Patient Experience & Quality Improvement Awards, 2019

Winners & Finalists

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Patient Experience & Communications Award

Co-created Services Award

Excellent Teamwork Award

Paul Thomas Perseverance Award

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Patient Experience & Communications Award

Winners

Acute:

Royal Surrey NHS Foundation Trust

OPAT (Outpatient Parenteral Antimicrobial Therapy) Team

The judges commented; "Lovely story with quotes included in the submission and used in the work, demonstrating the benefit to patients and families of the service they are running, they are honest that this is not novel or pioneering, but using existing tried and tested methods to improve patient experience, and using lots of communications methods to raise awareness and involving patients in those communications, and showing that they utilised patient involvement and co-production to make the best service that meets the needs of patients."

Mental Health and Community:

Solent NHS Trust

Patient Representatives for QI Patient Training Programme - Paula Marsh, Roger Stevens & Alice Roath

The judges thought this was a fantastic project, co-designed and co-produced entirely with patients who have been the driving force and leaders of the project. It shows excellent use of different communications that are patient-led and patient focused as well as benefitting professionals and demonstrating how this benefits patients and benefits professionals. It has also shown the benefits for the patients involved in the work - this isn't a traditional patient care style project or service, this is a patient-led quality improvement training programme, but you can see from the evidence the benefit to them of being involved and gaining skills and confidence."

Community and Other Organisations:

Hertfordshire Community NHS Trust

Special Care Dental Service and Communications Team

The judges were impressed with this great story-led, impact-evidencing video submission and description in the nomination of how they achieved the outcomes shown in the video. They thought it was great to see true co-production with patients via the expert by experience, and personalising the service (even down to colour scheme) to best meet the needs of patients. They loved that they're using different communication styles to improve patient experience and patient knowledge/education/activation, including the use of videos for patients. It shows how small changes can make a tremendous difference.

Finalists

Acute:

Lancashire Teaching Hospitals NHS Foundation Trust
Renal Frailty Multi-Disciplinary Team

The Christie NHS Foundation Trust
Lung Cancer Patients Starting Systemic Anti-Cancer Treatment

Mental Health and Community:

Lancashire & South Cumbria NHS Foundation Trust
Blackburn & Darwen Pulmonary Rehabilitation Team

Community and Other Organisations:

West Hampshire CCG
ICON Programme to Avoid Abusive Head Injuries in Children

Winner

Acute:

Royal Surrey NHS Foundation Trust

OPAT (Outpatient Parenteral Antimicrobial Therapy) Team

Over the last year, the Out-patient Parenteral Antimicrobial Therapy (OPAT) team at the Royal Surrey NHS Foundation Trust has been developed, allowing patients to receive intravenous antibiotics in their own homes. This is not a novel service however it has been developed using alternative methods to previous service implementation techniques. Specifically, our Trust has been at the forefront of launching a Quality Improvement (QI) programme and the OPAT team was in the first cohort enabling us to learn QI tools and applying them when designing the service. Ultimately, this was done with the aim of reducing hospital admissions, decreasing length of stay and improving patients' experience – the Trust's true north objectives.

Despite learning new QI skills, the most influential and inspirational in shaping our new service involved the patient story and perspective. This was initially prompted using a 'KANO analysis model' which is a tool that involves asking patient(s) which features of a service they would consider a 'Basic' requirement, 'satisfying' or 'delighter'. We decided to focus on in-patients with diabetic foot disease as these patients frequently have long lengths of stay in hospital, multiple co-morbidities and are regular users of healthcare services. We initially focused on obtaining feedback about a proposed model of care followed by implementation of a pilot study during which a patient received antibiotics at home rather than in hospital.

Two particular patients stand out during this initial phase. The first patient was a self-employed businessman in his 50s with type 2 diabetes requiring insulin. He developed a severe diabetic foot infection and was in hospital for intravenous antibiotics for 32 days. He would run his business via phone and skype from a hospital bed in a bay of 6 other patients but he could not be on the 'shop floor' of his warehouse which was where he needed to be. He also had a disabled sister whom he would normally visit every few days but in hospital was unable to do so. When we discussed a potential OPAT model of care his response was that it would be a 'life-changer' and that he just wanted to 'carry on with life as normal as possible'.

It also became clear that we needed to improve communication and letting patients know about key clinical decisions, having staff that knew about diabetic foot disease in charge of their care at all times, "being seen by right person in right place" and having nursing staff that were competent in applying dressings. However, it also highlighted easy ways that we could provide 'delighters' such as hand held notes, a point of contact for patients with any clinical concerns (a care co-ordinator) and the ability to receive intravenous antibiotics in their own home.

Using the feedback obtained thus far, we then trialled OPAT with a lady who was due to stay in hospital for 6 weeks for intravenous antibiotics for a diabetic foot infection. We were fortunate as many centres in the UK already have an OPAT service and the British Society for Antimicrobial Chemotherapy has guidelines and recommendations that we used. We did however involve the community services as well as patient feedback at an early stage and utilised the value of PDSA cycles to learn from mistakes and improve on the processes involved. For example, we created handheld notes to help with communication between healthcare professionals; provided key contact telephone numbers in case of any problems or concerns both in and out of hours; had a named consultant who was responsible for the patient even though they had been discharged from hospital; insisting on weekly follow-up by the specialty concerned to ensure continuation of ‘seen by right person in right place’ and held weekly Multi-Disciplinary Team (MDT) meetings in collaboration with the community team.

All of this work took longer than expected, however we were confident that we ended up with a safer, better experience for patients that was also sustainable. The feedback we obtained from our initial ‘trial patient’ was so positive that we asked whether we could use her story to promote the service going forward. It also coincided with the Trust rebranding itself and name to highlight the fact that Community Services were now a division within the Trust. The Trust changed its name from Royal Surrey County Hospital NHS Foundation Trust to Royal Surrey NHS Foundation Trust, removing the word hospital. This was done in order to highlight the move towards community delivered care and to foster closer working relationships. It was also in recognition that for a long time there has been a ‘them and us’ culture between community and secondary care and this is no longer sustainable or in patients’ best interests.

In order to share our experiences in developing OPAT and use it as an example of close working with community and patient partners, we enlisted the help of our Communications team. A variety of media outlets were utilised including the local newspaper, radio and BBC as well as the intra- and internet to publicise the service across the entire Trust and CCG. It was also on the Trust’s facebook page and twitter. Each week, the communications department also sends out a Trustwide e-mail called the ‘Huddle’ which included a video of me explaining what the service entails. Although as a team we were enormously proud of the publicity we gained, the most humbling aspect was hearing from the patient’s perspective what it meant for them. The patient agreed to be interviewed and one particular headline: ‘ “They came to my rescue”: Royal Surrey medics help woman attend granddaughter’s wedding’ was particularly humbling as it gave a first hand account of the impact of our service on a patient. We have since used such headlines and media excerpts at presentations both in primary and secondary care as an example of the processes we used and QI strategies and to promote the service.

Royal Surrey NHS Foundation Trust submitted a presentation alongside the above.

Winner

Mental Health and Community:

Solent NHS Trust

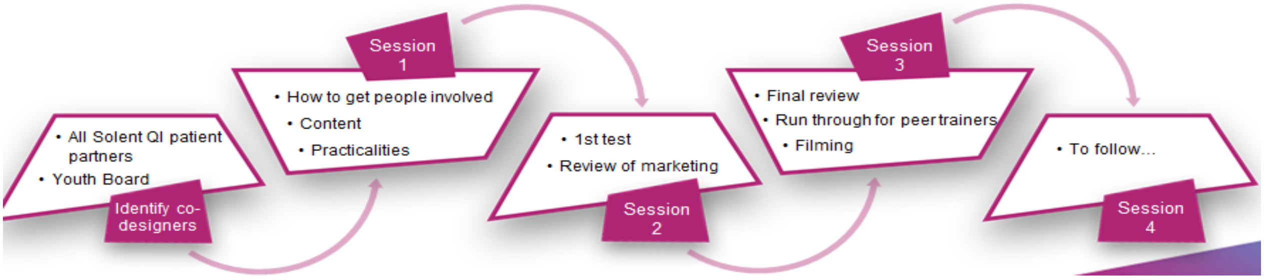
Patient Representatives for QI Patient Training Programme - Paula Marsh, Roger Stevens & Alice Roath

Communications: Designing Training Side by Side – the ‘Patients in QI Training Pack’

Most of the teams on our Quality Improvement training include patients, carers or other members of the public. Some of the participants suggested that a more patient-focussed introduction would be helpful. As a result, they worked with our QI team to design a “Patient QI training programme”.

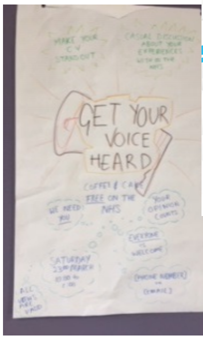
> *“It’s exciting, I’ve enjoyed every minute. I’ve learnt new things, I feel very supported and part of the team…. I’d really like to see more patients getting involved.”*
> *Paula, Mum*

These individuals are a mix of patients/ carers from Solent NHS Trust and young people from Southampton Children’s Hospital. This has been a collaborative project, and those involved have all had experience of working in partnership to improve. The young people from Southampton Children’s Hospital are part of their Youth Board, and have driven change in ward environments, meals and feedback mechanisms for children in hospital. The Solent representatives had all been members of QI teams on our programme – a mum of a boy with Autism who has helped redesign the referral pathway, a gentleman who used his experience of caring for two elderly parents whilst living with a long term condition, and a young adult who had been a patient and now volunteers on our neurological rehabilitation ward.



The design process took place over 4 morning sessions, and the result is a suite of patient facing QI materials, including posters, short films, personal stories, a welcome video and some interactive activities. These can be found at www.academy.solent.nhs.uk/joinin/improvementtraining.

The package of training materials to engage patients & others in improvement include:



- Posters
- A slidedeck to be used online or face to face that other organisations can adapt for their own brand/ logo
- A series of patient stories, both in written case study form and in video format
- A personal welcome and thank you, including the reasons they've been involved
- Interactive materials – including a large floor map with pins to show which services they use and where they live.
- Two short animated films – one explaining QI and the programme at Solent – this was done in partnership with our creative communications manager, Talia
- A dedicated way of getting feedback and encouraging suggestions or questions. A hatred of a feedback forms was declared (to quote, "the heart-sink end to any NHS day"), and instead have decided we should use a live feedback, comment and question platform such as Sli-do.
- They taught us never to hold an event without good quality snacks.

> *"I've come along to give a patient side of things… Not the main reason (to be involved) but the snacks are amazing and you get treated like a queen…. For people that have been in hospital, making their stay easie., you are going to change that hopefully and make it better" Alice, patient*

The story continues – those who have worked on the design will now be part of the delivery of the training sessions. The three adults from Solent service are just about to start our QI leader programme, learning with our clinical staff.

What we've learnt:

1. If you want patients to tell stories and help with delivery, you need to spend a lot of time building confidence and trust.
2. They are brilliant at thinking of ways to engage different groups and using different technologies.

3. All of those involved have decided that they would like to continue in some sort of peer training/ support role
4. They had fun
5. They may not have represented every group but they represented a range of people, which in turn would create a ripple effect to engage others because of the stories they were telling.

> *“ It’s done in a friendly, caring environment and it’s a good opportunity to have fun and learn about what’s going on and have your say. If you take part in this you will find it fulfilling because you can see the benefits of your work and your ideas” Roger, carer and patient*

Winner

Community and Other Organisations:

Hertfordshire Community NHS Trust

Special Care Dental Service and Communications Team

Video available at https://youtu.be/7_OT_eBvGhU

Hertfordshire Special Care Dental Service work tirelessly to improve our patients' experiences of dental care. In 2018 we moved to a fabulous new clinic and were keen to involve patients before the move so they could have a say in how we designed the surgeries. You can see the results in the attached video.

In 2017 we asked an expert by experience- Gavin- from the learning disability patient group Purple Star to get involved. Gavin has a learning disability and is very anxious about visiting the dentist. He agreed to sit in one of our waiting areas with one of our dentists so they could observe patients and staff interacting. This proved incredibly successful. Gavin is very astute and was able to provide fantastic feedback about how we could improve access for learning disability patients. He described how difficult it is for patients with learning disabilities to process information and suggested that we improve our digital resources to help with this. He thought using videos was a fantastic way of connecting with patients and would allow those with processing delay to re-watch messages again and again. We have worked with HCT communications team to develop a series of videos to link further with patients. This includes a video looking at oral health and toothbrushing as well as the attached video which aims to reassure patients about coming to see us as well as explaining what we do. We are very grateful to our patients Shaz and Megan for agreeing to be in our videos. Working with our wonderful communications team has been so successful that we are planning a series of videos in the future.

Gavin also stressed that making the surgery environment as welcoming as possible was really important. In Hertfordshire purple is the colour for learning disability and Gavin explained how often individuals with learning disabilities will worry about attending health care settings frightened that they won't be given the time and understanding that they need. Gavin said that "seeing the purple colour makes you feel safe". As a result of his insights we changed the way we had designed our new surgeries using the purple colour for our dental chairs and changing our services' uniforms to purple as well! The new surgeries are large and airy and we have installed a special kind of dental chair which looks more like an inviting arm chair than a frightening dental chair (it does convert into a dental chair when we need it to). Seeing patients' reactions to the new clinic has been very moving as they are all so excited by the facilities and they are better able to cope with their treatment too. A simple thing like making it easier to climb into a dental chair means they are less anxious and more able to listen to advice about brushing. This will reduce their risk of decay and improve their quality of life- a small thing but a big win/win for everyone.

Finalist

Acute:

Lancashire Teaching Hospitals NHS Foundation Trust

Renal Frailty Multi-Disciplinary Team

Frailty is highly prevalent in adults with chronic kidney disease (CKD) and, as in the general older population, patients living with CKD and frailty have worse outcomes than non-frail patients. The Department of Renal Medicine at Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) aimed to identify and support patients living with frailty and CKD, using patient experience to inform ongoing service development.

A frailty screening programme was implemented in August 2018 using the Clinical Frailty Scale (CFS). The CFS was used in outpatient clinics and integrated into the admissions process, ultimately being included within electronic patient care records. The CFS was also incorporated into the Holistic Care Tool used quarterly by dialysis staff nurses on haemodialysis units. The Holistic Care Tool's aim is to identify problems that a patient may be experiencing that is impacting on their psychological well-being.

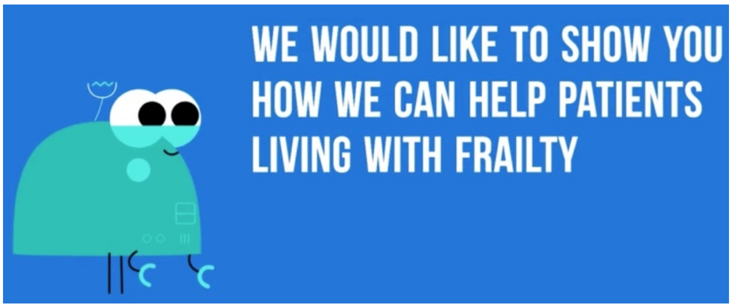
Figure 1. LTHTR Renal Holistic Care Tool.

A Renal Frailty Multi-Disciplinary Team (RF-MDT) was established, which included a clinician, dialysis sister, Kidney Choices clinical nurse specialist, dietician, renal psychologist, occupational therapist (OT) and social worker. Patients with CKD and a CFS score of ≥5, or those whose mobility, cognition or nutritional status is causing concern regardless of CFS score, can be referred to the RF-MDT.

Figure 2. LTHTR Renal Frailty Multi-Disciplinary Team.

Patients referred to the RF-MDT were offered a home assessment that used the principles of the Comprehensive Geriatric Assessment (CGA), termed a modified CGA (mCGA). Patient needs were discussed at monthly RF-MDT meetings and a personalised management plan was created.

An animated educational video was created and circulated within the department and displayed on trust screens (please see attached video file). The aim of the video was to explain the new Renal Frailty Service to patients and staff and highlight how patients can be referred to the RF-MDT.



WE WOULD LIKE TO SHOW YOU HOW WE CAN HELP PATIENTS LIVING WITH FRAILTY

Figure 3. Screenshot of the Renal Frailty Team Educational Video.

A total of 1160 patients were screened using the CFS, of whom 491 patients lived in the Greater Preston/Chorley and South Ribble CCGs. Figure 4 demonstrates the number of patients screened each week in these CCGs. One hundred and sixty-two patients (33%) were screened as living with frailty (CFS ≥5).

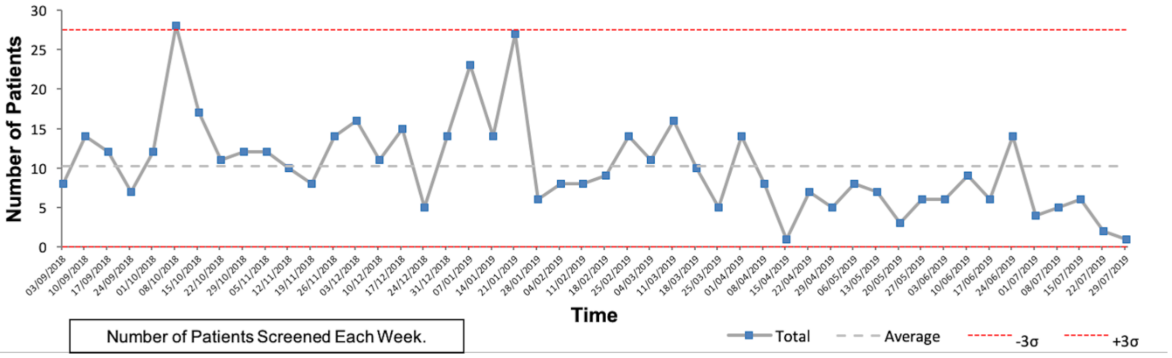


Figure 4. SPC Chart Illustrating the Number of Patients Screened Each Week.

One hundred and twenty-six patients (28%) had at least one hospital admission. Significantly more frail patients were admitted than non-frail patients (41% vs 21%, p<0.01). Twenty-seven (6%) outpatients died during the follow-up period. Significantly more frail patients died than non-frail patients (15% vs 2%, p<0.001). When adjusted for age, gender and dialysis-dependence, frailty was associated with an admission hazard ratio of 2.48 (95% CI 1.71-3.58) and a mortality hazard ratio of 9.24 (95% CI 3.39-25.20). These results confirmed that the CFS was appropriately identifying patients at risk of adverse outcomes and, more importantly, the need to offer more support for these vulnerable patients to improve health outcomes.

Twenty-six patients received a mCGA. Figures 5 and 6 illustrate the number of active problems and recommended actions for each patient.

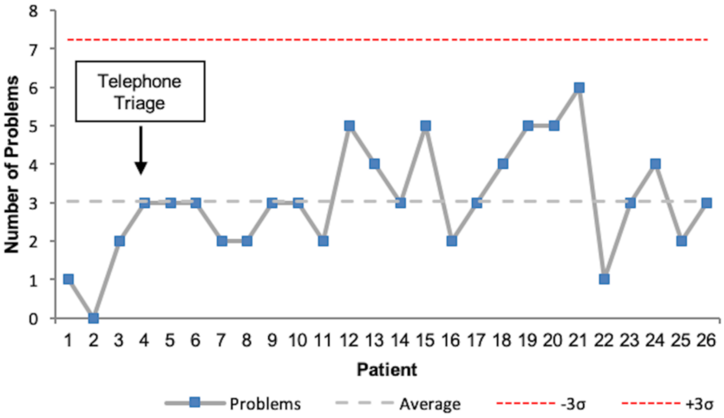


Figure 5. Number of Active Problems Identified for Each Patient.

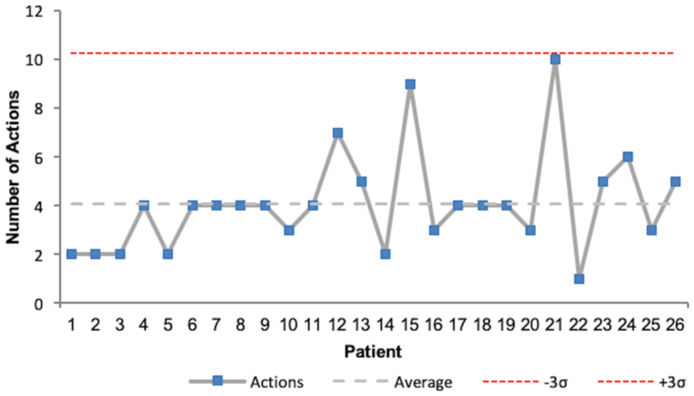


Figure 6. Number of Recommended Actions for Each Patient.

Twenty-four patients completed the EQ-5D-5L health-related quality of life questionnaire. Patients reported at least moderate problems with mobility (18), self-care (10), usual activities (17), pain/discomfort (16) and anxiety/depression (6). The mean EQ VAS score was only 43 (±23) out of 100.

The RF-MDT was keen to learn about the experience of older patients with advanced kidney disease who used renal services. Experience Based Design was used at the start of the improvement programme to invite feedback. The RF-MDT proposed emotional touch points for patients attending the outpatient clinic and created a patient experience questionnaire based upon those touch points. An emotional map was produced from patient responses to the questionnaire (Figure 7). Overall the feedback was largely positive although patients expressed understandable concerns about how their condition might affect their lives in the future, which highlighted the need to offer patients more support as their health worsens. This process took place before the implementation of the mCGA service.

