcers, infection and amputation, and that it was imperative to develop a new model and improved pathway of evidence based intensive multidisciplinary diabetic foot care.

Our model of care has been built up by making important innovations in strategy and personnel. We have established an open access emergency service to treat urgent problems within 24 hours. We have also developed a vascular fasttrack integrated pathway for community patients. Patients are assessed urgently in the diabetic foot clinic and vascular laboratory and proceed to angioplasty, as a day case, when possible, or for inpatient arterial bypass.

We have established joint diabetic/vascular ward rounds and clinics, and also joint diabetic/orthopaedic rounds and clinics. To reduce length of stay we have developed a home intravenous antibiotic programme and early discharge clinics, and also run a patient helpline. We have established the new post of diabetic foot practitioner in an extension of the traditional podiatrist's role to optimise multidisciplinary care of inpatients. We also treat inpatients from surrounding hospitals in the diabetic foot clinic in a shared care system.

Benefits

The initiative provided an absolute reduction of 50% in major amputations. We now have an extremely low rate of amputation of 2.1 per 100,000 people at risk, which is smaller than reported rates between 2.8 and 40 per 100,000.

We have achieved this with our instant access clinics (treating 892 emergencies in 2009) and the vascular fasttrack pathway. Initially 312 patients were treated in this pathway: 257 were suitable for angioplasty and 55 underwent arterial bypass including 48 distal below knee bypasses.

To reduce hospital admissions we also instituted day case angioplasty, with initial 96% success rate and no complications. Overall we have reduced the median length of stay from 32 to 18 days. In a hospital survey, 96% of patients expressed satisfaction with the diabetic foot clinic and would recommend it to others. Patient satisfaction was further reflected in the low "did not attend rate" of 4.7% in the diabetic foot clinic, compared with a mean of 14% for other clinics.

Financial implications

There was no initial cost at the outset of the project as the core members of the diabetic foot team needed for coordinated intensive care of these patients were in post and the service was based in the existing podiatry clinic.

Moving forward, business cases were established for additional podiatrists and nurses and for two diabetic foot practitioners. These business cases were supported by financial savings from a reduction of major amputations and a reduction in bed occupancy as a result of the service.

In the two years before the establishment of the clinic, there were 11 and 12 major amputations respectively. In the subsequent three years this number was reduced to seven, seven and five amputations respectively. The cost of an amputation associated with the diabetic foot can be as much as £38,000. Thus, prevention of 6 major amputations saves £228,000.

Contact

For more information on this initiative please contact
Chris Rolfe: *chris.rolfe@nhs.net*

FINALIST

Dementia programme

Bev Chapman and Kate Mitchell;
NHS Cornwall and Isles of Scilly

The initiative

The joint Cornwall dementia programme was launched to initiate, implement, evaluate and sustain high quality, countywide dementia care through collaborative partnership between various agencies. It is a local response to the national dementia strategy. When the Cornwall implementation plan was released only 33% of the expected numbers with dementia were diagnosed, leaving over 5,000 people undiagnosed; 18 months later we have found 47%, a number which continues to rise. The dementia programme comprises 10 work streams including:

- Raising professional and public awareness;
- Workforce education and training;
- Expansion of dementia liaison services;
- Memory assessment services;
- GP and nurse academies;
- Increasing non pharmacological interventions;
- Improving the quality of care in care homes and hospitals.

Small scale pilots and large scale system changes were tested simultaneously, sharing learning and expertise to inform subsequent initiatives.

The programme takes dementia out of the framework of a mental health illness to create an integrated, coordinated and person centred "dementia journey" accessing new and enhanced services for those living and working with dementia.

Benefits

The GP led memory clinics, supported by practice based dementia case managers resulted in an increase in rate of diagnoses to 68%. The "Worried About Your Memory?" public information initiative succeeded in communicating with hundreds of people who were not able to get to their GP. Case studies found that the increased menu of community interventions resulted in improvements in confidence and quality of life.

Financial implications

Continuously improving dementia services has involved providing the resources for service redesign rather than significant new investment. Funding for services have been reallocated to enable the commissioning of new and more personalised services. This has included moving £616,000 from funding rehabilitation units to pay for dementia liaison nurses, advocacy, carer education and an arts for health project.

The Department of Health awarded a total of £345,000 over two years to start integrated working and the growth of peer support networks. Small business cases have been successful in raising a total of £87,000 to fund training in care homes and new cognitive stimulation therapy groups with the independent and voluntary sector.

The £8m block contract with our community mental health provider has received no growth money for new services but has been commissioned to design, implement and evaluate a new countywide memory assessment service. The programme expects to contribute significant savings by:

- Reducing prescribing costs;
- Reducing acute hospital admissions;
- Providing more anticipatory, reactive care.

Contact

For more information on this initiative please contact Kate Mitchell: *Kate.mitchell@ciospct.cornwall.nhs.uk*

FINALIST

Communities of health

Sahdia Warraich, Ian McDowell and Philip Abiola;
NHS Newham

The initiative

The initiative was developed after NHS Newham became aware of a large number of undiagnosed diabetics, mostly from the Asian community, who were failing to manage their diet or take regular exercise, leading to serious health problems in middle age. We tried giving random blood tests in a local market, but when people were given letters advising them to see their GP, most ignored the advice.

NHS Newham's patient and public involvement team discovered a large community organisation next to the market which was already doing this work more successfully, and thus began communities of health, which creates self sustaining health partnerships with existing community groups and networks in partnership with local GPs and clinical nurse specialists.

Communities of health involves community centres, mosques, Hindu temples, black led churches, and older people's lunch clubs. Facilitated by the third sector, we visited local community groups to learn what makes the groups strong and resilient, and to understand the health challenges that the groups can support their members to overcome.

We used coaching and appreciative enquiry techniques to build trust and confidence in communities traditionally excluded from health services. We assessed group's governance frameworks and capacity, and held planning sessions where clinicians answered questions from members of the community, and community representatives were empowered to develop solutions to their most pressing health challenges. This has involved fundraising for physical activity sessions, healthy eating groups and hosting smoking cessation activities, all planned and impact assessed using the European Prospective Investigation of Cancer (EPIC) clinical evidence base.

In some cases, groups proceed to the next level of engagement, undertaking more extensive partnership activity with the local NHS, for example hosting health fairs to coincide with cultural festivals. The groups are also platforms for inclusive consultation and engagement.

Benefits

A recent impact assessment using the EPIC Norfolk Longitudinal Study projected over 4,000 years of extra life expectancy as a result of behaviour change directly attributable to communities of health activity.

Financial implications

The programme currently costs £100,000 a year. Social return on investment is assessed annually. Factors include increased health literacy, increased collaboration and resilience within groups, and locally led and measured lifestyle change. These lifestyle changes are based on the EPIC clinical evidence base, and include additional elements such as reduced salt and sugar intake.

The National Institute for Health and Clinical Excellence model for measuring the value of additional life expectancy is weighted for quality of life and puts the value of one year of increased life at between £20,000 and £30,000. This means the overall value added by communities of health is millions of pounds.

Contact

For more information on this initiative please contact Ian McDowell: *ian.mcdowell@newhampct.nhs.uk*

WINNER

Airedale Collaborative Care Team

Stephanie Lawrence and Enid Feather

Bradford and Airedale Community Health services

Background

The aim of the Airedale Collaborative Care Team (ACCT) is to prevent unnecessary hospital admission and to facilitate early discharge. The main intended outcomes were to increase patients' independence and their involvement in and choice about care decisions.

The objectives for the team were to develop clinical pathways that cross professional and organisational boundaries and to provide high quality evidence based, holistic care to patients closer to home while also achieving cost savings by enabling a model of step up provision. Step up is about preventing unnecessary hospital admission for patients who do not need acute medical intervention but rather increased health and social care support.

The process

Local intermediate care services were limited. The only inpatient facilities were within the general hospital, and the only community based service was a small rapid response team. It was clear that a new approach was needed, but the changes needed to be incremental to ensure quality and continuity of service.

We launched a recruitment drive after a careful mapping of what types of professionals and grades of staff would be needed and the community element of the team became operational in July 2008.

Additional multidisciplinary professionals enhanced the community support team across organisational boundaries. These included:

- A dedicated social worker;
- A mental health practitioner;
- An advanced nurse practitioner;
- A half time nurse consultant;
- A half time geriatrician;
- Occupational therapists;
- Physiotherapists.

We also procured and commissioned 16 beds in two care homes to accommodate step up and step down patients.

At the same time service development started in earnest with the creation of the first clinical pathways for the team. By December 2008 the inpatient service was launched, initially with three beds in two care homes. This slowly rose to the agreed commissioned level of 16 beds.

We now have a staff of over 50 and deliver care to patients in the community and the care homes via a range of clinical pathways, which include deep vein thrombosis, enablement and urinary tract infection.

Advice to other organisations

There is no reason why this model of delivery could not work in other areas. There are challenges in terms of working across professional and organisational boundaries, but, these are not insurmountable, and overcoming them can provide rewards for staff and patients.

Award sponsored by

UNISON Health Care

mip managers in partnership

Benefits of the initiative

We have been able to provide a complete and effective intermediate care service to the patients in our area. We have ensured patients are cared for closer to home and in a non hospital setting where appropriate.

Patients benefit from the fact we have an interdisciplinary team and are able to provide complete and holistic care both in patients' own homes and care home settings. The service is flexible and treats all patients and their families/carers as individuals with the patient central to everything we do.

The goals and care planning are based around patient's individual needs. Carers also benefit from the added resource of the carers resource worker within the team.

Benefits to staff include close partnership working with other organisations and the development of clinical networks as a result. There are joint governance arrangements within the team for all the partner organisations and this ensures shared learning across all professions and organisations.

Staff opinion and suggestions are paramount to the success of this team and are sought at every opportunity.

Financial implications

The cost of the initiative was more than offset by the decommissioning and closure of 16 intermediate care beds at our main secondary care provider, releasing £600,000.

Future plans

We are already promoting the ACCT at every opportunity. To this end we have given presentations at several regional conferences with more planned for the future.

Contact

For more information on this initiative please contact Stephanie Lawrence: *stephanie.lawrence@bradford.nhs.uk*

Judges

Geoff Alltimes, *chief executive, Hammersmith and Fulham Council and NHS Hammersmith and Fulham*

Jon Restell, *chief executive, Managers in Partnership*

Elisabeth Buggins, *chair, West Midlands Strategic Health Authority*

Karen Jennings, *head of health, Unison*

Mike Jackson, *senior national officer (health), Unison*

HIGHLY COMMENDED

Primary percutaneous coronary intervention

David Davis, Gary Lupton and Richard Heppell; East Kent Hospitals University FT

The initiative

The Department of Health and the British Cardiovascular Society jointly undertook a two year study and published the final report on the National Infarct Angioplasty (NIAP) project in October 2008. This project was a feasibility study looking at how far primary angioplasty can introduced as a main treatment for heart attack in place of clot busting drugs. The report concludes that it would be feasible to introduce 24/7 primary percutaneous coronary intervention (pPCI) for the majority of England.

A "Fit for the Future" consultation exercise was completed at the beginning of 2008. In conjunction with the NAIP report this prompted the decision that Kent and Medway provide 24/7 pPCI cover across Kent.

From the outset, South East Coast Ambulance Service wanted to have a single 24/7 service centre to avoid any confusion surrounding where to take patients and when. Comprehensive work on patient travelling times and distances was undertaken and William Harvey Hospital was chosen as the single provider as it was agreed that a 75 minute journey time ensuring coverage across the whole of Kent was acceptable.

Workforce and pPCI steering groups, reporting to the Kent cardiac board, were established with clinical and senior level involvement from all organisations to drive the project forward. The new service required a workforce that was:

- Drawn from several organisations;
- Specifically trained to deliver a pPCI service 24/7;
- Willing to work in one location for emergencies;
- Capable of maintaining routine cardiac services locally.

The service needed at least 10 consultants to sustain a rota, and more cardiac nurses, radiographers and cardiac physiologists. Through the network's clinical leadership, consultants from every hospital in Kent signed up to the rota. Other staff groups also agreed to work totally new shift patterns, extending a traditional nine to five role to 24/7.

The additional staffing and bed capacity required to run this service meant there was a need for additional investment. The network produced a business case requesting additional funding over and above the Payment by Results tariff and the PCTs agreed to fund the service.

Benefits

Patients who have been though the system have been so much better after the procedure that average length of stay has come down from six days to two to three days.

All patients are contacted for a follow up phone call questionnaire and this has demonstrated high levels of satisfaction.

Financial implications

We needed funding of £2.5m to set up the service the four acute trusts, ambulance trust and the three PCT's agreed to provide this. While cost savings are anticipated for the health economy these are not a priority. The primary purpose was to improve the service for anyone in Kent who might suffer a heart attack.

Contact

For more information on this initiative please contact Mandy Carliell: *mandy.carliell@ekht.nhs.uk*

FINALIST

A project to reduce delayed transfers of care from hospital

Shirley Mallon and Maureen Clark; NHS Birmingham East and North

The initiative

This was a joint initiative with the local authority to provide a seamless pathway from hospital for people with complex needs who are considered likely to need long term admission to a care home. The intention was that people with complex needs would be able to leave acute hospital as soon as they are medically stable. If this happens there is no need for reimbursement and excess bed day claims are eliminated.

The assessment of people with complex needs should take place away from an acute ward setting. The enhanced assessment units set up in the initiative provide intensive multidisciplinary team assessment in a community setting where service users are encouraged to self manage in order to identify residual needs for support. Relatives and users are closely involved in decision making and are given plenty of time to weigh up options.

A joint steering group involving the acute trust, PCT commissioners, intermediate care providers and the local authority undertook intensive planning to create operational policies and eligibility protocols and set up premises and funding over a period of six months in 2009.

Two units of 30 and 21 beds opened in refurbished former wards of two of the acute hospital sites in September 2009. The units were run and staffed by NHS Birmingham East and North (NHS BEN) with joint funding from the local authority.Referrals came exclusively from local acute trusts, and those patients admitted have been formally discharged from acute settings.

Service users are NHS funded during their period of assessment and local authority funded when they move into the interim phase for setting up of social care services. Handover to the local authority is automatic at the end of the assessment period and prevents delays from non acute settings. People eligible for NHS continuing health care funded services remain the responsibility of NHS BEN. The average length of stay is 28 days.

Benefits

Being in a homely environment with stimulation, social eating and expectations of self management enabled service users to regain their independence while identifying the areas where support would be required. All nutritional supplements were abandoned on admission to the units as they started to eat normally. Wound healing was faster.

The initiative saved the PCT £3.9m in excess bed day claims, with a net saving of £1.9m. The acute trust saw a 33% improvement in delayed transfers of care, which meant it was able to meet its national delayed transfer of care target for the first time in two years. The initiative released 1,500 to 2,000 bed days per month.

The local authority gained 1893 days of interim care in the community units for its investment, with 45% people diverted from premature admission to long term care homes.

Financial implications

The initiative cost £2.6m per year with a £0.6m contribution from the local authority. Set against this, over the first six months of the project there were savings of £3.9m in excess bed day claims

Contact

For more information on this initiative please contact Dawn Rayson: *Dawn.Rayson@benpct.nhs.uk*

FINALIST

Altogether now: a Legacy for Blackpool

Colette Cassin and Roger Reade;
NHS Blackpool

The initiative

Blackpool is the 12th most deprived local authority in England, with high levels of unemployment, deprivation, crime, domestic abuse and looked after children. It has the worst life expectancy rates in the country for both men and women; the highest rate of suicides and a high prevalence of mental illness.

Altogether now: a Legacy for Blackpool is an innovative, new programme supporting the SHA's directive to link the health agenda to physical activity.

Spearheaded by NHS Blackpool, working in partnership with Blackpool Football Club Community Trust and Blackpool Council, and supported by the third sector, the programme pledges to support every person in Blackpool, irrespective of age or ability, in the challenge to improve health and wellbeing.

