PATIENT SAFETY AWARDS 2020

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PROJECT SHOWCASE

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General Medical Council

END OF LIFE CARE AWARD

WINNER

LONDON AMBULANCE SERVICE IN COLLABORATION WITH MACMILLAN

BUILDING STAFF CONFIDENCE AND ALTERNATIVE CARE PATHWAYS IN END OF LIFE CARE

The London Ambulance Service NHS Trust (LAS) and Macmillan Cancer Support have collaborated in a programme to improve the quality of care provision for end of life care (EoLC) patients within the prehospital setting. A key aim of the programme is to care for patient in their home and reduce the number of patients conveyed to the ED. Reducing ED conveyances can contribute to patient safety through the prevention of unnecessary invasive procedures, exposure of hospital acquired infections and deconditioning that may occur whilst in the hospital setting. This was approached through the development of an EoLC Coordinator network which consists of volunteer ambulance staff supported by the Macmillan programme.

JUDGES COMMENTS

Judges said this was a very ambitious project, aiming for a positive change to end of life care across a wide area. There were clear goals and objectives surrounding preventing admissions and improving paramedic confidence in dealing with end of life care on the road, in patients' homes. The team successfully navigated the high number of stakeholders, and the interaction of this with other initiatives, to ensure a joined up approach rather than different initiatives in silos. All of this has shown an improvement in confidence and reduced hospital admissions. Well done, this is true cultural change.

END OF LIFE CARE AWARD

HIGHLY COMMENDED

Essex County Council with St Lukes, St Francis and Farleigh Hospices

Essex End of Life Hospice Programme for domiciliary care workers

ECC's QI team identified through information from CQC and health and provider feedback, a significant gap in knowledge and skill for domiciliary carers around end of life. Some domiciliary providers actively developed policies referring deteriorating people to hospital, resulting in most people dying there rather than their preferred place of death.

With a limited budget and timeframe, a collaboration formed with Essex Hospices to develop training specifically for domiciliary providers.

Measures of success included increased knowledge, skills and confidence in domiciliary carers, and a decrease in people at end of life being sent to hospital rather than supported at home.

JUDGES COMMENTS

This is a multi-provider education approach to people proving care in the community. Judges were impressed by the clear involvement from palliative services, council and domiciliary staff with evidence that showed that carers felt more comfortable and confident caring for patients at the end of life. The team were able to show financial benefit to upskilling domiciliary staff, but also highlighted the improved emotional impact on patients and families of preventing hospital admissions. The project has merit and no doubt has improved confidence for those who have engaged with it.

FINALISTS

Marie Curie Hospice, Newcastle

Introducing an Electronic Prescribing and Medication Administration System to Improve End of Life Care

In 2018 staff at Marie Curie Hospice, Newcastle reported 110 medication related incidents. 60 of these were related to prescribing or administration. Tasked with reducing this number, a review was carried out of all incidents, demonstrating that staff were more likely to make a prescribing or administration error within the first few months of employment. Unfamiliarity with the process was often cited as a contributing factor, leading the team to explore the introduction of an ePMA system to the hospice. While information gathering, it became apparent that ePMA systems outside of hospital settings were not commonplace and the team believe they are the first to look at introduction to a hospice setting. They also aim to develop a programme fit for purpose in a non hospital setting by reviewing incidents and making changes to the system.

Mid Essex Hospital Services Trust

Utilizng digital solutions to improve access to pastoral and end of life care

Mid Essex Hospitals NHS Trust has been using System C's CareFlow Vitals e-observations software for recording bedside clinical Metrix for several years. The software enables clinicians to share essential information regarding a patient's clinical condition through collating vital signs at the bedside. However, the End of Life Care Facilitator and Resuscitation Team identified an opportunity to use this software to improve care for those patients at the end of life. Through accessing the list of patients identified as not requiring signs monitoring, patients who may wish care from the pastoral and end of life team could be clearly identified. In discussion with the chaplaincy team, a programme of spiritual care interventions was established to those identified, ensuring that nursing staff approached these patients and families to ask if intervention from a chaplain would be valued.

END OF LIFE CARE AWARD

FINALISTS

Norfolk and Norwich University Hospitals FT

Hospital Palliative Care Team Implementation of Personalised End of Life Care

Our journey from requires improvement to outstanding. Putting the individual needs of the patient at the heart of all we do.

Having received 'Requires Improvement' from CQC, commissioners approved the palliative care business case and the hospital palliative care team (PCT) was expanded.
The main challenges were to ensure all patients received individualised end of life care; ensuring syringe drivers were always available and addressing unmet needs of hospital palliative patients at weekends

The team underwent a series of process transformations, but crucially prioritised moving to seven day working. They also made a commitment to see all adult patients dying in the trust to support teams in implementing the IPOC, including prescribing anticipatory medications and ensuring that, where possible, patients' wishes were achieved.

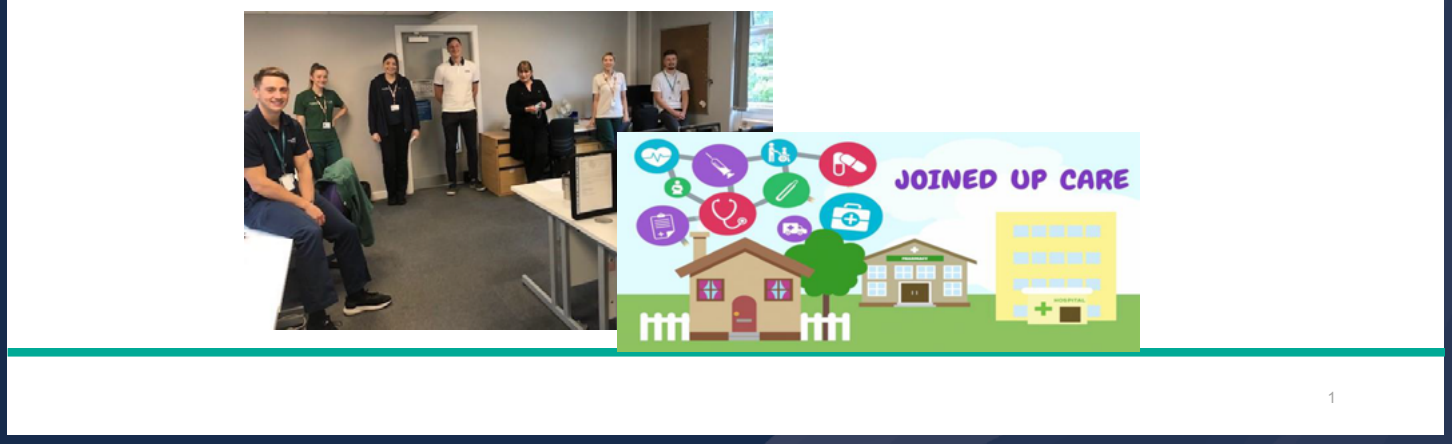
Nottinghamshire Healthcare FT, Beaumond House Community Hospice, Nottinghamshire Hospice, Primary Integrated Community Services, Sherwood Forest Hospitals FT and Cruse Bereavement

End of Life Care Together

End of Life Care Together sits within the ICP and ICS framework of Nottingham/Nottinghamshire. The ambition of the service is to deliver equitable access to all through collaborative working across providers. This ensures that patients do not fall through gaps of service and that all patients receive the care they need regardless of the stage of their disease. Referral to all services is via a single point of access, recording reasons for referral, and specialist advice and support is available 24 hours a day, seven days a week including consultant advice.

URGENT AND TRAUMA CARE SAFETY INITIATIVE

WINNER



TAMESIDE AND GLOSSOP INTEGRATED CARE FT AND TAMESIDE METROPOLITAN BOROUGH COUNCIL

INTEGRATED URGENT CARE DELIVERED AT HOME: DELIVERING CRISIS RESPONSE WITHIN 2 HOURS AND RE-ABLEMENT WITHIN 2 DAYS

Tameside and Glossop ICFT have established a number of innovative and integrated health and social care services to support people with long term conditions in their usual place of residence to avoid unnecessary GP and ED attendances, often leading to lengthy inpatient episodes. this includes Digital Health, an Integrated Urgent Care Team (IUCT) and Extensive Care. These services now work together to support older people living in the community (whether in their own home or in a care home placement) in an integrated model of care to deliver 'integrated urgent care at home'.

JUDGES COMMENTS

The winning team have developed a patient centred project with easier and quick access for patient care. The project involves digital health with data sharing and halves the 2-hr targeted national crisis response time to just 1 hour. The project has demonstrated significant cost saving and clinical benefits, improved patient experience and delivered financial benefits to local economy. The patient testimonials are very impressive, and judges feel that this is an excellent patient safety initiative which can be replicated nationally.

URGENT AND TRAUMA CARE SAFETY INITIATIVE

HIGHLY COMMENDED

Warrington and Halton Teaching Hospitals FT

The Introduction of a Thoracic Injury Pathway to a Major Trauma Unit

Chest trauma in older people (>65 years) following falls from standing height is emerging as a leading cause of morbidity and mortality in trauma patients, but diagnosis is frequently missed and subsequent management delayed. We introduced a Thoracic Injuries Pathway which aimed to reduce mortality and morbidity, improve patient safety and the patient experience in older patients following a chest injury.

The pathway advocates early senior review for high risk groups and includes guidance on: imaging; pain and function scoring; rib fracture scoring; pain management and referral to specialist teams including chest physiotherapy, critical care outreach and acute pain teams.

JUDGES COMMENTS

The judges felt that the team collaborated well on this project, and demonstrated good teamwork with strengthened links between involved teams. The team have also ensured the spread of this project beyond the referral pathway and helped implementation outside the trust. This is a noble project which will improve patient care and maintain patient safety.

FINALISTS

Bolton FT

Radiographer Led Discharge of ED patients

Collaboration between medical, nursing and AHP staff led to the development of a discharge pathway, so that patients with normal images can be safely discharged from the radiology department by the reporting radiographer and within a defined protocol. Patients are asked if they want to go on this pathway, and if they agree, they are given self-care advice by the referrer prior to imaging. Any patient with an abnormal image is sent back to the ED, as is any patient who needs further advice. This pathway is patient centred and not restricted by professional boundaries. It reduces the length of the pathway for these patients and frees up time in ED for the referring clinicians to continue seeing new patients, as well as freeing up time of the doctors who would normally check the images for the referrer.

London Ambulance Service Trust

Specialist Falls Service: To improve quality and safe care for older people

In 2019 the London Ambulance Service (LAS) piloted the introduction of a specialist falls services staffed by a Paramedic and Non-Emergency Transfer Service (NETS) member of staff with additional training in assessment, management and referral of older fallers. The falls service aimed to respond to patients in a timely fashion, reducing response times and focussing on prevention of unnecessary admission. The overall aim was to promote care closer to home, avoiding unnecessary conveyance and hospital admission where appropriate.

Warrington and Halton Teaching Hospitals FT

Improving patient safety by reducing length of stay in the Emergent Department

In May 2019 Warrington Hospital Executive Team set up an Urgent and Emergency Care Improvement committee. This was an executive led meeting, with all ED consultants and senior nurses as core members. The ambition was to ensure that patients received the 'Best Clinical Care in the most timely manner'. The principal goals were to improve performance against the 4 hour quality standard and reduce the amount of time patients spent in ED waiting for a bed. The team also hoped to improve staff morale.

West Hertfordshire Hospitals Trust

Senior Medics' Assessment and Review Trial (SMART) Initiative

The SMART initiative was designed to improve the admission process for acute medical patients presenting to the Emergency Department at Watford General Hospital.

This was a clinically conceived initiative embracing QI principles supported by an active 'command & control' review team with regular meetings initially on a weekly basis.

The intention was to optimise non-admitted pathways, whilst improving patient care by improving the 4 hour performance and quality of care by providing senior specialist opinion very early into the patient pathway.

DETERIORATING PATIENTS & RAPID RESPONSE SYSTEMS AWARD

WINNER

WEST HAMPSHIRE CCG AND WESSEX AHSN

RESTORE2: RECOGNISING AND RESPONDING TO DETERIORATING IN CARE AND NURSING HOMES

RESTORE2 supports staff in care/nursing homes to proactively recognise and manage physical deterioration to improve resident experience and outcomes. RESTORE2 stands for Recognise Early Soft-Signs, Take Observations, Respond and Escalate and uses National Early Warning Scores (NEWS) as a common language across the healthcare system. The project was undertaken using quality improvement methodology by West Hampshire CCG with the Wessex AHSN Patient Safety Collaborative and now been adopted by 20 CCGs nationally.

JUDGES COMMENTS

Judges thought this was a very ambitious and valuable project with clear objectives that have been achieved. The team have demonstrated an evident and clear spread through the community settings in order to identify deteriorating patients. The RESTORE tool is an excellent resource, with clear and very useful contents supported by educational resources. This complex project with lot of interventions has demonstrated excellent value, and is likely to have significant benefits to tens of thousands of people in terms of personalisation of care, process and outcome improvements going forward.

DETERIORATING PATIENTS & RAPID RESPONSE SYSTEMS AWARD

HIGHLY COMMENDED

Alder Hey Children's FT

Earlier Recognition of Deterioration In Children using e-Obs

A Vitals paediatric prototype was developed in partnership with System C, incorporating the Alder Hey age-specific Paediatric Early Warning Score, iteratively developed using statistical methods.

The study used Vitals software with integrated Connect communication app for active monitoring of inpatients to provide real-time data 'on the move' and automated alerts to reduce emergency transfers to PICU/HDU due to critical deterioration from all causes including sepsis, model the data to identify optimal thresholds and weighting for PEWS and for identifying early sepsis to improve prediction, and detect and promptly treat sepsis, thereby reducing complications from sepsis.

JUDGES COMMENTS

The judges felt that this project has shown excellent development of Vitals, applying existing adult technology to the paediatric patient population in a relevant way. It displayed good utilisation of end to end track and trigger with automatic alerting via Connect enabling real time feedback to the bedside nurse, enabling bundle implementation without delay.

FINALISTS

Cambridge University Hospitals FT

Recognition and escalation of the deteriorating paediatric patient

The aim was to develop a unique approach to improving the early recognition and escalation of deteriorating paediatric patients at Cambridge University Hospital, as an internal review highlighted that there was no formal group meeting to review the management of deteriorating paediatric patients.

The project utilised a Plan, Do, Study, Act (PDSA) cycle to evaluate changes, ensuring actions were responsive and clinically achievable. It developed a formal group of members of the paediatric MDT to review and initiate change within the division. The team updated the Trust's PEWS guidelines and created a training and education programme to communicate the changes to all staff groups and also created a nurse in charge A-E smart text for all patients with a PEWS score of 2 or above.

London Ambulance Service Trust with Abbott Point of Care i-STAT Analyser

Improvements in the prevention of patient deterioration through trialling Abbott i-STAT venous blood analyser

The Advanced Paramedic Practitioner in Urgent Care (APPUC) group trialled the Abbott i-STAT venous blood gas analyser to test its feasibility and impact in delivering patient care to a wide range of patients following a 111 or 999 call. The overall goal was to ensure that patients receive optimal care through the enhancement of the care-delivery experience patients receive from the APPUC team and to expand patient access to testing on the spot. The blood analysis tool allows a variety of often complicated tests with the patient to be carried out within minutes and on one single platform. This standardisation of testing across a variety of clinical settings and the rapid-decision making directly in the patient-care pathway all help eliminate often long-winded and complicated process steps, thereby reducing errors and promoting patient safety.

DETERIORATING PATIENTS & RAPID RESPONSE SYSTEMS AWARD

FINALISTS

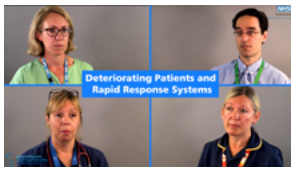
Royal United Hospitals Bath FT
Improving Patient Outcomes from Sepsis and Acute Kidney Injury

Sepsis and Acute Kidney injury are common causes of in-hospital patient deterioration associated with high morbidity and mortality. The team aimed to identify deterioration as early as possible, increasing prompt management and decision-making , improving outcomes by decreasing mortality, length of stay and preventing their occurrence.

Sepsis and AKI can occur anywhere in any speciality, so it was essential to engage multiple stakeholders, ensuring consistent management trust-wide; establish a specialist team to support and drive improvements; train a large number of multidisciplinary staff, provide simple tools; empowering staff to identify and treat early and establish reliable measures to feedback improvements.