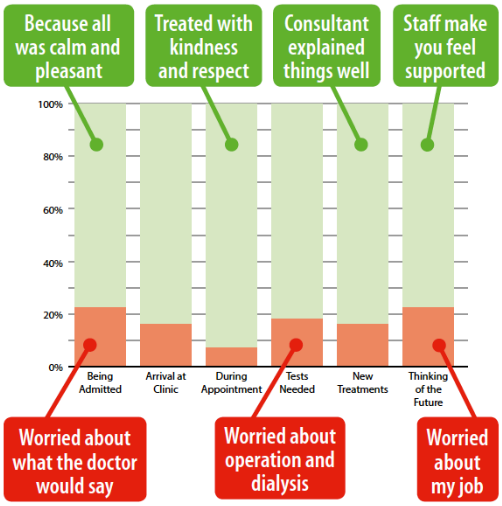


Figure 7. Emotional Map of Older Patient Experience of Outpatient Nephrology Clinics.

Patient experience was evaluated again after the mCGA service was established. Eleven patients participated in telephone calls to explore their experience of the service. Seventy-three percent of patients reported a positive experience during the visit. Patient comments included ‘it helped to talk through issues’ and nice to express how I felt - I wasn’t alone anymore and struggling’. Feedback also suggested that patients would benefit from more information prior to the visit and a clearer explanation of planned interventions.

Figure 8. Words Patients Used to Describe Their Experience During the Visit

Patients were also asked how the felt when thinking about the future. Only 46% of patients reported positively. Patient and relative comments included ‘I don’t like to think about it’, ‘she’s in pain and can’t walk, nothing can help this’ and ‘life is getting more difficult, I’m grateful for any help’. These comments emphasised that patients living with frailty and CKD are going through a very challenging time in their lives and that there is an obvious need for health services to offer patients more in an effort to improve their health and well-being.

Figure 9. Words Patients Used When Thinking About the Future

In summary, our work has demonstrated that patients living with frailty and CKD at LTHTR have a high number of active health problems, low health-related quality of life and an increased risk of hospital admission and mortality. We have demonstrated that it is possible to successfully implement a mCGA within Renal Services and in doing so otherwise unknown patient needs can be identified and managed by a MDT. We have used patient experience to evaluate our new Renal Frailty Service and, with recent funding receive from Kidney Care UK, we plan to continue to use patient experience data to further improve the service for patients and to build a business case for a sustainable RF-MDT.

Lancashire Teaching Hospitals also submitted a video alongside the above.

Finalist

Acute:

The Christie NHS Foundation Trust

Lung Cancer Patients Starting Systemic Anti-Cancer Treatment

The Christie NHS FT joined the NHS Specialized Clinical Frailty Network in 2018 with the aim to implement specific frailty assessments and management interventions for lung cancer patients starting systemic anti-cancer treatment (SACT), such as chemotherapy. This was developed as a quality improvement project and we gathered a motivated and multidisciplinary team under clinical leadership, of which I have been the deputy lead since its inception.

In this period we managed to implement the Rockwood clinical frailty scale as a screening tool on our electronic records by working closely with our digital team. This was a key aspect to make this implementation feasible and sustainable for clinicians in busy clinical practices. An online dashboard was also generated by close collaboration with the analytics team in order to automatically generate relevant data about patient characteristics and their journey through our pathways.

Over the last 10 months, close to 1.000 lung cancer patients were screened with 90% of all new lung cancer being screened. As expected frailty was associated with ageing and about 40% were classed as frail (CFS 4+). Interestingly, out of those selected for an anti-cancer treatment, those classed as ‘frail’ at baseline were 20% less likely to comply with the planned treatment, suggesting there is room to improve on patient selection, pre-habilitate and support them throughout treatment. Therefore an alert system was created for these frail patients in order to perform more specialized/holistic frailty assessments to find their needs, identify risks and get interventions and adequate support in place at start of treatment. This was only possible with a close collaboration with the nursing and AHPs, mainly occupational therapist. For that we also developed information leaflets for patients. Unfortunately, our current resources were quickly exhausted which presented a key limitation to expand this to more patients and more tumour sites.

Although and despite a still limited observation period, we already managed to see that by implementing measures at start of treatment for frail patients, in the event of an admission, this was significantly shorter since the required support was already in place allowing for an early and safe discharge. Moreover, we managed to prove that frail patients have worse quality of life than those fit at the start of their treatments, so we now monitor this as part of our standard of care and are hopeful we can make a positive change over time.

But although the aim is to implement changes that are improvements there is always the risk that this may not be the case. Particularly, we are always at risk of missing out on what really matters to patients. Therefore we decided to understand the patient experience before making changes in their care pathway, as our baseline. Interestingly, we found that patients had mostly positive feelings with their interactions with the team, yet felt particularly anxious with the waiting times in between referrals, assessments and the ultimate start of treatment. Reasonably the anxiety derived from the fear that their cancer could be growing and shortening their survival or impacting their quality of life. Therefore we quickly understood that whatever change we would like to do in the pathway, it could not result in delays for patients to get their treatments started. Hence the creation of an automatic alert system for those frail patients, which then prompts a holistic frailty assessment at the next visit to hospital.

Another key aspect has been communication and the importance of focusing on frailty in cancer patients, not just across the trust but also within Greater Manchester. Particularly because we recognised upfront our limited on-site resources and the need to link with community services. On that regard, we produced a promotional and educational video about our work and what frailty means for patients and presented this at our grandrounds, the main hospital-wide meeting open to all staff. With this initiative we invited all interested members of staff to join us in this joint effort. Moreover, we did our best to keep the spotlight on us (with all its added pressures) and over 10 months presented at multiple meetings across the different sectors and hospital departments to seek the support until we finally took our case to our board of directors. The impact has been very positive and all this work and commitment has resulted in a close collaboration with the Strategy Team and the current elaboration of a business plan to be submitted in early 2020 to set our very first Frailty Service. As part of this, patient voice is crucial and we are now organizing a focus group to help shape the design of this planned new frailty service and pathway for our cancer patients.

The Christie NHS Foundation Trust also submitted a 30 page presentation to support the above.

Finalist

Mental Health and Community:

Lancashire & South Cumbria NHS Foundation Trust

Blackburn & Darwen Pulmonary Rehabilitation Team

Blackburn with Darwen Community Pulmonary Rehabilitation – Use of Patient Activation Measure and Personalised Care

The Pulmonary Rehabilitation (PR) Team have had excellent patient outcome measures following the implementation of the Patient Activation Measure (PAM) within their service. The PAM tool is a validated licensed tool that assesses a service user's knowledge, skills and confidence (activation level) to manage their own health & wellbeing. It is a one page questionnaire that following completion provides a score based on a 0-100 point scale which then categorises the patient into one of four levels of activation. Level 1 being poor activation (disengaged and overwhelmed) and four being high activation (maintaining good health behaviours). It's used to identify areas of health improvement opportunity and to assist the health professional and the service user to work together in order to achieve the service users desired goals. This has been promoted by NHS England as part of the personalised care agenda and supported self-management. Evidence shows that when people are supported to become more activated they benefit from better health outcomes, improved experiences of care and fewer unplanned admissions. Patient activation can be increased by offering support and providing opportunities to develop both condition specific and general knowledge and skills. It is used to tailor interventions to individual needs.

The PR Service is a programme that includes individualised exercise and education for service users who live with a long term respiratory condition e.g. chronic obstructive pulmonary disease (COPD). The aim of the service is to improve a service user's knowledge, skills and confidence in managing their condition. This would improve their health and well-being resulting in them functioning better in their day to day life. Completion of the PR programme is a key indicator of success, better health outcomes and reduction in respiratory related hospital admissions. Generally the PR team receive positive feedback and outcome measures from service users on completion of the programme, however they wanted to further enhance the patient experience and completion rates therefore sustaining their behaviour change in managing their condition/health and well-being.

The team decided that it would be useful to utilise the PAM to identify the patients activation level at the beginning of the programme to establish what support they would require during the programme in order to improve patient experience and retention to complete the sessions. This was embedded as part of a quality improvement to improve personalised care.

Health coaching training was completed by the clinicians in order to carry out better patient driven conversations around the 'what matters to you?' approach. All the clinicians completed a PAM questionnaire at the patient's initial assessment. How the patient answered the questions and their PAM activation level would establish how the clinician would tailor the conversation, interventions and support required. Additional tools were developed to support this:-

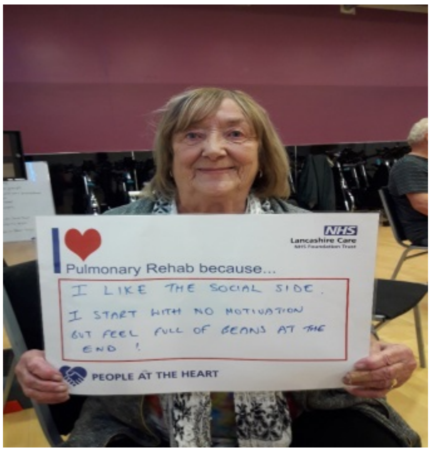
- Pulmonary Rehabilitation completion risk check list to discuss potential barriers the patient may have that would interfere with completion of the programme e.g. transport/travel issues, depression/anxiety, smoking status, caring responsibilities etc. This could then be discussed how best to manage this including signposting to other services for support.
- Flow chart guide developed for clinicians to look at potential pathways and interventions that would be offered according to the patients PAM level and clinical assessment.

The team then started to implement the PAM incorporating health coaching style questions using the additional tools that had been developed and ultimately putting the patient at the heart of the assessment – what mattered to them. From this those patients who didn't want to access the pulmonary rehabilitation programme (PRP) were provided with other appropriate interventions or signposted to other services/social prescribing. For those who did want to engage with the PRP a personalised approach was taken to support them in the groups e.g. all staff were aware of individual's PAM scores, their personal goals and any anxieties or barriers the patient may have whilst on the programme. This would ensure patients were supported and encouraged in the right way and the exercise and education sessions were tailored to meet their needs. Once they finished the programme a second review PAM questionnaire was completed and patient experience and feedback was obtained.

Initial outcomes have demonstrated that the PRP has had a positive effect on patient's activation and improving their knowledge, skills and confidence when providing a personalised care approach. Results so far have shown an average improvement in PAM® score from 56.1 to 64.0 - an increase of 7.9 points. The PAM indicates that when a score improves by five points that this is deemed as a significant improvement and sustained behaviour change in the person managing their health & well-being. The PR Team have been able to demonstrate this. In addition to this the team have been compiling case studies which have demonstrated a positive patient experience and improvement in quality of life. One of these stories was presented by the patient to the Trust Board as a 'Board story'. Our learning in relation to the PAM and personalised care has been shared with a number of other external and internal services. Information has also been shared on the NHS Collaboration Platform and with the NHS England Personalised Care Team.
Feedback has shown that personalised care and the PAM tool has been well received and the Trust are now promoting this approach with other services – the PR Team have been working with the Quality Improvement Team to provide mentoring and support internally.

This pilot is currently ongoing and further results will be available at the end.

Blackburn with Darwen Pulmonary Rehabilitation programme case study



Meet June, a 78 year old lady who was diagnosed with chronic obstructive pulmonary disease (COPD) and was referred to the pulmonary rehab programme by her respiratory nurse following recovery from a chest infection.

She attended the clinic for her initial assessment and **her initial PAM score was Level 2 score 53.2.** Definition of level 2 is that the patient is becoming aware but is still struggling, they believe that health is still largely out of their control.

Whilst using health coaching style techniques and asking what mattered to her she stated she felt very tired and breathless when trying to do her daily activities and had given up some of her enjoyable activities such as bowling. She couldn't walk into the kitchen due to her breathlessness and her daughter had to assist her with household chores and shopping.

June had already given up smoking and there was no other issues highlighted with other health and social areas that she was concerned about. When discussing her goals she wanted to become fitter in order to stay independent with all her daily activities and enjoy herself again. She was happy to attend the Pulmonary Rehab programme to try and achieve her goals.

All the staff were made aware of her concerns, goals and PAM level to give her personalised support in the way she needed in the groups and the exercises were modified to meet her existing energy levels and build on this. Education was also provided so she could learn to self-manage her levels of breathlessness on exertion and manage her COPD. Positive encouragement was given to June in the class by staff running the session and they reinforced how well she was doing and with this she was able to complete the programme.

At her discharge review – **her PAM score increased to level 3 – score 67.8** (this indicates a significant improvement in her knowledge, skills and confidence to manage her condition and an increase in over 5 points is deemed as a sustained behaviour change). The definition of level 3 is taking action – the individual has the key facts and is building self-management skills. They strive for best practice behaviours and are goal orientated. Their perspective is that they are part of their health care team.

June has now informed us that she has been able to undertake her bowling activity again and is now able to complete her own household chores without relying on her daughter. She has more energy and is now feeling a lot fitter and less breathless. Her walking distance has improved and she is now continuing with exercise provided by her local council.

(NB – June has given signed consent in line with Trust policy for her information and phot to be shared)

Our collage of patient feedback

Finalist

Community and Other Organisations:

West Hampshire CCG

ICON Programme to Avoid Abusive Head Injuries in Children

Abusive Head Trauma (AHT) is a devastating form of child abuse. Research literature points towards an inability to cope with a crying baby as being one of the key reasons for caregivers losing control and shaking a baby. However, whilst AHT is 100% preventable, little in the way of a co-ordinated prevention programme exists in the UK.

Nationally, Abusive Head Trauma (also referred to as Shaken Baby Syndrome) affects up to 25 children per 100,000 in the UK. A well- documented trigger is infant crying and evidence suggests male caregivers are responsible for inflicting AHT in about 70% of cases. There is a normal peak in infant crying. The research highlights that infant crying increases in intensity and frequency and reaches a peak, it then gradually reduces and plateaus. This is important information for parents and carers to understand before infant crying hits its peak.

The Hampshire Safeguarding Children Partnership (HSCP) & West Hampshire Clinical Commissioning Group (CCG) developed the programme materials with parents and carers who have been affected by AHT to create an eye- catching, suite of materials which supports parents to cope with a crying baby. It has a memorable identity, a simple message and the ability to be used across the UK.

The ICON Programme is a preventative programme, which reinforces a simple message to parents and carers regarding how to cope with infant crying. The core message delivery is completed by universal services, in a touch point format. Secondary and tertiary services, such as Children's Services and Early Years Settings also reinforce the ICON messages when they are working with families where additional needs have been identified, such as within parenting classes or within nursery settings

ICON refers to:

I – Infant crying is normal

C –Comforting methods can help

O – It's OK to walk away

N – Never, ever shake a baby

Interventions included:

- Engagement with parents and carers affected by AHT and children and young people to develop the ICON message
- Co-production of a leaflet, posters, fridge magnet, films, website & social media

- Design, use and evaluation of a GP led consultation template for use in the 6-8 week postnatal check.
- A public launch in January 2019
- A social media campaign
- The DadPad app, providing another channel to reach parents, especially men.

Evidence suggests Hampshire would expect four cases of AHT each year but the county has seen more than this – with one conviction in December 2018. It is aimed to reduce these cases, saving up to four or more lives a year.

The impact of the programme so far:

- The ICON Programme was launched in Hampshire in September 2018 to over 500 professionals, and to date over 1700 professionals across Hampshire have received ICON training
- ICON social media campaign reach estimated at over 58,000.
- 92% of GPs felt that using the consultation template had changed their practice
- 100% of the GPs found the ICON message and training helped them to discuss coping with crying.
- 70% of parents said they would change their behaviour in response to their baby's crying.
- 100% parents felt confident to share the ICON message with peers.
- Feedback suggests the key messages were understood and remembered by parents.
- Midwives and staff were comfortable supporting parents to talk about crying in babies.

As a result of the pilot, rollout has commenced across all universal services in Hampshire including midwifery, health visiting and primary care (GPs).

Below are some of the examples of the work which the HSCP and partners have completed to engage, spread and promote ICON, ensuring the message reaches more people and is able to have the desired impact:

- The Maternal Postnatal Template for the 6-8 week check has been included in the Royal College of GPs Safeguarding Children online Toolkit.
- The work has been formally endorsed by the National Paediatric Major Trauma Network.
- Information for parents/carers on coping with crying is available on the Wessex Healthier Together website.
- The ICON Programme has been nominated for a number of awards, including receiving the Regional NHS Parliamentary Award in July 2019 and was a finalist for a HSJ Award in May 2019.
- ICON has also been delivered at six national and local conferences including the Royal College of Paediatrics and Child Health (RCPCH) Annual Conference and the Child Death Overview Panel Annual Conference as well as at a number of local and regional forums.

ICON continues to be a successful campaign because of its simple key messages but also because of its scalability across the country and across historical professional boundaries.

The team is working collaboratively with other areas including Portsmouth, Southampton, Isle of Wight, North Yorkshire and York, Gloucestershire, Manchester, Lancashire, Cheshire, Merseyside, Sussex and a number of other areas to roll the ICON Programme out nationwide.

The HSCP has worked with national charity called ‘Fixers’ to produce a suite of materials including a film and information produced for children by children, which will support educational establishments to share this message with children and young people.

The ICON National Steering Group led by the WHCCG Designated Nurse are developing a number of films in 2019/20 to support the national roll, out including:

- Ellis’ Story: A parent affected by AHT has developed a film sharing her son Ellis’ Story
- Parent Film: The film describes the ICON Programme in more detail and is due to be launched imminently
- Holly Dolly: How to handle a baby safely and the dangers of shaking a baby.

The team plan to publish the ICON findings to date in the Child Abuse Review in 2019/20.

As part of the Boards appetite to learn, develop and evidence positive outcomes for children, further evaluation of the ICON Programme will take place during 2019/20.

The website with further information, videos and resources is http://iconcope.org/

Co-created Service Award

Winners

Mental Health and Community:

Lancashire and South Cumbria NHS Foundation Trust
The Seclusion Continuous Improvement Group

The judges thought this was a great project and particularly like the video involving patients. It's evident from the submission that changes have been put into place.

Community and Other Organisations:

Cardiff and Vale University Health Board
Community Neurological Rehabilitation Service Living Well Programme

The judges were impressed with the demonstratable good results and lots of patient involvement right from the start. They thought it was an impressive programme and clearly codesigned. An overall great example.

Finalists

Mental Health and Community:

Camden & Islington NHS Foundation Trust
Restraint Debrief Volunteer Team

Solent NHS Trust
Vocational Rehabilitation Service

Community and Other Organisations:

Central London Community Healthcare NHS Trust
Quality & Learning Division - Shared Governance

Oxfordshire Mental Health Partnership
Oxfordshire Recovery College

Winner

Mental Health and Community:
Lancashire and South Cumbria NHS Foundation Trust
The Seclusion Continuous Improvement Group

Lancashire and South Cumbria NHS Foundation Trust submitted a video in support of the story below.

Nominated Story:

Following a CQC inspection of the Trust, feedback from people with experiences of seclusion and family/carers improvement actions in relation to the use of Seclusion were identified. The Trust formed the Seclusion Continuous Improvement Group which came into effect following an initial thinking space event.

It was felt important to have both the patient and carer voice in the room so from the outset the group's membership includes clinical leaders and operational managers but also integral to the group are 2 family members and 3 people with lived experiences of seclusion.

This group have triggered and are supporting a number of quality improvement projects that have been designed by and co-produced with people with lived experiences of seclusion from both a user and family/carer perspective with support from the QI team.

It was important to the group that we had a wide and varied understanding of people's views and experiences of Seclusion, so, much of the work sponsored by the group has risen from an extensive Patient Perspectives' review.

During this review a number of patients who had recently experienced Seclusion were randomly selected to be interviewed about their experience.

For most of the patients we spoke to Seclusion was seen as a negative and unsupportive experience however, people understood its purpose and need. They were keen to get their messages of advice/improvement across and, although they were all seen individually there was surprising commonality in their feedback messages and suggestions for improvement.

Active Work Streams overseen by the Group:

Listening to Peoples Experience: A video has been co-produced featuring the personal stories of a former patient and the parents of another patient. This video has been shown at a meeting of the Trust Board of Directors and has been shared across mental health services for information and training purposes.

The film has been used within medical induction and will be offered for inclusion in the multi-professional preceptorship programme.

Link for Seclusion Video:
https://youtu.be/E53Wd4aRc4c

Therapeutic Engagement in Seclusion: Patients told us that whilst in seclusion the hours passed very slowly there was nothing to do and the time spent alone could be very boring.

They stressed the importance of engaging in meaningful activities, like simple distractional or occupational activities.

In response to this feedback, work is underway looking at a range of activities which can be provided. In a pilot scheme at one of our hospitals an activity library has been developed which includes a suite of activity boxes that can be selected by services users/noted as preferences on their ‘my wishes’ checklist. People with experience of seclusion report that this equipment has a big impact on patients.

There are plans to spread this to all in-patient settings across the Trust.

Debriefs for service users following seclusion: Debriefing is the practice of reviewing an event, in order to process aspects of the experience and learn from it. In the context of seclusion, debriefing is considered a fundamental prevention strategy, as it is designed to prevent further occurrences and is consistent with trauma-informed care and quality improvement principles, it is also, highlighted as a critical element within many quality improvement studies of seclusion reduction. Patients we talked to did not feel that they had been provided with adequate opportunity to talk through their feelings in relation to seclusion.

The group created a small ‘focus group’ of relevant professionals to discuss the de-briefing of patients following an episode and to look at this in relation to ‘trauma informed care’ and psychological first aid’, this work is currently underway.

Seclusion Information Leaflet: One suggestion that came out of our work with patients was about greater information, particularly for new patients, about Seclusion what it is and what will happen when it is used.

A ‘focus group’ meeting with a number of current inpatients discussed this issue and a draft template of an information leaflet was produced. This was then taken to another meeting of clinicians and the leaflet below was produced.

Seclusion
Information leaflet.p

Seclusion Room Environment: Patients that we spoke with generally gave negative feedback about the Seclusion room environment; they feel that these could be more patient-friendly.

