NURSING TIMES
AWARDS 2010
BEST PRACTICE REPORT
Celebrating inspirational nursing
Welcome to the Best Practice Report, recognising the achievements of those who have implemented outstanding projects to revolutionise the way their trusts treat patients. And it is a revolution in many cases — while some of our Nursing Times Awards have gone to those teams that have made small but significant changes, others have been an assertive overhaul of an entire culture or process. But all of them have been brave and brilliant.

These initiatives span many types of care — from midwifery, paediatrics to continence, cancer and accident and emergency care. But what is always constant, is that the patient is always the focus of the project. And the work not only spans the whole geography of the country with projects from Blackpool to Berkshire, but also caters for the mental, emotional and physical health and wellbeing in patients. The proven outcomes of the best practice examples in the following pages shows just how big an influence these projects have had on their patients, families and wider communities — not to mention staff morale.

What’s impressed our judges is that these projects have worked out where the biggest impact could be felt, and introduced processes that are not necessarily headline grabbing, but ones where they can really make a difference.

We hope that you find reading about these projects in detail will prove informative and instructive for those of you who want to follow suit. It details exactly how these outstanding teams went about changing their strategy, and documents the costs, offering advice to people who may be considering implementing something similar.

When it comes to costs, there have been some serious savings made for trusts involved in these processes, such as the Blackpool, Fylde and Wyre NHS Foundation Trust, which reduced caesarean sections by 4% and saved £29,000, as well as improving patient safety and wellbeing in the process. And of course some of our winners and finalists have cleverly introduced projects that have required zero investment, but have had remarkable results, such as the 5 Boroughs Trust who have picked up our Infection Control accolade this year.

Stockport’s NHS Foundation Trust’s award-winning project to introduce a falls prevention programme encouraged all the staff to have an input in multi-disciplinary working, which of course is something we celebrate at Nursing Times. It has so far saved £20,000 in reducing falls, but more importantly than that, like so many of our projects, it has saved lives and improved quality of life.

If you’re inspired by these pages, we have included the contact details so you can get more information directly from those who have introduced them. Congratulations to all our finalists, highly commended entrants and winners.

Jenni Middleton
Editor, Nursing Times
## WINNERS

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Uncompromising the compromised: caring for patients with drug, homelessness and safeguarding issues
Dave Roberts, Carol Holt, Clare Pritchard and Paul Thompson
Royal Liverpool and Broadgreen University Hospital Trust

Background
People affected by and compromised by drug and substance misuse are among the most vulnerable members of society. The devastating consequences of involvement in this potentially life-threatening and dangerous activity are often observed first hand by front-line staff within our trust.

The dedication and hard work of A&E staff, who deal with upwards of 90,000 attendances a year, is unquestioned. However, there was evidence to suggest that vulnerable patients with homelessness, drug and safeguarding issues, such as sex workers, experienced gaps in their journey from attendance to discharge, with potentially hazardous consequences.

If the trust was to implement the recommendations of the National Institute for Health and Clinical Excellence guideline on reducing substance misuse among vulnerable young people, and to meet the requirements of the local primary care trust in offering best practice and holistic care to this group, a tailored service was essential. The four trust leads for adult and child safeguarding, homelessness, and substance misuse agreed jointly to set up a dedicated 24-hour a day, 365 days a year service to ensure the highest standards of care and a seamless delivery of both trust and external services.

Each of us delivers education and teaching to all members of the multidisciplinary team, with the aim of changing attitudes and ensuring our patients’ needs are recognised and enhanced. Consistent and thorough implementation of standardised education packages has raised awareness of these socially excluded patients and removed previous barriers to healthcare provision. We also established links with the local PCT and universities, and practice facilitators within the trust.

The process
We realised at an early stage that patients affected by these issues often had gaps in their journey of care because the chaotic lifestyles they led frequently barred them from accessing services both within the trust, and in the community. We rapidly expanded our capacity to educate, inform and advise not only staff, but also patients. Fundamentally, our aim was to educate, and to form strong links both internally and externally with all agencies and departments involved in care provision.

Advice to other organisations
We envisage that through consistent and proficient education, our teamworking approach can be adapted in any healthcare area, whether hospital, GP or other services.

We hope that by providing evidence of best practice, and the positive feedback we have received from various disciplines, we can enable nurses to reassess their “care ethic” and their ability to think laterally as well as constructively in questioning preconceived ideas about the difficulties associated with caring for patients affected by drugs, homelessness and safeguarding issues. A sustained and positive approach is essential to maintaining best practice for this patient group.

We help some of the most vulnerable and frightened patients admitted into the trust, and acknowledge that we must recognise our own limitations. Our team approach means we can turn to each other for support and advice. Those planning a similar initiative must be passionate about providing the highest standards of care. Patients whose lives are already compromised need non-judgemental, supportive, and empowering care.

Benefits of the initiative
Our patients are our first priority. We endeavour to treat them all with respect, and to give them access to services and care previously denied on both a practical and an emotional level. Through education we hope to remove the stigma often attached to these patients so they feel their care is as valid, viable, constructive and healing as any other patient.

We have received extremely positive patient feedback from questionnaires about the accessibility of our service, and firm acknowledgment from local and national legislative institutions. In addition, patient research by the PCT has received positive feedback demonstrating that patients now feel confident that they will receive full, holistic care if admitted to the trust.

Close links established with both John Moores and Liverpool universities mean all four of us regularly teach both nursing and medical students, and qualified nurses and doctors. We also teach a range of community agencies about substance misuse, such as Liverpool School for the Deaf, and we spoke at a conference on chronic obstructive pulmonary disease in 2009, discussing the increasing incidence of COPD among heroin smokers. Our safeguarding leads for adults and children present nationally and locally, while our homelessness lead also is actively involved in policy and procedure writing.

Financial implications
While it is difficult to quantify the cost implications or savings in relation to our work to date, we have not incurred any additional costs for education and teaching. For example, we regularly invite guest speakers who kindly waive any fees.

Contact
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Judges
Natalie Forrest, director of nursing and midwifery,
Newham University Hospital Trust
Ray Greenwood, chief executive,
The St John and Red Cross Defence Medical Welfare Service
Janet Marsden, professor of ophthalmology and emergency care,
Manchester Metropolitan University
Kay Riley, chief nurse, Barts and The London Trust
Tameside and Glossop health mentors
Judith Grigg, Hilary Garratt, Anita Farmery and Daryl Weston

NHS Tameside and Glossop

Background
The health mentors project was undertaken to provide health and wellbeing help and advice for children and young people. It offers an accessible, personalised service which addresses adverse local healthy lifestyle issues in Tameside and Glossop. The objectives are to achieve 13,500 early interventions across the programme by 2011 including:
- Smoking;
- Healthy weight;
- Alcohol and drugs;
- Emotional health and wellbeing;
- Risk of repeat teenage conceptions.

The programme is needed to help deliver the Tameside Children and Young People Preventative Strategy (2008–11), which confirms the approach to early intervention needs of 4–16-year-olds to reduce high demand for more intensive resources in later years. The Department for Children, Schools and Families Children’s Plan, Building Brighter Futures, sets out the vision of achievement of goals for children through to 2020, including improvements in the integrated local delivery of early intervention and preventative services. Every Child Matters includes “be healthy” with the aims of physical activity, emotional health, sexual health, healthy lifestyles and choosing not to take drugs.

The service is a pioneering national pilot which provides one-to-one and group behaviour change sessions, tailored to the young person’s needs. It works in partnership with school and child health services, schools, children’s centres, extended schools, youth services and primary care, taking a whole family approach to promote health changing behaviour, and improves the accessibility of the service. For example, self-referrals can be made at www.healthmentors4life.net

The process
The service delivers interventions through one-to-one support to motivate health behaviour change, provide a personalised health plan for 4–16-year-olds rising to 18 for risk of repeated pregnancy. It signposts young people into specialist services when required. The service performance is managed by key performance indicators as agreed with commissioners.

The programme works with other agencies to develop the following pathways: smoking, obesity, repeated teenage pregnancy, emotional health, drugs and alcohol. These indicate the escalation points and entry and exit thresholds thereby ensuring that health mentors work within the scope of their skills.

Health mentors are clearly identified as offering early interventions, including one-to-one behaviour change through brief advice and intervention during which individual needs are identified. The brief intervention involves an agreed personal health plan, tailored to the needs of the child or young person.

Advice to other organisations
Advice for others planning similar activities would include ensuring that the programme manager is in post 3–6 months prior to the launch date to establish the care pathways and how the programme will be delivered. We encountered operational problems as the health mentors went into post. The management structure was initially deemed too flat so we recommend having a band 5 or 6 in post as well the manager, to oversee operational issues on a day-to-day basis.

Ten health mentors were allocated to the programme but 6.7 FTE were recruited initially in October 2009. This increased to 7.7 FTE in March but gives capacity issues. Our advice would be to recruit earlier and ensure the manager is included from the beginning of the process.

Marketing of the service is key to success and should be planned for the start of the programme. Communication with partners should be established well ahead of the start of the activity; our programme tried to promote its service as it went along, which meant awareness levels were low among partner agencies.

Benefits of the initiative
The first six months of the pilot have yielded the following:
- The number of young women contacted at risk of having repeat conception was 120 against a target of 72 — none of the young women referred have gone on to have a repeat conception to date;
- Of children and young people with a personal health plan 50% maintained change for three months;
- We receive 20 new contacts for brief advice or brief interventions per week;
- Client evaluation shows 100% satisfaction with the health mentors service;
- We have made 160 referrals to reduce overweight and obesity;
- We have made 156 referrals to reduce uptake of smoking;
- We have made 43 referrals to reduce alcohol consumption and drugs;
- We have made 160 referrals to improve emotional health and wellbeing.

Other benefits include shared learning across the partnership, which is realised from actions agreed at the regular steering group meetings which supports and oversees the development of the programme.

Financial implications
The cost of launching the project was £8,000. Ongoing running costs are £330,561 broken down into staff costs of £269,178 and non-pay costs of £61,384. £20,000 of branding costs were saved by adapting the Change 4 Life brand platform.

Contact
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Judges
Judith Ellis, director of nursing, London South Bank University
Sharin Baldwin, professional lead for children’s integrated services, NHS Harrow
Alan Glasper, professor of children’s and young peoples nursing, University of Southampton
Beyond traditional boundaries to promote quality, innovation and productivity in continence services

Jo Howells, Jo Cooke and Kerry Zgrzywa

Wolverhampton City Primary Care Trust

Background

Wolverhampton City Primary Care Trust’s community continence service exists to promote independence among service users, improve their quality of life and dignity and reduce the reliance on continence products as a first-line solution.

The service was redesigned to offer more timely support in the management of the physical and social consequences of continence problems, with a strong emphasis on promoting continence rather than managing incontinence. This required a reconfiguration of the workforce to increase skills across the wider team and release senior staff capacity.

Healthcare assistants (HCAs), after completing training and mentorship, undertake tasks traditionally delivered by nurses. They also support continence advisors in their clinical duties. A number of tools were developed to support education, nursing practice and workforce development, and to aid the reassessment of patients, and these are transferable to other services.

The process

Redesigning the continence service involved reviewing the skills across the workforce against service demands. This highlighted the fact that nurses spent considerable time undertaking tasks that, while necessary, impeded the timeliness, quality and productivity of the service. It also revealed that a significant proportion of patients receiving containment products were only reviewed if concerns were raised, which meant some would receive products even if new treatments became available that would promote their continence.

This initiative has enabled patients to be reassessed regularly. It involved the appointment of HCAs; the development of a competency framework to aid their practice and a reassessment tool to support standardised care; pilot and review of documentation; allocation of suitable mentors; regular clinical supervision; robust audit of practice; and appropriate governance arrangements which ensure HCAs are accountable to their allocated nursing staff.

Advice to other organisations

Anyone planning a similar initiative is advised to:

- Review demand versus capacity to determine the number of HCAs required;
- Develop a robust job description and person specification;
- Keep staff involved in decision-making and engage them to support mentorship and clinical supervision;
- Ensure staff are aware of legal and ethical implications of delegation;
- Use standardised training packages and reassessment tools specific to the field;
- Undertake appropriate audits to monitor outcomes.

Benefits of the initiative

The project has bought a number of benefits to the continence service and across Wolverhampton City PCT services. Its holistic approach to care promotes independence and reduces reliance on products. Patients receive dedicated, personalised training and a rapid response to any deterioration in symptoms. Their care is delivered closer to home, reducing hospital bed days.

Integrated working between HCA and nurses enables us to undertake planned reviews of existing patients to ensure they are offered any new treatments and standardised care based on an integrated care pathway. The initiative has also increased both job satisfaction and motivation among nurses and HCAs; overcome traditional boundaries of care; increased staff skills; released nurses’ time to undertake clinical work; increased productivity; and reduced waiting times for patients. It has demonstrated that products are not necessarily the only option for patients with continence problems and in some cases are not required.

Products are now distributed responsibly based on clinical need that is assessed regularly, reducing or eliminating rationing.

Financial implications

The initiative required investment for the recruitment of the appropriate skill mix to release registered nurses and redistribute work. This led to savings through:

- Increased productivity;
- Appropriate use of containment products;
- Reducing admissions and hospital bed days.

Freeing up nurses’ time also gave them the potential to undertake new therapeutic interventions, which could have cost implications incurred for continence promotion.

Future plans

The project was undertaken with the continence team and now the infrastructure is in place we plan to roll it out across Wolverhampton community services. As a result of its success the directorate is reviewing the potential for HCAs to support in the transfer of skills elsewhere to promote productivity; improve patients’ experience; and meet service demands.

Contact

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Judges

Adele Brodie, clinical education nurse, Coloplast
Sharon Eustice, nurse consultant for continence and chair, Association for Continence Advice
Gaye Kyle, lecturer and education coordinator, Association for Continence Advice
Eileen Shepherd, deputy practice editor, Nursing Times
Reducing caesarean section rates using organisational change — The Blackpool Way

Pauline Tschobotko, Moira Broadhead, June Davies and Nicola Parry
Blackpool, Fylde and Wyre Foundation Trust

Background
In 2006/07 at 28% the caesarean section rate in Blackpool was the highest in the North West, with a medical model for maternity care in place. The trust board was keen to see the maternity service’s improvement in caesarean section rates, from the perspectives of patient experience, quality, safety and cost.

The initiative was linked to the trust’s organisational strategy, The Blackpool Way, which focuses on effective employee engagement and high performance. As a result of changes in the organisational culture and a focus on normalising births, the caesarean section rate has fallen to 24%, while we have also increased the rate of vaginal births after caesarean (VBAC).

Realising the need to change the beliefs and behaviours of staff, changes to the management culture released the potential of staff to make changes. This work supports national policies that focus on:

- Offering choice to women about where they give birth;
- Increasing the percentage of women having a vaginal birth;
- Increasing the use of non-pharmacological pain relief, in particular the use of water in labour;
- Reducing the percentage of women whose birth is induced medically.

The process
The NHS Institute supported work to reduce the caesarean section rate. Improved training included normal birth initiatives, education about VBAC and improved training to monitor the foetal heart rate. We introduced VBAC clinics to explain to women that having had a previous caesarean section does not preclude them from having future normal births.

The trust has worked hard to normalise the birth environment, replacing beds with couches and beanbags. Following feedback from women, baths were added to en-suite rooms to help with non-pharmacological pain relief in labour. Although more staff intensive, staffing levels were increased to meet national standards and enable midwives to offer one-to-one care in labour.

A key change has been the introduction of a Situation, Background, Assessment, Recommendation (SBAR) board on which midwives and obstetricians write information relevant to each patient in the delivery suite. This provides a structured communication system and gives more junior staff a vehicle for making themselves heard.

Although they initially greeted the SBAR boards with scepticism, staff quickly realised their value and the system has been extended to handover between shifts and between wards, while other parts of the hospital are now adopting it as a communication tool.

Benefits of the initiative
A 4% reduction in the caesarean section rate equates to 82 fewer babies born by caesarean section each year, providing improved patient care and safety along with large financial savings. Local patient satisfaction surveys have demonstrated a significant improvement in how women rated their satisfaction of their maternity care, while a reduction in the length of stay following birth has enabled the maternity service to manage the increasing birth rate with no adverse effects to women and their families.

The maternity service has also reported continuing improvements in the results of staff satisfaction surveys. Reducing caesarean section rates and increasing successful VBACs (up from 50% to 65%) has created a palpable sense of pride. Staff confidence, particularly among more junior staff, has increased and we have moved from a culture of anxiety to one which is proactive in encouraging VBACs, but that also accepts that intervention is necessary in some instances.

Financial implications
The initiative incurred no financial costs as it was achieved through staff enthusiasm and commitment to improving patient care. The reduction in caesarean section has given significant financial savings — normal delivery costs £752 compared with £1,100 for a caesarean; 82 fewer of these procedures has therefore saved almost £29,000.

Contact
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Judges
Pippa Gough, assistant director for clinical quality (job share), The Health Foundation
Abigail Masterson, assistant director for clinical quality (job share), The Health Foundation
Katie Yiannouzis, head of midwifery, King’s College Hospital Foundation Trust
Dr Fiona Murphy, senior lecturer, research co-ordinator, school of health sciences, Swansea University
Service user involvement in infection prevention and control in a mental health and learning disabilities trust

Steve Hull, Julie Hughes, Eileen McDonnell and Harry Blackman

5 Boroughs Partnership Foundation Trust

Background
Patients in mental health/learning disabilities facilities often have more underlying physical health problems than the general population, which predispose them to risk factors for healthcare associated infections (HCAIs). Since they are often “revolving door” patients for acute healthcare facilities, infection prevention and control (IPC) is equally important in the mental health/learning disabilities setting. Some patients can also pose challenges due to underlying mental health or learning disabilities.

Service users and their carers are crucial to service improvement and in contributing to strategy in this area, so the nurse consultant infection control programme seeks to involve them in IPC to ensure that:

- Their views are represented on the infection prevention and control committees;
- They are actively involved and engaged in IPC.

From 2009 all trusts had to be registered with the Care Quality Commission (CQC) and comply with the Health and Social Care Act (2008). The outcome measures are now much more focused on patient outcomes than processes. This means service user involvement is crucial to addressing the IPC agenda. In addition, service user involvement and IPC are key trust objectives.

The process
After a presentation at the joint service user and carers involvement forum the nurse consultant asked for volunteers to become involved with IPC in the trust. Four people volunteered and briefing sessions were held to familiarise them with the subject before they attended the IPC committee and link practitioner group meetings.

Further involvement has included:

- Patient information and policy pathway development;
- Auditing ward practices such as hand hygiene, cleanliness of environment and patient equipment;
- Unannounced spot-checks to help quality control/assurance of the main audit programme;
- Helping with hand hygiene campaigns at the trust;
- Participating in a review of decontamination of patient care equipment such as beds and mattresses;
- Presenting their work at the service user involvement conference;
- Representation on decontamination and nutrition groups.

The service users also offer feedback at the joint service user and carer involvement forum, previously the nurse consultant’s role.

Advice to other organisations
The scheme has run relatively easily. There were initial concerns about service user involvement in ward audits but this was alleviated as they are accompanied at all times by the nurse consultant and a ward staff member.

In order to ensure the success of service user involvement it is vital that they are briefed thoroughly and have enough support and training to give them the confidence to contribute. Going through the agenda with them before any committees ensures they are fully briefed — while this may be time consuming it helps to get the best out of their involvement.

The nurse consultant has worked closely with the service user representatives to ensure they understand how audits are undertaken. They have learnt quickly and their contribution has been invaluable, not only in helping to action changes but also because their own backgrounds give a fresh perspective.

Benefits of the initiative
It is difficult to measure a reduction in HCAIs as an outcome measure, as rates overall remain low. However, a significant improvement has been seen in compliance with practice across the organisation. Hand hygiene compliance has improved from 45% to 95%, and 90% of areas passing the environmental audits — an increase from 47%. Patient satisfaction surveys have also showed increased cleanliness scores. While this cannot be attributed entirely to the initiative, it has played a significant part.

Just as importantly, service users have found the initiative beneficial. At a service user involvement conference they gave emotive speeches about how much their work had increased their confidence; it has helped them to feel valued and to realise that their support is very much acknowledged and appreciated and has also made a positive difference to other service users.

Financial implications
There were no financial costs involved in setting up the scheme. Ongoing costs include service users being paid travelling expenses to attend meetings and travel across sites. They are also paid a nominal amount to attend committee meetings by the Service Users and Carers Involvement Scheme.

Future plans
The service users and nurse consultant jointly presented the initiative at this year’s trust service user involvement conference and hope to collaborate on writing it up for publication. The nurse consultant also spoke at the National Infection Prevention Society Annual Conference.

Contact
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Judges
Tracey Gauci, nursing officer (health protection), Welsh Assembly Government
Eileen Shepherd, deputy practice editor, Nursing Times
Heather Loveday, principal lecturer, Richard Wells Research Centre
Margaret Tannahil, nurse consultant infection control, Care Commission, Scottish Commission for the Regulation of Care

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Diversey

for a cleaner, healthier future
You’re never too old: promoting health and independence for older people
Diane Singleton
Liverpool Primary Care Trust

**Background**
Identifying potential risks and preventing ill health among older people are fundamental to reducing inequalities in health and improving health and wellbeing. They benefit patients by improving their health and quality of life, are cost effective to the NHS in the long term.

As a community nurse I was alarmed at how little awareness many older people had about their own health, how to stay healthy, and the services available to improve their quality of life. I decided to address this by promoting health and independence, enabling older people to live healthier, more active lives in their own homes for as long as possible. I developed a preventative screening tool to identify need and refer on to appropriate services such as routine health screening, medication review and falls assessment. This involves undertaking a holistic home assessment to determine health and reduce inequalities, then putting preventative measures in place.

I discovered that many older people who were inactive and isolated needed support and guidance to get involved in any form of activity. In partnership with a school and other organisations I set up a centre where they can participate in a wide range of activities, which improve health and wellbeing, and reduce social isolation and inequalities in health.

**The process**
I researched my area, talked with older people, met service providers from agencies/services working with older people and developed a screening tool to be used in the home environment to determine health status, concordance and potential risks such as falls. Working in partnership with other agencies such as the fire service, pension service, citizen’s advice etc, I raised awareness of the initiative and encouraged them to identify older people in need and to refer to us. This is a reciprocal approach in that any needs identified during my assessment, such as for smoke detectors, are referred to the appropriate service.