Somerset FT
What to do if you can't do a NEWS2

Two years ago it was identified within Somerset Partnership mental health wards that patients following rapid tranquilisation were not always able to have vital signs or NEWS measured. The Clinical Practice team worked with the mental health team to develop a non-contact observation tool using quality improvement methodology. This is now used in daily practice within the acute mental health wards for patients in seclusion/following rapid tranquilisation. Since the merger of Somerset Partnership and Taunton and Somerset Trusts a wider quality improvement project has been set up with the aim to test, improve and implement the non-contact observation tool for patients who cannot have vital signs and NEWS2 taken, ready to roll-out trust-wide.



Somerset FT
Expanding the safety culture through novel reporting mechanisms

In 2017 the Trust set up the Deteriorating Patient Committee to focus on recognising and responding to deteriorating patients and collect data about potential patient harms.

The critical care outreach team (CCOT) review all patients who have a NEWS score of ≥5 were asked to note concerns about patient care during CCOT reviews, and met weekly with teams to feedback, enabling a rapid strategic response to any adverse events.

More importantly they identified a viable reporting system for patient safety concerns with different issues to those identified by the traditional reporting system, which could also be used to design simulation scenarios. Simulation was later identified as another source of learning, identifying potential issues before they actually happened on the wards.

The triangulation of these 3 different resources has provided a powerful tool for identifying and responding to risks across the trust.

Warrington and Halton Teaching Hospitals FT
THINK Delirium in Intensive Care

The team aimed to improve the management of delirium and hence the deteriorating patient in the ICU by implementing the NICE guidelines and standards and meeting the recent recommendations set out by the Royal College of Physicians, with the additional aim of reduced mortality.

They did this through organising an ICU Delirium Study Day involving all staff to develop a Delirium Strategy, assessing Patients on admission to ICU for delirium using a new training tool, introducing a tailored multicomponent intervention delirium package as recommended by NICE, developing a new Delirium Checklist on QS and auditing NICE QS 63 5 standards to ensure they remain compliant with NICE guidelines.

PERIOPERATIVE AND SURGICAL CARE AWARD

WINNER

THE DUDLEY GROUP FT

A SUCCESSFUL INITIATIVE TO IMPROVE PRE-OPERATIVE IRON DEFICIENCY ANAEMIA

International consensus and existing best practice advocates treating all surgical patients with pre-operative iron deficiency anaemia. When oral iron supplementation is contraindicated or impeded by time constraints, intravenous (IV) iron administration is recommended. The Dudley Group NHS Foundation Trust has developed a unique IV iron service with community-based administration.

Recognising that Dudley Group had a successful community IV team, a multidisciplinary working group was organised. The main aims of the group were to improve safety, clinical outcomes, transfusion rates and patient experience for those suffering from iron deficiency anaemia undergoing major surgery.

JUDGES COMMENTS

The judges felt that this project was a great common-sense intervention, and a strong example of using all members of the healthcare team to deliver an important pre-operative therapy. Whilst fairly small scale at present, this project has fantastic spread potential, depending on local community nursing availability.

PERIOPERATIVE AND SURGICAL CARE AWARD

HIGHLY COMMENDED

South Tees Hospitals FT
The Empty Recovery Concept

This entry describes a new process called the "Empty Recovery", it involves moving the static group of recovery staff into the theatres so that each theatre has two anaesthetic ODPs and the recovery area is empty except for a co-ordinator. Both anaesthetic ODPs attend the Safety Briefing with the theatre team but take it turns to assist the anaesthetist and support throughout the operation, the ODP then recovers the patient at the end of the operation in the recovery room staying with same patient throughout their journey.

JUDGES COMMENTS

The judges felt that this was a valuable model, particularly in an era of reduced staffing levels and whilst there is a need to limit staff-to-patient interactions. The project shows a good use of scarce resources and is potentially applicable to wide range of surgical theatres.

FINALISTS

Great Ormond Street Hospital for Children FT
The NatSSIPs 8 e-Learning Module

The team produced an e-learning module released through our hospital online training environment (GOSH Online Learning & Development) aimed at all staff involved in invasive procedures. The module had the objectives of understanding the rationale for the use of safety checklists; gaining an awareness of the NHS England 'National Safety Standards for Invasive Procedures' NatSSIPs and the GOSH Safety Standards for Invasive Procedures; learning the key steps to safe performance of invasive procedures; gaining insight and learning from recent incidents at GOSH; familiarising staff with the laminated checklists in use across the Trust and demonstrating integration of the checklist with the electronic patient record.

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

Providing optimal peri-operative care to surgical patients is challenging. In 2014, a pilot study of 100 patients was conducted as part of a NICE fellowship to investigate the impact of a dedicated surgical pharmacy service on the incidence of post-operative complications and length of stay in patients undergoing lower gastro-intestinal (GI) surgery. By optimising patients' pre-existing medical conditions prior to surgery and providing individualised patient care after surgery in accordance with published NICE guidance on medicines optimisation, there was a reduction in the number of post-operative complications and hence subsequent length of stay in the group of patients.

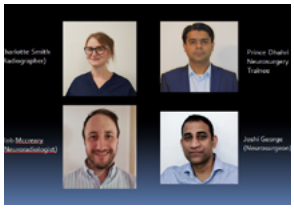
PERIOPERATIVE AND SURGICAL CARE AWARD

FINALISTS

Manchester University FT and Spire Manchester Hospital
NHS and Independent Sector Thoracic Service Collaboration

Spire Manchester Hospital, alongside Manchester Foundation Trust - Wythenshawe Hospital; have undertaken a new service aimed at supporting waiting lists at the Trust for patients who have been diagnosed with lung cancer. By implementing robust patient pathways and processes, and working closely with Wythenshawe Hospital, the team aimed to introduce thoracic surgery both safely and efficiently into the hospital.

This project made tangible advancements to the safe care of patients because although Spire Manchester had the capacity to safely carry out this service, they had never undertaken thoracic surgery before. It was a completely new service and there was a lot of new infrastructure that relied on collaborative working.



Salford Royal FT
Preoperative Gold Spinal Marking To enable Correct Site Spine Surgery

Spine surgery faces unique challenges in getting to the correct site for surgery. The team came across a promising technique from another field of medicine to enable to better localization of the correct level. This involved a gold injection technique used in cancer, for radiotherapy planning in Scandinavia. The team adapted this for spine marking and have now got a robust and accurate system for preoperative marking of the spine. Gold has the advantage that unlike many other materials, it can be seen on Xray, CT and MRI and hence we can make sure that the marker is indeed in the correct position using any of these modalities. The ambition is to now roll this out across the UK as well as the rest of the world!

Tameside and Glossop Integrated Care FT
Surgical Ambulatory Care Unit (SAU)

The SAU at the T&GICFT is a newly formed unit aimed to support patients attending the ED with surgical conditions. The overall aim of the service is to provide rapid assessment, diagnostics and treatment to patients by the most appropriate clinical professional, in an area outside of the ED. The ultimate ambition of the project was to avoid unnecessary acute surgical admissions and improve our patient's experience of surgical pathways.

MENTAL HEALTH INITIATIVE OF THE YEAR

WINNER

LONDON AMBULANCE SERVICE TRUST

MENTAL HEALTH JOINT RESPONSE CAR

The Mental Health Joint Response Car (MHJRC) launched in November, offers a specialist response to patients who have been identified as experiencing a mental health crisis. As part of the new scheme, call handlers work alongside a mental health nurse in the control room to decide whether to dispatch the mental health car to 999 calls. The mental health vehicle, operated by a paramedic and a specialist nurse, is expected to contribute towards reducing mental health hospital admissions from 58,000 to 30,000 per year once it is fully rolled out across London.

JUDGES COMMENTS

Judges felt this winning initiative demonstrated true logic and a way of overcoming structural barriers to meet the needs of patients and deliver better outcomes. The judges were inspired by the partnership spirit evident through this initiative, demonstrating all the values that the NHS stands for. The outcome measures were highly impressive with zero incidents reported since implementation. A fantastic innovation demonstrating how working at a system wide level can have a truly significant impact on patients enabling them to stay safely within their own homes. This is an excellent model that we can learn from nationwide.

MENTAL HEALTH INITIATIVE OF THE YEAR

HIGHLY COMMENDED

Cumbria, Northumberland, Tyne and Wear FT
SleepWell Project

The 'SleepWell' project aligns with the safety quality priority in CNTW and aims to improve sleep management on inpatient psychiatric wards in order to provide better and safer care for all patients, to reduce the use of restrictive practices and create a safe and nurturing environment.

Our goal was to improve sleep management on inpatient wards and embed service improvements into routine practice. This involved the introduction of Protected Sleep Time in which patients are no longer routinely checked hourly between midnight and 6am in a change to trust policy, routine screening for sleep disorders, and, on some wards, to offer Cognitive Behavioural Therapy for Insomnia. The ultimate goal of the SleepWell Pilot Project is to facilitate a trust-wide change to policy and embed good sleep management practices across all CNTW inpatient wards.

JUDGES COMMENTS

The judges felt that this was an excellent initiative that is patient focused and has made such a difference to the ward environment and to the recovery of patients. It is a great example of how small-scale logical changes can really enhance the experience of patients and aid their mental health. The level of co-production is to be commended involving patients, multi professional teams including corporate support teams as well as clinicians, students and experienced subject matter experts to develop small tests of change resulting in positive outcomes.

FINALISTS

Avon and Wiltshire Mental Health Partnership Trust
Reducing Restrictive Practice on a Medium Secure Unit

Bradley Brook is an 8 bedded male Psychiatric Intensive Care Unit Ward within a Medium Secure Hospital. They appointed a senior nurse to lead a Quality Improvement project to address the cultural and clinical care issues on the ward, which also aligned to discussions about a national improvement programme seeking to address the same issue that is widespread across the country. The aim of the Reducing Restrictive Practice project was to reduce restrictive practice (measured by number of restraints, seclusions and rapid tranquilisations) by 33% by March 2020

Bradford District Care FT
Creating and Embedding a Systematic Approach to Side Effect Monitoring of Patients Prescribed Clozapine

The care of people on clozapine (atypical antipsychotic) has always been a priority for the trust. The 'Clozapine Monitoring Review Tool (CMRT) was created in order to address all aspects of clozapine care and monitoring and to have this as a standard template on the electronic patient record. It also helped develop a treatment pathway with the local Cardiology department on how to manage patients on clozapine with suspected myocarditis and tachycardia. The trust also set up a clozapine clinic with the Airedale area to ensure patients are being monitored in line with those who attend the Bradford Clozapine Clinic.

MENTAL HEALTH INITIATIVE OF THE YEAR

FINALISTS

Kingston GP Chambers
Kingston Dementia Support Service

The aim of the Kingston Dementia Support Service is to provide a holistic service which offers clinical, emotional, psychological and social support for patients with an established diagnosis of Dementia. Their philosophy is 'Better Carers, Better Patients', supporting carers reduces the likelihood of carer burn out or developing mental health issues themselves. The twice weekly clinic gives extended appointments with the GPwSI who works in tandem with an Alzheimer's Support Worker. This ensures that not only are the clinical issues arising from the consultation managed appropriately but the ASW can assist in referring and signposting both patients and carers to alternative services.

NHS Lothian
'Feeling Safe': Implementing a Multi-Disciplinary Trauma-Informed Model of Care to Reduce Risk in an Intensive Psychiatric Care Unit

Ward 1 (IPCU) is an Intensive Psychiatric Care Unit in St. John's Hospital in NHS Lothian. Their initiative aimed to reduce emotional distress and associated violence and aggression through the use of multi-disciplinary trauma-informed model of care.

The trauma-informed model of care implemented includes weekly MDT formulation meetings, monthly reflective practice groups and a focus on psychosocial distress tolerance techniques as an alternative to medication. During the team formulation meeting, the multi-disciplinary team meet to develop a shared understanding of the individuals difficulties, recognising the role of previous trauma, identifying triggers for violence and aggression or re-traumatisation and planning interventions with the aim of reducing the risk of re-traumatisation as far as possible.

Northamptonshire Healthcare FT
Improving quality and patient safety outcomes in a female psychiatric inpatient setting

In 2019 a new mental health quality initiative/strategy was implemented at Sandpiper, a 16-bedded open female general adult psychiatric inpatient unit that serves the north of the county of Northamptonshire. This was based on a whole-systems multimodal approach and incorporated a combination of elements from various evidence-based approaches. Main targets for safe quality care improvement included a reduction in self-harm incidents, a reduction in the need for restrictive practice, and better utilization of available resources including more time-limited goal-focused admissions (i.e. reduced length of stay).

South London and Maudsley FT
Crisis Plus

Within Lewisham, as has proved typical across all SLaM boroughs, a small number of service users were found to make disproportionately high use of crisis services including repeated inpatient admissions and frequent attendance at liaison psychiatry.

Crisis Plus developed, with all teams, service-users and carers, a single, recovery-focussed care plan called an Anticipatory Management Plan (AMP). The AMP supported the service-user towards independence by ensuring care and risk management information are proactively shared in a way that allowed clinicians to intervene in line with a service user's wider care plan, not just react to their current acute crisis.

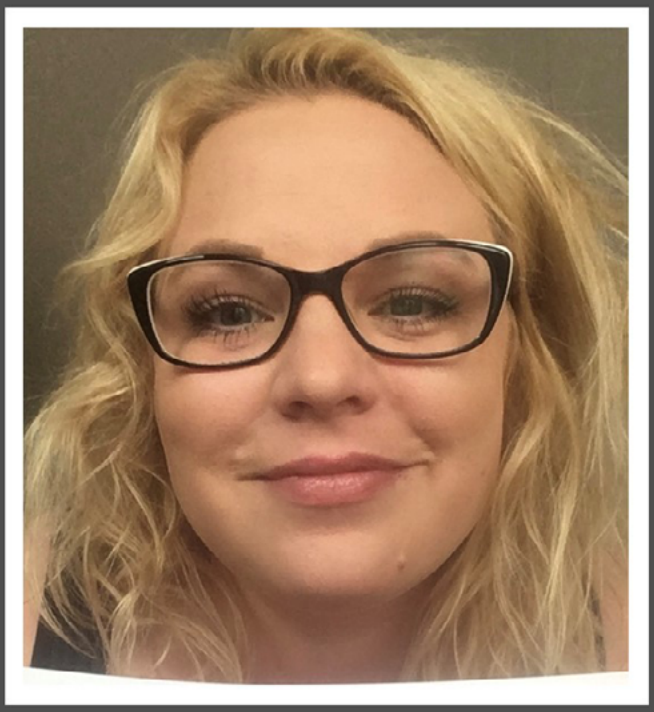
A key outcomes was to reduce crisis and acute service use for this cohort of service users. Other aims of the project were to increase clinician confidence in discussing and managing crisis and risk behaviours with service-users in ways which were consistently applied across teams and agencies. Finally to improve the confidence and safety of service users.

West London Trust
Safety Huddles in Mental Health Wards: Taking a QI Approach

West London NHS Trust in partnership with Imperial College Healthcare Partners took a quality improvement approach to testing and evaluating the use of safety huddles in different types of mental health inpatient wards. The QI project was designed to test safety huddles impact on reducing patient/staff harms; and improve communication, teamwork and sustainability. Whilst also designed to increase belief in QI application for cross service line improvement.

LEARNING DISABILITIES INITIATIVE OF THE YEAR

WINNER



SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST IN COLLABORATION WITH SOUTH WEST LONDON ALLIANCE (KINGSTON, RICHMOND, MERTON, WANDSWORTH & SUTTON CCGS)

LEARNING DISABILITIES MEDICINE OPTIMISATION IN CARE HOMES (LDMOCH) SERVICE

A two-year pilot project providing medicines optimisation reviews for adults with learning disabilities living in care homes was launched in January 2019 to address unmet needs surrounding medicines optimisation. Targets set for improvements in safe care included enhancing the quality of life for people with learning disabilities; reducing preventable harm from medicines; improving quality of care through better medicines use and integrated care. Various measures were taken, including supporting STOMP initiatives, improving monitoring of physical health and mental health, empowering patients, carers and families in the drive for safety by ensuring that they are fully informed about the patient's medicines and are involved in decisions about their care, and many more.

