NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Celebrating our fantastic Change Makers

Getting Back On Track
through improvement and innovation 2022/23

- Excellent quality patient care
- Fulfilled and supported staff
- Clinically ambitious and a leader in teaching and research
- Well managed, forward thinking organisation

PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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Introduction

I am delighted to introduce this document showcasing fantastic examples of improvement work from a wide range of areas across the Trust and led by you, our very own 'Change Makers.'

We have always been proud to make a difference to the patients we care for, our local communities, the wider NHS and of course each other, but the last two years have been challenging for many reasons and we know it has had a significant impact on our performance.

That was why we launched out Getting Back on Track programme to guide our improvement work.

The four key things we wanted to deliver were:

The work highlighted in this document, from improving the way we assess women on the labour assessment unit at Jessops to ensuring learning and development materials are inclusive for all staff, deliver across all these ambitions and more.

We wanted all of you be part of this improvement journey – it wasn't just a case of having a plan, it needed all of us to work together, respond to requests for change and to get involved and support the work.

This showcase demonstrate that you have done that in spades, and I would like to thank you all for collective contribution you have made.

Please take a little time to look through this document and learn more about some of the improvement work that has been going on. It really is inspiring and maybe will encourage you to pursue ideas in your own areas of work.

Thank you to all our Change Makers across the organisation for sharing positive and inspiring stories of improvement and innovation.

If you would like any further information about any of the stories please contact the Organisational Development Team: **sth.organisationaldevelopment@nhs.net.**

Kirsten Major
Chief Executive

Improving our maternity care

A huge amount of improvement work has been undertaken by our maternity teams over the past year and the benefits of this work are delivering demonstrable benefits for those using the service and maternity colleagues. Just a small sample of the changes are highlighted here.

Overhaul of triage process on labour ward assessment unit

Improved facilities and the introduction of a new process on the labour ward assessment unit has resulted in a dramatic increase in the number of women being triaged within 15 minutes from less than 10% to 80%.

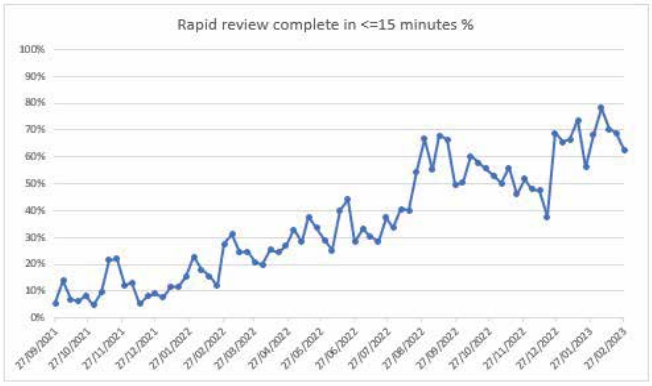
Last year, following feedback from women using the service and the Care Quality Commission the team worked together with other colleagues to introduce a number of changes including the introduction of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) on the Labour Ward Assessment Unit.

BSOTS is a nationally recognised system, in which women have an initial rapid assessment within 15 minutes of arrival to the unit.

Alongside this change, the physical space in the Unit has been improved including a dedicated rapid assessment room and a specific monitoring bay. New guidelines have been adopted to improve the assessment and recording of women's risk rating and there is now an overview of Red/Amber/Green (RAG) risk rating on a live dashboard for staff to see. Risk is assessed in a standardised, documented way with ongoing care prioritised based on this risk. Women are communicated to about their risk level based on their initial assessment.

As well as the improvement in triage time, there has been a reduction in complaints and an increase in positive feedback from both those using the service and staff delivering the care.

Background
Labour Ward Assessment Unit is open 24/7 via telephone and to physically assess, review and act on any maternity related issue >20 weeks gestation.



Improving the use of interpreters

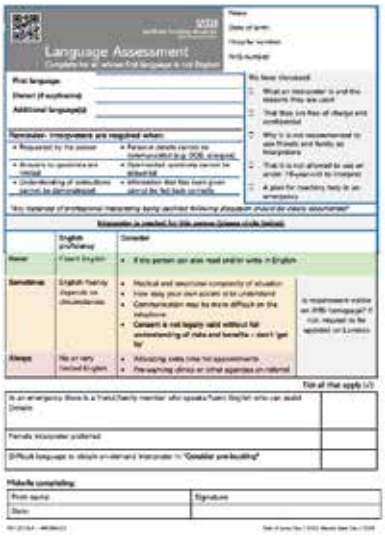
Following a safety incident in maternity, a review showed that there needed to be an improvement in the use of interpreters when delivering maternity care.

An audit showed that in 33% of contacts with women who needed an interpreter, an interpreter was not used. In a further 31% of contacts it was not documented if an interpreter was used or not.

Not having effective communication because of a language barrier is a patient safety issue and so an action plan, including the development of a new Communication Needs Assessment proforma, was developed by the Cultural Safety midwife and agreed by the Maternity Governance Group. The assessment proforma was launched in February 2023 and will help to ensure communication and interpretation needs are documented and acted upon.

The proforma is now In every set of handheld notes as a front page. It is completed at the start of a person's maternity care and then reviewed by every member of staff (community and hospital) at the beginning of every ongoing contact with the person.

An audit to assess the use and impact of the form is planned for late 2023.



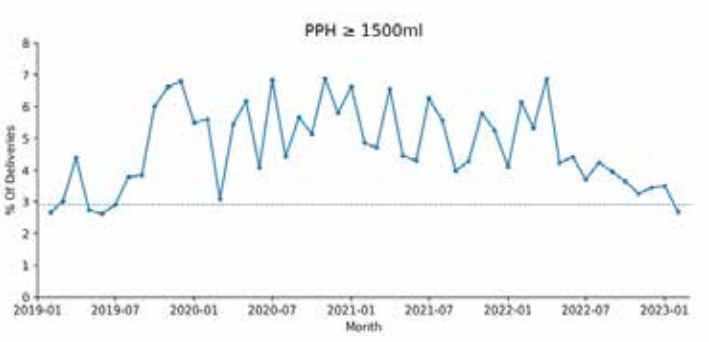
Labour ward - reducing the risk of post-partum haemorrhage

Post-partum Haemorrhage (PPH) is a leading cause of maternal morbidity and mortality globally. In 2019, Jessop Wing began weighing and measuring blood loss at all births and over time the number of women having a post-partum haemorrhage involving 1500ml of blood or more had significantly increased.

Since implementation of a new set of interventions and staff awareness campaign, the rate of PPH has now reduced back down to the low levels seen in 2019.

How did the team do this?

In 2022, an Multi-Disciplinary Team (MDT) review group came together involving the labour ward Matron, Senior Midwife, Lead Obstetrician, Anaesthetist and Quality and Safety Midwife to launch an improvement programme which raised awareness of the actions for colleagues to take that reduced the risk of Post-partum Haemorrhage.



Using standard proformas, all patients with post-partum haemorrhage greater than 1500ml were reviewed and discussed in a working group. Following the review, key interventions that reduced the risk were communicated to help staff to recognise, react and escalate early to stop bleeding from reaching 1500ml.

These actions are:

- **D**eltoid injection for third stage management
- **E**arly escalation for help – loss greater than 500ml
- **A**ccurate immediate weighing
- **L**eader monitoring
- **T**ranexamic Acid – 1000mg/ml
- **T**rauma – recognition and early suturing

Sharing learning together at new forum

The Maternity Learning Forum was established to provide an opportunity for staff to come together and share learning and expertise as a collective.

Led by representatives from Obstetrics, Gynaecology, Anaesthesia, Neonatology and Midwifery, colleagues from different departments can focus on learning from particular issues or incidents in an inclusive and non-judgemental environment.

The team worked hard to ensure that the forum was held virtually at a time when everyone was able to attend. For example, the meeting on the theme of Sepsis had over 60 attendees and feedback from staff who attended was very positive.

As a result of the Maternity Learning Forum, staff now have a valuable opportunity to discuss and review challenging cases with their colleagues from across the

maternity service. There is also space for quality improvement built into the forum.