I then set up an active ageing programme of six weekly sessions offering older people advice and information from health professionals and colleagues from relevant agencies. I also established partnerships with local schools, which allowed me to establish a day centre on school grounds. This enables us to deliver not only gym and exercise sessions, but also computer, healthy cooking/eating, art, dance and drama sessions. We charge £2 per session, and pay half of all income to the school as rent.

The service is successful because I involved service users in developing it. I recruited approximately 30 older people to act as volunteers, supporting staff and motivating older service users. Our champion for the service is a young and active 100-year-old — a fantastic role model. We instil a message that “you’re never too old to try something new”.

**Advice to other organisations**
Individual nurses wanting to set up an innovative project that will improve care and their patients’ lives need persistence and determination to make themselves heard. Be prepared for criticism if your initiative is out of the norm, collate facts to back up your beliefs and use service users’ views to shape your initiative. Look for alternative sources of funding, and set up partnerships with other agencies or organisations to share costs.

**Benefits of the initiative**
This initiative demonstrates the benefits of taking a preventative, holistic approach to service delivery and of working in partnership to deliver best practice. Identifying potential risks and preventing ill health is fundamental to reducing inequalities in health and improving health and wellbeing.

The main benefits to service users are improved health and wellbeing, confidence and self-esteem, improved physical activity levels, increased ability to carry out daily activities, reduced health inequalities, and prolonged health and independence. This means older people remain healthy, active and independent for longer, resulting in less need for NHS services.

**Financial implications**
The team is small and funded by the PCT. I have secured additional funding each year, which has supported many of our activities. However, our fitness instructor is now a full-time employee and delivers the majority of exercise sessions, while volunteers with areas of expertise deliver other sessions such as computers and indoor bowls; other activities are now delivered in-house at no extra cost.

**Contact**
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**Judges**
Maura Buchanan, chair of council, Royal College of Nursing
Phll Hoddinott, senior nurse pre-registration education, Imperial College Healthcare Trust
Lynne Maher, head of innovation practice, NHS Institute for Innovation and Improvement
Eileen Sills, chief nurse/chief operating officer, Guy’s and St Thomas’ Foundation Trust
Gail Mooney, framework director — postgraduate, School of Health Science, Swansea University
Young onset dementia service for Westminster and Kensington and Chelsea
Sean Mooney, Caroline Walker and James Warner
Central and North West London Foundation Trust

Background
There are approximately 18,000 people with young onset dementia (YOD) in the UK. The National Dementia Strategy emphasises the importance of developing specialist teams to provide good quality information, early diagnosis and interventions for people with dementia and their carers.

The experience of dementia in people aged under 65 years is often different to those of older people, both in terms of the type of dementias involved and the subsequent effects on the service user, carer and family. This means their needs also differ.

This initiative aimed to provide a coordinated service for referral, assessment and ongoing support of younger people with dementia in Kensington and Chelsea and Westminster, and their carers. It was set up after a report identified approximately 150 people with YOD in the area, and that their needs were going unmet. Support includes information/advice, pre and post diagnosis counselling, assessment and diagnosis, assessment of social and occupational needs, specialist day hospital support and therapy and carer support.

The process
This nurse-led multidisciplinary initiative first involved the development of a weekly therapeutic group programme at The Chamberlain Day Hospital. This requires significant ongoing input in terms of planning and facilitating the groups.

The team developed an operational policy and an information leaflet about the YOD service for users and carers, which we posted to GP surgeries and various teams and services in the area. We also met with local neurology services to establish close links and discuss referral pathways, and organised an official launch to help to publicise our service. We are a community service offering not only initial assessment, diagnosis and signposting to other agencies and teams, but also therapeutic interventions and ongoing social and carer support.

Two part time social workers (one for each borough) and a second dementia specialist nurse/deputy team manager have been recruited. We have developed our own initial assessment documentation and nursing and other staff routinely use the Addenbrooke's Cognitive Examination assessment tool. In 2009 we participated in a working party developing a business plan proposing expanding the YOD service to cover the Brent area.

Advice to other organisations
Since YOD accounts for only approximately 3% of all dementia cases, services like this require a large and/or well-populated catchment area. They also need to be well publicised to relevant teams and services, and especially to GP surgeries, as most GPs will only see one or two cases of YOD in their career; this increases the risk of misdiagnosis, for example as depression.

Close links with local neurology services are important to ensure referral pathways are clarified. It is also important to develop links with relevant local services such as day hospitals and centres; occupational, art, music and family therapy; and Admiral Nursing, and to develop or link into support groups for service users and carers.

Access to experienced social work support is crucial to provide social care and support including day care, home care, befriending, assistive technology, and placement in warden-supported, residential and nursing home care as required. Providing appropriate care, including residential and nursing home care can be challenging for people with YOD, as placements are difficult to find and geographically spread out. This requires a team with specialist expertise and knowledge of what is available locally and further afield.

Benefits of the initiative
A YOD service helps to achieve the National Dementia Strategy goals of providing good quality information, early diagnosis and interventions for people with dementia and their carers. Without a specialist service, people with YOD and their carers can be passed from pillar to post between adult, old age and neurology services, with no one agency taking responsibility for coordinating their care. This adds to service user and carer stress at a difficult time in their lives — our service aims to prevent unnecessary stress adding to their burden.

Financial implications
Research has suggested that compared with older service users with dementia, people with YOD appear to use fewer community resources and more institutional care, which is more costly. By providing community support and delaying the onset of institutional care, the YOD team can therefore reduce costs.

Future plans
We have developed a business plan proposing that the YOD service be expanded to cover our neighbouring borough of Brent, and regularly agree to requests to meet professionals from other trusts who are interested in setting up a specialist service for YOD in their area.

A working party has been set up to facilitate service user and carer evaluation/feedback using patient reported outcome measures (PROMS) and patient reported experience measures (PREMS).

Contact
For more information on this initiative please contact
Sean Mooney: seanmooney@nhs.net

Judges
Thomas Currid, senior lecturer/programme director, London South Bank University
Ben Thomas, director of mental health and learning disability nursing, mental health nursing lead, Department of Health
Peter Walsh, director of nursing practice, Central and North West London Foundation Trust

Click here to go to finalists
Recurring Admission Patient Alert
Sheran Oke, Megan Stowe and Sinead Kenny
Imperial College Healthcare Trust

Background
Recurring Admission Patient Alert (RAPA) is an automated alert system which sends an email when a known cancer patient registers in A&E. Before its introduction it was common for cancer patients to be admitted without any of the cancer team knowing. This can lead to a poor experience for the patient and their family, as well as unnecessary tests being ordered and patients not receiving the right care at the right time.

With RAPA, when a patient with cancer registers in A&E, an email is instantly sent to their clinical nurse specialist providing the opportunity for them to see the patient, inform A&E staff of the patient’s care plan and to support previously made decisions about the patient’s plan of care. In its first 16 weeks RAPA demonstrated a decrease in the length of stay for our patients. We have also utilised the technology in new ways to provide alerts for a number of professionals tailoring it to their individual patient needs.

The process
The project manager and clinical nurse specialists worked closely to assess and determine opportunities for RAPA within cancer. We decided initially to offer alerts to each tumour site. All participating clinical nurse specialists received an email as soon as one of their patients was registered in A&E.

Nurses were encouraged to consider what type of intervention they could make, for example, visiting the department to support the patient, notifying members of their multidisciplinary team or following up with the patient at a later time.

A key facet of introducing RAPA is to develop the alert response with the clinical nurse specialists. We have held two focus groups and also provided a great deal of one-to-one support to enable and support development of ways to use RAPA.

Advice to other organisations
It is essential to include stakeholders, the clinical nurse specialists, from the beginning in this sort of project. Collaboration and clear communication created support for and membership of the RAPA initiative and created a momentum for change. As RAPA transcends various departments within the organisation (such as information and communication technology, A&E, nursing and management) a strong project board with full representation is essential.

Benefits of the initiative
There are numerous benefits associated with using RAPA. Ultimately patients have a better experience when visiting A&E as they see a familiar face. Care plans and clinical decisions are maintained by bringing the clinical nurse specialist to the department, while unnecessary admissions are avoided, decreasing non-elective length of stay.

Though 75% of cancer attendances at A&E are not emergencies, those patients who do attend with a true oncological emergency benefit. For example, a patient with neutropenic sepsis will benefit from their clinical nurse specialist advising A&E staff of current treatment protocols.

Financial implications
By reducing length of stay through use of RAPA, we have an estimated saving of £28,600 in bed days alone just for non-elective lung cancer patients over one year (130 days saved charged at £220/day). It is difficult to quantify the savings associated with the unnecessary tests such as X-rays and blood profiles that have been avoided by having clinical nurse specialists attending the department when their patients are admitted.

Future plans
There is great opportunity to further develop RAPA, for example to create a neutropenic sepsis alert for patients currently receiving or just finishing chemotherapy who attend A&E. Generating an alert to a specific nurse would mean these patients could have instant access to the appropriate care.

In addition, an extension could be built on the RAPA software to enable clinical nurse specialists to measure and demonstrate how their time has been spent supporting patients. This could be audited to justify their use of time. Furthermore, by providing the opportunity for other professionals such as allied health professionals to receive RAPA alerts, patients with complex needs could be better supported when seeking support in A&E.

We hope to disseminate RAPA to all long-term conditions within our trust, and to provide infection control alerts to the bed manager (for example, a known patient with MRSA creates an alert). With prospective charging for readmissions, there is also the potential to have all discharged patients creating an alert if visiting A&E within 30 days of discharge.

We would also like to provide RAPA support for initiatives like enhanced recovery to enable us to track readmitted patients, giving us the opportunity to intervene with the appropriate care for those in A&E.

* This project was also highly commended in the Innovation in your specialty category.

Contact
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Judges
Christopher Harris: Commercial Director, Devices for Dignity
Barbara Stuttle: Deputy Chief Executive and Director of Quality, Clinical Development and Innovation, NHS South West Essex
Tony Paget: Lecturer in health informatics, School of Human and Health Sciences, Swansea University
Improving dignity in care for residents in care homes
Rita Jones, Janet Robson, Nikki Leach and Jill Pinington

NHS Tameside and Glossop

Background
After a successful funding bid in 2009, NHS Tameside and Glossop aimed to improve patient experience with regard to dignity in care. A nurse-led team was created and was asked to identify patient experiences with residents of local care homes, using the 10 elements of the government’s dignity challenge.

The initiative investigated patient issues that led to low standards of dignity in care. A unique partnership was established between internal and external stakeholders to ensure residents received the highest standards of care, delivered with dignity and respect.

The partnership provided the necessary skills and experience to address these issues. It was the small details that led to the big differences, often with no costs attached. For example, asking patients how they would like to be addressed by staff made a big difference to how they felt. The work addressed the personalisation agenda as identified in Putting People First: a shared vision and commitment to the transformation of adult social care.

The process
Using an interprofessional approach the team met internal and external stakeholders involved in delivering care to local residents. Discussions involved how we could demonstrate that care was being delivered according to the 10 elements of the dignity challenge.

Sharing best practice, a workbook was created and a pilot site chosen which included several providers. Evidence was provided against the 10 challenges and an observation tool was developed to confirm care was being delivered in the manner described. A patient experience survey undertaken in the pilot area asked patients if they felt they received care with dignity and respect.

All staff have received dignity training and the profile of dignity champions has been raised. In some areas there has been 100% sign-up of champions challenging poor standards of care.

A resource file sharing best practice has been developed and links through our website for the public and staff. On completing the process to ensure they provide dignity in care, individual care homes are awarded a plaque demonstrating to residents and families that care is delivered with dignity and respect.

Advice to other organisations
Communications and working in partnership with a number of providers has been crucial. When we initially approached external home care providers we were met with hostility and a “we already do this” response. However, by making them equals in examining poor care they became engaged and provided useful ideas in how to assess care delivery.

The 10 elements of the dignity challenge, the relevant Department of Health web page, champion’s information, and RCN train the trainer resource pack were all used to enhance the project and our patient experience group played a key role in delivering our survey.

One of our challenges was to ensure that there were no inequalities for any specific groups, such as residents with dementia. Working with a local care home we identified examples of excellent practice in seeing the resident not the illness.

Benefits of the initiative
An audit of our patient experience survey and the evidence demonstrated in the workbook showed 85% of residents now feel they receive care with dignity and respect. This is a significant improvement. Partners have benefitted from networking opportunities and interprofessional training, which has improved standards of care.

Residents were encouraged to complete a “This is me” resumé of their likes and dislikes which is posted in their room, ensuring they could receive personalised care.

Best practice is shared with all partners and a resource file is being developed. There is a dignity champions’ database highlighting the services where care is being challenged and dignity resources are at a premium.

Dignity is on everyone’s agenda including the PCT board where all members are champions and advocate that dignity is everyone’s business.

Financial implications
North West SHA provided funding of £200,000, which covered the costs of training, employed a team for 12 months to embed dignity in all partner organisations and paid for marketing resources to promote the campaign which are available for partners to purchase.

Staff have been trained to deliver future training needs. Ongoing monitoring of standards are being embedded in normal monitoring. Dignity will be part of all staff job descriptions and everyday activities and maintaining the focus on dignity should require no ongoing running costs.

Future plans
The resource file will be made available for other service users to purchase and will include a report of the project, pilot findings, details of best practice and useful contacts. A web page has also been developed for sharing of good practice.

Contact
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Judges
Julie Clark, founder and chair, Two Left Feet
Elaine Pierce, principal lecturer, institute for strategic leadership and service improvement, London South Bank University
Caroline Nicholson, post doctoral research fellow, National Nursing Research Unit, Florence Nightingale School of Nursing and Midwifery
Jill Maben, deputy director, National Nursing Research Unit, Florence Nightingale School of Nursing and Midwifery
Improving care in an acute hospital for people with a learning disability
Pamela McCarthy, Carol Edwards, Stephanie Read and Ben Mills
Norfolk and Norwich University Hospital Foundation Trust

Background
Norfolk and Norwich University Hospital (NNUH) believes that acute health services must be accessible and equitable for all people, including those with a learning disability. To this end an initiative was developed to ensure that these people received care and treatment that is appropriate for their special requirements when receiving medical, surgical or emergency interventions.

Since 2006 the trust has developed the care pathways for people with learning disabilities through staff education, working with advocacy groups, Norfolk learning disabilities services and carer organisations. The work was originally based on the Department of Health document Valuing People and the Disability Discrimination Act. However, other key policy documents have since been incorporated.

The Trust has been awarded the Care Services Improvement Partnership Award for Best Equality Project in the Eastern Region in 2008 and has taken part in the pilot work to develop the Care Quality Commission Standards for Learning Disabilities.

Throughout the initiative people with learning disabilities and their families inspired the drive for change and improvement with their stories and experiences, and their desire for the same life chances as everybody. They have become valued members of our team and their input and expertise have been welcome.

The process
The initiative involved collaborative working with primary care learning disabilities service, before, during and after admission of a patient with learning disabilities. The trust appointed a senior nurse to champion the project, developed a champion/link practitioner system, so a network of nurses could act as sources of information for staff and a point of contact for families and carers. It also employed two registered learning disability nurses and set up a steering group involving representatives from local learning disabilities advocacy groups.

Nine hundred staff have received training on learning disabilities each year, while signage has been improved, with input from people with learning disabilities. We use personal health information books to assist in the integrated delivery of care and treatment, while online resource documents offer staff clear information on subjects such as communicating with people who have learning disabilities; epilepsy; challenging behaviour; and consent/capacity issues. The resource also gives useful contact details and web links.

A DVD about the hospital was planned, acted and produced by and for people with learning disabilities, to help them to understand what to expect if admitted for treatment.

Advice to other organisations
Partnership working across health and social care is crucial, and it is vital to listen to and involve people with learning disabilities in all activities. They can be involved both individually and through local and national advocacy groups. Patient satisfaction should be assessed regularly through surveys using easy read/picture book materials

In terms of staff issues, it is useful to introduce learning disabilities champions in all areas and these staff need training and development; a trust champion at a senior manager level is also helpful. Employing a learning disability liaison nurse is useful, even on a temporary basis to prove the case for a similar initiative, or preferably as a permanent member of staff.

Once the initiative is established it should become part of the governance and safeguarding agenda.

Benefits of the initiative
The initiative has had a range of benefits including:

- Reduced length of stay — in one area an average of 41 days was reduced to 11;
- Improved client/carer satisfaction and reduced PALs referrals and reduced complaints;
- Improved health outcomes and safer and timely admission for patients undergoing elective surgery;
- Safer and more effective discharging processes;
- Individualised pathways (meeting reasonable adjustment under the DDA);
- Increased staff and student awareness/understanding of LD issues (training);
- Reduced risk and support for the trust clinical governance agenda.

Financial implications
The costs associated with the project were £50,000 per annum to employ a band 7 learning disabilities acute liaison nurse and £50,000 for a practice development learning disabilities nurse, and £2,500 for the production of a DVD (total £102,500). Over a six month period it has reduced bed days by 235.5, resulting in savings of £114,099.

Contact
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Judges
Juliet Chambers, clinical development and innovation programme manager, NHS Kirklees
Ros Moore, chief nursing officer, The Scottish Government
Mark Salmon, programme director for engagement and management, National Institute for Health and Clinical Excellence

Winner of the Chief Nursing Officer’s Award, sponsored by Derbyshire County PCT
Implementation of a multifactorial falls prevention programme
Bhoomeela Ramnauth, Cathy Gibson and Georgina Clark
Stockport Foundation Trust

Background
Reducing falls in hospital is one of the high impact actions for nursing and midwifery, which aim to improve care and save the NHS money. This initiative aimed to improve patient safety at Stockport Foundation Trust by:
• Reducing the number of falls;
• Reducing the harm rate from falls;
• Reducing the number of patients who fall more than once;
• Ensure that falls remains a key corporate priority for everyone (from board to all staff) across the trust.

The process
The multifactorial falls prevention programme involved a range of activities and initiatives, which included:
• Training: a specialised falls prevention and management education training package was developed and rolled out across the trust, to all levels of nursing staff and allied health professionals;
• Bed/chair sensor alarms: after being used successfully in high-risk wards we have now rolled these alarms out across all wards in the hospital — they are used for high-risk patients, such as those who are confused or unsteady;
• Low-profiling beds: these are rented by wards on a patient-specific basis for those who are likely to fall in the bed area and are high risk;
• Executive team safety walkrounds: these are undertaken on a frequent basis;
• “Safety huddles”: these are undertaken with falls collaborative wards on a regular basis to look at tests of change to be implemented and to check on progress;
• Board involvement: a section on falls, which contains an update on falls collaborative and current incident/harm rates is now included in the monthly quality reports reviewed at board level.

Advice to other organisations
If planning similar initiatives, it is important to engage all staff at the earliest possible stage, and identify key performance indicators. It is also important to hold regular reviews and progress meetings to keep all staff motivated and enthusiastic in order to achieve the overall objectives of the initiative.

Benefits of the initiative
The implementation of this multifactorial falls prevention programme has led to jointed up working across the trust and with other organisations across the north west, and has achieved board level involvement. It has improved multidisciplinary working across the trust — from all grades of nursing staff, medical staff, pharmacist, occupational therapists, physiotherapists and risk management.

The main benefit of introducing the programme is the improvement in patient safety. It also demonstrates clearly to patients, staff and visitors that the trust is committed to ensuring that we minimise the number of patient falls, and that every patient matters.

By introducing a range of falls prevention measures, and ensuring wards and staff have ownership of the project, it allows all staff to be involved in putting their ideas forward and implementing tests of change in order to reduce the number/harm rate from falls.

Financial implications
The National Patient Safety Agency estimates that the cost to the trust of falls would be £92,000 per year; based on the costs in the NPSA report the trust has so far saved £20,000 by reducing the number of falls occurring here.

Contact
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Judges
Lesley Doherty, chief executive, Royal Bolton Hospital Foundation Trust
Kate Jones, head of safer care, NHS Institute for Innovation and Improvement
Sara Johnson, head of patient safety, National Patient Safety Agency
Nurse-led outpatient antibiotic therapy
Paula Taggart, Lesley Hotchkiss, Dawn Passmore and Beth Swanson
South Tees Foundation Trust

Background
The outpatient antibiotic therapy (OPAT) clinic was formally established in 2007 to treat patients from South Cleveland with chronic infected wounds and other infections as outpatients, sparing them prolonged hospital admission. Patients who attend receive intravenous antibiotics and specialist wound management and care.

The initiative's aims were twofold:
- To reduce patient length of stay;
- To improve the quality of patient experience.

The benefits are significant for the patient and the organisation in reducing length of stay, and reducing the incidence of healthcare associated infections (HCAIs). Our patient feedback is consistently "excellent", with no complaints in over three years.

The process
The nurse-led OPAT service commenced hospital-wide in 2007. The original estimates of activity used within its business case proved to underestimate the usefulness of the service and in its first year the clinic doubled its estimated targets, saving 3,800 bed days. Since 2007 we have saved over 14,112 acute hospital bed days.

The OPAT clinic runs seven sessions per week, seeing on average 20 patients each session. As referrals are taken from all specialties, all types of wounds and infections are seen and treated. This requires advanced wound care knowledge. Essential to this is the strong working relationships between the consultant for infection control, the matron for wound care, the OPAT nursing team and other stakeholders. The OPAT nursing team consists of one band 7 sister, one band 6 sister, three RNs and two healthcare assistants. The OPAT service has expanded to include a nurse-led infliximab clinic and a MRSA decolonisation clinic pre-surgical intervention and post discharge follow-up.

Advice to other organisations
An effective OPAT service has been made possible after our business case was accepted by the trust board. The theme of the business case was that we should invest to save, and it clearly demonstrated the potential financial benefits to the organisation and the likely benefits to patients of introducing a nurse-led OPAT clinic.

Since it was established the clinic has flourished and this can be attributed to its strong nursing leadership, its dedicated team of experienced nurses and the team's willingness to work collaboratively with specialist clinicians, specialist nurses and local GPs. Building these relationships has been a key factor contributing to success.

We have tried throughout to be flexible, taking patients from all specialties with a wide range of infection and wound problems. The success of the initiative is also due to our commitment to the patient from initial referral, through antibiotic therapy to complete care of their wounds and resolution.

The nursing staff are experts and to date have not made a single intravenous drug administration error. They have used initiative and implemented a stopwatch system to ensure antibiotic therapy is administered within the correct time in accordance with British National Formulary advice.