It is one of the first programmes of its kind to be recognised as part of the London 2012 Inspire programme, with the full support of the London organising committee for the Olympic games. It is also backed by the Premier League.

The aim is to improve the health and wellbeing of people in Blackpool by delivering a coordinated year round programme of events and activities supporting the public health calendar. The programme promotes a positive view of how challenges can be tackled, supporting better self care and preventive measures.

A steering group chaired by the chief executive of NHS Blackpool, with the chairman of Blackpool FC as vice chair oversees the programme. There is a working group with members drawn from all key partners. Four advisory groups have been established, one for each workstream:

- Physical activity;
- Lifestyle;
- Mental health/wellbeing;
- Childhood health.

Benefits

Partnership with Blackpool Football Club has opened up many opportunities to connect with and improve the health and wellbeing of our community. Football clubs are recognised as a crucial channel to deliver health messages and interventions to a hard to reach audience. The club engages with thousands of people of all ages, backgrounds and abilities. Preventive campaigns, programmes and interventions will change behaviours, reduce costs and deliver longer term benefits. Some of the benefits and successes so far include:

- Providing mental health services for young men in football club changing rooms, removing the traditional barriers to access (all courses now fully booked);
- Using high profile football players to deliver proactive health messages;
- Delivering health information in programmes;
- Match day MOTs and consultations;
- Offering Chlamydia tests to fans queuing for tickets;
- Using concourse advertising, for example, testicular cancer awareness posters in the male toilets;
- Distributing leaflets and other materials at turnstiles.

Financial implications

A total of £15,000 was spent on materials and the website, with £5,000 coming from each partner. The initiative has benefited from considerable cost savings from economies of scale.

Contact

For more information on this initiative please contact Colette Cassin: *colette.cassin@blackpool.nhs.uk*

FINALIST

Devon drug and alcohol action team

Kristian Tomblin, Matt Edmunds and Iain Mellis;
NHS Devon

The initiative

We wanted to use a new approach to reduce the harm done by alcohol misuse — to minimise harmful behaviour and alleviate the impact on individuals, families and communities. We developed the Devon Partnership Alcohol Strategy 2008–11 in cooperation with a broad range of agencies, service users and carers.

The aims and objectives of this strategy were to:

- Reduce waiting times for alcohol treatment to six weeks by the end of year 1 and to three weeks by the end of year 2;
- Reduce the rate of increase in alcohol related hospital admissions by 1% per year against an 11% rising trend;
- Establish a baseline and subsequent target to reduce alcohol related attendances at A&E departments;
- Increase treatment capacity and reduce unit costs against the 2007–08 baseline;
- Train 150 frontline workers to deliver screening and brief interventions by March 2009, and 400 workers per year thereafter.
- Reduce the assault with injury crime rate by 3% by 2010–11.

A business case for the initiative was presented to Devon PCT in November 2007. After this in 2008–09 the partnership alcohol strategy was developed along with the service framework. The Devon alcohol strategy launched early in 2009 and was fully operational by 2009–10.

The service covers tiers 1 to 4, spread over three local areas:

- Exeter East and Mid Devon;
- South and West Devon and Teignbridge;
- North Devon, based in Barnstaple.

It has outreach across Devon, with provision in GPs surgeries, community hospitals, community mental health premises and local voluntary agencies. The service provides a single point of referral to treatment through multiple access routes.

Benefits

The increased investment has seen waiting lists reduce from up to 12 months for tier 3 services during 2008–09, to two months in 2009–10. Service capacity for harmful and dependent drinkers has increased from 700 intervention and treatment slots in 2008–09 to 2,500 during 2009–10.

At assessment, the average AUDIT (Alcohol Use Disorder Identification Test) score was 24. At completion of care, the average score is 12. On average, 85% of clients leave care in a planned way having achieved their treatment goals.

Alcohol related hospital admissions in Devon have levelled off and started to reduce after five years of 5–12% increases. This is not part of a broader trend of reducing hospital admissions in Devon, nor is it part of a broader trend of reducing alcohol related hospital admissions.

The work in Devon has been made possible by a clear expression of the harmful consequences of alcohol use and the benefits to all partners to be gained by pooling resources and working to a deliver a partnership strategy.

Financial implications

Before the initiative began the total alcohol budget for the whole of Devon was less than £500,000. An additional investment of £1m was made by public health. This funding went into every tier of alcohol services, from preventive initiatives and an extensive training programme to residential rehabilitation. The majority of the spend was invested in community services adopting a stepped care approach for dependent drinkers.

Devon has in the region of 2,000 fewer alcohol related hospital admissions than our LAA and Vital Signs Target and the rate of hospital admissions has begun to fall. At £2,000 per admission this represents a possible saving of £4m.

This return has been realised after one and a half years of investment.

Contact

For more information on this initiative please contact Emma Greenslade: *d-pc.AskAnn@nhs.ne*

FINALIST

Service improvement: everyone's business

Pam Dawson and Lesley Young-Murphy; NHS Newcastle and North Tyneside Community Health

The initiative

This initiative was developed in partnership with the University of Northumbria at Newcastle to equip staff from bands 1–9 with service improvement tools that they could apply in practice.

The idea evolved from a discussion on the national initiative to introduce service improvement within the undergraduate curriculum for health and social care and how this could be adapted for the wider workforce. The difference with this initiative would be that it was employer/educational partner based and was focused around the application of service improvement techniques within practice.

The partnership project developed a stratified approach to service improvement learning, which culminated in service improvement learning being embedded into work based learning CPD programmes.

The initiative involved offering staff the opportunity to celebrate their service improvements twice yearly in the form of a conference. As part of the conference there was a joint workshop where participants received training on a particular service improvement tool that could be used within practice. A number of action learning sets were established in order to help individuals to use the tools in practice and to develop service improvement initiatives within their own workplace.

The conference element now attracts over 150 attendees and we have now trained more than 450 staff in techniques such as process mapping, plan do study act and thinking differently and appreciative enquiry.

Benefits

Each conference has allowed up to 10 staff members, teams or services to present their service improvement idea to a wide audience. The improvements have showcased improvements to patient care.

Several individuals and services have used the project to support productivity initiatives that have subsequently resulted in a better use of resources and therefore cost effectiveness.

The initiative has allowed us to:

- Train up to 450 staff in service improvement techniques;
- Embed and apply service improvement in practice;
- Provide knowledge and skills framework evidence for staff;
- Promote service improvement as a tool to support improvements to patient care;
- Develop presentation skills in a supportive environment
- Develop a firm partnership with our local higher education institute.

Financial implications

The main financial resources were the conference costs and additional action learning set support. Many of the resources for the sustainability of this initiative have been generated from benefit in kind relationships as well as staff resource time to work up the programme/model and the formal evaluation process.

Contact

For more information on this initiative please contact Kelly Shaw: *kelly.shaw@northtyneside-pct.nhs.uk*

FINALIST

Improving the transition experience

Peter Tomlin, Elly Wright and Pauline Toohey; NHS Wirral and Wirral Council

The initiative

Transition from paediatric to adult services has been an area of government concern for many years. In 2009 *Valuing People Now* recommended that each area have a multiagency transition strategy. The transition self assessment questionnaire reinforced the need for more effective partnership working and better engagement of parents and young people within the borough. This very much resonated with the messages being received from parents and other stakeholders.

At the beginning of 2009–10 Wirral's governance arrangements for learning disabilities services were complex and focused on service delivery, not outcomes. Although levels of consultation were good, the links to effective decision making and strategic change needed strengthening. The transformation of transition was hindered by these governance arrangements.

The aims of the transition strategy group included reshaping and implementing more effective partnership arrangements. The group contributed to the development of a learning disability strategic commissioning framework with transition as a priority. These initiatives generated additional aspirations around developing a better integrated transition service; developing patient pathways and generating appropriate awareness and interest in these developments among parents and young people themselves.

The initiative involved:

- Creating new meaningful and expanded partnerships with parents and people with learning disabilities;
- Creating a clear governance structure that stimulated, discussed and developed relevant strategic direction and policy;
- Agreeing and producing a joint strategy identifying key priorities for local development;
- Initiating a change in the culture, custom and practice of frontline staff and services.

These initiatives generated additional aspirations around developing a better integrated transition service, developing patient pathways and generating appropriate awareness.

Benefits

The annual Your Future Your Choice event attracts over 1,000 people and the directory is sent to a huge number of people across the Wirral, with the focus on transitions. The feedback from parents of people with learning disabilities experiencing transitions is that significant progress has been made in consulting and involving them in developing a better experience of approaching adulthood.

Examples of this include the inclusion of transitions as a standing agenda item on the learning disabilities partnership board, joint presentations to the board and the resultant changes in the strategies being developed to improve experiences of transition.

These changes include:

- Developing a back to basics approach;
- Focusing on the ethos and values of transition planning not the tool used;
- Developing support for parents, young people and their siblings/wider family to contribute in transition reviews;
- Examining how we achieve person centred reviews within the time frame and staffing available in schools;
- Developing citizenship as part of preparation for adulthood;
- Developing person centred health plans earlier;
- Developing personal budgets and support planning training so that people are informed and included in the process of transition.

Financial implications

This initiative did not require additional investment; it used existing resources in a different way for improved outcomes.

Contact

For more information on this initiative please contact Peter Wong: *peter.wong@wirral.nhs.uk*

FINALIST

Champions for achieving better health in Sheffield (CABS)

Emelia Spencer and Permjeet Dhoot; NHS Sheffield, One Medicare and Sheffield Taxi Trade Association

The initiative

This project grew out of a desire on the part of NHS Sheffield to act on some alarming statistics relating to health inequalities for BME groups, namely:

- South Asian men are 50% more likely to die prematurely of coronary heart disease (CHD) than the general population;
- The prevalence of stroke is 70% higher in South Asian men than the average;
- The risk of type 2 diabetes in South Asians is up to six times higher than in the white population.

Public health lead for NHS Sheffield, Permjeet Dhoot, came up with the idea of working with a group of taxi drivers to address the issue. The vast majority of taxi drivers in the city are from a South Asian background and the sedentary nature of their work, coupled with late night shifts, poor eating habits and high levels of smoking, makes them a particularly high risk group.

Furthermore, the taxi drivers, visible and influential position, both within their families and wider communities, as well as their daily interaction with members of the public, means that they could play a potentially powerful role in passing on health messages.

Initial community engagement took the form of a half day consultation meeting attended by a number of drivers and provided an opportunity to share and discuss the vision for the project as well as presenting to drivers evidence of the elevated risk of CHD for the South Asian community.

One of the requests made by drivers was an opportunity to be screened for CHD and diabetes; this screening component consequently became the second strand of the project. One Medicare has been engaged in community outreach with a number of other organisations around Sheffield and offered to provide screening for the drivers at the Sheffield city GP Health Centre.

The centre is open 8am–8pm, 7 days a week, 365 days a year. Health screening was on a walk in basis and so offered the drivers an opportunity to access healthcare at a time and place which was convenient for them. Following the health screening many drivers with previously undiagnosed conditions were identified and referred for treatment by their own GPs.

As a result of the positive publicity the initial health champions project received in the local media, One Medicare, which runs the Sheffield City GP Health Centre, approached the PCT offering to provide cardiovascular screening for the drivers on an ongoing basis.

Benefits

The project to date has delivered a number of important outcomes:

- To date 32 South Asian taxi drivers have been trained as health champions and are undertaking informal health promotion activity in their communities;
- Over 150 taxi drivers have attended health screening at the Sheffield City Gp Health Centre with more events being planned in 2010. At all the events, over two thirds of drivers required some kind of intervention with many suffering from conditions that are potentially life threatening if left untreated.

The main focus of the project was the long term benefit to the local health economy through early diagnosis and treatment of undiagnosed conditions. However, one of the most important outcomes of the project has been the impact on the lives of the drivers who participated, and the informal work they are doing with others in the South Asian community to promote awareness and action around cardiovascular diseases and the benefits of a healthy lifestyle.

Financial implications

One Medicare purchased a Cholestech LDX machine providing instant result testing for cholesterol and blood glucose. This proved invaluable as it gave the drivers an on the spot result, maximising the impact of any advice given and also removing the need to call drivers in for second appointments to discuss their results.

The Cholestech LDX machine also proved valuable when further engaging the community as we were able to take the health screening activities from the centre out into the local community. With the machine we were able to run health screening sessions at the local Pakistani community centre. The centre has screened over 500 people in the last few months.

Contact

For more information on this initiative please contact Stephanie Burns: *s.burns@onemedicare.co.uk*

WINNER

Primary care chest pain clinic

Jo Medhurst, Kosta Manis and David Brennand-Roper

Bexley Medical Group

Background

Patients told us that their experience of cardiology care was unsatisfactory for a number of reasons. Starting from this point, our aim was to revolutionise the service greatly improving treatment of heart patients, while reducing the cost to the NHS.

We set out to address patients' concerns in order to provide world class cardiology care to patients in some of the country's most deprived areas, cut waiting times, and offer diagnosis, which takes a fraction of the time of traditional diagnostic methods, is more accurate, safer and prevents unnecessary intervention.

We also aimed to develop a GP driven, top quality, low cost service close to patients' homes by applying practice based commissioning principles. We set out to prove that GPs can offer their patients NHS healthcare that is better than any private medical scheme.

Our objective was to run the first chest pain clinic outside hospital. The Bexley Primary Care Chest Pain Clinic has made this possible because it is safe, effective and at the patient's doorstep (our cardiology bus picks patients up from their front door), providing 100% accuracy and no risk.

More than 80% of chest pain has no cardiac origin. Our scheme, involving a cardiologist and improved triaging, ensures we only deal with genuine cardiac pain.

The process

The initiative centred on the needs of patients. GPs listened to their concerns and assessed their needs; as a result, the first cardiology diagnostics clinic started in 2007 at a GP's surgery in Bexley, with state of the art equipment. It included standard ECG, 24 hour ECG, 24 hour blood pressure monitoring and echocardiograms.

Four local GP surgeries now offer a weekly specialist cardiology clinic with diagnostic tests and consultant appointments, as well as services from heart failure nurses. A rehabilitation scheme is also provided in the community. Patients are seen within a week of being referred, rather than having to wait for at least eight weeks.

Combining all these services into the clinics provides a one stop shop for patients and reduces pressure on local hospitals. The strong support of the service by patients and doctors created the right environment to create of the innovative primary care chest pain clinic, the first of its kind in the country. This project has been completed thanks to local GPs, with the support of their primary care trust. The result has been an unrivalled service to the people who need it most.

Advice to other organisations

Our initiative is an example of services being driven by those most in need with an approach that is starting to be echoed in other schemes and initiatives.

Benefits of the initiative

The main benefit of the project is that it meets the needs of patients; producing 100% accurate test results and saving lives while preventing unnecessary suffering, at less cost than traditional care pathways. Patient evaluation shows 100% satisfaction.

The best example of how the clinic has transformed care is the introduction of a piece of technology. The Aquilion ONE scanner took 10 years to develop, at a cost of $500m. There are two in Europe and only one in London. It is the world's first dynamic volume CT (computerised tomography) scanner, which can scan a heart in a single heartbeat.

The time taken to treat patients is dramatically reduced. They are taken to Harley Street in transport provided by Bexley Care Trust. The scanner's findings are checked by a highly specialised consultant from King's College Hospital. Those with normal results return home and those in need of intervention are treated promptly and can even be added onto the intervention list the next day if necessary at either King's College Hospital or St Thomas's Hospital.

Financial implications

Using the CT scanner is far more cost effective than traditional, often inaccurate and potentially risky stress tests and angiograms. As well as taking a fraction of the time (a few seconds, compared with weeks) the CT scan costs less.