People with experiences of seclusion who sit on the group suggested that, we shouldn't assume that changes to the environments can't happen because of the costs as the impact and potential to improve experiences is huge – start small in one place and think big' is the key.

For example: some of our Muslim patients complained that they were unable to pray whilst in Seclusion as there were no directional markers pointing east. Estates colleagues are now aware of this issue and have been putting directional indicators in Seclusion rooms across the Trust. Another example is the use of 'chalk walls' creating activity opportunities for the person in seclusion

Seclusion Documentation and the new RIO electronic system: A number of consultation events involving staff and people with experiences of seclusion have taken place across the Trust to inform the co-design of documentation to be included within the new RIO which is being used by the Trust.

A seclusion dashboard and associated documentation has now been co-developed using the information from the consultation meetings and is being piloted at one hospital.

All of the service improvement work that has been generated has had full user involvement, they contribute with their ideas, actively engage in the planning and keenly oversee actions produced.

Winner

Community and Other Organisations:
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board Community Neurological Rehabilitation Service Living Well Programme

When the Welsh Assembly Government (WAG) Neurological Delivery plan allocated £174k to Cardiff and Vale University Health Board (CAVUHB) to improve community rehabilitation for people living with neurological conditions, the words of one service user 'you won't make a difference by just doing more of the same' led to a co-produced redesign of neurological rehabilitation services.

CAVUHB has many separate specialist services providing neurological rehabilitation to people living in the community. These include condition specific specialized services, profession specific outpatient services and teams supporting transfer from hospital to home. At the time of the funding opportunity in 2016, all were struggling with capacity to manage demand and requesting more resource but was enhancing these services the right thing to do?

To answer this, the Community Neurological Rehabilitation Service (CNRS) project team held a 'Learning and Sharing Event' in Cardiff City Stadium and explored what the future of neurological rehabilitation should look like. The 100 participants represented neurological rehabilitation services users, people living with neurological conditions and their relatives, the neurological rehabilitation teams from Cardiff and Vale and charities and organisations working with people with neurological conditions. Smaller focus groups were then organised to hear from people who could not participate in this type of event including those with communication and cognitive difficulties.

At these events, the key message from the service users and stakeholders was that CAVUHB community neurological rehabilitation needed to do more to help people to self manage their condition long term and 'live their lives their way'.

The outputs from these events were used to design a service model focusing on needs led interventions and a robust pathway from hospital based specialist intervention to community support and integration. A stepped approach (figure 1) was used to enable people requiring specialized interventions to access condition or profession based specialist teams when required (Level 3 & 4) but co-ordinated all lower level rehabilitation, education and long term support into needs based Living Well programmes (Level 1 & 2), that could be accessed irrespective of neurological condition or prognosis.

Figure 1

Level 1	Level 2	Level 3	Level 4

Empowering living well with a neurological condition through co-produced education and support. Group programmes that are not condition based	Group rehabilitation programmes that address specific rehabilitation needs but are not condition based. E.g. upper limb activity conversation groups.	Specialized group rehabilitation programmes & 1:1 programmes that are delivered by trained support staff. These may be specific to a condition and will be delivered by CAVUHB specialist teams	Interventions & programmes delivered 1:1 by specialist CAVUHB staff and teams E.g. Community Brain Injury Team, Early supported discharge team for stroke, M.S. services and uni-professional teams.

Using the WAG funding, a small team was established to deliver these programmes locally in leisure centres and community centres across Cardiff and Vale and neurological clinical staff across the whole pathway were trained in the Bridges Self management Programme, a framework that aims to support self management through every patient/healthcare professional interaction.

The CNRS now offers 10 programmes as part of this Living Well Service. These were identified and prioritised with people with neurological conditions in a focus group but can be flexed and adapted in response to the needs of the people accessing them at any time.. They currently include fatigue management, mindfulness, social confidence and exercise and are run across 8 different local centres. To promote long term meaningful activity, the service has developed partnership arrangements with social enterprises and community groups and currently supports these organisations to provide ongoing activities accessible for people with neurological conditions.

The patient experience of these programmes has been positive with 100% of service users reporting that they would recommend their programme. 54% of people attending an exercise programme have continued to exercise in their local gym independently and people with neurological conditions in Cardiff and Vale have been supported to access activities such as walking football and netball, Tai Chi, and conservation work. The programme now has 6 service users who volunteer in CAVUHB peer support roles.

The model has also supported flow through neurological healthcare pathways, improving access to the specialized Level 3 and 4 services. The physiotherapy neurological outpatient service has experienced a new patient to follow up ratio reduction from 1:8 to 1:4, resulting in reduced waiting times for new patients from 13 weeks to 4 weeks. The Early Supported Discharge Team for Stroke has seen a mean reduction of 14 days for time spent with them.

In addition to these programmes, the funding supports the only specialist dietician for neurological conditions to work across the Level 4 specialist teams and an occupational therapist to provide a bespoke vocational rehabilitation service. It has enabled the purchase of active passive trainers that have been placed in leisure centres enabling people with neurological conditions to use this equipment independently rather than attending their hospital gym.

This current rehabilitation model now reflects the direction that the service users originally identified in the early development workshops. It has been well received by service users and outcomes have demonstrated that the Living Well Programmes supports people to move through highly specialized services to more local support and equips people with the knowledge, skills and connections to manage their neurological condition and well-being long term. Neighbouring health boards have shown interest in the service and there is recognition from within C&VUHB that this model could be replicated for wider chronic condition management.

Service user feedback :

‘The Community neuro team have changed my life. They started me exercising again and gave me the confidence to join classes in the local leisure centres. Their classes addressed my physical and mental health and wellbeing. They have helped my mind body and spirit’

Finalist

Mental Health and Community:

Camden & Islington NHS Foundation Trust
Restraint Debrief Volunteer Team

Our Restraint Debrief Volunteer Team supports some of the most vulnerable mental health services users in Islington and Camden boroughs.

On occasions some patients in psychiatric inpatients settings have to be restrained by staff for the safety of themselves or others. It may be due to violence or aggression, self-harm or a refusal to take medication deemed essential to their recovery.

National Institute for Health and Care Excellence (NICE) guidelines, [NG10] Violence and aggression: short-term management in mental health, health and community settings and [CG136] Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, advise that the patient should be given the opportunity to contribute to a debrief following any such interventions.

Historically, this has always been offered by staff. However, this can be a challenge as often patients may find it hard to engage with staff following such incidents initially, due to high emotions or feeling that staff shouldn't have restrained them. It can also be challenging as service users may feel that they can't say anything during a debrief, as they feel it may affect their care in a negative way.

As a way of changing this and increasing patient involvement in debrief, we introduced a volunteer debrief role. The aim of the role is to give patients who had been restrained a voice and an opportunity to reflect and feedback on the event from their perspective.

A number of our volunteers have lived experience of mental ill health themselves, and so can bring their valuable lived experience of mental ill health and being restrained to the role.

A couple of our volunteers have been involved from the very beginning and were consulted on whether they thought it would be a good idea to offer patients a debrief with volunteers. They have helped to design the right template and contributed to how it could be best implemented. They remain part of our on-going steering group to enhance the debrief volunteer role further and have been instrumental to our success, including supporting the project in securing a grant from Helpforce, a national movement on a mission to improve the lives of NHS staff, patients and communities through the power of volunteering. The grant from Helpforce has helped us to scale up the project and expand our measurement of its impact.

The debrief session allows patients to tell us in their own words what happened, if there was anything that was making them upset leading up to the incident and if there was anything that could have helped prevent it from happening and could be done differently in future. They are also offered support on advocacy services and the advice and complaints service.

In terms of impact, patients have responded very positively to having the opportunity to have their say, give their version of events and give their feedback, on what is often a very traumatic and upsetting incident for everyone involved. They benefit from talking to and being listened to by someone who is independent to staff and often can talk more openly and honestly in this forum. Having volunteers provide this service to patients shows them that people who aren't paid to be there care enough to come and speak with them to help improve things for them. This can play a vital part in boosting patients' self-esteem and sense of self-worth. It also supports the breakdown of stigma around mental health, highlighting that their voice is still important even if they are unwell.

One patient recently reported when completing the debrief with volunteers that it's the first time they have ever been asked about what they think about their care in 20 years of using mental health services. It left her feeling empowered that she was able to have her say and was listened to.

Others have seen their preferences put it to action and commented that staff have supported them in the way they requested through the debrief opportunity. It's provided them with a sense of control when often they feel their rights and control have been taken away from them when detained in hospital.

As an organisation, the information gathered during a debrief session allows us to better understand things from the patient's perspective, to learn lessons that can improve our practice or how we work with individuals and their preferences. It enables us to provide much more patient centred care and a better experience for patients.

In order to ensure we keep engaging and involving our patients, we attend our local service user groups and community meetings on the wards to let people know what we are doing, get their feedback on it and encourage them to get involved to help us create more positive change and improve our patients experience even more.

Finalist

Mental Health and Community:

Solent NHS Trust
Vocational Rehabilitation Service

Co-created services: Solent NHS Trust's Vocation Rehabilitation Service

Please see the service's twitter account - **@VRSSolent** for lots of examples of how this service is run collaboratively with its users, and loads of stories that will make you smile. A short film is available at https://youtu.be/5uD2isUiDnk

Solent's Vocational Rehab Service is for people with a neurological condition or neurological (brain) injury who are working towards getting back into employment. The service provides occupational therapy through outpatient care, where patients receive physical, mental and wellbeing goal focused interventions. The main goal is for service users to return to work but the broader benefits stretch far beyond this (peer support, communication skills, confidence building and so on).

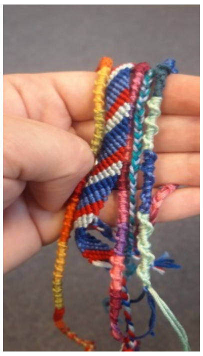
The co-delivery of this service started with the creation of a client forum which meets regularly - past and current users of the service are welcome to attend. Clients report that learning from each other and meeting peers at this forum helps with their recovery. The first big project that they identified together was the development of measures to track progress and outcomes. The service users and clinicians jointly developed measures that set goals for independent living and skills to enable a return to work. The key to this is that it is jointly owned by the clinician and the service user, with both able to view the progress visually – this also links to our clinical record system. The service users can now set their own goals and track progress, and therapy is built around this. This approach to rehab and the use of this outcome approach is now integral to the running of the service.

The client forum continues to develop and highlight new initiatives for the service. The second project was the development of a new Group Based Therapy, particularly focussed on peer support. The third project has been the running of events to sell products made by clients as part of their rehabilitation. The events have been arranged and publicised by the patients. The first was an Easter themed stall which was held at the local hospital – the proceeds were used to buy more ipad type tablets to support with therapy. A Christmas event is planned for the 5th December 2019.

> *"Work is underway for gifts to sell at our Christmas fayre… one client has been sharing her crafty skills with another and together they've been making these lovely bracelets"*

This is a service that is truly co-created and delivered by those that use it. They are involved both in service delivery and in its growth and development. This has given a voice to people who would not often be heard at significant transition points in their lives. This has helped boost their recovery and give them ownership of their own service. Anyone who uses the service is involved.

> *"A client set himself a project of designing and making a small table which fits over the rails of his profiling bed…"*



Finalist

Community and Other Organisations:

Central London Community Healthcare NHS Trust

Quality & Learning Division - Shared Governance

The CLCH quality strategy for 2017-2020, which is underpinned by Shared Governance continues to drive through improvements and influence change, the quantity of Shared Governance projects continues to grow and the trust endeavours to engage more staff and patients to help make its ‘Outstanding’ vision a reality.

CLCH has been actively recruiting staff and patients to join the Shared Governance Vision of Quality Improvements over the last 2 years. Giving all staff and our patients "a voice" allowing them to be joint, integral in decision-makers and change influencers.

The outcomes of the project delivery to date have been used to advise on changes required to make improvements. Quality Councils meet for 2 hours a month, which is protected time for all involved staff and continues to receive support from the Shared Governance Programme Lead, Senior Management, and the Continuous Improvement Team as required.

Just a couple of examples of the excellent work that has grown through the Shared Governance Programme are as follows:

Project Name - Mandatory Training Compliance: *A Small Scale Quality Improvement Study using a Shared Governance Approach.*

The involvement of the patient representative was integral to the success of this project. The patient representative was able to give the other side of the Stat Man issue, that being patients believe that the nurse caring for them is proficient, the risks of infection and possible death of vulnerable patients that may be being put at risk due to staff training not being up to date. Patient representative attended ‘Modelling the Way’ (Trust meeting re staffing, learning and training) meeting, he was also involved in making changes to the policy and presented at the Trust Coordinating Council on behalf of this specific shared governance council.

Project Name - Communication folder

Improving communications between patients, families and healthcare professionals in Merton Falls Prevention service

Rationale: Improved communication will provide excellent service where the patient and families will feel involved enabling family and friends to know what help is being given.
Services work together to help improve patient’s confidence to ensure they appropriately self-manage their health conditions.

Patient representatives supported staff with what was required in the communication folder from a patient's perspective and worked with the Quality Council to take this excellent project forward.

Project Name - Reception dialogue

Why did we do it?

This project was chosen by the patient representatives with the aim to achieve a satisfactory rapport between receptionists and patients so that both are more content each time a patient approaches a counter.

The patient representatives are integral to working with staff to decrease unacceptable behaviour and improve patient and staff relationships across the trust.

Rationale/Intended benefits:

A good environment for both the receptionist and the patients, with clear communication and a positive outcome.

How did we do it?

Patient representatives were trained in Continuous improvement and LifeQI, to ensure their understanding of the methodology. Using a Shared Governance approach the patient representatives were part of a Quality Council with frontline staff including an Improvement Facilitator.

How did you ensure it was representative?

More patient representatives than staff, two of the patient representatives have been given Chair training via the trust and one of the Patient representatives is now co-chair of this quality council.

MANDATORY TRAINING COMPLIANCE:
A Small Scale Quality Improvement Study using a Shared Governance Approach

Central London Community Healthcare
NHS Trust

Meenaxi Shah, Ed Michael Carbonell, Mercy Nhari, Benenia Magombedze, Johanna Law, Alan Kummer, Nicola Ireland, Frits Klinkhamer

Background and Aims of the Project

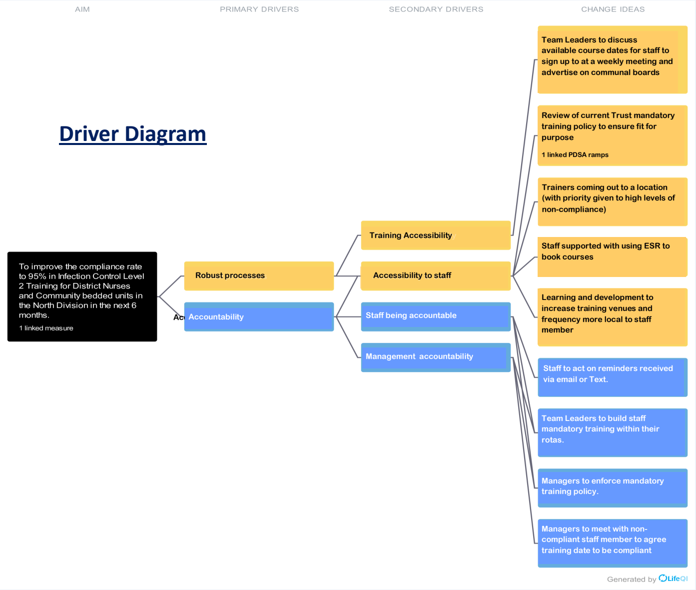
The infection control (level 2) mandatory training compliance in the North Division of Central London Community Healthcare NHS Trust was studied utilising the methods of Quality Improvement.

The aim of the project is to improve the compliance rate from 89% to 95% within a 6-month period (December 2018 to June 2019). This is just in the early phase of the study thus initially aiming to find out some of the factors that lead to the noncompliance of staff to the training as well as their perceptions on how support was provided by the management and/or organisation towards achieving compliance. The results of these can then be used to determine strategies or change ideas that can be studied whether they are effective in increasing the compliance rate.

Quality Improvement Model

The framework utilised in this project is the model for improvement which involves developing, testing and implementing changes leading to improvement. This model includes the Plan, Do, Study, Act (PDSA) methodology which enables testing for change on a smaller scale (NHS Improvement, 2018)

Driver Diagram



AIM

PRIMARY DRIVERS

SECONDARY DRIVERS

CHANGE IDEAS

To improve the compliance rate to 95% in Infection Control Level 2 Training for District Nurses and Community bedded units in the North Division in the next 6 months.
1 linked measure

Robust processes

Accountability

Training Accessibility

Accessibility to staff

Staff being accountable

Management accountability

Team Leaders to discuss available course dates for staff to sign up to at a weekly meeting and advertise on communal boards

Review of current Trust mandatory training policy to ensure fit for purpose
1 linked PDSA ramps

Trainers coming out to a location (with priority given to high levels of non-compliance)

Staff supported with using ESR to book courses

Learning and development to increase training venues and frequency more local to staff member

Staff to act on reminders received via email or Text.

Team Leaders to build staff mandatory training within their rotas.

Managers to enforce mandatory training policy.

Managers to meet with non-compliant staff member to agree training date to be compliant

Generated by LifeQI

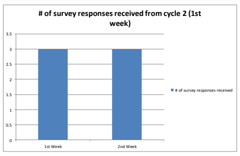
PDSAs

Cycle 1: 20-item survey questionnaires regarding Infection Control (Level 2) Mandatory Training compliance in MS Word format were sent to individuals according to inclusion criteria (e.g. noncompliant staff within district nursing services & etc.) via email. A total of 70 participants fit the inclusion criteria and email was sent to 70 people

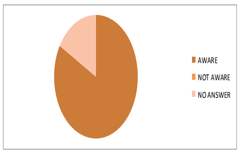
Cycle 2: Survey questionnaire items reduced to 10 questions and were made accessible via the survey monkey website. A total of 11 participants fit the inclusion criteria & email was sent to 11 staff. They were sent a link to complete the survey within 1 week from date email was sent.

Cycle 3: Deadline for completing the 10-item "survey monkey" survey was extended to another week and staff were sent another reminder email.

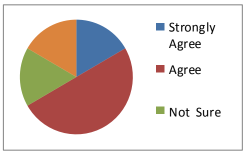
Survey Results



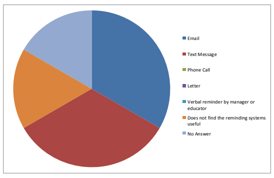
A total of 6 responses received out of 11 received for both 1st week & 2nd week



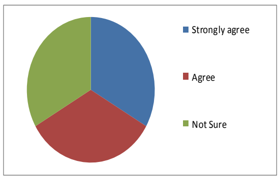
Participants aware of the Training as a mandatroy requirement



Perceptions of staff regarding their manager supporting them in being up-to-date with the training



Staff's preferred method of being reminded for the training



Perceptions of staff regarding protected learning time support when completing the training

Learning

- The team has found out that the high noncompliance rate was also influenced by several factors which includes staff that should not be on the noncompliance list as they have already left the Trust. Compliance / noncompliance to training lists must be updated properly. The relevant people responsible for this list has been informed.
- Several challenges were experienced while implementing the project especially in getting the participants for the survey. In order to increase the number of participants, the PDSA methodology was applied which later resulted to obtaining more than 50% of the respondents. The process involved in the making of the survey as well as its implementation took the team some time thus the initial 6-month period (December 2018 to June 2019) should be extended if the change ideas in the driver diagram needs to be tested.
- Even though that the study is still at its early stages, **the current compliance level for level two infection control is 93.7% in North Central Division** and this was quite a significant result. The exercise of sending emails to staff to complete the survey as well as making the managers aware of the noncompliance rate situation could have contributed to the significant rise in the compliance level.

Next Steps / Recommendations

Further work needs to be carried out to analyse factors that facilitate and hinder mandatory training compliance in Central London Community Healthcare NHS Trust.

Further work needs to be carried out to test the change ideas in the driver diagram using the PDSA methodology.

Reference:
NHS Improvement. (2018). *Plan, Do, Study, Act (PDSA) cycles and the model for improvement*. [online] Available at: https://improvement.nhs.uk/resources/pdsa-cycles/ [Accessed 25 Apr. 2019].

Finalist

Community and Other Organisations:

Oxfordshire Mental Health Partnership

Oxfordshire Recovery College

Oxfordshire Recovery College came to life as a new innovation in 2015, when Oxford Health NHS Foundation Trust joined with five local charities to form the Oxfordshire Mental Health Partnership. Working together, the OMHP provides a holistic service to adults struggling with mental ill- health, ranging from prevention to recovery to finding housing, and all stops in between.

At the Recovery College we take an educational approach to recovery – it's different to a clinical or therapeutic approach, but fits well alongside other sources of support. Our students can enrol themselves on our courses and workshops just as they would in any other College. There are no waiting lists or referral criteria. The College offers 22 courses and workshops on a range of issues around mental health and wellbeing, such as "Understanding Mental Health", "Introduction to Personality Disorders and "Creative Writing". Our courses are for service users, but also for carers, family and friends, as well as mental health professionals.

What really makes us different and eligible for this reward is the way we co-produce with service users. There would be no Recovery College without the continual involvement of people with lived experience of mental health issues. The cornerstone of our College is the fantastic tutors who deliver our courses - we now have around 50 tutors, many of whom offer their time voluntarily. All our courses are written, developed and taught by two tutors – one is a Tutor by Training (often someone working within mental health services in the Partnership) and the other is a Tutor by Experience, so someone with lived experience of the subject we are discussing, whether that be depression, psychosis or using Tai Chi in recovery. As an example, one of our newest courses this term is on Sleep and Wellbeing. The idea for the course came from one of our students who had just trained as a tutor and had many years of experience of struggling with sleep due to anxiety and depression. He worked together with a psychologist to write the course, working out how much background information from research would be useful and coming up with interactive ideas to engage students in sharing their own tips on sleep. When they'd created a presentation together, both our Tutor by Training and Tutor by Experience delivered the course to a pilot group of students first, then adapted it after their feedback, and now the new course is on our timetable and has proved very popular with students.