Staff have also benefited from the new working relationships and new lines of communication which have formed as a result of coming together in the forum.

The set-up team are most proud of the high level of attendance from across maternity services and the environment of inclusion, learning and collaboration which has resulted from this.

Lily helps colleagues support bereaved parents

Lily Dale, Bereavement and Mortuary Assistant, saw an opportunity to offer more regular bereavement information sessions in addition to the existing study days that happen once or twice a year, to help colleagues support parents who have suffered a bereavement.

Lily is now running less formal sessions every two weeks that attract a wider and more diverse group of staff.

The sessions offer information for any member of staff who is interested in expanding their knowledge or refreshing their skills for supporting parents who go through a bereavement. They are also taught how to do things such as taking hand and footprints, taking photographs and going through memory boxes with the parents.

Staff can drop in for as long as they wish and can ask any questions related to bereavement care.

The power of listening to our patients

During 2022, an engagement project took place, led by the Patient Experience team to gather experiences from patients who had recently used our maternity services.

The Team went to baby groups and breastfeeding support groups in areas across Sheffield to speak directly to parents. The findings and recommendations formed the foundation of the maternity improvement action plan which has resulted in significant improvements in care and patient experience.

As well as the visits to community groups, a poster promoting a feedback survey was translated into four languages and circulated, along with details of the project. The feedback mainly detailed qualitative experiences which gave a deeper understanding of the patient experience.

A number of key themes emerged, including the importance of staff behaviours and the impact of COVID-19 restrictions. The Maternity Improvement Team used this information to inform their action plans which included promoting positive staff behaviours, enabling partner overnight visiting where possible and increasing access to infant feeding support.

Consultant of the Week provides extra support

Traditionally the on call labour ward consultant for Jessop Wing had responsibility to cover labour ward, triage, antenatal ward, and the day assessment unit.

Often the consultant's time was prioritised to emergency work which meant longer waits for patients on the antenatal ward which had potential safety risks and a poor patient experience. It also meant there was not as much time to spend with trainees in all areas of the service.

Workload demands have continued to increase over the past two years and so it was clear that this way of working needed to be changed.

Members of the Jessops team came together to pilot changes to job plans and on-call working, as well as rota and administrative changes as part of the Consultant of the Week project.

This led to positive changes for patients, including:

- **Receiving timely senior reviews**
- **Having earlier discharges**
- **Receiving faster escalation**
- **Improved communication on care plans**
- **Reduction in waiting times**

Covid

So much innovation took place throughout the pandemic to keep our patients and each other safe and to deliver as much care as possible despite very challenging circumstances. Here is a snapshot.

Virtual support for Long Covid patients

The introduction of virtual sessions for patients with Long Covid has ensured timely and equitable access to specialist self-management advice in a forum where patients can share experiences and access peer support.

The initial evidence-based model was a 6-session cohort programme based around prevalent 'treatable traits'. As a rehabilitation hub, the focus was on self-management, with therapists drawing on their specialist knowledge to identify where they could add value. The sessions were delivered virtually via MS Teams.

"I found it helpful, knowing that I was not the only one suffering with this. It made me feel like I was not alone"

"I thought the expertise and accessibility was well-designed"

"It was very easy to access on my phone"

Sessions have been tweaked in response to evaluations, with provision of handouts, slides, and face to face delivery.

The hub is now established as a rehabilitation service, and the use of MS Teams was used as a case study by IT to demonstrate possibilities when delivering virtual treatment.

Rapid response from COVID Medicines service

During the pandemic the COVID-19 Medicines Delivery Unit (CMDU) based at the Hallamshire Hospital was set up to deliver tablets and intravenous (IV) treatment to patients who were at high risk of deterioration. The unit was up and running within two weeks.

Due to the timescales and the unpredictable nature of the pandemic everything including communication with patients was paper-based. As the pandemic continued, the referrals were coming through 24/7 from Track and Trace, 111, GP referrals alongside patients triaging from home.

A multi-faceted quality improvement initiative:

- Switching from paper prescribing to electronic prescribing for IV infusions and oral medications.
- Improving communications with patients through using SMS communication with Google map link included.
- Improving clinical governance and improving communication between colleagues.

Benefits of projects:

- Improved patient communication leading to a reduction in Did Not Attends (DNAs).
- Implementation of electronic prescribing.
- Utilisation of text-based messaging to patients.
- Streamlining of existing processes.
- New system able to meet 24/7 demand and allow flexibility of meetings.
- Detailed standard operating procedure (SOP) to enable spread to other areas.

COVID pre-admission screening for cardiac surgery patients

Chesterman 4 devised a bespoke screening programme that kept the ward Covid-free and enabled surgery to go ahead for high-risk pre and post-operative cardiac patients.

To do this they devised their own screening programme which prevented many patients from coming to the ward whilst they were either infectious or had been exposed which enabled the high-risk surgeries to go ahead as planned. Patients were swabbed regularly throughout their hospital stay, and the whiteboard reminded staff to swab the day before surgery, the day of surgery, then days 3, 5 and 7 post surgery. During this time, the ward did not have any visitors which also kept the risk of exposure down. Staff on the ward were also regularly tested to minimise the risk of transmission.

These new processes resulted in Chesterman 4 staying Covid free throughout the pandemic. Other wards also adopted the screening programme.

Chesterman 4 became one of the Covid minimised wards which meant it cared for hundreds of people from a wide variety of specialties that had a wide range of high-risk conditions.

"The whole team on Chesterman 4 worked so hard and learned a lot of new skills and procedures in a very short space of time."
Lena Carruthers - Staff Nurse - Chesterman 4 Ward

Equality, Diversity and Inclusion

Facilities Department spreads digital skills learning

The Facilities Department has undertaken extensive work to remove barriers for staff who needed to access online training and learning when face-to-face training was halted during the pandemic. A group came together and introduced the following changes which have helped colleagues with tasks both at work and at home.

- Barriers to completing mandatory training and job specific essential training such as PALMS access were identified and these courses were translated to paper-based with built in assessments.
- Two suites of computers were made available for staff to use along with 1:1 and group sessions to increase IT skills and literacy.
- An easily Accessible Sharepoint site using plain English was developed which helped staff navigate information and make it more accessible on mobile phones and tablets.

- A partnership with Sheffield College has provided access to Functional Skills courses to prepare staff who would like to re-enter education.

Staff feedback from the project has been extremely positive and the IT skills support has also opened up digital access to information including NHS records and pay information, staff support services and training packages.

Developing the modular learning resources meant Facilities maintained training compliance above 95% without the usual "dips and humps" caused by the difficulties of accessing training during the pandemic.

Walking in each others' shoes

Data shows that nationally people who have a disability, are from an ethnic minority background or identify as LGBTQ+ are more likely to face barriers to appointment or career progression, and more likely to be in lower pay bands. They also experience greater levels of bullying, harassment and victimisation and are more likely to face disciplinary actions than other staff.

With this in mind we launched our first Reciprocal Mentoring programme in June 2021, with a further three cohorts subsequently joining the programme.

94 people were included in the programme - 47 senior members of staff that included directors, non-executive directors, board members, matrons and others were matched with 47 junior members of staff.

The purpose is to establish a closer connection and deeper levels of awareness. Senior colleagues also support junior colleagues with the development of skills to enable progression into leadership roles.

91% of respondents said that they have benefitted from the programme

"Enhanced understanding of challenges of representation within a large organisation when unfamiliar structures and mechanisms can be perplexing and/or intimidating. Whole experience has been challenging, stimulating and inspiring".

"Knowledge of how my behaviour and how a lack of understanding of diversity could impact on both individuals and the organisation. I am now much more confident about discussing diversity and inclusivity issues".

85% of respondents said the programme has benefitted their work

"Increased confidence and assertiveness".

"It was helpful to understand that the negative experiences I have had were not as a result of my work but were experienced by others in different roles and levels of seniority too".

PROUD to celebrate our diversity

This year, thanks to incredible work from colleagues across the organisation we have been given a gold award for LGBTQ+ inclusion.