The scheme was funded by Bexley Care Trust, which showed remarkable foresight in giving GPs the power to design services. It has delivered savings of £300,000 a year against traditional outpatient angiogram pathways since it started in 2008. More accurate diagnosis means £1,000 is saved every time a patient is prevented from having an unnecessary angiogram, not to mention the hidden costs of misdiagnosis. Accurate results also mean a further £500 is saved each time a patient is prevented from further consultant visits.

Future plans

Following presentations to GPs and commissioners in Greenwich and Bromley, a process has started to create a cardiology company covering the GPs of all three PCTs.

This entry was also winner of the **Acute and primary care innovation award and a finalist in the **Quality and productivity** category*

Contact

For more information on this initiative please contact Lucy Huitson: *lucy.huitson@bexley.nhs.uk*

Award sponsored by

O2 health

Judges

Ben Page, *chief executive, Ipsos MORI*
Andrew Murrison, *MP for Westbury*
Keith Nurcombe, *head of health, O2*
Penny Woods, *chief executive, Picker Institute Europe*

FINALIST

InstantCARE

John Havard;
Commissioning Ideals Alliance

The initiative

In 2009 a group of eight GPs representing 50,000 patients from the CIA consortium sat down to try to identify what we could do better and where the gaps inpatient services were. One common source of frustration was people being admitted to hospital for social care rather than medical reasons.

GPs know that older people who live alone are vulnerable to falls, neglect and poor medication concordance, and it does not take much for an acute hospital admission to occur. A relatively trivial infection such as in the urinary tract can lead to mild confusion and unsteadiness, and a couple of days in hospital may seem a reasonable option if there are no relatives to help.

But the reality is that patients often become twice as confused in hospital, increasing the chance of falls and serious morbidity. Even if this hazard is avoided they still have little chance of a prompt return home because, once they are well, a home visit is needed to identify the need for grab rails and ramps as well as carpet and bathroom hazards. This is depressing and potentially institutionalising, when often all that is needed is someone living in the house to ensure patients eat and drink and take their antibiotics until normality is restored.

We wanted to come up with a simple scheme under which patients could be kept out of hospital, looked after round the clock by a carer in their house who would be there when they needed to be fed, washed, and so on.

Benefits

This initiative puts a live in professional carer into the home of a vulnerable patient for 72 hours within three hours of the request being made, at a cost of £370 compared with up to £2,500 for admission.

Financial implications

The initiative was funded with £20,000 allocated from our freed up resources by Suffolk PCT. To date the initiative has prevented 65 acute admissions saving over £40,000.

Contact

For more information on this initiative please contact John Havard : *john.havard@homecall.co.uk*

FINALIST

Dard-e-dil chest pain DVD

Mohammed Sharif, Z Hussain, Yakoob Ali and Rob Mooney;
NHS Bradford and Airedale

The initiative

The idea behind the *Dard-e-dil* (literally 'pain in heart') DVD initiative is to provide information in South Asian languages to raise awareness of the importance of dialling 999 immediately at the first signs of chest pain. The British Heart Foundation (BHF) survey revealed that four out of five South Asians over 55 would not call for emergency help straight away if they experienced chest pain.

The DVD's key objectives are to:

- Promote the involvement of patients in primary and secondary prevention of coronary heart disease (CHD);
- Reduce the death rates from CHD;
- Reduce inequalities in the risk of developing CHD.

In order to do this we sought the views of former heart patients and community members. They expressed a desire for a DVD in South Asian languages and featuring Asian actors.

Regular meetings with community members took place at which draft versions of the DVD were shown. Several changes were requested and incorporated.

The community members gave their agreement to interviews with heart disease sufferers and carers. This was vital to maximise the effectiveness of the DVD in getting the message across. A thousand copies of the DVD have been made to be distributed to GP practices, community centres, hospitals, the cardiac rehabilitation team, ambulances and the BHF.

Benefits

The DVD will encourage people to get treatment early. It will avoid long stays in hospitals and so free up beds in hospitals.

Financial implications

The total cost of producing the DVD was £4,400.

Contact

For more information on this initiative please contact Mohammed Sharif: *mohammed.sharif@bradford.nhs.uk*

FINALIST

Eliminating mixed sex accommodation

Garry Marsh and Trish Cargill;
Nottingham University Hospitals Trust

The initiative

Results from the Care Quality Commission 2008 national inpatients survey highlighted a need to improve the experience of patients at Nottingham University Hospitals Trust (NUH), including delivering same sex accommodation. Parts of the hospital are over 100 years old and therefore any initiative had to take account of the physical environment. The initiative aimed to:

- Eliminate mixed sex accommodation;
- Devise and implement a trust privacy and dignity policy;
- Ensure that all staff are aware that privacy and dignity are everyone's responsibility.

To evaluate the impact of same sex accommodation changes on patient experience we developed a questionnaire in conjunction with patient representatives. This provided baseline data on patients' perceptions about their hospital stay.

The trust network of practice development matrons oversaw a benchmark scoring process in clinical areas and acted as independent and objective members of the scoring team. The matrons worked closely with areas scoring red to develop action plans for improvement, reassessing the area within eight weeks to check improvement. Trained staff and volunteers gathered responses from patients on the wards, using personal digital assistants.

Benefits

As a result of the initiative the trust has made significant steps towards same sex accommodation. We achieved:

- Consistency across 13 best practice indicators in November/December 2009, compared with six in April 2009;
- One clinical area receiving a score of gold in November/December 2009 (16 out of 16 best practice indicators);
- An increase in clinical areas scoring green, from 10 to 47 areas (14 out of 16 best practice indicators);
- A reduction in clinical areas scoring red, from 17 to two areas (red scoring indicates the area achieved only 0–8 out of a potential 16 indicators).

In addition there have been many comments from patients and staff about the positive impact of the initiative.

Financial implications

Patients at our hospitals have benefited from the completion of an £8.4m programme across the East Midlands to improve privacy and dignity, including the provision of same sex accommodation. The campaign, pilot schemes and changes to wards have been supported by the government's £100m privacy and dignity fund. NUH received £2.2m to improve the provision of same sex accommodation across its hospitals.

Contact

For more information on this initiative please contact Chris Hughes: *chris.hughes@nuh.nhs.uk*

FINALIST

An outpatient parenteral antibiotic therapy service

Aodhán Breatnach and David Smith;
St George's Healthcare Trust

The initiative

The purpose of this initiative was to ease the pressure on inpatient beds by allowing administration of intravenous (IV) antibiotics after patients are discharged home.

Some patients remain in hospital only because they need IV antibiotics, and are otherwise mobile, well, and medically stable. These patients effectively block beds and remain at ongoing risk of contracting a hospital acquired infection, or another complication of inpatient stay.

The pilot project was funded by the PCT as part of a wider initiative to reduce length of stay. The service involved investment in five sessions of consultant microbiologist time, and a contract with an independent sector provider (Bupa) to deliver the community side of the service. The consultant assesses patients referred to the service by ward medical staff then:

- Suitable patients are switched to a once daily antibiotic, have a central line placed by the trust venous access service and are allowed go home. After which the consultant reviews them in hospital once weekly;
- Bupa arranges compounding and delivery of the antibiotics to patients' homes, and a nurse visits daily to administer the antibiotic. About one third of patients are trained to self administer the antibiotics.

Benefits

During the 11 months of the pilot 1,430 bed days were saved. Discharging patients earlier improves patient satisfaction and reduces patient exposure to other risks of inpatient care.

Financial implications

To continue the initiative, the trust needs to invest in five sessions of consultant microbiologist time and five sessions of nursing time, as well as an ongoing contract with an independent sector provider to deliver the community side of the service.

This investment does not directly generate savings, rather it allows increased inpatient activity with existing bed numbers, or the same inpatient activity if beds need to be shut.

Contact

For more information on this initiative please contact Eleanor Edwards: *eleanor.edwards@stgeorges.nhs.uk*

FINALIST

A home haemodialysis initiative

Siobhan Gladding, Sarah Kattenhorn and Juan Mason;
Wessex Renal and Transplant Service

The initiative

Recently, several patients asked if they could deliver their haemodialysis treatment themselves at home. Home haemodialysis has been NICE appraised and is expected to be available to all patients with end stage renal failure.

Most patients on haemodialysis receive treatment in a hospital or satellite unit outpatient setting. However, the constraints of centre dialysis, with inflexible session times based around the working day, do not fit comfortably with holding down a job, a healthy family life or other normal pursuits.

The dialysis nursing team looked for a cost effective machine which did not require technical staff to provide maintenance. We chose to trial the Kimal NxStage machine. This attaches directly to a tap, produces a small amount of waste down a domestic drain, and has easily changeable cartridge consumables. If it malfunctions it can be turned off and the company visits the next day.

The first patient to be trained was highly intelligent and well motivated, and the nursing staff learned with him. The dialysis prescription was carefully prepared and adjusted frequently while the patient's progress was monitored. His pilot was a success and four more patients have now been trained in the same way. Two others are currently in training and several more have expressed interest.

By rearranging shifts/places of work the dialysis nursing team were able to learn to use the machine and train the patients without an increase in staff numbers or time. The same staff were able to go home with the patients after training and be the telephone contact once they were established.

Benefits

The principal benefit is shifting the control of their condition back to patients, allowing them to deliver dialysis themselves in their home at times that suit them. There are several beneficial side effects to this:

- As they are dialysing six days a week rather than three the uncomfortable and upsetting swings in blood pressure, fluid load and toxin burden are reduced;
- All patients have stated their recovery time after dialysis is now negligible, rather than many hours;
- Energy levels are increased and sleeping patterns improved;
- Improvements have been noted in biochemical and haematological parameters of dialysis;
- Antihypertensive medication number and dosage have been reduced and phosphate control is improved, as is patient concordance with all aspects of their care.

Financial implications

No extra resources were required for this pilot. The nursing staff took the initiative to source the machines, to rearrange their time (with some given for free) to allow the patients to be trained and to change the way they worked to support them at home. Extra staff will be required to support any further increase in the numbers of patients dialysing at home, but financial analysis is expected to show that this form of home haemodialysis will be cost effective, even with a potential additional staffing resource.

Contact

For more information on this initiative please contact Tim Leach: *tim.leach@porthosp.nhs.uk*

FINALIST

Advance care planning in care homes

David Shovlin and Hilary Snowdon;
West Northumberland Practice Based Commissioning Group

The initiative

Since April 2009 West Northumberland Practice Based Commissioning Group (WPBCG) has been delivering a programme of advance care planning (ACP) to residents of local care homes.

The purpose of this initiative is twofold; to empower elderly residents of local care homes to become more involved in their care decisions and to improve communication between primary care, care homes and other agencies in order that care for this population can be improved.

Although ACP is not a new concept, it has yet to be incorporated into mainstream clinical practice. This initiative demonstrates how it can be delivered effectively across a locality to a population whose wishes are frequently not sought.

Residents are offered a structured interview with their usual GP in which they are given the opportunity to discuss care preferences such as preferred place of care, preferred place of death and decisions around resuscitation. Preferences are documented in a patient held record as well as on practice IT systems.

Care preferences and other important information are then communicated routinely by fax to the local out of hours provider and the ambulance trust. Visiting GPs have access to this information, which can assist in deciding how best to manage patients if they become acutely unwell, especially if their ability to communicate becomes impaired. It is envisaged that the initiative will lead to increased patient empowerment and a reduction in unnecessary acute hospital admissions. Full secondary care activity data is awaited, but individual case studies show that it is already having this effect.

Benefits

Over the past twelve months 303 patients living in care homes in West Northumberland have had an advance care plan completed. This represents approximately 55% of the population of residential and nursing homes. 298 of those patients have had care preferences documented.

The initiative has been well supported by all professionals and by care homes managers. Patient feedback has been positive and demonstrates the value of allowing this population to be more involved in decisions about their care.

Financial implications

Freed up PBC resources from the 2007–08 financial year supported the delivery of this initiative. In total, £49,500 was approved over a 12 month period. Because not all residents have proven to be appropriate for the ACP process there has been some slippage on the budget in the first year. This has allowed the initiative to be funded for a second year.

We do not yet have clear evidence about savings, however there is evidence that the initiative may be helping to slow or halt the upward trend in admissions from care homes in west Northumberland. Initial estimates suggest that if the levelling of activity seen in the second half of year 1 was as a direct result of the initiative then the savings created by the initiative will have been approximately £76,600 for non elective activity and £3,900 for A&E activity.

Contact

For more information on this initiative please contact David Shovlin: *david.shovlin@nhs.net*

FINALIST

Improving palliative care services in west Northumberland

Ian Williamson and David Shovlin;
West Northumberland PBC group

The initiative

The main purpose of this initiative was to improve and better coordinate palliative care services in west Northumberland. This work began ahead of national and regional strategies for end of life and palliative care.

West Northumberland had no dedicated palliative care/end of life facility. In addition, although there were hospice at home services and other statutory organisations providing care, there was no clear pathway, resulting in fragmented care. This was the issue we set out to address.

The Improvement Foundation ran a generic course in 2008 in the locality that we adapted to include palliative care as the main theme. This course brought all the key stakeholders together over the three days.

The course enabled us to broaden our view of what was needed to improve care and out of this came the palliative care steering group and an 11 point action plan. We wanted to use best practice to redesign services in the light of the gaps in care that we had identified. In particular we wished to:

- Develop practice palliative care registers to include both cancer and non cancer patients with life limiting illnesses;
- Implement advance care planning for those on the palliative care registers and those in care homes;
- Reduce unnecessary admissions to secondary care;
- Reduce the number deaths in the hospital setting,
- Support home care and deaths at home, if preferred;
- Develop a dedicated small community palliative care unit as an alternative to hospital admission.

We hoped that as a result patient, carer and staff experience of care would be positive.

Benefits

The main benefits of the initiative is that patients have more choice as to where they want to die and that the level and quality of care has improved. More people have a "good death" and fewer die in hospital.

We evaluate the initiative on a regular basis in a number of ways:

- Death audits — these show place and reason for death, monitor all aspects of advanced care planning, they are taken from practice clinical systems and are therefore an automated process;
- User/carer/staff surveys — monitoring choice and quality;
- Significant events — in order to continually improve the pathway.

Financial implications

Financial resources were required to enhance the hospice at home services, open three palliative care beds in a local nursing home and provide GP cover for the beds. The projected savings were only about 5% of the required resources but the qualitative benefits of the initiative ensured that it was approved.

Contact

For more information on this initiative please contact Ian Williamson: *ianwilliamson@nhs.net*

WINNER

Getting it right for every patient every time — timely antibiotics for patients with neutropenic sepsis

Hester Wain and Anne McDonald

Royal Berkshire FT

Background

It has been shown that if neutropenic sepsis is undiagnosed it has a mortality rate approaching 20–30%. In March 2007, a 60 year old gentleman was admitted to the Royal Berkshire Foundation Trust with possible neutropenic sepsis following adjuvant chemotherapy. There was a delay in the initiation of intravenous antibiotics and this patient subsequently died following neutropenic sepsis.

Following a full investigation a number of recommendations were made to improve patient safety, which included training in the recognition and treatment of neutropenic sepsis. During 2008 and 2009 further incidents occurred where patients with suspected neutropenic sepsis did not receive their antibiotics in time; all of these patients survived.

On average we admit seven or eight patients a month with neutropenic sepsis. In 2009, the trust introduced a care bundle for patients with suspected neutropenic sepsis to ensure that:

- All patients with suspected neutropenic sepsis receive IV antibiotics within one hour of presentation;
- All clinical staff can recognise neutropenic sepsis and sepsis and understand the urgency of antibiotic treatment.

The process

Initial work to ensure recognition and management of the condition included amending protocols, but this did not have a significant impact. Therefore, we introduced the neutropenic sepsis care bundle in October 2009. .

The care bundle was developed by a multispecialty steering group and contains the key steps required in the treatment of this life threatening condition:

- Blood sample sent for culture;
- Antibiotic administration;
- Referral.

Following the introduction of the care bundle challenges with interpretation and compliance were addressed and the bundle amended. From January 2010 formal monitoring of compliance has been undertaken by the assistant chief nurse and fed back to relevant areas. We also produced a DVD for junior doctors which clearly explains the recognition and management required.