Many of our current tutors first became connected with the Recovery College as students. Three times a year we offer a six session Tutor Training open to anyone interested, and on that Training people who left school with no qualifications develop their group facilitation skills alongside and equal to others with PhD's. This is Sarah's story, "My care coordinator told me about the College and suggested I try the course on depression. I wasn't keen, but the person I spoke to on the phone about the course was so encouraging, I forced myself to go along. I was a bit taken aback to be asked how I would describe what depression feels like, but I really liked hearing ideas from other students, and I felt listened to and valued. It meant a lot to me that the tutors talked about their own experiences, so there was no “us” and “them”. When I got home I signed up straightaway for three more courses, and it was the best thing I ever did to help me in my recovery. A few months later I decided to do the Tutor Training – just for fun and to boost my confidence really, but once I’d completed the training, the College supported me to start delivering bits of courses, and now I deliver a couple a month. I love it – a year ago I hardly left the house, and now I’m reaching out to other people struggling the same way I was, and showing them there’s hope for the future.”

We make decisions about future directions for the College at monthly meetings involving all our tutors, and termly forums to which we invite all our students. Co-producing everything we do from course delivery to writing our mission statement can be time-consuming, but it’s worth it because it inspires and invigorates everyone involved with the College. Our students engage in our courses because we want to hear about the reality of their experiences, good and bad, and everything we offer is based on what we’ve learnt from real experiences.

We are entering for this award now because we want to celebrate learning so much about co-creating and establishing a service in our first four years. Now our model is up and running, we’re ready for some robust evaluation and over the year ahead we will be assessing our impact and fine-tuning what works best – in a coproduced way of course. We’re also ready to take some of our courses out of our College and into other settings. We want to inspire anyone struggling with their mental health to believe that their experience is valid and valuable, and however bad things get, there is always hope.

Excellent Teamwork Award

Winners

Acute:

Manchester University NHS Foundation Trust

The Emergency Multidisciplinary Unit

The judges thought this was an "excellent QI project that demonstrates an improvement in PX through measurement." There was a clear vision for improving care and outcomes, and the team demonstrated their commitment to achieve the goal. They worked with other teams and with the Red Cross to enable the whole pathway for patients.

Mental Health and Community:

Solent NHS Trust

Brooker Award for Dementia Services led by Patient Representative

The judges loved this for a true patient representative lead project, working with people not for. There was a clear aim which is patient focussed, and clear team roles led by a patient representative, working both within and outside of the Trust with Alzheimer's society and research trust.

Community and Other Organisations:

West Hampshire CCG

New Forest Frailty Model

The judges were impressed with the clear aim to develop and deliver their Frailty Model, and their clear identification of each team members role so they can respond and treat as appropriate. Judges thought it was an overall great piece of work.

Finalists

Acute:

Homerton University Hospital NHS Foundation Trust

Get Hackney Talking! Speech & Language Therapy Team

North Middlesex University Hospital NHS Trust

Listening into Action Team - Caterina Raniolo

Royal Free London NHS Foundation Trust

The Frailty Journey Team

Calderdale & Huddersfield NHS Foundation Trust
A Collaborative Frailty Service

Imperial College Healthcare NHS Trust
Antenatal Big Room

Royal National Orthopaedic Hospital NHS Trust
Spinal Frailty Pathway

Mental Health and Community:

Lancashire & South Cumbria NHS Foundation Trust
Central Lancashire Moving Well

Community and Other Organisations:

Pembrokeshire County Council
Joint Discharge Team

Winner

Acute:

Manchester University NHS Foundation Trust

The Emergency Multidisciplinary Unit

Introduction: the Emergency Multi-disciplinary Unit

The project took place on the acute medical unit (AMU) of a district general hospital. The ambulatory care unit (ACU) was under-utilised and length of stay on AMU was frequently prolonged. Several areas for improvement were identified including performance against Trust frailty standards, compliance with quality standards and availability of clinical pathways. Feedback from both patients and staff identified further areas for improvement. An ACP- led Emergency Multidisciplinary Unit (EMU) was piloted as a test of change, providing same-day multi-disciplinary assessment and treatment in order to avoid acute hospital admission. Clinical pathways were developed to manage DVT, PE, anaemia, cellulitis and frailty on an ambulatory basis. The service was supported by care navigators, therapists and the Red Cross.

A pilot of the model ran for three weeks. Number of patients seen in EMU demonstrated an increase of 65% on patients previously seen in ACU. During the pilot, admission was avoided for 29 patients. Frailty Standards were maintained at 100% for all appropriate patients. Patient experience was improved dramatically. Length of stay on AMU was reduced by 30%. The pilot project provided evidence for change from which to develop a robust business case to continue the service.

Teamwork

Prior to implementation of the project, unit culture was not conducive to change due to limited job satisfaction, motivation and commitment along with anxiety, stress and increased turnover and absenteeism. In addition, several quality improvement projects had been previously attempted in this area with limited success. Motivation for change was therefore low, with staff demonstrating resistance to change. Effective team working was vital in order to ensure the success of the project.Staff engagement was prioritised throughout the project. Staff satisfaction with the previous service was low; all members of staff working in the previous service provided feedback regarding what they felt worked well and which areas were in need of improvement. Doctors, nursing and AHP staff of all levels provided suggestions for improvement which were incorporated into the service redesign.

The identification of a shared, inspirational vision was vital to the success of the project. Our vision centred on providing a high-quality service to meet the specific needs of our local population. Since loyalty to the hospital was high among staff, this was encouraged as a motivating factor. Low morale was countered by the vision of a future service recognised organisation-wide for provision of safe, high quality care.

Weekly meetings were held during the planning stages of the project. This gave the team the opportunity to identify objectives, plan actions for the following week and demonstrate progress. Decisions regarding changes to the service were made in conjunction with current staff and in accordance with collated staff feedback. Clinical pathways for the new service were developed with the involvement of therapy, pharmacy and radiology teams and with the involvement of our Urgent Care Centre. Engagement with the voluntary sector enabled daily presence of the Red Cross and Care Navigators throughout the pilot project, facilitating links with community teams and expediting discharges.

Patient experience was a primary motivating factor for the team. Patient feedback regarding the previous service had highlighted that improvement was required regarding waiting times and communication. Detailed quantitative and qualitative surveys were distributed to patients using the previous service over a three month period before the service development began. Patients highlighted several aspects of the service in need of improvement and made suggestions for service redesign which were incorporated into the final model. As a result, patient experience during the EMU pilot was significantly improved, which in turn improved staff morale.

A standard operating procedure clearly defined the roles and responsibilities of each team member, allowing members of the team to work independently and increasing effectiveness of communication. A senior member of the team was present at all times during the pilot to collect real-time data including staff and patient feedback. This enabled immediate troubleshooting and the opportunity for staff to debrief.

Updates regarding the success of the pilot were communicated to the wider organisation through social media. A celebration took place at the conclusion of the pilot to show appreciation towards all members of the team. The project has been presented both locally and nationally, being selected as the winner of the Trust's

recent Transformation initiative. In addition, an article regarding the project has been submitted for publication. Ongoing work following the pilot seeks to formally embed the service model and increase awareness of the service among our colleagues in the community.

Dr Sarah Ramsey, Dr Lauren Wentworth,
Dr Helen Hurst, Dr Carole Farrell

The Emergency Multi-Disciplinary Unit (EMU)

University of Bolton
NHS
Manchester University
NHS Foundation Trust

BACKGROUND

Trafford's Ambulatory Care Unit was consistently under-utilised. In August 2018, an average of 4.8 patients per day were seen on ACU, and **in July 2019 the average was 5.4** patients per day

National standards for provision of same-day emergency care services were not being met (NHS England, 2019)

Length of stay on AMU was frequently prolonged, with reduced availability of beds for repatriation of patients

Audit of patients attending due to suspected DVT identified **failure to comply with NICE quality standards** (NICE, 2012, 2013)

Poor performance against Trust frailty standards

Staff experience rated poorly due to inadequate staffing and disorganisation

Patient experience was also poor, with **regular complaints regarding waiting times and communication.** Failure to meet patient preference for ambulatory care (Clark et al., 2009)

QUALITY IMPROVEMENT PROJECT

After consideration of the suitability of a variety of potential service models, it was decided to pilot an **ACP-led Emergency Multidisciplinary Unit (EMU)**

Patients referred by EDs, GPs, community matrons and outpatient clinics would receive a comprehensive medical, nursing and therapist assessment, same-day investigations, diagnosis and treatment plan with ongoing follow-up to avoid acute hospital admission

With the **involvement of therapy and radiology teams**, clinical pathways were developed to manage DVT, PE, anaemia, cellulitis and frailty on an ambulatory basis (NHS Improvement, 2016)

Engagement with the voluntary sector enabled daily presence of the Red Cross and Care Navigators

Data collection and analysis took place throughout the pilot; results of the pilot informed a Business Case for continuation of the service

REFERENCES

Clark M, Moro D, Szczepura A. Balancing patient preferences and clinical needs: Community versus hospital based care for patients with suspected DVT. Health Policy. 2009;90:313-319.

National Institute for Health and Care Excellence. Venous thromboembolic diseases: diagnosis, management and thrombophilia testing: Nice Guideline [CG144]. London: NICE; 2012 (updated 2018).

National Institute for Health and Care Excellence. Venous thromboembolism in adults: diagnosis and management: Quality standard [QS29]. London: NICE; 2013 (updated 2016).

NHS England. The NHS Long-Term Plan. London: NHS England; 2019.

NHS Improvement. Maximising Ambulatory Emergency Care Services. London: NHS Improvement; 2016.

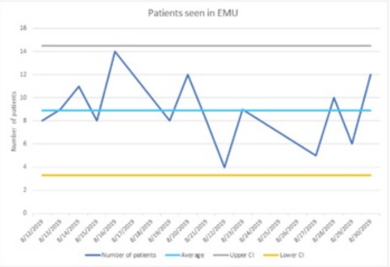
FUTURE PLANS

Embed pilot as 'business as usual' with ACP lead; review of AMU bed model

Promotion of the service across primary care, NWAS and re-ablement teams

Work towards provision of an acute frailty service for 70 hours a week as set out in the NHS *Long Term Plan* (2019)

EVALUATION



An average of 8.9 patients per day were seen on EMU during the pilot, an increase of **65%** on patients seen in ACU in July 2019

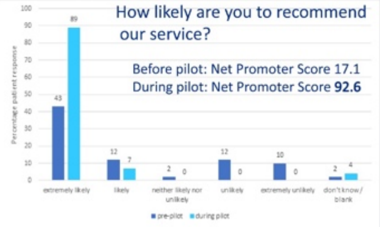
During the pilot, admission was avoided for 29 patients, all of whom would previously have been admitted to AMU

This included six patients managed on the ambulatory PE pathway, three patients on an anaemia pathway, two patients on a frailty pathway and 18 patients discharged on post-take to return for follow-up in EMU

There was a 30% reduction in length of stay on AMU during the EMU pilot

MFT Frailty Standards were maintained at **100%**

PATIENT EXPERIENCE



How likely are you to recommend our service?

Before pilot: Net Promoter Score 17.1
During pilot: Net Promoter Score **92.6**

> Lovely friendly efficient unit :)

We asked: Do you feel you were treated courteously and respectfully by the team?
Before: 88% Pilot: **100%**

> It's been amazing care from start to finish. Friendly, informative, helpful and efficient

> Fantastic staff, well looked after, excellent care!

> I feel the service here is fantastic, the care I received was brilliant

We asked: Were you given a full explanation of your treatment and follow-up plan?
Before: 76% Pilot: **100%**

Winner

Mental Health and Community:
Solent NHS Trust
Brooker Award for Dementia Services led by Patient Representative

The Brooker Ward team provides an inpatient facility for older patients with mental health illness, primarily acute dementia/ Alzheimers disease. This is a story of improvement work that has been led by a patient representative, supported by a clinical lead, but involved the entire team. We are nominating this team because of the way they have worked together with different staff groups, relatives and patients, using innovative approaches to ensure inclusion for those seldom heard (staff and patients) to improve patient care, experience and to change the culture of a service.

Mary's late husband died of Alzheimers Disease. After he died, Mary got involved in a number of research projects that were running in the service, and became a Patient Research Ambassador within our Solent Academy of Research & Improvement – she has since gone on to be a founding member of our Side by Side steering group, who give a patient/ carer voice to our strategic and operational objectives in the Academy. For example, they co-design our annual conference, run workshops on working in partnership with patients and plan annual engagement events.

Mary has continued her involved with our Older Persons Mental Health services, and became keen to run an improvement project that would directly impact patients and their families but also fit with the need of the service/ ward.

Working with Kate Legg, the lead therapist and Clinical Lead for Dementia, Mary suggested that one of the things her husband had struggled with was eating. His cognitive decline was such that he struggled to see the contrast between a white plate and food, and also tended to spill food – his nutrition was impacted. This was an issue that the ward were finding similarly challenging. The project was designed to include patients, their family members and all of the staff.

A number of QI approaches were taken – the aim was to improve the patient and family experience of mealtimes, and therefore nutrition. Focus groups were held with different staff members and family members. Staff members included clinical and non clinical staff, and importantly the staff in the kitchens and hostesses (people that will help to feed patients). Family members and , and families and staff members also observed mealtimes, ensuring all members of the team were involved not only in giving their views, but in collecting 'data' and making decisions relevant to their roles. .

A number of different plates were chosen for testing – differing in colour, weight and material. Again, ongoing feedback was taken from and by staff, involving them in change and the observations of mealtimes with patients. The evidence collated was clear: the colours of food presented and the colours of a plate would need to contrast in order to better support patients with dementia.

Through working together the team have been able to demonstrate coproduction practices and the implementation of the PDSA cycle. The '**P**lanning' of the project meant that Mary and the ward staff could work in a collaborative way in investigating various products. The '**D**o' aspect was evidenced in sampling the plate products on the ward with patients. The '**S**tudy' came in the form of asking patients for their opinions and personal preferences. The team subsequently '**A**cted' on the decision of patients and implemented their preferred choice.

The outcome of the project was the introduction of a blue rimmed plate. Observations showed improved eating and nutrition amongst patients, and improved experience for their families.

The kitchen and hostess staff have noted how they appreciated being involved and are engaged with using the plates – they have since ordered matching cups and bowls.

This sounds like a small project, but:

1. It has had a significant impact on the quality of care that is offered to patients, and on the experience of them and their families
2. It was initiated by a former family member of a patient
3. It involved a whole team –including those not normally involved, such as kitchen staff, porters, hostesses and volunteers.
4. It has led to lasting change and a spread in adoption
5. It has helped to bring the team together so that the entire ward is now engaged in QI. It has also shown that patients even with very impaired capacity can contribute to improvements in their care.
6. The story continues - Kate has become a QI leader to continue to drive QI with her team and with this patient group. One of the carers that was involved has joined another QI project as the carer expert, is on our QI training programme and is about to join our first QI patient leader training course. Mary and Kate are sharing learning from this at conferences.

Please do watch the film to see how the team have pulled together https://www.youtube.com/watch?v=ziDVJYrgVjw

Winner

Community and Other Organisations:

West Hampshire CCG

New Forest Frailty Model

The New Forest has the highest concentration of elderly patients in the country and a high number of care homes (56 care homes with 2,159 beds). This has huge impact on general practice and community staff and implications for secondary care. We know that deteriorating frail elderly people have better outcomes when they are identified earlier and cared for in their own home or residence.

In January 2016, an audit of the seven West New Forest practices showed that of 887 GP visits requested, 71.93% involved frailty.

Our ambition was to deliver a Frailty Model which reflects the natural communities and patient flows within the New Forest localities. This required integration across current service provision – acute, community, ambulance crews, primary, social and voluntary sector. The new model of care for frailty builds on current service provision with in the locality, is in line with national best practice guidance, and includes:

- 2-hour urgent care response
- Set up of three Frailty Support Teams (Lymington and New Milton, Avon Valley, Totton and Waterside) responsible for proactive and reactive care.
- Development of Multiprofessional Frailty Practitioners co-located from nursing, ambulance and re-ablement teams.
- Introduction of a robust induction programme to bring skills and competencies up to the levels required.
- Mechanisms to ensure proactive identification by “all” to ensure early input into those identified as either pre-frail or with frailty
- Each General Practice aligned to care / nursing homes to improve care with regular ‘ward rounds’ and advanced care planning in situ for the most vulnerable patients
- Rapid care provided as a positive alternative to admission – available seven days a week for up to a maximum of two-week period
- Staff and patients have been involved and have supported in the design and implementation of the frailty support team since its inception.
- A single point of access for advice, triage and intervention for those patients medically unwell or frail

This initiative has had a positive impact in a number of ways in the New Forest area:

- To date (since April 2018) 2,397 referrals have been received, 1,966 people have been supported to remain at home.
- The Hampshire County Council Frailty Reablement Team has supported more than 150 patients to remain at home safely.
- All patients have been supported on the same day and urgent assessments within 2 hours.
- Lymington New Forest Hospital utilisation increased by 308 patients (September 2019).
- The local health system acknowledge the impact of the Frailty Support Team through the increase in usage at Lymington New Forest Hospital and the number of people who have been referred with de- compensating frailty and subsequently managed by the Frailty Support Team.
- 17% of calls were referred directly by the ambulance service.
- The work of the Frailty Support Team appears to be impacting on the overall number of Non Elective activity into the acute trusts and is enabling growth to be below levels being experienced on a national level (3.8% growth compared to 5.7% nationally)
- £965,296 of savings have been achieved during 2018/19 and the project is on track to deliver a further £750,000 of savings in 2019/20.
- Improved access via a single point for advice, triage and intervention for patients and families
- Improved patient experience through the provision of a safe, clinically appropriate, dedicated alternative to acute hospital admission and support in remaining safely at home.
- Reduction in length of stay within acute setting due to a new model of health/ social care available to discharge patients home safely with appropriate community support.
- Staff have valued working more closely across organisation boundaries and share the single aim of keeping people safe.
- Satisfaction of staff working within the service has been positive and the multi-disciplinary approach cited as one of the key strengths of the team.
- Feedback from patients and/or carers has been extremely complimentary of the service and the level of support provided by the team.

The Frailty Support Service model is designed to be inclusive of all health and care providers, including all sections of the NHS, Adult Social Care and Voluntary sector organisations.

The model was piloted successfully following a full evaluation the learning has been used to inform expansion of the service into neighbouring localities.

Plans are in place to:

- increase the levels of referral activity to the Frailty Support Team
- increase the support given to care homes
- develop the interface to secondary care to enable the frailty team to accept referrals from the same day emergency care (SDEC) unit

Commissioners and providers are also looking at the potential to increase the scope of the service by harnessing the opportunities provided by digital transformation – such as a single shared health record, Skype and EMIS licences for members of the wider frailty team so they can update patient records (with the necessary IG consents).

West Hampshire CCG submitted a video alongside the above.

Finalist

Acute:

Homerton University Hospital NHS Foundation Trust

Get Hackney Talking! Speech & Language Therapy Team

Homerton Hospital's Speech and Language Therapy (SLT) team have a clear and inspirational vision – to Get Hackney Talking. Speech, language and communication skills are fundamental building blocks for life and without the adequate support for communication difficulties at the right time, children are at risk of long term consequences such as poor academic achievement, mental health difficulties and poor life outcomes.

The team of 75 SLTs in Hackney work with children and young people across the borough to ensure that every child reaches their full communication potential. The Speech and Language service enables good outcomes for children– 96% of children and young people fully or partially meet their therapy goals after a block of intervention and over 90% of children, parents and staff say that they are satisfied or very satisfied with their child's care, and that speech and language therapy has made a difference.

Despite these extremely positive outcomes, the NHS staff survey 2017 and 2018 indicated that staff felt they were not able to provide the care they aspire to and they were not satisfied with the quality of care they provide. Staff also indicated that they find it difficult to meet the competing demands at work and they frequently come into work when they are unwell, or work over their allocated hours.

This feedback was taken very seriously by the Speech and Language management team and the NHS Staff Survey was a real wakeup call. We knew from Michael West's work that the staff engagement and wellbeing was vital to shape the quality and experience of care for our clients. This provided the extra impetus for change, and we were committed to using the staff survey as a catalyst for improvement.

Communication with the whole staff team was prioritised throughout, the staff were aware of the manager's commitment to action and a Wellbeing Working Group was set up. Focus groups and surveys enabled staff to be given a voice, and a clear role in the project. As therapists, the team were already skilled in self-reflection and solution–focussed discussion and out of this strong foundation grew a shared responsibility for the project, as well as a strong understanding that an engaged staff team who are enjoying work is essential for good patient care.

Workforce data was showing that vacancy, turnover and sickness rates were all increasing. In particular, real time sickness data (both numbers of days and reasons for sickness) was a clear confirmation of the qualitative feedback being shared about staff wellbeing. Taking a Quality Improvement approach we started regularly collecting data and feedback from staff about their enjoyment and wellbeing at work, as well as frequent feedback on wellbeing initiatives that each team tried and tested.

Engaging staff in gathering and implementing ideas was complimented with leadership and ethos from the managers that staff were highly valued and their wellbeing was a priority. This dual approach built a culture of trust within the team and is reflected in the project's Driver

Diagram. Weekly surveys were analysed and change ideas were implemented. The working group meets every 6 weeks to discuss progress and plan next steps. Weekly emails celebrate progress and Whole Team meetings each quarter enable wider celebration. Social media (primarily Twitter) is also a great way of connecting with other wellbeing projects and celebrating progress.

