NATIONAL IMPROVEMENT CONFERENCE 2026

NHS IMPACT
Improving Patient Care Together

Leading with purpose to deliver lasting health improvement

In partnership with

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As part of the 2026 National Improvement Conference, we asked people to submit posters to share an example of improvement work that they were proud of, or to describe their organisational improvement journey. I'm delighted to introduce this repository of all the posters, which demonstrates the real depth and rigour of improvement work that is now happening across all parts of the health and care system, in all areas of the country.

One of our greatest opportunities in England is to learn how to learn better – being aware of great work that is happening somewhere else that might have some application in our own context, so that we can test, adapt and scale. I hope this compendium of posters sparks as much energy and as many ideas for you, as it does for me.

Professor Amar Shah
National Clinical Director for Improvement, England

Programme

	Session	Speakers
09:30	**Arrival, networking and posters**	
10:15	**Arrival and chairs' welcome**	
10:25	**Keynote speaker**	**Pedro Delgado**, Vice President, Institute for Healthcare Improvement
11:00	**Morning World Cafés** • Group 1: Partnership and co-production • Groups 2 & 3: Capability culture and leadership • Group 4: Data, measurement and digital	World Café sessions have several facilitators.
	Mainstage: Embedding a quality management system and what it means in practice	**Adam Sewell-Jones**, Chief Executive Officer, East and North Hertfordshire NHS Trust
11:50	**Refreshments**	
12:15	**Afternoon World Cafés** • Group 1: Equity, anti-racism and inclusion • Groups 2 & 3: Capability culture and leadership • Group 4: Pathway, flow and operational performance	World Café sessions have several facilitators.
	Mainstage: Connecting the dots – maximising and illustrating impact	**Dr Ailsa Brotherton**, Improvement Director, NHS IMPACT and Executive Director of Improvement, Research and Innovation, Lancashire Teaching Hospitals
13:05–14:05	**Networking lunch and guided group walk**	
14:05	**Keynote speaker:** Creating tomorrow when today is uncertain	**Dr Amina Aitsi-Selmi**, Leadership Advisory
14:45	**Breakout rooms:** • Skills for collaborative change by Q • Improvement career pathway focus group • Poster walk around	
	Mainstage: Improving together – delivering meaningful and lasting co-produced continuous improvement	**Helen Lee**, Experience of Care Lead **Cristina Serrão**, National Lived Experience Ambassador
15:15	**Refreshments**	
15:25	**Live podcast:** What next? Actions and aspirations for improvement in the NHS	Host: **Penny Pereira**, Managing Director, Q **Caroline Clarke**, Regional Director, London Region NHS England **David Fillingham CBE**, Chair, National Improvement Board, NHS IMPACT **Richard Amos**, Patient and Public Voice Partner NHS IMPACT
16:10–16:30	**Poster presentation awards ceremony and closing remarks**	

POSTERS

Decaf for safer care: Reducing stimulation related risk on an acute in-patient wards

Barnsley Hospital NHS Foundation Trust

WHAT DID WE WANT TO ACCOMPLISH

Problem: The tea and coffee offered to patients is (by default) caffeinated products.

Caffeine being a stimulant can exacerbate the bladder sensitivity resulting in frequent urination, increasing the risk of patient falls.

Our aim: Reduce the effects of caffeinated hot drinks for in-patients as demonstrated by monitored falls & the use of containment pads.