Benefits of the initiative
The provision of the nurse-led OPAT service has over the past three years allowed thousands of patients to receive specialist care as an outpatient rather than in hospital. This has had both physical and psychological benefits for patients, and enabled them to continue living normal lives meeting their family and work commitments. The feedback we receive demonstrates that patients want and need the service we offer.

The initiative has also had numerous benefits for the trust; it is estimated to have saved our organisation over £500,000 per year in inpatient treatment costs and has also freed up valuable inpatient beds for other patients.

Our infection control rate record for the last year was excellent. The overall rate of HCAIs was one per 3,479 procedures. This compares very favourably with published rates of infections. For example, US guidance suggests that bacteremia rates related to central lines should be below three per 1,000 days of treatment. Our clinic itself has had no bacteremias.

Financial implications
The development of an OPAT service required some investment, particularly to provide seven day staffing. However, within the same financial year, immediate savings can be achieved. These come from reduced length of stays, improved productivity and reduced HCAIs.

By concentrating expertise in one area, every patient receives optimal wound management and appropriate antibiotic therapy from their first visit. The OPAT model of service delivery offers an option for more complex outpatient specialist care to be developed. A service such as OPAT will help acute hospitals to meet the government's proposed 30-day discharge responsibility target.

Contact
For more information on this initiative please contact Elizabeth Swanson: b.n.swanson@talk21.com

Judges
Gail Adams, head of nursing, UNISON
Ann Moses, UNISON branch secretary, Northern Lincolnshire and Goole Hospitals Foundation Trust
Firas Sarhan, senior lecturer, Bucks New University
Mandie Sunderland, chief nurse, Heart of England Foundation Trust

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HIGHLY COMMENDED
Majors nurse practitioners in the emergency department
Fiona Lodge, Bill Coode, Andrew Frazer and Deirdre Barr;
Newham University Hospital Trust

The initiative
This initiative developed the skills and knowledge of senior nurses so they could practise at an advanced level in the emergency department. The aim was to enable majors nurse practitioners (MNPs) to independently see, treat and discharge patients with complex illnesses not normally covered by nurse practitioners, including chest pain, abdominal pain, asthma and chronic obstructive pulmonary disease.

Nurses are recruited and developed to MSc standard in management of complex illness; they work alongside medical staff and treat patients who would normally be the caseload of senior house officers or registrars. We developed a specific course with City University London on managing complex cases, which is taught at MSc level and taken after a course on physical assessment.

The initiative involved recruitment, education and training of three senior nurses and required the support of medical staff to develop the role, and to assist with change management and promote the role within the trust.

Benefits
The role enables us to recruit outstanding staff into the department, and enhances senior nurses’ options as they can continue to work directly with patients while progressing their career. It also gives junior staff something to aspire to, helps them to develop their skills through access to clinical exemplars and role models, and enhances the reputation of nursing in general within the department and trust.

With a range of practitioners able to see them, patients’ waiting time is reduced, particularly at night, when an MNP is working. They are seen by a nurse with perhaps 25 years’ experience in emergency care, rather than an SHO with perhaps a month’s experience. This initiative could and should be replicated nationwide.

Financial implications
The MNPs currently work at band 7. Since they are covering medical staff, the money is drawn from the medical budget.

Contact
For more information on this initiative please contact Andrew Frazer: andrew.frazer@newhamhealth.nhs.uk

HIGHLY COMMENDED
Impact of a nurse consultant in developing nurse-led ophthalmic A&E
Paul Johnson;
City Hospitals Sunderland Foundation Trust

The initiative
Paul Johnson has worked at Sunderland Eye Infirmary for more than 20 years and has dedicated his ophthalmic nursing career to A&E nursing services. He was directly responsible for the advent of the nurse practitioner role in A&E, facilitating a dramatic increase in the case mix nurses are responsible for, extending the role of the ophthalmic nurse and nurse practitioner. The aims of this work were to:

- Improve the patient experience;
- Reduce waiting times;
- Develop the nurse practitioner role to independent care delivery and prescribing;
- Facilitate the continued development of the ophthalmic nurse/nurse practitioner;
- Enhance the ophthalmic nurse’s portfolio of skills;
- Provide a continuous source of nurses with ophthalmic competencies;
- Achieve 50% of total patient experiences in A&E completed by nursing staff.

This initiative was aimed at advancing nursing practice by the development and delivery of nursing care within the ophthalmic A&E, and our nurse practitioners now complete autonomously more than 50% of A&E patient care episodes. Waiting times average 1.5 hours and all our patients are currently seen and discharged within four hours. Benchmarks with other units reveal ophthalmic nursing practice at Sunderland Eye Infirmary is at an advanced level. This has also freed up medical staff to improve outpatients and theatre productivity.

Benefits
The initiative has had a positive impact on the quality of patients’ experience, predominantly in reducing waiting times; in the current calendar year we have received only one complaint, which was resolved at an informal level.

There are currently six nurse practitioners providing cover 24/7 at Sunderland Eye Infirmary, all of whom Paul was instrumental in recruiting and training; he is also responsible for their ongoing supervision.

Paul has also developed a foundation in ophthalmic nursing module with Northumbria University, incorporating a portfolio of ophthalmic nursing skills for new nurses. This provides a robust core of registered nurses with ophthalmic skills that will assure the delivery of ophthalmic nursing care well in to the future.

Nursing staff now have a clearly defined career development pathway and, with the use personal objectives, can plan their career from registered nurse to ophthalmic nurse practitioner. This enhances the profile of the ophthalmic nurse, making the role more attractive to newcomers.
Accident and emergency nursing

Financial implications
These include:
- The costs of employing new staff;
- A change in infrastructure to provide space for new consulting areas and to equip these.

The department has seen an increase in turnover of approximately 1,000 patients per year over the last 10 years. As a result of this initiative the department has absorbed these numbers while decreasing waiting times.

Contact
For more information on this initiative please contact Hilary Lloyd; HILARY.LLOYD@chs.northy.nhs.uk

FINALIST

Specialist nurse-led assessment for patients with suspected first seizures attending A&E
Vicki Myson, Ruth Jordan and Malisa Pierri; Cardiff and Vale University Health Board

The initiative
The National Institute for Health and Clinical Excellence recommends that patients experiencing a first suspected seizure should be seen by a specialist within two weeks to ensure they have prompt access to specialist services. An audit in Cardiff and the Vale demonstrated the service provided to these patients was deteriorating; NICE guidelines were only being achieved for 35% and on average patients were waiting for 22 days.

One option identified to improve the service was to develop a nurse-led emergency unit assessment service. The epilepsy specialist nurses (ESNs) developed service protocols, developed and implemented a communication strategy for A&E staff and ensured audit and evaluation systems were implemented.

The service is initiated when staff bleep an ESN, who assesses the patient within four hours. A detailed history is taken from the patient and, where possible, an eyewitness to the episode, to determine whether or not an epileptic seizure is likely. Patients are then offered an appropriate outpatient appointment, and given advice and referral for further investigations where necessary.

The initiative has changed the way ESNs work. Previously they provided a nurse-led clinic for known patients but were not involved in assessment and triage of first seizure patients. They also provide ongoing education for A&E staff, and hold weekly meetings with a consultant cardiologist to review complex ECGs from patients they are bleeped to see.

Benefits of the initiative
Since the service began the number of patients seen by a specialist within the recommended two weeks has increased from 35% to 75% and the average waiting time has decreased from 22 days to nine. The ESNs are also bleeped when known patients with epilepsy attend the unit after a seizure. Anecdotally this has prevented a number of admissions and improved the patient experience.

Utilising the ESNs’ expertise when patients first present has improved the patient pathway and experience, while working with the cardiologist has improved team relationships and patient pathways, and increased the nurses’ knowledge. The model could be used elsewhere to improve the management of patients with suspected epilepsy or other conditions requiring quick access to a specialist but not needing admission to hospital.

Financial implications
The only cost associated with the initiative was £200 to purchase an additional bleep. There are no ongoing costs as the service was developed using the existing workforce in a different way.

Contact
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FINALIST

Implementing Transforming Care at the Trolley to improve the quality and delivery of care
Hayden Pugh, Beverley Cadman, Jessica Arthurs and Darren Baulch; Royal Gwent Hospital

The initiative
Transforming Care at the Trolley (TCAT) is adapted from the Saving 1,000 Lives campaign’s initiative Transforming Care at the Bedside. It was introduced to reduce complaints about nursing care, adverse incidents and waiting times, as we felt that the quality of care had suffered due to government driven targets such as the four-hour transit standard. Common complaints included a lack of nursing contact/communication with patients, and since documentation was poor nursing care could not be demonstrated. Quality outcomes were to:
- Increase time nurses spent at the ‘trolley’ to improve communication between patients and staff;
- Reduce falls by identifying those patients at risk and increasing nursing observation;
- Introduce live time documentation and transit boards in patient cubicles;
- Improve observation charts;
- Reduce length of stay in the department;
- Increase both patient and staff satisfaction;
- Significantly reduce adverse incidents and complaints.

Emergency care nursing documentation and discharge planning was introduced so it could be written live at the bedside with full patient engagement. The environment of care was improved through the creation of a majors area, which has facilitated
patient observation while maintaining privacy and dignity.

Baseline measures were agreed, taken from staff and patient satisfaction surveys, LEAN project, and adverse incident reporting statistics (including complaints). Plan Do See Act (PDSA) cycles were conducted to address the implementation of each TCAT stage monitoring changes and improvements.

**Benefits of the initiative**
The project is driven by a dedicated team of nurses, who are committed to transforming emergency care and releasing time to provide direct patient-focused care and improve documentation. TCAT has helped to improve the patient experience, which has been demonstrated by random satisfaction surveys undertaken in the department.

The whole team has taken ownership of this initiative to improve nursing practice. The changes have promoted shared responsibility/accountability for patients and have led to a reduction in complaints and clinical incidents.

**Financial implications**
The capital scheme had already been approved before TCAT was introduced, enabling us to improve the environment in which nurses undertake patient observations. Reusable transit boards and assessment area templates were introduced, while the finalised nursing document will be printed as a booklet. The department’s stockroom and equipment were labelled and levels were reviewed and decreased to reduce waste costs. TCAT is cost-neutral in terms of reduction in complaints and incidents generating legal and financial compensation claims.

**Contact**
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**FINALIST**

**Development of an alcohol liaison service in an emergency department**

Andy Whitfield and Valerie Beaumont;
University Hospital of South Manchester

The initiative
Recent figures suggest that approximately one-third of attendances to A&E departments are alcohol-related. Since research suggests those who are at risk from their alcohol intake will reduce their drinking to a less harmful level if offered screening and advice, these attendances represent an excellent opportunity to address the issue. The nurse-led alcohol liaison service was introduced at the University Hospital of South Manchester in August 2009 in collaboration with Manchester PCT with the aim of reducing the growing harm to health caused by alcohol.

The purpose of the development was to identify those attending the department who are drinking at increasing and higher risk levels and deliver brief advice with the aim of bringing about a change in behaviour. Between mid August 2009 and the end of May 2010 we screened 10,968 patients. Those drinking at a level considered to be increasing/higher risk were invited back to see the alcohol liaison nurse for up to six sessions of brief advice. The initiative involved the whole department and the introduction of a care facilitator who works with nurses to identify the top attendees and works alongside community services to devise care packages tailored to patients’ needs.

We developed the service around the needs of patients and the department. The process was undertaken in partnership with colleagues at the PCT, involved all members of the multidisciplinary team and used local knowledge and contacts.

The process involved providing lots of ongoing training to all members of the multidisciplinary team, and undertaking constant service evaluation and audit. We began by training all medical and nursing staff to identify alcohol use disorders and deliver brief advice. We used evidence-based frameworks to design the brief intervention clinics and consulted local experts for help. Data was collected on all patients screened to provide information on levels of drinking to help us to design future services around the needs of the local population. Small incentives were offered to nurses and doctors who screened the most patients.

The most significant barrier we encountered was negative staff attitudes to those who attended the department drunk. This was addressed by providing education and demonstrating the value of screening by providing regular feedback on results of the team’s work. This gave staff evidence of how participating in the screening process had reduced individuals’ alcohol consumption and made reattendance in the department less likely.

**Benefits**
Early results indicate a significant reduction in Alcohol Use Disorders Identification Test scores over six months for patients attending the rapid access clinic. We have also reduced length of stay for patients receiving inpatient alcohol detoxification. They can be discharged early at the tail end of their programme and return to the nurse-led clinic; finishing detoxification at home is proven to benefit the patient as well as reducing length of stay.

Results from a patient questionnaire have been extremely positive, with patients expressing appreciation for the subject of their drinking having been raised in a non-judgemental way and being given advice on how to address it. The service also benefits the local population by identifying harmful levels of drinking at an early stage and offering advice on how to tackle the issue.

Through regular teaching sessions and developing a team of ward-based link nurses we have helped to alter negative staff perceptions of patients needing alcohol-related health advice/interventions. These individuals receive increased support and are overseen by a nurse-led team. A new alcohol withdrawal pathway has been introduced to standardise and promote excellent care to this patient.

**Financial implications**
The project employs three full-time staff at a cost of approximately £90,000 per annum, and we have a budget of £3,000 a year for other items required. We aim to save money for both the PCT, by reducing attendances to the department, and the trust from reduced lengths of stay in the hospital.

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**HIGHLY COMMENDED**

**Discussing sexual and relationship health with young people within an acute paediatric hospital**

Lucy Bray, Caroline Sanders and Erica Pritchard; Alder Hey Children’s Foundation Trust

The initiative
Teenage pregnancy and sexually transmitted infections (STIs) provide tough challenges for the NHS, education and public health teams. Our nurse-led team understands the role of primary care in delivering sexual health advice but believe all NHS organisations have a duty to support health promotion and public health issues. We decided to examine how we might address the increasing numbers of STIs by considering missed opportunities for screening and education.

We explored the role and responsibility of acute paediatric health providers in relation to preventative and opportunistic sexual and relationship education, and looked at how we might raise sexual health issues with young people; what challenges and barriers staff may have when discussing sexual health with young people; and how to maximise learning opportunities. We were also mindful of the particular sexual health challenges some young people face if they have a long-term health condition.

The process
We used an action research cycle to initiate a change in culture to improve the sexual health services offered to young people within the trust. It has raised the profile of young people’s sexual health and relationship needs in acute care and the responsibility all health providers have to address public health issues.

The initiative involved securing funding to conduct a research project. Questionnaires were distributed to young people (aged 14 or over) and their parents; 100 were distributed with a 70% response rate. Young people identified a need for acute healthcare professionals to be competent and confident to discuss sexual health issues with them in an appropriate and meaningful way.

Semi-structured focus groups with multidisciplinary team members highlighted that staff often feel reluctant and ill-equipped to discuss these issues. Funding from Innovate NoW (www.innovatenow.org.uk) has enabled us to develop an e-learning staff education resource, which young people are helping design.

Benefits
A major benefit of the project was building working relationships with the young people, who are often keen to be involved in projects focusing on their needs. Development of an e-learning resource for healthcare staff working within acute care is almost complete; its design and content have been guided by young people. The initiative has begun to raise the profile and importance of sexual and relationship health for young people across the trust.

**Financial implications**
The project has been funded by the Burdett Trust for Nursing (www.burdettnursingtrust.org.uk) and further funds were sought to support implementation of the e-learning resource from Innovate NoW. It is hoped that the resource will be relevant to many other child health practitioners working within acute care, and that by developing a non-judgemental and open culture in relation to sexual health, young people will be able to access information and screening that will improve their health, reduce risk and have an indirect impact on health and long-term treatment costs.

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**FINALIST**

**Safeguarding improvement programme**

Joy Holt, Trish Morris-Thompson, Briony Ladbury and Sara Sunderland; NHS London

The initiative
In response to the Baby Peter Serious Case Review (SCR), the safeguarding improvement team (SIT) was created to assess the strength of London’s NHS organisations and their frontline practice, and examine how to provide assurances that safeguarding children services are at the required level to minimise the chance of a repetition. The aim is, through a series of discussions, interviews and service visits, to look at what is really happening in practice, and to offer an unbiased, external perspective on any improvements required. The peer review process allows for a “critical friend” approach, in a more relaxed (while still challenging) manner than a regulatory inspection.

The process relies on expert peer review teams, nominated by NHS organisations across London. Their two-day visits involve a briefing by the local senior team to help “set the scene”, interviews with managerial and clinical leaders and service visits to talk to frontline staff including GPs, HVSs and school nurses. This enables effective triangulation of findings and a good picture of how safeguarding works both in policy and practice.

Feedback is given at the end of the visit to the managerial and clinical leaders and safeguarding leads using open discussion between the health community and the peer review team. The health community itself is responsible for ensuring real outcomes are delivered as a result of the programme but NHS London and the SIT are available for advice and support.

Benefits
The visits give the local NHS a real focus on reviewing its safeguarding process. For two days, the whole health community is engaged in thinking about how to improve...
the way services are delivered to children. After the visit, the development of a health community action plan, with specific actions to improve the quality of care, helps to ensure that safeguarding children remains a priority and services demonstrate a real improvement. The emphasis on support helps managers and front-line staff to feel comfortable to talk about areas that may need improvement and, of course, to showcase areas of best practice.

Peers see the process as a developmental opportunity and a chance not only to share their expertise but also to learn from others. It is also a fantastic way for peers and those involved in the visit to network with other professionals. One consequence of this approach has been the successful implementation of a leadership programme for designated professionals.

Financial implications
The safeguarding improvement team utilises existing resources to deliver improvement. The peer review team are all volunteers from organisations across London, who have freed up their time as a contribution to improving safeguarding children. Peers are happy to commit to a two-day visit as they will be helping to develop the region’s safeguarding capability and gaining excellent experience for their own personal development. The programme enables organisations to assess resources and to ensure their most effective use. This allows forward planning and more effective deployment of resources.

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FINALIST

Getting it right from the start
Judith Grigg, Hilary Garratt, Karina Dyer and Catherine Mee;
NHS Tameside and Glossop

The initiative
We aimed to promote good infant and parent mental health across Tameside and Glossop in a way that was sustainable and cost effective, reaching the widest group of parents with minimal professional intervention. The objectives were to:
- Develop and distribute an educational DVD and booklet to every new parent promoting the development of sensitive and responsive parenting, a knowledge of infant development, and an understanding of “baby talk” based on evidence from research on early attachment;
- Develop resources so that they could be used in other areas, to support longer-term supply and development.

The project was a response to the growing body of evidence on the importance of early attachment. Local strategic drivers based on levels of need, including the higher than average teenage pregnancy rates, and the promotion of parent and infant mental health, influenced the project.

It was undertaken by the Tameside and Glossop Early Attachment Service — a unique partnership that focuses on health promotion and early intervention with the infant-parent relationship up to three years of age, and was funded by the Tameside Children and Young People’s Strategic Partnership.

The idea came from local parents who wanted accessible information and featured “ordinary” local people. We sought the expertise of professionals including Sir Richard Bowlby and Dr Joanna Hawthorne in developing the material, and recruited local parents to work with us alongside a television production company, graphic designer, and voice-over artist.

Benefits
Parents who were interviewed as part of the DVD and booklet have described it as an empowering learning experience, while parents and professionals who have seen the materials have said benefits included improved communication and sensitivity between parents and infants. They also reported improved parenting skills, confidence and emotional wellbeing. It is hoped babies’ mental, physical and social development will lead to improved long-term outcomes.

The project has enhanced the quality and cost-effectiveness of midwifery and health visiting services by focusing on the parent-infant relationship, which has empowered parents and reduced their needs for professional involvement. It has improved productivity by promoting early attachment to a large population, helping parents to “get it right from the start”, thus avoiding poor outcomes in the longer term. We have also seen a culture change through increasing confidence, skills and awareness of early attachment in the wider children’s workforce, and in all practitioners working with family members.

Financial implications
The total cost was £27,500, for which all new parents in Tameside and Glossop will receive their own copy of the booklet and DVD, for just over three years (10,000 parents). Ongoing running costs are minimal, and we hope that teams will find that the resources help them to support parents and infants more effectively, resulting in cost efficiencies. Longer-term savings, as with all public health preventative approaches, will be difficult to measure.

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FINALIST

Training hospital play specialists to administer Entonox
Jennie Craske and Shirley Sinnott;
Alder Hey Children’s NHS Foundation Trust
The initiative

Hospitals can be intimidating places where painful and/or frightening procedures take place. Hospital play specialists (HPSs) help children to manage the hospital experience, reducing fear and anxiety with the use of preparation and distraction. For blood tests and cannulas, needle pain can be minimised with the timely application of a topical local anaesthetic preparation.

When children are particularly frightened or for a painful procedure, Entonox is a useful adjunct as it provides conscious sedation, helping to reduce fear and anxiety and enabling children to tolerate procedures with less or no distress.

Administration of Entonox is a nursing role, but we felt it might be more appropriately taken on by HPSs. Training them to do this seemed a natural progression in their clinical role, enabling them, having already developed therapeutic relationships with children, to continue providing support and encouragement at a time of increasing stress and distress.

The process

The director of pharmacy agreed that HPSs, as qualified health professionals, could become second checkers for administration of Entonox. We piloted the initiative by training one HPS. Training mirrored that provided for qualified nurses, after which the HPS was supervised administering Entonox to two patients. A competency interview and documentation were then completed. A session was also provided about the theoretical, practical and legal aspects of drug administration.

Guidelines on safe sedation of children require that practitioners undertaking sedation can recognise and manage a child who falls into a deeper level of sedation than intended.

For this initiative it was agreed that the HPS role would include monitoring sedation levels and recognition of deep sedation. However, they would not be expected to manage the child’s airway in this situation, as at least one nurse or doctor would also be present performing the procedure; the HPS would alert one of these clinicians to manage the child’s airway.

Benefits

The role of the HPS in improving the hospital experience for children cannot be underestimated. Preparing children for and supporting them through procedures is a fundamental part of the role.

A predictable benefit of having HPSs administering Entonox was that more children could benefit from its use. Previously reliance on other nurses to give Entonox, meant its availability depended on staffing rather than clinical need. Another expected benefit is the improved patient experience as the trusted HPS provides Entonox rather than an unknown clinician. The positive therapeutic relationship between HPS and patient has also reaped rewards in terms of success with challenging patients.

An unexpected consequence has been the positive impact on expectations regarding procedural pain management in our hospital. Clinicians are increasingly likely to be involved in a well-run child-centred and successful procedure than before.

Financial implications

This initiative provides a cost-effective way of providing a high-quality, child-centred service. Prior to this initiative, using Entonox would have required another nurse, possibly leading to a delay. The advent of HPS administration reduces the number of clinical personnel required and minimises delays.