JUDGES COMMENTS

This winning initiative was a truly worthwhile intervention in relation to STOMP, and a simple yet highly effective and innovative approach to patient safety. This is something that is easily transferrable to other vulnerable groups

LEARNING DISABILITIES INITIATIVE OF THE YEAR

HIGHLY COMMENDED

Avon and Wiltshire Mental Health Partnership Trust and Wiltshire CCG

Improving Patient Safety on the Daisy Unit

A QI programme was established to embed a culture of innovation and improvement to enhance the experience of people who are using services provided by the Daisy Unit, based in Devizes, Wiltshire. The programme initially focussed on staff engagement and team building, which used an initial QI project focussed on improving the quality of incident reports. This was as an essential part of enabling effective learning and improvement in clinical care delivery. Following initial engagement, a further 3 projects were identified as a result of learning identified through the incident reporting system and the initial engagement with staff, including reducing restrictive practice by 60%, by March 2020.

JUDGES COMMENTS

The judges felt that this was a holistic and engaging QI approach in a very challenging area, which delivered great outcomes for patients and staff. They look forward to seeing how the achievements can be replicated in future years.

FINALISTS

Birmingham Community Healthcare FT

Nutrition Nurse Team: Improving care for adults with a learning disability who require enteral tube placement

The Nutrition Nurse Team for Adults with Learning Disabilities in Birmingham is a unique dedicated community service caring for adults with an enteral feeding tube.

The project introduced the use of ENPLUG's in patient's homes, day centres, colleges and respite units for adults with Learning Disabilities in order to avoid hospital attendance or to reduce length of stay when an enteral feeding tube comes out unexpectedly. It also empowered carers to manage the situation in a timely manner, reduces the amount of time a patient may be without nutrition and/or medication and reduce the inappropriate use of Foley catheters/NG tubes to keep tracts open.

East Cheshire Trust

Improving patient safety and outcomes through autism accreditation

East Cheshire NHS Trust is the first trust in the country to have key wards and departments accredited by the National Autistic Society in 2019. The accredited areas are: Accident and Emergency, Outpatients, the Children's Ward, Pre-op assessment, Day Case, Theatres, surgical wards, Dental Services and Customer Care. To achieve accreditation, the trust worked with local organisations that care for people with learning disabilities and/or autism to develop a working group to help improve the safety and experience of patients/service users. Key pieces of work that the Learning Disability and Autism group has undertaken include the development of a bespoke patient passport and numerous photo journeys. The trust has also created detailed flowcharts when dealing with patients with learning disabilities and/or autism in an elective, emergency and outpatient setting.

LEARNING DISABILITIES INITIATIVE OF THE YEAR

FINALISTS

Liverpool Women's FT

Using Virtual Reality as a Reasonable Adjustment

Since 2014 the Trust has embedded the process of completing Reasonable Adjustments Risk Assessments, under the Equality Act 2010 into the pre-admission phase. As part of this the Trust have embarked on a project to provide patients with an 'immersive' experience of coming into the Trust. A Virtual Reality programme allows users to experience a sense of presence in a computer-generated three-dimensional environment. It is expected, on completion, that this option to experience the hospital setting in the safety of the persons own home will significantly reduce any anxiety and therefore improve both the experience of the patient and their carers.

Norfolk and Norwich University Hospital FT

Children and Young People's Learning Disabiltiy Specialist Nurse: A Safety and Quality Improvement Initative

The Norfolk and Norwich University Hospital trust recognised that the implementation of a Children and Young People's Learning Disability Specialist Nurse would have a direct impact on improving patient safety and experience. The ethos behind this role is to ensure improved equitable access to safe, good quality healthcare, with the patient and their families/carers at the centre, to ensure the best possible health outcomes for the patient. Several key improvement objectives were set by the CYP Learning Disability Specialist Nurse upon commencement of the role, to ensure the safe care of this patient group. The job description has since been shared with other local NHS trusts for consideration of implementing the role within other acute hospitals.

Western Sussex Hospitals FT

The Ophthalmic Sunflower

The Hidden Disabilities Sunflower was first launched at Gatwick Airport in May 2016 and it was decided that SRH would trial this scheme. A "sunflower" could be added to triage notes by nurses, a patient could ask for one, or the admin team could also add a "sunflower" to a patients notes if they noticed on the patients presentation that they would benefit from being under the "sunflower" scheme. This means that on the day of the patients appointment, the patient has a designated person to assist them throughout the whole of their visit, enabling them to build a rapport with the patient and to avoid multiple staff interacting with the patient at different stages of their OPA.

MATERNITY AND MIDWIFERY SERVICES INITIATIVE OF THE YEAR

WINNER

WEST MIDLANDS AHSN, UNIVERSITY OF BIRMINGHAM, BIRMINGHAM WOMEN'S AND CHILDREN'S FT, NIHR ARC WEST MIDLANDS AND THE ROYAL WOLVERHAMPTON TRUST

BSOTS - BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

Prior to the development of BSOTS there was no standardised triage system for women presenting to maternity services with urgent concerns. BSOTS is a specific maternity safety tool for triage which was co-designed by clinicians and researchers to facilitate clinical prioritisation and improve safety. It consists of a prompt and brief assessment (triage) of women on presentation, which includes physiological observations, and then a standardised way of determining the clinical urgency in which they need to be seen. The system is easily understood by women and maternity staff, as it mirrors the well-established triage systems used in emergency departments.

JUDGES COMMENTS

The judges felt that enthusiasm from the staff about this innovative project shone through. The initiative has reduced variation, improved safety, and generated a positive experience for women. It also shows a wide spread of use and positive affirmation from stakeholders across the UK.

MATERNITY AND MIDWIFERY SERVICES INITIATIVE OF THE YEAR

HIGHLY COMMENDED

London Ambulance Service Trust

Expanding and enhancing maternity training in the London Ambulance Service

The LAS was the first UK Ambulance Service to recognise the value of a midwifery leader, employing a substantive Consultant Midwife role. In 2018, it extended its commitment to safe, effective and high quality training by expanding the reach of maternity training by developing a role of the practice lead for pre hospital maternity care. The ambition of the trust was to provide the first maternity training for emergency medical dispatchers to enhance call taking through specific training; to provide sector based joint maternity training aligned to the Local Maternity System geography engaging local community midwives; and to engage a maternity scenario in the core skills refresher training, offered annually to all frontline staff (targeting up to 3,000 clinicians).

JUDGES COMMENTS

The judges felt that this was an innovative project focused on key but often forgotten area of safety for women, and were thrilled to see the world of 'pre-hospital obstetrics' become safer. This project demonstrated improved outcomes and how to change practice through training and collaborative partnership working. The multidisciplinary training is particularly useful in normalising birth for the paramedics who do not see it every day.

FINALISTS

Baby Lifeline

Addressing variability in the community: giving midwives the tools to improve patient safety out of the hospital

Baby Lifeline's 'Childbirth Emergencies in the Community' training is a highly evaluated one-day course focusing on the practicalities of managing emergency situations which may arise during community births. Recognising the urgent need to standardise equipment carried by midwives to births in the community, as well as clear processes to keep equipment and supplies fully stocked and up to date, the charity worked with NHS professionals to convene a multi-professional clinical working group to develop a 'gold standard' community midwifery bag. Following a successful 4-month pilot scheme, Baby Lifeline is now supplying midwifery bags to NHS Trusts across the UK. The ultimate ambition for this project is to create a national standard and Baby Lifeline will continue to promote national uptake.

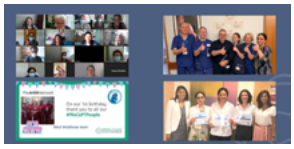
Cambridge University Hospitals FT

Obstetric Close Observation Unit

The Rosie Hospital, part of Cambridge University Hospitals (CUH) NHS Foundation Trust is a tertiary level centre with a birth rate of 5,400 per year. They provide care for a proportionate amount of women requiring complex medical and obstetric care. Prior to the implementation of the Obstetric Close Observation Unit (OCOU) women who needed acute care in the postnatal period were sent to the main Trust Intensive Care Unit or High Dependency Unit; this meant that the mothers were often separated from their babies. The ambition of this project was to improve care for women who required acute care as per the Intensive Care Society's "Level of Care Document". In 2013 OCOU, a 3 bedded unit staffed by 5.5 WTE Band 6 Midwives and 1 Level 3 WTE Maternity Support Worker (MSW), which had the facilities to monitor and care for women (along with their babies), inclusive of invasive monitoring and single organ support was opened.

MATERNITY AND MIDWIFERY SERVICES INITIATIVE OF THE YEAR

FINALISTS



Imperial College Health Partners with Maternity Services at Chelsea and Westminster Hospital FT, Northwick Park Hospital, Queen Charlotte's and Chelsea Hospital, St Mary's Hospital, The Hillingdon Hospitals FT and West Middlesex University Hospital

PReCePT-Preventing Cerebral Palsy in Preterm Labour

Imperial College Health Partners (ICHP) led a partnership which brought together 6 maternity services, Local Maternity Network, Neonatal Operational Delivery Network, Maternity Voice Partnership and voluntary sector to deliver Prevention of Cerebral Palsy in Preterm Labour (PReCePT) programme across North West London.

With the aim to reduce the incidence of cerebral palsy in babies born preterm, NWL set their ambition higher than the national target of 85% of eligible mothers receiving magnesium sulphate and kept the focus on achieving a stretch target always above 85%, achieving 93%. ICHP used a centrally-coordinated locally-led approach to build awareness, provide support and enable leadership around PReCePT to achieve this ambition.

Oxford AHSN, Oxford University Hospitals FT, Royal Berkshire FT, Health Education England e-Learning for Healthcare and OxSTaR

An 'Intelligent' approach to Intermittent Auscultation to improve outcomes for low risk mothers and babies in labour

In 2017/2018, two consultant midwives from Oxford University Hospitals and Royal Berkshire Hospital collaborated on a maternity and midwifery service safety initiative. They launched a unified approach to teach and assess competency of Intermittent Auscultation (IA), prompted by a worrying variation in how midwives' practice when caring for low risk women and babies in labour in their organisations.
The aim of the initiative is to improve midwifery knowledge and skills to undertake IA of the baby's heartbeat in an intelligent, safe and effective manner. It emphasises midwives' responsibilities to appropriately risk assess and escalate abnormalities in the baby's heart rate improving safety for low risk labouring women and their babies. By sharing data and problem solving together in an open and transparent manner the maternity services demonstrated a positive culture of collaborative working towards a common goal of improving safety for women and babies.

Tameside and Glossop Integrated Care FT

Making Smoking History

As part of the Greater Manchester's Smoke Free pregnancy programme utilising the Greater Manchester's wider Making Smoking History strategy the ambition is to continue to reduce the smoking rates in pregnant women. Historically the approach taken involved the team working alongside the generic stop smoking service. The initiative was taken to refer all pregnant smokers directly to a Specialist maternity service to undertake a collaborative approach utilising the proven 'Babyclear' model through which smokers who are pregnant are provided with behavioural support, medication and advice to quit.

This package of care has now enhanced in Tameside and Glossop and has actively reduced the Smoking at Time of Delivery figure for this area. The combination of this support and an innovative package of incentives aids women to stop smoking and stay quit up to at least their child's first birthday. The service is delivered by the Tameside Maternity Specialist Smoking Cessation Team and consists of midwives and maternity support workers.

Yorkshire & Humber AHSN and Calderdale and Huddersfield FT

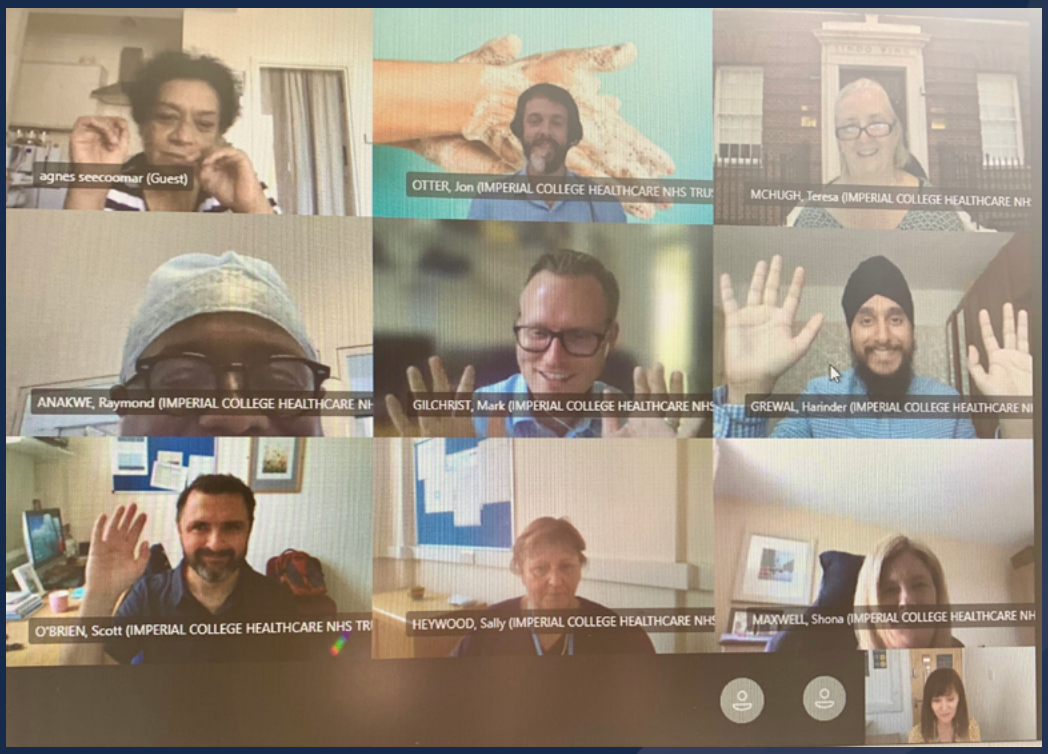
Improving detection and rule out of pre-eclampsia

Before Placental Growth Factor (PlGF) testing, women with hypertension were assessed and managed on clinical assessment, signs and symptoms, urinalysis and a Protein Creatinine Ratio test. Calderdale and Huddersfield NHS Foundation Trust implemented Roche's Elecsys SFIt-1/PlGF ratio test in October 2019. The PlGF blood test is used to identify those women at very low and very high risk of imminently developing pre-eclampsia. The test assists with clinical decision making and enables appropriate care and treatment for pregnant women with suspected pre-eclampsia. It also ensures only women in need of admission are admitted, allowing those who are found to be at low risk to be discharged home with robust plans in place for follow up and retesting. This frees up beds in the unit and provides both an improved patient experience and financial benefit for implementation.

INFECTION PREVENTION AND CONTROL INITIATIVE OF THE YEAR

WINNER

Partnered by BD



IMPERIAL COLLEGE HEALTHCARE TRUST

HAND HYGIENE IMPROVEMENT PROGRAMME

Hand Hygiene is one of Imperial College's trust-wide patient safety streams. Diagnostic work and audits by the Infection Prevention and Control (IPC) team revealed that hand hygiene opportunities were missed regularly on the wards and some wards had scored well below the 55% national average. An IPC driven Hand Hygiene Improvement Programme (HIPP) was set up as a collaborative, stakeholder-led, quality improvement initiative across the five hospitals. The HHIP brings together staff, patients, improvement leads and infection control experts on selected 'focus wards'. The aim is to raise hand hygiene awareness and practice among staff and patients, to significantly improve hand hygiene compliance scores (to over 60% in IPC audits), and to sustain these improvements in all future audits.

JUDGES COMMENTS

The judges felt that this winning initiative is a very impactful project that is targeting simple steps to address HAI and the spread of infections. The real value of this entry is the successful approach this team initiated which raised hand hygiene to the top of the organisational patient safety agenda and energised a campaign of improvement owned by the stakeholders. This is a fantastic example of teamwork across multiple sites and staff groups and was an innovative approach to a challenging problem.

INFECTION PREVENTION AND CONTROL INITIATIVE OF THE YEAR

HIGHLY COMMENDED

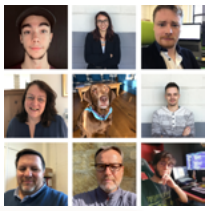
Northampton General Hospital Trust
Mouthcare really does matter!

The Infection Prevention & Control Team at Northampton General Hospital NHS Trust implemented best practice evidence based national guidance, 'Mouth Care Matters' to enhance the quality of mouth care provided. In 2018/19 a third of patients that developed C.difficile infection did so following antibiotics for hospital acquired pneumonia (HAP), of which poor mouth care is a significant contributory factor.The aim was to reduce antibiotics usage and associated C.difficile infection by reducing incidence of HAP through improving mouth care.

JUDGES COMMENTS

The judges felt that this was a super example of applied infection prevention innovation to improve patient experience, reduce measured incidence of infection and subsequently, the safety profile of a Trust. This impactful local project has demonstrated significant improvements in HAI prevention rates, improved staff training and skills development, as well as delivered dramatic reductions in HAIs.