Patients and families can now see more visible LGBTQ+ inclusion across the Trust, including rainbow badges that staff can wear and flying the progress flag during LGBTQ+ history month and Pride month. Patients, especially our gender diverse, non-binary and trans patients have given feedback that it has made them feel more comfortable in accessing services.

Training, resources, and videos have also been rolled out across the Trust relating to non-binary and trans identities, which has helped to improve knowledge and awareness, ultimately providing a better experience for our patients.

LGBTQ+ staff are now supported more than ever to bring their authentic selves to work and this will ultimately lead to a more productive and happier workforce.

STH is also now seen as an LGBTQ+ inclusive employer, which will benefit recruitment, retention and progression. We have excellent working links with a range of organisations and are seen as a regional and national leader in LGBTQ+ inclusion. For further information see link to **PROUDER Network Intranet Page**

Pharmacy staff welcome focus on Equality, Diversity and Inclusion

The Pharmacy Department have launched a mandatory equality, diversity and inclusion (EDI) session for all staff.

The session includes a personalised video with individuals sharing their real-life experiences. The session aims to increase awareness of EDI within the Pharmacy Department.

Sessions were delivered over a six-week period to enable as many staff as possible to attend and 96% of attendees found the session beneficial.

96% of attendees found the session beneficial

"I think it was very important to hear about real experiences, and some of them resonated with me and I felt my feelings were validated".

"It's made me reflect on certain phrases that I have said in the past and made me rethink on how I can say things in the future".

"'Very informative with lots of real-life examples".

Supporting colleagues with dyslexia

More than 100 colleagues have self-referred into the new Dyslexia Workplace Service since it was established last year.

The service was established in response to feedback received from dyslexic colleagues, including through the STHAbility Staff Network Group, about the challenges in their working roles.

There are now 24 trained Dyslexia Workplace Assessors supporting the service which provides advice to colleagues and their managers on reasonable adjustments and training which is available.

Feedback from those who use the service has been overwhelmingly positive, with many saying that the adjustments put in place have helped them in their roles, improved their working life and resulted in better patient service.

Of the colleagues who have self-referred to the service:

- 87% of colleagues reported that they found the referral process easy
- 100% said they found it easy to engage with their assigned assessor
- 100% reported that they felt they were well matched with their assessor
- 96% said they understood the process of the assessment
- 96% said they understood the Workplace Assessment report
- 100% said that they would recommend the service to colleagues

Home in Time for Tea

Ensuring beds on wards are freed up as quickly as possible once a patient is medically fit is critical in enabling patients waiting in A&E or our Assessment Units to be admitted in a timely way.

An improvement trial called Home in Time for Tea (HITFT) has proved to be a real success and really helped with the increase in demand we have seen over the past year. Two particular focus areas were improving the use of the patient discharge lounge and the use of a new rapid bed cleaning team.

Rapid Bed Cleaning Team

The Rapid Bed Cleaning Team was introduced on seven wards at the Northern General Hospital as part of the 'Home in Time for Tea' service improvement trial.

The aim was to help patient flow through the hospital by freeing up nursing time and ensuring ward beds were ready for the next patient as quickly as possible.

As well as performing additional cleaning duties normally undertaken by clinical staff, such as cleaning the bed and mattress and making up the bed with clean linen, Rapid Bed Cleaning Team took responsibility for updating the bed clean status on the ward whiteboards so that there was real-time information about bed availability at-a-glance. This meant that patients could be transferred from A&E or Assessment Units as soon as the bed was ready.

At one point the team did a phenomenal 598 bed cleans in one four-week period, with the bed being ready for the next patient within less than an hour of a patient's discharge in most cases.

Following the initial success of the project, the team has now been expanded to cover 24 wards and began working 12 hour shifts, 8am-8pm, seven days per week.

The team were nominated for the Healthcare Cleaning Team of the Year at the national My Cleaning Awards.

"The impact this team have had on wards to enable best use of the beds we have available every day during really busy periods has been incredible. They are a joy to work alongside and hugely professional."
Jo Marsden, Nurse Director, Surgical Services.

Discharge Lounge

The Discharge Lounge was identified as one area that could support improvement in patient flow from wards and benefit the patients by reducing the time spent waiting for discharge on the ward.

So a team came together including the Flow Steering Group and Organisational Development Department to trial some changes which have resulted in a sustained improvement in both the number of patients using the discharge lounge and the percentage of patients coming to the lounge prior to midday.

We know that the greatest demand for ward beds is earlier in the day and so if we free up beds before midday it helps enormously to manage the flow of patients who need to be admitted.

Building on the HITFT initiative we retained the specialist Bed Turnaround Teams through winter and increased the number of teams to three. These teams consistently delivered more than 400 bed cleans each (per month) which was time returned to ward teams for caring and preparing patients for discharge.

Key changes:

- Improvements to the physical environment
- A larger drug trolley for stock drugs.
- Improvements to the E-Whiteboard.
- New procedures and processes to facilitate transfers to the lounge earlier.
- Dedicated Porter support for transfers
- Support to prioritise discharge phlebotomy.
- Dysphagia Training for all staff.
- Pinpoint training for all staff.
- Outdoor signage and free parking for relatives/carers outside the discharge lounge.

Excellent quality patient care

Fulfilled and supported staff

Safety Huddles success

As part of a Trust wide focus on patient safety improvement actions, Multi-Disciplinary Team (MDT) Safety Huddles were established on wards within just 3 months thanks to incredible support from colleagues across the organisation.

And less than a year on, these daily get togethers of ward teams are having benefits for patients and team working.

The huddles have increased awareness for all staff on the ward of any patients at risk of harm. It has also created an environment of shared responsibility and transparency and there has been a steady decline in the number of falls across the Trust, including during winter when seasonal variance would normally be seen.

Although Safety Huddles are not the only reason for this, they are certainly a contributing factor by identifying high risk patients early and putting in appropriate fall prevention interventions.

A working group was formed including nursing, medical, therapy services, pharmacy, domestic services and the communications team to lead the implementation of the project.

The group used data and evidence gathered from inpatient areas to determine the seven key things to cover in all Safety Huddles. These were:

- **Falls**
- **Pressure Ulcers**
- **Mental Health /Mental Capacity**
- **Deteriorating Patients**
- **Nutrition/hydration**
- **Critical medicines**
- **Staff wellbeing**

A suite of resources that included an **intranet site**, prompt card and posters for all inpatient ward areas was developed and distributed to display and use.

Wards identified as high priority were also offered additional support in establishing the process. Regular revisits to the wards, observing huddles in practice, and supporting where needed helped to ensure consistency and standardisation.

An incredible improvement delivered by so many colleagues which has now become routine practice on our wards.

"I feel empowered to raise safety issues to the MDT" - Ward Nurse

Patient Initiated Follow Up makes best use of appointments

Patient Initiated Follow Up (PIFU) allows patients to arrange their own follow-up appointments for their condition as and when they need them. The aim of Patient Initiated Follow Up is to empower patients to:

- make choices about their own care
- receive care at the point of need
- reduce unnecessary appointments
- leave appointments free for patients who need them and
- reduce the clinical risk to those patients
- reduce Did Not Attends (DNAs) and patient cancellations

A group of clinical and operational staff from multiple services have worked together to develop a standardised way of implementing PIFU across the organisation. This has then led to the development of standardised implementation packs which are available to make this process as easy as possible to establish.

There is a focus on spreading PIFU across the Trust with the target of moving 5% of outpatient attendances to PIFU pathways and for all suitable patients to have the option of PIFU.

For more information, please see **PIFU Introductory video**

Through the process of implementing PIFU across the Trust, there has been lots of learning around what works well to help spread of improvement and what works less well. Through conversations with staff across the Trust, the team have learnt the importance of working closely with clinical colleagues to create opportunity for the adoption of PIFU. Providing an implementation pack, although extremely valuable, can be even more effective if coupled with close clinical engagement and making space for sharing of challenges, best practice, and success stories.