Contact

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Empowering young people through groupwork

Denise Davis (not pictured), Mike Foster, Zahera Kapasi, Kat Anderson and Matt Kent; Oxfordshire and Buckinghamshire Mental Health Foundation Trust

The initiative

Evidence suggests that many children find it difficult to share feelings in individual or family therapy but find it easier in a group with others of similar age. In the child and adolescent mental health service we discussed the possibility of piloting an anger management group to enable young people to explore issues in a safe environment with peers with similar difficulties.

Our aims included:

• Improving outcomes for managing anger;
• Improving management of emotions;
• Raising awareness of risk;
• Developing strategies to address risk;
• Building social networks;
• Increasing self-esteem;
• Improving use of resources;
• Following national and local guidelines in implementation, thereby addressing patient need and patient choice.

We carried out a caseload audit and set up a pilot group for young people aged 14–17 of mixed gender. Group size was set at 6–8, attending eight sessions starting with an ice-breaker session to enable them to decide whether they wanted to commit. We used a CBT approach for six sessions with a final summary session to end. Pre and post group questionnaires were used to measure outcomes and review group effectiveness.

Benefits

Pre and post questionnaires identified over half of the group (54%) felt more able to cope with anger and felt less angry about their experiences; 80% found sharing experiences most useful and 40% found relaxation helpful. In terms of productivity and cost effectiveness, 90% needed less input from CAMHS, 50% were discharged and 40% needed less intense intervention. Through observation and qualitative reports from young people self-esteem and confidence were improved, as was their ability to socialise and use social skills. Managing anger in school improved with better attendance and decreased risk of exclusion.

Financial implications

We had to book time out to prepare the group and develop the pilot. However, this is balanced by seeing several young people with similar presenting issues at the same time. We have found that after attending the group, individuals were able to be discharged from CAMHS or needed less input.

Contact

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Continence promotion and care

**FINALIST**

**Delivering continence education the “e”asy way**

Katherine Wilkinson and Jacqueline Andrews; Bradford and Airedale Teaching Primary Care Trust

The initiative

The Bradford and Airedale Continence Team serves a diverse population of almost 500,000, providing a clinical assessment service and education on all aspects of continence care to health and social care staff.

Good education is key to improving and maintaining standards of continence assessment and management. Many care workers are hard to reach due to shift working and organisational constraints, which can restrict their access to education.

The purpose of this initiative was to develop a high-quality educational programme that is easily accessible to all care workers in Bradford and Airedale, with the potential to become available nationally. We decided to use e-learning as the vehicle to deliver the education, as this ensures that the information delivered to learners is of a consistently high standard and uses technology to enhance the traditional approach to learning, and chose the Virtual College as our partner for this project as we had previously worked successfully with this company.

Three senior continence nurses met regularly with their content development manager to support the development of an e-learning module. National best practice guidance was used as a framework to ensure the programme is evidence-based and up to date. The module is currently being peer reviewed, locally and nationally before its launch.

Benefits

The module offers a comprehensive and user-friendly approach to learning the basics of continence care. It supports and promotes the implementation of best practice guidance and encourages learners to seek further information. E-learning puts learners in control, allowing them to learn flexibly and at their own pace, and is ideal for hard-to-reach groups such as night workers, nursing home staff and those working in remote locations.

On completing the module, learners have to pass a multiple choice test before a certificate can be printed out; if they fail they can revisit the module as many times as they need.

The virtual college keeps a database of all learners, which enables healthcare providers to keep track of those required to undertake the module. Learners also have a personal portfolio held by the Virtual College, which keeps a record of their learning. From a clinical governance perspective, this provides consistent education to all staff and frees up continence nurse specialist time by reducing demand for classroom education.

Financial implications

Although module development cost £12,000, the availability of e-learning will make savings in specialist nurse time and hotel costs as staff no longer need to take time out of work to study. It is widely acknowledged that a good continence assessment is both cost and clinically effective, so a workforce well educated in continence care is also likely to improve efficiency.

Contact

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**FINALIST**

**Reducing the numbers of non-attendances at continence clinic appointments**

Carolyn Freeman; Greenwich Community Health Services

The initiative

Patients failing to attend continence clinic appointments is a common problem throughout the South East Thames area. This initiative aimed to find out why patients do not attend (DNA) appointments and reduce non-attendances by involving them in finding a solution. This would result in better time management for the specialist nurse, shorter waiting lists and more structured clinic appointments, improving the cost effectiveness of the service.

Although Choose and Book has reduced non-attendances in many NHS clinics, due to the embarrassing nature of incontinence I felt it needed a different approach. I used process mapping to identify each step of the patient’s journey from referral to appointment to identify any areas of weakness in the system and see what could be improved.

This identified that the appointment letter did not give patients a clinic contact number to cancel their appointment at short notice and demonstrated that patients did not
Continence promotion and care

understand the consequences of failing to attend or what would happen at the clinic. All letters to patients now have clear contact numbers and information about what their appointment will involve (for example, urine tests), and patients are warned that if they fail to attend two appointments they will be referred back to their GP.

Patients are now sent satisfaction surveys after their appointment for feedback on the service they received.

Non-attenders were called or sent a form to ascertain why they missed their appointment. Most failures were due to forgetting the appointment, not finding the continence adviser on arrival, and embarrassment. This led us to put up a discreet sign up for the clinic and tell patients what to look for when arriving at clinic, while each patient is called before their appointment to remind them of the time and venue.

Benefits
This work has ensured patients are informed of what is expected from them at clinic, reduced fears of the unknown, and given them clearer information on finding the clinic or cancelling their appointment. Patients seem to like completing the short satisfaction surveys as they are returned by nearly all new patients and some attending for follow-up.

The sign tells patients where to wait and means they do not have to queue in the main reception, while patients appreciate the telephone reminders. Reduction in non-attendances means the clinics are now better utilised and cancellations can be used to book other patients, saving money, improving efficiency, and reducing both waiting times and stress on the continence adviser.

Financial implications
The project was carried out within existing resources, while cost of ongoing monitoring is minimal as the questionnaire is printed and sent out from the continence office. Feedback forms are handed to each patient after an appointment for optional completion and left in a box at the clinic.

The initiative
After an audit identified a shortfall in documentation of urinary catheterisation and evidence of several different catheter care plans being used and in some cases none at all, a pathway was developed to standardise care for all patients with a catheter in situ.

The documentation took into consideration: local policy for antibiotic prophylaxis; monitoring for the diuresis; a urine score to prompt nursing action; assessment of catheter care and review of the need for catheter every shift; infection control guidelines; and documentation of catheter removal.

The pathway aims to reduce urinary tract infections (UTIs) and provide evidence of quality of patient care as required by the high impact action on this subject. It was developed in a specialist area (urology) with the input and support of all key stakeholders, and after audit results demonstrated its benefits it has been launched trustwide. The pathway will be taught as part of the preceptorship programme for newly qualified nurses.

Information included on the pathway is based around the requirements of the Department of Health Saving Lives programme, infection control and best practice. It incorporates a urine score to aid consistent nursing assessment and evidence-based action, and its user-friendly format is based on the trust’s current cannula care pathway to make the form familiar to nurses.

A draft pathway was sent out for consultation key stakeholders, who included a consultant urologist and microbiologist, a urology specialist nurse, the infection control team and my ward manager. It was revised before a two-month trial was undertaken on the urology ward. Further developments were made following feedback and audit of the trial, and this version was ratified and launched trust-wide.

The pathway acts as an aide memoir for nursing staff; it has standardised practice across the trust, changed nursing practice to improve the quality of care, and become part of the trust’s educational programme for nurses. It can be updated to take account of new evidence or guidelines, and will continue to be audited as part of the nursing matrix and winning ways initiative.

Benefits
The pathway has standardised care for all inpatients with urinary catheters in place. Its one-page document is kept in patients’ notes, providing raw data that can be easily and readily available for audit. It facilitates constant monitoring of patients’ need for a urinary catheter and for early signs of infection, and reminds staff to ensure catheter care conforms to best practice and infection control guidelines. It has subsequently prompted the review of the current trust guidelines for catheter insertion.

Comprehensive documentation of catheter care in the trial area rose from 0% before the trial to 86% after the introduction of the revised pathway. While the aim was to reduce hospital acquired UTIs, it is currently too soon to make a direct correlation of this.

Financial implications
The only cost incurred is the printing of the pathway document. Its potential for cost reduction will depend on the reduction of catheter-associated UTIs, which cost the NHS over £120m per year.

Contact
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FINALIST

Development of a urinary catheter care pathway
Jo Oakley, Clare Williams, Emma Kennedy and Charlotte Wise; Frimley Park Foundation Trust

The initiative
After an audit identified a shortfall in documentation of urinary catheterisation and evidence of several different catheter care plans being used and in some cases none at all, a pathway was developed to standardise care for all patients with a catheter in situ.

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Continence promotion and care

**FINALIST**

**Joined-up care for women with over-active bladder**

Voirrey Johnson;
Isle of Man Department of Health

The initiative
The aim of this initiative was to use cross-boundary working to improve the care provided to women diagnosed with over-active bladder in a largely rural area by:
- Minimising the distances and difficulties associated with attending a hospital clinic appointment for monitoring, bladder training and support;
- Providing a high level of support during bladder training to those who need it;
- Ensuring those referred direct for continence advice can easily be seen by a consultant if necessary.

As a community continence advisor I spend one afternoon each week as part of the urogynaecology clinic team based at the local hospital, then see patients for subsequent appointments wherever suits them best, whether this is at home, in a community clinic or the original hospital clinic.

The initiative required the agreement of my manager for me to spend time in the main hospital, and the agreement of the hospital management for me to work in the women and children's suite alongside the consultant. It was also vital to develop a good working relationship with my medical colleagues.

Benefits
Patients can be seen weekly if they need to. More frequent appointments when necessary means they are more likely to continue with treatment — and achieve continence — than if only seen every eight weeks, which is the most frequent repeat appointment available at the consultant clinic.

Since some women have to take three buses to reach the general hospital the opportunity to choose where follow-up appointments are held means they are less likely to miss appointments. The fact that they can see the same person at each appointment gives them continuity of care and means they feel they have personal support. International Consultation on Incontinence Questionnaire (ICIQ-UI) short form scores show that many of the women regain continence, while others become much less incontinent.

The initiative also releases the consultant’s clinic time to see other patients, while giving these women a higher level of support than would otherwise be available. The benefits are such that the urology consultant and his hospital-based urology nurse specialist are beginning to also request that I take over some of their patients for care that does not require the hospital environment.

Financial implications
The fact that many patients regain continence and others become much less incontinent reduces the demand for incontinence products to be supplied by the health service, while a choice of appointment locations reduces demand on hospital transport.

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**FINALIST**

**Setting up a community continence and enuresis service**

Cath Williams and Dena James;
North Somerset Community Services

The initiative
A service was initially set up to provide a specialist nurse-led continence service for patients in North Somerset. However, the leadership and clinical specialism of the team has developed over time and they have now set up a highly specialised, multifaceted enuresis service, supporting children, young people and their families to manage this difficult issue sensitively and effectively.

This is an ongoing initiative and the service continues to develop. The team regularly review local and national figures to ensure they are providing a valued and effective service to the people who need it most. They have targeted hard-to-reach groups and work effectively with a range of organisations and teams to develop the services they offer.

Benefits
The service has received accolades from a range of services and the patient satisfaction surveys have highlighted the high regard service users have for the team.

Financial implications
The service provides pads for some nursing homes and has evidenced that the careful prescription of pads for the correct use has saved on the unnecessary use of the most expensive types.

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Improving maternity services

HIGHLY COMMENDED
Centering pregnancy: a feasibility study
Eunice Ximines, Yvonne Menka, Anna Gaudion and Cathy Walton;
King’s College Hospital Foundation Trust

The initiative
Centering Pregnancy is a group approach to the provision of antenatal care developed in the US by the Centering Healthcare Institute (www.centeringhealthcare.org). It is underpinned by self-efficacy; that is of women taking a central role in their own health with the confidence to make informed choices that are right for them. This partnership is conducted within a framework of safe clinical standards.

Eight to 12 women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a peer support network; a midwife is available to undertake standard physical health assessments. Each group meets for 10 sessions throughout pregnancy and early postpartum period.

This service development pilot was undertaken to ascertain whether the model could be adapted and implemented within a UK setting, specifically within the diverse population in south east London. The evaluation also aimed to establish whether this model of care was acceptable to midwives, women and their families.

The project began in 2008 with the adaptation of the Centering Pregnancy model to conform with policy and guidance from the Department of Health, the Nursing and Midwifery Council, the National Institute for Health and Clinical Excellence, and with local guidance. Information resources for women and professionals were developed, and training and ongoing support set up for the midwives. This consisted of support in group sessions, one-to-one reflection and discussion sessions, guidance documents and workshops.

Six Centering Pregnancy groups were recruited (60 women and 20 partners) and subjected to ongoing evaluation. A seventh group was then recruited to bring all the learning together and inform the writing of an operational guidance document and health economic review.

Benefits
The feasibility study demonstrated Centering Pregnancy can be transferred to the UK, and we now plan to mainstream the model and undertake further research. A randomised controlled trial in the US has demonstrated that it has positively influenced rates of prematurity and breastfeeding; mean birth weight; and women’s satisfaction with antenatal care. There have been a number of unexpected spin-offs from the project here; for example blood pressure improved after the additional training provided to midwives.

The women have unanimously commented that meeting other women in the same position as themselves has been highly beneficial. Partners reflected that they felt included and integral to the pregnancy journey. They benefitted by being able to ask questions, share emotional responses, be involved in making choices and in supporting their partners.

Financial implications
Initial start-up costs included: training the midwives, administration, purchase of basic equipment, development of information leaflets and booklet for participants. Ongoing costs include: room hire, light refreshments for the women at each session, further training and support for midwives and administration. Once the project is rolled out with a complete group of 8–12 pregnant women it is likely to be cost-neutral. A health economic review will be completed in 2010.

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FINALEST
Midwives examination-of-the-newborn clinic
Belinda Ackerman, Mary Sheridan, Jan Powell, and Julie Cooper;
Guy’s and St Thomas’ Foundation Trust

The initiative
A midwife-run examination-of-the-newborn clinic was set up within the hospital to operate seven days a week providing the full examinations of babies required within 72 hours. Women and their partners are given vital health information about their baby before leaving the hospital with minimal delays.

The trust funded the midwives to attend university to study the six-month post-registration Neuro-Behavioural and Physical assessment of the Newborn programme/Examination of the Newborn, and set up a home-from-home birth centre working group (involving both midwives and women). Midwives examination of the newborn guidelines were developed and published online within the trust, after which midwives who were trained in EON carried out all examinations on babies in the home-from-home birth centre after six hours to ensure they could be transferred to their family home as soon as possible. Previously this examination was carried out by neonatologists; where necessary babies are referred promptly for further examination by a neonatologist.

An information leaflet was produced for women and their partners, explaining the service, and a room in the postnatal ward was refurbished to serve as a clinic, and equipped with a neonatal examination table with radiant heater. A maternity support worker is allocated daily to assist the midwife on duty in running the clinic. Ongoing bi-monthly meetings of the examination of the newborn group are held to discuss clinical cases, relevant research and plan changes within the service.
Improving maternity services

Benefits
Every baby receives a full neonatal examination within 72 hours of birth, before being transferred to their family home, while parents have a chance to receive health education about the newborn baby and time to discuss any concerns about the baby with the midwife.

The service prevents delays in women and babies leaving the hospital in a timely manner and frees up the neonatologist’s time to concentrate on sick babies.

Setting up the clinic has increased the midwives’ autonomy and job satisfaction. They can now provide total care to women and babies throughout the birth experience without requiring referral to a doctor.

Financial implications
The financial implications are that the cost is attributed to highly trained midwives who are experts in the examination of the normal baby instead of neonatologists who are experts in the sick baby and whose salary is much greater. Therefore it is a benefit to the health service in terms of finance.

Contact
For more information on this initiative please contact Belinda Ackerman: belinda.ackerman@gstt.nhs.uk

FINALIST
Acton African Well Woman Clinic: a community based midwifery-led deinfibulation service
Juliet Albert, Denise Henry and Melanie Mendel; Imperial College Healthcare Trust

The initiative
This initiative aimed to empower women who are suffering from the health problems associated with female genital mutilation (FGM) to be deinfibulated before their wedding night and/or childbirth, and to provide care in a less overwhelming setting than the hospital.

Local audit highlighted the need for the service to improve equity of access to healthcare for women with FGM, so we presented a proposal to the director of midwifery, who was keen for us to set up the service.

Training for the deinfibulation procedure came from observing an obstetric consultant in theatre; we then attended the first FGM module at King’s College and had the opportunity to observe and have hands on teaching and practice with Comfort Momoh, FGM specialist midwife.

Engaging the relevant stakeholders involved setting up a steering committee including representatives from Imperial College Healthcare Trust, Ealing PCT commissioners and local multidisciplinary healthcare workers — mainly GPs and equality and diversity leads. We also needed a venue and found an amenable GP surgery with facilities for minor surgery. This means there is a doctor available if needed.

The clinic provides both antenatal and preconceptual care that is freely accessible to all. We also aim to provide a more cost-effective service that offers a fast response (within two weeks) and therefore avoids the usual waiting lists. Women can self-refer, bypassing the usual gatekeepers, who may act as barriers to them accessing the service. For example, women may not wish to see their GP about this issue.

The service is run by women for women — the team consists of two specialist midwives, a counsellor and a Somali and Arabic-speaking health advocate worker. It is publicised through posters and leaflets, and an advertisement has been filmed and shown on Somali satellite television.

Benefits
The clinic has improved the long-term health of women who have experienced FGM. They attend primarily for deinfibulation, but we also offer education and advice on UK legislation, sexual health and contraception. We work hard to ensure the service is culturally sensitive.

We have seen more than 20 women with severe perineal trauma as a result of a combination of FGM and childbirth. Often these women have a thin posterior vaginal wall, having suffered many years of forced vaginal penetration. They may also have a tear or episiotomy as well as (or sometimes instead of) deinfibulation during childbirth, with the resultant problems of severe perineal damage.

Financial implications
It is far more cost effective to deinfibulate women under local anaesthetic in the community clinic than for them to go through the hospital and on a theatre list as a day case. Deinfubulating before conception or in the antenatal period reduces potential morbidity during labour and birth and the potential costs of emergencies procedures. Some units still see FGM as a reason for a caesarean section, which is far more costly than a vaginal birth.

Contact
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FINALIST
Increasing normal labour by outpatient cervical ripening and reducing caesarean sections
Ruth Steward, Sarah Reynolds and Amanda Pachulski; Bedford Hospital Trust

The initiative
This initiative aimed to increase normality in childbearing and
Reducing the caesarean section rate.

Enabling women to be in their own environment during the cervical ripening stage of induction of labour – women attend the maternity day assessment unit (DAU) then go home until labour begins or return the next day for further induction;

- Reducing the caesarean section rate. Ambulatory cervical ripening releases midwives’ time to care for women in labour, while lower caesarean rates release both midwives and obstetricians.

- Ensuring mothers remain mobile for as long as possible encourages normal physiological processes, reducing the need for interventions and their associated risks, and reduces the risk of subsequent caesareans.

Cervical ripening as an outpatient has been undertaken locally since 1996. At term +12 days women are referred by the community midwife for a stretch and sweep procedure in the DAU. If they do not go into labour spontaneously, induction is planned for 42 weeks.

We challenged established practice and decided to offer low-risk mothers the choice of going home after their first (and later second) prostaglandin pessary if no other problems were apparent. They then return the following morning to be assessed by the obstetric consultant if labour has not commenced.

Promoting normality throughout the service is essential to reducing the caesarean rate. Encouraging women to participate and be in control reduces unnecessary intervention. Appropriate diagnosis of established labour is paramount.

We enabled midwives, obstetricians, managers, support staff and users of maternity care to work together to improve services through multidisciplinary workshops built on being a pilot site for the self-assessment toolkit from the NHS Institute. As a result of these workshops vaginal birth after caesarean clinics were introduced.

Benefits

The project is effective in meeting women’s choice and increasing normality in both areas, yet is cost effective and safe — our perinatal mortality rate has remained below the national average throughout these initiatives (5.4/1,000 in 2009/10), while promoting normality reduces short, medium and long-term morbidity for mothers.

The initial 100 women undergoing outpatient cervical ripening were audited — 75% went into labour without any further intervention, while the remaining 25% returned for induction the following day; over 1,000 women have now gone through the process. Women state their satisfaction and now ask to be allowed home. We have had no adverse outcomes directly attributable to this group. The caesarean rate has reduced from 24.5% to 20.3% in the past three years, and vaginal birth after a previous caesarean is now achieved in over 75% of eligible cases.

Financial implications

Based on the 2009/10 figures, outpatient cervical ripening delivers an average productivity of £350 per woman induced. This equates to £63,000 for 180 women. The annual saving for a unit delivering 3,000 babies per year is £20,000 for every 1% reduction in the caesarean rate. This means that we are delivering at least £90,000 real-cost annual savings to the community.

Contact

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Infection prevention and control

**HIGHLY COMMENDED**

**Infection Prevention — It’s Everyone’s Responsibility**

Susan Osborne, Jenny Kirton, Mandy Bailey and Caron Crumbleholme;
University Hospital of South Manchester Foundation Trust

**The initiative**

At the beginning of 2009 cases of MRSA were at an unacceptable level. We were in breach of our target and our regulator had expressed serious concerns. Trust chief nurse, Mandy Bailey worked with colleagues on a campaign that would:

- Bring about a culture change where every member of staff saw infection prevention as a priority;
- Engage staff, patients, visitors and other stakeholders to work together and turn the problem around.

Mandy headed the *Infection Prevention — It’s Everyone’s Responsibility* campaign, which continues to have a high presence throughout the trust. This involved a poster campaign depicting staff members washing their hands with supporting messages underneath; a mass handwashing demonstration involving over 1,000 staff members and the public, which was made into a training video; infection prevention and control roadshows; screensavers/pop-up messages on trust computers. Staff visit local schools to teach hand hygiene; the infection prevention and control team regularly speak on the trust’s weekly radio show.

**Benefits**

The campaign has led to over a 50% decrease in MRSA and *C. difficile*, made infection prevention and control a priority and boosted staff morale by involving everyone. It has given everyone a lift to see we are dealing with important matters and asking staff to get involved in their solutions. Feedback also shows that staff respect and like our transparency in regularly publishing infection rates and not hiding bad news.