FINALISTS



Focus Games and NHS Partners
FluBee Game

Engaging with staff is the starting point for any vaccination campaign. This especially important for staff with doubts about flu or the vaccine.

In 2016 Focus Games worked with Joan Pons Laplana and James Paget University Hospitals to develop a digital game that would engage staff and challenge common myths. It was called Flu Bee Game.

The game improves vaccine uptake by engaging staff on their phone. It does two vital jobs:
1. Challenges common misconceptions
2. Tells staff where to get vaccinated

Since 2016 the game has been used in over 40 NHS trusts and 300 care homes.

Southern Health and Social Care Trust
Carbapenem Reduction Programme

Between April-2018 and March-2019 a 25% increase in the use of carbapenems was observed in the Southern Health and Social Care Trust (SHSCT). Whilst working to identify strategies to reduce carbapenem use, an audit highlighted that although microbiology recommended most of the carbapenems prescribed, the lack of a 72-hour review was the main factor driving carbapenem consumption. The proposed intervention developed in response to this focused on improving the review of carbapenems though Consultant Microbiologist/ID Physician/ Antimicrobial Pharmacist led ward rounds.

BEST HEALTHTECH SOLUTION FOR PATIENT SAFETY

WINNER

COUNTY DURHAM AND DARLINGTON FT

HEALTH CALL DIGITAL CARE HOME

To improve the safety and care that is provided to care home residents, Health Call Digital Care Home (HCDCH) was developed. HCDCH is a digital solution that enables care homes to provide information to the health care setting. Using the recognised SBAR Tool (Situation, Background, Assessment and Recommendation) and calculating the NEWS2 score from clinical observations provided.

As part of the implementation, care home staff are upskilled to be able to take the observations and how to input the information into the app, using a WASP framework. Training is provided about 'normal levels' and what the NEWS2 scores mean, but we don't expect unqualified care workers to make any clinical or escalation decision. The unique element of HCDCH is that information is sent directly to a clinician and the escalation and priority is determined by nursing staff.

JUDGES COMMENTS

Judges said this is an excellent entry, addressing a key patient safety issue in linking care homes with acute care, and exemplifying the benefits for patients in connecting professionals via timely and relevant information. It is a fantastic example of multidisciplinary work that has resulted in enhancements to both the patient and professional experience, as well as the widespread embedding of national standards. Overall this project demonstrates how patient safety and care can be maximised in a setting that is facing very challenging times.

BEST HEALTHTECH SOLUTION FOR PATIENT SAFETY

HIGHLY COMMENDED

South Tyneside and Sunderland FT

Development of an Electronic Paediatric Emergency Department Asthma Assessment Tool (PEDAAT) and Care Pathway

Reducing the UK Paediatric asthma mortality rate, the highest in Europe, is a NHS 10 year plan priority. The National Review of Asthma Deaths (NRAD) concluded that 46% were preventable. An electronic Paediatric Emergency Department Asthma Assessment Tool (PEDAAT) has been developed using NRAD History and Discharge Care Standards, linking to an 'Asthma Care Pathway' on meeting ≥1 of the 4 Secondary Care Follow Up standards. A dedicated clinic provides patient-focused care within 2 weeks aiming to empower parents with asthma management using BeatAsthma resources(www.beatasthma.co.uk). PEDAAT has captured 100% of high-risk children and has reduced PED attendances(62%) and inpatient stays(71%).

JUDGES COMMENTS

An incredibly powerful message sits behind the PeeDAT initiative, and the passion behind the project is apparent. Whilst this project does not show significant financial savings, patient safety benefits are clear, compelling, and well evidenced, partially due to the excellent collaboration levels with other local organisations. Scaling this nationally, and also into adult asthma alongside paediatric asthma, would be massively beneficial for patient safety, improved experience, and efficiency.

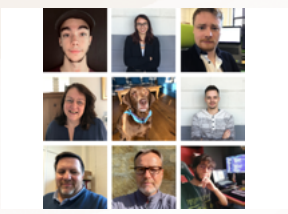
FINALISTS

Coventry and Warwickshire Partnership Trust

Safer acute inpatient care in Mental Health

Coventry and Warwickshire Partnership NHS Trust have been working in partnership with technology provider (Oxehealth) for the past three years, to closely develop and deploy a digital tool to improve patient safety.

At the Caludon Centre, the acute inpatient facility in the trust, the team have deployed the technology and found a reduction in self-harm and assaults as well as improvements to patient and staff experience.



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BEST HEALTHTECH SOLUTION FOR PATIENT SAFETY

FINALISTS

Healthier Lancashire and South Cumbria ICS

WelLPRES: Digital Solution for enhanced delivery of coordinated care and self management

WelLPRES is a patient- centric solution, designed to support clinicians to deliver quality care, as well as empowering patients to co-manage their health condition(s) along a managed care pathway.

The solution has been co-designed by patients, clinicians, and technology providers etc., through a programme of engagement workshops. WelLPRES was implemented across the Lancashire and South Cumbria region in October 2019. The recent integration of WelLPRES with our Local Person Record Exchange Service(LPRES) enables clinicians to access their patient's wider clinical documents securely, and link these to their patient's care records. This will reduce duplication, human errors, economise staffs' time helping to ensure data integrity. These improvements have had a significantly positive effect on Patient Safety.

North Tees and Hartlepool FT

CareScan+

As one of the Scan4Safety demonstrator sites, North Tees and Hartlepool NHS Foundation Trust relished the challenge of breaking new ground by showing how barcodes on surgical implants, medical instruments and general medical products can be used to verify that they are safe prior to use. The team fulfilled this ambition when they developed CareScan+ which is a purpose built decision support tool making use of 'a simple scan' to enable the provision of real-time and fully audited patient safety alerts. CareScan+ also registers surgical implants for track and trace purposes.

CareScan+ was built by the NHS for the NHS.

Tameside and Glossop Integrated Care FT

Supporting safe patient care through information technology

The District Nursing Team were reporting pressures on their service due to increased demand, which they felt was impacting on the care they delivered.

In the co-design of the tool the District Nurses were insistent that in order to ensure patient safety and to enable them to provide the right care at the right time, the tool needed to support them in providing individualised care. By using the tool, they are able to monitor a patient's progress, and are aware if a patient's conditions are becoming more complex. This allows the team to have 'safer person-centred rather than task orientated' conversations with patients and health and care professionals.

Tameside and Glossop Integrated Care FT, Safe Steps and Health Innovation Manchester

Safe Steps: Developing an evidence-based digital risk assessment platform

Safe Steps is an app to help reduce falls through standardised and effective falls risk management. Assessing 12 key risks - based on NICE guidelines - and providing CQC approved recommendations for multifactorial intervention via a secure, easy-to-use web application.

Safe Steps has been implemented at the Stamford Unit - a 93 bed intermediate care unit in the grounds of Tameside & Glossop Integrated Care NHS Foundation Trust. In this setting - a first for the UK as previously only used in Care Homes - it has been used almost 3,000 times by 46 members of staff and helped to reduce falls in the first 6 months by 29%.

BEST EMERGING SOLUTION FOR PATIENT SAFETY

WINNER

FOCUS GAMES AND NHS PARTNERS

FLUBEE GAME

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Since 2016 the game has been used in over 40 NHS trusts and 300 care homes.

JUDGES COMMENTS

Judges said that this was a fantastic innovation, demonstrating clear staff safety improvements and value creation, and how a small idea can have big results. It is no wonder that it has proven popular with the Scottish Government, who have now bought it for use across Scotland, and it is also impressive that they are planning to include a potential Covid vaccine in the future. Overall, a creative proposition that is timely in going 'viral' with a broad population wide benefit.

BEST EMERGING SOLUTION FOR PATIENT SAFETY

HIGHLY COMMENDED

South Tyneside and Sunderland FT in collaboration with Newcastle upon Tyne Hospitals FT and North East and North Cumbria AHSN

BeatAsthma+: A Health Promotion Initiative to Identify and Manage High Risk Children with Asthma and to provide a structured Education Package for Families in Primary Care

The UK has the highest Paediatric asthma mortality rate in Europe. The National Review of Asthma Deaths (NRAD) concluded that 46% are preventable. We have developed a Paediatric Emergency Department Asthma Assessment Tool(PEDAAT), using NRAD Standards, to identify high-risk children with asthma. PEDAAT has combined with BReATHE(Beating Regional Asthma through Health Education) to create BeatAsthma+, a Primary Health Improvement Initiative, which enables early identification, management and treatment and delivers an education programme to families(www.beatasthma.co.uk). PEDAAT captured 100% of high-risk children, reduced PED attendances (62%) and inpatient stays (71%). BReATHE reduced hospital admissions (29%) and improved Asthma Control Test score (6 points). BeatAsthma+ will save lives.

JUDGES COMMENTS

This is a great example of system working for patient safety, and it is fantastic to see a successful innovation continuing to be developed over time. Clearly paediatric asthma care is complex, and the team have strengthened their approach by combining two strategies to form Beat Asthma+ with more impressive data. The stakeholder engagement and outcomes data are particularly impressive. A truly commendable piece of work with potential for national spread.

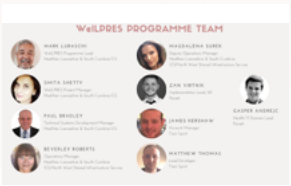
FINALISTS

Alder Hey Children's FT

Early detection of deterioration in children in hospital to prevent critical care transfer: The DETECT Study

Missed or late identification of deterioration in children in hospital results in unplanned admission to critical care, with associated morbidity and mortality.

System C, in collaboration with Alder Hey Children's NHS Foundation Trust, developed an age-specific electronic solution that uses the CareFlow Vitals platform and Connect mobile applications to pro-actively monitor, detect, escalate and track the response to deterioration in hospitalised children. It incorporates the Alder Hey Paediatric Early Warning Score, which has been iteratively developed at Alder Hey, using statistical methods and published reference ranges. Once signs of deterioration have been detected, the app provides real-time alerts and key data to the responsible clinical teams and ward leaders, about the sickest children, so that care can be augmented.



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BEST EMERGING SOLUTION FOR PATIENT SAFETY

FINALISTS

Northumbria Healthcare FT

Berwick Dementia Aid

Inpatient falls cost the NHS around £630 million per year. Walking aids when used appropriately can reduce the risk of falls and improve independence. The goal was to try and reduce the number of falls in patients with dementia by finding ways to improve the utilisation of walking aids. Several hospitals have explored the use of red Zimmer frames to aid patients with dementia with NHS Forth Valley finding that this improved usage of the walking aid from 18-61%. The team explored cost effective ways in which a contrasting colour could be added to the patients existing Zimmer frame, and designed a red clip that can be attached to a patients existing Zimmer frame to improve the use of the walking aid and reduce falls.

Royal Free London Hospital FT

Translational Simulation in Robotic Surgery: Development of an Emergency De-Docking Algorithm

The team developed a cardiac arrest de-docking algorithm following human factors principles, using iterative testing with point of care simulated crisis scenarios with multidisciplinary operating room personnel.

This novel approach to designing an algorithm follows Safety II principles and is fundamental if new technologies are to be integrated safely into an established healthcare system. The template algorithm can be easily adapted to other operating theatres.

Southern Health and Social Care Trust

Implantable Loop Recorders: Improving timeliness of treatments

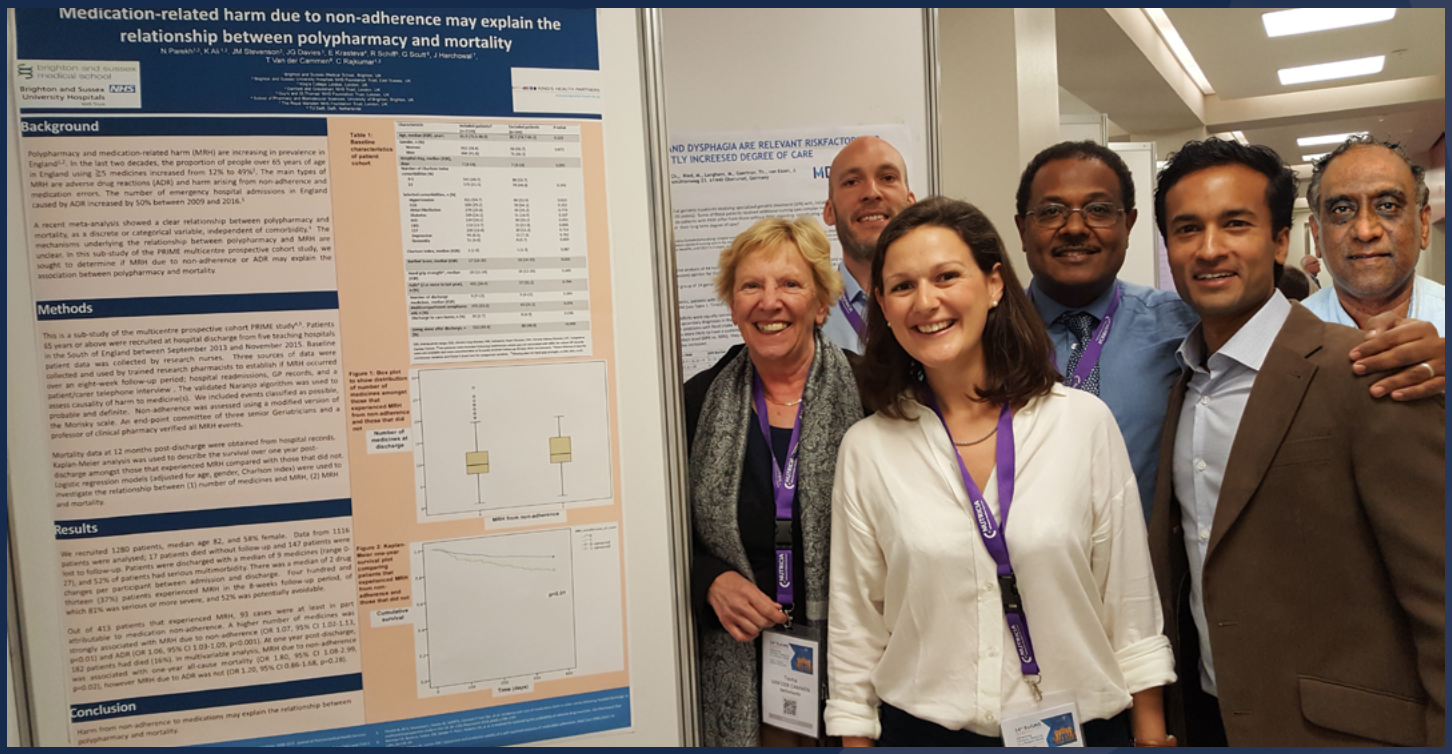
Within the Cardiology service patients waited greater than twelve months for insertion of ILR (implantable loop recorder) implant.

The project aimed to increase the capacity to implant a greater number of Loop Recorders per week, increase the knowledge and skills of the team, improve the timeliness of patient care by training Cardiac Physiologists in the insertion of ILRs, and reduce costs of procedure. Patient safety was the over-arching priority; having the Loop Recorders implanted in a timely manner to ensure the service users were being monitored appropriately.

IMPROVING SAFETY IN MEDICINES MANAGEMENT INITIATIVE

WINNER

Partnered by BD



BRIGHTON AND SUSSEX MEDICAL SCHOOL, BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST, GUY'S AND ST THOMAS' FT, WESTERN SUSSEX HOSPITALS TRUST AND PORTSMOUTH HOSPITALS TRUST

REDUCING MEDICATION-RELATED HARM (MRH) IN OLDER PEOPLE DISCHARGED FROM HOSPITAL

Reducing the burden of serious and avoidable medication-related harm by 50% by 2022 is WHO's third global patient safety challenge.

Older adults are especially vulnerable to medication-related harm due to multimorbidity, polypharmacy, age-related changes in pharmacokinetics and pharmacodynamics.
Risk stratification using prediction tools is recognised as one solution to enhance the cost-effectiveness of interventions targeting patients likely to derive greatest benefit. This project surrounded the development of a risk prediction tool to identify older patients at high risk of MRH requiring healthcare use within 8 weeks following hospital discharge.

JUDGES COMMENTS

Judges felt that this was an ambitious initiative that has led to an increased national awareness and work across 5 separate NHS organisations. It is an excellent example of multidisciplinary working, which took into account the value that patients and carers themselves could add and has great potential for national adoption.