After this the steering group developed a neutropenic sepsis recognition leaflet based on the HEAT acronym (history/examine/action/treat) from the Sussex Cancer Network campaign. The leaflet was distributed to junior doctors, GPs and the ambulance service.

Advice to other organisations

Our results since January show that use and monitoring of the care bundle has resulted in an increase in antibiotic administration within one hour from 20% to 94%. The care bundle was presented as a poster at the Patient Safety Congress in May 2010 and has been disseminated to other trusts to use or adapt to their local requirements to improve patient safety.

Benefits of the initiative

In five months monitored 134 patients attended with suspected neutropenic sepsis, 59 of these were admitted and coded with neutropenic sepsis. Compliance with antibiotic administration within one hour has increased from 20% to 94%.

There have been no patient deaths following delayed antibiotic administration for neutropenic sepsis since March 2007. However, incident reports of near misses has increased from three (January to May 2009) to seven (January to May 2010). We believe that these results show increased reporting, rather than an increase in actual incidents. We would expect that for the same time period in 2011 there would be fewer incidents.

Financial implications

Producing the training DVD cost £2,500 which was funded from the medical education budget; all participants/actors gave their time at no cost. The care bundles (which are self adhesive) cost £330 per 1,000; these are funded via individual departmental budgets.

It was estimated in 2004 that it cost £3,188 per febrile neutropenic event. An audit of cancer patients presenting with febrile neutropenia over a five month period in 2009 showed that the average stay in hospital was 12 days. During 2009–10 we treated 131 neutropenic patients. If we administer timely antibiotics to these patients they will be less ill so their length of stay will be shorter reducing the total cost of their treatment.

Future plans

We still have the challenge, once diagnostic results are available, of ensuring that antibiotics are stopped for those patients who are not neutropenic. We are investigating near patient testing options to address this issue.

Contact

For more information on this initiative please contact Hester Wain: *hester.wain@royalberkshire.nhs.uk*

Award sponsored by

St Andrew's HEALTHCARE

Judges

Kevin Stewart, *medical director, Winchester and Eastleigh Healthcare Trust*
Maxine Power, *national improvement advisor, Department of Health*
Jane Jones, *assistant director, transforming organisations, Health Foundation*
Carol Rooney, *deputy director of nursing, St Andrew's Healthcare*

FINALIST

Multiagency working to promote safety for patients, staff and the public

Hilary Grant, Karen Burnham and Jo Hemming; Birmingham and Solihull Mental Health FT

The initiative

The initiative was developed as a response to low workforce morale in Ardenleigh Unit as a result of physical and sexual assaults on staff not being pursued by the criminal justice system (CJS). A recordable pattern demonstrated that service user attitudes to violence was poor. This was as a result of inconsistent or non existent consequences for violent and aggressive behaviours.

It is an integral part of our therapeutic objectives that young people have clear boundaries and that there are consequences if they engage in violent behaviour. Actively addressing this issue is also an important part of risk assessment and management.

We have developed partnership working between our 20 bed medium secure forensic child and adolescent inpatient unit, the police, the CJS and the Crown Prosecution Service (CPS). This partnership is aiming to address patient, staff and public safety:

- Improve staff morale;
- Increase public confidence in our service;
- Optimise therapeutic working with our population;
- Dispel the young peoples' myths around the police;
- Ensure that people are cared for under the correct part of the mental health act (such as hospital disposals);
- Conduct interviews and provide a base for the police officer on site;
- Provide expert reports to inform and provide recommendations to assist the courts in their decision making about our young people;
- Provide reports to the CPS to increase understanding of the links between mental disorder and offending and why charging the young people is appropriate and meets the public interest test.

Due to the complex difficulties of our patient population violence and aggression is often a predominant feature of their presentation. Ardenleigh's philosophy is that the ward should function as a community/neighbourhood. Therefore we felt there should be equivalent consequences for those within the service as there would be for those in the community if they behave violently or aggressively.

The project also involved working with the CJS and particularly with the CPS to ensure that the young people are dealt with in a way that meets their mental health needs throughout their care pathway.

After discussions with the police a joint strategy for working with the young people in Ardenleigh was developed.

The strategy involved promoting and utilising resolution work on the unit. We also ensured that there was a close liaison between the two systems to support charges and convictions being sought, this includes devising reporting templates for the CPS.

We have supported the police in having a high visibility approach so that young people see police on the unit as routine rather than only in a crisis.

Benefits

Since the initiative began there has been a significant decrease in violent incidents, and an increase in positive social behaviours by the young people. This has resulted in the ward functioning more as a community. The young people have developed a respectful regard for the police, helping them to learn that their concerns as victims will be taken seriously as well as their actions as perpetrators. There has also been an improvement in staff morale and a reduction in sickness and injury rates.

Several cases have been taken forward by the CPS. Two young people have completed their court processes for assaults on staff and we are awaiting the completion of two more cases. This is a significant breakthrough for both the mental health services and the police, as historically the CPS would not have processed these cases further than considerations.

The CPS is using the templates developed for the reports to assist other services, and the police are planning to introduce this model into other inpatient services. This has fostered a mutual understanding of the aims and procedures of the agencies involved, notably, mental health services, CJS, CPS and the police

Financial implications

The costs associated with setting up this new way of working consisted of staff time. Savings that have been made for the service as a result of this include:

- Increased staff retention;
- Reduced staff sickness and injury;
- Reduced staffing levels due to reduction in violent behaviours;
- Reduced maintenance costs due to reduced destruction to property.

Contact

For more information on this initiative please contact Madeleine Stuart: *madeleine.stuart@bsmhft.nhs.uk*

FINALIST

Levels of specialling

Sandra Coles and Denise Shanahan; Cardiff and Vale University Health Board

The initiative

The purpose of the initiative was to develop clear decision making guidance and procedures for assessing and prescribing special levels of observation within general adult wards. General adult care wards include assessment, medicine, surgery, neurosciences, emergency care, rehabilitation and continuing healthcare environments.

The initiative aimed to address the assessment and intervention needs of patients who are generally confused, wandering, falling or at risk of harming self or others, pulling lines or tubes that may result in significant harm or who are exhibiting challenging behaviours.

We are providing care and treatment for increasing numbers of patients who present with both physical illness and mental health problems. At times such patients may present with associated risks or challenging behaviours and need close observation. This observation must be in the best interests of the patient; there had been some suggestion of an over reliance on requests for 1:1 specialling by registered mental health nurses within general adult wards with 1:1 specialling sometimes leading to a custodial rather than a therapeutic approach.

A sub group of the vulnerable adult risk management group undertook the work. The group included representation from integrated medicine, medical rehabilitation, neurosciences,

neuropsychiatry, mental health services for older people, unscheduled care, surgery and workforce planning.

As a group we reviewed the literature and other organisational guidelines as well as existing local procedural guidelines. We developed clear decision making guidance and procedures for the use of levels of nursing specialling within general adult wards; this guidance is incorporated into a risk assessment tool.

The tool was refined using the model for improvement by planning, trying, observing the results, and acting on what was learned using plan do study act (PDSA) cycles. Education was provided by practice development nurses and cascaded though the ward staff. The tool was found to be easy and logical to use and was well received by nursing staff.

Our work identified that the development of clear roles and responsibilities to deliver shared care is key to improving standards of patient care.

Benefits

This tool was selectively introduced in October 2009 and ratified for use across the university health board in November 2009. It has supported both nurses and senior managers in optimising the use of the nursing workforce specifically in relation to the specialling of patient in general adult wards.

Improved decision making has been observed. There is evidence within the healthcare records of more timely assessments, referrals and appropriate interventions being undertaken. These in turn reduce risks and improve the quality of care delivered.

The tool also requires a reassessment of the risks each shift and asks the question "Can the patient's care be safely maintained within usual staffing levels?" If not, the risks and reasons are coded, recorded and signed by the nurse making the assessment.

Financial implications

The launch of the tool was associated with an increased scrutiny of requests for nurse bank and agency shifts for the specialling of patients. We have achieved a significant reduction in the use of bank and agency cover for specialling patients with the risk assessment tool ensuring that quality and safety of patient care has remained central to the decision making process. Education, training and implementation have been provided through existing resources.

Contact

For more information on this initiative please contact Denise Shanahan: *Denise.Shanahan@wales.nhs.uk*

FINALIST

The review of all emergency bleep calls and high level incidents related to delayed recognition and response: developing actions and improving processes from each incident

Sarah Ingleby and Peter-Marc Fortune; Central Manchester Healthcare Trust

The initiative

In 2007 the National Patient Safety Agency reported that in 11% of patients deaths identified as potentially avoidable clinical deterioration had not been recognised or acted upon.

On average the Central Manchester Foundation Trust has between five and eight emergency bleep calls a week. These are promptly responded to by specific clinician or arrest team as indicated by the caller.

A group of clinicians was established in October 2009 to review calls on a weekly basis. High level incidents reporting delayed recognition or response to patient deterioration were also brought to this group.

For each call the group determined whether the patient's deterioration was potentially avoidable. For those falling into this category the medical and nursing team supervising their care were then instructed to use a template to review the 12 hours preceding.

They were asked to identify areas of good practice and areas where alternative actions or alternative methodology might have prevented the call. In both cases the information has been shared throughout the organisation in order to optimise practice everywhere.

This process involved reviewing the case notes of the patients whose care generated emergency calls.

A weekly emergency bleep review meeting was established. At these meetings the overall management of the patient was reviewed with a focus on:

- Standard of observation recording;
- Standard and appropriateness of the response to the early warning score or deteriorating condition;
- Recognition of deterioration or need for further intervention.

Each week the core group reviewed a summary of each case. Those teams involved in deterioration that was judged potentially avoidable are invited to a subsequent meeting to present and discuss the case. The teams are required to submit an action plan for areas of potential improvement. These plans are then discussed, modified and ratified in collaboration with the core group.

Benefits

This process has seen a major change in culture across the trust through its championing of a shared responsibility to achieve optimal patient safety. This has manifested itself through direct feedback from individual staff members.

There has been a measurable reduction in emergency calls and the hospital standardised mortality ratios have reduced over the last 12 months. This effect is most marked in the areas that have regularly and actively engaged with this process.

The process has also been successful in raising awareness thematic problems. Through the cascade of this information issues that were initially seen on a weekly basis have been almost eliminated during the first year of this initiative.

The ability to direct appropriate education to the correct personnel has been vital, with all levels requesting education from the junior nurses to the consultants as they too recognised from the discussion that there were areas in which they would like to have increased training.

Financial implications

The time needed to attend the weekly meetings has been absorbed into existing job plans. The clinical teams say that the initiatives introduced through this process have made their practice easier and saved them time.

We expect a sustained financial saving through a reduction in patient morbidity.

Contact

For more information on this initiative please contact Sarah Ingleby: *sarah.ingleby@cmft.nhs.uk*

FINALIST

Clinical human factors approach to sepsis/ deterioration

Matthew Inada-Kim;
Royal Hampshire County Hospital

The initiative

Awareness of the seriousness of severe sepsis remains low despite its high mortality (30–50%). It is frequently under diagnosed and those interventions that have a proven mortality benefit are not being applied uniformly, consistently or in a timely fashion.

The speed of administration of antimicrobials is a key determinant of patient survival; for every hour that antibiotic administration is delayed there is an 8% reduction in survival. Severe sepsis is extremely common, killing 1,400 people worldwide every day.

A trust wide audit demonstrated the average delay for antibiotics was seven and a half hours. It took five hours for a chest Xray. Marked improvement was required.

A detailed analysis was undertaken of the human factors errors (recognition, assessment, management, diagnostics and training/information) contributing to delayed antibiotic administration. This led to a large scale improvement plan, culminating in timetabled two hour training symposiums using:

- Simulation — crew resource management;
- Practical — IV antibiotic administration;
- Theory;
- Action learning — suspicion of sepsis boxes.

Each symposium trained 130 doctors/nurses. The aim was to do this cost neutrally, but still deliver improved safety, quality and change the culture of the organisation and the priorities of frontline staff in the pursuit of safer care.

Incoming clinicians are taught to be more reliant on clinical skills in determining diagnoses rather than relying on investigations.

Benefits

The average time to antibiotic administration time once severe sepsis has developed has reduced from 450 minutes (before the intervention) to under 100 minutes.

Severe sepsis mortality has reduced from over 26% to 16%, while length of stay has reduced by 2.2 days per patient (20%).

Financial implications

Training materials cost £200 to print. The initiative has saved £0.5m per year in bed day costs alone and has contributed to being able to shut a ward.

Contact

For more information on this initiative please contact Matthew Inada-Kim: *matthew.inada-kim@wehct.nhs.uk*

FINALIST

Outpatient antibiotic therapy clinic

Radha Brown and David Charlesworth;
South Tees Hospitals FT

The initiative

The outpatient antibiotic therapy clinic (OPAT) was set up to provide a central service within the South Tees area for the treatment of patients with chronic infected wounds and other infections.

The OPAT aimed to:

- Reduce hospital admissions and lengths of stay;
- Improve patient safety and the quality of patient experience.

Taking referrals from all divisions within South Tees Hospitals Foundation Trust and local primary care, the OPAT operates a highly specialised service managing complex wounds and infections seven days a week. It provides around 3,500 days of patient treatment each year.

Before the creation of the OPAT, individual divisions and services within the trust, and colleagues within primary care were responsible for managing wound infections. This frequently resulted in the need to admit people to hospital or extend their hospital stay so their infections could be treated.

By establishing a nurse led team of wound care experts, the service has taken this responsibility from individual services within the trust, and primary care colleagues. As well as providing the clinic it also acts as a centre for specialist knowledge and advice.

From the initial service the OPAT has expanded to offer an infiliximab clinic, MRSA decolonisation clinic, presurgical intervention and post discharge follow up.

Benefits

The OPAT was launched in 2007 with a target of saving around 1,500 bed days a year. In the first 12 months 3,800 bed days were saved and since then over 14,112 bed days have been saved.

Despite the significant infection risk posed by its patients, OPAT has not had a single case of *Clostridium difficile* or MRSA colonisation acquired through the service, and just one bloodstream infection associated through the use of central and peripheral cannulae.

The OPAT receives consistently excellent patient satisfaction scores in regular surveys.

Financial implications

The OPAT was set up in 2007 with an initial investment in the following posts:

- One band 7 sister;
- One band 6 sister;
- Three registered nurses;
- Two healthcare assistants.

In terms of return on investment, the service saves over £500,000 a year in inpatient costs.

Contact

For more information on this initiative please contact Caroline Parnell: *caroline.parnell@stees.nhs.uk*

FINALIST

Introduction of an early warning score tool into mental health inpatient wards for older people

Lesley Chapman and Paula Atkinson;
Tees, Esk and Wear Valleys FT

The initiative

The project aimed to develop and introduce an early warning score (EWS) tool to recognise and respond to physically deteriorating patients in mental health inpatient services and to help mental health staff to recognise patients at risk of physical deterioration.

Although EWS tools are well established in acute hospital settings, their use in mental health settings is not.

Older people with mental health problems have more physical health problems than the general population, and these needs have often previously been undetected or untreated, not least because many of them are unable to articulate that they are feeling unwell.

Our older people's inpatient areas were audited to assess current practice, including observations and investigations undertaken on admission, at routine yearly review and when a physical illness or fall occurred. The audit revealed that practices varied across the trust, and that staff frequently failed to recognise and respond appropriately to the physically deteriorating patient.

We devised an EWS chart based on those already used in acute settings but modified to suit the mental health context. A training package was also developed at the same time to ensure that staff skills and competencies were up to date.

A three month pilot of the tool was undertaken on four assessment and treatment wards to assess the impact on patient care.

The feedback following the pilot was extremely positive. Guidance was changed to ensure all patients having their EWS calculated daily, and the tool was rolled out across all older people's inpatient wards in the trust. Minimum standards flowcharts ensured that every patient had the same observations, investigations and assessments on admission and annually where appropriate.