Patients feel reassured that we are doing everything possible to combat infections and like the fact that we are coming up with new ways of addressing the issue. Our work is sustainable and the campaign will continue and adapt as situations change.

**Financial implications**

Initial costs included: photography, poster production, making easy-clean A1 frames video filming and editing. We will not need to buy more frames and our image bank will help us renew posters without additional photography. All other work is cost-free. The campaign cost £25,000 in 2009/10 but should be no more than £1,000pa in 2010/11 and thereafter.

**Contact**

For more information on this initiative please contact
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**HIGHLY COMMENDED**

**Catheter associated urinary tract infection; a thing of the past?**

Sarah Mimmack and Laura Ludman;
Royal Orthopaedic Hospital Foundation Trust

**The initiative**

A snapshot audit in our elective orthopaedic trust revealed a urinary catheterisation rate of 21% when the national average is 12.6%, and a catheter-associated urinary tract infection (CAUTI) rate of 32%, when the national average is 7.3% in hospitalised patients. Even at the national average, we were spending over £185,000 a year treating CAUTI, when we should be preventing them.

We used standard PTFE Foley catheters, but studies showed that silver alloy hydrogel catheters could prevent CAUTIs. These were approximately seven times more expensive, but the business case clearly showed that by investing — even at the national rate of CAUTI of 7.3%, the trust would save in excess of £185,000.

We introduced the aseptic non-touch technique protocol (ANTT) as our clinical practice gold standard, including insertion and handling of catheters. This was taught in all clinical areas, reinforced on all mandatory training and became part of an optional clinical skills course. We aimed to reduce risk by adopting a chain of prevention approach, based on neurolinguistic programming, linking words, actions and behaviours to protect patients.

**Benefits**

Patients are now highly unlikely to develop a CAUTI with the associated increased length of stay and mortality risk. Any initiative that reduces the use of antibiotics also reduces the risk of antibiotic resistance. Financially the benefit to the trust is a significant cost saving; in our case the CAUTI rate has consistently been zero for the past year. The teaching element has also raised staff knowledge around the prevention of infection across all clinical interventions, which is hugely valuable to patients and the trust and may explain why the MRSA bacteraemia rate has remained at zero for the last year and the *C. difficile* rate has also dropped dramatically. Furthermore the catheterisation rate has also dropped from 21% to 14%.

**Financial implications**

The trust was spending a huge amount of money treating CAUTIs. According to the Ploughman model (1999) each CAUTI was costing £1,563 to treat: additional nursing care £539.43; microbiology £10.60; additional antimicrobials £4.71; additional length of stay £627.76; plus other additional consumables £82.45 and additional costs £298.05. Even if our CAUTI rate was only 7.3%, to reduce it as we have done to zero would mean a minimum cost saving of over £85,000. At a rate of 32% at £1,563 per patient, potentially the savings were worth over £215,000.

**Contact**

For more information on this initiative please contact
Laura Ludman: laura.ludman@blueyonder.co.uk
Swine and seasonal flu vaccination for healthcare workers in a tertiary cancer centre

Linda Wild, Pete Lightfoot and Oonagh McGugan;
The Christie Foundation Trust

The initiative
The Christie in Manchester is one of Europe’s leading cancer centres, treating 40,000 patients every year. The vast majority of our inpatients are severely immunocompromised due to disease and treatment which leaves them highly prone to acquiring infections. The infection control nurses decided they had to lead on providing an effective, comprehensive vaccination programme to protect staff and patients from contracting swine flu and maintain core services.

Infection control link nurses were identified as potential vaccinators and attended an education day, while a patient group direction was provided by the antibiotic pharmacist.

Peripatetic teams visited all clinical areas to vaccinate staff, targeting high-risk patient areas first. Two fixed vaccination venues were also staffed and equipped from 8am to 5pm, while vaccinators came in for some night shifts and some fixed site sessions started earlier to accommodate night staff. Consent forms and vaccination records were produced in house.

Senior board members were role models for vaccination. Human resources provided a staff register which gave real-time monitoring of uptake. Non-attendees were contacted by letter inviting them to participate or provide evidence that they had been vaccinated elsewhere. Clinical areas with low uptake were intensively targeted by the roaming teams.

Benefits
The infection prevention and control nurses provided a bespoke vaccination programme, so staff did not have to be absent from the ward. The trust was in the top 10 in the country for uptake of swine flu and seasonal vaccine, and the potential of staff to patient transmission was reduced, resulting in reduced side room utilisation, CCU beds, and prolonged inpatient stay.

Financial implications
Compared with an outside occupational health service the cost saving from providing the service in house was considerable. Staff protection from swine and seasonal flu probably resulted in fewer absences and reduced need to employ agency and bank staff. Prevention of spread to immunosuppressed individuals was a priority as our experience with these patients demonstrated that they were swine flu positive for months after diagnosis.

Contact
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A reduction in MRSA bacteraemia and infections through evidence-based practice and innovation
Alison Burgess, Nicola Cerullo, Debbie Weston and Sue Roberts;
East Kent Hospitals University Foundation Trust

The initiative
Before 2007, work within the trust around reducing MRSA bacteraemia/infection focused on high-risk surgical patients. However, after the introduction and attainment of Department of Health MRSA bacteraemia reduction targets, we had to identify new strategies. Analysis of our MRSA bacteraemias revealed that the majority occurred within medicine and elderly care, and that emergency medical admissions represented a more significant risk. We therefore began screening all emergency admissions, along with the pre-emptive decolonisation of those who were at high risk. In order to reduce the number of MRSA contaminated blood cultures, emphasis was placed on blood culture collection. While there was a whole-team approach, infection prevention and control nurses were responsible for the development and implementation of the initiatives described.

Robust action planning was initiated if a ward experienced three or more colonisations in a month, and root cause analysis was undertaken for all bacteraemias.

We specified that Chloraprep must be used for CVC insertion and dressing change, Chloraprep Frepp for peripheral cannula insertion, and Bardex IC silver urinary catheters as standard. We also developed a blood culture policy and in-house blood culture collection pack, which contains Chloraprep Frepp, a 5 Important Points for Blood Culture Collection leaflet, Clinell wipe for bottle tops, and a blood culture collection label for insertion in the medical notes. A mandatory e-learning package was developed and staff were trained in use of invasive devices.

Benefits
Robust evidence-based practices have seen MRSA bacteraemia rates fall even further, and the percentage of patients found to be MRSA-positive on admission has decreased. There is a greater sense of ownership and responsibility within directorates, and a greater awareness of the importance of infection control. The trust has among the lowest MRSA bacteraemia rates in the NHS.

Financial implications
Business cases had to be developed to introduce Chloraprep, Chloraprep Frepp and Bardex IC silver catheters. The implementation of a trust-wide MRSA screening programme is potentially a significant laboratory cost.

Contact
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Sceptical about asepsis? Where does the learning begin?

Jane Tordoff, Ian Carruthers and Helen Inwood; University Hospital of North Staffordshire

The initiative
The purpose of the initiative was to standardise use of aseptic technique across the trust. We initially planned to train all senior nurses with a view to them cascading training to all nursing staff by March 2011. This was subsequently revised with a plan for ongoing formal training to support the cascade trainers. A policy on asepsis, competency for preceptorship and formal competency assessment criteria were subsequently introduced.

The senior charge nurse for surgery, Infection control team and the Health Care Careers and Skills Academy worked together to identify areas for development, and an on-line learning package was developed. An audit of aseptic technique across the surgical division revealed a huge range in ability and technique between newly qualified and experienced staff members and a lack of standardised practice.

We rolled out a trust-wide programme training asepsis champions, developed a protocol on asepsis and a teaching package, linked with local pre-registration courses, produced a DVD demonstrating technique and implemented a trust-wide plan to retrain all staff within 12 months followed by annual updates and compliance auditing.

Benefits
The initiative has improved the standard of care by standardising aseptic technique, and will significantly reduce the number of line and wound infections. The education programme has resulted in the engagement of clinical teams, with many reviewing current practice. Staff have started to challenge poor practice and taken steps to effect change. Monitoring of aseptic technique through an initial pilot audit has shown a massive increase in staff compliance; this audit will be extended to all nursing teams in 2011. Every staff member will have access to the e-learning system.

Financial implications
Having the DVD produced professionally would have cost over £5,000. Producing it in house incurred no additional costs. Apart from existing nursing staff time, and consumables there have been no additional costs. Financial savings will be realised over an extended period and can be validated through use of the surgical site infection data and our ongoing surveillance reports in addition to the compliance audit.

Contact
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Implementing infection prevention and control in the community care environment

Melanie Milburn, Carol Butler, Susan Shannon and Naomi Kelly; NHS South of Tyne and Wear

The initiative
In 2009 NHS South of Tyne and Wear employed eight additional staff for its community infection prevention and control team — five nurses and three healthcare assistants — to focus on infection prevention and control best practice in nursing and residential care homes.

Through carrying out surveillance and root cause analysis, the team identified misconceptions and gaps in knowledge among staff in these settings. There was no mechanism for providing standardised and consistent support, and it was agreed that this should be developed and led by the local PCTs.

Care homes were identified and initial contact made. A work programme was developed to identify outcomes and actions to support all homes in self-assessment; deliver standard training in all homes and bespoke training and advice in response to queries or incidents; carry out clinical placements with frontline staff; identify link practitioners and set up link groups.

Benefits
Improvements have been made in compliance with the Health and Social Care Act (2008), while good relationships with staff have developed, and they now contact the team for advice on infection prevention and control. The development of clinical protocols and guidance has lead to some notable improvements in practice such as quicker identification of C. difficile and isolation of symptomatic patients.

Follow-up of cases where alert organism have been identified is more complete — for example, after root cause analysis, outcomes are shared with the relevant home and actions planned and completed to address gaps in practice. Relationships with key people in local authority and in larger care organisations have developed to help ensure a consistent approach to training, and we are looking at ways to work with commissioning to further support improvements in practice within care homes.

Financial implications
Providing a beneficial level of support within nursing and residential homes required significant additional staffing. Across the three PCT areas there are 150–160 care homes and eight additional staff were recruited. Some recommendations offered by the team to care homes to improve the environment and their practice have resource implications.

Contact
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Patients on research trials also generate alerts reinforcing the importance of palliative care. These alerts are tailored to each patient group to ensure that specific tumour sites receive alerts. For example, a patient who has recently finished chemotherapy could generate an alert to a specific hospital ward. The ward’s clinical nurse specialist (CNS) would receive an email informing them of the patient’s needs, and they could then make arrangements for the patient’s care. The CNS can advise staff of current treatment protocols, and this could help to minimise delays and ensure that patients receive appropriate care when they experience crises. The CNS can also inform A&E staff of the patient’s care plan and support them in making decisions about the patient’s care. The introduction of RAPA has been crucial for the initiative’s success. The system has been implemented in a flexible and adaptable way. For example:

- Alerts are tailor-made to each patient group to ensure they get the right care. Nurses use their time in the best possible way.
- Specific tumour sites receive alerts. This means that clinicians can focus on the patient’s specific needs.
- Palliative care patients are specified in alerts, supporting their wishes for end of life care.
- Patients on research trials also generate alerts reinforcing legislation on follow-up care.

Benefits

Ultimately, our cancer patients have a better experience as a result of the introduction of RAPA. The system has led to a reduction in the number of unnecessary tests being ordered and patients not receiving the right care at the right time. RAPA gives the CNS the opportunity to see the patient, inform A&E staff of the patient’s care plan and support them in making decisions about the patient’s care.

The initiative

In an emergency situation, time is precious. The introduction of emergency care plans for patients with long-term conditions minimises delays and ensures that patients receive appropriate care when they experience crises. They initiate and maintain a relationship between patients, long-term conditions teams and emergency care providers; support safe clinical decision-making.

The plans set out an agreed self-care plan for patients in addition to providing an effective means of communication between healthcare professionals who provide acute or ongoing care for them. Fundamentally, the aim was to ensure consistency in care and reduce inappropriate hospital admissions.

The project is a classic example of partnership working and it would not have succeeded without the commitment of patients, community matrons, ambulance staff, A&E staff and GPs. As it has evolved over the past 12 months, district nurses, secondary care consultants and social services have also become involved.

A pilot study was undertaken to test the effectiveness of the document on a small group of patients, which resulted in streamlining of the document with the final paper including allergies, medications, past medical history and baseline observations and contact details for health professionals. The plans have evolved over the past 12 months, district nurses, secondary care consultants and social services have also become involved.

Since its launch, approximately 400 emergency care plans have been issued. Work continues to ensure that all patients on a community matron caseload have a plan in situ. This phased approach was necessary to allow the time needed to develop individual emergency care plans, which involve collaboration with other professionals and full involvement of the patient.
Innovation in your specialty

Benefits
Early audit and feedback demonstrate a clear benefit to patients and improved partnership between healthcare professionals. Results and evaluation have shown a 70% reduction in the number of A&E attendees and a 16% reduction year to date in 999 calls, while subsequent emergency hospital admissions have been avoided.

Reviewing existing pathways, evolving services and improving ways of working across healthcare boundaries has facilitated a significantly improved service for both patients and healthcare professionals, while achieving local and national healthcare targets. Patients have a better understanding of what is normal for them, and of how to self-manage their conditions, the risk of prescribing errors is reduced as information follows patients when they need to attend hospital.

Contact
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FINALIST
Homeless intermediate care pilot project
Kendra Schneller, Lisa Burnard, Carmen Rojas, and Samantha Dorney-Smith; Lambeth Community Health

The initiative
The two primary aims of this initiative were to reduce mortality and morbidity in ex-street homeless clients residing at a 120-bedded homeless hostel in Lambeth, while reducing emergency and secondary care usage within this client group. Historically this St Mungo’s hostel has had high client morbidity and mortality on site. For example, in a survey undertaken in 2005, 93% of residents had a substance misuse problem, 61% had a mental health problem, 56% had a physical healthcare need, and 15% had had a recent hospital stay; in 2008 seven deaths occurred on site, at an average age of only 38 years. We also wanted to address inequalities in health service provision for the client group, and to develop a gold standard model of homeless intermediate care that can be replicated nationally.

Services are provided in a flexible, client-centred way; health assessment and care planning are truly holistic and address physical health, mental health, addiction and social problems. Funding was obtained from Lambeth PCT, initially for the one-year pilot. The project is staffed by a full-time clinical nurse specialist, a full-time health support worker (funded by the PCT and St Mungo’s) and a 4.5 hour on-site GP session each week. Initial service development included developing operational guidelines, criteria for referral, and publicising the project.

Residents are referred via joint in-house meetings involve all staff involved in client care. Due to the high levels of complex need the service was initially was made available to six patients, but this was later increased to 10. Length of admission is planned for 12 weeks, and includes an assessment phase for engagement, as well as a step-down phase preparing for discharge. Care is provided within the hostel environment, and can include personal and clinical nursing interventions and psychosocial support.

Benefits
The pilot project halved the number of A&E visits, and reduced the number of inpatient episodes in the hostel cohort by a factor of four. In four comparable hostels in the local area with no similar service the number of A&E visits increased in the same period, while the number of inpatient episodes increased in three of the four. The number of deaths at the hostel significantly reduced from seven the previous year to one.

Clients managed by the project significantly increased their SF-12 general health score, and their self-rated wellbeing thermometer score from the EQ-5D. Their level of nurse dependency also reduced.

Financial implications
The pilot project costs totalled approximately £100,000 (£50,000 nurse; £15,000 GP session; £15,000 50% funding health worker; £20,000 sundries), while management of the project probably amounted to a day a week of the manager’s time. The Guy’s and St Thomas’ Charitable Foundation provided £20,000 to fund independent analysis and write-up.

The Department of Health economist estimates that the project has saved nearly £100,000 in reduced inpatient costs, and £5,000 in reduced A&E visits. As such it has been cost-neutral with improved outcomes.

Contact
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FINALIST
Improving access to hepatitis C testing in injecting drug users within a needle exchange centre
Jan Tait, Brian Stephens and Sonya O’Keeffe; NHS Tayside

The initiative
Hepatitis C virus (HCV) infection is a major public health problem, with up to 80% of people exposed to the virus developing chronic disease. It is estimated that around 185,000 individuals in the UK are chronically infected, but as most are asymptomatic for years many are unaware that they are infected and therefore may unknowingly infect others. Although there is no vaccination for HCV there is an effective treatment which can result in clearance of the virus and prevent future complications.

Contact
For more information on this initiative please contact Sonya O’Keeffe: Sonya.Okeeffe@tayside.scot.nhs.uk
Diagnosing HCV in current injecting drug users has often proved challenging due to individuals’ reluctance to attend hospital clinics, lack of testing within drug services and difficulty obtaining a blood sample because of poor venous access. Dry blood spot testing (DBST) recently became available and is a robust and easy method of determining HCV status. With appropriate training it can be carried out by all staff working in drug services.

The introduction of DBST was commenced in August 2009 in a fixed needle exchange centre in Dundee. Staff within needle exchange services were given appropriate training — the majority were drug support workers who did not have a nursing or medical background. They were supported in implementing this by two hepatitis specialist outreach nurses. All individuals who accessed services were offered HCV testing and a follow-up appointment two weeks later; those who tested positive were offered a referral to hepatitis specialist services.

**Benefits**

Out of 361 individuals tested over an eight-month period 97 (26%) were diagnosed with hepatitis C; 337 of those tested (93.3%) attended a follow-up appointment for their results. A positive diagnosis gave staff the opportunity to reiterate appropriate harm reduction measures, and anecdotal evidence from staff reported that this had a positive impact on uptake of sterile injecting equipment; 79% of those with a positive diagnosis attended a follow-up appointment. A diagnosis also motivated some clients to seek referral to services for drug treatment. Interestingly, in some cases a negative diagnosis also resulted in improved uptake of injecting equipment as it removed their fatalistic belief that they were already infected and permitted staff to encourage them to examine their injecting practices.

The initiative has shown that DBST is easy to use, cost effective and can be carried out by staff within needle exchange services. The offer of HCV testing was well received by this particular client group, and the high rates of individuals returning for their results and for follow-up appointments suggest that providing hepatitis C testing is valuable in a group often envisaged as being too chaotic to engage with health services.

**Contact**

For more information on this initiative please contact Jan Tait: jantait@nhs.net

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**The initiative**

Portrait of a Life is a nurse-led initiative run by members of a life story network who worked with staff in different settings (including mental health services, acute hospitals and care homes) to promote the benefits of life story work and encourage its use. The team found that staff lacked the information, evidence and resources to take the work forward; we were also aware of the growing enthusiasm for this type of work and felt there was a need to increase understanding of its risks as well as its benefits. We felt that a resource pack/toolkit would be useful but there was no other multimedia resource available to support staff wishing to facilitate life story work, so we developed our own.

The multimedia toolkit primarily focuses on the needs of people living with dementia but also supports work with people with other needs such as depression. It is suitable for a wide range of users from inexperienced/junior staff to qualified nurses/occupational therapists as well as family carers or people wishing to carry out their own life story work, including those living with dementia. It consists of a training DVD (75 minutes), a written guide and resources to photocopy all in a handy A4 package and is designed to suit a range of learning styles and transferrable into a wide range of practice/educational settings.

The project team worked closely with people living with dementia, staff and family carers in developing the toolkit; we also collaborated with organisations and individuals who could contribute their skills and expertise to elements of the toolkit.

**Benefits**

The toolkit brings together, for the first time, evidence and information related to life story work, along with the practical approaches/guidance supporting staff in this area where there is growing interest/activity. Evidence suggested that life story work has many positive outcomes relating to improved wellbeing and quality of life including:

- Avoidance of medication such as anti-depressants and anti-psychotics;
- Improved scores on the mini-mental state examination;
- Reduction in carer stress and burden;
- Improved personhood and maintenance in community settings
- Improved family relationships.

Portrait of a Life is now implemented locally on the nurse training curriculum and the one-day training associated with the toolkit is commissioned locally for care homes and delivered to trust staff. Staff say the approaches within the toolkit are changing the culture of care from a monitoring to a person-centred approach, and are using the life story principles and practice as the foundation for delivering the highest standards of care. Levels of wellbeing are raised, quality of life is improved, and appropriate prescribing and drug reductions are positive outcomes that have delivered cost savings and efficiencies including reduced falls and drug interactions.

**Financial implications**

The initial funding to develop the toolkit was through a grant from the Mental Health Foundation, which provided £15,000 to cover the development of the filming for the DVD and other associated costs. The trust allowed staff time to develop the project running alongside team members’ existing roles, and funded the production of 1,000 toolkits post evaluation, as well as a launch event.

**Contact**

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HIGHLY COMMENDED

*Getting to Know Your Baby (The Social Baby)*
Christine Brace, Donna Carlyle, Paula Willerton and Julie Fraser;
Child and adult mental health service, South of Tyne and Wear PCT

The initiative
Secure attachment with their parents makes children more co-operative, empathic, socially competent, invested in learning and exploration, and self-confident. Supporting the parent-infant relationship promotes secure attachment. Recent developments in neurobiological research illustrate the importance of early life experience and the impact of child abuse and neglect.

In partnership with the community midwives, Sunderland's early years mental health specialists are delivering an antenatal, parentcraft group session called *Getting to Know Your Baby*, designed as an early preventive intervention to raise awareness of babies' social and emotional abilities. A volunteer parent offers peer support by talking about adjusting to parenthood and describing how they got to know their baby. The early years mental health service booklet *Getting to Know Your Baby*, is used to reinforce key themes.

Group discussion is encouraged and *The Social Baby* DVD and book provide a useful vehicle for parents-to-be to gain insight into the process of getting to know their baby. This innovative approach highlights that newborns are able to communicate with their parents. The session's overall aim is to help parents-to-be to reflect on forthcoming relationships with their baby.

Benefits
By raising awareness of the importance of early parent-infant relationships there are positive outcomes to be gained for children and young people. Our audit/service user evaluations are demonstrating positive outcomes.

Financial implications
There is a strong link between increased maternal anxiety and depression during pregnancy and impaired cognitive development in children and an increased risk of behavioural and emotional problems. By promoting secure attachments from the antenatal period and by taking a family systems approach we consider that postnatal depression and attachment disorders can be prevented. This has huge cost implications in terms of support services that are currently under pressure to meet growing demand. Early intervention reduces the need for access to tertiary and specialist services.

