

Shine: Improving the value of local healthcare services

How healthcare teams took on the challenge to
improve quality while reducing the cost of services



Learning report
February 2014

Acknowledgements

This learning report is based on the following reports submitted to the Health Foundation:

- End of award reports from each of the Shine programme project teams (see Appendix 2 for the full list of awards)
- Springfield Consultancy: Support provider report Shine Awards 2010 cohort 1
- Springfield Consultancy: Support provider report Shine Awards 2011 cohort 2

We would like to thank all of the Shine project teams for their hard work and dedication.

Contents

Foreword	4
1 Introduction	5
About Shine	5
2 Using information technology to improve services	7
What the projects did	7
What was the response?	9
Did the projects save money?	10
Spread and sustainability of the work	10
3 Changing the way services are organised	12
What the projects did	13
What was the response?	16
Did the projects save money?	17
Spread and sustainability of the work	18
4 Improving access to information	19
What the projects did	19
What was the response?	20
Did the projects save money?	21
Spread and sustainability of the work	22
5 Support and training for staff and service users	23
What the projects did	23
Did the projects save money?	25
Spread and sustainability of the work	26
6 Lessons from the projects about success in local innovation	28
Success factors	28
Challenges	29
Challenges for future innovation	30
Appendix 1: Further information and resources	33
Appendix 2: Shine awards 2010–2011	37

Foreword

Healthcare services are facing a period of intense pressure to get better value from resources, to save money and at the same time to increase the quality of services. This is a tough proposition as the health sector can be risk averse, and often offers little encouragement for local experimentation with changing roles and models of service delivery.

However, even in this climate, the response to the Health Foundation's Shine programme shows how many innovative ideas are out there for improving the value of services. The Shine programme seeks to encourage front-line innovation and develop ideas from the people who best know the day-to-day opportunities for providing a better service for patients and trimming wasteful use of resources.

This report draws out the lessons from the first 32 projects in the Shine programme. It captures a range of achievements and challenges faced by the projects, to show what can be done with a relatively small amount of money and over the short timescale of just over a year. All the teams were asked to measure the impact of their work in terms of the actual cost reduction, or potential for cost reduction, and to demonstrate how quality had been improved as a result of the project.

Unsurprisingly, perhaps, many teams struggled to demonstrate definite cost reductions – it is well-reported how few really robust studies have been able to accurately record costs and cost savings of improvement work.¹ Healthcare organisations in the UK are highly complex and, inevitably, changes at the clinical micro system level are being introduced alongside a myriad of other initiatives. This all makes

the collection of accurate cost data difficult – and demonstrating any actual cost savings and tracing attribution to an improvement intervention even more so.

However, in terms of quality improvements, the achievements of the Shine teams are much clearer. The projects made changes that have provided better quality of care and improved patient experience. In addition, the projects report how changes have increased staff motivation, through better job satisfaction, development of new skills and improved understanding of the roles of other services.

It is striking that, for all the Shine projects, changes have been actively led by committed clinical leaders who have used local data and reported patient experience to convince their peers to be part of the change process.

After completion of a year-long Shine project, the challenge is to ensure that the improvements in care are sustained locally and that every opportunity is explored to share the lessons learned and encourage take-up and adaptation by other services.

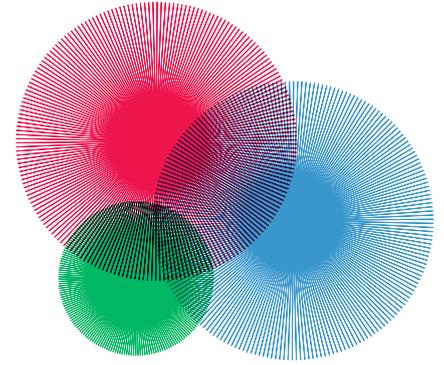
So I hope that this report, and the further resources from the projects listed in Appendix 1, introduce some excellent innovations that have potential to greatly improve the quality of care in a variety of settings. I encourage you to find out more and to get in touch with the Shine innovators, who are committed to sharing their work, their experience and the tools they used, to help others to benefit from the effort they have spent improving their service.

Helen Crisp
Assistant Director of Research,
the Health Foundation

¹ Ovretveit J, *Does improving quality save money? A review of which improvements to quality reduce costs for health service providers*, London, The Health Foundation, 2009.

1

Introduction



This report shares the successes and lessons from the first two rounds of the Health Foundation's Shine programme: annual awards to test small-scale innovative interventions that aim to improve the quality, safety and value of healthcare services.

Through the Shine programme, participating clinical teams are able to develop and test their initiatives, putting them into practice for the first time and gathering evidence about how the new approach improves quality and whether or not it saves money. In many cases, the ideas have not only been successfully implemented, but have the potential for spreading to other healthcare providers.

This report gives a flavour of the types of innovative ideas that got off the ground and the impact they had within participating organisations. It also reflects on the challenges inherent in trying to introduce change in complex healthcare settings. The aim is to stimulate others by showing what is possible at the clinical team level to improve service quality while reducing costs, getting better value from the resources used.

About Shine

The aims of the programme

The first two rounds of the Shine improvement programme had four main aims. These were to:

- stimulate thinking and activity among clinical and operational staff, at a local level, which leads to the development of new approaches to improving quality and saving money
- generate clinical ownership of the cost agenda and demonstrate how it aligns with clinical concerns and priorities

- illustrate the degree to which inefficient use of resources not only wastes money but also has a direct bearing on quality
- build a portfolio of well described, real-life examples available to other healthcare organisations, which demonstrate how to improve quality while saving money.

As this report illustrates, the projects had considerable success in achieving each of these aims. Taken as a whole, the portfolio of projects funded by the first two rounds of Shine represent a significant addition to the knowledge base for what works to reduce costs and maintain quality in healthcare. This has been borne out by:

- projects being shortlisted for and winning national and regional award schemes such as HSJ Awards, Nursing Times Awards, local innovation awards, NHS Innovator of the Year and industry awards in use of text messaging
- inclusion of project write-ups in best practice collections, notably the QIPP evidence collection assessed by NICE
- invitations for project leads to present the project work at numerous national and international professional conferences.

Shine award holders

Applications for the Shine awards came from healthcare provider organisations from across the UK (both NHS and voluntary sector). The 32 projects chosen were based across healthcare settings, with the majority in acute hospital trusts. The range of settings for the projects is illustrated in Figure 1 overleaf. See Appendix 2 for a full list of projects.

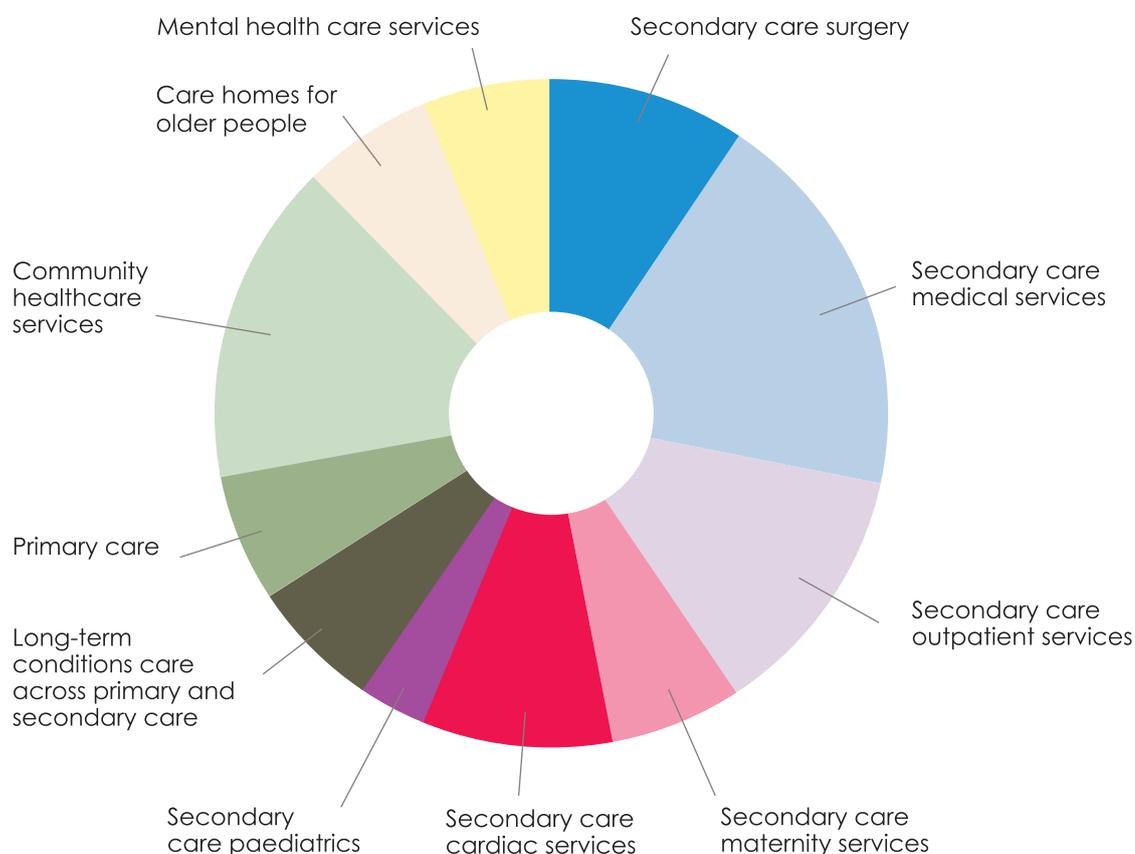
The types of innovations tested in these settings were equally diverse. Although difficult to categorise due to the multifaceted nature of the interventions, this report groups the Shine projects into four broad categories, depending on the primary focus of the intervention being tested, and summarises the lessons learned. The categories are:

- using information technology to improve services (7 projects)
- changing the way services are organised (12 projects)
- improving access to information for patients and clinicians (5 projects)
- supporting and training staff (8 projects).

Chapters 2–5 of this report explore what the projects did, how staff and patients responded, to what extent the projects saved money and how the innovations were spread and sustained. In Chapter 6, the success factors and challenges experienced by the project teams are discussed, along with the challenges for future innovation.

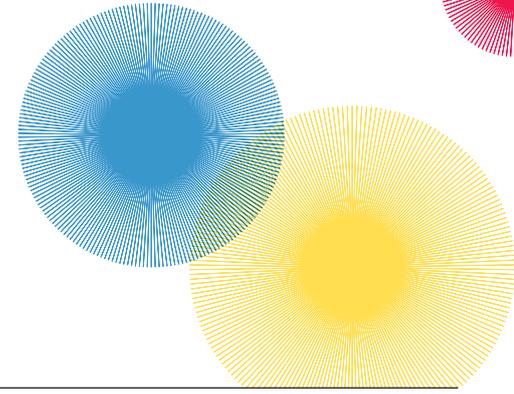
Please note: The organisation names used in this report are those which were current when the Shine awards were made.

Figure 1: Profile of projects by setting



2

Using information technology to improve services



Seven projects were primarily technological interventions: using information or communications technology to involve patients more closely in their care and improve communication channels and the efficiency of health service systems. The projects were:

- Birmingham Children's Hospital NHS Foundation Trust – Young Lives: early warning through continuous remote monitoring
- Newham University Hospital (now part of Barts Health NHS Trust) – DAWN: Diabetes Appointments via Webcam in Newham
- NHS Bolton – Alcohol relapse prevention programme
- NHS Stoke-on-Trent – Using interactive text-based telehealthcare support in the management of hypertension in general practice
- Royal Orthopaedic Hospital NHS Foundation Trust – Computer system for pre-operative assessment of patients undergoing elective surgery
- University Hospitals of Leicester NHS Trust – Activate Your Heart: web-based rehabilitation programme
- University Hospital of North Staffordshire – Perineal assessment and repair e-learning system (PEARLS.net).

What the projects did

Using different approaches to information technology

Developing new IT systems or software can empower patients and give them more control over care pathways, improve access to important information and overcome the difficulties posed by travelling to service providers and fitting this around work and family commitments. In the Shine projects, using innovative IT solutions also led to a number of improvements for organisations, cutting down staff time on repetitive work and reducing time wasted waiting for patients who do not attend appointments.