A reaudit has been carried out to evaluate the use of the EWS charts and the admission and annual flowcharts. This audit has shown improvements in the recognition and response to physical deterioration as a result of the introduction of the tool.

Benefits

Some of the key benefits of the initiative are:

- Increasing evidence of early detection and response to physical concerns;
- Patients receive better care and staff are more skilled in the taking of observations, interpreting the EWS and responding to the scores;
- Illness has been detected, even when patients have appeared well, allowing rapid treatment.

Nursing practices now includes daily EWS recording. Before this project, many patients would only have their observations recorded infrequently.

Staff are more aware that we need to care for a patient holistically and not just treat their mental health problem;

We now have evidence about interventions when high early warning scores (EWS) were obtained, and of the tools effectiveness in alerting staff to the physical deterioration of the patient before this is visually evident;

Information provided by the service to emergency services and acute trusts is more credible and relevant.

Financial implications

Set up and running required staff time in developing the tool and training, and audit work associated with implementation. The tool will deliver cost savings as a result of early identification and treatment of physical illness, appropriate use of emergency services and admissions to the acute sector and reducing avoidable acute hospital transfers.

Contact

For more information on this initiative please contact Jayne Lamplugh: *jayne.lamplugh@tewv.nhs.uk*

FINALIST

Reduction in hospital acquired pressure ulcers

Lindsey Bullough and Linda Smyth; Wrightington Wigan and Leigh FT

The initiative

Pressure ulcers continue to be an important problem in NHS hospitals, resulting in a detrimental effect on the individual's health and wellbeing, causing pain and discomfort and an overall poor experience for those patients affected. In some cases pressure ulcers can be a cause of death.

Economic consequences for the health service associated with pressure ulcers include high costs in human and material resources, and associated litigation. The economic burden for the National Health Service as a whole is considerable.

In the year 2007–08 a total of 70 patients at Wrightington, Wigan and Leigh Foundation Trust acquired a pressure ulcer while in hospital. In 2008 the trust set an objective within its nursing strategy to reduce hospital acquired pressure ulcers by 90% over five years. The purpose of the initiative was to enhance patient experience, improve safety and ultimately reduce length of stay.

The trust adopted a zero tolerance approach to hospital acquired pressure ulcers, with clear executive commitment. The approach built on learning from the successful reduction in cases of MRSA bacteraemia.

The role of the tissue viability nurse was enhanced and given a higher profile and increased resources to focus on the initiative.

The nursing record as a whole was under review and this provided an opportunity to review pressure ulcer prevention records including risk assessment tools within a risk assessment booklet that included a repositioning chart.

Monthly audits of nursing care conducted by quality and safety matrons included specific measures for the prevention of pressure ulcers. Each case of hospital acquired pressure ulcer was subject to an executive review in which the director of nursing met with ward staff and matrons to review root cause analysis outcomes and agree action plans, which were then monitored by the tissue viability nurse.

In order to optimise the availability and efficient use of pressure relieving mattresses an equipment loan store was developed. This provides a decontamination facility which has enabled ward staff to obtain pressure relieving mattresses quickly, in turn ensuring a minimal delay in implementing preventive strategies.

Benefits

The initiative enables us to reduce its incidence of hospital acquired pressure ulcers in the trust from 70 in 2007–08 to 11 in 2009–10. We are on course to achieve the initial objective of a 90% reduction in five years and move towards total elimination of such incidents.

Financial implications

Financial resources were required to increase the hours of the tissue viability nurse and the operational costs of the equipment loan store. We calculate that the 84% reduction we have achieved to date equates to an annual saving of £408,000 two years after implementation.

Contact

For more information on this initiative please contact Lindsey Bullough: *lindsey.bullough@wwl.nhs.uk*

WINNER
Capital equipment planning and procurement

Jason Lavery
NHS Supply Chain

Background

NHS Supply Chain's capital team was created to address the problem of fragmented procurement and aimed to save individual NHS trusts' money and time. We are committed to transforming the purchasing, leasing, maintenance and disposal of capital equipment. One of our key roles is saving trusts money by both taking the responsibility of *Official Journal of the European Union* (OJEU) tendering on their behalf and by buying efficiencies through greater aggregation of NHS spend.

The process

The formation of the capital team at NHS Supply Chain involved migration from a model anchored around a five year £550m centrally funded government initiative for cancer and heart disease managed by the NHS Purchasing and Supply Agency, to a privately funded model which aimed for a different approach in the market with an offer that reflected:

- The needs of the customer in respect of equipment choice, finance options and guidance;
- The policies outlined by the Department of Health and central government with respect to the health service;
- The continued support offered to the national screening programmes and expenditure of capital allocations

This had to be accomplished while building a team focused on national savings and policy objectives.

Using the National Imaging Board with the Health Protection Agency as chair we undertook a project to identify a full database of imaging equipment in England. The results enabled the capital team to cover all imaging modalities under one framework, providing the health service with a single source for capital imaging equipment.

From conception in 2006 to the present day, the capital team has achieved verified NHS savings of over £60m and has become the method by which almost 50% of all capital equipment within the NHS is procured. Our services are designed to cover everything needed for the planning, purchase, maintenance and disposal of capital equipment, but the individual trusts decide exactly what level of involvement they require from the capital team.

Our knowledge of the marketplace is combined with a deep understanding of the special requirements of the NHS. This means that when we offer solutions they are going to work in the real world, where restricted finances and the ideals of healthcare have to live side by side.

Benefits of the initiative

Some of the significant benefits the capital initiative has achieved since its inception include:

- Quantifiable savings of over £60m;
- Removal of the burden of OJEU;
- Increased speed;
- Cost effectiveness;
- Alignment to Department of Health policies;
- Process enhancement;
- Access to new technologies.

Award sponsored by

Financial implications

From the very beginning the capital team has continually evolved its offer with the aim of ensuring we provide a full and complete service for NHS trusts from conception of project to disposal of aged equipment. This evolution has involved a significant amount of investment from the wider business — not only in the procurement personnel themselves but also in the equipment and systems to support the growth of the team and expansion of the overall offer.

The financial commitment made by the business to the development and success of the capital offer can be demonstrated when contrasting the position in 2006 to that of today.

	2006	2010
Staff	5	55
National frameworks	6	40
Sales revenue	£46m	£390m
NHS savings	£4m	£27m

In addition to the investment in the above, the business also provided an injection of capital exceeding £45m which has been used by the capital team to bulk buy equipment from suppliers with a view to creating economies of scale.

Future plans

The capital team is an expansive entity that will continue to evolve to encompass further equipment and service offerings. Over the next five years the main task will be to address the constraints of capital funds in the NHS using:

- Alternative funding models;
- Expansion of capital equipment planning;
- Increased project management;
- Provision of MES offer;
- Outsourced services.

Contact

For more information on this initiative please contact Jason Lavery: *jason.lavery@supplychain.nhs.uk*

Judges

Philippa Slinger, *chief executive, Berkshire Healthcare Foundation Trust*

John Warrington, *deputy director, procurement, investment and commercial division, Department of Health*

Nick Gerrard, *chief operating officer, NHS Supply Chain*

Mike Hogg, *general manager, Shell Gas Direct*

HIGHLY COMMENDED

Technology tackles no shows to save NHS £millions

Andy Brown and Trevor Ingham;
NHS Collaborative Commercial Agency

The initiative

The Department of Health estimates patients not attending routine and follow up appointments cost the NHS approximately £600m per year through wasted clinical resources and administration costs. Over 5.5 million appointments were missed in 2007–08.

Several hospitals had successfully piloted innovative technological solutions for improving communications with patients. Data from the hospital episodes statistics team acknowledges these solutions have improved patient attendance — creating an opportunity for savings and cost avoidance.

Recognising that these technologies could be made more widely available, the North West Collaborative Commercial Agency (NWCCA) lead a national procurement initiative in collaboration with nine other regional hubs, national standard agencies and acute trusts in an attempt to save the NHS £86m. The objectives of this initiative were to:

- Create a contracting vehicle for the NHS;
- Save money on up front costs;
- Reduce the level of do not attends (DNAs);
- Address bad publicity;
- Implement effective two way communication using new media.

In May 2008 representatives from other procurement hubs, Connecting for Health and the Purchase and Supply Agency engaged with the hospital episodes statistics team to gather the baseline data required on DNAs and the estimated costs involved. The team scoped the procurement to include a range of communication solutions to suit the diversity of patients. These included:

- SMS messages;
- Automated email reminders;
- Automated telephone messages;
- Agent calls and call centre solutions;
- A fully managed service option including a bulk buying solution allowing trusts to access cheaper rates on the solutions that appeal most to their patients.

The technical specification demanded that each solution be capable of:

- Interacting with existing patient administration systems;
- Protecting patient confidentiality;
- Interacting with other technologies;
- Receiving communication from the patient.

At the end of this process eight suppliers were awarded two year contracts across the lots of activity following a restricted *Official Journal of the European Union* procedure. To allow some element of choice at local trust level, more than one supplier was appointed across each lot.

Benefits

The overall result of this project has been the implementation of a national framework, meaning organisations do not need to run their own procurement processes. This saves the NHS valuable time and resources while reducing the level of supply chain risk. The team has established national specifications flexible enough to be adapted as technologies and solutions evolve.

Not only does this project enable the NHS to deliver information to its patients in a creative manner, the technology is also capable receiving information from the patient that can be manipulated and analysed by NHS trusts, providing them with meaningful data.

Financial implications

Based on an outturn analysis, evidence suggests this project will save the NHS £86m a year on a recurrent basis. For example, a text message costs around 14p to send, compared with a letter, which costs on average 83p.

This project is also the largest collaborative procurement exercise undertaken since the NHS established regional collaborative procurement organisations in 2004. The benefits will play a major part in helping the NHS to achieve the significant budget efficiencies required over the next three years as a consequence of the global financial crisis and public sector debt in the UK.

Contact

For more information on this initiative please contact Jenny Graham: *jenny.graham@nwcca.nhs.uk*

FINALIST

Making more efficient food services delivery to our clients at better value

Neil Hathaway, David Evans, Faheem Uddin and Robert Macchi;
Birmingham and Solihull Mental Health FT

The initiative

The initiative began in 2009 with a decision by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) to review catering services. The trust was keen to deliver a more sustainable approach to catering through:

- Sustainable procurement;
- More efficient energy usage;
- Better waste management and recycling.

At the same time we recognised that food is integral to the health, well being and morale of our patients. The long stay, specialist care of our patients, requires us to have a unique, flexible, quality catering service.

We engaged with a range of stakeholders through patient surveys, staff feedback, user forums, meetings and consultation. We wanted to produce a strategy that all stakeholders would own and buy into, and ensure that our strategic goals were based on empirical evidence. Our planning, development and processes were set against achieving service improvement within ever increasing pressure on resources. These service improvement objectives were to:

- Deliver improved service change to our 52 wards for our 800 inpatients across all sites;
- Enhance our patients' experience, health and wellbeing through food choice, food quality and effective provision;
- Identify and deliver measurable efficiency savings;
- Comply with local and national strategies;
- Deliver value within finite resources.

A key part of strategy delivery has been raising awareness through posters, leaflets, information packs and promotion via our intranet. Our front line staff have also been instructed to engage with our customers to promote the changes in a positive way.

Implementing our strategy is an ongoing process. We are

involved in a number of individual new projects to support the strategy, including:

- Introducing new seasonal trustwide menus;
- Producing more fresh food;
- Upgrading kitchens and equipment;
- Developing and training our staff;
- Encouraging patient involvement;
- Rolling out a robust budget management system;
- Reviewing food procurement with NHS supplies.

Our strategy has allowed us to embed the new service within the planning and development of two new trust hospital building programmes.

Benefits

Mental health patients have very different care needs to acute patients, and we aim to provide an outstanding catering service that recognises their unique circumstances. We aim to contribute to patients' care pathways in every way we can, and we have already seen some positive results.

There are numerous other benefits of our initiatives, some of which are listed below.

- More patient choice, including multicultural meal choices;
- Improved patient wellbeing and morale;
- The home grown project (patients growing food in allotments);
- Improved supplier relationships and locally sourcing food where possible;
- Reduction in waste;
- Efficient management of our costs and budgets including reductions in food costs;
- Clinical staff have noted that patients are more amiable since the introduction of the changes.

Financial implications

There was a small capital investment required totalling £25,000 for kitchen upgrades. This was funded through current budget savings. In addition there was a time resource investment from the whole trust. The initiative has produced financial savings including:

- £30,000 annual saving on food costs at Reaside Hospital;
- £10,000 annual saving on food costs ay Ardenleigh Hospital;
- £30,000 annual saving on food costs at the Barberry Hospital;
- A 12% reduction in food waste through recycling, better management of production and portion management;
- A reduction in electricity and gas consumption through more efficient catering equipment.

Contact

For more information on this initiative please contact Robert Macchi: *Robert.Macchi@bsmhft.nhs.uk*

FINALIST

Refocusing cataract services: clearer benefits for all to see

Carole Hodgkinson and Pamela Bethell; Contract and Information Shared Services Unit

The initiative

The objective of this initiative was to procure a high quality cataract service on behalf of four PCTs. The initiative was jointly managed by Cheshire and Merseyside Contract And Information Shared Service Unit (CISSU) the North West Collaborative Commercial Agency (NWCCA) and Wirral PCT. The service it superseded had been delivered via a national contract. The key objectives of the initiative were to:

- Establish a new service capable of functioning at an optimal capacity thereby efficiently adhering to national waiting time targets;
- Provide some element of choice to patients in terms of service provider;
- Maintain the high quality patient centred service delivered via the original contract;
- Stimulate the market to support and develop local ophthalmology providers;

We began this joint venture by establishing the service requirements of each PCT, which included a full capacity review, demand modelling and market analysis of the current service.

After the review it was evident that the existing service needed to be replaced. Clinicians were engaged to champion this change to their peers. After a period of consultation clinical leads and optometric advisors across the PCTs signed up to the new service. Working together they devised the clinical pathway basing on learning from the previous national contract and the *Focus on Cataracts* publication.

The performance model was outcome based, focusing on key performance indicators such as complication rates, infection rates and clinical outcome measures.

Wirral PCT with the NWCCA led the procurement part of the process. Following contract award CISSU launched a rapid mobilisation process and will contract manage the two successful providers.

Benefits

Clinical benefits of the initiative include:

- Having a single consistent evidence based clinical pathway across a number of PCTs;
- The opportunity to benchmark clinical service across a number of providers and PCTs;
- The development of clinical outcome measures and patient reported outcome measures;
- Direct optometrist referral for cataract surgery now possible.

Procurement benefits of the initiative include:

- Reduced costs from undertaking one procurement exercise as opposed to four:
- A final contract awarded at a tariff lower than Payment by Results:
- The development of a healthcare market for ophthalmology services:

Patient benefits of the initiative include:

- Choice;
- Fewer hospital visits.

Financial implications

The collaborative approach minimised additional cost above existing staff complements and funding agreements. CISSU supported three of the four PCTs in this process through their existing service level agreements. The fourth PCT funded one quarter of CISSU's time at cost.

The NWCCA's time was funded using the "free project days" available via the three PCTs' subscription to the service, topped up with a small number of additional days. Wirral PCT's contribution was making the clinical and management staff available to take the project forward. Some additional resource was required for legal advice and clinical input; the cost was shared across the PCTs.

The resulting contract has also released cost. One provider has been awarded a contract with a minimum guarantee of 50%

of the contract value in the first year for a significant discount. The NHS provider has also offered a discount for activity above a certain level.