Strategic objectives that align with this project:

Best for Patients and the Public

Best for Performance

Led by
Rachel Jane, Falls Prevention Lead
Lindsay Reynolds, Continence Specialist Nurse, and QI Facilitator **James Cole**

TESTING CHANGE IDEAS

Tasting Event and Initiative Poster

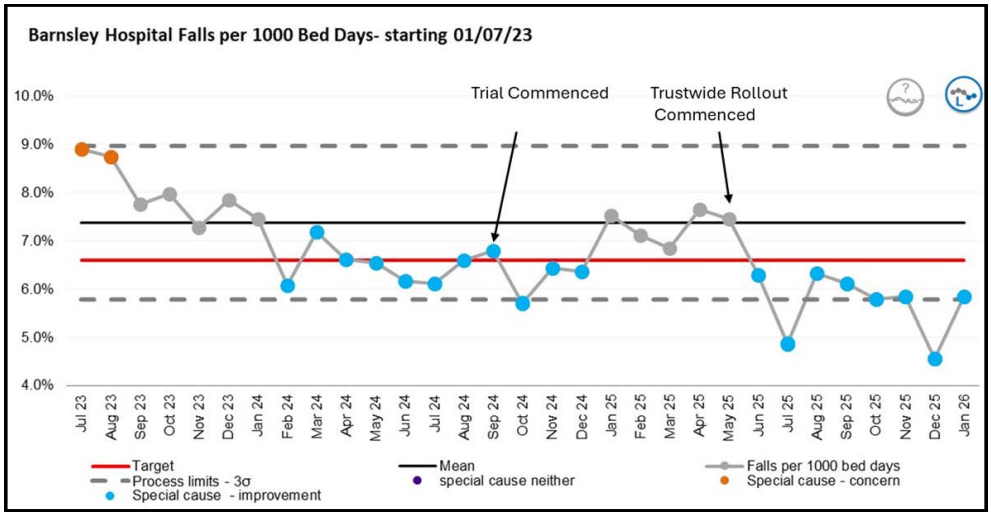
What we did: As part of the promotion of the initiative the team held a '*Taste the difference event*' where staff & visitors were offered to see if they could tell which of the hot drinks on offer were decaffeinated or not. Results from the trial showed that;

- 30 visitors, patients and staff joined the challenge
- 57% preferred the decaffeinated drinks, 36% the caffeinated and 7% could not tell the difference; and
- 57% would consider swapping to decaffeinated post taste test, 13% wouldn't and 30% already drank decaffeinated

A trial of changing to decaffeinated (as standard) commenced 30th September 2024 on Wards 30 and 35 and was extended to the Acorn Unit 21st October 2024. The catering team were fully briefed and on board with the switch with no additional costs incurred. Patients always had the option to choose a caffeinated drink if they preferred. A positive response was received and the decision made for the initiative to be rolled out Trustwide from May 2025.

WHAT WE ACHIEVED

- During the seven-month trial period, there was a measurable reduction in both night-time falls and toileting-related falls across the pilot areas.
- Containment pad usage decreased by 10.2%, resulting in a cost saving of approximately £91 per month across those areas.
- Following the successful trial, a business-as-usual rollout was implemented across all inpatient areas of the Trust from May 2025, with falls continuing to reduce and remaining below the target threshold.
- Further cost saving expected of containment pad usage.



WHAT'S NEXT

What's next: Falls Data and containment pad usage will continue to be monitored as the change has now been embedded on all Adult inpatient wards. Work will continue with supplier of containment pad company to look at pad usage.

Improving Patient Safety: a daily MDT approach on an acute Orthopaedic Ward

Barnsley Hospital NHS Foundation Trust

Significant and sustained improvement in medication errors, antibiotic stewardship and VTE compliance

Led by ACP Claire Lawson

along with Ward 33 Trauma & Orthopaedic MDT colleagues, and QI facilitator Dr Clare Ginnis

WHAT WE WANTED TO ACCOMPLISH

Problem: There are missed opportunities to highlight and address patient safety factors, clinical concerns and workload factors that affect experience, efficiency and flow during current board rounds. It matters to work on this because having regular, streamlined, focussed multidisciplinary discussions about a range of factors that affect safety, efficiency and experience can improve outcomes for patients, as well as improving team culture and education.

Our aim: We aim to undertake a focused MDT safety round on Ward 33 100% of weekdays by April 2025, and to have demonstrable improvements in a range of patient safety parameters.