Improvements have ranged from notice boards displaying health and wellbeing tips, to social events, shared lunches and lunchtime activity sessions. Resilience training and support for managers has also built skills and knowledge. The changes made have not been costly or difficult to implement but the improvement in staff wellbeing has been significant. Sickness rates have also decreased.

Organisation-wide forums and connections have enabled good practice in other teams to be learnt from and adapted. Learning from the SLT team has also been shared across the division and in wider networks within the Homerton and beyond.

Improving the wellbeing and enjoyment at work of staff has led to a happier and healthier team. Simple changes and a forum through which to raise concerns have enabled staff to concentrate on what really matters to them – making a difference to children and families in Hackney. By listening to one another and working effectively together as a team, the Speech and Language Therapy service at the Homerton can continue to Get Hackney Talking!

“Our Speech and Language Therapists have been outstanding this year and children with special needs have made real progress because of the work that the team have been doing. They work well together, they have built great relationships with staff and parents and have made a real difference at the school” *Head teacher at a Hackney School*

Homerton University Hospital NHS Trust submitted a video alongside the above.

Finalist

Acute:

North Middlesex University Hospital NHS Trust

Listening into Action Team - Caterina Raniolo

The Listening into Action (LiA) Team has demonstrated excellent teamwork in successfully leading the Listening into Action programme at North Middlesex University Hospital (North Mid). It has resulted in high staff engagement and participation with staff-led improvements in their departments.

This was achieved by having:

Clarity around team roles, responsibilities, tasks and vision

The team's vision was to increase staff engagement to implement staff-led changes that would improve patient care, services and staff experience. In order to ensure a successful programme, the team clarified their roles and responsibilities:

- Caterina Raniolo, the programme manager, oversees the programme, identifies and supports project teams, facilitate workshops, coordinates the day-to-day activities to achieve progress and reports to the Senior Responsible Officer
- Ella Schiavone, the programme support officer, is responsible of the administrative tasks
- Sumit Wadhia, the communications and engagement manager, is responsible for the design and delivery of the communication plan inside and outside the organisation.

Clear articulation of the skills they each bring and contribute to enable them to achieve their shared purpose and how they meet regularly

One of the strengths of this team is the diversity of each team member and their different skills that each of them bring.

Caterina, the programme manager, has extensive experience in quality improvement methodology and its implementation in NHS Trusts. She is a midwife and this front line experience gives her the ability to really understand the issues that clinicians face and uses this knowledge to help them find practical and sustainable solutions. She also very visible around the hospital, and uses her extroversion to her advantage.

Sumit, the communications and engagement manager, has worked in communications for a number of years. He used his knowledge to make the communications strategy and engagement campaign people-focussed, by putting staff who have been making the improvements at the forefront, which has created a snow ball effect in further engaging other staff.

Ella, the programme support officer, has worked in various administrative roles at North Mid for over 13 years, including in health records and as a patient pathway coordinator. This means she has direct experience of the frustrations that staff on the shop floor experience on a daily basis and uses this to engage and encourage them to lead the changes that they want to see.

The team meets weekly and begins by sharing good news to start the meeting off on a positive note. They talk through the priorities for the week as well as identifying any support they might need from each other in order to achieve a priority.

Team objectives identification

The vision has always been clear: to increase staff engagement to implement staff-led changes that would improve patient care, services and staff experience.

The objectives to deliver the vision were well defined from the outset of the programme and included:

1. Encourage participation of the Listening into Action Pulse Check to generate ideas to improve. Based on average NHS Staff Survey completion, the target was to achieve 35% response rate
2. Identify 10 project teams in different departments, including three trust-wide team projects
3. Organise and facilitate a workshop for each of the team projects to identify quick wins and improvement ideas
4. Monitor team progress, offer support where needed and help unblock any barriers that were impeding progress
5. Share and celebrate successes using different communication methods
6. Organise, promote and facilitate a trust-wide celebration event

Team members coproduction and partnership working with service users and other teams both within and outside of their organisation

The team uses the skills highlighted above to tailor the support for each project team and have worked in partnership with them to run successful projects. For example, our health and wellbeing project team wanted to promote their service provision to staff so the communications and engagement manager redesigned the provision of services available on the staff intranet to make it more accessible and designed a booklet that was distributed during each staff member’s appraisal.

Workshops were organised around staff so that as many of them had the opportunity to share their ideas as possible. This included finding suitable dates for teams well in advance, using existing team meetings, having drop-in sessions and going out to areas to talk to staff.

Beyond the walls of the hospital, there were two teams we worked with significantly to achieve our vision. The first team was Optimise (the company that own the Listening into Action brand), who supported us with materials, setting up the LiA Pulse Check and the analysis of the results. The second team was Healthwatch Enfield who helped one of our projects to improve patient experience.

Team measured achievement

1. Over 1600 staff members (51%) participated in the LiA Pulse Check and generated over 2000 ideas to improve. To put this into context, only 39% of staff completed the staff survey in that year.
2. 16 project teams came forward to lead changes in their areas and were enrolled in the programme. Team members included staff from different disciplines and levels of seniority.
3. 13 departmental and three trust-wide workshops took place with over 500 staff taking part.
4. All teams (16) successfully completed their improvement projects and this is evidenced by the high number of staff-led changes implemented (over 150).
5. Twenty articles were publicised on a range of channels, including the trust intranet, Facebook page, Twitter, CEO newsletter, road shows, posters and corporate publications, team briefings and emails.
6. All 16 teams showcased their improvement at the trust-wide celebration event that was standing room only. They used different methods such as presentations, posters and road shows.

This team has hosted other hospitals to help them understand of how North Mid achieved their successes. Moreover, they have been shortlisted in the Staff Engagement category for the prestigious Health Service Journal Awards.

NHS
North Middlesex
University Hospital
NHS Trust

Encouraging staff-led change at North Mid

Our vision

To increase staff engagement to implement staff-led changes that would improve patient care, services and staff experience.

Our objectives

The objectives to deliver the vision were well defined from the outset of the programme and included:

- Encourage participation of the Listening into Action Pulse Check to generate ideas to improve. Based on average NHS Staff Survey completion, the target was to achieve 35% response rate
- Identify 10 project teams in different departments, including three trust-wide teams
- Organise and facilitate a workshop for each of the team projects to identify quick wins and improvement ideas
- Monitor team progress, offer support where needed and help unblock any barriers that were impeding progress
- Share and celebrate successes using different communication methods
- Organise, promote and facilitate a trust-wide celebration event

The impact we had

- Over 1600 staff members (51%) participated in the LiA Pulse Check and generated over 2000 ideas to improve.
- 16 project teams came forward to lead changes in their areas and were enrolled in the programme. Team members included staff from different disciplines and levels of seniority.
- 13 departmental and three trust-wide workshops took place with over 500 staff taking part.
- All teams (16) successfully completed their improvement projects and this is evidenced by the high number of staff-led changes implemented (over 150).
- Twenty articles were publicised on a range of channels
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The team has been shortlisted in the Staff Engagement category for the prestigious Health Service Journal Awards.

Listening into Action

#NorthMidLiA

Finalist

Acute:
Royal Free London NHS Foundation Trust
The Frailty Journey Team

The Frailty Journey: more than just a study day

Background / patient focus

Barnet Hospital, a busy district general hospital in North London, joined the Acute Frailty Network (AFN) in October 2017. The borough of Barnet has a large, expanding population of older people living with frailty. One of the AFN's key principles is to *'put in place appropriate education and training for all staff'*. The Frailty Journey (FJ) was conceived to educate, inspire and empower others with the overarching aim of improving care for these vulnerable patients.

The Frailty Journey team

The core team comprises four consultant physicians: Dr Debbie Bertfield (Frailty lead, Barnet), Dr Shama Mani (Dementia lead, Barnet) and Dr Cliff Lisk (Acute and community physician), who are all geriatricians, and Dr Jo Brady, a palliative medicine consultant with a specialist interest in frailty. The complementary skillset and strong commitment to improving care for older people living with frailty has been central to the success of the project.

The study day

In October 2018, the team ran the first FJ study day. The experiences of a fictitious patient (Mrs B) are used to emphasise important, relevant examples of frailty management. Each lecturer starts with a clinical vignette and uses this as a vehicle for more general discussion. For example, Mrs B's first presentation is to the Emergency Department. This is then related to wider issues such as recognition of frailty and frailty syndromes. As she becomes increasingly frail, advanced care planning and end of life care are discussed. As a metaphor for Mrs B's increasing frailty, each lecturer removes blocks from a large Jenga set which tumbles at the end of the study day.
Using a fictitious patient has been described as *"practical and relevant"* in delegate feedback. All four members of the FJ team lecture on the training day with other invited speakers who sit on a panel to facilitate discussion with the audience at the end of the day.

The FJ team decided that inter-disciplinary training, involving primary and secondary care providers, was crucial to the success of the project. This closely aligns with the AFN's principle: *'strengthen links both inside and outside the hospital'*. In addition, all members of the multi-disciplinary team are welcomed, thereby ensuring an opportunity for networking amongst colleagues when examples of good practice and experiences are shared. One delegate reports *"the best thing was the interaction with secondary care colleagues".*

To date there have been three FJ study days with more than 200 delegates. The fourth is scheduled in December 2019. The feedback has been overwhelmingly positive, with the training described as “excellent”, “well-organised” and “relevant to daily practice.” Overall, 94% of delegates rated the sessions at 8-10/10.

Debriefing / regular meetings

The FJ team debrief following each training day to evaluate and act upon feedback received. For example, speakers now include a GP to provide a community perspective and an occupational therapist to discuss ‘Frailty at the front door’. This widens the appeal of the study day. Following more specific feedback, further training days to include the carer perspective (Mr B), ageing well with frailty prevention and more in depth discussion of end of life care are planned.

To ensure patient and public engagement, the FJ team has created a virtual patient and carer group to gauge opinion on the study day. Comments included *“the use of Jenga blocks is a brilliant visual way to show increasing frailty”* and *“the interactive panel discussion is an excellent way for professionals to meet, interact and develop relationships to provide joined up care”.*

The FJ team’s objectives are to:

a) Create frailty champions
b) Inspire others to ensure learning is cascaded
c) Evolve the study day using feedback from previous events

One example of how this has impacted others is the work of an orthopaedic physiotherapist who attended the study day. Empowered by the FJ team, she has educated her own team and a quality improvement project to improve frailty recognition on the orthopaedic ward is underway.

Working with teams within and outside Barnet

The FJ team’s work has extended beyond the scope of a study day. Within our Trust, we have encouraged and overseen the formation of an accredited frailty study day at Middlesex University for multi-disciplinary staff. The FJ was awarded a Trust excellence in education award. Inspired by Barnet, Kingston Hospital has run a FJ study day and we have had interest from other Trusts. Members of the team were invited to speak on a podcast: https://www.mixcloud.com/199Radio/playlists/we-remember-lives-the-hospice-biographers. The team have presented posters on the FJ nationally (BGS Spring meeting, Cardiff) and internationally (EUGMS, Krakow).

Mrs B’s frailty journey Moodle

The AFN / NHS Elect have provided strong support to the FJ team. The team has presented the study day at cohort launches of the AFN as an example of good education practice and the FJ team have been invited to run an education webinar for AFN members in November 2019. In October 2018, the FJ was filmed, and working closely with the team at the AFN / NHS Elect, a Moodle (online educational course) entitled “Mrs B’s frailty journey” was created (see attached video). Studio links were filmed with FJ team members and Professor Simon

Conroy (AFN's clinical lead). These discuss the issues highlighted in the FJ lectures and relate it to the national perspective.

The Moodle was launched and made available to all members of the AFN in October 2019 and to date over 150 members have registered.

Celebrating success and future projects

The success, enthusiasm and drive of the FJ team has encouraged further projects. The team have been invited to run a "Medicine for Members" meeting in January 2019 for local members of the public. The team recently met with both the Trust's Chief Executive and Medical Director who, now appreciating the importance of frailty, are considering it one of the key strategies for the Trust.

The FJ core team bring together different skills and have had an impact beyond that of a training day.

Royal Free London NHS Trust also provided a video in addition to the above.

Finalist

Acute:

Calderdale & Huddersfield NHS Foundation Trust

A Collaborative Frailty Service

The frailty service at Calderdale and Huddersfield has grown significantly over the last 3 years to meet the needs of our frail patients living across both localities. There has been significant investment each year with each investment exceeding the KPIs set.

A vision was developed at the beginning of the frailty journey and is always at the forefront of what we are all striving to achieve for our patients. The team revisit the vision together regular to ensure we are all still agreement and whether we needs to make any changes.

It is wonderful that we have increased the number of frailty patients seen, increased the number of admissions avoided, which has then impacted on frailty Length of Stay and Occupied bed days, but what is most wonderful is that we have completed a comprehensive geriatric on all of these patients timely. Working with the multi-disciplinary teams we are then able to plan their care whether that be home or in hospital. As our service has grown, so too has our collaborative working because we have continued to engage with key stakeholders and design acute, community, social, mental health and voluntary services to meet the needs of our frail patients travelling through all of our services.

The service is now assessing an average of 600 new patients a month all of which have a full CGA completed that travels with them through their journey. We are avoiding an average of 250 admissions a month. An MDT is held twice a day with key staff from all services to ensure us a good plan of care and the patient is cared for in the right environment. We push them boundaries and think outside of the box to make things happen. We don't accept that things can't be changed if it is the right thing for our patients. This enables us to care for an average of an additional 200 more patients at home a month that would have been previously cared for in a hospital bed.

We have thoughtful Thursday every week before the MDT where we celebrate a good patient experience over the past week and a patient journey that has not gone as well as could have done. This is a time to celebrate and share our good work but also learn and change what hasn't gone well. The learning identified is always shared and actioned and this ensures we are keeping it patient focused at all times.

There is monthly frailty meeting where key stakeholders attend from acute, community, social, mental health, ambulance, commissioners, project managers for acute and CCG in both localities. This is where we can really drive change and ensure changes that are close to each service can be made and pathways reassessed to meet the need of the frailty patients. Throughout the last few years we have reviewed services collaboratively and redesigned them to ensure the patient journey is seamless. The quorum is always excellent.

The team have now got rolling education for the staff across the areas and community but also enhanced education and training for the frailty team in line with a medical teaching plan. The frailty team members also work on QI projects and For example we looked at all our readmissions over a period of time last year and identified key themes such as advance care planning, communication and discharge letters, response from community mental health team and response from community services on discharge. From this review a readmissions summit was held with key stakeholders and the key themes are now under a QI project with some funding for some roles for Advance care planning. Mental health team is now integral to our team working alongside us and with a plan to be part of our frailty clinics in the community. Understanding why patients readmit but being considerate of the challenges other services face and again working together to support rather than being critical and working in isolation having the best frailty service across the area and not just in your organization is an important value to share.

Escalation process needs to have a prompt response in order for staff to continuously to make change to pathways and see this being actioned.

The frailty service has shown true innovation to drive change through working collaboratively as a team. The team are leading on QI projects and ensuring they keep it all about quality and patient experience to improve the patient journey

Please see video below

https://www.youtube.com/watch?v=J9uOc-1-0I0&feature=youtu.be

Finalist

Acute:
Imperial College Healthcare NHS Trust
Antenatal Big Room

Antenatal Big Room, Queen Charlottes and Chelsea Hospital (Imperial College Healthcare NHS Trust)

WHAT IS A BIG ROOM?

The Big Room idea originated in 1994 in the Japanese motor industry. In healthcare, it has been adopted as a regular, standardised meeting which provides time and space for staff and service users to come together and make Quality Improvement business as usual.

The Antenatal Big Room first convened in June 2018, and has been running weekly. People ask when the "project" is finishing and the answer is "Never!" Big Room is a way of working, rather than a "project". We have a clinical improvement coach (a Consultant Obstetrician) and a non-clinical improvement coach, both trained in improvement science and coaching skills to facilitate productive action amongst the team.

WHAT IS THE VISION FOR THE ANTENATAL BIG ROOM?

Early on in the Antenatal Big Room journey, we mapped out the macro- system of the antenatal pathway. This led us to our vision, which states:
"We aim to provide family-centred care and an excellent experience for women and families, that is consistently efficient, individualised, seamless, standardised, kind and responsive to changing needs."

We begin each Big Room with a "Patient Story", which can be from inviting a service user, an audio recording using a service user's own words, a complaint/compliment, or a team member describing a story. Stories help us focus on our vision.

WHO FORMS THE TEAM?

Anybody and everybody is welcome to attend the Big Room. Some people attend just to observe and contribute on the day. Most people come regularly so they can be active team members that can make actual improvements. The Big Room has brought together members of the Maternity Voice Partnership (a group representing service users), the local CCG, the Trust Communications team, the complaints team, the central booking office (who books all our first midwife appointments but till the Big Room had never met maternity staff as they are based on a different site), the ultrasound department, IT, PALs, business intelligence, security, community midwives, hospital midwives, doctors, managers, maternity support workers, admin staff and more.

We have every staff member, from Directorate leads to students, all entering the Big Room with equal voices, in order to share their viewpoints and ideas.

Our co-coaches have worked hard to make the Big Room inclusive, productive, and diverse, spending a lot of time on stakeholder engagement. The Big Room has developed a strong regular attendance of a solid, multi-professional team. About 10-15 members attend on a weekly basis (sometimes more).

HOW DO WE INVOLVE SERVICE USERS?

Members of the Maternity Voice Partnership sometimes attend in person. Sometimes, we invite women from the ward to participate.

We also have regular contributions from a group of service users through a Whatsapp group. They provide valuable feedback and help us sense check our processes. They also help us with information on our process mapping from their points of view (what we think happens doesn’t always happen).

Their involvement in the Big Room has directly influenced service re- design. For example, in designing our new Maternity Triage space, we received feedback that women would like out-patient inductions to be carried out there. This made sense to women because if they went into labour, they would be expected to go back to this area.

HOW DO WE MEASURE IMPROVEMENT AND KEEP TRACK OF OUR ACTIONS?

We define our global aims and specific aims, construct driver diagrams, and define outcome, process and balancing measures. We use both qualitative data and quantitative data in our PDSA cycles.

One of our global aims is to increase our numbers of women meeting our target for having their first midwife appointment before 10 weeks gestation, and to increase our numbers of women booked onto a continuity of carer pathway. This aim is very complex and has several more specific aims, to do with increasing ease of access to the service, decreasing Do Not Attends, improving miscarriage reporting, etc. One improvement idea was to launch an online self-referral form with all the relevant clinical questions asked in a woman-friendly way. We designed this form with multiple stakeholders and input from women, and our web team also included a translation option for women who cannot read English. We are measuring the success of the form through business intelligence tracking of the number of women using it to refer themselves, and the number of women who then are assigned an appropriate appointment with the appropriate team. We also have qualitative measures of success in the form of anecdotal patient stories. For example, on the day we launched our new form, we received a self-referral from a woman with mental health issues and complex social needs. This information was captured and the day after she self-referred, she was assigned her own caseloading midwife who contacted her and offered her an appointment two weeks later. This is a success story and one Big Room team member commented “this story literally has brought tears to my eyes because we have worked so hard to launch this form and it will make such a difference to women.”

WHY SHOULD WE WIN?

The Big Room philosophy incorporates all the principles of Michael West’s work. We always start the meeting with introductions and include “something that makes you human” (e.g. what made you happy this week? What “NHS problem” frustrated you this week? What are you doing this weekend?) – not only does this make it easier for team members to speak up during the meeting, it has helped us bond as a team and informs our work. We recognise that in addressing the daily “pebbles in our shoes”, we enable staff to find “joy in work”, and

that a joyful team is an engaged team. We practice improvement and reflection on every level and we end each meeting with a quick feedback on what went well and how we can improve our meeting.

Finalist

Acute:

Royal National Orthopaedic Hospital NHS Trust

Spinal Frailty Pathway

The Royal National Orthopaedic Hospital is a 220 bedded tertiary referral centre for orthopaedic surgery that deals with Spinal Cord Injury, Peripheral Nerve Injury, Sarcoma, Joint Reconstruction, Shoulder, Foot & Ankle and Spinal Surgery.

The Frailty project at the RNOH was developed to meet the various needs of our complex frail patients by offering sophisticated multidisciplinary team input, leading to a clear management plan and improved experience for these patients. This is a cross-divisional, multiprofessional team that has to work across boundaries for the benefit of the patient.

The core team is:

- Prasan Panagoda: Consultant Anaesthetist.
- Charlotte Pratt: Consultant Geriatrician.
- Gemma Bruce & Elena Bennett: Physiotherapists.
- Dawn Lewinson: Service Manager and Project lead.
- Mr Robert Lee: Spinal Consultant.
- Mr Sean Molloy: Spinal Consultant.
- Lucy Davies: Exec Lead.

The team developed a new pathway with multidisciplinary assessment, optimisation and prehabilitation to improve functional status preoperatively, in order to improve postoperative recovery. This is in line with recommendations from various organisations, including the Royal College of Anaesthetists “Fitter, Better, Sooner” programme. The aim of the new pathway is to improve frail patients’ experience and outcomes from surgery, in a holistic nature.

The work began with the multiprofessional improvement team ensuring that the process was well mapped and the proposed change cycles were well understood by all members of the immediate team, as well as members of the wider team.

A driver diagram developed at the beginning of the project honed in on effective communication and interpersonal working between members of the multidisciplinary team. It also led the team to develop a staged approach that aimed towards MDT pre-assessment, but that allowed key elements to be quickly and easily tested in PDSA cycles.

The challenge of the frailty project was well understood by the team as primarily about communication and process improvement.

With a clear and shared aim in place, the team has been meeting regularly to work on the problem and really understand the contribution that each makes to the patient pathway.