IMPROVING SAFETY IN MEDICINES MANAGEMENT INITIATIVE

HIGHLY COMMENDED

Yorkshire & Humber AHSN, Airedale FT, Barnsley Hospitals FT, Bradford Teaching Hospitals FT, Calderdale and Huddersfield FT, Hull University Teaching Hospitals Trust, Leeds Teaching Hospitals Trust, York Teaching Hospitals FT and Leeds, York Partnership FT and Community Pharmacy West Yorkshire

Medicines support to improve patient safety

NHS England commissioned the AHSN Network to roll out the Transfer of Care Around Medicines (TCAM) programme in April 2018 to support patients who may need extra help taking their prescribed medicines when they are discharged from hospital. The initiative has shown that patients who see their community pharmacist after they've been in hospital, are less likely to be readmitted and, if they are, will have a shorter length of stay. TCAM has the potential to help alleviate pressure on GP services, by building public confidence and acceptance of the pivotal role community pharmacists can play in health promotion, disease prevention and the management of urgent and long-term conditions. It also helps to reduce waste in the system and maximises opportunities for those who need it, providing patients with safer care and preventing them from harm.

JUDGES COMMENTS

Judges found this to be a great initiative bringing primary and secondary care together, with wide-reaching safety benefits for patients. Originally tested in cardiology, it is fantastic to see it being rolled out in other patients and cohorts, and even better that the team have now developed an evaluation tool that can be taken 'off the shelf' for others to use.

FINALISTS

Hertfordshire Partnership University FT

Medicines Optimisation Clinic

One of the key priorities in the Trust is around Shared Decision Making (SDM) and this is highlighted in both our Medicines Optimisation and Trust Quality Strategies.

This project surrounds a six month pilot pharmacist-led medicines optimisation clinic launched in an adult community mental health team. This aimed at evaluating the impact of a pharmacist in community based services and facilitating SDM in practice, using evidence based medicine and enhancing patient safety, thus optimising the use of medicines. Healthcare professionals worked together to individualise care, monitor outcomes more carefully, review medicines more frequently and support patients when needed.

Marie Curie Hospice, Newcastle

Reducing Medication Errors through the Introduction of an Electronic Prescibing System within a Hospice Setting

In 2018 staff at Marie Curie Hospice, Newcastle reported 110 medication related incidents. 60 of these were related to prescribing or administration. Tasked with reducing this number, a review was carried out of all incidents, demonstrating that staff were more likely to make a prescribing or administration error within the first few months of employment. Unfamiliarity with the process was often cited as a contributing factor, leading the team to explore the introduction of an ePMA system to the hospice. While information gathering, it became apparent that ePMA systems outside of hospital settings were not commonplace and the team believe they are the first to look at introduction to a hospice setting. They also aim to develop a programme fit for purpose in a non hospital setting by reviewing incidents and making changes to the system.

IMPROVING SAFETY IN MEDICINES MANAGEMENT INITIATIVE

FINALISTS

Neighbourhood Integrated Practice Pharmacists in Salford (NIPPs)

Rationalisation and Safety Review of DOACs in Primary Care

Many patients are given DOACS for VTE with a finite treatment period intended, however some patients continue to receive these drugs beyond the indicated end date, resulting in potential morbidity, health risks as well as cost implications. The development of proformas to guide local pharmacists in Salford in best practice was undertaken, and during this time it became clear that this exercise was also required for several other patient groups. The target was for the NIPPS team to review all these patient groups across the region ensuring no patients were on a DOAC inappropriately and conversely to ensure all patients with a confirmed diagnosis of non-valvular atrial fibrillation diagnosis were informed of the risks of not being anticoagulated as well as those already anticoagulated being on the correct dose.

Salford Care Organisation, part of the Northern Care Alliance Group

Medicines Related Admissions: Identifying and preventing medicines related harm across care boundaries

The Medicines Related Admission (MRA) project was developed by Salford Integrated Medicines Optimisation Team (SIMOT) to assist with achieving it's aims of improving medicines safety and optimisation across care boundaries. Where adverse medicines events result in admission to Salford Care Organisation they are recorded quickly using an 'MRA order' which can be requested for a patient in seconds. The data gathered from the use of the MRA order is used to identify and reduce harm from medicines across care boundaries in Salford, and where adverse drug reactions are identified to improve reporting to the MHRA via the Yellow Card scheme.

CLINICAL GOVERNANCE & RISK MANAGEMENT IN PATIENT SAFETY AWARD

WINNER

GUY'S AND ST THOMAS' FT

PROSTHETIC PRESSURE ULCER REPORTING AND MANAGEMENT

NHS Improvement pressure ulcer guidelines were launched in 2018. The Trust identified a risk of the prosthetic MDT service not being compliant with the guidelines and developed an action plan to gather data, improve our compliance and governance in this clinical area.

Initial data collection identified how many prosthetic patients attend our outpatient clinics presenting with a pressure ulcer on their residual limb(s) and confirmed the need to improve staff knowledge of wound classification, management and reporting of pressure ulcers. A secondary, more detailed action plan was agreed, involving bespoke training by our local tissue viability team, agreeing standardised clinical actions, advice to patients, and onward referrals.

JUDGES COMMENTS

The judges loved the drive and ambition to improve outcomes for prosthetic patients, and the interaction of community stakeholders that was required to deliver this. They were impressed that the project has been shared with two academic institutions and with 6 other prosthetic centres. There are clear benefits of the programme directly linking to outcomes identified in the NHS Long Term Plan. The approach used has the potential to become a national best-practice exemplar and can be scaled across the UK and even further.

CLINICAL GOVERNANCE & RISK MANAGEMENT IN PATIENT SAFETY AWARD

HIGHLY COMMENDED

Solent Trust and Portsmouth Hospitals Trust

Collabrative risk assessment: championing the use of aquatic physiotherapy in the ventilated critical care patient with Guillain-Barre Syndrome

This project involved the use of aquatic therapy (AT) in critical care patients with Guillain-Barre Syndrome (GBS), a condition in which significant recovery can be achieved, aided with physiotherapy intervention. Providing an alternative therapy environment to that of critical care (CCU), AT can also improve psychological well-being.

In 2018 the hydrotherapy unit received its first referral from CCU - a 60-year-old, ventilated GBS patient. To enable treatment to occur the team developed a bespoke and staged risk assessment tool for the AT intervention.

JUDGES COMMENTS

Whilst the project is still in its infancy, the presentation provided judges with clear detail pertaining to the process involved and how the risk assessment tool has been developed. There is evidence that the tool is comprehensive and improved risk management for individual patients using this innovative service. The patient video was fantastic and the spread within the organisations and external to them is to be commended.

FINALISTS

Cambridge University Hospital FT

Improving patient safety through risk management

Cambridge University Hospitals NHS Foundation Trust has a long-term risk management programme to embed a risk aware culture. This is underpinned by a robust and effective process and electronic risk register, a divisional quality governance structure and a clear oversight and assurance framework. The trust's goals are to make risk management an integral part of patient safety through a robust risk management framework that supports informed decision-making, and improved accountability and processes for sharing of patient safety risks across divisions.

Mountain Healthcare

Custody Early Warning Scores; do they predict patient deterioration in police custody?

National Early Warning Scores (NEWS) has been seen to reduce morbidity in health care settings and with police detainee deaths and serious adverse events continuing to occur in police custody, some forces have adopted an altered version of this system; the Custody Early Warning Score (CEWS).

Mountain Healthcare conducted a 3-month trial of this new and untested system to see how effective it was at identifying detainee morbidity and prioritisation, but found that the scoring system was not sensitive or specific enough to identify this in the detainee population. They are therefore calling for changes this policy and are working to assess detainees effectively, supported by their near miss reporting."

IMPROVING CARE FOR OLDER PEOPLE AWARD

WINNER

CAMBRIDGESHIRE COMMUNITY SERVICES TRUST

POPULATION HEALTH MANAGEMENT FOR FRAILTY

This approach to population health management was developed as part of a wider programme of work to address frailty and multi-morbidity in Luton.

The approach has been enabled by a population health risk tool, and live information from partners via an online analytics dashboard. The team can see who has attended A&E and been discharged from hospital up until midnight on the previous day. This gives services a 2-3 day head start by enabling them to ensure responsive care plans, medication reviews and visits are put in place on the morning following a patient's discharge.

JUDGES COMMENTS

This is an excellent example of improving care for older people. Patients too often fall through the gaps and there often isn't the technology to identify these patients. The population health tool is a great example of being able to identify patients early and put steps in place to prevent a deterioration of their condition. Clear benefits have been described with lots of stakeholder involvement and buy-in. This is a truly responsive collaborative partnership approach to supporting older people with clear benefits applied during covid-19.

IMPROVING CARE FOR OLDER PEOPLE AWARD

HIGHLY COMMENDED

Northamptonshire CCG
Yellow Bracelet Scheme

The Yellow Bracelet is a pioneering scheme targeting better care for older vulnerable people throughout Northamptonshire. It is a paperless communication aid that shares care information and enables Health and Social Care sectors to make real time risk assessments and informed decisions ensuring the best outcomes. This simple idea has been designed to improve patient safety and well-being, by reducing the service user impact associated with delayed transfers of care (DTOC); provide better outcomes; reduce avoidable admission through application of real-time communications; reduce delays in discharge for patients in hospital who have a current care package; reduce bed days spent in hospital; allow domiciliary care providers to maintain active control over their care packages and stop cancellation of domiciliary care packages.

JUDGES COMMENTS

This is a great adaptation of existing patient information sharing platforms currently in use across the country. The roll out of the yellow bracelet scheme clearly has older people at the heart of its approach. Significant qualitative and quantitative gains were made, spread across health and social care settings, with even more added value during covid-19. The judges are keen to explore how the scheme could further support differing groups of vulnerable clients and diverse communities in the future, and see it replicated in other areas.

FINALISTS

Northumbria Healthcare FT
Nerve Centre 4AT delirium screening project

The project's ambition was to screen 80% of all admissions over the age 65 years for delirium within 12 hours of admission to hospital using the 4AT assessment tool, as non-detection of delirium is a Patient Safety emergency affecting up to 30% of admissions with high mortality associated. This work built upon the team's previous AFLOAT (Avoiding Falls Level Of Observation Assessment Tool) project which was HSJ Patient Safety finalist in 2019. The team are moving from a model of increased observation, to increased therapeutic intervention.

Sherwood Forest Hospitals FT
MDT Leadership to support reducing Length of Stay in a Care of the Elderly Unit

The project was designed to demonstrate the impact of compassionate, inclusive leadership on the multidisciplinary team, average length of stay care and quality outcomes on an acute elderly ward. The care improvement on ward 52 arose from the need to reduce delayed transfers of care for patients, increase discharges earlier in the day and reduce the length of stay of 8.9 days.

The team put in place Monday - Friday intervention goals consisting of daily Consultant review of new /sick patients before the 9am board round; Consultant led board round at 9am; daily Consultant "check ins" with the team and reinforcement amongst the wider team of the key principles. These included the ethos that once a patient is no longer receiving treatment they can only have in secondary care, the best care they could give is to help progress the patient home.

IMPROVING CARE FOR OLDER PEOPLE AWARD

FINALISTS

Tameside and Glossop Integrated Care FT, Safe Steps and Health Innovation Manchester

Safe Steps: Developing an evidence-based digital risk assessment platform

Safe Steps is an app to help reduce falls through standardised and effective falls risk management. Assessing 12 key risks - based on NICE guidelines - and providing CQC approved recommendations for multifactorial intervention via a secure, easy-to-use web application.

Safe Steps has been implemented at the Stamford Unit - a 93 bed intermediate care unit in the grounds of Tameside & Glossop Integrated Care NHS Foundation Trust. In this setting - a first for the UK as previously only used in Care Homes - it has been used almost 3,000 times by 46 members of staff and helped to reduce falls in the first 6 months by 29%.

The Queen Elizabeth Hospital King's Lynn FT in partnership with Norfolk Community Health and Care Trust and West Norfolk CCG

Rapid Assessment and Frailty Team

Back in 2006 the trust's community service paired with the acute therapy service on an informal basis, to assist in diverting unnecessary admissions to hospital. The vision was to support patients in the most appropriate way, with being at home, now known as 'Home First', being at the heart of the service.

This service has now grown to 10.3 WTE, and provides a 7-day service to cover all emergency access areas within the acute trust including the Emergency Department, Acute Medical Unit, Ambulatory Emergency Care, Same Day Emergency Care, the Surgical Assessment Unit and a number of clinics including Frailty & Fracture Clinic. The team has reduced the time older patients spend in the emergency department, thus improving patient experience and helping to avoid the admission risk of hospital acquired infection.

West Midlands AHSN & NIHR ARC West Midlands

SPACE - A Quality Improvement Initiative in Care Homes

In 2016 the West Midlands Academic Health Science Network recognised that care homes were pivotal to the local health economy and wanted to co-create a programme of work to reduce avoidable harm using QI techniques with all stakeholders including homes and commissioners. SPACE was developed, designed and delivered in collaboration with Walsall and Wolverhampton CCG. The programme had two main elements - the first was training events and workshops, which aimed to help care home staff and managers, develop relevant skills and enhance their understanding of safety-related service improvement. There were also facilitated sessions delivered in care homes, which supported staff to implement changes to practice to reduce avoidable harm relating to specific safety concerns such as falls prevention and pressure ulcer management.

Western Health and Social Care Trust

Acute Care at Home: A Shift to the Left

Evidence points to various drivers for developing a Hospital at Home service for older people. The Western Trust Hospital at Home service, entitled 'Acute Care at Home' (ACAH) was commissioned by the Public Health Agency to implement the Department of Health strategy "Health & Wellbeing 2026" – Delivering Together. The service was established in August 2016 and has a dedicated multi-disciplinary team that is Consultant Geriatrician led.

The ACAH model delivers on the key healthcare theme of realising the 'left shift'. A concept that strives to move clinically appropriate care and treatment for patients from hospitals into the community; with the intention of leading to better health and wellbeing, better quality of care as well as sustainable and efficient services – the Triple Aim.

NHS SAFEGUARDING INITIATIVE

WINNER

THE 8 CCG'S OF LANCASHIRE AND SOUTH CUMBRIA, THE 7 MAIN HEALTH TRUST PROVIDERS AND THE LOCAL NHS REGIONAL TEAM

DEVELOPMENT OF A COLLECTIVE FULLY INTEGRATED SAFEGUARDING HEALTH SYSTEM ACROSS OUR ICS

The designated nurses and professionals across the Lancashire and South Cumbria system worked with the National team and our local providers and NHS E regional team to devise what an integrated health offer could look like. The aims were to ensure Primary Care Networks, NHS Trusts and Private Health Care providers could feed challenges from bottom-up; create a transparent and effective governance framework for multiple organisations which allowed a single voice for health; ensure senior Safeguarding engagement at all levels of system leadership and many more, to ensure the health system is fit for purpose.

JUDGES COMMENTS

The judges felt this was an excellent example of system wide restructuring of safeguarding arrangements which will improve sharing of learning and avoid duplication of effort across multiple groups. The project leads and stakeholders demonstrated a real passion for change and the need to improve the service to safeguard patients and ensure a more joined up approach to patient care.

NHS SAFEGUARDING INITIATIVE

HIGHLY COMMENDED

Homerton University Hospital FT and City and Hackney CCG

The Primary Care MARAC (Multi-Agency Risk Assessment Conference) Service

In 2015 the Designated Nurse from City and Hackney Clinical Commissioning Group and a Hackney Council Public Health Strategist approached the Safeguarding Children team at Homerton University Foundation Trust, to pilot an innovative nurse-led MARAC Liaison Service (MLS). The goal was to build a service that addressed the gap regarding the sharing of health information between the MARAC and GPs, ensuring informed decision making and safety planning for victims of domestic abuse. Feedback from GPs and MARAC partners helped shape the service and positive outcomes achieved resulted in recurrent funding of the service.

JUDGES COMMENTS

The judges felt that this team provided a comprehensive overview of the development, and demonstrated excellent outcomes in relation to improved engagement in primary care. It was great to see the multi-agency team working together to optimise the opportunity to safeguard patients.

FINALISTS

Blackpool Teaching Hospitals FT

Health Setting Domestic and Sexual Abuse Safeguarding

The ambition of this project was to improve support for domestic and sexual abuse victims, patients or staff, who are presenting within local health settings. To raise awareness and transform the response to provide a more streamlined service from the victim's first disclosure to the pathway of appropriate and consistent support.

The initiative is to expand the knowledge and expertise of the workforce, revise and improve policies and training, and to empower staff to respond appropriately to circumstances of abuse to improve patient safety.