For example, two projects used web-based training, though for different audiences. Activate Your Heart was a rehabilitation programme for cardiac patients, while PEARLS.net provided clinical update training in surgery techniques for perineal assessment and repair. Both interventions were designed to provide information in an interactive format, with flexibility as to when and where people chose to access the information. Using the internet as a platform for the information and learning tools meant that they were widely accessible, could be used on a typical home or NHS office computer and could be updated easily.

Using everyday technology

Three of the projects used widely available computer and mobile phone technology to connect with service users and facilitate flow of information and better continuity of care. These innovations demonstrated that use of technology does not need to be expensive, or always require the development of bespoke systems.

For example, the DAWN project in Newham used widely available computer hardware (desktop, laptop or smartphone) to hold diabetes appointments over Skype. This made it appealing to service users, who did not need any new equipment (except possibly an inexpensive web-cam) or to become familiar with a new system, as many people were already using Skype to stay in touch with family and friends.

Two projects used text messages to engage service users:

- Flo, developed by NHS Stoke-on-Trent, used interactive text messaging to support people with hypertension
- NHS Bolton alcohol relapse prevention programme worked with clients to develop a series of personalised text messages to motivate individuals to stop drinking.

The alcohol relapse prevention project used texting as a way to improve the communication and connectedness that clients and key workers depend on for the aftercare service to work. By providing a daily 'mood/behaviour monitoring' text message, it helped clients stay in touch with the service between appointments. This led to fewer clients dropping out of aftercare, relapsing and re-entering the service some weeks or months in the future.

Both systems used standard mobile phone handsets. IT development was limited to systems for automatically generating text messages that respond to texts received from the service user.

Adapting technology from other settings

The Young Lives project at Birmingham Children's Hospital involved more intensive technology design and development than the other technology-focused projects, although not the massive resources required for primary development of new technology. The project was a partnership between the hospital and McLaren Electronic Systems and aimed to translate the expertise of real-time continuous monitoring and analysis of the performance of Formula 1 racing cars into a similar system to continuously monitor the condition of sick children. The system uses the analysis of

patterns in the data collected to predict future deterioration in very sick children.

The project only required incremental investment in hospital IT infrastructure to enable the link-up to the software routinely used in Formula 1, with fairly minor adaptation for monitoring physiological data. There were, however, large challenges in negotiating the NHS firewall requirements to allow the flow of data on and off site. The benefits of using these data are enormous in terms of aiding clinical decision making that can save lives. There is also a cost-saving benefit, as long hospital stays could be avoided if crises in physical symptoms can be averted. Less dramatically, in future the system may enable children to be discharged after an examination, or avoid a hospital admission altogether if they can be monitored remotely. At present, many children with long-term illnesses spend long periods in hospital 'for observation' because it is not known if their health status is stable or deteriorating.

Using technology to increase choice and access

A common objective in all these projects was to create greater choice and broaden access to services while relieving pressure on clinicians. In particular:

- Increasing use of the internet by patients and their desire for credible health-related information to self-manage their condition was a key driver for Leicester's Activate Your Heart online rehabilitation project.
- The flexibility of appointments over Skype meant that diabetes patients in Newham no longer had to travel to the hospital for a 20-minute routine appointment, in some cases taking a half day off work. Instead, they could have the appointment with half an hour away from their desk or from home.
- The IT approach to assessment at the Royal Orthopaedic Hospital aimed to save clinical staff time by collecting the information once and making it available for use many times. This approach also benefited patients who otherwise had to spend time going over the same basic information with several members of the care team.

What was the response?

The experience for patients

Feedback from patients across these projects has been positive, with the timeliness and convenience of these innovations proving very attractive. People with hypertension using the Flo' text message service reported it was 'very easy to use and definitely preferable to repeated visits to the surgery and having to book appointments to do so'. Being responsible for checking their own blood pressure and reporting it to the GP practice meant that several patients reported, 'I understand more about my blood pressure and how to control it better'.

Patients felt that talking to the Newham diabetes care team by Skype rather than attending the clinic was 'just the same' or in some cases 'better because I feel more in control of the conversation'. Because the web-based consultations were more convenient, patients reported that they were 'more likely' or 'much more likely' to attend. The benefits of the online environment also extended beyond scheduled web-cam appointments: nurses can see which of their contacts are online and have been able to contact people who have missed appointments and arrange impromptu online catch-up consultations.

Feedback from patients using the Activate Your Heart programme showed that the vast majority would not have attended conventional rehabilitation classes requiring them to go to the hospital or health centre for a regular session time. Using the web-based programme meant that rehabilitation could fit around work and home life. They found the programme easy to access and felt that it provided useful information on diet, exercise and reducing the risks from smoking and alcohol.

Clients on the alcohol recovery programme in Bolton described how the text messages gave a sense of continuity and provided support beyond the time of receiving and responding to the text:

'It doesn't matter that it's automated... you know the work that has gone into creating the messages.'

'It made me think differently because it brought back memories of what's been said to me in the past. Each message triggers a memory.'

The experience for staff

A common finding from staff across the technology projects was that, once initial barriers to introducing the new technology had been overcome and the systems were familiar, the technology itself was easy to use and fitted well into clinical routines. What proved time-consuming was carrying out the data collection to monitor the project's progress and the innovation's effectiveness.

Projects developing IT to support patient care reported that team members gained experience and developed new skills in project management, negotiation and communication. They developed technical specifications, legal contracts and agreements, and also improved their own skills in using IT and web applications. For example, the Activate Your Heart team at Leicester Hospitals reported a much better understanding of service costing and the potential for making savings as they developed their project, which involved detailed discussions with accountants and business analysts. For the cardiac rehabilitation staff, the use of the web-based programme by the fitter, more able patients freed up their time to care for higher risk patients.

There were other unexpected benefits for staff relationships with patients. While introducing technology might seem as if it would create more distance between staff and service users, the opposite was found. Some workers in the community alcohol team in Bolton reported that data from daily text message responses allowed them to gain more continuous information about how clients were coping with their recovery programme, as opposed to meeting with clients once a week or less, with no contact between appointments. Using data generated through the text messaging service, face-to-face appointment time can concentrate on exploring how the client is feeling and developing strategies, rather than catching up on progress with the programme.

In addition, a new interactive texting application, Flo' telehealth for doctor and nurse work stress, is being trialled by interested GPs and practice nurses across the UK.

Did the projects save money?

All seven projects showed potential to save money by applying technology to enhance services for patients. In most cases, however, the technology based service would need to be introduced more widely, with corresponding scale-back of existing conventional services, for these cost benefits to be realised.

Nonetheless, some savings would come from increased efficiency:

- The Royal Orthopaedic Hospital computer-based pre-operative assessment cut down staff time spent on duplicating collection of basic information about the patient – a non-value-adding task.
- The Activate Your Heart programme made sure that places at 'in person' rehabilitation classes were taken by patients who had opted for the class, with a commitment to attend, while many more patients benefited from rehabilitation through the online course. There were future cost benefits from more people engaging in rehabilitation, as they were likely to make a better recovery and therefore have less need for intensive cardiac care in the future.
- The appointments by Skype in Newham increased the efficiency of the service as fewer patients missed their appointments. Again, there were also future benefits, as it seemed that this approach enabled the service to engage users who otherwise may not be managing their condition well. This had the potential to avoid some emergency admissions to hospital.
- The Flo' text messaging service also demonstrated cost benefits: it costs £5 per week for patients to measure their blood pressure and text in the results twice a day for a week as opposed to £24 per surgery appointment. Again, there was the longer-term potential cost benefit of patients better managing their condition and so avoiding the need for emergency care.

- Text-based support for people on the alcohol recovery programme showed potential to reduce the costs involved when people dropped out of the programme and were then re-referred to start the treatment again. In this area of care, approaches that reduce re-referral have great potential to cut costs, as relapse back to alcohol dependency is currently predicted for 80-90% of clients. The costs of alcohol dependency are not only high for associated healthcare services but also involve corresponding welfare and criminal justice costs.

Spread and sustainability of the work

The projects that made use of everyday technology showed great potential for the wider take-up of their approach. NHS Stoke-on-Trent's Flo' text messaging system has won several awards for digital innovation and been taken up by over 60 NHS organisations. The approach has now spread from the original focus on measuring blood pressure to monitor hypertension, to a range of clinical conditions including improved control and medication adherence for chronic obstructive pulmonary disease (COPD) and asthma, heart failure, stress incontinence in women and smoking cessation. There is also international interest in the methodology and the US Department of Veterans Affairs has recently adopted it for a large-scale deployment.

The system of follow-up appointments by Skype, pioneered by the DAWN project, is now being used across East London by Barts Health NHS Trust for a range of different clinical conditions. The work has also gained research funding for a study of the use of Skype and digital health interventions in the management of young people with diabetes.

The alcohol relapse prevention text messaging system has also been taken up by more services, managed by the company d2 Digital by Design, who developed the approach with NHS Bolton. Public Health England is now running a randomised control trial (RCT) of the system with drug misuse organisations in the north of England. The RCT involves testing the effects of the system on re-referrals, while a second group is testing the effects on successful treatment completion and progress through treatment.

Box 1: Tips for successfully using information technology

Involve the right people

Early involvement of stakeholders and potential users, while important in all innovation projects, is essential where an IT development is planned. Without the involvement of the service users and staff who will be using the system, a design is unlikely to capture how things need to work in practice – changes to IT systems at later stages are expensive and can add long delays. The proposed end users need to test early prototypes to help design user-friendly systems that are more likely to benefit the majority of service users.

Clinical teams need to ensure that they have support from people experienced in contracting and procurement. Teams are likely to need advice on selecting, appointing and contracting with external suppliers. A detailed technical specification is essential to manage expectations and enable progress with IT suppliers to be effectively monitored.

Keep it simple

- People who are expected to use a new IT system need to understand it easily, so information materials need to be sufficiently detailed but jargon free and practical.
- Easy-to-follow instructions on how to get started – with on-screen prompts – are important, along with information on how to get IT support with using the system and also how to seek advice from the clinical team at any stage.

NHS services have sometimes been overcautious about introducing IT interventions as not everyone has access to the technology, be it mobile phone or Skype. However, the vast majority of patients, including the elderly, are increasingly using technology in all other areas of their lives, so there is no need for healthcare to be an exception.

Data collection

- To collect data on usage, experience and outcomes, project teams recommended developing, piloting and agreeing a questionnaire on the project from everyone involved.
- Participants recommended using email and secure log-ins to collect data from service users and health professionals.
- Secure email was also used to answer queries and share advice and this was generally seen as an easy and accurate way of recording information.
- Giving a specific staff member the task of collecting data can help guarantee consistency and validity. The Activate Your Heart project had to rely on people not directly involved to provide data reports. This was time-consuming and led to challenges with analysis and interpretation of the data.

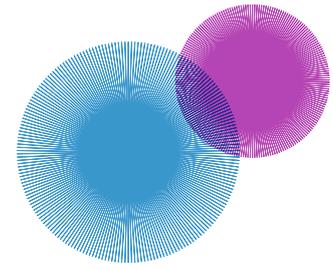
Confidentiality issues

Concerns about confidentiality can be a major obstacle for innovations seeking to make use of information technology.