The team used Plan Do Study Act cycles to understand the impact of the changes and help the team engage other members of the wider care team. An initial PDSA tested the screening process for a limited time with a small number of patients:

- PDSA 1, Aim: to ensure all appropriate patients (listed for degenerative spine surgery, > 55yo) are screened for frailty in OPD using Rockwood Clinical Frailty Score

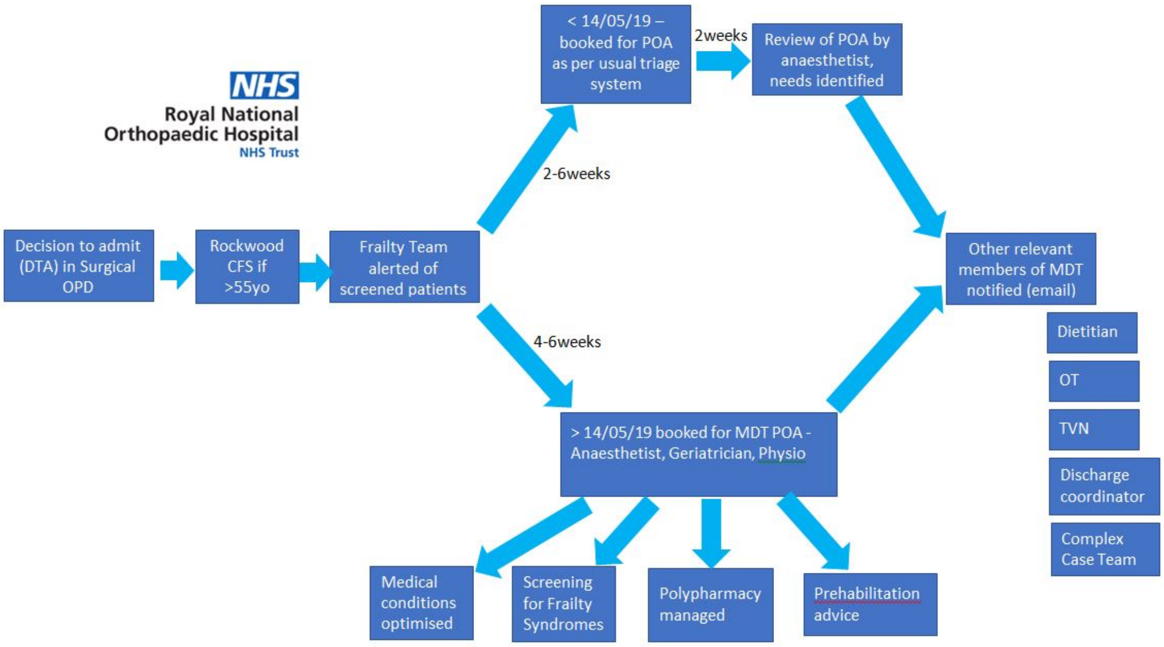
This PDSA helped the team understand the scale of the project, map out what resource would be needed and the role of each team member in delivery. The learning from this led to a second cycle which specifically tested the multidisciplinary team approach:

- PDSA 2, Aim: Frail patients identified through Rockwood CFS should have an MDT assessment from the Frailty Team

This PDSA began to gather information about the impact on patients, and allowed the team to understand the capacity issues that moving to the new model would have. It built evidence and addressed key concerns in a way that involved the whole team in the development and that could be shared with colleagues not directly involved in the PDSA. This has helped make the case to a greater number of surgeons and facilitate discussions in different departments.

The two PDSA cycles were applied to patients belonging to two RNOH spinal surgeons - Mr Molloy & Mr Lee. A member of the surgical team completed the Rockwood Clinical Frailty Score in the outpatient clinic. All patients identified as frail were then flagged on the RNOH information systems and the frailty team informed. These frail patients would attend a multidisciplinary pre-assessment appointment. At this appointment they were assessed by a consultant anaesthetist, consultant geriatrician and expert physiotherapists. They were provided with advice for optimisation of medical conditions, polypharmacy and falls, and given bespoke prehabilitation advice by the expert physiotherapists. They were also given two-weekly follow-up telephone calls by the physiotherapy team with modification of prehabilitation advice as required. Members of the wider MDT were involved where necessary (dietitian, TVN, OT).

A new process has been developed based on this learning and team approach:



This process has been applied to 100% of eligible patients, and 56% of those have entered the new frailty MDT pathway. On reviewing early outcomes of the new pathway, we believe that the MDT process has led to improved shared-decision making between members of the team, and most importantly the patient. It has put the patient front and centre of their proposed treatment, engaging them in their preoperative preparation and postoperative recovery. Feedback has been extremely positive – patients have had a much-improved experience of our service. Interdisciplinary working and communication have also vastly improved.

We have gathered patient experience using a national tool developed by NHS Elect. This has been sent to all patients on the pathway with follow up from the data administrator and to date 13 responses have been received from 33 discharged patients. On the three point scale 11 were happy with their admission and first assessment, and the other 2 scored at the midpoint. These two expressed worry about the procedure, and this links to the work we are doing prior to admission in helping patients understand what is planned.

We have also concentrated on understanding the patient journey from the patient perspective, developing a number of case studies that have helped us design the service.

For example, a 75 year old patient who was supported on this new pathway, who had a clear risk-benefit discussion with the anaesthetist and underwent a thorough assessment by the physiotherapist, with advice on how to improve his functional status. Following this process, he decided not to proceed with surgery as his level of function had improved and he couldn’t justify taking on the risks involved with anaesthesia and surgery given his improvement! He is now being conservatively managed, and is happy with his treatment choice.

Other patients have also fedback about their improved mobility preoperatively with an improved quality of life and a better chance of a swift recovery:

One very pleased patient progressed from using a walker to walking with only sticks for support during her prehabilitation:

The success of the team approach and the clarity it has brought to roles in the team can be clearly seen in the new Frail pathway at RNOH:

- the surgeon deciding that the patient requires surgery and promptly completing a Frailty screening tool
- the surgeon highlighting frail patients to the frailty team
- the administrative staff booking these patients an MDT pre-assessment slot
- the consultant anaesthetist, consultant geriatrician, expert physiotherapists as well as wider members of the MDT working in close conjunction to optimise the patient in every possible way prior to their surgery
- most importantly, the patient as a vital, central part of the multidisciplinary team, subscribing and engaging in their own surgical journey and recovery

Finalist

Mental Health and Community:
Lancashire & South Cumbria NHS Foundation Trust
Central Lancashire Moving Well

Central Lancashire Moving Well (CLMW) is a truly integrated service with co-production at its heart. The service consists of five specialties provided across two organisations with Lancashire and South Cumbria NHS Trust as the lead provider and Ascenti as the subcontracted provider. The team referred to in this submission is the entire service; subcontracted partners, patients and everyone within that team has a voice which is heard. The structures in place are robust and efficient, allowing for the two way flow of information and for everyone to input and feel valued. This is demonstrated with an engaged workforce, positive staff feedback and a low staff turnover. Multi-disciplinary working is key and is evident across the whole of the patient pathway; being part of an effective Multi-Disciplinary Team (MDT) means that everyone understands their own role and the role of others, and in turn the effect and impact of their input. The success of the MDT has been highlighted on numerous occasions, from team members understanding how to spot warning signs from a patient in an unfamiliar area of expertise to the ever-increasing positive impact on associated referral pathways. Communication is vital and our team of triaging clinicians regularly discuss referrals to ensure every patient is seen by the right person first time. Our triage team meet monthly to ensure the quality of referrals is being maintained and the triage process is running efficiently. There are weekly MDT meetings to discuss complex cases and if patients need to be seen by

another team within the service this is actioned. This has helped to streamline the patient pathway as previously the GP would have had to onwardly refer. A discharge plan is agreed with each patient and patients have access to re-refer themselves within a year of discharge, again helping to streamline the pathway for patients and primary care colleagues. The entire service comes together every quarter to share learning and good practice. The service recently celebrated its one year anniversary so the entire team had a team building afternoon. Part of that afternoon was a reflection of the successes from the first year and the response from the entire team was overwhelming with many of the comments relating to co-production and communication across the service.

What makes CLMW different is the drive and enthusiasm shared by the whole team to truly deliver a different type of service where the patient really is at the centre. The way in which CLMW put the patient at the centre is through the Shared Decision Making (SDM) culture which is at the heart of what we do. The whole team uses a “Solution Focused” approach to SDM which focuses on the patients’ hopes and goals and what they want to achieve from their journey. This provides clinicians and patients with a shared purpose and ultimately results in the patients being able to better self-manage their condition, thus reducing wider system pressures. All clinical staff receive training in Solution Focused Therapy and this is evaluated to identify actions for ongoing training and development and areas for improvement. Every staff member also has a SDM objective within their appraisal. In addition, the team carries out patient audits to ensure that the people receiving our care are also feeling the benefit of our SDM ethos. Every quarter, we ask 100 patients a number of questions about the care they receive to ensure that patients understand their health issues and to ascertain whether they feel that their clinician has understood and taken on board what matters most to them. The results are reviewed each quarter and additional comments are collated. The feedback received has been extremely positive. The audit tool we use is called CollaboRATE (designed by AQuA) which we have amended to include additional written feedback. The CollaboRATE tool asks patients to score how involved they felt in decisions about their care by asking a range of questions of which the patient can score their experience on a scale of 0-4. In quarter one, the service received an overall average score of 3.59 out of 4 and in quarter two this increased to 3.77 out of 4.

A key focus for the service is self-management and in order to effectively support patients to self-manage, the team has joined with third sector partners who support the clinically led patient groups that the team has implemented. This approach provides much appreciated support for patients who may need ongoing input, but not necessarily within a health care setting. The team is also looking to help facilitate additional patient led groups to further support our population. We already have this type of group for our Rheumatology patients and it is very successful and a great way to engage with our patients.

Service decisions are discussed at every level to ensure input from the entire team and the team also find ways to engage with service users for their feedback. The team is currently updating the CLMW website and patient literature and service users are regularly asked for their feedback on the information provided and its usability. A clear and robust governance structure ensures that decisions have clinical and operational input and collaborative working is held in high regard, with all team members respecting the views and expertise of others.

As highlighted throughout this nomination, the CLMW team share a joint objective to improve patient care and self-management through a shared decision making approach and culture; the impact of this ethos is demonstrated through the outcomes of the service and the values of the team. The attached infographic provides some additional supporting information about the way in which we work and aims to demonstrate the impact of our approach on staff, patients, performance and the wider health and care system.

"Grow the Team Grow the Individuals"

Service Ethos

What our team say about working here:

Feel we work well as a team which includes the patients as team members

Everyone is included in any decisions

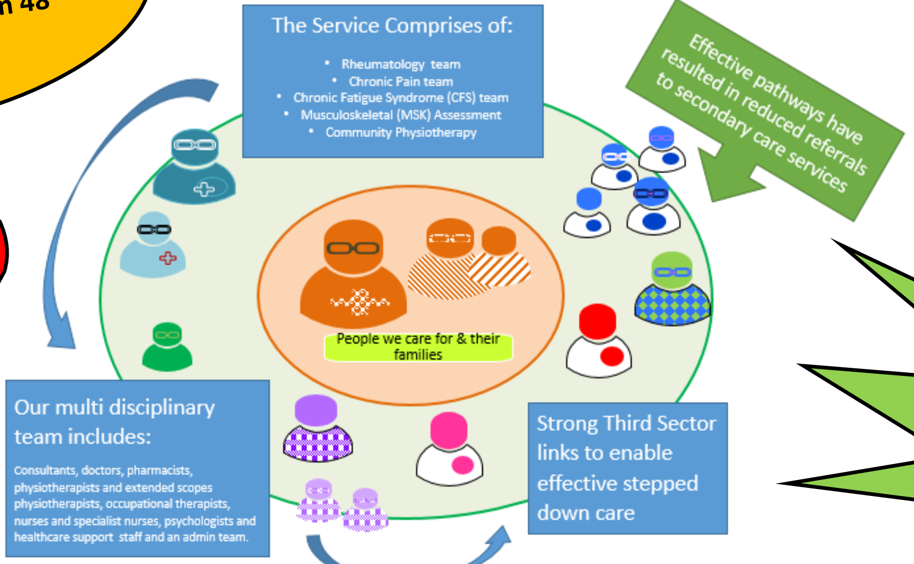
Good interaction with each other

No one feels that they are not able to speak freely

Low staff turnover and sickness absence rates

Working together means that we triage over 98% of patients to the right clinician within 48 hours of referral

Shared Decision Making at our heart



The Service Comprises of:

- Rheumatology team
- Chronic Pain team
- Chronic Fatigue Syndrome (CFS) team
- Musculoskeletal (MSK) Assessment
- Community Physiotherapy

Effective pathways have resulted in reduced referrals to secondary care services

Our multi disciplinary team includes:

Consultants, doctors, pharmacists, physiotherapists and extended scopes physiotherapists, occupational therapists, nurses and specialist nurses, psychologists and healthcare support staff and an admin team.

Strong Third Sector links to enable effective stepped down care

Find out more about us here: https://www.lscft.nhs.uk/central-lancashire-moving-well

What our patients say about their care:

Patients Told us We have…

Effective care pathways
entering the service – leaving the service

Joined up care …
"telling their story once"

"Friendly and helpful, nothings a problem. Keep doing what you're doing."

"I feel so lucky to live within 20 minutes of this fantastic specialist centre. Every member of staff is caring, knowledgeable and professional. Thank you for the amazing service!"

"Made my independence totally complete, all effort made"

What our partners say:

"Working in partnership with the wider CLMW team ensures patients are managed through the most appropriate pathway"

"Having a common goal to enable patients to manage their condition can only be achieved through the collaboration of all the teams within CLMW"

"Sharing practice across the CLMW team through peer review, joint meetings, shadowing of practice has improved knowledge across the team which improves patient management"

Our integrated pathways mean that we save over 100 Primary Care attendances each month

Finalist

Community and Other Organisations:
Pembrokeshire County Council
Joint Discharge Team

The Joint Discharge Team is an amalgamation of nursing and social care staff working together to facilitate safe discharge from hospital primarily; supporting individuals and patients in achieving their goals through joint working and assessing individual's needs holistically. The team has recently (over the past 12-24 months) expanded to support individuals post-hospital discharge through completion of timely reviews / Multi-Disciplinary Team meetings in order to ensure the best outcome in line with the individual's wishes and feelings is achieved.

The team are conscientious of boundaries, timescales, pressures and various processes and procedures and work together throughout the day on a daily basis to work within these aspects, whilst working to achieve the most appropriate outcomes for the individual themselves to promote their voice, choice, wishes and control alongside their independence and right to different services / funding streams including continuing healthcare and social care funding where appropriate.

Although not officially part of the Joint Discharge Team, Occupational and Physiotherapy teams regularly work closely with the team to support and enable the same unified goals as stated above. The team covers both the acute and community hospitals and designates a minimum of one discharge liaison nurse and one social care worker to each ward or hospital. Both these members of staff in each area work closely together, utilising individual skills and training to work towards the most appropriate colleague acting at the 'right time'.
You could call these 'sub-teams' within the Joint Discharge Team where between 1-3 members of the team work extremely close together at all times and continue to feed into the larger team on a daily basis.

The joint working approach used within the team has proved successful in positive and rapid outcomes being achieved in line with the individual's wishes and feelings; alongside challenging times such as hospital pressures and service changes that arise. Team members have full respect for one another's roles and remits however, all will regularly work 'above and beyond' to support their colleagues even if this is out of their own role's job description or expectation.

The objectives of the team can be measured and monitored regularly through the hospital discharges which are monitored closely by the team itself and the organisation. The impact of how the objectives are achieved is monitored through close monitoring through re-admissions; working within the community in attending regular Community Resource Team meetings – these are held across the county within multiple GP surgeries which the team has a presence in each to link the hospital working and information with the community services. The impact is also monitored through reviews undertaken by members of the team post-discharge to measure the intervention's goal achievement and services provided to ensure suitability.

Feedback received from community services such as GP surgeries is that the input from the Joint Discharge Team in the Community Resource Teams is beneficial and supports the varying MDT members with valuable information of the individual’s time in hospital, along with any discussions, assessments or services that were had / arranged during hospital admission.

The team will sit together at the end of every week at 3.30pm called “Tea at 3.30”. This gathering involves all team members reflecting on the week and discussing positive and any negative experiences team members may have had. Part of this discussion includes appreciative enquiry where all members will be listening to individual colleagues discussing ‘what has gone well or positively this week’. Through this discussion we all endeavour to support and congratulate one another and when needed provide support and advice to one another to aid in moving forward. This weekly discussion will include celebrating the team’s successes as well as individual team members through encouraging the sharing of these successes and ensure to reflect on these. The team will often use humour and applause to aid in commemorating the successes of the team and the individual team members. This regular meeting has become somewhat of a ‘treasure’ within the team, with other colleagues outside of the team expressing positive feedback and can see the positive impact this has on the team as a whole as well as the outcomes the team achieves and the individual well-being of team members.

Paul Thomas Perseverance Award

Winners

Acute:

Royal Surrey NHS Foundation Trust
Acute Frailty Team

The judges commented; "Brilliant project, over two years of focused work to transform care for patients with frailty and a true QI approach to demonstrate improvement."

Mental Health and Community:

Oxleas NHS Foundation Trust
Greenwich CAMHS Generic Pathway

The judges commented; "Great use of PDSAs and of staff and family engagement and real results in a truly important area."

Community and Other Organisations:

Hertfordshire Community NHS Trust
Always Event End of Life Care

The judges commented; "Fantastic project supporting families at a difficult time, with lots of evidence of trying new ways of working and involving staff in change."

Finalists

Acute:

Northampton General Hospital NHS Trust
QI in Infection Prevention and Control

Weston Area Health NHS Trust
Geriatric Emergency Medicine Service

Mental Health and Community:

West London NHS Trust
QI for West London & Safety Huddles Project Manager / QI Coach - Jenni Guest and Emma Brown

Community and Other Organisations:

Southern Health & Social Care Trust (Northern Ireland)
ACCESS Craigavon Area Hospital

Winner

Acute:
Royal Surrey NHS Foundation Trust
Acute Frailty Team

The Acute Frailty Team (AFT) has continuously improved its' service for over 2 years with the aim of reducing the amount of unnecessary time older people needed to spend in hospital.

In 2017, older people living with frailty were poorly identified in the Emergency Department and there was no standardised comprehensive geriatric assessment (CGA). Over 75s were more likely to breach and fewer than 20% were discharged from the Emergency Floor (24 per week day 0 and day 1 admissions). 40% of the acute medical take included older people living with frailty and yet the front door liaison service only managed 3 new patients per day. Variation in referral to the liaison team compounded poor quality and Hospital performance through unnecessary admission, protracted length of stay (LOS- 16 days mean and 14 days median on the Older Peoples Unit) and exposure to hospital acquired harms. Patients living with frailty would often be managed outside older people's wards or as a medical outlier in surgical beds (75% of >75s in outlying wards had markers of frailty). The Department of Ageing and Health created a vision for an integrated pathway to support older people in the acute care setting. The following entry describes the improvements in quality and flow for older people living with frailty and the methodology used on this continuous improvement journey.

The programme of work began in May 2017 when the Trust became part of cohort 4 of the Acute Frailty Network (AFN). The team combined the 10 AFN principles with the 'Big Room' approach adapted by the successful Flow Coaching Academy and from the Toyota Production System. Existing processes were mapped, problems were generated and the team gained understanding of measurement for improvement through statistical process control. This enabled stakeholder ownership of measuring the impact of their own changes. The weekly 'big room' had a standardised agenda including patient stories, a QI tool or technique, reviewing tests of change through PDCA cycles, the project plan and measurement.

Within 3 months, resources were reconfigured to create an AFT including Geriatricians, therapists and two specialist nurses. Improvement focussed on identification in ED and early CGA. A standardised CGA tool was developed and is still evolving. The team soon began managing all patients with markers of frailty in the emergency floor, including a morning post take ward round of new patients. By November the team realised it lacked a short stay facility to compliment on-going CGA. A 16 bedded general medical ward was transformed in 6 weeks to become the Older Peoples' Short Stay Unit (OPSS). Patients with an estimated discharge date of within 72 hours were transferred to the unit.

The impact of improvement work at the front door reduced time in ED by 19% (4.4 to 3.6 hours) and increased day 0 and day 1 discharges by 22%. The conversion of a ward to OPSS reduced mean LOS by 48% (14 to 7 days) and median LOS by 51% (10 to 5 days).

Weekly discharges increased by 184% (from 5 to 14). Trust wide median LOS in >75s was reduced by 24% (4 to 3 days) and mean LOS was reduced by 14% (9 to 7 days). This has been sustained over 2 years and reduced the amount of unnecessary time older people spent in a Hospital bed by 40,000 hours per year. Return on investment through bed day reduction is estimated at an annual saving of between £520,486.72 and £1,937,789.36. Crude mortality in >75s was reduced by 0.9%. The number of older people managed as outliers in surgical beds was reduced by 33% (Average 14 to 9), keeping a surgical ward shut at a cost saving of £1M.

The Big Room continued in 2018 and new work streams were developed. The Older Peoples Unit (60 beds) project focussed on prevention of deconditioning and standardisation of unit processes. Mean and median length of stay on the OPU were reduced by 14% (mean from 16 to 14 and median from 12 to 10). Patients, carers and relatives were engaged through experience based design. This tool uses a series of emojis to capture patient's feelings (happy, sad or indifferent) in certain clinical situations. Categories scrutinised include being admitted, initial assessment, comfort, communication, treatment, hygiene, dignity and respect and preparing to leave hospital. This then generates an emotional map to help the team focus on areas for improvement highlighted by actual patients. The team also engaged with Healthwatch Surrey to find out more about older people's expectations and experiences of being discharged from hospital. Healthwatch visited the OPU twice and used an online survey to gather views. A nurse led project to standardise our discharge processes led to improvements in the emotional map generated by patients.