Hertfordshire Community Trust

Paediatric Liaison IT Solution for sharing information between Hospital and Provider Services

When funding to support paediatric liaison in West Hertfordshire was withdrawn in 2017, there was an urgency to develop a process to ensure information was shared between Hospital and HCT in a consistent, timely, safe way, to ensure children were followed up when needed and continuity of care and support was not compromised. As a result HCT, Central Midlands South Child Health Information Service and West Hertfordshire Hospital Trust worked together to develop an innovative paediatric liaison IT bulk-upload solution to safeguard and improve outcomes for children. This IT initiative is now County-wide and has expanded into a neighbouring county.

NHS SAFEGUARDING INITIATIVE

FINALISTS

Isle of Wight CCG
Safeguarding Leadership and Primary Care

The Burdett Trust supported the IOW CCG to introduce a safeguarding leadership project, to drive the development of contemporary and standardised safeguarding systems and processes across primary care, developed and embedded with and by the primary care workforce.

Overall aims of the project included improved identification and referral to adult and child safeguarding; Improved understanding and practice in mental capacity assessment and Deprivation of Liberty Safeguards; improved outcomes feedback to Primary Care and many more.

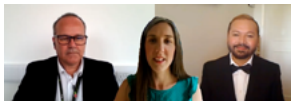
Northumbria Healthcare FT
Integrating a Domestic Abuse Health Advocate Service Across Acute Hospital Services

NHCFT has a clear vision and Strategy for Safeguarding across the organisation and a well-established Safeguarding Board incorporating a highly specialised safeguarding service. In 2017 the safeguarding service were successful in obtaining 3 years funding from the Police and Crime Commissioner for a Domestic Abuse Health Advocate to work with all victims who attend hospital where domestic abuse is a concern. The aim of the project was for a Domestic Abuse Health Advocate to be embedded into A&E, Maternity and Gynaecology as these were identified as high-risk areas where victims where most likely to present to or disclose domestic abuse. Due to the success of this in safeguarding patients, this is now a permanent trust-wide role which is fully integrated into the safeguarding service and now includes sexual violence.

Royal Devon and Exeter FT
Supporting Victims of Domestic Abuse using a Multi-Systems Approach

The team identified a need for a greater number of opportunities to identify, refer, support and protect victims & survivors of domestic abuse.

Through our existing Domestic Abuse Operational Group and with help from the Pathfinder Project, we developed, enhanced and updated our existing Domestic Abuse policies and processes to improve safety for both patient and staff victims/survivors. The overall desire was to increase awareness of domestic abuse across the Trust and use innovative ways to provide as many opportunities as possible for victims/survivors to gain help and support.



Safeguarding Adults National Network and Health Education England
Safeguarding Adults Level 3 and 4 Training

The project aim was to improve safeguarding knowledge and skills of all national registered health care professionals, ultimately ensuring that adults at risk of abuse and neglect are protected and kept safe. HEE has a system-leadership role for development of e-learning for the health and care workforce, working with partners and using proven internal expertise to ensure that where possible, e-learning which meets common learning needs is developed once, well, nationally and made freely available to all. Safeguarding adults is now an area of mandatory compliance training.

Wolverhampton CCG, Wolverhampton Domestic Violence Forum and Wolverhampton Refugee and Migrant Centre
Empowerment of Hard to Reach Communities in the Prevention of Violence Against Women and Girls

NHS Wolverhampton CCG has statutory safeguarding responsibilities. This project responded to the need to raise awareness of illegalities and long-term harms of VAWG with women and men from new arrival and established BAME communities in Wolverhampton. The project improved knowledge and confidence in how to report abuse, signposted to advice and support, and provided resources for community self-help.

Partnership working facilitated the project successfully safeguarding those at risk of serious harms - CCG for funding and coordination, Refugee Migrant Centre for premises and access to participants, and Wolverhampton Domestic Violence Forum for developing and delivering safe training and resources.

SERVICE USER ENGAGEMENT AWARD

WINNER

SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST

CO-PRODUCTION OF A COMIC BOOK IN HMP HYDEBANK WOOD SECURE COLLEGE WITH YOUNG MEN IN CUSTODY

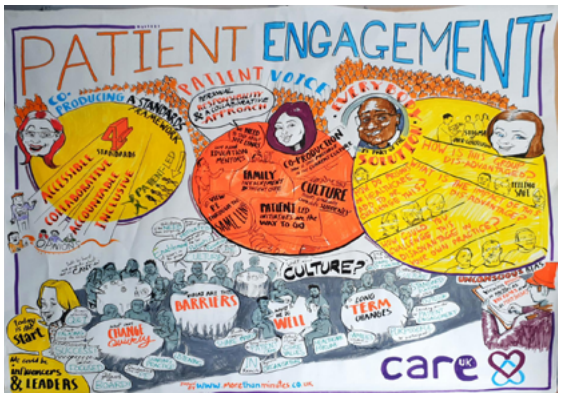
The aim was to co-produce a comic book with young people in custody to deliver a pertinent healthcare message to others of the dangers of drug misuse, by bringing their personal stories to life through storytelling and pictures and utilising it to educate and help others in custody. The resulting Comic Book is a humorous, relatable, amateur publication. Without the involvement of young men in custody in HMP Hydebank Wood College, the comic would not have been possible. Their unique insight into prison life and drug misuse has been invaluable. Their creativity and engagement has helped to produce an informative and educational yet relevant and humorous source of information.

JUDGES COMMENTS

This winning organisation has created a really innovative model to engage with a hard to reach population tackling challenging health issues in prison. There was good evidence of service user involvement and all feedback from these service users has been 100% positive. This project not only improved the health of the prison population but also improved skills of those involved in the project creation and implementation.

SERVICE USER ENGAGEMENT AWARD

HIGHLY COMMENDED



Practice Plus Group

Using Prisoner Health Champions to Enhance Health and Wellbeing Outcomes

Throughout 2019 the Health in Justice patient engagement team conducted a national review of patient peer roles and participation in design, delivery and evaluation of prison healthcare services. This identified a need for a standardised peer role and bespoke training. A bottom-up approach ensured that patient voice and experience drove project development, via focus groups and consultations facilitated by a lived experienced colleague.

A successful Health Champions scheme used across 12 West Midlands prisons was used as the framework for national implementation. Following a pilot across 6 further prisons, the goal is to integrate Health Champions nationally by 2021.

JUDGES COMMENTS

This was a fantastic initiative engaging a hard to reach group. Co-production by the inmates produced a successful and meaningful model that prisoners valued and utilised, resulting not just in improved health outcomes but also giving individuals a greater understanding how to maintain a healthy lifestyle once they leave prison. The judges felt this innovative project has such huge potential for use elsewhere.

FINALISTS

Belfast Health and Social Care Trust

Active Birth Centre

Robust clinical evidence supports establishment of Alongside Midwife-Led Units (AMU'S), co-located to Obstetric-Led Units with a shared philosophy and understanding of normal birth. The Active Birth Centre (ABC) first opened in 2015 however, activity levels were consistently lower than anticipated, with an absence of standard operating procedures and pathways and not all women eligible for the unit were offered or aware of, the opportunity to labour and birth there.

The ABC project had the aim of embedding the ABC as a 'true' AMU and viable birthplace option for all women with low risk pregnancies birthing within this Trust. Key drivers are to increase activity within the ABC, normalise birth and reduce interventions, improve women's birth experience and increase midwifery confidence.

Cardiff and Vale University Health Board

Co-Production: Public and Professional working together to redesign and implement a model of care for newly diagnosed Coeliac Disease

Variations in service delivery were identified for patients with newly diagnosed Coeliac Disease (CD), with some patients waiting twice as long as our service standard.

The service model at the time was based around a traditional 1:1 outpatient consultation. Through service user engagement we established our ambition to transform the traditional model, retaining the elements valuable to patient care, whilst modernising and improving aspects patients and staff did not find valuable. The team hypothesised that an 'e-dietary advice' video containing quality information, accessed via our Health Board's 'YouTube' channel, could improve patient experience.

SERVICE USER ENGAGEMENT AWARD

FINALISTS

Royal Brompton & Harefield FT

Engaging people with Cystic Fibrosis to improve service delivery

The Royal Brompton Hospital is one of the largest Cystic Fibrosis (CF) Centres in Europe and has experienced increased waiting times for annual review appointments, clinic appointments and day case reviews. This project describes the introduction of technology for both data collection and storage, and virtual consultations, with the goal of reducing the burden of seeking care, provide a platform to self-monitor health outcomes and to relieve the concerns around cross infection, time, cost and travel constraints.

The co-production of this initiative has been patient driven but adopted and developed by the CF team and their technology partners.

Royal Devon and Exeter FT

Using Patient Engagement and Co-Production to Introduce a New Cancer Rehabilitation Programme

In 2018 the Royal Devon and Exeter NHS Foundation Trust received funding through the Peninsula Cancer Alliance transformation funding to help transform the patient pathway and implement personalised care and support for people living with and beyond cancer. The aim of the initiative was to introduce a rehabilitation service which would provide much needed education and exchange of information alongside specific targeted group exercise programs to help people to better understand, manage and improve the side effects of cancer treatments.

Warrington and Halton Teaching Hospitals FT

Hearing those hard to reach voices: using social media as a platform for engagement

Nationally the Maternity Voice Partnership (MVP) is a significant platform from which engagement relationship are initiated and maintained with local service users and maternity service providers. Over the past 5 years, Warrington Hospital have tried a number of times using various approaches to engage service uses to lead the MVP. This project describes the "blog" project that the hospital utilised once they acknowledged the power of social media and had seen a significant increase in user engagement through the Maternity Face book page over the previous 6 months.

Worcestershire Health and Care Trust

BESTIE - Mobile Application

The team designed and built a bespoke CAMHS resource called BESTIE (Balance Energy Support Thrive Interactive Evolve). The BESTIE project brief was for young people, clinicians, IT professionals and Designers, to collaboratively design, build and develop an online resource and app, to help young people in Worcestershire better manage their mental health needs. CAMHS was involved in the initial development of the Trust's GDE application and was able to highlight how the use of new technology could potentially be used to support the mental health and emotional wellbeing of children and young people within their region.

BEST PARTNERSHIP SOLUTION IMPROVING PATIENT SAFETY

WINNER

IMPERIAL COLLEGE HEALTH PARTNERS WITH MATERNITY SERVICES AT CHELSEA AND WESTMINSTER HOSPITAL FT, NORTHWICK PARK HOSPITAL, QUEEN CHARLOTTE'S AND CHELSEA HOSPITAL, ST MARY'S HOSPITAL, THE HILLINGDON HOSPITALS FT AND WEST MIDDLESEX UNIVERSITY HOSPITAL

PREVENTION OF CEREBRAL PALSY IN PRETERM LABOUR (PRECEPT)

Using a gold standard approach to partnership working, Imperial College Health Partners (ICHP) brought together 6 maternity services, Local Maternity Network, Neonatal Operational Delivery Network, Maternity Voice Partnership and voluntary sector to deliver Prevention of Cerebral Palsy in Preterm Labour (PReCePT) which led to the prevention of 3 cases of Cerebral Palsy in North West London between September 2018 and February 2020 avoiding an untold degree of emotional and social burden on individuals and families and saving an estimated £2.4 Million in life time care cost on the NHS.

With the aim to reduce the incidence of cerebral palsy in babies born preterm, NWL set their ambition higher than the national target of 85% of eligible mothers receiving MgSO4 and in fact achieved 93%. ICHP used a centrally-coordinated locally-led approach to achieve collaboration, overcome implementation barriers, provide support and enable leadership around PReCePT to achieve this ambition.

JUDGES COMMENTS

Judges said this initiative, driven by an impactful partnership across NW London, had a very clear and robust ambition that was designed to make a great difference to patient and carer health and wellbeing. The outcome of the initiative was evident, with the patient and carer ambition met, and significant cost savings to the NHS. The partnership has made substantial progress on spreading intelligence learned on the initiative across England already. A great example of a simple initiative that can really change lives. Very well done.

BEST PARTNERSHIP SOLUTION IMPROVING PATIENT SAFETY

HIGHLY COMMENDED

Bolton FT, Homeless Welfare, Bolton Council, Homeless Aid UK, St John Ambulance and Greater Manchester Mental Health

Bolton Homeless Outreach Nursing Team Collaborations

The Homeless Nursing Team (Bolton NHS FT) and Homeless Welfare (Bolton Council) identified that they were seeing patients on the streets, who did not attend clinics elsewhere. The patients said that they were attending a street kitchen provided by Homeless Aid UK, so the team commenced fortnightly visits.

They then contacted St John Ambulance, who provided a clinic facility with one of their mobile treatment units. It was then highlighted at complex cohort meetings that this would be an ideal opportunity for housing and drug/alcohol services to do some effective outreach work with a 'one stop shop' approach. This is now a regular weekly occurrence for the nursing team with fortnightly support from Bolton Council Homeless Welfare team and Greater Manchester Mental Health Assertive Outreach team.

JUDGES COMMENTS

This is a strong project with clear goals, and a focus on collaboration across the whole integrated care sector to support health and mental wellbeing. Good evidence was provided around spread, harm reduction and prevention for a hard to engage area of the population. Details regarding transferability to other organisations was shared and the qualitative feedback clearly reflected both staff and patient satisfaction with the service. The fact that this service has not required additional costs is admirable and will ensure that this model will be attractive to other similar organisations.

FINALISTS

Cambridgeshire and Peterborough CCG on behalf of Cambridgeshire & Peterborough STP

System Wide Out of Stock Working Group (SWOOSWG)

Our partnership was set up to develop further collaborative and integrated working across the wider Cambridgeshire and Peterborough health system, by reducing duplication and improving communication between healthcare professionals across health sectors to mitigate any risk to patient safety in relation to medication shortages.

The virtual "System Wide Out of Stock Working Group" (SWOOSWG) was set up to manage any critical drug shortages within a timely manner (24 to 48 hours), to ensure safe patient transfer between health sectors and to alleviate any risk to patient safety.

Coventry and Warwickshire Partnership Trust

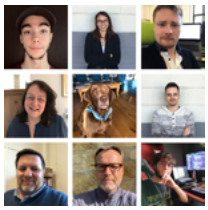
Fewer incidents and better care in inpatient Mental Health hospitals

Coventry and Warwickshire Partnership NHS Trust have been working in partnership with technology provider (Oxehealth) for the past three years, to closely develop and deploy a digital tool to improve patient safety (e.g. reducing falls, self-harm and assaults) in inpatient mental health hospitals.

The trust's clinical knowledge with the provider's technical expertise have complemented each other to create a successful partnership that is delivering improvements in inpatient safety across mental health. The partners have built in feedback loops that have resulted in quick iterations and improvements to the digital tool – improving its utility on the ward and impact on safety and experience.

BEST PARTNERSHIP SOLUTION IMPROVING PATIENT SAFETY

FINALISTS



Focus Games and NHS Partners

FluBee Game

Engaging with staff is the starting point for any vaccination campaign. This especially important for staff with doubts about flu or the vaccine.

In 2016 Focus Games worked with Joan Pons Laplana and James Paget University Hospitals to develop a digital game that would engage staff and challenge common myths. It was called Flu Bee Game.

The game improves vaccine uptake by engaging staff on their phone. It does two vital jobs:
1. Challenges common misconceptions
2. Tells staff where to get vaccinated
Since 2016 the game has been used in over 40 NHS trusts and 300 care homes.

Leeds Community Healthcare Trust, Leeds Beckett University, Leeds Teaching Hospitals Trust, Leeds and York Partnership FT, Leeds City Council and Leeds Health and Partnerships Team

Occupational Therapy First

Leeds trailblazing the First Contact Practitioner role for Occupational Therapy after a successful project. Occupational Therapy First provides a timely response to healthcare, offering assessment and interventions which complement the medical model but draw on the professions dual training in both physical and mental health. Occupational Therapy First delivers a left shift model utilising a proactive self-management approach. Occupational Therapy First demonstrated a reduction in the number of initial appointments directed to GPs' and reduced repeat GP appointments, including those considered as frequent attenders. The outcomes achieved have enabled the model to be replicated to deliver sustainable efficiencies for the city.

Staffordshire and Stoke on Trent CCGs and Staffordshire County Council

Provider Improvement and Response Team

The Provider Improvement Response Team (PIRT) has been operational since March 2019, it is an integrated service jointly funded by Staffordshire County Council and Staffordshire and Stoke-on-Trent Clinical Commissioning Groups to work with Care Home services identified as being in urgent need of support. PIRT work collaboratively with providers across the Health and Social Care system with an ethos of supporting the delivery of the Enhancing Health in Care Homes Strategy with a predominant focus on ensuring safe, effective, evidence based and high quality care to patients and residents.