- The project teams found that it was essential to build a close working relationship with the internal IT department and check in with those responsible for patient confidentiality at every stage. Although time-consuming, this helps to avoid delay or, worse, being forced to abandon a project at a late stage because the appropriate data permissions cannot be given.
- Challenges were also reported with the technical difficulties of negotiating IT firewalls and the compatibility of systems to enable data transfer, even when permissions had been given. Early testing using non-confidential or dummy data is advised, so that the technical work can progress, while negotiation on the use of the real data continues.
- To help overcome the challenges to confidentiality and safeguarding when using Skype for consultations, the QIPP team at the English Department of Health have produced guidance. See: www.connectingforhealth.nhs.uk/systemsandservices/qipp/library/skypefs.pdf

3

Changing the way services are organised



Twelve of the Shine projects tested innovative ideas to change and improve ways in which healthcare services are organised. The projects aimed to improve patient pathways and make better use of resources (including expert clinical time and high intensity care settings) to improve quality, team working and overall patient experience. The projects were:

- Airedale NHS Foundation Trust – Conserving a scarce resource and improving outcomes: blood conservation for primary joint replacement
- Bangor University School of Medical Sciences – From push to pull: using advanced triage to facilitate early discharge, escalation to critical care and referral for rehabilitation in acute medical units
- Derby Hospitals NHS Foundation Trust – A ‘team without walls’ approach for pre-pregnancy care in diabetes (PROCEED)
- Great Western Hospitals NHS Foundation Trust – A radical restructuring of antenatal care for high-risk pregnancies
- Heart of England NHS Foundation Trust – Rehabilitation for operated lung cancer
- Imperial College Healthcare NHS Trust – Transformation of urology outpatients at Charing Cross Hospital
- NHS Fife – Micro-enterprise care solutions to reduce acute hospital admissions and facilitate earlier discharge
- Salford Community Health (now part of Salford Royal NHS Foundation Trust) – ‘Working Well’ service for NHS staff with musculoskeletal disorders
- Sheffield Teaching Hospitals NHS Foundation Trust – Development of a novel ambulatory haematological cancer service
- University College Hospital – The use of pre-operative iron therapy in anaemic surgical patients to prevent peri-operative blood transfusion
- University Hospital of North Staffordshire NHS Trust – Ambulatory heart failure unit
- University Hospital of Wales Cardiff and Vale University Health Board – Outpatient operative hysteroscopy: a cost-effective alternative to day-case theatre.

Of these 12 projects, three involved a redesign of how services were organised and staffed, three moved service delivery from highly intensive to less intensive care settings, five introduced new elements of healthcare and one developed a new social care approach.

What the projects did

Changing service organisation and staffing

Setting up a 'one-stop' service

The 'urology transformation' project at Charing Cross Hospital developed a new pathway and introduced a 'one-stop' service to:

- reduce waiting times
- reduce the number of follow-up appointments
- offer a more timely and responsive service to patients.

The pathway included improved access to diagnostics and better use of clinical time and expertise. The aim was to show that replacing a large weekly clinic with daily smaller clinics would make the service much more accessible and allow a more rational workflow, with access to diagnostic services during the initial clinic visit, allowing on-the-day diagnosis. Too often in the past, patients would receive a follow-up appointment before the requested diagnostic test results were available, thus wasting the limited capacity of patient appointments for the clinic.

The service introduced daily one-stop clinics for up to 10 patients, maintaining the same weekly patient capacity as the previous service model but spreading it throughout the working week. This ensured that demand on the service was better managed; both for the urology team and, just as importantly, for the supporting teams providing blood tests and ultrasound scans. By making demand more even, it was possible to provide same-day diagnostics with minimal impact on the workload across the clinical teams involved.

A one-stop service replaced multiple hospital visits with a single, though longer, visit. Patients need only travel once, minimising the time they need to take off work and reducing the overall financial burden. Rapid access to the clinics, supported by their one-stop design, also means that anxiety is reduced and patients can benefit from receiving all their treatment in one place.

Using senior clinician time effectively

Two projects had a specific aim to ensure better use of senior clinician time. In the first, Great Western Hospitals restructured the antenatal service to reduce the number of appointments needed by women with pregnancies categorised as 'high risk', while ensuring better continuity of care. Specific clinics for expectant women with diabetes, epilepsy, high blood pressure or multiple births meant that their appointments could be scheduled with the consultant in that specialty. The previous service supported a general 'high risk' clinic that did not ensure input from a specialist in a particular condition, leading to some inconsistency in advice given and a tendency to advise a further appointment 'to be on the safe side'.

The second, the PROCEED project in Derby, was developed to ensure that women with diabetes received advice and specialist care from pre-conception onwards to reduce the risk of complications in the pregnancy and achieve a healthier baby. The service was designed to best use the time of the multi-professional team, while offering a flexible service in terms of the timing and location of clinic sessions (see 'Changing the setting of care' below). This means that the consultant only sees women with more complex care needs, while other women using the service gain continuity of care delivered by specialist nurses.

Both of these initiatives led to better use of clinicians' time and a decrease in low-value repetitive clinical activity. The streamlining of services has helped meet the increasing demand placed on health services. At Great Western Hospitals, the trust is coping with a rising birth rate (a 25% increase since 2003) with the same staff resources. The new model of working has also been incorporated into the service guidelines and clinical pathways, so that it is now the 'official' way of working.

Changing the setting of care

Women with diabetes in Derbyshire were also able to benefit from the flexibility of appointments offered by the PROCEED project. These were available as face-to-face appointments either at the hospital or in community health centres and were offered in the evenings as well as during core hours.

Follow-up consultations were also available by telephone and email. This meant that mothers with young children did not need to find the time to attend a hospital appointment or travel long distances and working women did not need to take time off.

Three projects demonstrated new areas of acute care that could be delivered as an outpatient, rather than inpatient, service.

- The Cardiff and Vale gynaecology service shifted operative hysteroscopy from an inpatient operating theatre procedure to an outpatient procedure under local anaesthetic, with reusable equipment.
- At University Hospital North Staffordshire the traditional patient pathway for people with heart failure suffering gradual decompensation over days or weeks was care delivered through an inpatient admission. The average stay was 11 days, with only periodic specialist input. The new heart failure day clinic offers the same care as a cardiology inpatient ward but in a day-care clinic setting, with carefully scheduled tests, patient monitoring and necessary changes to therapy. Clinical nurse specialists and doctors provide this over 5–7 hours at the hospital and many patients are then able to manage at home.
- At Sheffield Teaching Hospitals, patients with haematological cancer normally required an inpatient stay of up to 25 days for their chemotherapy treatment. With the new service model they can now access that care on a day-case basis if they live locally. If they live more than 30 minutes from the hospital they can stay, with their carer, in a self-contained flat on the hospital site.

The benefits to patients of these three developments have been enormous. Patient feedback across all three projects has highlighted how the new care setting is much less disruptive to family life, requires less time off work for patients and carers and, in general, is more comfortable for people than a hospital stay. The patients in Sheffield also described how sleeping better and eating better at home improved their ability to cope with the gruelling chemotherapy treatments.

Introducing new elements of care

The Heart of England NHS Foundation Trust developed a rehabilitation programme for curative lung cancer surgery patients – improving people’s fitness and lung functioning prior to the operation, thus reducing the chances of post-operative complications. The programme included smoking cessation, dietary advice, exercise for pulmonary rehabilitation and patient self-management. Patients reported feeling more empowered due to the holistic assessment and from gaining greater knowledge and skills to know what to expect after surgery and how to manage their condition to improve recovery. Clinical outcomes showed that programme participants had fewer complications and shorter length of stay compared with patients who did not take part in the programme.

The introduction of advanced triage in the acute medical unit at Betsi Cadwaladr University Local Health Board in Bangor led to a more streamlined, standardised approach to care for patients, the vast majority of them elderly people, admitted as medical emergencies. Patients with a low risk of mortality and no expected benefit from a hospital stay are often admitted as inpatients unnecessarily and their length of stay is highly variable. At the same time, delays in management of higher risk, unstable patients contribute to worse clinical outcomes for such patients.

The project introduced the new role of ‘care navigator’ to assess patients on arrival in the acute medical unit and assign them to one of three risk groups:

- low risk, who are unlikely to be admitted
- frail patients, whose care plan requires communication with rehabilitation and social services to organise a suitable discharge
- high-risk patients, who should be transferred to intensive care within four hours of identification.

Two projects (University College Hospital and Airedale NHS Foundation Trust) introduced a more proactive approach

to optimising patients' blood iron before elective surgery. The aim was to reduce the need for routine blood transfusions. A blood transfusion increases the risk of complications, which then lead to a longer hospital stay as well as increased discomfort for the patient. The projects also wanted to help conserve stocks of blood for emergency use. By introducing testing for anaemia earlier in pre-operative care, patients with low blood iron counts could be treated for anaemia before surgery, thus decreasing the need for blood transfusions.

Tackling NHS staff sickness

Healthcare staff can also be users of health services. If the amount of time staff spend off sick can be reduced and staff helped to return to work, with appropriate arrangements to safeguard their health, significant cost benefits can be realised.

Salford Community Health Services introduced the Working Well project to support staff who were struggling to stay at work, or return to work, while coping with pain and limited function due to musculoskeletal disorders. These are the main cause of both short- and long-term sickness, accounting for 40% of all ill health retirement costs across the NHS. The Working Well innovation included:

- a specifically work-focused assessment of the individual and their capability to continue working
- liaison with the workplace manager to devise transitional work arrangements
- advice on adapting working practices
- ongoing support by telephone and email for up to six months after a return to work.

The project was designed to provide a rapid access service, relevant to the needs of the staff member and the workplace, safely minimising time off through a tailored and flexible approach to physiotherapy treatment and agreeing suitable work activities.

Bridging the health and social care divide

NHS Fife's project took a more radical approach in seeking to address the challenges of increasing demands for health and social care from an ageing population. The project started from the view that current ways of working are unsustainable. However, rather than redesign one aspect of an existing healthcare service, the project team engaged in an ambitious approach to encourage the development of new micro-enterprises to support older people to continue living in the community.

The team identified that many frail older people were admitted to hospital following a healthcare 'crisis' leading to them being unable to manage at home. A careful analysis of needs and capabilities of these patients revealed, in the majority of cases, a gradual deterioration over days or weeks. If this had been identified early, the patient could have been helped and the admission prevented.

Working practices in community health and social care services do not provide the opportunities to spot signs such as increasing forgetfulness and being less steady in walking. Older people may not be aware of these subtle deteriorations nor want to report them to the GP, as it may seem to be 'making a fuss'. Many older people are isolated in the community and even if they are not, people such as shop staff or postmen who are in daily contact with them are unlikely to be equipped, or feel it is their role, to consider whether someone's health and wellbeing are declining.

Local people were clear that they wanted low-tech, coordinated care to support people living at home, yet services are set up to provide an institutional response and reactive care after a crisis. The project approach was to step back from the usual health service provision and consider holistic support that would enable older people to live well independently. This covered a wide range of activities of daily living such as help with shopping, help around the house, transport to visit family and join in social events, and many other specific and individual services and support.

In considering how this level of support could be provided, it was clear that a response from statutory services alone would not be

appropriate. The Health Board worked with a community development agency to think about how a mix of changing the role of health and social care professionals, voluntary effort, and growing the local workforce through the development of micro-enterprises could help to meet these needs.

What was the response?

The experience for patients

Patients who were able to have day care rather than an inpatient stay were very satisfied that the service was responding to their personal needs, especially family life and work commitments.

'I wanted an alternative to sitting on a ward for days going stir crazy.'

'It helped me to get home in hours, not days, and that was the best outcome for me.'

(Heart failure patients, North Staffordshire)

'I liked the fact that I knew what was happening during the procedure!'

'...the overall experience was great. Atmosphere was relaxed and staff were friendly.'

(Women having outpatient hysteroscopy at Cardiff and Vale University Health Board)

People able to have chemotherapy as day patients at Sheffield Teaching Hospitals valued the fact that, 'Staying at home had the added benefit of being able to sleep in your own bed.' A patient who stayed in the on-site flat said, 'The best thing was being able to see my kids a lot more.'

Patients in the 'low-risk' category who benefited from the care navigator at Bangor were pleasantly surprised with the speed with which they were seen, treated and discharged. This gave rise to comments such as 'This service is so efficient' and 'I can't believe I am having my bloods and x-ray done so

quickly'. One patient who was seen, examined, assessed, had blood samples taken, x-ray performed and was discharged within one-and-a-half hours commented, 'Gosh, that was quick – I expected to be here all day waiting!'

Satisfaction rates among women using the antenatal service at Great Western rose with the increased continuity of care. Survey results reported increased levels of confidence in the expertise of the staff. User surveys prior to the intervention had picked up frustration from women being called back to the hospital for repeated outpatient appointments with different staff, repeating tests and scans and being offered contradictory advice.

Likewise, women with diabetes reported great satisfaction with the personalised and continuous care provided through the PROCEED project, which helped to reduce stress levels, making it much easier to cope with the numerous challenges of managing diabetes through pregnancy. The greatest benefit to patients has been reducing the percentage of babies stillborn to mothers with diabetes from 6% to 0%, eliminating enormous grief and distress.

The experience for staff

Following the changes to service delivery, Shine project leaders have reported many benefits for staff, including:

- better clinical quality
- more appropriate use of junior doctors
- increased job satisfaction
- more professional support for nurses and other staff.