Strategic objectives this work aligns with:

Best for Patients and the Public | Best for Performance | Best for People

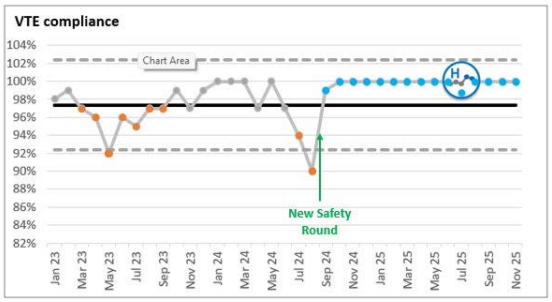
WHAT WE TESTED

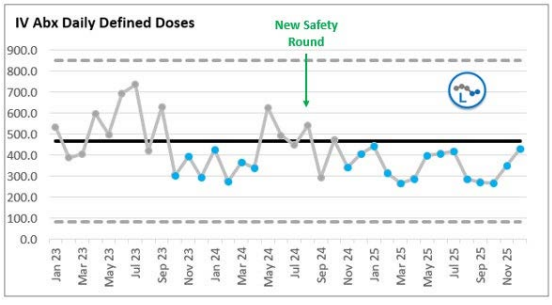
Full MDT: ACPs, resident doctors (each with a designated digital platform to check/update), lead nurse, T&O seniors, orthogeriatrician consultant, AHPs, discharge coordinator, trauma coordinator:
- any MDT member can lead the Safety Round

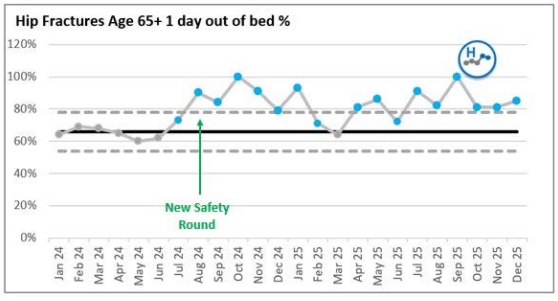
Structure:
- Concerns/unwell patients discussed first
- Falls / new confusion / wound concerns / high Patient Wellness Question scores
- Then all patients:
  - Progress & updates/results etc.
  - VTE prophylaxis
  - Meds (including Abx, analgesia, nephrotoxins)
  - Discharge plans / D1s
- Operational issues & learning points

WHAT WE ACHIEVED

- We achieved **100% compliance** with weekday MDT Safety Board Round PLUS:
- **Nearly 50% reduction in medication errors from average of 6.4 per month to 3.6 per month**
- **VTE compliance sustained >98% for over 12 months & counting!**
- **Sustained reduction in IV antibiotic daily doses, leading to a saving of £15,324 in 12 months, plus an estimated 620 hours of nursing time saved over the year**
- Falls, AKI, ART calls about deterioration/concern have not shown any significant changes.
- 'Day 1 out of bed' post hip fracture surgery for patients 65+ years showed significant improvement – this overlapped with re-structuring the therapy team, whilst also being promoted during the board round
- **100% of MDT staff surveyed feel the new Safety Round is beneficial & relevant, highlights deteriorating patients and allows concerns to be raised & addressed**







WHAT WE LEARNED AND WHAT'S NEXT

What we learned: Having a thorough, structured MDT daily meeting has helped our ward team work more efficiently and has made improvements for patients. Tracking data has meant we are able to prove the value to patient safety

What's next: Continue to follow our safety board round structure, and approach other surgical wards to see if a similar approach could be useful.

Improving Antenatal detection of Small for Gestational Age (SGA) babies at Newham Hospital

Project Team: *Victor Oji, Jenise Jarvis, Alfrina Thomas, Leidimela Amado, Olufunso Dare, Tandiwe Ncube, Berlene Mounkela, Serena Fisher, Louise Jordan*

Barts Health NHS Trust

Introduction and Context

Newham Hospital Maternity Services supports delivery of 5,500 births annually, with 72% of service users being from Black, Asian, and other minority ethnic backgrounds. These groups face higher levels of socioeconomic deprivation (ONS) and lower levels of health literacy, increasing risk of poor maternal and neonatal outcomes.