Contact

For more information on this initiative please contact Carole Hodgkinson: *carole.hodgkinson@cissu.nhs.uk*

FINALIST

Working together for better health

NHS Collaborative Commercial Agency; Trevor Ingham and Andy Brown

The initiative

Social marketing has been identified by the NHS in the North West as an approach that has the potential to change people's behaviour to effect lasting health improvements. The North West has a number of health inequalities that could be helped by social marketing including:

- The highest rate of premature deaths from heart disease;
- The largest number of alcohol related hospital stays;
- 1,334 excess deaths from cancer each year compared with the rest of the UK.

As the procurement agency of choice for the North West NHS, the NHS North West Collaborative Commercial Agency (NWCCA) was asked to lead a procurement project to establish a framework of the best companies to deliver social marketing services.

Once selected these companies would be used by our 24 PCTs to facilitate focused interventions. This would save each PCT significant time and effort in selecting a supplier as well as exploiting the purchasing power from a combined £30m budget over the next three years.

It was decided that a framework agreement for the North West was required covering a complete range of services. Having established a network of leading suppliers vetted for quality and value for money trusts could commission social marketing initiatives safe in the knowledge that a full *Official Journal of the European Union* (OJEU) compliant procurement process had taken place.

The pre qualification questionnaire (PQQ) issued with the OJEU notice prompted the largest response the NWCCA has ever had to any tender. A total of 121 companies submitted, all of which had to be assessed against clear criteria. A sub group reviewed each submission before shortlists against "Lots" were established. Ultimately 45 suppliers received the invitation to tender with 19 suppliers selected on award.

Benefits

The framework has enabled PCT commissioners to focus on selecting the right partner for particular health campaigns without the need to conduct lengthy time consuming OJEU processes. In some cases this will save up to six months in deployment of the actual health intervention to the target population.

The resulting key performance indicators and contract management methodology is being used to develop closer working relationships with key providers that will ultimately provide learning and enable continuous improvement from each project as it is deployed.

For our public, better and wider use of social marketing techniques will improve the overall delivery of public health programmes and lead to a higher uptake. In time this will start to address the inequalities that exist and ultimately save lives.

Financial implications

The collaborative approach adopted for this project minimised any additional cost above existing staff complements and funding agreements. Evidence of healthcare gains will take years to be realised as the framework suppliers work closely with PCTs on specific projects across the North West.

There are direct benefits in that can be seen by comparing the pricing for the few projects that were being run prior to the framework, we can see a direct annual savings of £329,000 based on the revised rates agreed, ensuring value for money.

Contact

For more information on this initiative please contact Jenny Graham: *jenny.graham@nwcca.nhs.uk*

FINALIST

Local food onto patient's plates: improving quality and sustainability

Kirsty Edmondson-Jones and Dave Elsom; Northern Lincolnshire and Goole Hospitals FT

The initiative

The NHS spends over £300m on food and £500m on catering overall each year. The UK food chain employs 12.5% of the UK workforce and accounts for 8% of the economy. The NHS accounts for 5% of all road traffic in England and 3.2% of total carbon emissions in England. With these facts in mind, the purpose of this initiative was to increase the amount of sustainable local produce served to patients/staff/visitors while investing in the local community and reducing carbon emissions.

The main impediment was the lack of local suppliers on NHS Purchasing and Supply Agency Framework agreements. This meant that we could not procure sustainable local food as they did not have authorisation. Getting authorisation is prohibitively complex and costly for smaller suppliers. We had to develop our own innovative systems and processes to enable access to local suppliers. The use of the multiquote IT solution has been integral to the transparency of creating our own system for smaller local suppliers and our sustainable procurement strategy.

Benefits

As a result of the initiative, 50% of the food on our menu now contains sustainable local ingredients. Our Patient Environment Action Team results were "Excellent" for food services this year. Wastage has been reduced as patients eat more food and this improves their outcomes.

Our innovative tender process means we can now tender more regularly and get better deals. This has released funding to introduce premium ingredients onto the patient menu.

Many of our suppliers are now within a 50 mile radius of the trust, most within 10–15 miles, saving transport costs and reducing carbon emissions. A significant proportion of the trust's food budget of circa £1.5m is now spend locally.

Financial implications

No resource was available to fund this. We saved money on food costs for poor quality ingredients and now can afford higher quality local ingredients.

This entry was also a finalist in the **Good corporate citizenship category*

Contact

For more information on this initiative please contact Kirsty Edmondson-Jones: *kirsty.edmondson-jones@nlg.nhs.uk*

WINNER

The care of the acutely unwell adult project

Pete Murphey and Pete Turkington

Salford Royal FT

Background

The purpose of this initiative was to reduce cardiac arrests outside critical care units by 50% by March 2010. Over the last decade publications by the Department of Health and other agencies highlighted the complexities of managing acutely unwell patients. The National Institute for Health and Clinical Excellence (NICE) challenged trusts to dramatically improve the quality of services in accordance with evidence based best practice. The reports *Comprehensive Critical Care* and *The Nursing Contribution to the Provision of Comprehensive Critical Care for Adults* highlighted the need for critical care services to be available to all patients in hospital, regardless of their location.

Before the initiative began in April 2008 local data showed that since the inception of the adverse incident database there were 29 reported incidents which identified suboptimal care contributing to patient deaths and 100 incidents reported unexpected deterioration. There were approximately 135 cardiac arrests annually with a survival rate of approximately 10–15%.

The process

We identified 12 wards for the first year of the programme and a further 11 wards for the second. For each year we invited wards to attend an informational workshop. This provided an opportunity to communicate the aim, ambition and structure of the collaborative model and enabled the teams to ask any relevant questions.

We ran a breakthrough series collaborative in which teams were able to learn from each other and from experts. Teams committed to work together and attend a series of learning sessions. In between the sessions, teams participated in action periods where they tested changes. During these periods, participating teams had executive mentoring visits, access to the project lead, an improvement advisor and one another via a web based portal (extranet).

In January 2010, we scaled up across the organisation. All wards were required to test implementation of the seven successful changes developed by the pilot teams:

- Reliable manual observations;
- Nurse led response;
- Allocation of roles;
- Code red;
- Structured ward round;
- Ceilings of care;
- Nurse led DNA-CPR.

Advice to other organisations

We have received many enquiries from organisations across the NHS concerning our move from automated observation monitoring equipment to manual sphygmomanometers for recording pulse and blood pressures.

Benefits of the initiative

There has been a 48% reduction in arrest rates as a result of identifying deteriorating patients earlier and responding to their changing condition more appropriately.

Before the initiative began many patients who were at the end of their life did not have do not attempt resuscitation orders made for them. This often meant that they died suffering the indignity of a resuscitation attempt. We know from our own patient stories that such occurrences have a negative impact on the families of our patients. We also know that they have a significant detrimental impact on our junior medical staff who make up the crash team.

Financial implications

Without this initiative it is likely that the trust would have followed many other organisations in setting up a rapid response team to reduce arrests at an estimated annual cost of £330,000. As the project progressed it became clear that the reduction in cardiac arrests achieved by some organisations that implemented a rapid response team were well within the capabilities of the project. We can confidently say that our trust has saved at least £330,000 a year, since others have introduced rapid response teams and not achieved the 48% reduction in arrest rate yet spent considerably more.

In addition, the move from automatic to manual observations has saved the trust money in contract and repair costs agreements relating to automatic observations equipment.

Future plans

The method used to run this project focused on empowering individuals and teams to make changes that will improve the care they deliver. Our intention is to change the culture of the organisation through empowering staff and we believe that this initiative has been a significant catalyst.

Contact

For more information on this initiative please contact John Bellerby: *john.bellerby@srft.nhs.uk*

Award sponsored by

Capsticks

Judges

Peter Edwards, *senior partner, Capsticks*

Jim Easton, *national director for improvement, Department of Health*

Jane Cummings, *director of performance, nursing and quality, NHS North West*

Samantha Riley, *head of the quality observatory, NHS South East Coast*

HIGHLY COMMENDED

A radical and innovative model of antenatal services for high risk pregnancies

Harini Narayan;
The Great Western Hospitals FT

The initiative

Improved healthcare and technology have reduced maternal and perinatal mortality and morbidity, but the changing profiles of more complex pregnancies present new challenges.

Birth rates are increasing nationally but high risk pregnancies are rising disproportionately, forming over 40% of any pregnant population The quality of antenatal care determines the outcomes of two individuals in every high risk pregnancy.

The term "high risk pregnancy" is often misunderstood resulting in unnecessary investigations and interventions.

The absence of local, regional or national clinical pathways for individual high risk pregnancies means that there is differing, opinion based advice for identical complex pregnancy conditions. There is also little or no continuity of care, resulting in unnecessary revisits, investigations, admissions and interventions. Vast resources are currently wasted on several repetitive, insular, clinical activities with little evidence of their effectiveness.

The aim of this initiative was to provide a top quality, patient-centred, clinically effective, evidence based service using existing resources efficiently.

We began by undertaking qualitative and quantitative audits of users and providers of antenatal care for complex pregnancies. This revealed that in 2008 1,600 women with complex pregnancies received 17,800 hospital antenatal appointments plus innumerable community visits. Different non consultant grade doctors with varying experience levels saw over 70% of complex pregnancies.

Our initiative involved creating a patient centred service, replacing 16 consultant named antenatal clinics by 11 condition based clinics. Each clinic was headed by one consultant who led a small team of one specialist doctor and one midwife. This new team structure used experienced midwives — a neglected existing resource.

We developed Compendium with evidence based guidelines, care pathways and patient information for each of 85 complex pregnancy conditions. We also set up primary care collaborations with joint algorithms and shared workshops.

Benefits

The project has enabled us provide a top quality, patient centred, clinically effective dynamic service with efficient use of existing resources and significant waste reduction. This has given us increasing capacity to meet rising birth rates. In addition, every woman with complex pregnancy now experiences continuity of care and consistent evidence based advice.

Pregnancy management plans are provided by the same small specialist team and are based upon up to date guidelines. This has resulted in significant reductions in unnecessary follow ups (down by 30%), admissions and interventions without compromising safety or quality.

Financial implications

The initiative was cost neutral because the project's lead obstetrician voluntarily worked more than 750 hours of unpaid time over a period of 18 months on the audit, design and authorship of the Compendium. Saving resulting from the initiative include:

- A 30% reduction in outpatient appointments in the first year, at a cost of £66 per appointment, equivalent to savings of £293,376;
- A 5% reduction in unnecessary inpatient admissions, at a cost of £541 for an inpatient stay not resulting in delivery, equivalent to savings of £112,636 a year.
- A 2% reduction in elective caesarean sections, each costing £620 more than vaginal delivery, equivalent to savings of £12,400 a year.

Contact

For more information on this initiative please contact Harini Narayan: *harini.narayan@virgin.net*

FINALIST

A primary care chest pain clinic

Kosta Manis, David Brennand-Roper and Clare Ross;
Bexley Medical Group

The initiative

More than 80% of chest pain has no cardiac origin. National and local data shows a clear need for more accurate, less invasive diagnostic tests for heart patients. The Bexley Community Cardiology Service fulfils this need. Our scheme, with a cardiologist at the font line and improved triaging, ensures we only deal with genuine cardiac pain.

The first cardiology diagnostics clinic started in 2007 at a GP's surgery in Bexley, with state of the art equipment. It included standard ECG, 24 hour ECG, 24 hour blood pressure monitoring and echocardiograms.

Soon afterwards, four local GP surgeries offered a weekly specialist cardiology clinic with diagnostic tests and consultant appointments, as well as services from heart failure nurses. A rehabilitation scheme is also provided in the community. Patients are seen within a week of being referred, rather than having to wait for at least eight weeks.

Benefits

The clinic produces 100% accurate test results, saving lives while preventing unnecessary suffering, at less cost than traditional care pathways. Patient evaluation shows 100% satisfaction.

The best example of how the primary care chest pain clinic has transformed care is the introduction of the dynamic volume computerised tomography (CT) scanner, which can scan a heart in a single heartbeat.

The time taken to treat patients is dramatically reduced. . The scanner's findings are checked by a highly specialised consultant. Those with normal results return home and those in need of intervention are treated promptly.

Financial implications

Using the CT scanner is far more cost effective than traditional, often inaccurate and potentially risky stress tests and angiograms. As well as taking a fraction of the time (a few seconds, compared with weeks) the CT scan costs less.

The scheme was funded by Bexley Care Trust. It has delivered savings of £300,000 against traditional outpatient angiogram pathways each year since it started in 2008. More accurate diagnosis means £1,000 is saved every time a patient is prevented from having an unnecessary angiogram. Accurate results also mean a further £500 is saved each time a patient is prevented from further consultant visits.

Contact

For more information on this initiative please contact Kosta Manis: *kosts.manis@nhs.net*

FINALIST

Improving efficiency in healthcare delivery while providing optimal patient care: a single stage diagnostic and treatment pathway for carpal tunnel syndrome

Mick Pearse and Jagdeep Nanchaha; Imperial College Healthcare Trust

The initiative

We aimed to reduce multiple hospital attendances associated with common conditions and shorten treatment times while achieving optimal outcomes and high patient satisfaction. We chose carpal tunnel syndrome (CTS) because it is the most common hand disorder and is traditionally associated with multiple hospital visits and prolonged waiting times for investigations.

We designed an optimal single stage pathway led by fellowship trained consultant surgeons. We overcame the long waiting times for nerve conduction studies (NCS) by adopting technological advances and introducing new practices by training hand therapists to utilise portable nerve conduction devices. This allowed us to develop a comprehensive, one stop service.

We also wanted to radically reduce costs and, achieved substantial savings by introducing a highly efficient dual theatre model that maximises theatre use and minimises surgical downtime leading to greater efficiency.

Channelling the referrals to our novel clinic run by a team of dedicated multidisciplinary staff enabled the development of this successful service.

Referrals were screened and unsuitable patients, such as those on warfarin, were routed to regular clinics. Patients were sent an information pack with details of the same day surgery service and were contacted by the clinic coordinator to arrange a convenient appointment. Clinics were held on a Saturday morning staffed by a receptionist, a nurse, two consultant surgeons and two hand therapists. Two operating theatres were staffed by two theatre nurses and a healthcare assistant.

A surgeon assessed patients and those with clinical signs of CTS were referred to the hand therapists, who measured sensation, grip and pinch strength and undertook NCS. The conduction data are relayed to the US and the report is emailed back within 15 minutes. Patients were reassessed with the results. A small number with mild symptoms received steroid injection.

Patients with established CTS underwent surgical decompression under local anaesthesia. Two adjacent operating theatres were used to maximise efficiency. Patients were reviewed after surgery by the hand therapist and received postoperative instructions and a high sling. A letter was dictated to the GP on the day and patients were advised attend their GP practice nurse at two weeks for suture removal.

Benefits

Our clinical model has steadily treated more patients without increased resources or reducing patient satisfaction. Initial clinics had 20 patients with up to 12 undergoing surgery but as the pathway became established, the numbers doubled.

Mean surgical and patient turnaround times reduced as the service became more streamlined, yet the clinical outcomes at one year were uniformly excellent. A total of 84 patients (92 hands) participated in the outcomes study. The clinical measurements showed a significant improvement in absolute indicators of hand function such as pinch grip and digital sensation at one year ($p<0.001$). These results are comparable to the best published results in the literature.

No patients during the study period developed a wound haematoma, infection or slow healing; 12% required additional advice regarding scar management or postoperative recovery of sensation and function.

The Picker satisfaction survey asked if patients would recommend the service to their family and friends; 85% replied "definitely" and 11% stated "probably", while 65% rated the care they received as "excellent" and 28% as "very good".

Financial implications

Minimal additional financial resources were required to develop the initiative. Existing vacant theatres and outpatient spaces were used and all staff are employed by the trust. The only additional expense was the purchase of a portable NCS system for £4,000. This was more than offset by the 30% reduction in referrals to the neurophysiology department.

The initiative has resulted in financial savings to both to the PCTs and the hospital trust. Most importantly, by delivering assessment, diagnostics and treatment all on the same day, there were considerable savings for the patients by avoiding repeat hospital visits and time off work.