Tameside and Glossop Integrated Care FT, Safe Steps and Health Innovation Manchester

Safe Steps: Developing an evidence-based digital risk assessment platform

Safe Steps is an app to help reduce falls through standardised and effective falls risk management. Assessing 12 key risks - based on NICE guidelines - and providing CQC approved recommendations for multifactorial intervention via a secure, easy-to-use web application.

Safe Steps has been implemented at the Stamford Unit - a 93 bed intermediate care unit in the grounds of Tameside & Glossop Integrated Care NHS Foundation Trust. In this setting - a first for the UK as previously only used in Care Homes - it has been used almost 3,000 times by 46 members of staff and helped to reduce falls in the first 6 months by 29%.

PATIENT SAFETY EDUCATION AND TRAINING AWARD

WINNER

Partnered by General Medical Council

CAMBRIDGE DIABETES EDUCATION PROGRAMME (CDEP)

DIGITAL INSULIN SAFETY TRAINING FOR HEALTHCARE STAFF

CDEP has collaborated with Dr Sam Rice (Diabetes Consultant), Chris Cottrell (Diabetes Specialist Nurse) and eHealth Digital Media (creators of PocketMedic) to create a 'bite-sized' educational film and competency-based e-learning topic designed to support ward staff improve insulin safety skills and reduce insulin errors. This digital innovation addresses the time pressure issues that staff experience as this insulin training is deployed quickly and is accessible at point and time of need. Staff can improve or confirm their knowledge in a matter of minutes with key information relating to the safe delivery and management of insulin on the ward.

JUDGES COMMENTS

The judges felt that this winning project had potential for large-scale roll out. The bite-sized training offered within this project reduced errors for those being cared for with diabetes. There was strong evidence of collaboration and the cost savings were impressive.

PATIENT SAFETY EDUCATION AND TRAINING AWARD

HIGHLY COMMENDED

Oxford AHSN, Oxford University Hospitals FT, Royal Berkshire FT, Health Education England, e-Learning for Healthcare and OxSTaR

Listening with Intelligence: An Evaluative Training Initiative to improve safety for low risk mothers and babies in labour

Two consultant midwives in Oxford and Royal Berkshire Hospitals who teach an 'intelligent' approach to IA based on physiology (understanding a baby's response to stress in labour) were astonished at the variation in midwifery practice of IA.

In 2017 integration of 'real' fetal heart sounds in their teaching enabled assessment of accuracy and competency of IA. Goals of this project were to convert the teaching programme into an e-learning package enabling national dissemination and inclusion in mandatory training timetables, and to ensure equity and improve safety for mothers and babies.

JUDGES COMMENTS

The judges felt that this high commendation is an innovative and potentially global influencing programme. It is an important piece of work in an area of care prone to serious failures with terrible consequences for everyone involved. This project makes a real difference to outcomes for mothers and babies whilst also increasing the confidence of midwives at the same time.

FINALISTS

East Suffolk and North Essex Trust

Stroke Oral Care Training Programme

The multidisciplinary team of speech and language therapists, physiotherapists and stroke consultants sought to improve provision of oral care in stroke units in 2013 in an attempt to reduce aspiration pneumonia rates and to improve patient well-being.

The aims of this ongoing project were to survey the knowledge and attitudes of staff in the provision of oral care in stroke patients and identify the areas of focus for developing stroke-specific training. Then a training programme for nursing staff and other allied health professionals involved in the care of stroke patients was developed and implemented. A structured oral care protocol in the stroke unit was rolled out, and an e-module on oral care for East of England stroke unit staff was developed to ensure training can be sustained.

Somerset FT

Suicide Prevention and Serious Incidents Reduction

This project aimed to take learning from patients and carers with lived experience of suicide and self harm, and develop simulation training for Mental Health staff to reduce harm and embed a culture of co-collaboration within the development of mental health services. The intention was to engage staff on an emotional and empathic level, acknowledging that people learn most effectively when training is interactive, safe, replicates real life and where the "head and heart" are engaged. It was developed in collaboration with a range of multi-disciplinary staff, patients and carers with lived experience of suicide and self harm and was led by the Project Lead with support from a part-time Expert by Experience.

PATIENT SAFETY EDUCATION AND TRAINING AWARD

FINALISTS

South West Yorkshire Partnership FT
Improving training and education in care homes

To improve health care knowledge and skills in local care homes, South West Yorkshire Partnership NHS Foundation Trust created a training and education co-ordinator role.

The role allows training and assessment of competencies by providing small training groups that suit the care home's requirements, giving individuals a comfortable and friendly environment to learn. The role has created a proactive service which has become a contact point for care homes and domiciliary agencies in developing their staff to deal with issues that may arise in the future. The training sessions have upskilled carers by providing knowledge of early interventions, and evidence based care has enabled carers' confidence to grow to ensure their residents are receiving up to date first class care and all their needs are met.

Southern Health and Social Care Trust
Dysphagia Awareness & Management Training

The Northern Ireland Report on the Regional Choking Review Analysis (2018) commissioned by the HSC and the PHA emphasized the risks associated with dysphagia, suggesting regional actions to reduce and prevent reoccurrence of dysphagia related incidents. A key theme identified from this was the need for more dysphagia training and awareness.

Our project aimed to address this need. Training was developed in partnership with clinicians and nursing staff in the care home setting, enhancing links, promoting greater collaboration and co-design of services while creating a positive impact on patient experience. Our goals were to improve staff knowledge, confidence and practice with the over-arching aim of improving safety, quality of life and mealtime experience for people living with dysphagia.

Spectrum Community Health CIC
The CSE Respect Programme

In 2018, Spectrum expanded their Relationships and Sex Education (RSE) provision by developing the Child Sexual Exploitation (CSE) Respect Programme, a targeted project aimed at young people (aged 11-18) who are identified as being at potential risk of sexual exploitation. The six-week programme provides lessons to small groups of students who are displaying risk factors and would benefit from additional support around relationships and sexual health.

The overarching ambition of the CSE Programme is to deliver a focused intervention aimed at de-escalating safety risks and supporting young people to build resilience.

Due to the complex needs of these students, each group contains a maximum of six young people. Students can be supported 1:1 if they prefer, or if they struggle during group lessons. If any evidence of Sexual Exploitation or abuse is revealed during the Programme, the young person is immediately referred to social services.

The Mid Yorkshire Hospitals Trust
Assistant Quality and Safety Educator Project

The Mid Yorkshire Hospitals NHS Trust formulated a plan to deliver harm free care to our patients. The trust created a new role called 'The Assistant Quality and Safety Educator' and it was introduced to provide bespoke, ward-based training and support clinical staff to provide Harm Free Care.
The educators rather than completing lectures work directly alongside the clinical staff, physically showing what is expected in assessing, mitigating and documenting against harms. The impact of the educator's work is measured through the monthly documentation audits, confidence questionnaires given out to staff and feedback including patient experience.

CHANGING CULTURE AWARD

WINNER

ROYAL SURREY FT

DEVELOPMENT OF THE ALCOHOL CARE TEAM AND THE POSITIVE IMPACT ON PATIENT CARE AND OUTCOMES

The service was initially developed in 2014 following a review of inpatients and a significant number of patients were identified with alcohol difficulties.

The lead Gastroenterologist initiated the development of an inpatient alcohol liaison team and in 2014 there was a hospital CQUIN to support this. Since the inception of the service it has been noted that the service was needed in all areas of the hospital and quickly expanded in getting referrals from all areas including paeds, mental health, oncology and outpatients. The service then expanded and developed an outpatient clinic 2 sessions a week and the general view that more resource was required. The Risky Behaviour CQUIN (2017-2019) allowed for further funding to be drawn down following building a successful business case and maintaining data to show outcomes to ensure continued funding.

JUDGES COMMENTS

The judges said the ambition of setting up a new service and involving all key stakeholders instantly elevated this project. The winner gave a very good presentation demonstrating the development of the service through the increase of the team, and how it has effectively embedded across multiple areas over time. The benefits to the patients were clearly set out and the use of the patient story gave a good indication of value. Not many initiatives change the culture of both the service and the patient. Well done!

CHANGING CULTURE AWARD

HIGHLY COMMENDED

The Clatterbridge Cancer Centre FT
'Culturally Aware'- Learning from deaths in Tertiary Cancer Care

In 2017, to improve their culture of learning from deaths, the team appointed key patient safety champions from floor to board to oversee the mortality review process. They developed a process for involving bereaved families in learning lessons from deaths and embedded a bespoke statistical dashboard and peer review process to 'check their blind spot'. By 2020, evidence of the change could be seen in consultant and multi-professional engagement, an improved reporting culture, and a suite of quality improvement projects stemming from the mortality process. The positive change has facilitated collaborations between trusts to improve patient safety across the region.

JUDGES COMMENTS

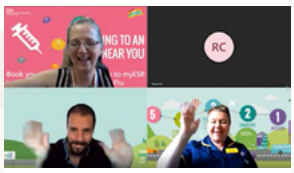
Judges considered this to be a great initiative that has engaged the full multidisciplinary team and spread best practice across other units. The project shows interesting developments in cancer care and the level of honesty in the evaluation they undertook should see this initiative demonstrating ongoing improvements in the culture.

FINALISTS

Hertfordshire Partnership University FT
Fostering a 'just culture' of learning and safety

Hertfordshire Partnership NHS University Foundation Trust's Quality Strategy has a key focus on safety, which is a top priority. It is about asking services users what matters to them, as feeling safe when at you are most vulnerable is a key component of providing high quality services.

The Quality Strategy formalises the work carried out over the previous 18 months focusing on improving safety by creating a 'just and fair culture' and being honest and open, as opposed to a set of actions. The Quality Strategy sets clear objectives, with a priority on learning from incidents, by listening to staff, service users, their carers and families and then taking positive action, when changes need to be made.



Northamptonshire Healthcare FT
Quality and Safety at the foundation of all we do: Keeping Everyone Safe Week

Co-produced Trust-wide, NHFT's strategy includes 'Quality and Safety at the Foundation of all we do' – a resounding endorsement of the importance of safety from ward to board. Previous activity focussed on promoting learning, transparency and no blame, ensuring staff feel confident to report errors and incidents, and embedding safety discussions as business as usual. Keen to continuously improve, NHFT renewed its commitment to safety in 2019 by embarking on a priority programme – Keep Everyone Safe, which included a flagship event – Keep Everyone Safe (KES) Week. The main goal was to raise the profile of safety in the organisation, and positively impact safety culture by encouraging staff to consider the many different elements and how to improve.

CHANGING CULTURE AWARD

FINALISTS

Oldham Care Organisations part of the Northern Care Alliance Group

The Kindness Collaborative

Oldham Care Organisation joined the Northern Care Alliance in 2016/2017 and, as a result of the amalgamation of the Trusts, a new management team was introduced. During the winter period of 2017 & 2018 the Director of Operations noticed a number of challenging behaviours (developed under the previous regime), that would – if left unaddressed – undermine the focus on safety, governance and quality. From these observations the Director of Operations and the Quality Improvement (QI) team developed the framework that would later become the Kindness Collaborative. The aim of the project was to create a "culture of kindness" across the organisation by using the literature to underpin a Breakthrough Series Collaborative approach and QI methodology.

Sandwell and West Birmingham Trust

Positive Pioneers

The Trust had an ambition to improve multi-professional working and joined up decision making. A Pioneer programme was established within the Trust, which offered teams and Departments the opportunity to apply to be a early adopter pioneer team, with the aim of improving engagement, team work and ultimately patient safety.

The City ED team were awarded pioneer status which meant they had investment and support from the Trust, with two executive sponsors, to bring alive new staff ideas for improvement around workforce and safety. One of the key areas where value can be seen is around recruitment and retention, and the pioneer programme also had an impact on sickness absence rates, with overall sickness reducing within ED.

Sherwood Forest Hospitals FT, Nottingham University Business School and East Midlands Patient Safety Collaborative

An evaluation of the impact of the PASCAL safety climate survey on Quality Improvement

Between 2014 and 2020 Sherwood Forest Hospitals NHS Foundation Trust has improved their CQC rating from 'special measures' to 'good' with 'outstanding' for care. A Patient Safety Culture programme was central to the sustained improvements. An independent evaluation of the programme undertaken by the East Midlands Patient Safety Collaborative and Nottingham University Business School, found that the PASCAL safety climate survey in particular the debrief conversations, contributed positively towards engagement between the executive board and the clinical frontline. The leadership in the organisation, quality improvement plan and the Service Improvement team were also key factors in the improvement that occurred.

University Hospital Coventry & Warwickshire Trust

Saving babies lives: meeting national targets through a change in safety culture

In 2016, the Saving Babies Lives Care Bundle (SBLCB) was launched. UHCW noted a concerning increase in stillbirths towards the end of 2018, so UHCW Improvement methodology was applied to a Safety Improvement Plan and the organisation has now seen a step change in outcomes. Staff and patient engagement was pivotal to the plan to ensure all understood the rationale of SBLCB and associated approaches to care.

Support has come through leadership at all levels; two board-level Maternity Safety Champions attend the Labour ward bi-weekly to openly discuss MDT key performance indicators, and learning is shared from recent cases. A patient is invited to attend each session, with Patient Experience Midwife support.

QUALITY IMPROVEMENT INITIATIVE OF THE YEAR

WINNER

WEST QUAY MEDICAL CENTRE, CARDIFF & VALE UNIVERSITY HEALTH BOARD

IMPROVING PATIENT SAFETY THROUGH BETTER ACCESS TO APPROPRIATE PROFESSIONALS IN PRIMARY CARE: A WHOLE SYSTEM APPROACH

The Practice has an embedded culture of Quality Improvement, allowing the practice to work as a team to achieve complex goals quickly and efficiently. One patient safety aspect identified was the ability for patients to gain prompt access to Primary Care Services.

The Access QI project aimed to improve access and capacity for services, following prudent healthcare principles, ensuring patients receive the health care they need, when they need it, and those with the greatest health need are seen first.

JUDGES COMMENTS

The judges felt that this team demonstrated outstanding work with extremely good use of QI methodology and marked improvements. They particularly liked the way that patient/service users were engaged, and how their experience remained central to the QI project. They were also impressed by the scaling up of the project, with other GPs using the project outcomes and methodology.

QUALITY IMPROVEMENT INITIATIVE OF THE YEAR

HIGHLY COMMENDED

Barking, Havering and Redbridge University Trust

Transformation to reliable and safe Stroke Care with VMI Quality Improvement - The Prideway

In September 2018, a joined-up approach was launched that aimed to provide reliable, faster care for stroke patients at stroke beds, as well as reducing the variation of care. The team designed a clinically-led workstream as part of the Pride way of working with Virginia Mason Institute methods and multiple changes in objective manners with measurement of change. The team collected data from National stroke audit (SSNAP) and local project data. There were more than 42 changes delivered within 18 months, leading to safer and efficient stroke care with National A level rating.

JUDGES COMMENTS

The judges felt that this was a fantastic improvement to a service with good use of QI tools and methodology. It was great to see that the learning has been shared with wider STP, internally with other specialities and externally with other stroke services. What stood out was the feeling of 'empowered leadership' and 'permission to fail' whilst continuing with QI approach.

FINALISTS

Avon and Wiltshire Mental Health Partnership Trust and Wiltshire CCG

A Collaborative QI approach to improving the quality of care on the Daisy Unit

A QI programme was established to embed a culture of innovation and improvement to enhance the experience of people who are using services provided by the Daisy Unit, based in Devizes, Wiltshire. The programme initially focussed on staff engagement and team building, which used an initial QI project focussed on improving the quality of incident reports. This was as an essential part of enabling effective learning and improvement in clinical care delivery.

Following initial engagement, a further 3 projects were identified as a result of learning identified through the incident reporting system and the initial engagement with staff, including reducing restrictive practice by 60%, by March 2020.

Berkshire Healthcare FT

Achieving Gold Standard in Patient Safety through QI and ISO13485

East Berkshire Specialist Wheelchair Service is commissioned to provide assessment, prescription and fitting of specialist wheelchairs, customized seating, positioning and pressure care equipment for patients who suffer from severe, long term, life limiting medical conditions which affect mobility and result in postural challenges.

The project objective was to comply with medical device regulations by meeting the requirements for a Quality Management System (QMS). This involves demonstrating the team's ability to provide medical devices related services that consistently meet the needs of the customers and ongoing rigorous and evolving regulatory requirements. The team must demonstrate that the foundations of the service are able to support the output required.