(Jardine, J., Walker, K., Gurol-Urganci, I., Webster, K., Muller, P., Hawdon, J., Khalil, A., Harris, T. and van der Meulen, J. (2021) ' Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study.' The Lancet, 398 (10314) pp.1905-1912.)

Why focus on SGA babies?

The occurrence of SGA babies is more common in ethnic minority populations and is linked to higher risk of stillbirth and neonatal morbidity. This project began in 2022 building on a Clinical Negligence Scheme for Trusts (CNST) audit, followed by a deep dive into service data, which investigated the SGA drivers within our patient population.

Aim

By following the National Growth Assessment Protocol (GAP), the aim is to reduce the number of low-birth weight babies on (Live births and Stillbirths) at or above 40 weeks gestation through full implementation of GAP care pathway which includes a 3rd Trimester scan at 38-39 weeks gestation by March 2025 by 5%.

Understanding the problem:

Methods/PDSAs

Using the WeImprove methodology, and Model for Improvement identified our aim

Used QI tools to understand the problem:
- Focus group meetings
- Process mapping sessions
- Fishbone analysis
- Literature review

Staff feedback
Patient feedback
Audit/Deep dive
Datix

Developed a Driver Diagram to identify Primary and Secondary Drivers and change ideas

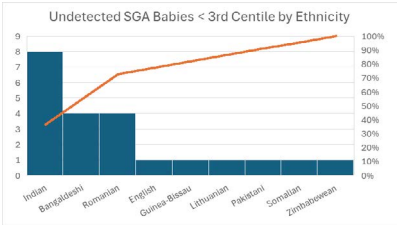
Implemented change ideas

Measurement and Data:

In 2022, GAP training compliance for midwives was at approximately 62%, which was not ideal. In 2023, concerted efforts to specifically address the community midwives, who see the bulk of low-risk birthing individuals, led to more regular, though still ad hoc, delivery of necessary training, with improved compliance to 81%.

In 2024, the launch of Grow 2.0 introduced system improvements and the recruitment of a specialist midwife trainer in collaboration with the Perinatal Institute to further develop training delivery. As a result, compliance levels have increased dramatically to 92%. Consequently, an increase in detection from 39.1% baseline in 2022 to 51% in Q3 2024 whilst the national average remained static at 42% was seen.Q4 showed a slight decrease assumed to be associated with digitised GROW 2.0 assumed to impact on the information available for clinician's decision making.

Sustained downward shift and reduced variation seen for last 46 weeks with a new average of 1.8 SGA babies being born each week, down from 3.19 – a 43% reduction! Still births at term (40wks) have also reduced.



Case note review of 22 births shows Indian, Bengali, and Romanian birthing people are more likely to have SGA babies born under the 3rd centile. We would suggest further research be undertaken to understand causation for those from a South Asian heritage.

Impact and Lessons learned:

By improving the understanding of risk, we aimed to encourage early booking in subsequent pregnancies, optimise booking risk assessment for SGA and the allocation of resources i.e. Low dose Aspirin prophylaxis and ultrasound scan surveillance.

- This QI project led to a further QI project looking at Scan capacity (balancing measure).Reduction in weekly numbers of SGA babies being born. Improved detection rates.
- Earlier identification of babies at risk, enabling safer, timelier monitoring and intervention.
- No SGA related term (40 weeks) stillbirths for two years, improving safety for birthing people and babies
- Improved support in future pregnancies via SGA Alert cards and system flags
- Emerging actions included the review of USS images as part of the analysis when moving towards sustainability. Deeper dive into ethnicity relevance of birthing people impacted i.e., South Asian community.