Some projects, like Heart of England's lung cancer rehabilitation intervention, led to much closer engagement between staff and patients, providing opportunities for effective support and health education – something participants said was not possible previously. Since this project was introduced, staff said they have broadened their own interest and knowledge of services and are very enthusiastic about the potential for rehabilitation classes to help give patients the best chance for recovery.

Reorganising services to improve patient care and access and make better use of staff time involved exploration, negotiation and working closely with other departments that staff previously knew little about. This helped to create an integrated view of care and to identify areas of practice that needed further improvement. For example, the Airedale NHS Foundation Trust's intervention led to the realisation that the existing pre-operative assessment service was reactive rather than proactive. The change involved taking blood tests in the surgical clinic as soon as patients were listed for surgery. Patients identified with low iron went to a follow-on clinic, and a substantial proportion were treated 'there and then' with intravenous iron to optimise their blood iron stores before surgery, without having to schedule additional treatment sessions.

However, attempts to change the roles of health and social care professionals did not always go smoothly. The team in Fife, seeking to reduce reliance on healthcare through stimulating a greater range of care and support in the community, found that they had massively underestimated the impact of the change they were seeking on how staff saw their professional identity and role. Nurses, physiotherapists and occupational therapists needed ongoing support and 'permission', far beyond the scope of initial training days, to feel comfortable doing things differently, through focusing on the whole person and their life rather than concentrating on delivering defined aspects of traditional health and social care.

Did the projects save money?

Some projects were able to demonstrate robust cost savings within their department. In other cases, the pilot project service model would need to be rolled out much more widely to other teams and services to be at a scale that could contribute real savings for the organisation.

- The new approach to hysteroscopy at Cardiff and Vale showed a saving per procedure compared with other ways of organising the service. The new approach costs £651 less per procedure than if

carried out in the operating theatre with a general anaesthetic, or £153 less per procedure than if carried out in the operating theatre with a local anaesthetic. Other cost benefits include freeing up operating theatre sessions for other procedures, thus reducing waiting lists.

- The Heart of England pre-operative rehabilitation approach for lung cancer patients cost £188 per patient for the pulmonary rehabilitation element of their care. The team was able to demonstrate a reduction in complication rates and therefore reduced admissions to intensive care and reduced length of stay in high dependency care for participants. The average reduction in care costs was £1,049 per patient. The difference between the cost of the rehabilitation care and the savings from need for intensive care and high dependency care therefore result in a notional net saving of £861 per patient.
- PROCEED in Derby was able to increase the productivity of the team, who doubled the number of women seen by the service compared with the previous 12 months, and reduced the waiting time, primarily by changing the role of the consultant. The greatest potential for savings is by reducing the number of babies with congenital abnormalities, as there is a much higher risk for babies born to women with diabetes than across the general population. However the savings are very difficult to assess.
- The antenatal services at Great Western Hospitals were able to show a 10% reduction in follow-up antenatal appointments, allowing the service to cope with increased numbers of women with high risk pregnancies with the same staff resources.
- By reducing the length of hospital stays for chemotherapy, Sheffield Teaching Hospitals demonstrated the potential to treat more patients, thus increasing the overall productivity of their service.

However, it was very hard for some of the projects to effectively link their work to reduced costs. The Salford Working Well project noted that, through prioritising job

retention, only 52 service users were off sick at the time of referral – although it was extremely difficult to say with confidence how many staff would have been off sick without the intervention.

Spread and sustainability of the work

Several of the initiatives that changed the way care is delivered were successful in making the transition from ‘project’ to being the standard way that care is now delivered.

- Charing Cross Hospital’s ‘one-stop’ approach not only continues in urology services but has been adopted by other specialities:

‘By building a coalition amongst the clinical and nursing team we are in a position where the changes to the service are sustainable... We are sharing the workload around the clinical team – ensuring that this project is not seen as an individualised activity but a team activity. We are also in a position where we can develop the services offered within the one-stop clinic to encompass other nurse-led activities relating to patient experience and education.’

- The shift of hysteroscopy to outpatients at Cardiff and Vale has continued to be provided as the standard method of care, as has the reorganised approach to antenatal clinics at Great Western Hospitals. Both these project teams put a lot of effort into getting all the protocols, policies and procedures to support the change signed off and embedded in the organisations’ documented systems, which helped to provide a context for permanence.
- The ambulatory heart failure clinic at North Staffordshire was developed as part of a strategy to prepare services to move to a new hospital with fewer inpatient beds, so it was always envisaged as being an integral part of the redesigned services. Its success meant that the cardiac beds were closed early in the implementation of the plan.

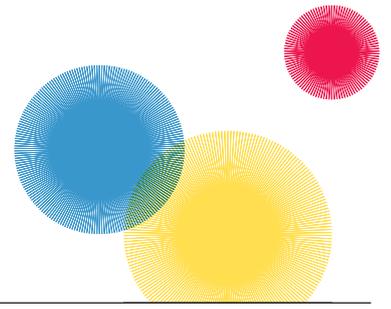
- The optimisation of patients’ blood iron pre-operatively continues to be routine practice in Airedale and is predominately nurse led. While the lead consultant tried to transfer the project to a large teaching hospital when he moved, this was not possible due to the greater complexity of the organisation. However, this hospital is now setting up an iron clinic for patients of all specialties and some of the protocols used in Airedale have informed their thinking. There are also plans for the development and staged roll-out of a patient blood management strategy, which will develop the evidence base and methodology of the Airedale project.
- The similar project at University College Hospital, to minimise post-operative blood transfusions, was pivotal in setting up a multicentre trial funded by the National Institute for Health Research (NIHR). The small-scale study enabled initial data collection which made the case for the larger study. This approach is now also being explored by a Department of Health working party to develop guidelines on pre-operative anaemia management.

The sustainability of some Shine projects has, however, been affected by organisational and structural changes in the NHS. The examples above tend to be in hospital inpatient services which have been a more stable context in which to introduce innovations in 2010–13.

Projects operating in community healthcare and primary care have found it more challenging to become established as the infrastructure and service boundaries have shifted. In such a period of uncertainty, securing funding for a further year or two has been a good result for projects such as PROCEED in Derby and NHS Fife’s micro-enterprise approach. The PROCEED approach has now been commissioned as a pre-conception service for Southern Derbyshire, making the vital shift from ‘project’ to ‘service’ status. The idea has also been taken up for local adaptation by services in Leeds and Norwich.

4

Improving access to information



Five projects explored ways of improving access to information for patients and increasing information flow between services, aiming to improve quality of care and reduce future use of services through better management of the condition. The projects were:

- 3 Counties Cancer Network – Transforming chemotherapy to involve patients in their treatment.
- Abertawe Bro Morgannwg University Health Board – ELIJAH electronic linkage for inflammatory bowel disease (IBD) to deliver joint access to health records
- Betsi Cadwaladr University Health Board – Virtual cardiology clinic
- Heart of England NHS Foundation Trust – Clinical laboratory database for early identification of patients at highest risk of developing end-stage renal disease
- NHS Redbridge – Empowering patients with chronic obstructive pulmonary disease to access high quality care

What the projects did

Giving patients and professionals better access to better information

Many patient complaints about health services stem from a lack of information, or inconsistent information. Equally, lack of communication of important information between organisations and between health professionals does not promote efficient and effective care. These five projects all sought to improve the way health services enable and promote information access for patients and

information flow between health professionals that would support better care management. While these projects made greater use of information technology to achieve their objectives, they were not primarily technology interventions.

Improving service user access to information

Three projects (ELIJAH at Abertawe Bro Morgannwg, the COPD checklist developed by NHS Redbridge and 3 Counties Cancer Network) focused on improving access to information for service users. The other two (the clinical laboratory database development at the Heart of England Trust and the virtual cardiology clinic at Betsi Cadwaladr) were developed to enable healthcare professionals to get earlier and easier access to expert information to facilitate better patient care.

The ELIJAH and NHS Redbridge projects had similar aims: to make information about disease and treatment – inflammatory bowel disease (IBD) and chronic obstructive pulmonary disease (COPD) respectively – more accessible to people with these conditions.

The team behind ELIJAH wanted to evaluate the extent to which a shared health record (between the hospital service, GPs and patients) could facilitate better communication, increase individual responsibility for healthcare and reduce demand for health resources.

The hospital team in the department of gastroenterology had already done considerable work to develop a local electronic record system prior to the inception of the Shine project, which was to develop the system for use beyond the hospital

department. Patients contributed to the development through focus group meetings and individual feedback on the presentation and format of information. The development enabled individual patients and their GPs to get much more detailed, individualised information about their condition.

The NHS Redbridge COPD project had some similarities, in that it was able to use work that had already been done to build up comprehensive electronic records in primary care for this patient group. In order to help patients gain a better understanding of the condition and their care, the project set out the elements of care recommended by the NICE 2010 guideline in an illustrated checklist. This was then personalised for the individual patient, showing which elements of care their record showed that they had received.

Enabling more effective use of data

Heart of England NHS Foundation Trust had pioneered the collation of test results for patients with kidney disease over time on cumulative graphs, to highlight if there was rapid loss of kidney function, which if not well managed could result in renal replacement therapy (RRT). This had already demonstrated success in reducing the number of expected patient referrals for RRT from the local population.

It was recognised that the existing customised local database, devised and managed by a renal consultant, would not facilitate the spread and uptake of this innovation. The aim of the project was, therefore, to develop an approach that could come up with the same easy-to-read graphs, using standard test results routinely collected by pathology departments.

From the start, this project was clear that the development had to be simple and compatible with all the main pathology IT systems to facilitate wide adoption. The other key element was to devise software that would enable laboratory staff to review the cumulative graphs in order to free up consultant time without adding a significant time burden for laboratory staff to review 400–500 cumulative graphs per week.

Developing better patient information

The 3 Counties Cancer Network project's aim was to develop better information for patients about chemotherapy in print and electronic formats and to encourage their involvement in care through an interactive website and real-time monitoring of side effects by mobile phone. However, the wide range of chemotherapy treatments and the complexities of delivering them meant that, within the project timescale, the main achievement was to raise awareness among healthcare staff providing cancer care services about toxicity assessment processes in chemotherapy and the need for a common approach. This was clearly an essential precursor to the development of information for patients and their closer involvement in care.

Keeping things simple

The successful projects all ensured that information was made available in a simple and accessible format. Presenting information diagrammatically and in plain English for IBD, COPD and reduced kidney function not only benefited patients but also enhanced the immediacy of the information for GPs and other healthcare professionals.

When introducing new ways of working it is important to be clear about what is involved. Use of terms such as 'virtual clinic' give a snappy title and a modern feel to the innovation but unless it is explained exactly what this is and how it is intended to work in simple terms, it is open to wide interpretation. Betsi Cadwaladr UHB's project aimed simply to offer clinician-to-clinician advice from hospital consultant to GP by email and telephone; it was not an 'artificial intelligence-driven, web-based avatar providing an alternative interface with patients' that the name virtual clinic might have suggested.

What was the response?

The experience for patients and staff

Feedback from COPD patients to NHS Redbridge was very positive about how the checklist helped them to understand their condition and how they could better self-manage. The checklist gave people the

knowledge to be more confident in asking questions of their GP and requesting the interventions recommended by the NICE guidance that they had not received, such as post-bronchodilator spirometry.

Patients' perceptions were backed up by an audit of primary care records. These showed that the percentage of patients with a self-management plan had increased from 7% to 20% and that post-bronchodilator spirometry had increased from 9% to 18%. Patients also reported that they made appointments with their GP or nurse specialist after receiving the checklist as it reminded them that they had not had an appointment for a while, or because there was a specific issue related to care as outlined in the checklist that they wanted to discuss.

Patients who accessed detailed records of their IBD care and treatment through the ELIJAH project used the 'My Plan' section of the record to check what the recommended action was with regard to varying medication in response to symptoms. They were then able to follow the recommendations with confidence as a first response, only contacting clinicians in primary or secondary care if this did not resolve the symptoms. Patients were also able to email or telephone the hospital care team about changes in their condition, resulting in more timely updating of their care plan. Patients reported feeling more knowledgeable about their condition, which gave them a greater sense of control.