QUALITY IMPROVEMENT INITIATIVE OF THE YEAR

FINALISTS

Birmingham Children's Hospital
Learning from Excellence Quality Improvement - LFEQI

This submission described a Quality improvement (QI) project, utilising an innovative approach to QI, and the subsequent spread of the project methodology. This spread was delivered during 2019 via a training programme for 14 centres across the NHS. The team devised the QI project based on the LfE philosophy. The project took place in a Paediatric Intensive Care Unit (PICU) in a children's hospital in the UK, to reduce antimicrobial use (“”consumption””) in PICU by >5% over a study period of 6 months.

Following completion of the project, members of the LfE community were invited to apply to learn how to apply our methods in their own QI projects. The team named this method “”LFEQI””.

CBC Health
Assuring the quality of spirometry for diagnosis of Asthma and COPD in a primary care setting

National guidance to improve the quality of diagnostic spirometry recommends that all professionals performing and interpreting spirometry are trained to Association for Respiratory Technology and Physiology standards and entered on to the national register by March 2021. At CBC Health the team have designed and implemented the Gateshead Diagnostic Spirometry Service which is commissioned by the Gateshead CCG. It follows the guidance in the NHS Long Term Plan.

Chelsea and Westminster Hospital FT
Introducing an oral care assessment tool with advanced cleaning products into a high-risk clinical setting: Acute Stroke Unit

Evidence suggests poor oral hygiene may be a significant risk factor for the development of pneumonia, therefore it is important to reduce the number of pathogens in the patient's mouth and ensure the oral cavity remains healthy as part of NV-HAP prevention. The aims of this study were to establish whether the introduction of a 24hr Oral Care kit and an oral care assessment tool that would meet the needs of patients and carers. This clinical impact study was conducted on the acute stroke unit within the facility of the Chelsea and West Middlesex NHS Foundation Trust.

Great Ormond Street Hospital
Reducing Laboratory Sample Rejections Due to Pre-analytical Errors in a Paediatric Setting

Through manually recorded data, GOSH laboratory identified 4900 patient samples were rejected in 2017 due to pre-analytical errors. A QI project was set up late 2018 with the aim of reducing laboratory sample rejections due to pre-analytical errors by November 2019. The project was extended to June 2020 with an extensive focus on improved data quality and visibility.

The structure engages multi-disciplinary roles across the Trust through various working groups. These groups update the project Steering Committee chaired by an Executive Sponsor which reviews progress. The improvement work continues now in a sustainable operational structure.

West Midlands AHSN & NIHR ARC West Midlands
SPACE - A Quality Improvement Initiative in Care Homes

In 2016 the West Midlands Academic Health Science Network recognised that care homes were pivotal to the local health economy and wanted to co-create a programme of work to reduce avoidable harm using QI techniques with all stakeholders including homes and commissioners. SPACE was developed, designed and delivered in collaboration with Walsall and Wolverhampton CCG. The programme had two main elements - the first was training events and workshops, which aimed to help care home staff and managers, develop relevant skills and enhance their understanding of safety-related service improvement. There were also facilitated sessions delivered in care homes, which supported staff to implement changes to practice to reduce avoidable harm relating to specific safety concerns such as falls prevention and pressure ulcer management.

PATIENT SAFETY INNOVATION OF THE YEAR

WINNER

OXFORD AHSN, OXFORD UNIVERSITY HOSPITALS FT, ROYAL BERKSHIRE FT, HEALTH EDUCATION ENGLAND, E-LEARNING FOR HEALTHCARE AND OXSTAR

USING 'REAL FETAL HEART SOUNDS' AN INNOVATIVE SOLUTION TO TEACHING AND ASSESSING COMPETENCY IN INTERMITTENT AUSCULTATION: IMPROVING SAFETY FOR LOW RISK MOTHERS AND BABIES IN LABOUR

Two consultant midwives in Oxford and Royal Berkshire Hospitals who teach an 'intelligent' approach to IA based on physiology (understanding a baby's response to stress in labour) were astonished at the variation in midwifery practice of IA.

In 2017 integration of 'real' fetal heart sounds in their teaching enabled assessment of accuracy and competency of IA. This innovative approach has enabled midwives and student midwives to listen 'intelligently' to identify those babies at risk of deterioration in labour for whom rapid escalation of care is critical to improve safety. Goals of this project were to convert the teaching programme into an e-learning package enabling national dissemination and inclusion in mandatory training timetables, and to ensure equity and improve safety for mothers and babies.

JUDGES COMMENTS

The judges felt that this winning innovation has the potential to positively impact a significant number of individuals across the country, with clear benefits to both staff and patient outcomes. It is already starting to become best practice and is clearly outstanding work that has already been well received by users and associated stakeholders. The project leads demonstrated a thirst for expansion and wider sharing of the benefits of the project.

PATIENT SAFETY INNOVATION OF THE YEAR

HIGHLY COMMENDED

NHS Lanarkshire
The Patient Transfer Scale

The Patient Transfer Scale was developed to provide healthcare professionals the tools for accurate treatment, and to provide education for improved patient outcomes. Invented by NHS Lanarkshire Nurse Gillian Taylor, The Patient Transfer Scale is the solution to weighing immobile patients quickly and easily. Utilising the existing process of lateral transfer from trolley to trolley or bed to bed; the 'PTS' means clinicians no longer have to estimate a patient weight prior to treatment. The Patient Transfer Scale is now in use in 60% of UK Trusts and 33 countries worldwide.

JUDGES COMMENTS

The judges felt that this product has a huge potential impact on the safe administration of medication, particularly within the most vulnerable cohorts of patients (children and frail older people). As it is already in 60% of hospitals their ambition to achieve 100% adoption seems achievable. The patient transfer scale is a simple but valuable innovation that has a rational use in clinical practice.

FINALISTS

Doncaster and Bassetlaw Teaching Hospitals FT
Sharing How We Care: A Monthly Patient Safety Newsletter and Annual Conference

To improve patient safety, the trust also needed to also improve communication. This was also a theme from staff who regularly said they didn't get feedback from incidents they report. In 2018, the trust held their first Sharing How We Care conference to include Trust staff in how to share learning from innovation across the Trust. This was followed by a monthly patient safety newsletter, started in September 2018. To compliment staff communications, new bedside information folders were also developed.

To ensure better information for patients and families on ward areas, the trust also developed Sharing How We Care for you Welcome Boards, using QR codes to signpost patients and families to specialist support for the clinical area.

Focus Games and NHS Partners
FluBee Game

Engaging with staff is the starting point for any vaccination campaign. This especially important for staff with doubts about flu or the vaccine.

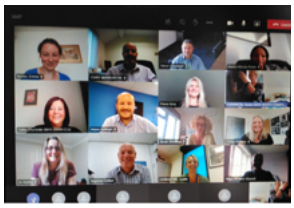
In 2016 Focus Games worked with Joan Pons Laplana and James Paget University Hospitals to develop a digital game that would engage staff and challenge common myths. It was called Flu Bee Game.

The game improves vaccine uptake by engaging staff on their phone. It does two vital jobs:
1. Challenges common misconceptions
2. Tells staff where to get vaccinated

Since 2016 the game has been used in over 40 NHS trusts and 300 care homes.

PATIENT SAFETY INNOVATION OF THE YEAR

FINALISTS

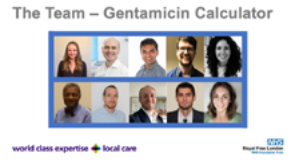


National Home Oxygen Safety Committee and North Hampshire CCG

Reduction in fatalities following the introduction of the Initial Home Oxygen Risk Mitigation form to all new patients on Domiciliary Oxygen

Home Oxygen can be ordered by any registered healthcare professional in England and Wales. No specialist training is required to request Home Oxygen and there was previously no mandatory clinical evaluation of safety or risk before oxygen was requested for patients.

This project started as a risk assessment tool for one CCG, it grew into a regional form and we then set out to change national behaviours by developing a mandatory risk mitigation form that would be completed by all healthcare professionals before requesting a patient's home oxygen for the first time. This resulted in the IHORM which was introduced for mandatory use from 1st August 2017 and is now used in Wales too.



Royal Free London FT

Gentamicin Dose Calculator

Gentamicin is the first line antibiotic at the Royal Free London NHS Foundation Trust for indications such as sepsis. The gentamicin calculator, within the Electronic Patient Record, was developed with Cerner with the aim to reduce dose error rates to zero across the Trust. The calculator was deployed in November 2018 and calculates the dose of gentamicin based on either actual body weight or dose corrected weight (depending on patient factors).

Salford Care Organisation, part of the Northern Care Alliance Group

Medicines Related Admissions: Identifying and preventing medicines related harm across care boundaries

The Medicines Related Admission (MRA) project was developed by Salford Integrated Medicines Optimisation Team (SIMOT) to assist with achieving it's aims of improving medicines safety and optimisation across care boundaries. Where adverse medicines events result in admission to Salford Care Organisation they are recorded quickly using an 'MRA order' which can be requested for a patient in seconds. The data gathered from the use of the MRA order is used to identify and reduce harm from medicines across care boundaries in Salford, and where adverse drug reactions are identified to improve reporting to the MHRA via the Yellow Card scheme.

Tameside and Glossop Integrated Care FT

An Innovative Approach to District Nursing Service Redesign – A service fit for the future

Nationally, it is acknowledged that data quality in District Nursing Services is poor with no agreed national safer staffing levels. There is a national crisis in relation to valuable workforce evidence due to the lack of complexity tools available to identify levels of care to meet the needs of an ever aging population with complex co morbidities, polypharmacy and a myriad of psychosocial needs. The Complexity and Dependency Tool was developed and integrated into the Trust EPR and was mandated to be populated at every new patient assessment to allow early identification of complexity level. This ensured that staff with the right skillset provided the care at the right time to ensure the best possible outcome for the patient.

West Midlands AHSN, University of Birmingham, Birmingham Women's and Children's FT, NIHR ARC West Midlands and The Royal Wolverhampton Trust

BSOTS - Birmingham Symptom Specific Obstetric Triage System

Prior to the development of BSOTS there was no standardised triage system for women presenting to maternity services with urgent concerns. BSOTS is a specific maternity safety tool for triage departments which was co-designed by clinicians and researchers to facilitate clinical prioritisation and improve safety. It consists of a prompt and brief assessment (triage) of women on presentation and a standardised way of determining the clinical urgency in which they need to be seen. The system is easily understood by women and maternity staff and facilitates clear communication, as it mirrors the well-established triage systems used in emergency departments.

PATIENT SAFETY TEAM OF THE YEAR

WINNER

ROYAL UNITED HOSPITALS BATH FT

THE SEPSIS AND KIDNEY INJURY PREVENTION (SKIP) TEAM IMPROVING OUTCOMES FOR PATIENTS

Sepsis and Acute Kidney injury are common causes of in-hospital patient deterioration associated with high morbidity and mortality. The team aimed to identify deterioration as early as possible, increasing prompt management and decision-making, improving outcomes by decreasing mortality, length of stay and preventing their occurrence. Sepsis and AKI can occur anywhere in any speciality, so it was essential to establish a specialist team to support and drive improvements. Innovative awareness campaigns, '60 days for Sepsis 6' and 'UR'INE Trouble', were used to train a critical mass of staff rapidly.

JUDGES COMMENTS

This winning project is an amazing and inspiring piece of work which clearly demonstrates the desire to improve outcomes for patients. There were impressive results, showing improvements in safety across a range of indicators, and great methods of engaging staff. The judges felt that this displayed fantastic learning that should be rolled out nationally.

PATIENT SAFETY TEAM OF THE YEAR

HIGHLY COMMENDED

Nursing & Midwifery Council
The Public Support Service Team

The PSS was created to ensure that patients, family members and users of services are at the heart of our fitness to practise process. The service was co-produced by the Public Support Steering Group made up of patients, relatives, external healthcare stakeholders and our own staff. As an organisation, we set out for the PSS to play a significant part in helping us to ensure that our process is person-centred and that we can meet the needs of patients, families and the public. This was a huge challenge, involving the need to make significant cultural change: from the way we approached our fitness to practise process, how our processes work and the way we engaged with people; to thinking about the impact on people of each single aspect of our work.

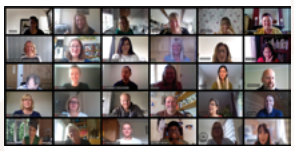
JUDGES COMMENTS

This project was vital work which is truly patient centred, a valuable initiative which enables patients to share their experiences. The real strength of this project is that the NMC are demonstrating learning and are now listening to and engaging with those who were previously treated like evidence rather than people with feelings. Well done to all those involved.

FINALISTS

Portsmouth Hospitals University Trust and Wessex AHSN
Time to ACT Project Team

In September 2016 a multi-disciplinary working team was formed to undertake a quality improvement initiative linked to deteriorating patients. The first initiative chosen was to develop and implement a Deteriorating Patient pro forma across all adult in-patient wards. Improvement targets for this initiative included the number of patients with a new NEWS score of 5 or more that had an increased frequency of vital signs recording and were escalated and seen in a timely manner. It also included the grade of responder and time to patient review as measured against the organisations escalation protocol. A final measure was the presence of documentation of actions post clinical review including treatment escalation plan, consultant discussion and documentation of communication.



PRIMIS at the University of Nottingham and the AHSN Network
The PINCER Team

A replication model for the scale and spread of PINCER, a pharmacist-led IT-based intervention to reduce medication errors in general practice, was developed by PRIMIS and researchers at the University of Nottingham, for national rollout in partnership with the AHSN Network. PINCER involves searching general practice clinical systems using computerised prescribing safety indicators to identify patients at risk from their medications. Pharmacists, specifically trained in PINCER, then review the outputs and work with practices on an ongoing basis to reduce both current and future patient risk, using a range of quality improvement tools. The vision is to make primary care prescribing even safer for patients by implementing PINCER in at least 60% of general practices in England by 2023.

PATIENT SAFETY TEAM OF THE YEAR

FINALISTS

Royal Devon and Exeter FT
The Chest Trauma MDT

The Chest Trauma MDT was formed to improve the safety and outcomes of patients who sustain chest traumas. Together the team improved the detection and recognition of chest trauma patients through trust wide education and exposure. They also developed the Care Pathway to suit the changing needs of the Trust, and improved knowledge and Nursing skills on the ward level to create Chest Trauma Trained Nurses to manage these vulnerable patients. By providing the Nursing Team with education and training support they are now a settled and empowered workforce resulting in the lowest staff turnover for 2 years. This then benefits the safety of these patients by having continuity of specialist care and compassionate, enthusiastic care providers.

South Tyneside and Sunderland FT and Sunderland CCG
Older Person Care Home Team: Digital NEWS Project

Sunderland CCG has invested in digital technology to improve the monitoring of residents' health in the 49 nursing and residential care homes operating across Sunderland, using the National Early Warning Score tool. The system encourages proactive monitoring, enabling health professionals to identify deteriorating patients quickly then guide them to an appropriate escalation route required. They are also able to communicate observations across organisations robustly, resulting in improved quality of care, outcomes and better response times. The training is designed to upskill and develop the workforce regardless of ability, by encouraging proactive monitoring and linking with specialist nurses.

Southend University Hospital FT
Acute kidney Injury Policy and Specialist Nurse

The team developed a simple, consistent and sustainable approach to an electronic Acute kidney Injury (AKI) alert. The overarching ambition of the project was to reduce deterioration in AKI by 20% over two years and also reduction in length of stay and mortality. An "AKI clinical nurse specialist," was appointed from initial data. The role included engaging frontline staff and driving organisational change towards improved AKI management for improved patient safety. They showed a reduction in length of stay, from 14 days to 10 days; and 30-day mortality from 30% to 20%, amounting to cost savings of 1.19 million/year.

West London Trust
Taking Safety Huddles the Extra Mile: Windrush Ward

West London NHS Trust (WLT) in partnership with Imperial Collage Health Partners took a QI approach to testing and evaluating safety huddles in mental health inpatient settings. The project aimed to test the introduction of multi-disciplinary safety huddles into daily ward practice and measure impact on locally identified harms, teamwork, communication and safety culture. In February 2019 Windrush ward had been locally identified as a 'struggling ward'. In the past 12 months Windrush Team have used the opportunity of the Safety Huddles project and QI approach to proactively review and develop a safe ward culture. Windrush Ward has transformed to a safer more enjoyable place to work and be cared for, through testing new ways of work, demonstrating excellent leadership and team commitment to learning.

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