Contact

For more information on this initiative please contact Jagdeep Nanchahal: *j.nanchahal@imperial.ac.uk*

FINALIST

Flushed with success

Andy Brown and Ian Dodd; NHS North West Collaborative Commercial Agency and Becton, Dickinson and Company

The initiative

When patients are admitted to hospital it is routine practice to insert vascular access catheters into the back of their hands for the regular injection of drugs. The canulas need to be flushed with saline when first inserted and then every time a drug is administered. This involves a nurse drawing saline from an ampoule into a hypodermic syringe before connecting it to the canula to flush the device. Studies show that the contamination rate of this technique may be as high as 8%. Some hospitals undertake 40,000 of these procedures a month amounting to 3,200 potential contaminations. There is also the risk of needlestick injuries to nurses or patients and of medication errors.

Becton, Dickinson and Company (BD) has developed a range of prefilled saline syringes specifically designed for flushing in-situ vascular access catheters. This product offers many advantages, including a vastly reduced preparation time, reduced potential for airborne or skinborne bacterial contamination and the elimination of needles from the entire process.

North West Collaborative Commercial Agency (NWCCA) clinical advisor, Ian Dodd, saw the potential of these syringes and set out to encourage trusts to adopt this innovative product which could save nursing time and make patient care safer. The research found the cost of the prefilled syringes, along with a reluctance to change traditional methods, had limited their adoption. In response, Ian started discussions with BD in June 2009 about an innovative collaborative procurement deal for NWCCA's member trusts.

At the same time, The Christie Foundation Trust was on a drive to reduce hospital associated infections (HCAI). Nursing staff completed a questionnaire on how they carried out the process using the traditional needle and syringe method; 80% admitted to poor practice that could have led to incidents of HCAI. The hospital therefore undertook a two month trial of the syringes on the haematology transplant unit.

As a result of these actions the NWCCA has committed to an annual volume of 3ml, 5ml and 10ml syringes from BD. A retrospective rebate amount based on the contracted cost price into NHS supply chain applies.

This has brought down the cost of the syringes to a level where they are only slightly more expensive than the six components involved in the conventional method. When the reduced time spent preparing the saline flush is factored in, the new solution is significantly less expensive.

Benefits

A second audit undertaken by the Christie Foundation Trust showed 100% compliance with aseptic non touch techniques. Infection rates were closely monitored during the trial and a reduction was noticed even during this period.

As a result prefilled saline syringes were adopted throughout the hospital. Staff found an average 40 second saving per flush when they moved to the BD prefilled saline syringe. Based on a 40 hour working week, this releases approximately 50 weeks of nursing time over the duration of a year, releasing valuable nursing resource which can now be focused directly and more productively on patient care.

With no needle being used in the flushing process, needlestick injuries have been eliminated and the design of the BD product minimises blood exposure, thus reducing clinicians' risk of contracting bloodborne viruses.

The product has other benefits. The design of the syringe barrels ensures lower pressure during the flushing process and therefore reduces the risk of damaging the vein. In addition, the piston is manufactured from a latex-free bromobutyl formulation avoiding potential rubber-related reactions. With the prefilled syringes being clearly labelled, the danger of medication errors has been substantially reduced.

Financial implications

The collaborative procurement approach taken by the NWCCA has seen the unit cost of the prefilled syringe fall by 50%. By committing to an annual volume of syringes from BD, significant savings have been achieved. The NWCCA estimates that if all its member trusts in the North West adopted the new system, they would collectively save more than £1.5m a year.

Contact

For more information on this initiative please contact Jenny Graham: *jenny.graham@nwcca.nhs.uk*

FINALIST

Simple Telehealth, the revolutionary low cost option

Philip O'Connell;
NHS Stoke-on-Trent

The initiative

NHS Stoke-on-Trent had already been involved in a commercial telehealth pilot that had produced positive benefits before this initiative. However with the high costs and limited number of suitable patients, Terry Hawkins of NHS Stoke-on-Trent set the brief for an initiative based on the question: "What would happen if the telehealth agenda was driven by practical NHS need and not by the need of manufacturers?" It was decided that the initiative should have the following aims:

- Personal, monitoring/alerting for at a cost at least 80–90% less than existing systems;
- An intuitive, easy to use solution;
- Methods to reduce avoidable use of NHS resources;
- A set of tools to enable new, quantifiable, effective and innovative use of telehealth;
- Massive and rapid scalability from 100 to 100,000 patients;
- A way to quickly and easily allow actual and virtual groups of clinicians to collaborate;
- A way to shift the emphasis onto the patients to lead their own self care;
- A method of giving patients choice and enabling shared decision making to provide a personalised and flexible service for each patient.

After the presentation of the project concept in March 2009, the PCT's personalisation director adopted the project.

To protect the intellectual property for the NHS, technical specifications were documented and a patent protection date was secured. A simulation was created and a wide range of stakeholders were consulted, who gave valuable advice and assistance, steering the project through clinical, policy, legal and commercial issues.

A specialist collaboration partner was identified, Mediaburst Ltd, with whom we could work to jointly turn the concept and specifications into reality.

In December 2009, an updated patent was filed and development began. By April 2010 the system passed its initial tests and the first of 10 patients started to use it for technical trials.

By June 2010 the system had passed its trials showing significant benefits for the management of long term conditions including the identification of tachycardia and hypoxaemia and major treatment concordance improvements. In July 2010, it went operational across all UK mobile phone networks as a free service to patients and the rollout to thousands of patients started.

Benefits

Comparing the same value of investment between a traditional monitoring system and Simple Telehealth:

- Vital signs: 10 times as many patients and a 10:1 return on investment (ROI) in year 1;
- Mental health compliance: 41 times as many patients and up to 300:1 ROI in year 1;
- Weekly blood pressure: 71 times as many patients;
- Community matrons report the system is effective and increases productivity;
- Mental health case managers report major benefits after just a few weeks of use.

Financial implications

NHS Stoke-on-Trent and Mediaburst Ltd have jointly invested £80,000 to develop a prototype and full production system. A further £40,000 joint investment is planned to bring additional features to the system, including an interface to provide interoperability with clinical and commercial telehealth systems.

With deployment to thousands of patients already planned, a return on investment will be seen in year 1. However, during preproduction trials directly attributable benefits were already being accrued of at least £8,000 through mental health concordance improvement enabling independent living (two patient cohort) and the avoidance of two serious exacerbations and acute care admittance (four patient cohort).

Targeted use of the system in line with its microbusiness case methodology will allow organisations to achieve high ROIs. Trials to date have shown ROIs ranging from 7:1 to 38:1 in year 1.

Contact

For more information on this initiative please contact Philip O'Connell: *philip.oconnell@stoke.gov.uk*

FINALIST

Oesophageal Doppler monitoring

Colin Callow and Stuart Gold;
NHS Technology Adoption Centre in collaboration with Derby Hospitals FT; Whittington Hospitals Trust; Central Manchester University Hospitals FT

The initiative

The purpose of our project was to improve patient outcomes following major surgery through the adoption of an innovative technique to guide fluid management known as oesophageal Doppler monitoring (ODM).

Despite a comprehensive evidence base demonstrating significant improvements in surgical outcomes, uptake of this technology has been poor across the NHS. We wanted to see if the outcomes achieved in clinical trials could be replicated in the real world. We also wished to provide relevant information to help providers and commissioners make informed choices about how the technique could make a positive difference to the wellbeing of patients and NHS performance while at the same time offering significant potential to reduce healthcare costs.

Three very different hospitals, Derby Royal, Manchester Royal and the Whittington in London, were chosen as the pilot sites. ODM was used in a range of elective and urgent surgical procedures, including colorectal, vascular and orthopaedic operations.

The first stage at each site was for ODM to be procured through the normal trust channels. This allowed the trusts to identify practical barriers to adoption and routes past these barriers.

Having secured business case approval and purchase, clinician adoption at all three sites was promoted through a number of routes. Practical education in the use of the ODM was provided through the manufacturer's (Deltex) standard training, to ensure that any benefits seen could be generalised to other trusts. Clinicians were encouraged to use ODM in all eligible cases through an educational campaign combined with advocacy by clinical champions.

The use of ODM was audited for a year at each site. Data was collected prospectively in a predefined patient group. This included length of stay, complications, readmissions, reoperations and mortality. This was compared to the same predefined, historical case matched controls from the previous year at each site.

Benefits

The project demonstrated that the pilot hospitals were able to achieve the clinical benefits in practice that have been suggested by research.

A total of 626 patients were included in the implementation group, compared with 621 in the historical control group. The implementation group experienced the following:

- 3.5 day decrease in postoperative length of stay;
- 23% reduction in use of central venous catheters;
- 33% decrease in readmissions;
- 25% decrease in the rate of re-operations.

The results from the project clearly indicate that patients experienced a better quality of intraoperative care through use of an innovative technology. As part of this pioneering project they avoided staying in hospital for 3.5 days and avoided the risks of healthcare acquired infection, venous thromboembolism and central venous cannulation to which they would normally be exposed. The reductions in bed day requirements also enabled productivity to be increased.

Financial implications

It was necessary to purchase new equipment in order to implement the project. Each CardioQ-ODM machine cost £11,000 (+VAT), and individual probes an average of £67. With an average bed day costing £250, approximately £800 per patient was saved due to shorter lengths of stay. If replicated across the NHS, it has been estimated that ODM could save more than two million bed days and more than £500m each year.

Contact

For more information on this initiative please contact Debbie Lynes: *debbie.lynes@cmft.nhs.uk*

FINALIST

Creating a framework for quality assurance

Caroline Alexander and Vanessa Lodge;
NHS Tower Hamlets

The initiative

Taking into account the next stage review expectations on quality, the NHS constitution, the 2010–11 operating plan and the quality board's response to the recent scandals, NHS Tower Hamlets wanted to create a framework that would allow it to be confident that it was able to identify quality issues.

A wide range of stakeholders were involved in a series of workshops that set out the ambitions and objectives of the framework. Stakeholders included commissioning managers, clinical leads, providers, the council, the trust board and patient groups. Later, the workshops were used to test the framework, gather feedback and then strengthen the work.

After publication of the report into the Mid Staffordshire Trust the framework was crosschecked with the report by asking staff to review chapters, Responses were analysed and additional metrics and approaches were added to the framework.

Observation of the care environment and the patient experience is also a useful, practical and visual method of triangulating the evidence. So alongside the more usual range of evidence provided to assure commissioners that services comply with the standards set, services are also visited.

Over a period of one year NHS Tower Hamlets developed, consulted, tested, authored and published the framework. Implementation happened in all areas, thanks to the commitment of leaders in the organisation.

Benefits

The process has enabled NHS Tower Hamlets to sign off the providers' quality accounts this year. There is a better understanding of the providers' quality issues — both successes and challenges — so the framework for quality also helps us to establish and develop good working relationships with our providers. The board of Tower Hamlets has not only gained a greater understanding of the quality agenda but now proactively leads it.

Financial implications

The total cost of the initiative was £2,000, which included facilitation of workshop sessions, and design and printing of the framework publication. Because of the nature of the initiative, this has been more about improving the quality of services that we commission rather than achieving cost savings.

Contact

For more information on this initiative please contact Jacqueline Katz: *jacqueline.katz@thpct.nhs.uk*

WINNER

Our future workforce today

Claire Nicholls and Ricky Manton-Leigh
NHS Birmingham East and North

Background

The geographical area in which NHS Birmingham East and North serves covers half of Birmingham. It is an area with one of the highest rates of unemployment within the UK and skill levels below the national average.

As a healthcare organisation we are aware of the correlations between unemployment and low skills, and how these lead to increased health problems. We are also aware of the issues that will result from an ageing workforce. There was a need to engage with the younger population of our local community, and to resource new talent. The aims and objectives of our apprenticeship scheme reflect this need to:

- Develop the skills of the young local population;
- Engage them in future opportunities;
- Increase their potential professional development;
- Retain and use these skills through our talent management programme.

The process

We work closely with our training provider, who filters the applications on our behalf. We consider these carefully then interview and assess candidates for motivation, commitment and a willingness to learn. Once the apprentices are on placement, an assessor visits them regularly to monitor their progress in completing relevant NVQ qualifications.

As well as using the national apprenticeship matching website, we also advertise opportunities and the scheme at various local events, by working in partnership with Job Centre Plus, Connexions and the local community.

Since our first apprentice in November 2005, we have supported 117 individuals to achieve their apprenticeship qualification. To date, 73% of apprentices have gained permanent employment either in our organisation or within our local health economy. Six per cent have gone on to higher education and 15% were employed outside the health service, but continue to use skills and support attained from our scheme. Retention of our previous apprenticeship workforce who have gained permanent employment is 96%.

Advice to other organisations

The workforce issues we face are not unique. The scheme enables organisations to grow their own highly skilled workforce from their local community, enabling them to meet their wider social responsibility.

Benefits of the initiative

Workforce planning is vital to the survival of our organisation. By taking a strategic overview of our organisation and that of the rest of our local health economy and partner organisations, we are able to identify potential future workforce gaps. This has allowed us to gain high level support and management to develop apprenticeship placements at the forefront of local healthcare provision.

As our apprentices go onto fill future workforce gaps, we are able to retain the vast majority within the organisation and offer them career progression.

The local people we recruit bring a vast amount of community knowledge to their new role. This is immediately put to use in health promotion, patient and public involvement to name a few. During our apprentice project week, we tasked them with real life projects that were of relevance and benefit to the trust.

Through the apprenticeship scheme we are also tackling health inequalities among our local population, thus working towards our organisational goal as a healthcare provider. Our apprentices become health ambassadors within their families and peer groups, sharing health promotion messages.

Financial implications

The only cost incurred in hosting an apprentice is the apprentice's study allowance, which is currently an annual cost of £5,200. This is deducted from the departmental budget when the apprentice starts.

Apprentices further benefit from all training opportunities within the trust that correspond to their job role. This training is provided via the in house training team. Further costs include the external hosted events such as the apprentice challenge week. However, the benefit to the apprentices that this event created far outweighed any initial cost.

Future plans

Over the next 12 months our apprenticeship programme will focus on four key areas:

- Routes into apprenticeships and promotion;
- Progression — working with education to help next steps;
- Higher apprenticeships — in partnership with higher education;
- Sharing best practice via a local health economy group.

Contact

For more information on this initiative please contact Dawn Rayson: *Dawn.Rayson@benpct.nhs.uk*

Award sponsored by

Skills for Health

Judges

Carol Black, *chairman of the governance board, Centre for Workforce Intelligence*

Janet Davies, *executive director, nursing and service delivery, Royal College of Nursing*

John Rogers, *chief executive, Skills for Health*

FINALIST

Creating a multiskilled primary care workforce

Sarah Rhodes and Gillie Reed;
Avicenna Medical Practice

The initiative

The initiative arose from the observation by the practice manager that administrative staff were not working to their full potential; she had staff who were extremely experienced in various administrative aspects but were not using these skills in their daily work. This seemed a waste of skills and was also affecting morale as staff felt undervalued, and unable to show initiative and use their skills.

The practice manager asked staff to complete a matrix in which staff scored themselves on particular duties. This highlighted where they felt strongest and where the training needs were. The aim was then to devise a tailored training package for all staff, so they would be fully competent in all administrative areas allowing the team to flexible and multiskilled.

On completion of the matrix it was clear that there were certain areas where training would benefit the whole team, and for these areas the manager devised short training sessions. Step by step guides were written for staff as a fall back resource once they had completed the training. The guides could be used to as a revision tool when required.

The training sessions were run at times agreed with all the team so attendance was excellent. The result of initiative was that the team as a whole had similar capabilities and were able to fulfil their job roles in full. This kept their minds active, gave them variation and stopped them becoming bored by doing the same duties everyday.

Benefits

The practice now has a multiskilled workforce. Patients and clinical team members are never kept waiting for something while another member of staff is away on annual leave or sickness as there is always someone to step in and complete the work required.