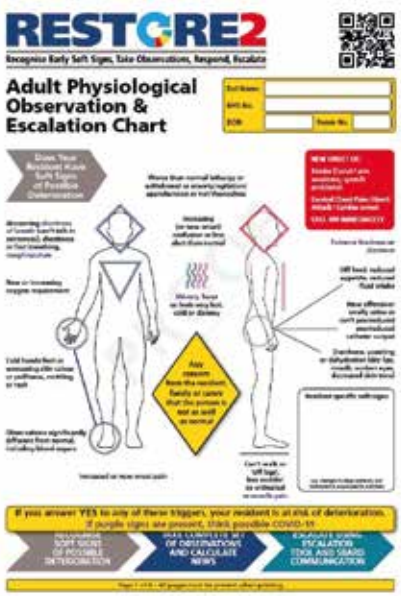
Faster identification of deteriorating patients using RESTORE2

Our Integrated Care Teams are often the first line of communication for housebound patients in the community and therefore the first to notice if a patient under their care becomes unwell.

This contact can lead to the identification of symptoms crucial to the early detection of sepsis. The ICT therapy team recognised the need for a method of identification and escalation for deteriorating patients and piloted the use of the RESTORE2 tool in January 2023.

RESTORE2 can be used when visiting patients to understand if actions need to be taken to escalate their care for urgent assessment (e.g. via a GP, Active Recovery or Community Matron), regular monitoring and support (e.g. via Active Recovery) or emergency assessment via 999. Upon discovering a deteriorating patient, the RESTORE2 prompts visiting staff to ask about the symptoms of sepsis, obtain a full set of observations and use these to calculate the NEWS2 (National Early Warning Score) for the patient.

By using language that aligns with reporting of patient status via NEWS2, visiting staff are able to communicate the needs of the patient more effectively, resulting in appropriate escalation of care.



The use of RESTORE2 has been piloted in the ICT-Therapy North Neighbourhoods and has resulted in an increase in patients identified each day for escalation.

Patients have reported feeling reassured by staff being thorough and case studies have indicated extremely unwell patients being treated urgently in hospital as a result of escalation.

Staff found the process easy, useful, and benefitted from improved communication with GP and ambulance staff.

The pilot is being evaluated and improvements to the tool are being implemented before RESTORE2 becomes part of the standard operating procedure for ICT staff in the community.

Human Factors masterclass

Since March 2022 almost 500 colleagues have attended the new Human Factors masterclass.

Human Factors training concentrates on improving patient safety by understanding the effects of teamworking, tasks, equipment, culture, and communication on human behaviour. The training allows teams to look at the way they work, why errors occur and how we can design better ways to make things safer for patients. One-day masterclass training is offered 3-4 times per month and teams are encouraged to attend together, including the whole Multi-Disciplinary Team (MDT) and governance leads.

"I would recommend this course for all frontline teams and it is an absolute 'must do' for anyone serious about wanting to improve patient safety." Dr Jennifer Hill, Medical Director

Sth.humanfactorsadmin@nhs.net

"It has made me reflect a lot on teams that I work with and how we might all work better if we understood some fundamentals on human factors and team working."

"I am more aware of how distractions can impact patient safety and have put measure in place to minimise distractions"

"I have particularly focused on how I communicate both verbally and by email - in particular being clear from the outset what I am wanting to get out of the communication. "

"I consciously promoted a culture of psychological safety where staff can openly raise and be honest about safety concerns; to have clear shared goals communicated within the team and develop effective strategies to manage overload."

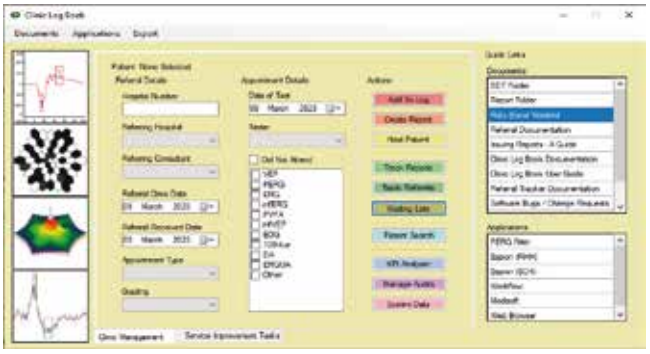
Development of Electrophysiology 'Clinic Logbook' software brings down waiting times

The development of Clinic Logbook software has helped to improve the management of waiting lists within the Visual Electrophysiology service in Ophthalmology.

Patients of the service are seen at both STH and Sheffield Children's Hospital, each of which have their own procedures and systems. This can make accessing and managing multiple waiting lists complex and time-consuming.

A member of the team, Katherine, who has a background as a software engineer, thought it would be possible to develop a Waiting List screen for the Clinic Logbook, to view all the waiting list information. The Information Services teams at STH and the Children's Hospital were able to work together to arrange the necessary database access and the code was then written to provide the specific functionalities required.

When the team started using the new screen, they noticed variation in waiting times for different types of appointment, ranging between four and seven weeks. The waiting list screen allowed the team to try out different combinations of clinic appointments and view the estimated wait times this would produce. They were able to rearrange clinic schedules to equalise waiting times to five weeks and lower overall waiting times for patients.



Benefits

- Ability to view upcoming booked appointments for their clinic slots and therefore plan ahead for any specific patient requirements.
- Ability to monitor waiting lists for each clinic.
- Ability to take ownership of co-ordinating the different clinic slots to best fit the waiting patients.
- Ability to track waiting list figures over time to better inform future planning.
- Shorter waiting times for patients.
- Patients have a better idea of waiting time to aid planning of follow-up etc.

The waiting list screen (patient hospital numbers greyed out):

Domestic Services sustainable cleaning products

The Domestic Services and Materials Management team are working to introduce more environmentally friendly products which can provide equivalent or improved effectiveness at no additional cost.

For example, Dillan Stephenson, Materials Management Supervisor, undertook a piece of work to change a toilet cleaning product to one that was more sustainable. Following a successful trial in Palliative Care, Dillan and his team rolled out the product across the Trust.

The new product provides an improved performance which assures a clean and safe environment, is simple and safe to use and reduces carbon emissions and plastic and cardboard waste.

An annual supply of sachets will take up less space than a month's supply of traditional liquid product, eliminating 95% of deliveries & associated carbon emissions. The new product saves over £10k per year.

Outpatient option for newborn hearing screening cuts unnecessary referrals

The Newborn Hearing Screening team has tailored the hearing screening pathway to reduce the number of unnecessary referrals to diagnostic testing by working with families to screen babies at the optimal time for their baby.

Parents are now given the option of completing the screening as an outpatient to allow sufficient time for the most accurate outcomes rather than conducting the assessment prior to discharge after birth.

By giving parents the choice of having their baby's hearing screened whilst still in hospital or as an outpatient, the number of neonatal audiology referrals to diagnostic assessment has dropped from 4.6% to 3.1%.

This has reduced demand on the diagnostic audiology service due to fewer unnecessary referrals and most importantly reduced parental anxiety.

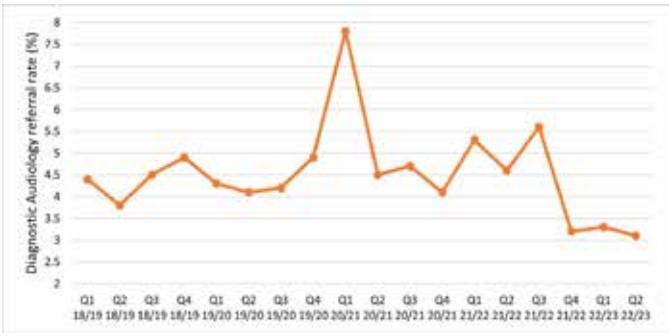


Illustration
Referral rate in Jul - Sept 2021 = 72 babies
Referral rate in Jul - Sept 2022 =48 babies
Clinic time slot = 90 Mins
This equates to an additional 36 Hours of clinic testing time available for those babies and families that need them.

Appointments for diagnostic neonatal audiology are now able to be offered sooner for babies that do require them - improving outcomes and promoting attendance.

Clinicians have more time to test babies, particularly in complex cases, thus improving the overall experience for parents by being able to give an outcome that may have previously required a second appointment.