Contact
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FINALIST

*Achieving effective quality healthcare through clinical excellence*
Seraphim Patel
Central and North West London Foundation Trust

The initiative
As a nurse and clinical audit facilitator specialist I provide support mental health services in quality and service improvement initiatives. These are presented around seven strands: safety, patient experience, leadership, clinical effectiveness, prevention, technology and innovation. Initiatives I have facilitated in the last 12 months include:

- Developing a Driving with Dementia project in Harrow, which involved understanding patients' needs, undertaking a critical analysis of current services and creating a poster;
- Developing and implementing a Respect Privacy and Dignity audit in collaboration with staff and patients;
- Creating an e-bulletin in collaboration with nurses and the communication team, which involved preparing and assessing the current services and prioritising key features to be published supporting the readership and organisational core values;
- Developing clinical audit educational material for nurses;
- Developing and implementing an electroconvulsive therapy audit tool.

Benefits
Stopping driving has been documented to have several negative effects on older people, including loneliness, lower life satisfaction and depression. There has been considerable emphasis on safety but little on promoting independence; the poster allows patients and carers to explore alternative positive strategies and consider health and other benefits of not driving.

The Respect Privacy and Dignity audit measures patient care and compassion using selected appropriate questions, enabling services to improve patient care. Audit results were positive — patients found their concerns were listened to. An action plan has been implemented to sustain the improvements.

The e-bulletin keeps nurses and other professionals up to date with changes in the evidence base and shares good practice, raising standards of practice. The ECT audit has enabled the service to produce a proforma, ensuring relevant standards are recorded for patients undergoing this treatment.

Financial implications
Using current resources and working collaboratively saves cost. For example, when developing the poster I liaised with the communications team who produced it at no cost to our department. Using electronic systems to develop audit tools and capturing data saves cost, while the e-bulletin saves paper and printing.

Contact
For more information on this initiative please contact Seraphim Patel: seraphim@raphaeloftherosedesign.com

Nursing Times Awards 2010 Best Practice Report
**Mental health**

**FINALIST**

**Releasing time to care**

Kristin Jordan, Guto Davies and Eleri Davie; Hywel Dda Health Board

**The initiative**

One of the most common complaints made by nurses is that they want to spend more time caring for patients, and less on meaningless tasks. Releasing Time To Care (RTTC) uses lean thinking to streamline processes, making them more efficient and giving nurses more time to spend on direct patient care. It relies heavily on team engagement and effort and nurses on St Non ward embraced this challenge with enthusiasm.

Initially we measured how much time staff spent on routine tasks and direct patient involvement and how many times they were interrupted. These became the baseline against which improvements were measured.

We then looked at individual areas, examining their function and fitness for practice and undertook a workplace organisational process termed 5S: sort (eliminating non-essential items); set (organising necessary items); shine (regularly cleaning and maintaining the area); standardise (putting procedures in place); and sustain (audits to maintain improvements). All evidence collected was discussed as a team and we looked at what worked well in each area, and where we were wasting time. A suggestion board also gave all staff the opportunity to contribute ideas over the next few days.

We then assessed our ward round, admission process, medication round and meal times. The same structure was applied to each, with the emphasis being on safety and efficiency.

**Benefits**

The project identified weaknesses and inefficiencies in our systems, thus enabling us to save money by reducing the amount of medication, stock and laundry needed to meet day-to-day needs. This streamlined the ward environment, reducing time spent searching for equipment and stock.

Staff can spend more time with patients leading to better therapeutic relationships; changes in patient behaviour are noticed earlier and increased one-to-one time reduces aggression and agitated behaviour. Staff have set up a gardening project for patients to help to grow their own vegetables. Staff morale has increased and sickness levels are reduced. Patient’s families have also benefited as staff have more time to spend on direct patient care. It relies heavily on team engagement and effort and nurses on St Non ward embraced this challenge with enthusiasm.

**Financial implications**

Some notable successes include the ward being re-credited over £1,000 from returning excess medications, due to personal medication being used. We now use more generic stock to minimise wastage. Further savings have been made by rethinking the laundry system, and reducing the amount of stock and stationery ordered. Reduced sickness levels and use of bank staff to cover sickness has also saved money.

**Contact**

For more information on this initiative please contact
Guto Davies: Guto.Davies@wales.nhs.uk

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**FINALIST**

**Involving hard-to-engage service users in conference presentations and educational events**

Joe Forster; Mersey Care Trust

**The initiative**

The purpose of this initiative was to improve the involvement of detained service users with severe and enduring mental health problems in planning, designing and developing services. This was done by enabling service users themselves to elicit and publicise their needs instead of them being interpreted by professionals. It involved creating and maintaining measures to enable people with complex problems affecting their thinking and communication to present in person at meetings, conferences and other formal events where service development is discussed.

Our service users have severe and enduring mental health problems, are detained under mental health legislation and are unaccustomed to public speaking. Joe Forster developed support to overcome the barriers and enable them to speak for themselves. This entailed working with clinical colleagues to set up “complex escort” trips to get to conferences, working with service users to build their confidence in participating, and negotiating with event organisers to modify programmes and presenting styles to suit service users’ needs.

Eight service users have now co-presented at 10 significant events, including a trust board meeting, a national NHS estates conference, national mental health conferences, a local public health forum and a university module.

**Benefits**

Understanding service users’ real needs can make services more efficient as they engage with people more directly and effectively. This initiative has put service users centre-stage to advocate for themselves with a more powerful voice, bringing them into several forums where they would normally not have directly represented themselves.

Some have described becoming more confident and are proud of their achievements, while some have reported experiencing alternative ways of achieving satisfaction (rather than using street drugs for example), finding useful ways of contributing to society, and gaining self-esteem and status.

**Financial implications**

The costs of the initiative are relatively modest, entailing staff time, travel and subsistence, conference place fees, hourly payments to service users and so on. Potential efficiency savings from services learning how to be more responsive to users’ real needs are significant.

**Contact**

For more information on this initiative please contact
Joe Forster: joforst80@hotmail.com
The initiative
This project involved setting up a memory assessment and support service (MASS) in collaboration with the Alzheimer’s Society. It provides a single point of entry for new referrals with dementia/possible cognitive impairment irrespective of age, and a full diagnostic, treatment and support. The service aims to:

- Improve/provide local services;
- Improve pre and post diagnosis and offer continuous support;
- Reduce isolation through peer support;
- Promote awareness of dementia;
- Harness resources to maximise patient outcomes;
- Provide support in accessing benefits and legal advice.

Benefits
MASS provides a centralised, single point of access for all new referrals for the assessment of impaired cognitive functioning, and streamlined referral pathway. With the help of the Alzheimer’s Society the service is able to offer more meaningful support, explanation and communication with patients diagnosed with dementia and their carers. The service has also promoted awareness of dementia through distribution of information sheets and literature.

Financial implications
The service complies with the QIPP agenda by examining and reviewing new ways of working to enhance patients’ and carers’ experience. Service redesign can help to maximise the use of existing resources to add value to what we do, but MASS also clearly identified unmet needs. By pooling resources we have been able to produce consistently better outcomes. We are in discussions with our commissioners regarding increased activity.

Contact
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FINALIST
Memory assessment and support service
Vickie Glass, Michelle Thompson, Beverley Abbott and Naushad Nojeeb;
North Essex Partnership Foundation Trust

The initiative
Aeromedical evacuation (AE) is a prime responsibility of the RAF Medical Services (RAFMS). It deploys AE personnel to provide a transfer injured or ill patients by air in the fastest, safest, and least stressful way. Patients requiring mental health AE may be serving military personnel, United Nations staff or civilians.

Mental health AE is organised through the AE control cell at RAF Brize Norton. Three mental health nurses based at RAF Lyneham are dedicated to this worldwide service, augmented by RAF mental health nurses throughout the UK spending one-week periods on call. Personnel strive to deliver gold standard nursing care, albeit within the constraints of time and austere environments. This is the primary role of mental health nurses in the RAF and they complete six weeks of intense training before undertaking missions. Since they may also escort patients with medical problems or injuries, a broad skill set is needed.

Mental health AE is essential to ensure the seamless transition of vulnerable patients to an appropriate environment for further assessment and treatment. Each case is individually assessed and an escorting team may also include a medical assistant and doctor, depending on the level of risk and medication required.

It is often necessary to transfer patients on aircraft with critically ill patients, perhaps from the same unit, which may exacerbate their problems. The therapeutic skills of the mental health nurse are essential in continual management during transfer.

Benefits
The health and wellbeing of military personnel is vital to maintain a steadfast defence service. Exposure to challenging and traumatic situations can have an adverse effect on mental health. Those detached to benign areas, such as the Falkland Islands, are not exempt from stress — separation from support networks, increased working hours and unfavourable working conditions present their own problems.

Financial implications
For this service to be second to none, the cost implications can be great. However, this is balanced against the wellbeing and recovery of our greatest assets, our people. The service strives to work in the most cost-effective manner, always ensuring that patient and staff safety remains paramount.

Contact
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FINALIST
Royal Air Force Mental Health Aeromedical Evacuation
Lyndsay Atkinson, Simon Lynn and Adele Phoenix;
Royal Air Force
Nursing and technology

HIGHLY COMMENDED

Putting the Mental Capacity Act on the map
Kate Isherwood, Chris Sayer and Madeleine Peters;
Hywel Dda Local Health Board

The initiative
Making Mental Capacity Act (MCA) legislation meaningful to staff in clinical practice was proving a challenge despite considerable efforts in respect of training and intranet based resources. Although awareness of the Act had increased, audit showed that application in practice was variable and many staff lacked confidence in this.

We identified the need for an accessible way to support professionals and decided to use an existing resource in a different way. We used the Map of Medicine to create MCA pathways to help health professionals support patients who may lack capacity to make decisions for themselves or whose care necessarily involves a possible deprivation of liberty. The work was undertaken in collaboration with Swansea University.

Nurses worked with Richard Griffith (senior lecturer in healthcare law, Swansea University) to create an algorithm representing key MCA processes. The pathways contain fully referenced extracts from the Act’s codes of practice to assist decision-making on each step of the processes, along with links to other resources.

Benefits
The user-friendly layered format of the pathways provide a ‘one-stop shop’, providing basic guidance as well as detailed, specific information like case law. They are the most visited map pathways for our healthcare community. Staff interviews indicate that using the pathways has informed the way they have supported patients where there were doubts about capacity. For example, discussing a patient with learning disabilities having chemotherapy one said: “The pathway is really excellent. We proved he had capacity to decide for himself.” Using it when considering accommodation change for a service user another said: “I used the pathway because I wasn’t sure who should be ‘decision maker’ or quite how to go about determining his best interests. It was great — I know what I’m doing now!”

Financial implications
The main benefit is a better patient experience, but the increasingly litigious context within which nursing care is delivered means unlawful treatment represents a considerable clinical risk. We feel that better informed nurses will help to avoid complaints and litigation. Over time the development of local expertise may reduce reliance on external sources for case guidance.

Contact
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FINALIST

Nurse-led optical coherence tomography scanning for lucentis service
Elizabeth Hughes, Manoj Kulshrestha and Mia Lewis;
North Road Eye Clinic

The initiative
Wet age-related macular degeneration is one of the most common conditions causing blindness in this country. It is treatable by ranibizumab, given by intravitreal injection. Patient assessment as to whether therapy is needed is undertaken by retinal scanning using optical coherence tomography (OCT). This is carried out monthly for a minimum of two years. There are 200 patients in our service undergoing this treatment who need monthly follow-up with OCT.

When the ranibizumab service was introduced in our region a doctor or photographer carried out OCT scanning. Employing a photographer cost £1,000 per clinic, while doctors are busy seeing other patients. Nurses were therefore trained to carry out OCT scans by the consultant ophthalmologist in a practical three-hour training session followed by lectures, and demonstrations from OCT company reps. Once all nurses in ophthalmology outpatients were competent to carry out OCT under supervision, nurse-led OCT clinics were set up alongside general ophthalmology clinics.

Scans taken by nurses are shown to the consultant in the general clinic, who decides whether the patient needs a ranibizumab injection. This allows the consultant to make decisions on up to 15–20 patients, and at the same time see up to 15 general ophthalmology patients. Nurses also check logMAR visual acuities in clinic, allowing monthly assessment of vision for these patients.

This initiative has allowed us to continue all general ophthalmology work alongside a nurse-led OCT clinic; it has increased our capacity, incorporating 200 additional patients a month on top of our normal workload.

Benefits
Nurses have enhanced their skills, enabling them to become more involved in the care of the patients using the latest technology to undertake technical retinal scanning, which they enjoy. The trust does not have to employ another doctor or photographer to do the job, which saves significant costs.

Financial implications
There are significant cost savings associated with using nurses to carry out OCT scanning. Employment of an ophthalmic photographer cost up to £1,000 per clinic.

Contact
For more information on this initiative please contact
Manoj Kulshrestha: manojkulshrestha@aol.com
**FINALIST**

**Development of the Electronic Birth Book**
Denise Horsley, Hilary Asl and Chris Winter; NHS South of Tyne and Wear

**The initiative**
The details of preschool children are routinely handwritten in health visiting birth books. Because this data is registered manually, its extraction is subject to delays, errors, duplications and inconsistencies. For instance, finding out how many smoking households health visitors come into contact with involves searching birth books for approximately 30,000 children across Gateshead, South Tyneside and Sunderland and preparing tally sheets.

In order to improve efficiency, an electronic system was introduced in 2009/10. This contains demographic and health information for every preschool child within the three PCT areas and can provide data at a range of levels including individual caseload, team, service, neighbourhood or GP practice. Such data can inform service and workforce planning; facilitate the development of community profiles; provide evidence of our contribution to meeting public health targets; support information governance requirements and CQC standards; and give commissioners evidence of health visiting outcomes.

We developed and tested a template on an Excel spreadsheet, which evolved into the birth book in its current format. Those involved in the development then supported its implementation by training staff. Team birth books are stored on a shared drive. Each team can only access their own birth books but the modern matrons and business manager responsible for children’s services can access all birth books for monitoring and reporting.

**Benefits**
The initiative has allowed more effective workload planning at individual and team level. Allocation of workload is fairer as health visitors have access to the total numbers of clients on their caseload and teams can see where particular pressures lie.

The electronic birth book also supports the identification of service gaps — for instance, a high teenage pregnancy rate in a neighbourhood could indicate the need for a more integrated approach to service delivery to reverse this trend. It can be used to generate, process and report a wealth of information, and could be used to assist with school enrolment and transfers of cases within and outside the area.

**Financial implications**
The only costs have been associated with staff time to develop and implement the tool. While all staff need access to computers, this was already part of the wider strategy.

**Contact**
For more information on this initiative please contact Denise Horsley: denise.horsley@sotw.nhs.uk

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**FINALIST**

**Falls prevention and management in primary care**
Joy Kelly, Julia Bradbury, Sue Evans and Jill Pinington; NHS Tameside and Glossop

**The initiative**
The aim of the project was to develop a comprehensive integrated strategy to reduce and manage inpatient falls at Shire Hill Intermediate Care Unit (SHICU). It has brought many disciplines together resulting in a workable, holistic, patient-centred strategy that includes the use of assistive, sensory technology and has significantly reduced the number of falls.

Falls is a complex area especially in a setting like Shire Hill. Patients present with a wide range of functional abilities. The project was developed in line with the National Service Framework for Older People, NICE guidelines and NHS Litigation Authority standards. Expert advice on risk assessment and clinical governance was sought, and incident forms were analysed to establish trends and provide a baseline.

Falls categorisation was revised to further inform audits and care, and emerging trends were analysed, such as times when falls were more likely to happen. Unit practices and activities at these times were observed and analysed to inform practice.

Staff surveys and process mapping sessions were conducted; visits to other units undertaken; documentation revised; and Chubb engaged to fit sensory equipment. Training sessions were and continue to be conducted regularly, together with staff awareness sessions. Falls champions were identified, and regular audits analysed and fed back to staff.

**Benefits**
In April 2008, the number of falls stood at 19 per 1,000 bed days; this has reduced by 30% to 12.6 per 1,000 bed days. Evidence suggests that an older person is more likely to fall a second time than to fall in the first place. Audit results show that in 2009 80% of patients who fell were prevented from falling again.

It is accepted that the risk of falls can never be completely eliminated. However many of the avoidable and reversible factors both intrinsic and extrinsic which impact on a person’s risk of falls have been addressed, improving care and patient safety.

**Financial implications**
Apart from the initial £14,000 purchase of the sensory equipment and pendants and minimal in-house maintenance, there is little financial cost. Ongoing training is provided by staff and the falls champions.

**Contact**
For more information on this initiative please contact David Bourque: david.bourque@nhs.net
**HIGHERLY COMMENDED**

**Dignity for all**

**Juliet Miller, Margaret Harries, Sue Atkins and Louise Denner;**

University Hospitals Birmingham Foundation Trust

**The initiative**

The dignity in care team was set up to ensure that patient dignity was at the heart of everything we did as a trust. We aimed to recruit champions across the trust who would promote dignity, develop patient centred services, be sensitive to the needs of our most vulnerable patients and challenge unacceptable attitudes and care. The project was based on the national Dignity in Care campaign and built on our existing older people’s champions project.

Staff launches take place each year highlighting the project for the following year, as well as patient/public launches with comment slips for patients and carers to record whether they have been treated in a dignified way in our inpatient and outpatient settings.

There are champions on every ward and department within the organisation. They act as a conduit for any changes in policy or procedures that could be associated with dignity.

Champions attend a series of workshops which include the fundamentals of care. They also cascade information and training to their team and return action plans; complete the annual dignity benchmarking; receive a monthly newsletter; and are invited to the annual birthday celebration and conferences to highlight good practice. An intranet site is being developed to provide information. A successful workforce development bid enabled the trust to employ two dignity nurse educators who train staff, manage key projects, carry out audits, support individual champions with audits and action plans and assess their progress and impact using dignity rounds.

**Benefits**

We are addressing the needs of all patients, but particularly those who are most vulnerable — frail older people, those with dementia and delirium, people with learning and physical disabilities, and military patients with polytrauma. Dignity in care is embedded within the organisation, even junior staff feel empowered to make suggestions that would improve the quality of care and challenge any practices that could be seen as undignified. There is a clear structure within the organisation to address dignity issues as well as a clear mandate to take action.

**Financial implications**

Much of what we do is about challenging the way we provide care and the attitudes of our staff. We have applied for funding from our trust charity and through workforce development to provide dignity educators, funding for our annual dignity conference and a specialist Ability not Disability toolkit for every ward and department to aid communication in emergency situations.

Contact

For more information on this initiative please contact
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**FINALIST**

**Development of the Nursing Assessment and Accreditation System**

**Fiona Gratrix, David Melia and Helen Carter**

Salford Royal Foundation Trust

**The initiative**

The **Nursing Assessment and Accreditation System (NAAS)** is a document designed to help nurses in practice by measuring and monitoring the quality of care they deliver. It is based on the trust’s Safe, Clean and Personal approach to service delivery and combines key performance indicators and Essence of Care standards. The framework is designed around 13 standards, each subdivided into elements of environment, care and leadership.

The assessment consists of observing care, reviewing nursing documentation, asking staff and patients pertinent questions and observing meal time delivery. Wards are assessed on a traffic light system:

- Red wards, which fail five or more standards, are reassessed in two months;
- Amber wards, which fail three or four standards, are reassessed in four months;
- Green wards, which fail two standards or below, are reassessed in eight months.

If their application is successful, wards gain SCAPE status – Safe, Clean and Personal Every time. This allows the ward manager to become a ward matron and have total autonomy of the ward.

Unannounced ward assessments take place mid-morning with the NAAS lead observing staff’s practice. The ward receives immediate feedback, and the NAAS lead returns the following day to give formal feedback to the ward manager. All wards complete an action plan, which is disseminated to the whole nursing team.

All wards within the trust have been initially assessed, and the cycle is ongoing. The NAAS is embedded into the trust’s culture from service reviews to executive safety walk rounds.

**Benefits**

The introduction of the NAAS has given ward managers a clear indication of what the trust expects their priorities should be. It assesses their performance on fundamental care issues, such as patient dignity, while reviewing how effectively the ward is managed. The scheme gives a clear indication of the quality of nursing within the trust – the board is aware of green, amber and red wards within the hospital. Wards that have initially been assessed at red or amber have improved patient care to become green, while those showing no improvement are closely monitored and the ward manager’s performance is closely monitored and the ward manager’s performance is...
Patient dignity

reviewed. This has led to one manager being removed from post after consecutive poor performances.

The NAAS examines how effective the leadership of the ward is, and provides significant evidence for the relevant regulatory bodies; a framework on which wards can build to achieve SCAPE status; and a real time patient feedback on specific questions.

Financial implications

The financial implications involve employing a full-time NAAS lead. This is a senior nurse with the relevant professional experience and authority to produce change. The NAAS works in collaboration with other trust-wide quality initiatives to safely reduce costs, and helps to standardise practice.

Contact

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FINALEST

Bright ideas — the light weight red jug and beaker scheme

Jason Manning, Sharon Brierley, Nicky Makepeace and Nicola Firth
Stockport Foundation Trust

The initiative

The aims of this initiative were to improve nutrition and hydration for patients on a fractured neck of femur ward; improve their dignity and independence; and prevent weight loss. Doing this would also reduce their length of stay. The majority of patients on the ward are older and frail, and at increased risk from the effects of malnutrition and poor hydration. These include: muscle wasting; pressure ulcers; falls; and infections.

Patients needing help with nutrition and/or hydration are identified using the malnutrition universal screening tool (MUST) within 24 hours of admission. We already used the red tray system to highlight patients needing help with feeding and wanted to incorporate lightweight red water jugs and beakers to highlight those needing help with their fluid intake.

After securing £500 funding from the Bright Ideas fund, which is part of the Department of Health’s Dignity in Care campaign, we purchased the jugs and beakers, and introduced a new fluid balance chart which identified patients using the jugs. A questionnaire was devised to get feedback on the jugs and beakers from patients and relatives, and observed patients using them to check they were being used successfully.

Benefits

The initiative has enabled some patients who previously needed help to pour their own drinks and hold the beakers themselves. At one point we had 12 patients out of 17 identified using the red jugs and the red tray system.

The ward staff feel more confident in looking after the patients, and the quality of care has improved as staff are more aware of the patients needing help with their fluids. This reduces the number requiring cannulation to receive intravenous fluids than before the initiative.

Also we have some wonderful volunteers trained in feeding patients, who come on to the ward at meal times to help with feeding. They say the red jugs and beakers make them more aware of the importance of helping patients to drink. Another benefit is that patients’ relatives feel more involved knowing that they also can help by encouraging them to drink more fluids.