Early detection of loss of kidney function, as highlighted by cumulative graphs developed at the Heart of England Foundation Trust, has enormous benefits for patients. Early detection enables optimisation of treatment for blood pressure control, including the correct drug therapy, education and lifestyle support that significantly delays the progression to end-stage kidney disease and the need for RRT – which may entail haemofiltration, haemodialysis or kidney transplant. The project surveyed GPs about how useful they found the 'alert' letter that goes out in response to cumulative loss of kidney function being noted from pathology results. Over 70% of GPs reported that they found these

alerts useful and, as they regard the data as highly credible, they are used as the basis for initiating a review with the patient.

Feedback on the virtual cardiology clinic was positive from GPs, who gained rapid access to advice on diagnostic and medication issues together with signposting appropriate paths for referral. The benefit in the acute hospital setting was a reduced number of hospital visits booked for patients who were not appropriate for the cardiology outpatient clinic and more rapid access for patients needing urgent appointments. Equally, patients were able to get rapid resolution of problems, within days rather than weeks, with reassurance for those who did not need a secondary care consultation and more timely access to care for those who needed examination and treatment from the hospital specialist team.

Did the projects save money?

- The potential for the Heart of England pathology database to save costs is significant. If consultants and their patients are able to act on the early warning and address the factors leading to the loss of kidney function, and so delay or even prevent the need for RRT, it saves in excess of £25,000 per patient, per year. The data from the pilot phase show the Trust's expenditure on RRT is static, in an area of high prevalence of diabetes and kidney disease, while hospital trusts serving comparable populations are showing increased costs for this therapy as a result of escalating morbidity. The development of the pathology based screening system enabled the screening of 400–500 cumulative graphs of test results per week and an additional 3% of patients were identified as being at risk of developing end-stage kidney disease. Highlighting this risk meant that the consultants were able to develop care management plans that can delay or prevent the need for RRT, thus potentially saving over £500,000 per year in treatment costs for these patients.
- The COPD checklist for patients included information on costs and this led to mixed reactions. Some patients found this interesting and reassuring, some

were encouraged to take better care of themselves and be more active in managing their symptoms: ‘... it opens your eyes to see what the NHS is doing for you... if they’re spending all this money then play the game and do the thing properly.’ Others found it worrying and that they were being made to feel guilty for using services that they needed: ‘What is the point of telling me that a 999 call costs £279? What difference is that going to make if I need a 999 call?’

- The Shine project timescale did not allow for any significant quantitative results to show costs saved from reducing emergency hospital admissions for COPD. However, COPD is one of the top five ambulatory care sensitive conditions (conditions that could be treated out of hospital) and accounts for 50% of unplanned emergency admissions to hospital for patients with these conditions. Over time the COPD checklist could help patients to manage their condition, with timely support from the primary care team, and could make a significant impact on the number and costs of unplanned admissions.

Spread and sustainability of the work

Some of the common experience across these projects with regard to sustaining and spreading the ideas was the importance of getting support from a range of different players in the healthcare system. GPs, practice nurses, patients’ groups, hospital specialists and the voluntary sector all had a part to play in convincing their peers and the other players to give the new approach a try. In many instances the GPs or the hospital specialists were key in getting the project off the ground, but in terms of further spread, demand from patients and information put out through voluntary sector channels were very important in gaining wider buy-in. The project leaders recommended building a community of stakeholders in the work, keeping them informed of progress and also using them actively to communicate the work and report it to their local networks through meetings, newsletters and in conversation.

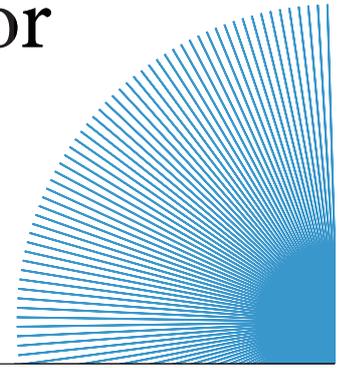
In common with other approaches, the sustainability of information-based interventions was linked to the project’s ability to become part of the commissioned service. Where it was not possible to generate cost data this was harder to achieve. Qualitative data relating to improved patient experience and a view that patients with access to more information would be able to better manage their care over time was useful in that it chimes with current policy initiatives related to patient choice and joint decision making.

A couple of the projects struggled to sustain their work as, over time, it became clear that they were not sufficiently aligned with trust-level plans for information sharing developments. Where these took a different direction, the projects struggled to realign their work to take advantage of the organisational levers.

In addition, the projects found it was essential to thoroughly research the current use of and familiarity with information technology if their information sharing intervention was to have wider applicability. Some parts of the NHS are still quite far behind other industry norms for email and internet knowledge transfer; even a simple email system for sharing knowledge may not be feasible if one of the partner organisations is not routinely using email in the same way as the others. Likewise several projects, such as the 3 Counties Cancer Network, planned to produce a DVD to provide information to patients but found they were behind the consumer curve, where patients expect to be able to access information via the internet and many modern home computers do not have DVD drives.

5

Support and training for staff and service users



Eight projects used training interventions to explore ways of supporting and up-skilling staff members and service users to enable them to provide a more effective service and/or to access services more appropriately. The projects were:

- Cardiff and Vale University Health Board, Mental Health Services – Reducing harm through training in use of a safety care bundle in inpatient mental health wards
- Central London Community Healthcare – The treatment of frozen shoulder with arthrographic distension, a specialist physiotherapist-led service in primary care
- Derbyshire Community Health Services – SIPS: strategy for integrated preventative pathway for swallowing difficulties
- Manchester Community Health – Facilitating multidisciplinary teams in providing nursing home residents with the right care in the right place at the right time
- North Bristol NHS Trust – Multidisciplinary team training to improve use of early warning scores in acute surgical wards
- NHS Stoke-on-Trent – Managing the demands for pathology testing from general practice.
- Poole Hospital NHS Foundation Trust – Stop chronic back pain
- University Hospital Southampton NHS Foundation Trust – From university to primary care: improving diagnosis and management of chronic obstructive pulmonary disease (COPD)

What the projects did

The training interventions aimed to enable services to reduce costs and improve quality by variously:

- training healthcare professionals to target treatment to the appropriate patients
- training staff in more appropriate (and often cheaper) interventions
- training staff to quickly identify patients at risk of harm.

Some of the projects trained staff within a service in a new skill or approach, such as the North Bristol training in early warning scores or the frozen shoulder service in Central London. Others were using the training intervention to spread ‘specialist’ knowledge into different healthcare settings, such as the Southampton COPD initiative, NHS Stoke-on-Trent’s approach for GPs on ordering pathology tests and two projects in Manchester and Derbyshire where community healthcare services worked with and trained staff in care homes. Only one project provided training directly to service users – the Poole initiative to tackle chronic back pain, which was unique among the projects in the way it integrated service users throughout.

Developing knowledge and skills for healthcare staff

Several of the interventions were introduced to provide enhanced knowledge and skills to a range of healthcare professionals, so that this would facilitate better use of healthcare resources. They focused on the right care in the right setting, with a special emphasis on preventing unplanned admissions to hospital from care homes and among people with COPD.

The Manchester Community Health project took a holistic approach to preventing unplanned admissions by concentrating on the area of end-of-life care plans for residents, tackling the emergency admission of people at the end of life for whom hospital care provided no benefit. The team ran workshops for care home staff to learn generic improvement methods and work through examples of practical improvement, focusing on quality of care for residents and building staff confidence that they could provide this in the care home setting.

The SIPS project in Derbyshire also worked with care home staff in the area of patient nutrition and appropriate care for people with swallowing difficulties. Older people with swallowing difficulties who had previously developed aspiration pneumonia accounted for 119 emergency admissions to Derby Hospitals in 2009–10. With more knowledge of how to care for people with swallowing difficulties in care homes, many of these admissions could have been avoided. Speech and language therapists developed and delivered a training package that enabled care home staff to recognise and respond appropriately to swallowing difficulties.

The Cardiff and Vale project aimed to tackle incidents of violence and aggression towards staff by introducing an evidence-based care bundle for patients on their initial admission to the acute mental health service. The aim was to lessen emotional distress to patients and staff while also reducing sickness absence, therefore reducing staff costs for the service.

The North Bristol staff training had similar aims, in the acute hospital setting, of both reducing harm to patients through unrecognised deterioration in their condition and reducing staff stress levels associated with dealing with cardiac and respiratory arrests. The training programme was designed to train ward staff to more readily recognise patients who need rapid intervention through the application of an early warning score and the correct calculation and response to the score. This would then enable patients to be admitted to intensive care in a timely way, reducing both patient harm and the length of stay in intensive care as patients would

not be so ill when admitted. In addition, it was hoped that better understanding of how to apply early warning scores would reduce stress levels among staff and therefore sickness absence levels.

Holding learning events for GPs and primary care teams

NHS Stoke-on-Trent developed a learning and development initiative to change GP behaviour when requesting pathology tests. The aim was to reduce unnecessary usage and to increase knowledge about cheaper alternatives that provide the same, or better, information than more expensive tests and to support this with individualised practice based reports.

In Southampton, the ‘From university to primary care’ project also aimed to enhance knowledge in primary care to address the diagnosis and management of COPD. The project team worked hard to encourage integrated working, with the involvement of secondary care nurses and clinicians, community care specialists and GP and nursing leads in the area. An audit of emergency hospital admissions related to COPD was commissioned before the Southampton project launched. This revealed that 34 patients were each admitted more than three times the previous year and were responsible for 176 of the 800 admissions. This helped identify a key pattern in service use and allowed specialist care to be targeted to the patients who really needed it.

Both projects managed to:

- successfully pitch their ‘offer’ for GPs and primary healthcare teams
- transfer the knowledge to enable changed practice
- get GPs and the wider primary healthcare team engaged in the delivery of the project aims.

Such achievements are crucial to make any progress with the policy of shifting care and management of long-term conditions from acute to primary care. In a situation where hospital clinical specialists, national

healthcare charities and continuing education leads for primary care are all trying to get access to GPs, provide ‘training’ and change practice to ensure better primary care support for a multitude of different conditions, finding approaches that lead to ‘win-win’ situations with benefits for all, is crucial.

- The team from NHS Stoke presented their initiative as a masterclass, which recognised the existing level of expertise among GPs and supported improvement through reports to each practice demonstrating improved adherence to best practice pathology ordering.
- The Southampton COPD team worked to a great extent with practice nurses, helping them to improve the way they performed roles and tasks they were already engaged in, such as spirometry tests. They were not presenting extra work but offering greater ease in carrying out existing work, supported by web-based guidance on the latest evidence and who to contact locally for more information and support.

Training to provide a new service

Specialist training for physiotherapists in the Central London Community Healthcare project equipped them with the skill to undertake treatment for ‘frozen shoulder’ that is cheaper and can be more effective than the conventional hospital-based approach. It also enabled the service to be relocated from hospital to the community health service.

This generated new income for the organisation while saving money for the health economy. In addition, the new service was far more convenient for patients as the patient pathway from referral to end of treatment was two weeks, rather than 18 weeks on the conventional pathway.

Empowering service users

Poole Hospital’s ‘Stop chronic back pain’ project was one of the most successful in engaging service users. It aimed to provide timely intervention (training and support) to enable people with chronic back pain to cope better with the pain. The pain management programme was offered if back pain was

not resolved within three months. This was an alternative to the linear approach of consultation, leading to investigation and then possible intervention, which often extends beyond three years, while the person with back pain becomes less able, over time, to change their approach to managing the pain. Service users also used social media to support the project, setting up and running a Facebook page that many found more accessible than the website.

In order to ensure that the service was relevant and provided accessible support, service users were involved from the outset; sitting on the steering group, planning the content and being part of the delivery of the pain management programme. Healthcare professionals who took part reported how the new approach has changed their practice towards being more collaborative with service users:

‘... instead of telling them what to do I am mentoring them... into a new way of coping with their pain.’
(Mufeed, GP)

Did the projects save money?

Some investments in training showed clear cost savings.