Patient feedback prompts new venue for neuromuscular clinics

Neuromuscular clinics are being run at Graves Leisure Centre to provide a more patient-centred service following feedback from neurological patients (especially wheelchair users).

Previously clinics were on M floor at the Royal Hallamshire, but this meant patients having to use the lifts, particularly those who needed to use a changing area that was only available on B floor. The team also found that with an increase in video appointments, there were patients who did not attend clinic appointments.

To be more responsive to patient needs, the team ran a trial running the clinics at Graves, which has facilities tailored to wheelchair users and easy parking.

Patients now benefit from a longer appointment (1hr compared with 30 mins previously) at a venue to suit their needs.

Following the success of Graves, clinics are now also booked at Concord Leisure Centre.


Graves Leisure Centre Sheffield


Concord Move More Centre, Sheffield

"Pippa & Katie were friendly, supportive, courteous and informative as always. Always a pleasure to see them and at Graves which I find to be more welcoming than a hospital."

"Very pleasant consultation with the physio."

"Thank you for the excellent consultation. I very much appreciate the NHS"

Education programme boosts spinal cord injury patients' confidence to exercise

The Spinal Injuries Centre developed an evidence-based physical activity education programme to increase patients' knowledge and confidence to participate in physical activity.

The programme was developed following a study undertaken in collaboration with the Peter Harrison Centre at Loughborough University.

People with SCI show the lowest physical activity levels of populations with chronic disability. Following discharge from hospital there is a rapid decline in physical activity with subsequent weight gain, reduced independence, increased risk of cardiovascular diseases and development of secondary complications. Survey results indicated that an evidence-based physical activity education programme, delivered during inpatient rehabilitation could make a significant difference.

Educational videos were developed, co-produced with patients, on several different physical activity topics. The videos contained a mix of professional advice and filmed interviews of people with SCI. These were delivered within a weekly physical activity session.

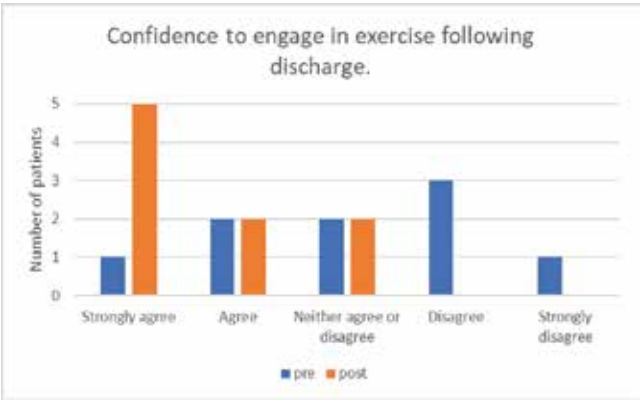
Surveys undertaken prior to and following the physical activity education programme showed that participants reported increased knowledge and confidence to participate in physical activity.

"Sport was very fun, videos were very informative, great to hear from peoples experience"

"Fun session…illustrates the importance and benefits of exercise"

Wider benefits of the project have included:

1. Presented at National SCI conference and fostered an interest in physical activity promotion at the Sheffield Spinal Cord Injuries Centre (SCIC)
2. Created and strengthened a relationship between SCIC and the Peter Harrison Centre for Disability Sport. Together we have secured funding to develop professionally produced videos promoting physical activity and clinical translation of the scientific guidelines
3. Supported a successful bid to Sports England (£2500) to gain further sport equipment and training for staff



International nurses inspiring others with help of leadership programme

A leadership programme has enabled international nurses to take on new roles at the Trust and provide support to colleagues.

The LEAD: CPD funded leadership & management development programmes were specifically developed to introduce a structured and inclusive approach to the systemic development of the Trust's nursing and midwifery leadership pipeline.

The PROUD Behaviours framework, which provides clear examples of the behaviours we do and don't expect to see from all of our colleagues, is a golden thread running through the STH Leadership &

"These conversations have had a positive effect within the culture of the team." - Delta David, B6 Sister, MAPS.

Moni Verma: Project Support Nurse International Recruitment

Management Development programmes.

Staff Nurse Moni Verma, who joined the Trust via the international recruitment programme, has undertaken the LEAD programme, and now supports fellow international nurse recruits to pass their OSCE (Objective Structured Clinical Examination).

She has also taken up a project support role to ensure that all nursing colleagues are aware of the PROUD behaviours by signposting to the framework, leading by example and inspiring others to do the same.

Learn more on the PROUD Behaviours Intranet Site.

Caring for Dying Patients

Over the past 12 months, the End of Life Care team has implemented improvement work in the following areas to support staff to provide compassionate End of Life Care (EoLC) for patients and those important to them.

Identification of dying

Launched an e-whiteboard icon to be used by the Multi-Disciplinary Team (MDT) to identify inpatients who are dying (last days-hours of life).

Personalised Care Planning

Provision of care plans to be used for inpatients who are recognised to be in their last days of life. These care plans support staff to establish patient wishes and to deliver holistic and personalised EoLC.

- Updated and promoted the EoLC section of the Lorenzo Care Plan resulting in a 24% increase in its use.
- Rolled out the 'Caring for Dying Patients: Personalised Plan of Care' (CfDP:PPC) document to be used by medical staff and all other MDT members. Comparative audit showed that using the CfDP:PPC led to improvement in all EoLC standards.

EoLC Education & Training

- Including dedicated EoLC PALMS page, key points videos, Microsoft Teams teaching sessions and study days.

Promotion of Services

- Worked to increase staff awareness of the EoLC support available from the Hospital Specialist Palliative Care Team, Chaplaincy Service and Bereavement Service.
- Promoted staff health and wellbeing support services.

To find out more, contact the EoLC Improvement Facilitators (rachael.keegan@nhs.net / d.sherman@nhs.net)

What Matters to You? Our journey to compassionate care: Combined Community and Acute Services

What if every person-centred service started with asking the question 'What Matters to You (WMTY)?' every time? What if people-centred services aimed above all else to meet people's needs as defined by them, and all outcomes were set with this in mind?

The Leadership team in the Combined Community and Acute Care Group have pledged to build the WMTY culture into every aspect of our business as usual. It features in our business planning processes and documents, and our service development and improvement plans.

- Talking about WMTY whilst walking 1:1s in Community Nursing.
- A Masters dissertation exploring WMTY and Health Coaching in Community Nursing
- The introduction of WMTY patient boards in one of our rehabilitation bedded units in the community.
- A pilot using new paperwork to support WMTY appraisal for staff – 85% of staff experiencing the appraisals process said they want WMTY to be included every time!

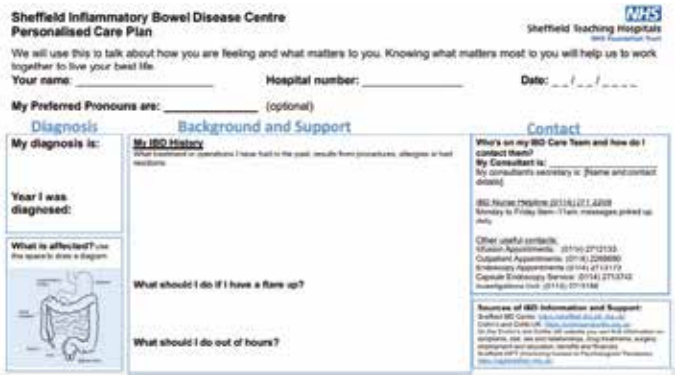
Board from one of our bases – Team leader initiated WMTY Day 2022

"It drew out information from the appraisee about things that really matter to them, and it was an individual, personalised approach "

IBD Personalised Care Plan

The Inflammatory Bowel Disease (IBD) Aware project has seen a personalised care plan focussed on 'what matters to you?' developed and tested to help prepare patients for appointments.

The project has been running for over a year, and is led by Sam McCormick, a patient microsystems coach (click here to read her story). The team includes both patients and clinical members of the IBD team. Having patients in the microsystem adds huge value as they contribute their experience to the discussion.