Staff morale has increased, staff stated in their annual appraisals they feel much more part of the practice and team. Sickness levels have reduced considerably as staff say they feel valued and needed and have been given the opportunity to shine by showing what they can do and offering assistance to others. They can now assist patients in a more professional manner, by offering more information and help at the front line.

Financial implications

Staff time was the only resource required for the initiative. No additional pay resources were required to reimburse staff for their time. There have been savings generated in the reduction of staff sickness. Total sick days in the year 2008–09 were 112; the year 2009–10 had total sick days of 31. When this was discussed in appraisals and performance reviews staff acknowledged that they now wanted to come to work, they were no longer bored and felt challenged and part of the practice as a whole.

Staff turnover has also reduced and we have not needed to replace or advertise and recruit in the last 14 months; this has saved the practice money. In previous years staff turnover was approximately one every six months.

Contact

For more information on this initiative please contact Sarah Rhodes: *sarah.rhodes@bradford.nhs.uk*

FINALIST

Developing a faculty of education

Mandy Coalter and Kerry Jones;
Heart of England FT

The initiative

The Heart of England Foundation Trust makes a multimillion pound annual investment in workforce development. However the trust was becoming increasingly dissatisfied with the return on this investment in terms of impact on individual and organisational performance.

In 2009 the organisation began to develop a workforce development strategy. In order to ensure the strategy was explicitly linked to business needs an extensive research project was undertaken engaging staff at all levels within the organisation.

The emergent strategy contained a set of core deliverables:

- A centrally managed workforce development portfolio explicitly linked to business needs, workforce plan and clinical vision;
- A clearly defined, accessible education service;
- The elimination of fragmentation, duplication and variability of learner experience;
- Effective educational frameworks and curricula that have high impact on service quality and safety;
- Effective educational governance and quality management;
- Education interventions measured against intended impact and return on investment;
- A self sustaining service that generates and uses its income to expand access to a full range of education and development opportunities for all staff.

The key feature of the strategy that emerged from the research was the Heart of England Foundation Trust Faculty of Education. The "HEFT Faculty" provides a strategic umbrella for the education and development of employees.

Drawing on learning from successful US corporate models, the faculty is central to disseminating the organisation's culture, fostering the development of job skills and core workplace skills such as learning to learn, leadership, creative thinking and problem solving.

This marks a shift in focus from employee training to employee education. The HEFT Faculty, in partnership will its accrediting partners, enables the trust to provide a portfolio of business focused and patient centred education for employees that can evolve with ever changing organisational needs.

Benefits

The faculty provides a total workforce development solution delivering an in house prospectus which is linked to the business plan and appraisals. It makes available development ranging from key skills to master's level modules.

There is a work related learning unit offering placements to young people and others. It is also working with local schools to deliver the School Health and Development Diploma.

The faculty provides for the development of 200 apprentices, including the local long term unemployed through a "step into work programme".

A dedicated healthcare careers development unit has been set up. This offers readily available information advice and guidance on work related learning to all employees, as well as supporting development and career progression for all non clinical staff and professionals, including frameworks for administration, finance, and HR staff.

Financial implications

The initiative was delivered within existing education and organisational development budgets. By having a more blended portfolio of in house and commissioned education we have increased the value of our existing educational spend by the equivalent of £1.2m.

The NHS Litigation Authority recently audited the organisation. Effective central management systems for induction and mandatory training resulted in a £850,000 saving on insurance premiums. Potential savings associated with enhanced quality and safety; retraining and redeployment of staff; and skill mix review have yet to be fully evaluated.

Contact

For more information on this initiative please contact Naomi Holland: *naomi.holland@heartofengland.nhs.uk*

FINALIST

Professional development programme

Paul Murphy, Caroline Smith and Lesley Logan; NHS Blood and Transplant

The initiative

Organ donation rates in the UK are among the lowest in the developed world. Every day three people die as they wait for an organ. The organ donation taskforce was set up to tackle this situation, and in January 2008 it called for a 50% increase in organ donation rates by 2013.

The taskforce highlighted the need for every UK hospital to identify key clinical staff to champion organ donation within their hospitals, and for these champions to be supported by donation committees. It also directed that people involved in the care of potential organ donors should receive bespoke training for their role.

In September 2009, NHS Blood and Transplant (NHSBT) started work on the professional development programme. The aim was to provide 350 NHS consultants and organ donation chairs with the clinical expertise, leadership and change management skills to improve organ donation processes within their hospitals.

The professional development programme for organ donation seeks to:

- Deliver clinical material that is relevant to increasing rates of donation;
- Develop the leadership skills necessary to implement effective change;
- Establish the foundations of a business relationship between donating hospitals and NHS Blood and Transplant.

In the design phase of the initiative we worked with Deloitte to analyse the areas of clinical practice in which the rates of organ donation could be increased, and to identify the skills that effective leaders would require to put theory into practice.

Clinical material includes sessions on the diagnosis of death, non-heart beating organ donation and donation in emergency medicine. It challenges senior doctors to re-examine their clinical practice through the lens of these objectives.

Following a national launch in February 2010, the programme is rolling out 40 events across seven regions.

Benefits

Since programme delivery began in February 2010, there has been a 15% increase in donor numbers. This has resulted in a 10% increase in kidney and lung transplantation, and a 5% increase in heart transplantation.

In addition, by bringing together donation champions from across the UK, the programme allowed new regional networks of colleagues in neighbouring hospitals to share best practice and support each other.

Financial implications

Transplantation improves lives, prolongs lives and saves lives. Although transplantation also offers economic benefits, the gift of life is priceless.

The contract with Deloitte was equivalent to the savings made by performing two kidney transplants (when compared with the costs of dialysis), and this is an expense we hope to recover many times over as organ donations rise. Most of the material was presented by clinical experts or NHSBT staff, amounting to an estimated 150 days of design and delivery. Travel and accommodation costs were kept to a minimum by delivering much of the material regionally.

Kidney transplantation offers clear economic benefits over the alternative of dialysis. It is estimated that within the average lifetime of a transplanted kidney the costs of dialysis exceed those of transplantation by £225,000.

The economic benefits of liver, heart or lung transplantation are less clear, since the alternative is premature death. However, patients with life threatening organ failure may spend significant time in intensive care, which is extremely expensive

Contact

For more information on this initiative please contact Lesley Logan: *lesley.logan@nhsbt.nhs.uk*

FINALIST

Service provider model (band 5+ a sustainable career pathway for health visitors)

Anne Hall and Rebecca Ryder; NHS Cornwall and Isles of Scilly PCT

The initiative

Cornwall's children's directorate was unable to recruit health visitors to its service, and held eight vacancies. Care provision within health visiting focused on crisis management only, which was not a sustainable position. The aim of this initiative was to offer a sustainable and flexible work based learning approach to widen the access to the health visitor role.

The objectives of the initiative were to:

- Achieve rapid expansion of skills, knowledge and competence;
- To stabilise the workforce;
- Provide a BSc (Hons) in healthcare studies with an emphasis on public health;
- Establish a clear, structured career pathway;
- Develop practitioners in child and family mental health/wellbeing.

We also wanted learners to hold a health visitor caseload when they were signed off as competent. In some cases this would involve taking responsibility for a child protection/safeguarding caseload within four months.

We created a competency based approach that is also academically credible using the agenda put forward in *Every Child Matters* and *Facing the Future*. To do this we worked closely with several stakeholders, including:

- Cornwall's health visitors;

- Skills for health, to provide 58 public health competencies;
- The Nursing and Midwifery Council (NMC) to validate Cornwall's pathway;
- The local university.

The initiative yielded 65 applicants from whom we recruited 13 band 5+ learners.

Benefits

The initiative facilitates a clear, structured career pathway. It is financially sustainable, and only requires tuition fees of £6,600, as compared with secondment and tuition fees of £35,000.

Learners hold a health visitor caseload when they are signed off as competent. It is flexible and adaptable enough to suit the changing needs of the workforce and allows immediate application of skills, knowledge and competency to practice. Learners remain remains part of the health visitor team, earning while learning. The approach has delivered a full complement of health visitor staff across the children's directorate — we are now fully staffed.

Financial implications

The South West Strategic Health Authority agreed the project proposal and allocated £109,000 in funding. This was the equivalent of four full time university places for the BSc specialist community public health nurse programme — the traditional academic route.

The funding supported the 13 band 5+ practitioners to study on the workbased learning career pathway for health visitors and school nurses at a cost of £85,800. This represents a saving of £28,400 per student.

Contact

For more information on this initiative please contact Rebecca Ryder: *Rebecca.Ryder@CIOSPCT.Cornwall.nhs.uk*

FINALIST

Whole systems approach to widening participation

Peter Blythin and Paula Dabbs; NHS West Midlands

The initiative

As a region we recognised that a more refined approach to the Widening Participation agenda needed to be developed; one that would ensure flexible and accredited pathways of learning, both personal and professional, to enable better transferability of skills and competencies between organisations.

NHS West Midlands supported organisations to implement a whole systems approach that promotes access into entry level roles within the NHS by recruiting young people through a high quality apprenticeship. The apprenticeship provides opportunities for local people from the most disadvantaged communities. It also enables career progression for our existing bands 1–4 workforce.

The whole systems approach ensures the health economy has a suitably trained and equipped workforce, that can adapt to the changing needs of the healthcare service and is representative of the local population.

The initiative began by establishing a regional Widening Participation alliance with representation from 20 agencies including social and independent organisations and representatives from the five regional workforce locality boards. Four subgroups were developed to drive the agenda, each leading on one of the following:

- The 14–19 agenda;
- Access to work;
- Apprenticeships;
- Assistant practitioners.

Workshops were held showcasing early implementer sites and the benefits and achievements that came about as a result of using the whole systems approach.

Benefits

There have been a number of benefits from the initiative:

- The West Midlands NHS workforce is now much more representative of each area within the region;
- The number of new apprenticeship starts in 2009–10 totals 1,454, this exceeds the original target by 73%;
- There have been significant improvements in data quality regarding workforce supply;
- There has been cultural change with our local higher education institutions in the design, delivery and evaluation of education programmes with employers as the key driver.

In addition we now have apprentices within clinical services where previous entry has been limited. Organisations have already recorded improvements in patient experience and retention of their support workforce. Productivity is improving as these learners in practice are developing skills and competence within their roles, freeing "time to care" for other staff.

Financial implications

Finance for the initiative came from apprenticeship funding allocated by the Department of Health and the West Midlands joint investment framework.

Education and training packages have enabled staff to deliver care in a more productive and cost effective way. In addition, as a result of the whole systems approach staff retention has increased and therefore recruitment costs have reduced.

Contact

For more information on this initiative please contact Jennifer Bond: *jennifer.bond@westmidlands.nhs.uk*

FINALIST

A multiprofessional approach to the development of clinical support staff

Cath Siddle and George Allen; North Tees and Hartlepool FT

The initiative

The aim of the initiative was the creation of a band 4 associate practitioner role and a career framework for unregistered staff in all clinical disciplines.

This involved the creation of a career framework straddling the traditional unregistered/registered boundary thereby widening access to employment and preregistration training. Examples of the way in which this could allow development are:

- An entry level healthcare assistant employed as an apprentice. Once successfully completed they are eligible to apply for a band 2 post;
- A number of band 2 posts, dictated by the needs of the organisation, would either;
  - Enter a one year training contract to acquire NVQ 3 and therefore a band 3 senior healthcare assistant post, or;
  - Enter a two year training contract to acquire university qualification and therefore a band 4 associate practitioner post;

- In turn the band 4 posts would then be eligible to either:
  - Gain direct entry into preregistration training, or;
  - Gain direct entry into the second year of the foundation degree which would APEL them into the second year of preregistration training;
- Once registered the options of specialist, advanced or consultant practice would be open to them.

The development of these roles is facilitated through the trust's staff turnover rate, which is currently 8% (122wte) for non medical clinical professionals. The proposal will need 30% of this turnover rate over the life of the plan, which permits opportunities for graduate recruitment.

Benefits

The initiative has increased productivity by ensuring that:

- Support staff have been developed into a role enabling them to take on the maximum of tasks not requiring registration;
- Professional staff are only deployed in roles that require their level of skill, knowledge, experience.

It has also increased the quality of care by freeing professional staff to do what only they can do and increased retention by providing a career framework for unregistered staff.

Financial implications

The programme was supported with £300,000 over a three year period by the strategic health authority through its workforce development funds. We now have 80 apprentices and 85 associate practitioners employed within the trust. They have made a significant impact upon the quality of patient care and experience.

This initiative has also enabled us to cover long term sickness and maternity vacancies with trainees, giving continuity of care while reducing reliance and cost associated with agency and bank use. Once fully implemented the recurring cost base for staffing will reduce by £942,000.

Contact

For more information on this initiative please contact
Cath Siddle : *cath.siddle@nth.nhs.uk*

FINALIST

Creating capability for continuous improvement — c3i

Michael Pantlin and Ann Spence;
Royal Surrey County Hospital FT

The initiative

The creating capability for continuous improvement programme (c3i) was developed in order to increase the capacity of our existing staff to make the frontline changes needed to improve simultaneously patient care and efficiency. We have achieved this through two steps: first creating a process improvement methodology tailored to the health setting (DECODER); second, training our front-line staff in this approach using a live project method.

The initiative has been undertaken to ensure that the trust has a supply of experienced patient care, service and quality improvement experts. It uses an apprenticeship model whereby different levels of training build on each other, working towards expert "black belt" status. The individuals trained in the methodology have the tools to improve quality, patient experience and productivity.

The initiative began with the design and development of the DECODER methodology. This was successfully piloted on patient pathways. Once we were confident that it worked we designed a programme to train people in the new approach, giving them the skills and behaviours needed to apply it.

In July 2009 the yellow belt course was delivered. This is a two day introduction course with a mentoring apprenticeship programme for each participant on a trust project. It culminates in a viva to a trust leadership panel. This course is run quarterly for 20 staff.

This was followed in February 2010 by the green belt course. This more extensive programme is conducted over six months designed to build a team of confident DECODER practitioners. It involves in depth training, coaching and mentoring from black belts. Each participant works on a substantial trust project. Two programmes run each year.

The programmes are mutually reinforcing: high performing yellow belts are selected to attend the green belt programme; green belt graduates are now training and mentoring the yellow belts. All attendees of the management development programme also receive a day's training in the methodologies.

All new starters have a one hour session on the lean methodology in order to ensure that these ways of working are embedded across all staff.

Benefits

The benefits have been significant over the last 12 months in terms of improved staff motivation, successful delivery of large numbers of projects, and new ways of working for hundreds of staff members and their teams.

Over 100 people have participated in courses and had the opportunity to receive recognition for their achievements. Sixty five per cent of staff would recommend the trust as a place to work or receive treatment in 2009, compared with 61% in 2008.

Over 100 service improvement projects have been delivered during the first year of the programme, including developments on MRSA screening, reductions in patient suspensions, improving the efficiency of our cleaning staff and improvements in specific patient pathways

Over the year we have seen sustained changes in staff behaviours and ways of working. Staff have taken strong ownership of the new tools and approaches and are already using them well beyond the areas of their original projects.

In addition, the programme contributed to our successful foundation trust application.

Financial implications

The resources required for this initiative were for development of the overall methodology and approach, delivery of the green belt courses and support and delivery of the yellow belt courses. The overall cost for these three areas was approximately £195,000, and there were costs associated with freeing staff time to attend the courses.

There are over 100 improvement projects being carried out as part of the training, so each of these only has to save £1,950 in order to cover the costs of the development and delivery. Application of the DECODER methodology on major improvement projects within the trust has been shown to yield savings of between £300,000 and £1m over 12 months, and individual projects typically generate savings of over £10,000.

The trust has also saved over £20,000 in recruitment fees by being able to develop our own staff rather than recruiting externally.

Contact

For more information on this initiative please contact
Lisa Ward via: *adele.carter1@nhs.net*