- The Southampton COPD project to support better care in the community estimated that, in the 12 months after the project was established, there was a reduction of 160 COPD emergency care hospital admissions for the patients identified as most at risk of emergency admission. The average cost of an emergency admission for COPD was estimated at £2,000. The staff inputs needed to carry out the detailed audit of admissions by a nurse, plus 16 sessions of consultant time to carry out discovery interviews with the patients at highest risk of unplanned admission, were estimated at £8,200. Therefore, a saving of £311,800 was estimated over the year.
- The new Central London Community Healthcare care pathway for frozen shoulder demonstrated that the investment of £8,800 for two staff to be trained in

the procedure could be recouped after 58 procedures, as it cost £148 per patient, compared to £302 via the traditional care pathway (a saving of £154 per patient). The two trained staff undertook eight frozen shoulder treatments per month, so the break-even point was reached seven months after completing training in the technique. These figures include an element of London weighting for the staff costings; to generalise these across the UK, the cost per treatment by a physiotherapist was estimated at £121, compared to £251 for the usual pathway, a saving of £130 per patient treated.

- The ‘Stop chronic back pain’ intervention with service users was designed to be completed over seven weeks, with a weekly 6.5 hour session for participants – a total of 45.5 hours. This was opposed to the normal pain management course, which was two days a week for eight weeks, plus weekly hydrotherapy, plus a final half-day session, totalling 112 hours of therapist input. The intervention therefore reduced the staff time needed to run one course by more than half. In addition, the new programme was run in a range of different community settings, demonstrating that it was not necessary to use the relatively expensive ‘clinic’ environment. The potential wider benefits to society of early intervention include retaining people with chronic pain in the workforce and reducing the need for long-term physical, psychological and mental health inputs for people with chronic pain.
- Manchester Community Health reported a reduction in the number of inpatient admissions and the average length of hospital stay per admission of residents from the care homes that were part of the collaborative. This led to savings of approximately £120,000 over the project (just less than a year), based on an average inpatient bed day cost of £255.

For other projects, measuring the training’s ‘success’ in reducing cost or improving quality was challenging, particularly the further the training intervention was from the desired improvement in service outcomes. It proved

very difficult to make a causal link in terms of reduced cost and improved quality of care at North Bristol hospital to the provision of staff training in early warning scores. Likewise, in the Cardiff and Vale mental health inpatients service, training staff in the admission care bundle was hard to link to measures of cost and quality for mental health services. Any conclusive link between undertaking this training and rates of staff sickness absence, due to stress, proved even more elusive, particularly as unrelated organisation-wide cost reduction measures changed or eliminated the use of agency staff, one of the measures initially selected to demonstrate the cost effectiveness of the intervention. The training in both cases made a valuable contribution to overall improvement in patient safety, equipping staff to prevent harm, but the economic measures available were not robust enough to make a business case in terms of reduced costs.

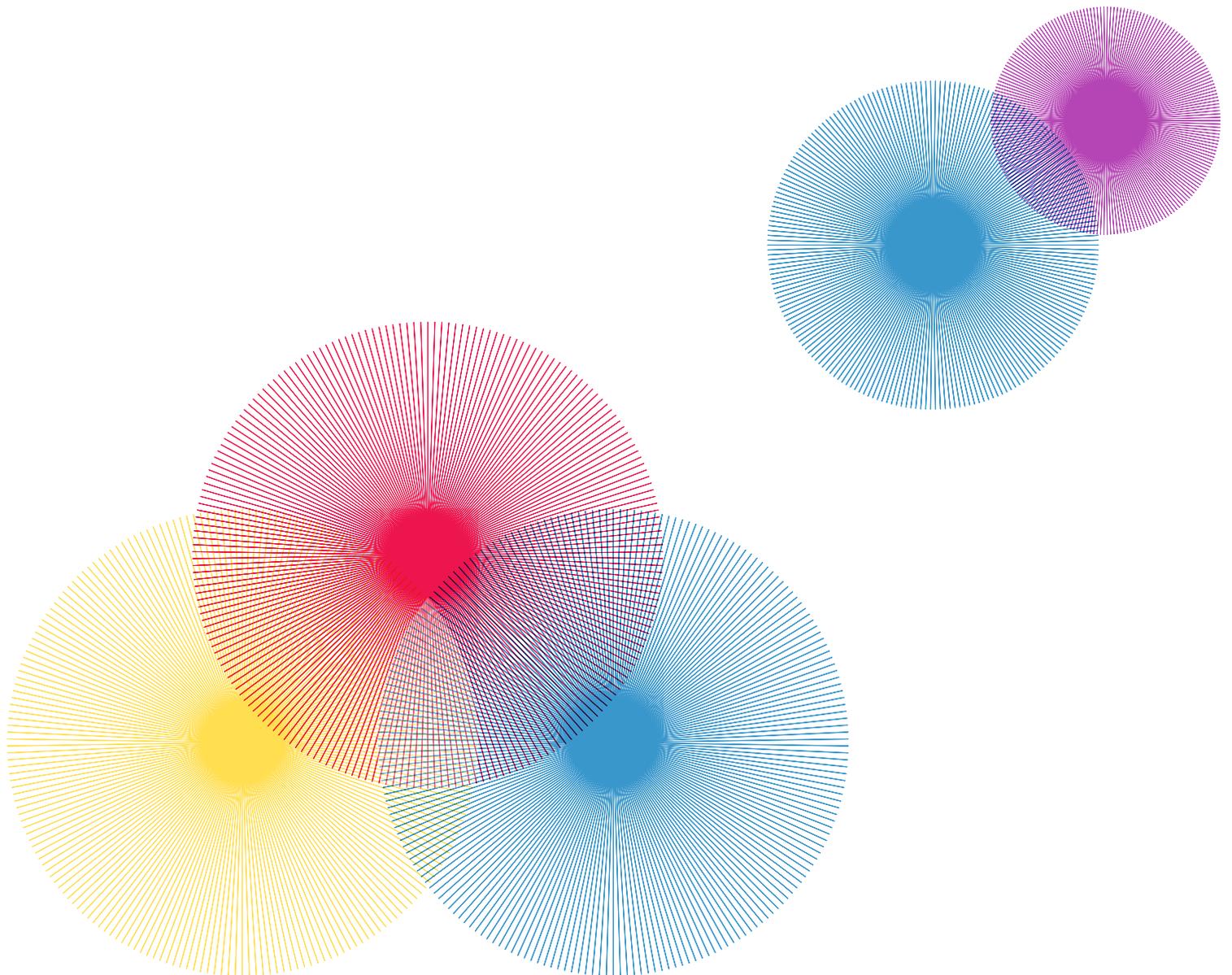
Spread and sustainability of the work

The Manchester care home collaborative reported that collaborative working between the NHS community health service and the private sector care homes empowered staff to lead improvements and make changes to care planning to respond to residents’ preferences. The development of new knowledge and skills for quality improvement helped to improve staff attitudes and work satisfaction. The project was instrumental in considerably reducing the barriers to communication that existed between the community health services and the care homes. A project team member commented: ‘Working on collaborative teams has led to an increased understanding of different services and an improvement in the communication of vital information.’

The ‘Stop chronic back pain’ approach in Poole has been used as the basis for commissioning community back pain services across the county. The pain service for Dorset will use the two-tier model of multidisciplinary early intervention and prevention combined with peer support for people with chronic pain, through the ‘Pain Chain’ in which trained volunteers – who themselves have chronic

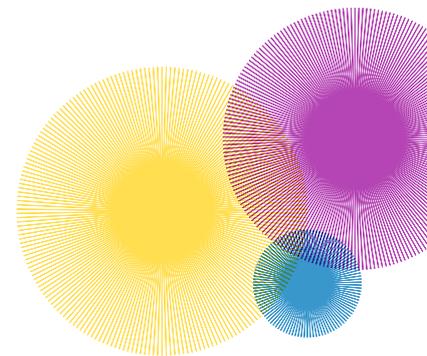
pain – support others in techniques to manage the pain. The pain service will also include education for primary care teams, ensuring a wider understanding of the psychological aspects of pain management alongside the physiological treatment options. While this presents a great opportunity for effective, person-centred care in pain management, there are also challenges in this expansion of the service, not least the requirement to increase the number of voluntary coaches for the ‘Pain Chain’ approach to meet the demands of a countywide service.

The development of web-based resources has enabled the continued support for the management of COPD in primary care across the Southampton area. The input from the acute team has led to more detailed and accurate disease registers in primary care and, on the acute side, has resulted in better management of referral and admission systems for COPD patients when they do need to go to hospital. Southampton’s respiratory centre as a whole has been able to take on more quality improvement work.



6

Lessons from the projects about success in local innovation



Success factors

Local clinical leadership

The local clinical leadership of the work was one of the crucial factors for the successful Shine projects. Each project was targeted on an intervention for which there was significant clinical recognition that local improvement was needed, and the idea was developed and led by the clinical leaders of the service. Success was built on a lot of voluntary effort to develop the innovation and extra hours worked to support its implementation, through tasks such as writing protocols.

This ‘bottom-up’ approach to improvement meant that there was local ownership of the project work. In the course of developing their application for the programme, clinical teams had to demonstrate from their own data (which they trusted) the problem with the current service delivery that their project was designed to tackle and their case for change. This process meant that clinical teams not only agreed that there was a problem to be fixed but they were involved in developing the local solution to it.

Clinical leadership also facilitated the promotion of the project ideas, as there are clear opportunities for peer-to-peer learning through professional seminars and conferences. Clinical professionals in similar services recognise the scenarios that have led to the need for improvement and can identify how something similar might work in their own setting.

Project management

The implementation of the projects clearly demonstrated the importance of having a dedicated project manager to work alongside the clinical lead for the project. Project

managers were vital in making sure all the logistics were in place for the innovations to be implemented in the midst of ‘business as usual’ clinical processes. This included liaison with IT departments, setting up meetings with the key project members, such as nursing home managers and staff from other departments, getting patient information leaflets produced and collecting feedback data to measure the project impact.

Planning

It is not surprising that detailed planning, before starting project implementation, was a key factor in the success of Shine projects. The discipline of applying for the award and then discussing the project plan with a consultant from Springfield (the organisation commissioned to provide external advice to project teams) helped projects develop thought-through implementation plans before getting started. This approach suggests that there is a useful role for internal improvement teams to work with clinical teams on their innovation and change projects.

Teams also noted that it was important to involve the whole project team in the planning and then to communicate the plan to all the staff in the services who would be affected. This was particularly useful in identifying possible barriers and starting work to overcome these.

Communication

Effective communication is vital to engage staff and stakeholders in a project. It is important to keep messages consistent to help avoid confusion and misunderstanding. Regular meetings and updates with team members and stakeholders can also help

identify problem areas and encourage ideas about how to tackle them from across the project team and the wider organisation.

Early interaction with senior managers can also be helpful in ensuring that there is top-level knowledge of the project and support for implementation, increasing credibility. Too much focus on ‘bottom-up’ development and local clinical ownership can mean that other departments and services ignore the initiative and find reasons why it is not relevant for them to implement. Disseminating information about the initiative to senior managers across the organisation is useful and, in turn, helps spread successful innovations.

Presentations to board members, staff and managers were very effective in engaging people in the projects. Projects also found posters, leaflets and articles in staff and service user newsletters useful for communicating about their work.

Challenges

A number of obstacles prevented some projects from achieving their original objectives. The most common challenges are summarised below.

Data collection

A major lesson that emerged is the difficulty of using routinely collected quantitative data to measure changes or the effectiveness of a new approach. Many projects found that once their data were submitted to an organisational, regional or national data collection, it was no longer possible to disaggregate the data to provide local figures. Others found that routine data were poorly collected and not accurate enough for their purposes.

Even when there was a suitable source of data, project teams reported that it was difficult to engage the required expertise to extract it from a multiplicity of systems in any timely way. Gathering data can be extremely time-consuming for clinicians who are trying to evaluate their own practice. Inconsistencies in the ways data are collected can also cause delays and confusion. For example, the Cardiff mental health project reported:

‘We found significant challenges in obtaining robust data concerning ward routine. We had envisaged that such routine clinical data would be simple to collect and reliable. However we found the reliability of the data was variable, and considerable time was required to assess its validity and conduct necessary data cleaning. There was also unexpected variability in time lag between incidence occurrence and central data collection.’

Underestimating the work involved

This was reported by a number of teams, particularly regarding:

- data collection on measures for costs and quality
- preparation of documented protocols to support new ways of working
- recruiting staff to project posts, particularly where these were deemed to be ‘new’ posts and organisations were under a recruitment freeze. This meant extra negotiation time was needed to make the case for ‘exceptions’ to the policy as the posts were supported by external funding.