Sheffield Inflammatory Bowel Disease Centre
Personalised Care Plan

Sheffield Teaching Hospitals

We will use this to talk about how you are feeling and what matters to you. Knowing what matters most to you will help us to work together to live your best life

Your name: _____ Hospital number: _____ Date: __/__/____

My Preferred Pronouns are: _____ (optional)

Diagnosis | Background and Support | Contact

My diagnosis is:

Year I was diagnosed:

What is affected? (use the space to draw a diagram)

My IBD History

What should I do if I have a flare up?

What should I do out of hours?

Who's on my IBD Care Team and how do I contact them?

My Consultant is: _____

Other useful contacts

Sources of IBD Information and Support

Testing of the care plan started in October 2022 and so far approximately 15 – 20 patients have tested out the form. The care plan is a form that patients complete prior to their outpatient appointment that documents their IBD history and asks the question 'what matters to me?' It helps to structure the consultation and focuses on what is important to the patient.

The project will continue into the summer, with a view to it being formalised and integrated into all IBD patient care later in 2023.

Sam, who is also a patient, said: **"IBD not only affects me physically, but it also affects my mental health and other aspects of my body. Asking 'what matters to me?' on the care plan has given me permission to ask the questions that I haven't been able to ask before. There isn't a one size fits all, and it is essential that care is personalised to the individual patient".**

Shared care approach empowers dialysis patients.

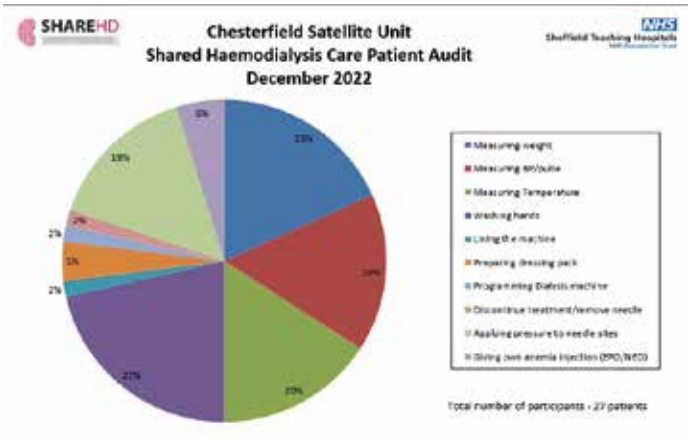
SharedHD Care empowers patients on dialysis by giving them the opportunity to be involved in their treatment. Patients can do small tasks from taking their own blood pressure, temperature and weighing themselves, to bigger tasks like preparing their own packs, lining the machines, programming their session, disconnecting from the machine after dialysis, removing needles, applying pressure and taping themselves. The aim of this is to help improve patient experiences and outcomes within the dialysis unit.

To implement this, staff attend two-day training on shared care so that they can be able to train and support the patients. An appointed SharedHD Care team with a link worker oversee the whole programme within the unit, carry out the audits and share the reports of the progress.

Patients have a competency document which they work through with the staff. Once they achieve the competency this is signed off by the staff member doing the training.

The benefits for patients are:

- Shared decision making
- Improved patient participation
- Improved patient confidence
- Improved dialysis outcomes
- Improved mental health and wellbeing as expressed by some of the patients
- Improved staff-patient relationship and vice versa



The benefits for staff are:
Staff have acquired knowledge and developed better understanding of SharedHD care and their role in supporting the patients who are interested in participating in their care.

"As a Renal dialysis nurse, we support patients with shared care. It gives them a sense of joy that they are doing their own dialysis under the support of the staff. The shared care training was an eye opener as I learned a lot from other people based in different units across the Midlands and Yorkshire. I have realised that shared care is not just for the assigned champions on the unit but for the whole team to join hands and support the patients." Staff nurse - Gloria Right

"I now feel that I am in greater control of my dialysis. I have ownership of my dialysis." - Charles Robinson

"Shared care has given me confidence and independence and I feel that am contributing into my haemodialysis care. This has also given me a sense of belonging as I feel valued and part of the team." - Roy Marther

Frailty Unit Virtual Ward supports patients to remain at home

The NHS is increasingly introducing virtual wards to support people and monitor their condition at home.

The national focus for virtual wards is in two areas: frailty and acute respiratory infection.

We have launched a Frailty Virtual Ward (VW) to enable more patients who are stable and can safely recover outside of hospital to get the care they need at the place they call home, including care homes. These patients receive the acute care, remote monitoring and treatment they need while in their own environment, with daily reviews by clinical staff to ensure any issues are promptly picked up.

Patients benefit from a reduced stay in hospital and less exposure to the risks associated with admission, and the safety of familiar surroundings and the closeness of family and carers who know them. It also releases bed capacity for patients requiring acute care.

So far more than 20 patients have been transferred from the acute setting to the virtual ward, and the aim is to create a 60 bed capacity for the virtual ward by April 2024, allowing for 257 patients per month to benefit from being cared for in their own homes. This

work will support the Trust to develop other virtual wards in respiratory and heart failure.

Frontline teams from the community and acute setting, along with project managers, have collaborated using the established Frailty Big Room and Flow Coaching Academy to design and test the new process and ensure the patient is at the heart of the improvement work.

The ambition is to scale up the service by introducing additional functions to manage more complex clinical needs like IVs and oxygen therapy, and look for patients from base wards. The team are also evaluating how patients can remain at home without coming into the acute setting.

Neurology Enhanced Triage Virtual Clinic reduces need for appointments by 18%

In response to a year-on-year rise in patients referred to Neurology outpatients, a post-referral advice service was introduced to triage all referrals with the additional ability to offer immediate advice and guidance or arrange diagnostic tests.

This benefitted patients by providing earlier advice and/or diagnosis and reducing waiting times.

The service resulted in an 18% reduction in appointments required.

The clear advantage was the speed of advice (average turnaround time six days) when compared to the wait for an outpatient appointment (up to 51 weeks) for both patient and referrer. More rapid access to diagnostics was also an advantage with the ability to arrange investigations prior to or instead of an outpatient appointment.

"This service was perfect for my type of question" - Sheffield GP

"The patient's referral letter was triaged, MRI cervical scan arranged, cervical cord compression diagnosed, and patient referred and treated by neurosurgery in less time that the wait for the appointment would have been. What a great service." - Neurology Consultant

Following the success of the pilot the service was rolled out to all Neurology general clinics in the South Yorkshire and Bassetlaw.

An implementation pack has been developed to make it easy for other services to implement enhanced triage and advice and guidance services. The pack can be found on the **Trust Folder icon on the intranet.**

Active Together service prepares patients for cancer treatment

Active Together is a service which supports people with cancer to prepare for and recover from treatment through physical activity, nutrition, and psychological wellbeing support. The service is a partnership between Sheffield Teaching Hospitals and Sheffield Hallam University's Advanced Wellbeing Research Centre with funding from Yorkshire Cancer Research.

The service is designed to optimise cancer treatment, minimise the length of time spent in hospital and reduce the likelihood of complications from surgery.

The service launched in February 2022 and has so far helped 265 people with upper gastrointestinal, lung or colorectal cancer. Expansion into other cancers is also planned for this year.

Elaine's story

Elaine found a small amount of blood after going to the toilet and requested a bowel check. Within a week she had an appointment for a colonoscopy. Elaine was scheduled to have surgery and was referred to Active Together to help her prepare.

Elaine, 79, has been taking part in the Active Together service after she was diagnosed with bowel cancer.

Elaine's first appointment with the Active Together team included some simple tests to establish her physical strength. Following her assessment, Elaine was offered one-to-one appointments with a physiotherapist.

Each patient works with staff to design a plan for their care including exercises to do at home. Elaine's plan was specifically designed to improve the mobility in her legs and included cardiovascular and pelvic floor exercises. She described how her husband has been getting involved too.

"He joined in when he could. I've never missed a day. I thought they would be easy, but I was really feeling it the next day."

"The surgeon warned me before I went in that I would be in intensive care for at least a week after my operation and I wasn't, I was in overnight and that was it. He couldn't believe it; the surgeon was really impressed."