The AFT continued to test changes and learnt from failure as much as success. ED in-reach ambulatory care projects failed but there was learning to help inform future projects. In 2018 the Trust joined the NHSi Vital Signs programme which attempts to embed Lean QI methodology within the organisation. The AFT adapted and in October 2018 led a week long system wide stakeholder event mapping and end to end pathway for patients living with frailty. This informed the integrated care and frailty transformation programme. 4 members of the team were part of the inaugural Quality Improver training week in May 2019 using the A3 approach to tackle problems.

OPSS became the Acute Frailty Unit in June and the team focused heavily on improving continuity of care and standardising processes such as board rounds. This redesign has led to 100% increase in daily discharge (2 to 4), increase in 0-3 day LOS from 30% to 50% and reduced median LOS from 4.89 to 3.0.

In the coming months, team leaders will undergo training in the 'kata' with the aim of embedding QI into daily work. In winter the AFU will be extended to include a dedicated ambulatory facility for older people as the AFT enters its' third year of continuous improvement.

Winner

Mental Health and Community:
Oxleas NHS Foundation Trust
Greenwich CAMHS Generic Pathway

Greenwich CAMHS Generic Pathway team began their quality improvement (Qi) journey in August 2018 at a team away day. During this day, colleagues expressed concern about waiting times and decided they would like to explore this problem using a Qi lens. The team felt waiting times in this service was an acute problem and they were passionate about trying to make an improvement.

A project team consisting of an Art Therapist, Administrator, Clinical Psychologist, Nurse, Team Manager, Psychiatrist and Psychotherapist was formed and the Qi Project commenced in October 2018.

With support from a Corporate Qi Lead, the project team started by exploring and understanding the problem of wait times in the Greenwich CAMHS service. This exercise uncovered long standing waiting list issues with an audit indicating that the times people waited was variable from one month to one year and on some occasions people became lost in the system. Patient Experience feedback was generally negative and themed around a service that was hard to access with long waits and that once you had received an assessment, there was another significant wait to follow.

"*It's a difficult and frustrating service to be able to access…especially when you're living it and you know your stress levels are at the highest anyway because you're dealing with these issues, for it to be so difficult to get help, it's quite upsetting" - Parent*

There was an overwhelming passion and sense from staff involved that something had to happen and this problem had to be solved. The project team however encountered a massive hurdle that threatened to derail the project before it even got started. When initially exploring the problem it was found that the database held by CAMHS concerning assessment to treatment times was fundamentally flawed and it took six months of perseverance by the CAMHS teams to fix it. A Junior Doctor reviewed 400 waiting cases and this was used to develop a new database. A quality assurance measure was also added in (rota for senior staff to check the database monthly) to ensure the new system is maintained over time. This whole process was demoralising for staff but they persevered and did not give up!

The project team adopted the Model for Improvement (MFI) approach to help them arrive upon a project aim and to carry out a series of small scale tests of change ideas using PDSA cycles. Their project aim is for 95% of children and young people to start treatment within 120 days of assessment by December 2019. Baseline data indicated that the median average number of days on the waiting list before onset of this project was 231. The team wanted to reduce this wait time by 48%.

Thirty possible change ideas were identified in the first instance and the team voted for the first three to be tested using PDSA framework. These were those that they thought would have high impact but would be relatively easy to test – 'low hanging fruit'. Following these initial

PDSA's the following changes were implemented: the duty clinician role was streamlined and clarified, the internal referral criteria was clarified with other CAMHS teams, part of which involved ensuring treatment modality was identified by teams referring in to the Greenwich CAMHS Generic Pathway. The positive affect of these changes were evidenced in the outcome measure (please see attached poster).

A large scale patient experience structured interview was designed and completed as part of this project. Six parents/carers and five young people were interviewed to ascertain their experience of the waiting times in this service. This feedback was used to inform the change ideas, further develop theory of knowledge and gain valuable insight into the experiences of those accessing the service. Staff found this feedback moving and further propelled staff enthusiasm for this project.

The next change idea identified for testing involved enforcement of the current DNA policy. The team felt that reducing DNA's would help positively affect the waiting list. The project team tested this out by adding DNA's to team meeting agendas and by including it as a standing agenda item in supervision sessions – to ensure that the policy was being implemented. Staff feedback in the 'study' part of this PDSA was that it was a painful and wholly uncomfortable exercise and the process measure data detailed that in fact, it was not working to reduce DNA rates. Further, staff felt uncomfortable that the people who generally did not attend appointments were the higher risk families and those who needed the support the most. As a result, staff were not enforcing the DNA policy and the change idea was discarded.

The next stage in this Qi project involved the team turning their attention to care plans. Staff reported they were spending 4-5 hours per week writing or updating care plans and they felt they were not as meaningful as they could be. The project team felt that if the amount of time spent writing care plans could be reduced, that would release more time to see service users.

Shamara, a nurse who is the CAMHS Team Manager used to work in adult mental health (AMH) services. In these services, a care plan form in RiO called 'my care plan' is traditionally used. The team decided to learn from the success of 'my care plan' in AMH and test to see if it could be adapted to work in CAMHS to make the care planning process more time effective with the end result being more meaningful. This PDSA is still in the 'Do' phase but anecdotal feedback is that staff find it less time consuming and are happier with the end result.

This Qi project remains on-going and change ideas continue to be tested with text message reminders to help reduce DNAs being next on the list.

Data, detailed in the attached poster in a run chart, shows a 'shift' which is indicative of a fundamental change to the system, beyond that of chance. So far, waiting times have reduced by 26%.

Greenwich CAMHS Generic: Reducing Waiting Times

Project Leads:
Dr Shahana Hussain:
Consultant Psychiatrist
Shamara Bailey:
Team Manager

Project aim:

95% of children & young people to start treatment within 120 days of assessment by December 2019

Reasons for project:

- Long standing situation where young people experience long and highly variable waiting times.
- Reduce crisis presentations while young people on waiting list.

What we did:

- **Clear data set** - initially it was unclear what our wait times were. This Qi project gave us the opportunity to fix these issues.
- **New version of our care plan** – the previous version of our care plan was time consuming and clinicians felt it wasn't helpful for young people. We replaced this with a simpler more goals orientated care plan.
- **Clear role for duty clinician** – Our duty clinicians now have reduced responsibilities, and fewer issues come up because young people spend less time on wait lists.
- **Internal referral criteria** – internal transfers from other CAMHS teams must now identify treatment modality.

Future plans:

- **Text message reminders** - the team initially tried to reduce DNAs by enforcing the already existing DNA policy (for low risk cases 2 DNAs = discharge). However the team found this difficult to adopt due to cases that DNA often being the most chaotic and risky cases. Instead we are trying to improve engagement by introducing text message reminders.
- **Patient contracts** – to help manage patient expectations at beginning of therapy:
    - 3 initial session then a review on the 4th before proceeding with further sessions
    - Therapy will focus on agreed goals

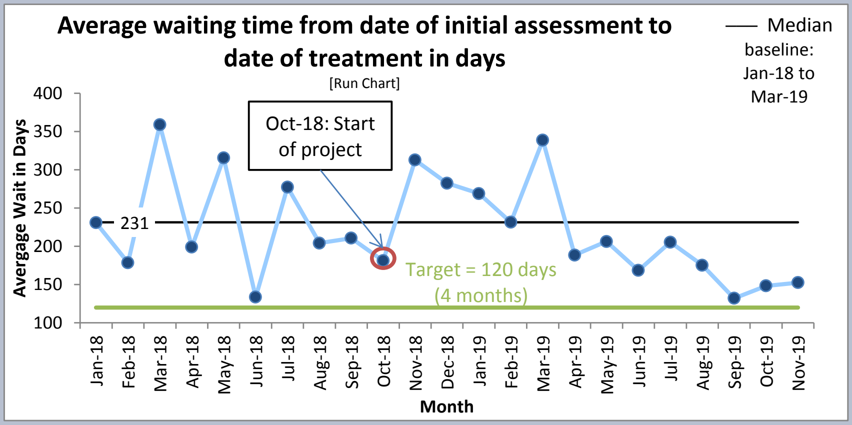
www.nhselect.nhs.uk

theox.oxleas.nhs.uk/Qi

Driver diagram

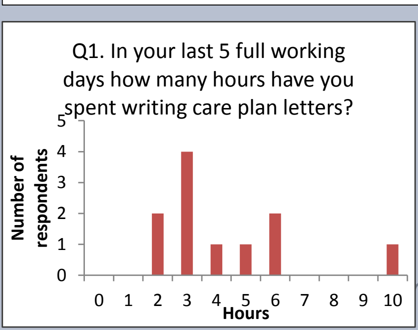
Aim	Primary Drivers	Secondary Drivers	Change Ideas
95% of children & young people to start treatment within 120 days of assessment	Capacity	DNAs	Text message reminders
	Demand	Triage consistency	Patient contracts
	Throughput	Clear formulations	Treatment groups
	Triage	Reducing work of low value	Better care plan
		Duty Tasks	Reliable data
			Clearer duty clinician role

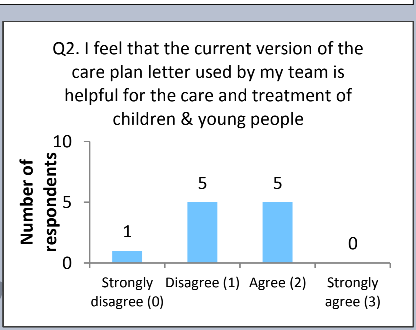
Outcome Measure Results



Care Plan Survey

Before we changed our care plan we ran a survey to get a baseline of how clinicians felt about the current version. Now we have introduced our new care plan we plan to rerun this survey.





Winner

Community and Other Organisations:

Hertfordshire Community NHS Trust

Always Event End of Life Care

Ruth and I have worked hard to embed the Always Event methodology and approach. Our Always Events focus on improving End of Life Care and the experiences of Carers. Working on delivering what matters most to our patients, their families and carers has challenged us to take a different and more measured approach in partnership with them.

We have tried and tested a number of different approaches throughout our Always Event journey, learning from things that didn’t work and those that did.

One learning example was adapting the Systm1 Core Assessment template at the suggestion of community nursing staff to ensure we could record that what matters most is being provided. It had initially been suggested to trial a paper form to record the Always Event which community nursing staff told us was not practical and complicated the process. We learnt the importance of continually involving staff, giving them the opportunity to provide different ideas and feedback. This turned out to be a simple and effective change, but not one that we would have readily thought of without the input from community nursing staff.

Another example from the testing phase includes the realisation that the information we were auditing was recorded in 2 separate forms of patient documentation. We had only been looking in one area so this resulted in a change in our process to accurately capture the data. In addition it uncovered a discrepancy in the operational definition of the carer handbook on the discharge checklist resulting in staff not recognising this as the information they had provided to carers and therefore not recording this. This was changed for the second PDSA cycle.

Ruth and I are Always Events buddies and have used this opportunity to speak with other buddies who have been on the Always Event journey to understand what worked well for them, and their learning.
We have also shared our learning and experiences with other organisations to help them on their journey. I presented with a colleague at national cohort launch day and as a consequence was approached by an organisation keen to carry out an Always Event for End of Life Care, and understand how we approached this.

The following sustainable improvements have been made so far to improve outcomes for patients, their families and carers:

- Increased number of carers accepting referral to Carers in Herts to access carer support and information
- Increased number of carers interviewed who report being involved in care planning and discharge of the patient they care for in the Always Event pilot site
- Addition to the Systm1 Core Template to accurately record that End of Life Care patients understand why they are being visited, by whom and how they can contact the service day or night

- Using existing ‘read codes’ available, monthly reporting implemented to measure number of core assessments where End of Life Care Always Event has been followed and recorded
- Positive feedback from staff and patients, their families and carers following PDSA approach about the End of Life Care Always Event

Ruth and I have engaged and involved patients via:

- Always Event working group (carer and patient representation)
- Visit to End of Life Care community clinic to understand what matters most to patients
- Short telephone and paper surveys to understand what matters most to patients, their families and carers

We have persevered to increase the understanding of the quality improvement approach through the Always Events, and have worked hard to maintain enthusiasm and celebrate the improvements that have been made as a consequence.

Finalist

Acute:

Northampton General Hospital NHS Trust

QI in Infection Prevention and Control

Background

This quality improvement project was conducted at Northampton General Hospital NHS Trust, a district general hospital in the heart on England that has 750 beds and serves a population of 380,000. In order to maintain good standards of quality of nursing care, the wards have an Assessment & Accreditation process to provide the best possible care for patients. There are 15 standards, of which standard 5 is Infection Prevention & Control (IPC), to protect patients from developing an infection in hospital.

In July 2018, 17 out of 22 wards scored red for standard 5.
Therefore data collection commenced in January 2018 and continues today. The aim of this project was to reduce the number of wards scoring red for standard 5 IPC, in Assessment & Accreditation, by 40% from the July 2018 baseline of 17, by September 2019.

Method

To improve IPC practice at the hospital, 5 PDSA cycles were implemented:

1. PDSA 1 – Monitoring quarterly themes at the Infection Prevention Operational Group and Steering Group meetings – although this PDSA didn't affect a change as such, it enabled to project lead to identify issues in practice and informed subsequent PDSA cycles that aimed to address these issues.
2. PDSA 2 – IPC Nurse walkrounds with the ward managers – again this PDSA didn't instantly lead to a reduction in the number of ward that scored red for their IPC element of the Assessment & Accreditation, but doing this highlighted the lack of IPC knowledge demonstrated by ward teams and so informed PDSA 3.
3. PDSA 3 – infograms, posters and 'hot topics' information sheets
4. PDSA 4 – the project lead contacted other IPC colleagues in other hospitals to understand how they utilise the green 'I am clean' stickers as there was a lot of inconsistency and lack of clarity around these. Understanding how different hospitals used them gave the IPC Team the confidence to develop a standard operating procedure for the use of these stickers in the hospital by adapting the good ideas of colleagues to improve this element of standard 5.
5. PDSA 5 – update the hand hygiene policy to include datix of staff who are repeatedly non-compliant

Impact

This project was hard work and took a long time to affect a successful change, however there are now 9 red wards. Using a QI methodology, IPC practices were ultimately improved. Despite early delays in achieving the aim, through withdrawing PDSA cycles that did not work and sharing ideas from IPC colleagues in other hospitals to affect change, the aim was exceeded. This project has enhanced patient care by protecting patients from infection.

Improving quality – going green in standard 5

Background

At Northampton General Hospital NHS Trust, wards have an Assessment & Accreditation process to provide the best possible care for patients. There are 15 standards, of which standard 5 is Infection Prevention & Control (IPC) – to protect patients from developing an infection in hospital.

In July 2018, 17 out of 22 wards scored red for standard 5.

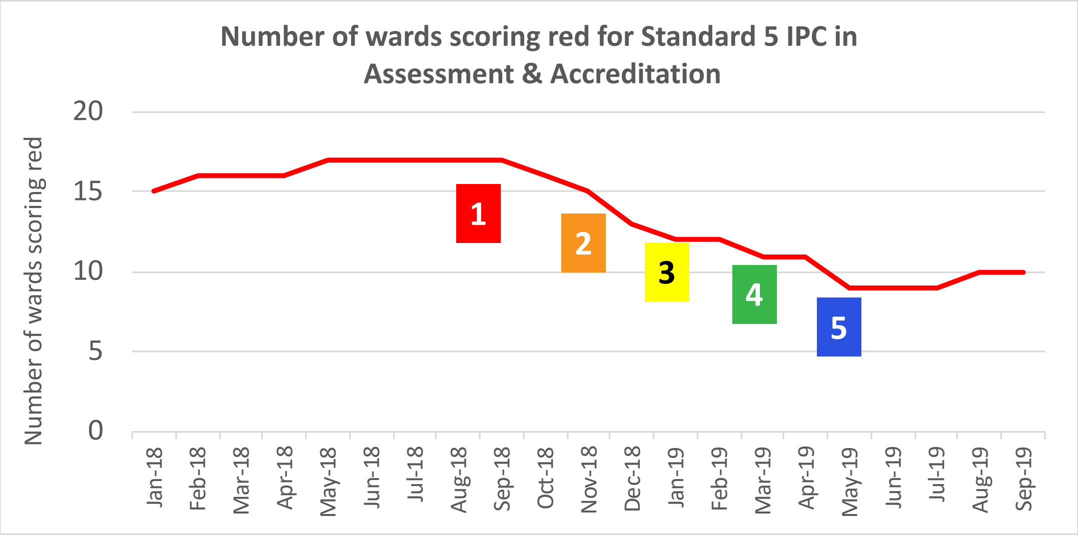
Aim

To reduce the number of wards scoring red for standard 5 IPC, in Assessment & Accreditation, by 40% from the July 2018 baseline of 17, by September 2019.

Method: 5 PDSA cycles

1	2	3	4	5
Monitoring themes IPC Operational Group / Steering Group	IPC Nurse walk rounds	Hot Topics, posters and infograms	Changing green stickers and line label work	Update hand hygiene challenge process

Results



Impact

Now there are 9 red wards. Using a QI methodology, IPC practices were ultimately improved. Despite early delays in achieving the aim, through withdrawing PDSA cycles that did not work and sharing ideas from IPC colleagues in other hospitals to affect change, the aim was exceeded. This project has enhanced patient care by protecting patients from infection.

Finalist

Acute:

Weston Area Health NHS Trust

Geriatric Emergency Medicine Service

1. **The entrant has been working to deliver improvement in their area for a while**

The first of it’s kind, developed over three years, launched in March 2019, our acute frailty service is a holistic clinical service based in the Emergency Department (ED) at Weston General Hospital treating frail patients over 75 years. Run by a small team it cares for the patient and those who care for them. The frail, elderly arrive at ED with a multitude of complex issues and factors. It’s rarely ‘just a fall.’

According to the national Geting It Right First Time (GIRFT) programme Weston has the oldest population coming through A&E than any hospital in the country. Out of a 241 hospital bed base 30% of patients are aged over 80 and 60% of patients are aged over 65.

The lead frailty doctor Dr Rachael Morris, was instrumental in developing the service. She started working in the discipline as part of her specialty training in emergency medicine in 2015. She enjoyed it so much she resigned her training in emergency medicine to focus on building the speciality service.

After meeting Advanced Physiotherapist Joe Middleton they started building the service together.

Building the service wasn’t easy. Alongside working two days a week, a high turnover of operational managers in ED created challenges in building relationships and laying the foundations for the service. In 2017 the ED in Weston enacted a temporary overnight closure due to problems staffing the clinical rotas. Uncertainty around the department’s future while developing a fledgling service has required huge amounts of resilience and belief in the service and its contribution to patient care.

2. **The entrant has tried different approaches and learnt from them (some evidence of the use of PDSA cycles would be brilliant), especially learnt from things that didn’t work as well as those that did**

Quality improvement methodology has been central in developing our frailty service. It has evidenced our work and determined what impact, if any, our suggested change has made. In addition we use it to motivate colleagues and demonstrate to them why our suggested changes benefit patients and colleagues.

We tried a variety of approaches with different measures of success. Run charts were used to track changes and provided a useful timeline to record our interventions. The PDSA cycle was used to implement frailty identification in ED. We added the Clinical Frailty Scale (CFS) to the paper triage form, and later to the electronic ED system and recorded its use.
Despite repeated education and prompting we failed to achieve a 100% success rate. Our plan now is to add the CFS to a mandatory computer assessment field in ED.

We realised that education and training for colleagues of all disciplines and professions would help embed the service into the fabric of the hospital, garner greater understanding of what the sevice does and the support we can offer. Also raise the care standards for this specialist patient group.

3. **The entrant has worked to learn from other people (within and out of their own organisation), taking and adapting the good ideas of others where relevant**

We've learnt from experts as part of the Acute Frailty Network. Rather than repeat mistakes we learnt from colleagues in other hospitals who were also building, or had already established an acute frailty service. We actively contact and discuss best practice with other hospitals and host reciprocal visits.

Effective use of resources has been extremely helpful including The Royal College of Emergency Medicine, The British Geriatric Society and Age UK.

Learning from colleagues we work with daily who are experts in their field such as the Parkinson's Specialist Nurse and Admiral Nurse has been important. Also listening to and learning from Nursing Assistants who spent a lot of time with patients and their carers and from Housekeeping too. As a result we've implemented hot meals in ED outside of meal times, worked with dieticians to provide appetising high calorie and protein patient snacks and drinks and provide warm fleece blankets to our patients via the Red Cross.

4. **The entrant can demonstrate some sort of sustainable improvement and improved outcomes for patients or staff**

Our daily practice is to layer specialist expertise into ED. We teach and support people 'on the shop floor.' ED staff have reported they are more confident in caring for this vulnerable group of patients. Junior ED doctors have fedback through medical training that having acute frailty doctors on hand has benefited their professional learning.

Using the hospital's weekly 'Teaching Thursday' session - drop in learning sessions open to all clinical and healthcare staff - we demonstrate the specific clinical and associated needs of the frail and elderly to a variety of staff groups.

We also conduct education for wards and departments including specialist sessions on conditions like delirium and dementia. We deliver formal teaching programmes for junior doctors, nurses and medical trainees on rotation. We also work closely with the Trust Board the local Clinical Commissioning Group, showcasing the proven benefits to patients and colleagues professional expertise.

We have a strong presence both regionally and nationally. One of the team sits on the Bristol North Somerset and South Gloucestershire acute frailty hospital network. We are influencing regional planning for acute care for older people and share our approaches to building strong relationships with community services part of our regional Sustainability and Transformation Partnership.

5. The entrant has engaged or involved patients or carers (ideally in some form of co-production)

The patient is always at the heart of what we do. We want them to be in control of their health.