Workforce issues

Small project teams are susceptible to delays if team members are absent or on sick leave. For some projects, the absence of a key team member meant that work was unable to progress without their specific knowledge or input.

Some projects also found it hard to keep all members of the project team motivated, as they were having to work on the project while also doing their ‘day job’.

The Urology Rapid One Stop project at Imperial College Healthcare reported:

‘The nursing team have been supportive of the activity but it became clear very early in the programme that their initial establishment was insufficiently

stable to support effective delivery of the service. At the start of the programme nursing was delivered by a small number of employee staff with a significant number of outstanding posts filled by short term Bank staff. This lack of stability, coupled with limited full-time nursing supervision led to challenges around communication and consistency of service.'

This was resolved through a review of the nursing establishment to determine appropriate staffing levels.

Lack of engagement beyond the project team

A lack of engagement with key staff groups can lead to misunderstandings and misconceptions. For example, in one project it was reported that a lack of engagement with administrative staff led to a belief that their workload was set to increase. Misunderstandings like this can lead to reluctance to embrace proposed changes to the way services are delivered.

Some of the projects also suffered when there was a lack of engagement and follow through by executives who had supported the application. The executive sponsor needed to be seen to support the project through attendance at key events, and to confirm that the work was a priority, thus encouraging the engagement and support of others throughout the organisation. Where this was lacking, projects reported:

- delays when input was needed from teams and departments beyond the core project team
- a drop in project team morale
- difficulty in getting access to the meetings and individuals needed to support continued investment in the work.

Failing to demonstrate clear benefits

Following the end of the programme, 20 of the 32 Shine projects were able to influence local decision makers to continue the new way

of working and to establish this as 'business as usual'. A further four, while not able to secure a permanent change to using the new approach, were able to secure continued funding for one or two more years to test their concept and/or develop the work further.

For those that were not able to secure funding to either sustain or spread their innovation, this would appear to be in part due to having no data to show how the intervention led to quantifiably improved quality for patients, although almost all projects were able to provide a narrative of improved quality of care.

More significantly, few of the projects that did not secure future funding were able to generate robust evidence on the extent to which the changed practice generated actual savings or showed clear potential to save money through reducing staff time on aspects of care or treatment, such as reduced length of stay. The projects that did not identify clear measures of how the changes improved the way service was delivered found it hard to convince managers to retain the piloted innovations. In order to persuade decision makers to implement any changes on a permanent basis, reliable data on costs, savings, patient outcomes and improved patient experience – in that order – are essential.

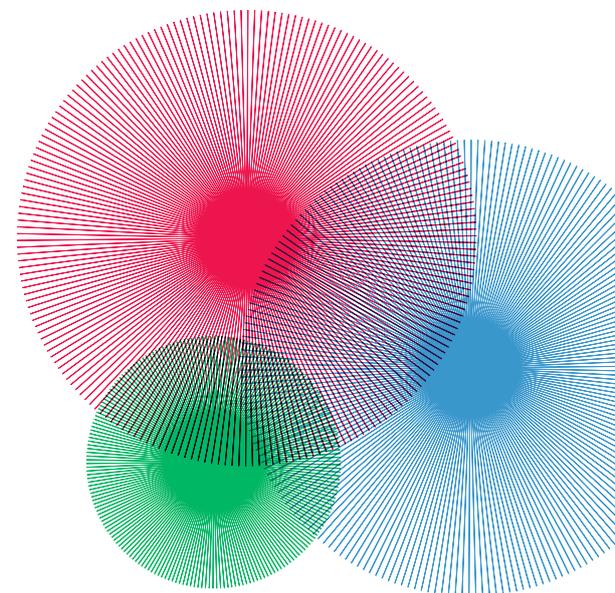
Challenges for future innovation

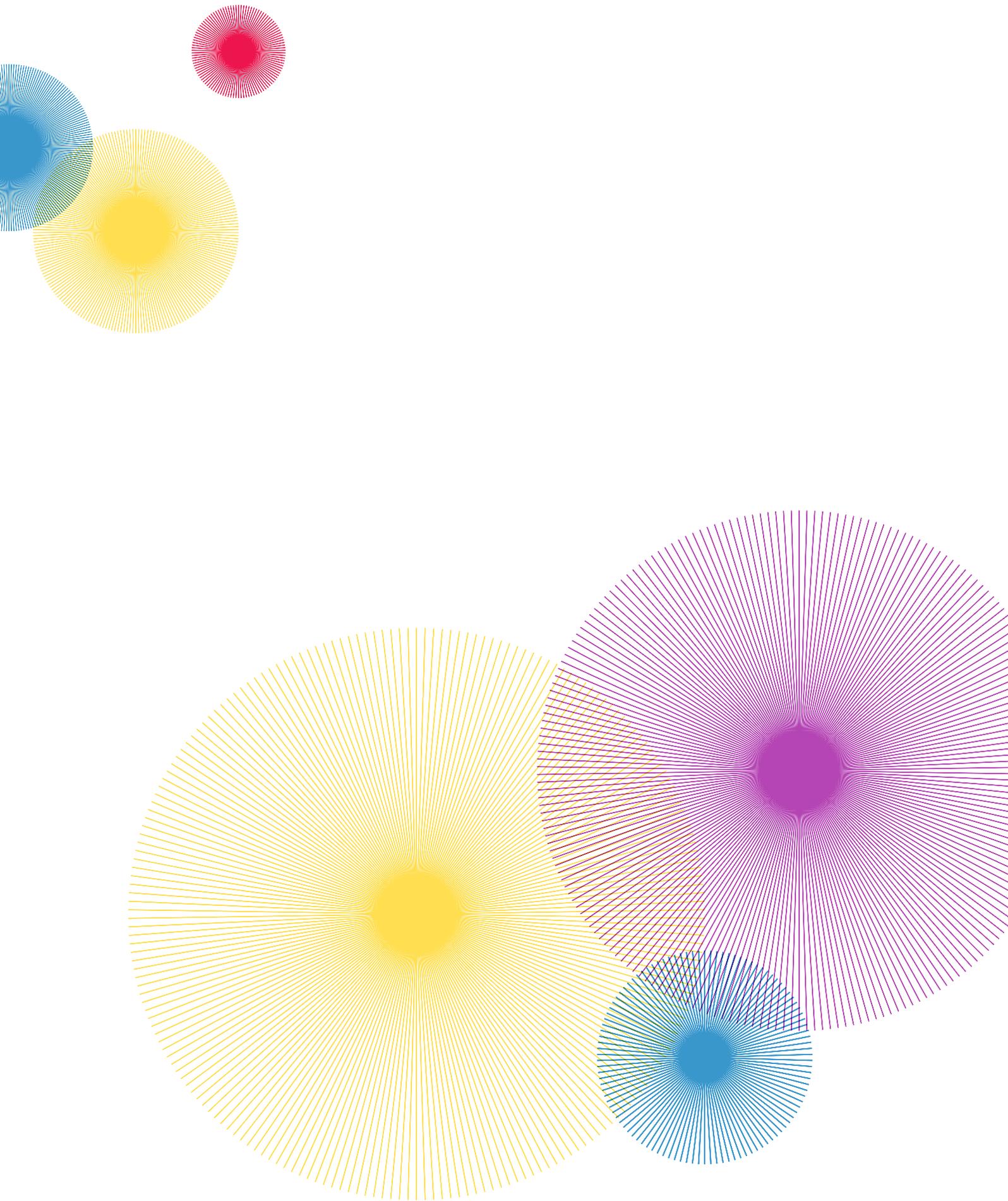
Despite the projects' successes, it is not clear to what extent the approaches they tested have been adopted outside the originating organisations. There is definitely wider interest in the work and project teams have made numerous conference presentations, held local seminars and made visits to other organisations to discuss adopting the approaches. However, even when innovations are shown to be successful in one setting, there are enormous barriers to introducing such changes into other healthcare organisations. These include the lack of external funding to provide back-fill pay for the extra work when clinicians are adapting the approach for local implementation; and the nature of healthcare organisations to be risk averse and unwilling to invest in changing their service on the basis of one exemplar project. There is also a potential barrier of a lack of 'kudos' in taking on an idea from elsewhere, as opposed to local innovation.

Before starting the Shine programme, many of the projects had already done some small-scale tests and the Shine award gave them the opportunity to pilot the new approach to service provision for real. It was striking that many of the project proposals had a well-worked-through business case for their innovation and were clear about its potential to save money or increase productivity, yet winning the external funding from the Health Foundation was the only way to get started.

The NHS will be operating in a period of constrained funding for several years to come and it is vital that services are creative in finding ways to deliver more within the current resources. However, every potential change has an 'opportunity cost', in terms of staff time and energy and the willingness to invest in trying to make the change effective. Clinical leads and service managers have to be convinced that the change is targeting a problem in their service that they recognise as real, such as poor quality for patients or less than optimal use of resources, and that the intervention proposed to tackle this offers clear benefits compared to current practice.

The challenges facing the NHS are greater than ever and it is hugely important that innovative approaches to tackle these issues are developed and ideas implemented in practice to test, measure and explore rigorously whether and how they work. The Health Foundation, through our Shine programme, will continue to support healthcare organisations to develop new and creative ways to improve services.





Appendix 1: Further information and resources

For more details about the Shine projects see the Health Foundation website:

www.health.org.uk/areas-of-work/programmes/shine-ten/projects

www.health.org.uk/areas-of-work/programmes/shine-eleven/projects

Awards, articles and other resources from the projects

Awards won by the projects

DAWN: Diabetes Appointments via Webcam in Newham

- Winner 2013 Quality in Care Diabetes Awards
- Finalist of 2013 EHealth Insider Awards
- Best Poster Prize 2013 International Society for Quality in Healthcare (ISQua), Edinburgh

Derby Hospitals NHS Foundation Trust – A ‘team without walls’ approach for pre-pregnancy care in diabetes (PROCEED)

- Health Services Journal and Capgemini-Liberating Ideas 2011 prevention category
- Health Enterprise East award 2012 for innovation in Long Term Conditions
- Winner 2012 Quality in Care Diabetes Award

NHS Stoke-on-Trent Flo’ text messaging

- NICE Shared Learning Top 20 – 2012/3
- NHS QIPP Challenge Award 2012
- The NHS Innovator of the Year 2012 (Phil O’Connell project lead)
- West Midlands NHS Inspirational Leader of the Year 2013 (Phil O’Connell project lead)

University Hospital Southampton NHS Foundation Trust – From university to primary care: improving diagnosis and management of COPD

- HSJ Award for innovation, 2011

University Hospital of North Staffordshire NHS Trust – Ambulatory heart failure unit

- Nursing Times, Cardiac Team of the Year, 2011

Journal and general media articles

NHS Stoke-on-Trent Flo’ text messaging

- Cottrell E, Chambers R, O’Connell P. Using simple telehealth in primary care to reduce blood pressure: a service evaluation. *BMJ Open* 2012;2:e001391 doi:10.1136/bmjopen-2012-001391.
- Cottrell E, Chambers R, McMillan K. A cross-sectional survey and service evaluation of simple telehealth in primary care: what do patients think? *BMJ Open* 2012;2:e001392. doi:10.1136/bmjopen-2012-001392.
- Chambers R. Telehealth no longer a remote possibility for general practice. *GP* 9 January 2013. www.gponline.com/News/article/1165775/telehealth-no-longer-remote-possibility-general-practice/
- Chambers R. Phone it in. *BMA News*; 26 January 2012; 10.
- Chambers R. Series of five articles in *GP Online* on how Flo telehealth is applied in clinical practice eg obesity – see, for example:
 - www.gponline.com/News/article/1172963/Adopting-remote-monitoring-via-telehealth-CCGs-practices---part-1-hypertension/

- www.gponline.com/News/article/1173456/Adopting-remote-monitoring-via-telehealth-CCGs-practices---part-2-inhaler-reminders/
- Chambers R. How can telehealth help patients take responsibility for their health? *The Guardian* 21 May 2013. www.guardian.co.uk/healthcare-network/2013/may/21/telehealth-helps-patients-responsibility-health-wellbeing

University College Hospital: Increasing patients' blood iron to reduce transfusions for elective surgery

- Musallam KM, Tamim HM, Richards T et al. Preoperative anaemia and postoperative outcomes in non-cardiac surgery: a retrospective cohort study. *Lancet* 5 October 2011;378(9800):1396-407.