"I've lost four stone over the last year and that has reversed my diabetes, so I'm no longer diabetic. I saw a dietitian during my last visit to Active Together and she gave me a few hints and advice about my diet. The service has been helpful the whole way through my treatment."

Elaine has now finished her cancer treatment but has continued to receive support from the Active Together team to support her recovery.

Electronic MRI referral system is a gamechanger

Working in collaboration with British Heart Foundation and Barts Health Trust, Medical Physics and Cardiology implemented a new electronic system for receiving, processing and managing MRI referrals for patients with cardiac devices.

MRIs are very complex for patients who have pacemakers and most can be scanned safely if pre-defined protocols are followed. The process can involve up to six different staff groups that must all communicate and input into the process. The previous process involved a paper-based system and sending email communication between referrers and the various staff groups.

What Improvements has this system made?

- Improved communication between referrers and
- Staff groups all in one place
- Easier for referrers to make referrals
- Reduced time to handle referrals
- Reduced delays to making appointments
- Helped to increase the number of patients with pacemakers receiving MRI scans each week

Improved quality safety and governance

- Provides customised risk statements for individual patient circumstance depending on presence/absence of higher risk features.

"Quicker and easier to track and check progress of referral and add data at a later date"

"100 times better. Hugely reducing delays from decision to do MRI to the request. Reducing clinician and secretarial time"

Automated cardiac MRI analysis within 60 seconds

The number of cardiac MRI scans performed annually has been steadily increasing with over 2,000 scans performed in the Trust per year. Historically, these scans were always analysed manually by expert staff in the 3DLab or by doctors. The process involves drawing around the chambers of the heart and analysing them to obtain information about how much blood is pumped out on every heartbeat. With the increase in scans required, this manual process, which takes between 20 and 40 minutes, has become time-consuming and has caused delays in reporting the MRI results, which can impact patients' diagnoses and treatments.

To help improve these issues, an Artificial Intelligence tool has been developed and implemented that accurately measures heart function on the scans. The tool analyses the heart and sends the results straight into the electronic imaging system for the clinicians to review within one minute. To date over 3,000 scans have been automatically processed using this tool, freeing up the Radiographers to perform more scans on patients or do other types of analysis, meaning that more patients have received the diagnostic care they need.

Won the **"Artificial Intelligence (AI) to improve patient services and/or safety"** category in the Medipex NHS Innovation Awards and was also the overall winner receiving a £5,000 award.

Deaf Awareness Pack

A Deafness Awareness pack has been developed to increase awareness of issues faced by the Deaf Community and improve communication with patients with hearing impairment.

It was developed as a direct result of feedback from patients with hearing impairments and their carers. The pack includes 'hearing impaired' stickers which patients can choose to use to identify that they have hearing or communication needs.

These stickers were created and successfully piloted in Accident & Emergency (A&E) by Chrissy Patterson, a nurse whose own experience as a carer for her deaf son motivated her to improve communication for all patients with hearing impairment, particularly due to the additional barrier of mask wearing which inhibited lip-reading and other non-verbal communication.

The pack also includes a Hospital Communication Booklet, which is a book of images and simple text to help communicate about basic needs, medical procedures, dietary requirements, and many other common issues. It also gives advice about communicating with people with different needs.

The packs also include a British Sign Language alphabet, details about further training and resources, and top tips for communicating with people with a hearing impairment.

The packs were developed with feedback from Healthwatch and Citizens Advice as well as Speech and Language Therapy and the STH Equality, Diversity and Inclusion Team..

Packs have been sent out to all wards, outpatient departments and community areas and all the resources are available on **SharePoint - Deaf Awareness Resources**

Supporting the carers

We value the role that carers and young carers play in the support and recovery of their loved ones, and have developed a number of resources to help staff signpost carers to support.

Unpaid carers can be any age, including children and young people (known as young carers). Carers provide support in many circumstances, perhaps due to illness, frailty, a disability, memory problems such as dementia, or other mental health conditions.

The Patient Experience Team has worked with Sheffield Carers Centre and Sheffield Young Carers to develop resources including a leaflet, **"Do you look after someone?"**, containing information about support available which should be given to anyone undertaking a caring role for a relative or loved one.

A carers' policy has also been developed outlining the responsibilities of staff working with carers, to identify unpaid carers and support and work with them as partners in the patient's care. Staff can also refer directly to Sheffield Carers Centre and Sheffield Young Carers.

There is also a short, interactive PALMS training which covers the key points in the policy and is ideal for any staff member wanting to find out more about how they can support unpaid carers. Search on PALMS for: Information and Support for Carers.

The **Do you look after someone?** leaflet is available to order via Web Basket.

Reducing ambulance handover delays

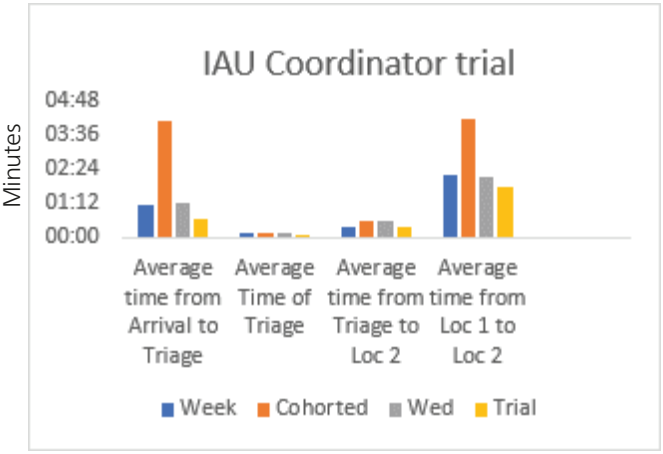
Acute & Emergency Medicine staff took part in a joint improvement initiative with the Yorkshire Ambulance Service (YAS) using the Rapid Process Improvement Week (RPIW) methodology to address the issues of delayed ambulance handover within the Integrated Assessment Unit (IAU) area of the department.

During the pre-work period teams from both organisations met to agree the scope of the project and arranged for key staff to be released from their substantive role to commit fully to the project.

Colleagues from both organisations worked together to explore and understand the problems identified and identify solutions.

The time for triage within IAU significantly reduced as a number of ideas were implemented and monitored.

The work has cemented relationships between the organisations to enable further improvement conversations.



The changes included staff no longer entering retrospective observations and the introduction of an IAU co-ordinator as an additional stand alone position.

YAS have also introduced a co-ordinator role tailored to meet the exact requirements of the Northern General Hospital and have rolled this same model to other acute settings in the South Yorkshire area.

Spinal Muscular Atrophy Clinic for Novel Therapies is UK first

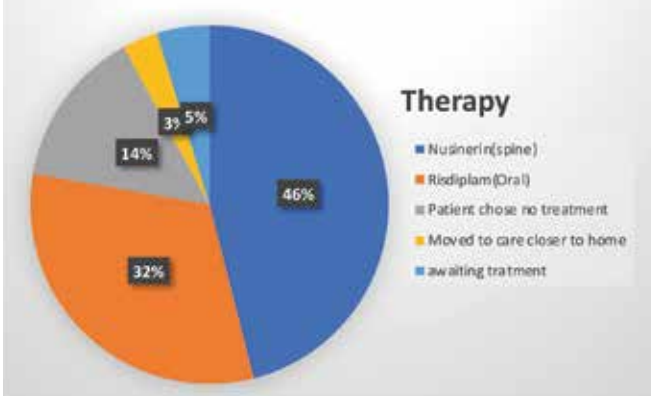
Our Clinical Specialist Physiotherapists have ensured that Spinal Muscular Atrophy (SMA) patients continued to get their care during the COVID-19 pandemic by opening a new specialist clinic which is the first in the UK.

The SMA Novel Therapy clinic (SMANTc) for adult SMA patients was developed following new oral and intravenous drugs being developed which required mandatory detailed eligibility assessments and monitoring of outcome measures.

Footfall through the hospital was minimised by telephone assessments prior to attending SMANTc from both the Neurology Consultant and Specialist Neuromuscular Physiotherapist. The Multi-Disciplinary Team (MDT) then reviewed the telephone information and prioritised patients to four different therapy outcome groups.