The funding had given us enough money to purchase more jugs and beakers for the rehabilitation ward, where the majority of our patients move to. This has improved the continuity of their care.

Financial implications

The money from the Bright Ideas grant paid for the implementation of the jugs and beakers for two wards. If other wards and trusts were able to purchase these jugs and beakers to highlight those vulnerable patients who need help with fluid intake these patients’ of the complications associated with inadequate hydration, and therefore their length stay. This would save the NHS millions.

Contact

For more information on this initiative please contact Sharon Brierley: sharonbrierley3@ntlworld.com

FINALEST

A trust wide approach to promoting dignified care in mental health and learning disability services

Sandra Anderson, Malcolm Allen, Joan Breckon and Corinne Aspel
Tees, Esk and Wear Valleys Foundation Trust

The initiative

Primary care trusts have been required to work with acute trusts to deliver substantial reductions in the number of patients sharing sleeping or sanitary accommodation with members of the opposite sex. In our trust it was reported that by 2010 90% of inpatients would be accommodated in single rooms, most of which have ensuite facilities. It was therefore important to ensure that the care they received also contributed to them having a private and dignified care experience.

The key aims of this initiative were to:

• Provide evidence of compliance with single sex standards via trust wide privacy and dignity environmental audits across nearly 200 sites;
Collect real-time patient experience data through surveys.

Having essential services available 24/7 to all those who need them.

Increase the profile of privacy and dignity throughout the organisation.

Making end-of-life care training available to care home staff.

Ensuring carer's needs are appropriately assessed and managed sensitively.

Setting up effective mechanisms to identify people approaching the end of life.

Ensuring people approaching the end of life are offered a comfortable and suitable environment.

A training package was developed and delivered to over 760 staff in six months; this included DVD clips that used dark humour to illustrate poor practice and stimulate debate. All issues raised in training are collated and a report is compiled to identify key concerns in relation to delivering dignified care.

Benefits

The trust declared compliance with the Delivering Same Sex Accommodation standards in March 2010. Audits demonstrated areas for improvement and all remedial work required has now been completed. This ensures that patients experience care in a comfortable and suitable environment.

Raising the public profile of privacy and dignity across the trust stuck a chord with most staff and they evaluated the training well. Training allowed staff to discuss difficult issues associated with delivering private and dignified care, for example when carrying out enhanced observations or in restraint situations. It also gave them the opportunity to consider how these can be managed sensitively and effectively.

Financial implications

The Delivering Single Sex Accommodation fund awarded £17,000 to implement the initiative, while remedial works were funded from capital budgets. There are no ongoing running costs. An e-learning package has been developed and all materials used in the initial training programme, such as DVDs, presentations, posters and supporting resources are now available for loan from trust libraries.

The lead senior nurse managing the project is now the trust lead for patient experience working alongside complaints and PALS. This will ensure that privacy and dignity remains at the core of how we deliver services.

Contact

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

The initiative

This initiative followed the identified need to enhance the care given to residents in care homes across the borough of Hillingdon as they approached the end of their life.

A scoping exercise undertaken to establish how many deaths occurred in nursing homes and how many in hospital found that of 206 deaths, 119 (58%) occurred in the nursing home and the remainder in hospital.

Research has highlighted the potential value of developing links between specialist palliative care teams and care home staff, to promote high quality, comprehensive end of life care. This project was set up to train care home staff to use end of life care tools, leading to the implementation of a management plan for each patient identified as nearing the end of life.

The aim was to improve the quality of care provided for all residents approaching the end of life and reduce hospitalisation, enabling more to die with dignity in the home, if that is their wish.

This involved the following:

- Developing an action plan for the delivery of high quality end of life care for patients with all diagnoses;
- Setting up effective mechanisms to identify people approaching the end of life;
- Ensuring people approaching the end of life are offered a care plan and that any preferences and choices they express are documented and communicated to appropriate professionals;
- Ensuring carers' needs are appropriately assessed and recorded;
- Setting up mechanisms to ensure care is co-ordinated across organisational boundaries;
- Having essential services available 24/7 to all those approaching the end of life;
- Making end of life care training available to care home staff to increase their confidence in caring for patients at end of life.

Benefits

From data available to March 2010, 355 care home patients were identified as having a limited prognosis, and all were given a management plan. It is known that 270 of the patients have died: 260 in their preferred place of care, with just eight being admitted to hospital.

One impact of this work has been an improvement in documentation and record keeping; of 14 participating nursing homes, 11 had project documentation available. Home managers have written to the team stating how beneficial they have found the education — it has also been effective in retaining staff.

There has been interest from other professionals including dietitians, rapid response and speech and language therapists who have identified their own issues with care homes. Individuals have been invited to join the team’s regular care home meetings.

Financial implications

The financial implications of this project would be measured in terms of cost savings associated with reducing admissions from care homes into the acute hospital setting at end of life. Before the project 41% of patients died in the acute sector; to date this has been reduced to less than 5%.

Contact

For more information on this initiative please contact
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The patient pathway: making quality count

HIGHLY COMMENDED
Management of early pregnancy loss — a collaborative approach to a seamless pathway of care
Maggie Coleman, Jacqui Rutter and Rachel Jones;
Heart of England Foundation Trust

The initiative
This project was led by the gynaecological nursing team in collaboration with healthcare professionals from all involved disciplines. It aimed to streamline the care pathway for women suffering early pregnancy loss, which had often been fragmented and not conducive to their emotional needs. These women receive care from many disciplines from presenting at their GP or A&E to discharge from hospital. Poor communication between disciplines led to delays in care; patient experience was poor and key quality indicators and guidelines were not being met. We needed to address these issues and ensure these emotionally vulnerable patients experienced a seamless care pathway. Areas of concern throughout the pathway were:
• Poor referral processes with a lack of coordination;
• Lack of availability of scan appointments — this often led to women waiting over 48 hours;
• Lack of bed availability, resulting in delayed treatment;
• Lack of privacy for those requiring admission;
• Lack of theatre space for those requiring surgical management resulting in increased hospital stay;
• Lack of coordination between disciplines.
A working group was set up to include representatives from all involved disciplines. Referral processes were streamlined with the use of a dedicated telephone number. Deficits in care were addressed by expanding nurses’ roles in scanning, venepuncture and gynaecological examinations. A new pathway was developed for women requiring surgical management. A preoperative assessment process was introduced and a side room was made available exclusively to women suffering from pregnancy loss.

Benefits
Communication and referral pathways between disciplines improved, while a one stop clinic meant women could be seen within 48 hours. This reduced A&E attendance and increased day case surgical and medical management. A guaranteed theatre slot first thing in the morning allowed for early, same day discharge.

Financial implications
The biggest expense was training the clinical nurse specialist in ultrasonography. This was funded from the directorate’s staff development budget. Other nurse training was provided in-house with the introduction of a competency package. The single room decoration was paid for from a charitable fund. HCAs were trained in phlebotomy and taking swabs, and they took on clerical duties to ensure accurate data input for clinical coding and audit. Reduced overnight stay and admissions have led to cost savings.

Contact
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FINALLIST
Reducing caesarean section rates using organisational change – The Blackpool Way
Pauline Tschobotko, Julia Thompson, Kashier Mulgabal and Barbara Ellison;
Blackpool, Fylde and Wyre Foundation Trust

The initiative
In 2006/07 at 28% the caesarean section rate in Blackpool was the highest in the north west. The trust was keen to see this improve, from the perspectives of patient experience, quality, safety and cost. The initiative was linked to the trust’s organisational strategy, The Blackpool Way, which focuses on effective employee engagement and high performance. As a result of changes in the organisational culture and a focus on normalising births, the caesarean section rate has fallen and we have increased the rate of vaginal births after caesarean (VBAC).

The trust has worked hard to normalise the birth environment, replacing beds with couches and beanbags and adding baths to en-suite rooms to help with non-pharmacological pain relief in labour. Staffing levels were increased to meet national standards and enable midwives to offer one-to-one care in labour. A key change has been the introduction of a Situation, Background, Assessment, Recommendation (SBAR) board on which midwives and obstetricians write information relevant to each patient in the delivery suite. This provides a structured communication system and gives more junior staff a way of making themselves heard. Although they initially greeted the SBAR boards with scepticism, staff quickly realised their value and the system has been extended to handover between shifts and between wards, while other parts of the hospital are now adopting it.

Contact
For more information on this initiative please contact Jacqui B Rutter: jacqui.b.rutter@heartofengland.nhs.uk
The patient pathway: making quality count

Benefits
A 4% reduction in the caesarean section rate equates to 82 fewer babies born by caesarean section each year, improving patient care and safety while saving costs. Local patient satisfaction surveys have demonstrated a significant improvement in satisfaction with maternity care. Reduced lengths of stay following birth has enabled the service to manage the increasing birth rate with no adverse effects on women and their families.

Financial implications
The initiative incurred no financial costs as it was achieved through staff enthusiasm and commitment to improving patient care. The reduction in caesarean sections has made significant savings — normal delivery costs £752 compared with £1,100 for a caesarean; 82 fewer of these procedures has therefore saved almost £29,000.

Contact
For more information on this initiative please contact Pauline Ts chobotko: pauline.ts@live.co.uk

FINALIST
Rapid improvement event to improve the patient pathway for patients admitted with abdominal pain
Joanne Coleman, Debbie Wright, Dawn Roberts and Paul Moss;
Gateshead Health Trust

The initiative
This one-week rapid improvement event aimed to establish an improved seamless journey for patients attending hospital with abdominal pain, from the A&E department through admission to the ward, to discharge. We gathered information on admissions, and collected patient stories and ideas from ward staff.

The patient journey averaged 48 hours and every person admitted with abdominal pain had an ultrasound scan. There were a number defects in patients’ journeys including the length of time kept nil by mouth, or waiting for a scan, analgesia or medical review. The team also looked at how long it took nurses to complete admission paperwork.

Benefits
Requests for ultrasound are now completed when a patient arrives at A&E rather than when admitted to the ward. The ultrasound department has a number of emergency slots available and patients are allocated one immediately. When they are admitted to the ward the nursing staff now have all the paperwork ready.

The ward has four assessment beds allocated for patients with abdominal pain; this ensures they receive the appropriate medical reviews and have a seamless pathway. A care standard has been developed to ensure no one is nil by mouth for longer than necessary and that patients receive appropriate hydration if necessary. Length of stay has been reduced from an average of 48 to 22 hours, while patients also have a care plan within four hours of admission. The amount of nursing steps to admit patients with abdominal pain has been reduced.

Contact
For more information on this initiative please contact Joanne Coleman: joanne.coleman@ghnt.nhs.uk

FINALIST
Annual Health Checks for people with learning disabilities
Katy Welsh and Lorraine Youdle;
Devon Partnership Trust

The initiative
Whilst the white paper Valuing People set out to address the inequalities faced by people with learning disabilities, there is still some way to go in healthcare. People with learning disabilities often have poorer health outcomes, uptake of health screening and access to treatment in primary care than the general population.

This project aimed to address the issue of quality and focus on the experience of people with learning disabilities having an annual health check. This was achieved by engaging with people with learning disabilities to develop a questionnaire.

We engaged with local self-advocacy groups to explore what people with a learning disability thought about going to the doctor or nurse for a health check. Having established the need to find out more, we developed a questionnaire. The learning disability lead within the strategic health authority offered financial support which enabled us to contact the university for help in gathering and interpreting data. The questionnaire was finalised and made into an ‘easy read’ document.

Over three months, 62 people with learning disabilities were interviewed about what they thought about their annual health check. It demonstrated clearly what they liked and disliked.

Benefits
The main benefit has been for people with learning disabilities to have had the opportunity to express their opinions about their annual health check. This has helped us to identify good practice and feed this back to primary care and to address any problems locally.

Financial implications
The project required £3,000.00 funding to allow the 62 people to be interviewed using the questionnaire and also included the interpretation of the data.

Contact
For more information on this initiative please contact Katy Welsh: kathy.welsh@nhs.net
Introducing a Health and Social Care Team for end of life care
Sue Pender, Sally Jackson, Elaine Harrison and Angie Orr;
City Health Care Partnership

The initiative
The end of life care pathway respects patients’ wishes for the preferred place of care, yet locally less than 20% of people with advancing illness appeared to be achieving their wishes. In 2007 we surveyed perceptions of community services locally and why end of life care patients were not discharged to their preferred place of care.

The key message was that patients/relatives wanted a flexible service offering capable/caring carers, 24/7, which could respond to the needs of that particular day. We aimed to introduce responsive and accessible team, delivering health or social care as needed, irrespective of diagnosis.

Before introducing the service we held a stakeholder event to map out the needs of end of life care patients in the community and, importantly, the gaps. Induction of new staff was based on the Skills for Health Council’s competency framework. All staff undertake placements within the hospital and hospice.

The service was launched in June 2009 and we undertook an evaluation of its first three months, which included qualitative feedback from patients and bereaved carers. After the evaluation we implemented a number of changes including staggered shift start times, and recruiting additional part-time staff. After an audit of its first year commissioners agreeing to redeploy funding from other continuing care area into the service.

Benefits
Staff report high levels of job satisfaction, feeling they have the time and skills to deliver care while respecting the wishes of the dying person. Referrers report speed of response from request to decision making (our standard is two hours but we aim to give immediate response). We are overwhelmed by compliments from service users, for example: “They were like a breath of fresh air. We both looked forward to their visits. Not one of the staff left the house without asking after me” Mrs MB bereaved relative.

Financial implications
This service was implemented to address ‘gaps’ within community care, provide additional carers and drive up the quality of care rather than to save money. However analysis of our expenditure has generated interest from our commissioners in terms of our cost effectiveness and their intention to save the local NHS end of life care expenditure.

Contact
For more information on this initiative please contact
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Emergency care plan: a valuable patient pathway for long-term conditions
Cathryn James, Angela Harris and Janet Walshaw;
Kirklees long-term conditions team/Yorkshire Ambulance Service

The initiative
In response to government drivers for patient-centred care, providing care closer to home and improving choice and personalisation for patients with long-term conditions, this project involved partnership working to develop and implement an individualised patient emergency care plan.

The aim was to:
- Agree a care plan with patients, identifying signs of deterioration in their condition and appropriate actions;
- Enhance communication between the ambulance service, community matron team and secondary care;
- Provide essential information for ambulance staff to help them to manage patients with long-term conditions, including hospital avoidance.

A pilot study was undertaken to test the effectiveness of the document on a small group of patients, after which it was streamlined. The care plan was introduced through roadshows at three of the main hospitals within Kirklees. This provided an opportunity to network across disciplines, launch the document to as many staff as possible and raise awareness of other community matron initiatives.

Benefits
This whole process has improved communication and networking across healthcare boundaries. This has proved extremely valuable for the community matron teams at a time when the value of the role in co-ordinating complex case management is high on both local and national healthcare service specifications.

These preliminary findings have shown that some patients have been safely and appropriately managed at home, when previously they would have been taken to hospital. This change to practice has resulted from improved awareness among staff of each other’s roles and particularly the role of the community matron in the management of long-term conditions. It has also led to significant improvements in communication between disciplines and across healthcare boundaries.

Financial implications
The initiative has had a range of financial benefits including a reduction in bed days for those in target group, a reduction in A&E attendances and a reduction in 999 calls.

Contact
For more information on this initiative please contact
Angela Harris: angela.harris@kirkleeschs.nhs.uk
HIGHLY COMMENDED
Reducing caesarean section rates using organisational change — The Blackpool Way
Pauline Tschobotko, Louise Dowell and Nicola Parry; Blackpool, Fylde and Wyre Foundation Trust

The initiative
In 2006/07 at 28% the caesarean section rate in Blackpool was the highest in the north west. The trust was keen to see this improve, from the perspectives of patient experience, quality, safety and cost.

The initiative was linked to the trust’s organisational strategy, The Blackpool Way, which focuses on effective employee engagement and high performance. As a result of changes in organisational culture and a focus on normalising births, the caesarean section rate has fallen and we have increased the rate of vaginal births after caesarean (VBAC).

The trust has worked hard to normalise the birth environment, replacing beds with couches and beanbags and adding baths to ensuite rooms to help with non-pharmacological pain relief in labour. Staffing levels were increased to meet national standards and enable midwives to offer one-to-one care in labour.

A key change has been the introduction of a Situation, Background, Assessment, Recommendation (SBAR) board on which midwives and obstetricians write information relevant to each patient in the delivery suite. This provides a structured communication system and gives more junior staff a vehicle for making themselves heard. Although they initially greeted the SBAR boards with scepticism, staff quickly realised their value and the system has been extended to handover between shifts and between wards.

Benefits
A 4% reduction equates to 82 fewer babies born by caesarean section each year, improving patient care and safety while saving costs. Patient surveys have demonstrated a significant improvement in women’s satisfaction with maternity care, while reduced lengths of stay have enabled the service to manage the increasing birth rate with no adverse effects on care.

Financial implications
The initiative incurred no financial costs as it was achieved through staff enthusiasm and commitment to improving patient care. The reduction in caesarean sections has made significant savings — normal delivery costs £752 compared with £1,100 for a caesarean; 82 fewer of these procedures has therefore saved almost £29,000.

* This initiative won the Improving Maternity Services award and was highly commended in the Patient Pathway award.

Contact
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HIGHLY COMMENDED
Using a Recurring Admission Patient Alert to improve care for patients with cancer
Sinead Kenny, Megan Stowe and Sheran Oke
Imperial College Healthcare NHS Trust

Background
Recurring Admission Patient Alert (RAPA) is an automated alert system that sends an email to the clinical nurse specialist (CNS) when a known cancer patient attends A&E. Before its introduction patients were often admitted without the multidisciplinary team knowing, which can lead to a poor patient experience, unnecessary tests and patients not receiving the right care at the right time. RAPA enables the CNS the to see the patient, inform A&E staff of the care plan and support previous care decisions.

The project manager and CNSs worked closely to determine opportunities for using RAPA, and the system was implemented in a flexible and adaptable way. For example:
- Alerts are tailor-made to each patient group to ensure nurses use their time effectively;
- Specific tumour sites receive alerts;
- Palliative care patients are specified in alerts, supporting their wishes for end-of-life care;
- Patients on research trials also generate alerts reinforcing legislation on follow-up care.

Benefits
Ultimately patients have a better experience because they see a familiar face when visiting A&E. Care plans and clinical decisions are maintained, while unnecessary admissions are avoided, decreasing non-elective length of stay.

RAPA presents a great opportunity to develop out-of-hours care, and create patient lists to suit a changing or challenging population. An example of a further potential improvement would be a neutropenic sepsis alert; patients receiving or just finishing chemotherapy could generate an alert to a specific nurse, giving them instant access to the appropriate care. In addition, an extension could be built on the RAPA software to enable CNSs to measure and demonstrate how their time has been spent supporting patients.

Financial implications
By reducing length of stay through use of RAPA, we have an estimated saving of £28,600 in bed days just for non-elective lung cancer patients over one year (130 days saved at £220/day). It is difficult to quantify the saved costs of avoided unnecessary tests such as X-rays and blood profiles.

* This initiative won the Nursing and Technology award and was a finalist in the Innovation in your Specialty award

Contact
For more information on this initiative please contact Megan Stowe: megan.stowe@imperial.nhs.uk
Patient safety improvement

FINALIST

Improving the door to needle time for febrile neutropenia
Angela Allsop, Marilyn Maynard, Marjorie Small and Lynda Baker;
Pan-Birmingham Cancer Network

The initiative
Neutropenic sepsis is a life-threatening condition requiring urgent administration of IV antibiotics. The urgent nature of the condition at times requires treatment from acute medical teams. Regionally, trusts within the Pan Birmingham Cancer Network audited their delivery of antibiotics within one hour from patient presentation. Birmingham Heartlands Hospital (part of Heart of England Foundation Trusts) began a project to improve the performance of the out-of-hours neutropenic sepsis pathway. Its purpose was to ensure the administration of antibiotics within one hour of the patient's presentation. The initiative has many components but is mainly comprised of an alert card for patients and staff regarding the symptoms and who to contact if symptoms arise; competency-based training on the management of neutropenic sepsis; and a box containing appropriate antibiotics and trust policy on the management of the condition. The initiatives have resulted in a three-day reduction in the average length of stay and a 50% improvement in the numbers of patients receiving antibiotics within one hour. The initiative involved the following approach:
• Capturing a baseline to understand the current level of performance;
• Engaging and sharing baseline information with key stakeholders;
• Process mapping and root cause analysis;
• Development of a project plan and group to take the work forward;
• Working with teams outside of the haematology oncology specialty such as acute and emergency medicine teams;
• Continued data collection and analysis to monitor the improvements.

Benefits
The initiative has achieved a three-day reduction in length of stay, while the pathway performance has increased by 50%. Nursing staff are now more aware of the symptoms and treatment of neutropenic sepsis and the condition has become a part of acute nursing staff's documentation. Patients are receiving their antibiotics in a more timely manner and experience a shorter length of stay and are at less risk of hospital acquired infections.

Financial implications
The three-day reduction in length of stay has the potential to save costs associated with bed days. This bed day cost is estimated to be £300. With exception of printing the alert cards there has been no financial extra outlay for the initiative.

Contact
For more information on this initiative please contact Catherine Price: catherine.price@westmidlands.nhs.uk

FINALIST

Get it on Time campaign
Raj Senniappan, Daiga Heisters, Karen Guy and Apu Chatterjee;
Royal Berkshire Foundation Trust

The initiative
This initiative aimed to ensure patients with Parkinson's in hospital get their drugs on time, every time so that their disease is well controlled, reducing complications through drug omission or delay. Ultimately this increases patient satisfaction and reduces their length of stay in hospital.

We have taken the original Parkinson's UK campaign, launched in 2006, much further than its original parameters. We have used a proactive approach, training nurses on the emergency and elective wards at handover, involving patients; pharmacists, physiotherapists and occupational therapists in training and in delivering the message.

This involved a multidisciplinary approach to getting patients' medication on time and a pre and post campaign audit. We used teaching sessions for those who deliver direct care and clinical governance meetings and grand rounds to spread the word, and introduced Parkinson's advocates on wards to address specialised issues. We also worked with the communications department to develop a screensaver and publications for patients and staff.

A roadshow was produced by occupational therapists and a series of educational leaflets were produced and local policies developed for inpatients with Parkinson's. We also broadened the spectrum of Parkinson's drugs on wards and in the emergency cupboard.