Patients arrive in ED frightened and worried, often not about their health but over things like who’s looking after the dog. They may have missed a meal and are parched. Our first question is do they want a cup of tea. We then sit and talk to them to understand their needs, conduct a full gold standard Comprehensive Geriatric Assessment and decide ‘what next’ together - admitting into hospital if needed.

This learning has been used in service design and we are starting to undertake patienr experienced based design with the Acute Frailty Network. In response to feedback the service is also running monthly drop in memory café’s in the hospital for people living with dementia and their carers.

Finalist

Mental Health and Community:

West London NHS Trust

QI for West London & Safety Huddles Project Manager / QI Coach - Jenni Guest and Emma Brown

I nominate Jenni Guest (Head of QI) and Emma Brown (QI Coach/Project Manager) for the Paul Thomas Perseverence Award, who have used QI methodology to reinvigorate and build forward in effectively testing and measuring the introduction of safety huddles (SH) in a cross cutting project in different inpatient mental health settings.

Since 2016 West London NHS Trust (WLT) had varied attempts of launching and adopting the use of safety huddles within our diverse inpatients settings (mental health Inpatient acute, forensic wards & high secure services) as a proactive tool to improve patient and staff safety. Isolated wards have demonstrated measurable improvement to safety during active projects but often with poor local sustainability, lack of spread and limited understanding of improvement or impact. This has led to a pattern of repeated re-launches in different settings, poor spread of learning and inadvertently repeating the ‘same’ approach to re-establish their use over this three year period.

Although as a Trust engagement and sustainability to date has been inconsistent, the projects completed have instilled a degree of belief that SH can meaningfully contribute to a reduce patient/staff harms and improve communication and teamwork. With central leadership from Jenni and Emma WLT have been able to take a dynamically different improvement approach this time working to break the cycle of ‘project’ and ‘re-launch’.

A successful bid with Imperial College health partner’s patient safety programme enabled the appointment of a fulltime QI coach/project manager to lead, with our Head of QI, a 6 month Safety Huddle ‘collaborative breakout series’. They provided a foundation of improvement methodology and measurement for improvement, to enable a cross cutting small scale ‘improvement collaborative’ where local and wider learning is now informing further testing and adoption of SH.

The collaborative breakout series method was used to ensure shared learning in this cross cutting multi-service line project, whilst also meeting the local needs of each individual ward. The QI coach added rigour to this project by using the model for improvement and PDSA cycles, supported by data to enable real time team, service level and WLT learning. Each team were personally coached to develop their aims and family of measures in order to support local ownership of the changes tested and their team level data. The project had clear process, outcome and balancing measures (see attached document for more information).

Although it is still too early to concretely say that a sustainable improvement has been embedded (and the work continues) the tenacity, creativity and personal leadership of this project has led to demonstrable real positive shifts in ward level measures (please see attached document for more details) and broader team benefits. They have been able to show focused reduction in a number of locally identified harms, including self-harm and a reduction in restrictive practices. Secondary benefits through improvement in team communication and self-reported safety climate among staff has contributed to establishing key principles that both impact on reduction in harm through safety huddles and also in the approach and success of establishing safety huddles in teams daily functioning.

Service users were engaged and involved in the project on all wards, with one ward being selected to have more involvement re: co-production. Service users on all wards involved were introduced to the project via community meetings and invited to discuss two key questions 'what they identified were the main safety issues on the ward?' and 'what factors contributed to them feel safe on the ward?'. One ward took this contribution further to coproduce a 'safety board' and the safety huddles, were services users input was represented both on the board and in the huddles of services uses comments on 'what keeps them safe?' on a good day and a bad day'.

When engagement and buy in was difficult they sought, Jenni and Emma effectively engaged the service senior leadership (Suzanne Morton, Head of Nursing, Local services; Matthew Wilding, Deputy Director of Nursing West London Forensics; Jimmy Noak, Deputy Director of Nursing, High Secure Services) as sponsors to work to identify and remove barriers, surfacing their own purpose and impact within the improvement journey with both respect and challenge. There utilisation of the NHS Improvements Sustainability Model tool highlighted in a measured and representative way the areas that both strategically and practically needed to be focused on so any gains established were sustained. The collaborative breakout series approach supported engaging all colleagues together on this learning, involving all levels, professionals and roles from the team and was also invaluable in this project.

Emma as the QI Coach, with support and mentoring from Jenni, has been central to the achievements made. Emma has proactively worked through historically established perceptions around SH from the past 3 years, to build strong relationships at all levels across the teams and services, blending the role of coach, project manager and teacher to authentically support real time improvement. This success is represented through one service line locally funding an extension to the initial 6 month role to continue the SHs work on the remaining inpatient mental health wards.

Attached is a PDF presentation summarising the outcomes and learning from the project. This was an excellent piece of work that continues to be on-going at WLT. I think Emma and Jenni deserve recognition for the improvement achieved, working to enable a shift in local level ownership taking an improvement approach and testing a cross service line breakthrough series approach to wide-scale improvement. They have also enabled a shift the conversation in conversation with service level senior leads and clinicians on factors impacting on building a culture of improvement across WLT. That supports our wider aspiration to engage these colleagues as a central part of the realisation of Trust QI strategy.

West London Safety
Huddle Perserverence

Finalist

Community and Other Organisations:

Southern Health & Social Care Trust (Northern Ireland)

ACCESS Craigavon Area Hospital

ACCESS (Ambulatory Care Craigavon Emergency Surgical Service) was set up in March 2017 following months of planning. An increasingly aging and co-morbid population was putting continuously increasing demands on the Emergency Surgical Service in CAH. Inspired by the success of other Emergency Surgical Ambulatory Care units across the UK, the ACCESS team pitched the idea of a new way of managing selected groups of emergency surgical patients to the management team. The key components of the service are- Senior Decision Makers (Consultant delivered service), access to dedicated imaging and theatre capacity with the aim to improve patient experience, promote admission avoidance and decrease length of stay. There was some initial reluctance from some members of the multi-disciplinary team to introduce the new service due to several factors.

We made contact with other Surgical Ambulatory care units to learn from their experiences and conducted a site visit to another unit to see firsthand how this improved patient care.

After many meetings and presentations to key stakeholders illustrating the benefits of the new service by referencing the success of other well established units throughout the UK, the ACCESS service was launched in March 2017.

We had the privilege of being part of the second cohort of the National Surgical Ambulatory Emergency Care Network which enabled us to hear about areas of good practice from other units and adapt them to enhance our own service. We conducted PDSA cycles to help us develop the service. With the support of the network, we conducted an Evidence Based Design patient survey which showed high rates of satisfaction with the new service. The network has also assisted us in measurement and data capture in order to evaluate the impact of our service which has demonstrated that > 70% of patients managed via ACCESS avoid hospital admission.

Please see attached our case study detailing the service. Thankyou.

Ambulatory Emergency
Care Network

Ambulatory Emergency Care
A first for Northern Ireland

www.ambulatoryemergencycare.org.uk

Introduction

Craigavon Area Hospital is the first hospital in Northern Ireland to join the Surgical Ambulatory Emergency Care (SAEC) Network. It has introduced a consultant-led surgical Ambulatory Emergency Care (AEC) service for patients with urgent conditions requiring surgery. The Southern Trust's ACCESS (Ambulatory Care Craigavon Emergency Surgical Service) service is reducing unnecessary overnight hospital stays and transforming care for patients.

Eighty per cent of patients who used the service in the first year (March 2017 to February 2018) avoided being admitted to hospital prior to surgery. This has resulted in a reduction of 264 bed days over 12 months, saving the Trust £99,000. Critically, the service is freeing up hospital beds for patients who need them more and is proving popular with patients.

Like most trusts, prior to the introduction of the new service Craigavon Hospital was struggling to cope with demand for beds. Elective surgery was regularly being cancelled and emergency patients faced a prolonged inpatient wait for diagnostics and surgery – up to three days in some cases.

Acute surgeon, Susan Yoong had worked in a trust in Nottingham that had developed a Surgical Triage unit. She got to hear about the SAEC Network and thought it might help Craigavon to tackle some of its challenges.

She said: "Getting It Right First Time, the programme by NHS Improvement, quoted 30% fewer general surgery emergency admissions a year among trusts that had introduced a consultant-led surgical assessment service. The idea was pitched to the Surgical team and then across the wider Trust. Initially it was met with a lot of resistance. People did not understand how it could work, they were bewildered by the idea. I explained that it wouldn't mean we were doing different work but the same work done in a different way."

Overcoming resistance

Susan met with clinical leads to explain the concept of Surgical Ambulatory Emergency Care and how it could make a difference to patients.

She explained: "I had to keep going back and saying the same thing again and again to get message across. I reiterated we would not be the first ones to do it and that it had worked well in other hospitals in the UK. In the end, it was telling patient stories and really articulating the benefits to patients that convinced colleagues – the young mother needing emergency surgery but worried about her children at home, for example. People got this, they empathised and saw the benefits of the patient being able to go home if it was safe to do so rather than waiting as an inpatient for surgery."

ACCESS

The ACCESS service was set up in March 2017 with a dedicated area on the acute surgical ward. It is led by Susan, as Consultant Surgeon. However, it is the team approach that has been crucial to its success, with involvement from ward/ theatre managers and nurses, clerical staff, radiology, anaesthetics, pre op assessment and ED. The service has its own dedicated clinical room with two trolleys, daily ultrasound slots available to its patients and a weekly theatre list of its own, with access to emergency theatre at other times.

From Monday to Friday between 10.30am and 12.30pm patients attend the ACCESS clinic where they are immediately assessed and referred for any diagnostic tests. If it is deemed safe to do so, they are discharged and given a time to come back into the hospital for surgery. The service sees a maximum of five patients a day, but more typically two or three.

Surgical Ambulatory Emergency Care Network

In February 2018, Craigavon joined the Surgical Ambulatory Emergency Care Network. Susan said: "The team had been keen to join since we started but it took a while to get everyone on board and get the funding. The advantage of joining a year after the service was established was that we had already learned the hard way and so could share our experiences with others.

"Becoming part of the Network helped to raise the profile of Surgical Ambulatory Emergency Care and it gave us a degree of prestige as we were the first trust in Northern Ireland to join. It also generated interest in our unit, we have had site visits from other trusts wanting to follow a similar model. And it has helped to maintain momentum and supported us to keep moving forwards."

Chief Executive of the Southern Trust, Mr Shane Devlin said:

"The Southern Trust is privileged to be working collaboratively with the SAEC Network. The Trust is committed to providing a high quality surgical service to our patients through interfacing with our emergency department to ensure patients are managed in the most appropriate manner. With the guidance and support of the SAEC Network, the Trust's surgical ambulatory team led by Ms Susan Yoong, Consultant Surgeon has already made strides in operationally changing the way we treat our surgical ambulatory patients and it is our objective to improve upon the good work to date by bringing on board the Network's knowledge and expertise"

Success factors

Setting a date and getting going: Setting a start date and going for it, even in the face of resistance, is one of the things that Susan and her team are most proud of. Without this, they believe the service may never have got off the ground.

"One of the Ward Managers, Sister Emma McCann said to me to set a date and go for it. There will always be something that isn't right but you have to start somewhere," said Susan. "This was great advice."

Core enthusiasts: Building a core group of enthusiasts was also key, particularly in the early days.

Susan said: "A small group of us started the service and spread the word. We saw it as something new and exciting, all of us could see the potential and we really believed in it. Every time we got disheartened we kept each other going and each time we came across a hurdle, we talked to each other about what to do."

"In the General Surgical Department there was an air of "this is the way we have always done it, so why change", but just knowing our ACCESS idea would positively change the pathway for some patients really drove us. Two years on we still have that same drive. Our enthusiasm continues to grow as we have identified new ways to enhance our service and further improve the emergency surgical patient's journey," added Amie Nelson, Head of Service

Data collection: One of the specialty doctors, Mr Richard Mayes, took on responsibility for data collection so that they could monitor the impact that the service was having. Initially, he manually assessed data from the Northern Ireland Electronic Care Record, the Theatre Management System and ACCESS care records. Currently the service is negotiating with the data collection team to implement an electronic data capture system.

Data shows that the service saved the trust £99,000 in the first twelve months and avoided 264 admissions. Patients are enthusiastic about the service, according to satisfaction surveys.

Amongst their comments are:

"Very happy with my service today. Everyone was very pleasant and I was well looked after. Thank you"

"Quick, well-organised service. Needs to be run out across all specialties."

High-level support: The service has been under pressure at peak times to provide additional bed capacity. However, high-level support from the Chief Executive, who is aware of the early impact the service has made, has helped the team to resist this pressure.

Key learning

The service began by focusing on a limited number of conditions: right upper quadrant pain; right iliac fossa pain; perianal superficial abscess; and painful hernia that is not obstructed or strangulated. The idea is that the majority of patients with these conditions can be assessed in ACCESS and safely discharged to await further diagnostic tests or surgery. The service is not available to high risk patients, those with significant comorbidities, people aged 75 and over, or children. The average age of patients is around 40, with more female than male.

Currently, the service only has dedicated daily ultrasound slots but it is hoping to introduce CT and MRI scans. There is a dedicated ACCESS theatre list once a week and the rest of the week patients go onto the emergency theatre list.

Susan believes senior management buy-in is key to the success of a service like this and is confident that being part of the SAEC Network has helped with this. "Members of the Network visited our site and talked to senior managers. This made them more aware of what we were doing and the fact that we were the first trust in Northern Ireland to join the Network, which gave us credibility and helped to raise our profile."

She believes that a willingness to keep going, even in the face of criticism, has been crucial. "There will always be doubters," she said, "but don't let that stop you. Talk to people on a one-to-one basis, explain what you are doing and how patients will benefit, try not to get defensive."

What's next?

The ACCESS service is hoping to introduce dedicated CT and MRCP slots to complement the daily ultrasound slots, and to introduce electronic data collection. A business case has been submitted for a second weekly ACCESS theatre list and it hopes this will increase to three lists a week over the next three years. It is hoping too to create a list of patients who can be called in for surgery at short notice, for example patients with gallstone pancreatitis.

Susan says: "Since ACCESS was introduced, patients who can safely go home are discharged and aren't lying in beds for days on end waiting for investigations or a management plan. It is reassuring for them to seen by a consultant straight away and to have a scan or blood tests and then to be able to go home. This has saved bed days, decreased length of stay and improved the experience of patients, which is what we were aiming to achieve. There is more to do but we are pleased at the early impact the service is having."

For more information contact Susan Yoong on:
Susan.Yoong@southerntrust.hscni.net

Judges Award

For staff nominated by their colleagues who embodied the essence of all 4 awards to deliver compassionate care to patients and inspired their team in their leadership.

Winners

Mid-Essex NHS Trust
“Blossom Suite” (Baby LOSS on Maternity) Bereavement Midwife Tabitha Stuthridge

Oxford University Hospitals NHS Foundation Trust
Dr C Kearns - Neuro Intensive Care Consultant and Medical Director

Winner

Mid-Essex NHS Trust

“Blossom Suite” (Baby LOSS on Maternity) Bereavement Midwife Tabitha Stuthridge

Tabitha has been a Midwife for 17 years and as a military wife has worked all over the country at lots of different hospitals. Despite seeing many areas of good midwifery practice over the years, she had sadly experienced some shocking bereavement care, making her feel uncomfortable and upsetting to witness.

In her own words;
I knew there must be a kinder more respectful way to care for these families and their precious babies. The responsibility for bereavement care was daunting and I remember feeling uneasy at the prospect of getting it wrong. The time available for bereaved parents to make precious memories with their babies is short, and I didn’t feel confident in my ability to do this well. I remember feeling physically sick and shaking stood outside the bereavement room waiting to take over care of a bereaved family, not knowing what to say or do.

On entering the room, I realised something that would change my outlook and career pathway forever. I realised that my feelings paled into insignificance when I realised how scared, lost and hurt the parents were. I realised that I could help. By listening and being led by the family, by being kind and doing what felt right at the time I could help and support them. I actually felt like I was helping in some small way at such a devastating time.

An opportunity arose to join the bereavement team, and by taking the plunge, and challenging my fears I found a burning passion to provide the best bereavement care possible. Idea after idea came flooding in about how to improve care, knowing that if it just made a difference to one family it was worth doing.

I was given an amazing opportunity at Broomfield hospital and become their first ever Bereavement Midwife. A challenge I was ready to take on now, knowing that this was my opportunity to really make a difference to the local community and their experience at this devastating time. But I was embarking on this journey on my own this time and the responsibility to get things right was huge.

The service has been transformed now they have a Bereavement Midwife with dedicate hours every week to concentrate solely on bereavement care. I know that with every little accomplishment – free parking, home visits, more memory making choices – the families will benefit.

The bereavement suite has been given an identity and is named the “Blossom Suite” (Baby LOSS On Maternity) following a staff vote, it has been updated, and the store room within the suite has been transformed into a nursery for the parents to use with their baby. It has all equipment the parents might need…changing table, bath, clothes, mosses baskets, cold cots, memory making equipment and even a pram. The Blossom Suite has become a special place full of love from each family who uses it, because at the heart of every new idea, innovation and facilities provided are the families. Listening to families about what they want and need at this terrifying and deeply sad time ensures that we get it right and provide the best care possible. I learn something new from my families every day! I now offer 3D hand and foot casting at Broomfield to all parents whose baby's skin can tolerate it. These I take home to dry, finish and paint, and then deliver them to the parents when ready. I enjoy taking the time to do this for parents. It's healing for me to spend time doing this. Seeing the parent's faces when they receive them, hold them close, and marvel once again at their tiny fingers and toes, is incredible.

"Tabitha takes casts of our Angels hands and feet and paints them in her own time at home – ensuring we have the best memories of our babies"

Postnatal support was lacking for bereaved families and this was an area that required improvement straight away. The introduction of a mobile phone with direct contact with the Bereavement Midwife via calls or text has been invaluable, and families are now offered home visits and contact for however long they require and even during subsequent "rainbow" pregnancies. To further support this additional care a Bereavement support MCA role was created to increase the amount of visits and support that can be offered as the caseload naturally grows. Better communication amongst the multidisciplinary team – chaplains, funeral directors, mortuary, midwives and doctors means a more seamless service can take place.

"Tabitha is always at the end of the phone, we just become part of her blossom suite family and the true love she has for us as parents and the way she cares for our babies is beyond human"

There is no better support than other parents that have been through a similar experience so I have set up a few Facebook groups: "Blossom Suite Support Group" just for parents that have lost a baby at Broomfield hospital and "Blossom and Rainbows" for my families who are pregnant again after loss . These are safe places where parents can talk about their feelings, share pictures of their baby and ask for advice. Many strong friendships have "blossomed" from these groups with parents meeting up and taking their friendships beyond the groups. Parents know they are not alone and it gives our families another place to turn to for support. I have also set up another support group for my families experiencing loss following the difficult and uncertain journey of IVF – "Blossom and IVy Friends and fertility" acknowledging the additional support needed and unique challenges these families also face.
A big part of my role is teaching, supporting and enabling Midwives, Nurses, Doctors, and Students to give the best care they can, knowing they only get one chance to get it right. I want all staff to have a bereavement service they are proud of with the tools and equipment they need to provide the best care emotionally and physically. I want to prevent staff feeling frightened and lacking the skills to be confident in this situation like I did years ago, and that way parents will feel well supported and cared for. I believe that good bereavement care from the very start has a positive impact on the family, and at a time where midwives often feel they can give nothing, we can actually give choice, kindness, care, support and the time needed to give the family the best start to their grief journey.

Winner

Oxford University Hospitals NHS Foundation Trust

Dr C Kearns - Neuro Intensive Care Consultant and Medical Director

We recently had a very traumatic emergency situation on one of my wards where a patient with advanced throat cancer suffered a catastrophic bleed from his throat in the middle of the ward in the corridor. A cardiac arrest call was put out and the major haemorrhage protocol activated. As well as being our medical director Dr Kearns is also a NICU Intensivist and he was on duty at the time and attended SSIP as part of the emergency response team. Dr Kearns took the lead immediately and did all that you would expect as a Consultant Anaesthetist in this situation. This situation was not an ordinary situation to lead however as was incredibly distressing for the nursing team and ward doctors. Dr Kearns acted quickly with unfaltering clinical leadership skills and calmed the team sufficiently so that we were able to perform at our best. He was an outstanding role model. What has prompted my nomination is what happened afterwards. The patient sadly did not survive despite the team’s best efforts. Dr Kearns stayed on the ward long after his colleagues, the cardiac arrest team and ward doctors had departed and assisted the nurses in carrying out last offices for the patient. As you can imagine the clean-up operation was immense, and we were able to do this together with Dr Kearns while still treating our patient with dignity, kindness and respect. Dr Kearns stayed and helped with the whole process, from holding the patients head while I washed the blood out of the his hair to cleaning the room and bed. The kindness and compassion that Dr Kearns demonstrated to the nursing team helped our psychological recovery from this incident and was reproduced thereafter between us.

Dr Kearns surpassed being a role model that day and went, in my opinion the extra mile for his nursing colleagues. This has helped me in the support that I have been providing in the days that followed to my nursing team and how irrespective of grade, role or position we should and are all here for each other. Emergency situations sadly do happen in all of our clinical areas from time to time. The nursing team are often left, after the commotion of cardiac arrest to clean up, care for the patient and their relatives, and look after each other. It is fully appreciated that it is not always possible for medical colleagues to contribute to this process due to other clinical commitments but if just 1% of what Dr Kearns provided is emulated by his colleagues then ward level staff would be better supported in these types of situations. If we can't treat each other with kindness, respect and compassion then how can we truly offer this to our patients? My junior nursing colleagues were asking me afterwards, who was that doctor that stayed and helped? I was so proud to say "that is our divisional medical director".