Patients assessed as eligible were contacted by the Specialist Physiotherapist to provide further information about attending the SMANTc and to arrange a face-to-face assessment. Patients not eligible were contacted via letter and informed of the reasons. Patients had the option to speak with the specialist neuromuscular physiotherapist, with this personal approach helping to manage patient expectations.

Results: 63 patients in total with an SMA diagnosis were assessed by the MDT and found to be suitable for the SMANTc.



Health coaching for patients with Atrial Fibrillation

The Cardiac Rhythm Management team has helped atrial fibrillation (AF) patients with additional risk factors to access support and become more engaged in their treatment.

The team brought together consultants, registrars, nurse specialists, administrative staff and two patients in a 'Big Room' to assess the service and design an inclusive improvement concept with the aim of delivering better health outcomes for patients.

They used evidence-based learning from Australia to adapt and implement a health coaching model working with patients to help increase their levels of engagement and activation.

It offers patients with AF the chance to attend health coaching sessions in parallel to their existing medical treatment for this condition. This enables patients with additional risk factors such as obesity, sleep apnoea, poor exercise tolerance and smoking to access services both within and outside Sheffield Teaching Hospitals including cardiac rehabilitation classes, weight loss services and smoking cessation. It also increases their own skills and confidence in managing these factors.

So far a benefits appraisal has indicated increased engagement with condition management, reduced hospital admissions and improved skills, knowledge and confidence for both patients and staff.

Advanced Clinical Practice (ACP) Role Review

A need was identified to develop clear, consistent roles for our Advanced Clinical Practitioners (ACPs) which presented fair and transparent career progression opportunities.

There was an opportunity to adopt the Health Education England (HEE) ACP guidance including the creation of standardised Job Descriptions. By reviewing national profiles, analysing exit interviews, and utilising the Trust's Role Evaluation and Competency Tool (REaCT), new standardised job descriptions and person specifications were created, including for a new trainee ACP Band 6 role, a qualified Band 7 role and a new tier of Band 8a ACP roles defined across the 4 pillars of advanced practice (Clinical, Leadership, Education, Research).

This means there is now a defined range of senior roles which can be introduced into multi-professional clinical teams and staff will benefit from a clearly structured career framework, with progression opportunities within the Trust.

"Vital to the recruitment and retention of the advanced practice workforce here at STH"
Suzanne Owens - Consultant Nurse, Professional Lead for Advanced Clinical Practice

Preventing alcohol related admissions

There are high numbers of alcohol related deaths in the UK. Setting up Alcohol Care Teams is a country-wide initiative to help to improve clinical outcomes. A team has been established at STH.

We aim to:

- Prevent hospital admissions
- Reduce length of stay
- Prevent re-admissions
- Act as a conduit between community services
- Reduce stigma
- Make treatment safer and more holistic

The initiatives we have implemented:

- Giving harm reduction advice
- Undertake motivational interviewing
- Identify patients early and have conversations with patients early so ward staff can be freed to treat other patients
- Link with community services and make referrals
- Making referral processes easy
- Needs met in hospital – correct medication at the right time

Care delivered to:
1600 ward based patients
250 Emergency Department (ED) patients
350 outpatients

Feedback from our patients

"I received a prompt, proactive service at the point of need"

"Absolutely amazing. I am now feeling very positive about my future without alcohol"

"Very informative & helpful. Made me realise I had to take steps sooner rather than later"

New Tobacco Dependency Treatment Service

Smoking cessation reduces preventable illness, health inequalities and cost and demand on healthcare across the region whilst improving clinical outcomes.

Our Healthy Hospital Team is a small team set up to identify and treat patients who smoke when they attend or are admitted. Clinicians should ask all patients on admission if they smoke to identify smokers to treat their tobacco addiction and withdrawal symptoms with support and nicotine replacement therapy (NRT). The team also offer referrals for outpatients who are wanting support to stop smoking. The staff stop smoking service is an in-house service which offers 12 weeks of support and nicotine replacement therapy.

Did you know?

- The team currently assess around 400 patients per month.
- Around 30% of these agree to a Community Stop Smoking referral after discharge. Around 80% of these take up the offer, so that's around 100 people / month giving quitting a go who otherwise wouldn't have done.

"I wouldn't have been able to stop without the nicotine replacement therapy and support during my hospital admission." – Anonymous Patient

"I am doing it for my kids as well as my own health and feel much more optimistic about the future." - Stacey Sanderson, Domestic Assistant

Faster cancer diagnostic imaging results

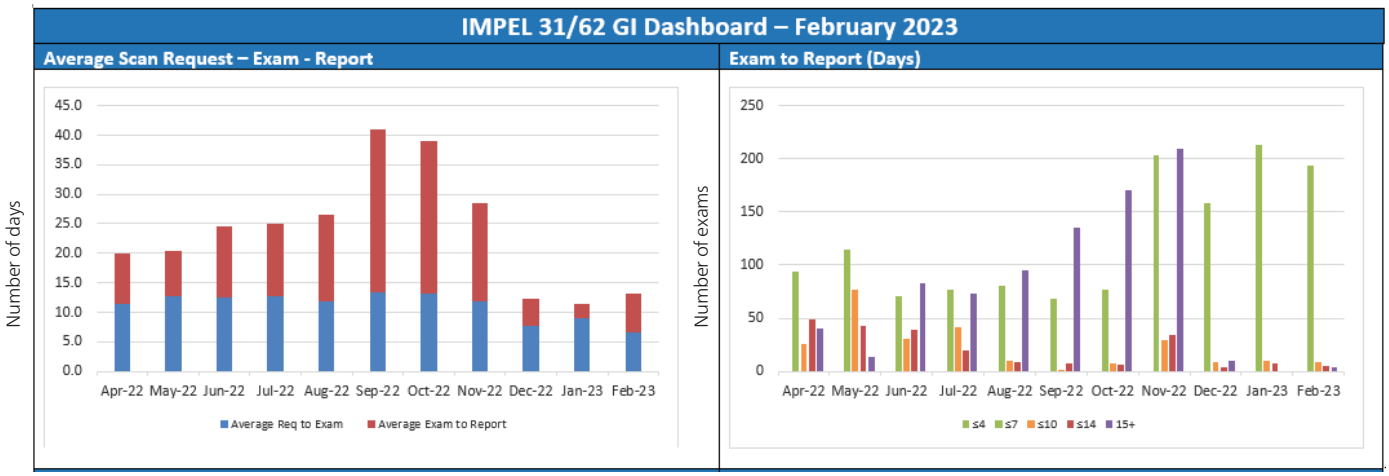
An improvement group has been established with staff from radiology, operational management, and cancer tumour site representatives to understand the cause of diagnostic imaging delays and to develop short, medium and long-term interventions.

The aim of the IMPEL Improvement project was to reduce delays in diagnostic imaging, from request to report, supporting patients to receive their diagnosis as quickly as possible following referral. Already there has been a significant reduction in turnaround times from image request to exam, and exam to report has also dramatically reduced.

Some of the immediate actions taken have included:

- The development of a dashboard which allows colleagues from local tumour sites to see the anticipated turnaround times, setting expectations that enable the rest of the patient pathway to react accordingly to meet cancer targets.
- Clear and immediate contact points which support easy and timely issue escalation, thus enabling radiology to be reactive with slot allocation and prioritisation.
- Clear and immediate contact points to escalate issues with requests such as incomplete requests, non-raising of bloods etc.
- Increased management of requests at patient level to identify and remove barriers to scheduling tests
- Improved vetting turnaround times of cancer requests

The main benefits of the interventions are that patients are either told that they do not have a cancer diagnosis, referred for further investigations or offered a treatment plan in a timely way with the care delivered with the fewest amount of hospital attendances possible.



Thank you

If you or your team have a story of improvement or innovation that you would like to feature in future showcases please let us know by scanning the QR code.

ORGANISATIONAL DEVELOPMENT

Excellent quality patient care

Fulfilled and supported staff

Clinically ambitious and a leader in teaching and research

Well managed, forward thinking organisation