DAWN: Diabetes Appointments via Webcam in Newham

- O'Shea T, Morris J, Patel S, Maddin S, Greenhalgh T, Gill M, Partlett T, Vijayaraghavan S. DAWN: Diabetes Appointments via Webcam in Newham. *Journal of diabetes nursing*, Sept 2012
- Hospitals and patients urged to take action on missed appointments. Department of Health press release. 27 August 2012. <http://mediacentre.dh.gov.uk/2012/08/27/hospitals-and-patients-urged-to-take-action-on-missed-appointments>
- Secretary of State address on technology in health: <http://mediacentre.dh.gov.uk/2013/03/13/13-march-2013-jeremy-hunt-innovation/>
- Missed NHS appointments cost millions. *The Guardian*. www.guardian.co.uk/society/2012/aug/27/missed-nhs-appointments-cost-millions?newsfeed=true
- Smith, R. Skype and text to avoid patients missing appointments NHS told. *The Telegraph*. 27 August 2012. www.telegraph.co.uk/health/healthnews/9497471/Skype-and-text-to-avoid-patients-missing-appointments-NHS-told.html

- Pickover E. NHS paying huge price for missed appointments. *The Independent* 28 August 2012. www.independent.co.uk/life-style/health-and-families/health-news/nhs-paying-huge-price-for-missed-appointments-8082537.html
- Doctors told to Skype and text to tackle millions of missed appointments. *The Daily Mail* 27 August 2012. www.dailymail.co.uk/health/article-2194106/Doctors-told-Skype-text-reduce-number-missed-appointments.html
- *London Metro* <http://e-edition.metro.co.uk/2012/03/22/>
- Heighton L. The doctor will Skype you now. *The Sun* 27 August 2012. www.thesun.co.uk/sol/homepage/news/politics/4506371/NHS-doctors-ordered-to-use-Skype-to-see-patients.html

Derby Hospitals NHS Foundation Trust – A 'team without walls' approach for pre-pregnancy care in diabetes (PROCEED)

- King P. A new model for preconception care in women with diabetes. *Journal of Diabetes Nursing* 17:56-61, 2013
- King P. Update on PROCEED as part of Integrated Care in Derby. *Diabetes Update*, Summer 2013.
- King P. *PROCEED preconception care for diabetes*. Health Foundation patient safety resource centre, accessed via: www.patientsafety.health.org.uk/resources/proceed-preconception-care-diabetes

Heart of England NHS Foundation Trust – Using pathology data to identify risk of end-stage kidney disease

- Rayner HC, Hollingworth L, Higgins R, Dodds S. Systematic kidney disease management in a population with diabetes mellitus: turning the tide of kidney failure. *BMJ Quality & Safety Online*, 30 June 2011.

University Hospital of North Staffordshire– Perineal assessment and repair e-learning system (PEARLS.net)

- Mahmud A, Kettle C, Bick D, Rowley C, Rathod T, Belcher J et al. The development and validation of an internet-based training package for the management of perineal trauma following childbirth: Maternity PEARLS. *BMJ Postgraduate Medical Journal*, 30 March 2013.

Useful websites and resources

- Derby Hospitals NHS Foundation Trust – Approach for pre-pregnancy care in diabetes: www.derbyproceed.co.uk
- Dorset Pain Society – information on managing chronic pain: www.dorsetpain.co.uk
- Heart of England NHS Foundation Trust, Rehabilitation for Operated Lung Cancer Programme Manual
<https://custom.cvent.com/464E3F92FA17483BB9CCBE2A3058CD61/files/ae47c2268ea747f5951e71775dac506e.pdf>
- NHS Bolton Alcohol relapse reduction programme: www.relapseproject.co.uk
- NHS Fife Reshaping care for older people, information on implementing a personal outcomes approach: We've got to talk about outcomes. Report 2: *A question of purpose*. www.alliance-scotland.org.uk/resources/library
- Southampton University Hospitals patients' education website on COPD: www.copdeducation.org.uk/patients
- Stoke-on-Trent telehealth text messaging: www.stoke.nhs.uk/simple/aim
- University Hospitals of Leicester – Activate Your Heart: www.activateyourheart.org.uk

NHS Evidence Shared Learning and QIPP Collections

Interactive simple telehealth for the management of blood pressure

- www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=617

Service redesign: early identification of patients at risk of developing end-stage kidney disease

- https://www.evidence.nhs.uk/document?ci=http%3A%2F%2Fwww.evidence.nhs.uk%2Fresources%2FQIPP%2F237569&ReturnUrl=%2Fsearch%3Fom%3D%5B%7B%22srn%22%3A%5B%22%2520qipp%2520%22%5D%7D%5D%26fs%3Dqippcat.WorkStream_LongTermConditions

Presentations

The projects have been widely presented at healthcare conferences, both clinical speciality conferences and events focussed on quality and safety. Selected presentations on the project work include the following:

DAWN: Diabetes Appointments via Webcam in Newham

- London Health Symposium, 2011
- NHS Future Forum Panel Discussion and Report, 2011
- International Forum of Quality and Safety in Health Care, Paris, 2012
- National Diabetes in Pregnancy Conference 2012
- Diabetes UK, 2012
- International Society for Quality in Healthcare, Edinburgh, 2013

University College Hospital: Increasing patients' blood iron to reduce transfusions for elective surgery

- British Blood Transfusion Society Hospital Transfusion Specialist Interest Group, Glasgow, 2011
- Network for Advancement of Transfusion Alternatives, Dublin, 2011
- Irish National Haemovigilance Conference, Dublin, 2012
- Preoperative care, London, 2012
- Patient Blood Management 3, London 2012
- Network for Advancement of Transfusion Alternatives, Copenhagen, 2012

- Anaesthesia for Major Surgery, Royal Marsden, 2013
- Patient Blood Management in Gynaecology, Zurich, 2013
- Royal College Anaesthesia training day, London, 2013
- British Blood Transfusion Society, Birmingham, 2013
- British Blood Transfusion Society Hospital Transfusion Specialist Interest Group, Birmingham 2013
- Network for Advancement of Transfusion Alternatives, Vienna, 2013

Derby Hospitals NHS Foundation Trust – A ‘team without walls’ approach for pre-pregnancy care in diabetes (PROCEED)

- NHS Diabetes and Pregnancy, four regional network events, 2012
- NHS Diabetes Yorkshire and Humber improving diabetes through Primary Care, 2013
- NHS Diabetes, 2013
- Diabetes UK Annual Professional Conference, Manchester, 2013
- 2nd National Diabetes and Pregnancy meeting, 2013
- Future of Healthcare - long term conditions meeting, 2013
- International Society for Quality in Healthcare, Edinburgh, 2013

Great Western Hospitals NHS Foundation Trust – A radical restructuring of antenatal care for high risk pregnancies

- Royal Society Of Medicine, Study day on cost and quality, November 2010
- Harvard Business School, Value in Health Care Seminar, 2012

Heart of England Foundation Trust – Rehabilitation for operated lung cancer

- Society of Cardiothoracic Surgeons Annual Meeting, 2011
- British Thoracic Oncology Group, National Conference, 2011

- European Society for Cardiothoracic Surgeons Conference, 2011

Heart of England NHS Foundation Trust – Clinical laboratory database for early identification of patients at highest risk of developing end-stage renal disease

- International Society for Quality in Healthcare, Edinburgh, 2013

NHS Bolton – Alcohol relapse prevention programme

- International Forum on Quality and Safety in Health Care, Paris, 2012
- International Society for Quality in Healthcare, Edinburgh, 2013

NHS Fife – Micro-enterprise care solutions to reduce acute hospital admissions and facilitate earlier discharge

- International Society for Quality in Healthcare, Edinburgh, 2013

Poole Hospital NHS Foundation Trust – Stop chronic back pain

- British Pain Society, National Conference, Bath, 2011
- International Forum on Quality and Safety in Health Care, Paris, 2012
- INVOLVE National Conference, Nottingham, 2012

University Hospital Southampton NHS Foundation Trust – Improving diagnosis and management of COPD

- British Thoracic Society, Summer Conference, 2011
- Primary Care Respiratory Society, Annual Conference, 2011

University Hospitals of Leicester NHS Trust – Activate Your Heart: web-based rehabilitation programme

- Health Services Research Network UK Symposium, Nottingham, 2013

University Hospital of North Staffordshire NHS Trust – Ambulatory heart failure unit

- International Forum on Quality and Safety in Health Care, Paris, 2012

Appendix 2: Shine awards 2010–2011

Please note: All the organisation names are those which were current when the Shine awards were made.

Shine awards made in 2010

3 Counties Cancer Network – Transforming chemotherapy to involve patients in their treatment

Abertawe Bro Morgannwg University Health Board – ELIJAH electronic linkage for inflammatory bowel disease to deliver joint access to health records

Airedale NHS Foundation Trust – Conserving a scarce resource and improving outcomes: blood conservation for primary joint replacement

Betsi Cadwaladr University Health Board – Virtual cardiology clinic

Cardiff and Vale University Health Board, Mental Health Services – Reducing harm through training in use of a safety care bundle in inpatient mental health wards

Great Western Hospitals NHS Foundation Trust – A radical restructuring of antenatal care for high risk pregnancies

Heart of England NHS Foundation Trust – Rehabilitation for operated lung cancer

Imperial College Healthcare NHS Trust – Transformation of urology outpatients at Charing Cross Hospital

Manchester Community Health – Facilitating multidisciplinary teams in providing nursing home residents with the right care in the right place at the right time

North Bristol NHS Trust – Multidisciplinary team training to improve use of early warning scores in acute surgical wards

Royal Orthopaedic Hospital NHS Foundation Trust – Computer system for pre-operative assessment of patients undergoing elective surgery

Salford Community Health (now part of Salford Royal NHS Foundation Trust) – ‘Working Well’ service for NHS staff with musculoskeletal disorders

University Hospital Southampton NHS Foundation Trust – From university to primary care: Improving diagnosis and management of chronic obstructive pulmonary disease (COPD)

NHS Stoke-on-Trent – Managing the demands for pathology testing from general practice.

University College Hospital – The use of pre-operative iron therapy in anaemic surgical patients to prevent peri-operative blood transfusion

University Hospitals of Leicester NHS Trust – Activate Your Heart: web-based rehabilitation programme

University Hospital of North Staffordshire – Perineal assessment and repair e-learning system (PEARLS.net)

University Hospital of Wales Cardiff and Vale University Health Board – Outpatient operative hysteroscopy: a cost-effective alternative to day-case theatre

Shine awards made in 2011

Bangor University School of Medical Sciences
– From push to pull: using advanced triage to facilitate early discharge, escalation to critical care and referral for rehabilitation in acute medical units

Birmingham Children's Hospital NHS Foundation Trust – Young Lives: early warning through continuous remote monitoring

Central London Community Healthcare
– The treatment of frozen shoulder with arthrographic distension, a specialist physiotherapist-led service in primary care

Derbyshire Community Health Services – SIPS: Strategy for integrated preventative pathway for swallowing difficulties

Derby Hospitals NHS Foundation Trust
– A 'team without walls' approach for pre-pregnancy care in diabetes (PROCEED)

Heart of England NHS Foundation Trust
– Clinical laboratory database for early identification of patients at highest risk of developing end-stage renal disease

NHS Bolton – Alcohol relapse prevention programme

NHS Fife – Micro-enterprise care solutions to reduce acute hospital admissions and facilitate earlier discharge

NHS Redbridge – empowering patients with chronic obstructive pulmonary disease to access high quality care

NHS Stoke-on-Trent – Using interactive text-based telehealthcare support in the management of hypertension in general practice

Newham University Hospital NHS Trust
– Diabetes Appointments via Webcam in Newham (DAWN)

Poole Hospital NHS Foundation Trust – Stop chronic back pain

Sheffield Teaching Hospitals NHS Foundation Trust – Development of a novel ambulatory haematological cancer service

University Hospital of North Staffordshire NHS Trust – Ambulatory heart failure unit

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.

We are here to support people working in healthcare practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

The Health Foundation
90 Long Acre
London WC2E 9RA
020 7257 8000
info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

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