Benefits
Patients get their drugs on time and are not developing complications due to omissions, while understanding of Parkinson's and patients' needs has improved.

Financial implications
There are small-scale financial costs for the production of the literature and teaching notes, advocate badges and posters. Most of the cost is time and the small changes we have made have significantly improve patient safety and mitigate against litigation and compensation costs.

Contact
For more information on this initiative please contact Carrie Wedgwood: pr@parkinsons.org.uk
Patient safety improvement

**FINALIST**

Introduction of an early warning score tool into mental health inpatient wards for older people

Sarah McGeorge, Lesley Chapman, Julie Oakes and Paula Atkinson;
Tees, Esk and Wear Valleys Foundation Trust

**The initiative**

Older people with mental health problems have more physical health problems than the general population, because many older people with mental health problems are unable to articulate that they are feeling unwell.

Within the trust all older people's inpatient areas were audited to assess current practice, including observations and investigations undertaken on admission, at routine yearly review and when a physical illness or fall occurred. Practices varied and staff frequently failed to recognise and respond appropriately to the physically deteriorating patient.

There was no evidence of early warning score (EWS) tools being used within psychiatric settings so we developed an modified version for mental health settings, to help staff to recognise patients at risk of physical deterioration. A training package tool was also developed to ensure staff skills and competencies were up to date. A three-month pilot was undertaken on four wards, after which guidance was changed to ensure all patients had their EWS calculated daily. The tool was then rolled out across all older people's inpatient wards. A re-audit has shown improvements in the recognition and response to physical deterioration as a result of the introduction of the tool.

**Benefits**

Audits show patients receive better care and staff are more skilled in taking observations, interpreting the EWS and responding to the scores; and that illness has been detected, even when the patient appeared well, allowing rapid treatment. Nursing practice now includes daily EWS recording and staff are more aware that we need to care for patients holistically.

**Financial implications**

This project has been incredibly cost effective. Key impacts in set up and running costs include staff time in developing the tool and training, and audit work. No significant costs are associated with the production of the tool, only copying costs for wards. This tool will allow us to deliver cost savings as a result of early identification and treatment of physical illness, appropriate use of emergency services and admissions to the acute sector, reducing avoidable acute hospital transfers.

**Contact**

For more information on this initiative please contact
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**FINALIST**

Innovation in training to eliminate infection

Julie Treadgold, Wendie Richardson, Sharon Lowe and Linda Coleman;
 Trafford Healthcare Trust

**The initiative**

This initiative aimed to reduce infection rates associated with peripheral devices and to reduce incidence of MRSA bacteraemia. We achieved this by introducing a number of initiatives and reinforcing the importance infection prevention and control standards. We introduced a dedicated staff member to act as an aseptic non touch technique trainer.

Further initiatives addressed the use of skin cleaning products, the Saving Lives high impact interventions and the way blood cultures were taken, looking at new products to reduce the risks of potential false positives.

The main responsibility of the trainer was ANTT for all invasive procedures including wound care and blood culture collection training. The ANTT trainer galvanised the entire workforce behind the initiative. Intensive training was carried out to ensure all relevant staff could carry out ANTT competently. Audits were carried out to ensure standards were monitored and management structures informed of progress.

The initiative also involved looking at all aspects of infection prevention, involving ward managers to monitor and audit their own areas. Rolling out the Saving Lives high impact interventions, monitoring cleaning at ward level using the bioluminescence (ATP) testing, standardising line care products, the Saving Lives high impact interventions and the way blood cultures were taken, looking at new products to reduce the risks of potential false positives.

**Benefits**

The initiative reduced MRSA bacteraemia rates by 90% over the previous year. Standardised ANTT practice and equipment across the whole organisation has enabled practice to be audited. We have a key focal contact for ANTT issues and a key representative to inform and bring ideas and concerns to management.

Patients’ risk of infection has been reduced and safety in IV therapy has greatly improved. Patients can be reassured about the care they receive when they need IV therapy.

**Financial implications**

The initial cost of employing a specific ANTT trainer has been offset by the savings realised through the accomplishment of standardised ANTT throughout the organisation. The cost of training equipment came from the infection control budget and clinical areas provided their own equipment in line with guidance from the ANTT trainer and infection control team.

**Contact**

For more information on this initiative please contact
Linda Coleman: linda.coleman@trafford.nhs.uk
The initiative
Royal Air Force Aeromedical Evacuation Teams repatriate sick and injured service personnel, civil servants and their families from overseas locations 24 hours a day, 365 days per year. Comprising of general nurses, mental health nurses and medics the teams ensure that personnel are repatriated quickly and receive the level of nursing care to ensure they arrive in the UK in the same, if not better condition.

The teams provide pre-flight assessment and care, in-flight care and a seamless handover to the other providers. The nurse-led service can be augmented by other healthcare professionals to provide holistic care during transfer, often over prolonged periods; this can range from a single nurse or medic moving to multi-disciplinary teams as needed.

Being able to deliver high quality, patient-focused care in the air relies on the seamless marriage of relevant clinical skill and robust management processes. Accurate pre-flight patient assessment is key to successful transfer by air, combined with an understanding of the physical effects of altitude. Tools have been developed to objectively assess patients, plan their move, then evaluate and document their in-flight care.

Staff and patient safety in the air is paramount, and team members must remain current in all aspects of this training. Modular airworthy medical equipment has been developed allowing pertinent medical supplies and equipment to be transported to ensure that patient care is maintained at the highest level in the air, while remote management and tracking of patients and teams ensure the service is efficient and effective.

Benefits
The knowledge that any service person, civil servant or dependant in an overseas location, often in a hostile environment, can be quickly and safely repatriated for medical care has an immeasurable effect on morale.

Financial implications
Aeromedical evacuation is a costly business; however, this is balanced against the well-being of the personnel around the world knowing that if necessary they can be repatriated using a tried and tested system. The cost of treatment overseas can be balanced against the cost of air transportation.

Contact
For more information on this initiative please contact Alex Leivers: aesqnwo1@tmw.raf.mod.uk

FINALIST
Putting patients and families at the centre of intensive rehabilitation services
Viv Delafuente, Kerrie Naylor, Sarah Coleman-Williams and June Plevin; South Birmingham Community Health

The initiative
A nurse-led project concentrated on developing the contribution of a multiprofessional team in an intensive rehabilitation unit to achieve shared responsibility for patient outcomes; fusion of roles and tasks; absorption of role boundaries and barriers; and collaboration between colleagues.

Moseley Hall Hospital’s inpatient neurological rehabilitation service has a team of highly skilled and diverse professionals providing first class intensive rehabilitation services for patients with brain injuries. However, exceptionally successful patient outcomes were unproven without proper written evidence.

Concern related to care plans and multiprofessional planning led to a review of the service to identify areas of good practice and areas for improvement; introduce evidence-based multiprofessional individual patient care plans; maximise the value of the team; centre care around the patient, families and carers; and ensure sustainable improvements in response to staff dissatisfaction, high staff turnover, high volume of patient complaints and poor communication within the team.

A working group addressed team communication, evidence to prove patient outcomes, and patient and family involvement in decision-making. The nursing care was of the highest standard yet documentation did not support this. It was evidenced via patient outcomes and discussions with patients/carers.

Patients/carers are now involved in assessment within 24–48 hours of admission to assist in care planning to ensure it suits the patient’s individual needs. Ward meetings promoted documenting care and individual patient care plans were formulated using the Roper, Logan and Tierney Model of activities of daily living, and all patients receive individualised care plans.

A six-month audit of patient care plans highlighted how practice had improved and we were initially awarded an amber rating. A month later, after an unannounced audit we received a green mark. The productive ward initiative supported this process.

Benefits
The initiative has had a range of benefits including a reduction in patient falls and critical incidents, and clear patient goals and outcomes that are agreed by staff, patients, carers and families. Staff can see patients’ status at a glance and mandatory training outcomes were unproven without proper written evidence.

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Benefits
Team of the year

Financial implications
Smarter working practices have led to a reduction in average length of stays month-on-month, changes in nursing documentation has released time for care. We have also seen a reduction in staff absences and in incidents leading to a risk of negligence claims.

Contact
For more information on this initiative please contact Vivien Delafuente: Vivien.Delafuente@sbpct.nhs.uk

FINALIST

Better care for patients, better experience for staff through belief in the team
Steve Wharnsby, Jacqui Duncan and Godwin Eze; Guy’s and St Thomas’ Foundation Trust

The initiative
By unlocking the potential of the ward team the aim was to transform the way the ward was organised and run. The team aspired to a gold standard of patient care for patients and through a renewed vision, a deep seated belief in the possibilities and the energy within the team, the aim was to have a calm, organised, efficient environment and culture for dignified, high quality care.

Creating a new ward vision involved true engagement from the whole team led by the ward manager. Creating a new way of running the ward was achieved by implementing a more effective patient allocation system. This was triggered by the introduction of the new patient status board, which had an unforeseen benefit of improving efficiency in care delivery.

A complete change in staff culture on the ward was achieved thanks to the ward manager engaging and believing in all staff and releasing their energy and potential. This involved persevering in a genuine search for ideas to improve practice in a way that put patient care firmly at the core, and trying, valuing and celebrating all efforts no matter how small. Staff now feel ownership and pride in their ward, they make decisions, use initiative, and solve their own problems. There is a real energy and staff are flourishing.

Benefits
In terms of patient care there has been a reduction in drug errors and falls; near complete elimination of pressure ulcer acquisition; and elimination of acquisition of MRSA and C. difficile. In turn this has led to a reduction in sickness absence and performance issues. Staff retention has improved and staff on rotation choose to stay rather than move on, while students love their clinical placements. In addition staff no longer phone the ward manager on his days off as they take responsibility, use initiative to solve problems, and assume accountability for their decisions.

Financial implications
Reduced staff absence has cut the costs of temporary staffing and we have also reduced costs associated with overstocking by returning overstock to suppliers. This means we are able to treat more patients with the same resources.

Contact
For more information on this initiative please contact Yvonne Wimbleton: yvonne.wimbleton@gstt.nhs.uk

FINALIST

Setting up a model of care for stroke
Yvonne Goddard, Laura Willoughby, Margaret Fry and Arindam Kar; Imperial College Healthcare Trust

The initiative
Following a successful bid and public consultation, Imperial College Healthcare NHS Trust was chosen by Healthcare for London as one of eight designated providers of hyper-acute stroke care in London, forming part of a strategy to improve stroke services within London, ensuring patients receive specialist care following a stroke. The aim is to reduce mortality and improve patients’ functional outcomes.

The unit improves immediate access to expert skills across all disciplines within stroke care, diagnostics and acute rehabilitation services in a patient’s local area. In managing services, nursing teams develop critical skills in acute care across the pathway. Concentrating the expertise in this way promotes quality, with high expectation and standard setting for those experts. This reflects directly on the patient care outcomes.

The initiative involved refurbishing a 20-bed stroke unit; recruiting and training over 100 nursing staff for the unit; embedding a new model of care for stoke within a large organisation; and ensuring strong managerial medical and nursing leadership was in place to take the initiative forward.

The stroke team has also established excellent relations with social services and external rehabilitation units, ensuring seamless care after patients are discharged. This enhances patient outcomes and promotes independence, always placing patient wellbeing at the heart of the process.
Benefits
Patients benefit significantly from having immediate access to stroke care that involves a multidisciplinary team including nurses, therapists, doctors and pharmacists working in partnership with patients and their families and carers. They have access to new and established medical treatments with good outcomes, and to nursing expertise that ensures the patient care pathway flows smoothly. Higher numbers of patients receive thrombolysis, which increases their chances of making a full recovery and leading an independent life. Between December 2009 and April 2010, 65% of patients receiving this treatment made a complete recovery or recovered substantially enough to live independently. Sixty-seven patients were repatriated to their local stroke unit, ensuring they are closer to home, and their relatives/carers.

The Department of Health states that by end of 2010/11 80% of people with stroke should spend 90% of their time on a stroke unit. The stroke team has ensured that 91% of patients spent 90% of their time on a stroke unit in quarter 4 of 2009/10, an improvement of 50% over quarter 3.

Contact
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FINALIST
Improving healthcare for women in south east London

Rachel Woods, Lucy Machin and Angie Rantell; 
King’s College Hospital Foundation Trust

The initiative
The team of eight senior gynaecology nurses are an expert group of nurses who have led a number of initiatives to address issues around access to care, quality of care, outcomes of care and public health issues for women. Examples of their work include: introducing HIV screening and nurse consenting to the termination of pregnancy service; introducing training packages to facilitate the development of extended nursing skills in the assisted conception unit; developing a care pathway for women undergoing a termination for foetal abnormality and improving the quality of care; undergoing training to offer a fully nurse led colposcopy clinic; introducing nurse-led expectant management of pregnancy loss to the early pregnancy and gynaecology assessment unit; and introducing patient classes in urogynaecology. The motivation for all the initiatives is to improve access and care as well as efficiency.

These initiatives have been successful through team working, sharing experiences, knowledge and skills among the senior nurses. The team has shown initiative, creativity and persistence to achieve their objectives whilst acknowledging and accepting the changing healthcare environment. All the initiatives required leadership by the senior nurse in their specific area. Once the objectives had been defined the senior nurses coordinated a project plan, in which communication and negotiation with the lead consultant, medical and nursing teams and wider disciplinary team were essential.

The senior nurses supported and learnt from each other, sharing tools and ideas. All manage busy departments and their enthusiasm and commitment to these projects while meeting trust-wide objectives and targets has been inspirational. They have succeeded in maintaining and improving their services for women during difficult times.

Benefits
Women have improved and timely access to reproductive healthcare such as patient classes and nurse colposcopy clinics. Improvements in the quality of care includes the patient pathway for women undergoing a termination for foetal abnormality. Improved understanding among the nursing team inspires confidence and there has been positive feedback from women on the care they received.

Continuity of care has improved — for example in gynaecology endocrine/breast clinics women can see staff from both specialisms at one appointment. Team working, morale and motivation of the senior gynaecology nursing team have also improved.

Financial implications
Some of the projects undertaken by the team could be transferred to other areas — for example the training tool in the assisted conception unit could be adapted for nurses in other gynaecology areas to learn a new skill. All projects are completed within the work remit of the senior nurse and most are cost-neutral (apart from initial set up costs) or will improve the use of resources.

Contact
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FINALIST
Establishing a sleep service for Portsmouth

Liz Walker and Neil Titmuss; 
Respiratory Centre, Queen Alexandra Hospital

The initiative
When NICE guidelines for obstructive sleep apnoea (OSA) were published in 2008, Portsmouth City and Hampshire PCTs agreed to fund a complete sleep service. Previously there had only been a diagnostic service, and once diagnosed, patients had to fund their own treatment. It became clear that OSA was a huge local problem and over the last two years the team has grown from one specialist nurse doing two sessions a week to a nurse-led multidisciplinary team with two full-time nurses, one
full-time sleep technologist and 0.4 of a respiratory physiologist. A respiratory consultant supports the team with more complex sleep problems.

The team provides a seamless service for patients with OSA from their first appointment with the lead nurse or respiratory physiologist, to their overnight sleep study (done as an outpatient), and their treatment set up (continuous positive airflow pressure: CPAP) and necessary support. Continued support is essential even once treatment is fully established.

Developing the team has been a challenge, but it has grown slowly over two years. Since the NICE guidelines were published many more providers wanted to develop services, and finding people with appropriate experience is difficult as there is no formal education for nurses at present. Most education has been in house, attending national conferences and some from CPAP equipment manufacturers.

Procuring equipment was very important and after a tendering process we agreed contracts with two providers — this arrangement is working well. A care pathway was written so primary care (mostly GPs and practice nurses) could understand the process. Two years ago we received around four referrals a week — this is now up to 20. We also receive referrals from further afield as our reputation is growing.

**Benefits**

Our local population has access to a high quality, seamless service for the treatment of OSA. The team is highly motivated and keen to improve the service — recent patient satisfaction surveys were positive but of course can always be improved upon — relevant changes have been made. The CPAP compliance audit will also inform us how effective we are and how to improve further.

**Financial implications**

This service does cost money, but untreated OSA has a huge impact on patients' quality of life — many cannot work because they feel so sleepy. There is also a massive increase in the risk of road traffic accidents. Snoring is another significant symptom they feel so sleepy. There is also a massive increase in the risk of disease. CPAP generally resolves all these issues.

**Contact**

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**Team of the year**

**The initiative**

A number of national initiatives in the past decade led to radical reforms across the NHS workforce, demanding more front line staff, working in new ways to reduce waiting times and improve the quality of care for patients in local hospitals, clinics and surgeries.

Our professional development team identified that, in line with the ageing population, NHS Tameside and Glossop PCT had an ageing workforce that could limit its ability to deliver these national initiatives.

A district nursing development programme was introduced to modernise staff’s leadership and clinical skills. The aim was to begin succession planning and develop new ways of working through an interprofessional model.

Patient experience surveys identified the staff development needed to deliver high quality care closer to home, and workforce planning techniques were used to balance patient needs with demands on the service. The programme was advertised on our local intranet and selection was based on interviews.

Successful candidates were placed with a mentor for half a day a week and offered a module at local universities, which could be accredited towards a degree.

Team leaders undertook a leadership module to raise their awareness of managing change and supporting their teams, while staff completed self-assessments that demonstrated strengths and weaknesses which could be transferred to skills and knowledge. The workforce team offered support and provided staff supervision.

**Benefits**

Following the programme we have recruited candidates to the specialist practitioner degree programme and have identified a further cohort for the development programme. This has begun to address our district nursing workforce succession plans.

Workforce identified that prescribing by all band 5s and above would enhance the patient experience and decrease inequalities. A second cohort of staff is currently completing this module, reducing the time taken for patients to collect prescriptions and the cost to the trust through a decrease in stock items. We aim to train all district nurses to be prescribing by 2012, and have already trained 31%.

Patient experience has been greatly improved due to the staff being more aware of issues affecting the local community and how that care is delivered. This outcome has been achieved through the attendance and involvement of a recent review of our services, and being involved in GP alignment, practice based commissioning and transforming community services.

**Financial implications**

Launch costs included staff time for interviewing the candidates; training and mentoring costs were funded via the North West Strategic Health Authority CPD credits scheme, while indicative 2009/10 university costs were £310 for level 6 students and £420 for level 7 students and indicative mentoring costs were £550 and £850 depending on the university.

Ongoing running costs include time in releasing staff to complete the modules and also from the team in offering support. Stationery costs included £740 for portfolio files. There were savings identified by the reduction of prescribing stock items and the use of prescriptions.

**Contact**

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**FINALIST**

**Team improvements to the Community Nursing Service**

**Julie Howard, Clare Downey, Janet Robson and Nikki Leach;**

**NHS Tameside and Glossop**

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**Contact**

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Continence and stoma care

Platinum winner
Flexi-Seal Faecal Management System, ConvaTec
Judges’ comments: “This company has really taken on board feedback from nurses and product development. The product ticks all boxes regarding QIPP as well as significant potential cost savings.”
Gold
Cohesive Paste, TG Eakin
Finalists
LoFric Sense, Astra Tech
Pelican Select Convex 60mm Range, Pelican Healthcare

Dignity and daily living

Platinum winner
Homefill II Oxygen filling system, Invacare
Judges’ comments: “Being able to fill up oxygen bottles at home is going to make a world of difference to COPD patients. "I see patients who can’t live their lives or leave their homes, and this will mean they can go out to the theatre or anywhere they live with complete freedom," said one. The judges liked the impact the product could have on a potentially huge market, that cylinders were lighter and easier to carry. "It’s the tops," said one judge.
Gold
Seal-Tight Wound Protector, Autonomed
Silver
The Hydrant, Hydrate for Health
Finalists
LoFric Sense, Astra Tech
PIM (Patient Immobility Monitor), Synidor
Cohesive Paste, TG Eakin

Infection prevention and control

Platinum winner
Stalham infection control mobile sani/shower chair, James Spencer & Co
Judges’ comments: “This product has the potential to make a huge impact on patient care, due to ease of cleaning and the ability to swap individual parts – and it is recyclable at end of product life. It could be used across the whole spectrum of care delivery.”
Gold
MedMat, ErgoMedica
Silver
VitalPAC, The Learning Clinic
Finalists
Safe Snap amp snapper, Exchange Supplies,
Clinell Chlorhexidine Wash Cloths, GAMA Healthcare,
Tristel for Surfaces range, Kapler Communications
KimVent Oral Care Kit, Kimberly-Clark Health Care

Intravenous therapy

Platinum winner
Introcan Safety Non Ported Safety IV Cannula, B Braun Medical
Judges’ comments: “Excellent presentation and comprehensive evaluation of both patient and clinician perspective. User feedback was utilised to make product improvements; this is ongoing for future developments.”
Gold
Tegaderm CHG, 3M
Silver
Guardrails CQI Dose Error Reduction Software System, CareFusion
Finalist
VitalPAC, The Learning Clinic

Intravenous therapy

Patient observation

Platinum winner
Optyse, lens-free ophthalmoscope, Ophthalmos
Judges’ comments: “Huge potential for spread into all practice and use across all the health sectors. Cost benefit very clear, and it improves quality and productivity.”
Gold
VitalPAC, The Learning Clinic
Finalists
FreeStyle Lite Blood Glucose Test Strips, Abbott Diabetes Care
Tegaderm CHG, 3M

Productive working

Platinum winner
BARD BARDEX IC Comprehensive Care Foley Tray, Bard
Judges’ comments: “This was the most patient focused presentation, well formed, in line with the current nursing agenda and high impact actions.”
Gold
BD PosiFlush, Becton Dickinson
Silver
Cobas IT 1000 with Cobas Academy, Roche Diagnostics

Wound care and pressure ulcer prevention

Platinum winner
Aderma, FPD Medical
Judges’ comments: “Brilliant,” said our judges. “It is repackaged, repurposed and simple and easy to use.” This product has been around a while, but has been shaped and moulded into something that is really useful. What the judges loved was that it could be used on smaller areas of the body that are often overlooked. “It will make a massive difference to patients’ lives,” said one judge. “It is focused on the solution,” said another. “And that is why it is my number one in this category.”
Gold
Tegaderm Absorbent Clear Acrylic Dressing, 3M Health Care
Silver
PolyMem, Aspen Medical Europe
Finalists
ToTo Lateral Tilt or Turn, Genie Care
Mepitel One, Mölnlycke Health Care
RENASYS GO Device, Smith & Nephew
PIM (Patient Immobility Monitor), Synidor