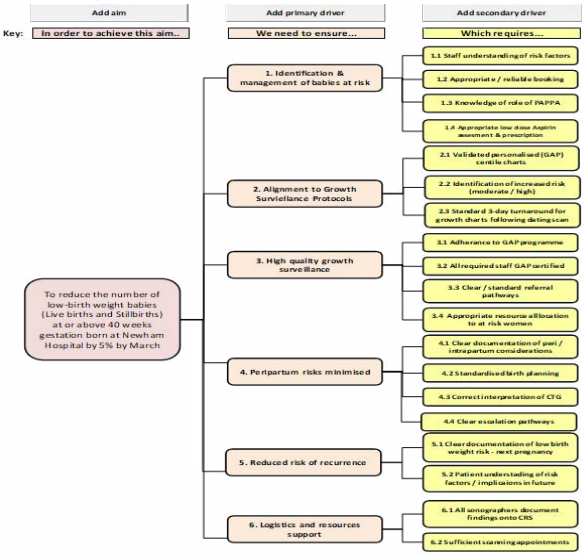
Key Findings of deep dive:

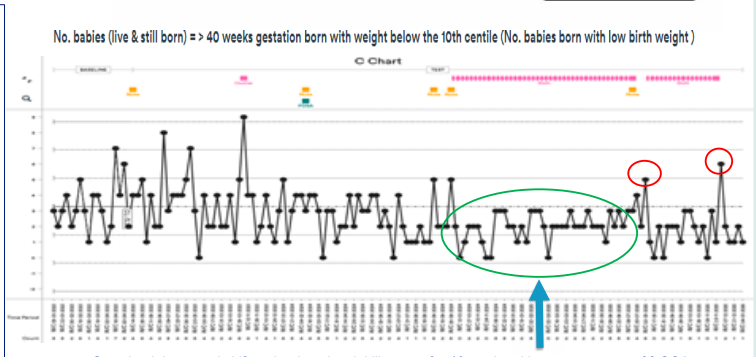
Our analysis highlighted several critical gaps:

- Limited awareness of individual risk status among birthing people
- Delays in early antenatal booking due to systemic barriers e.g. informational inequalities and language barriers
- Lack of timely education around the implications of having a low-birth-weight baby and the interventions available

These findings emphasized the urgent need for a more proactive, informed, and equitable approach to care, particularly for those at risk of SGA pregnancies.

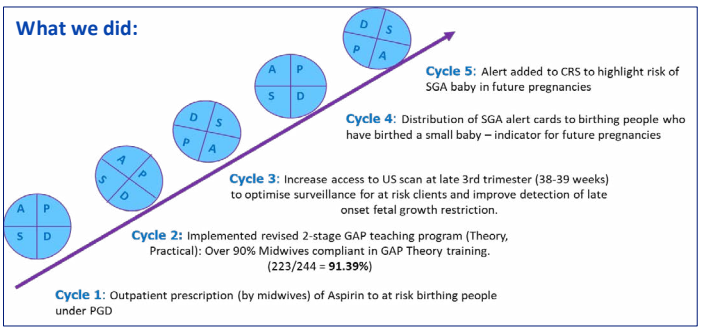
Our theory for change (Driver Diagram):

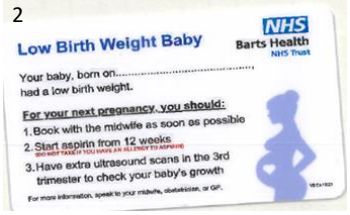




Sustained downward shift and reduced variability seen for 46 weeks with a new average of 2 SGA babies being born each week. No still births at term (40wks) for 2 years. Aim of project met.

What we did:





Pic 1: Antenatal education, awareness and feedback session held with local community groups
Pic 2: SGA alert card – co-designed with Maternity & Neonatal Voices Partnership members

NATIONAL IMPROVEMENT CONFERENCE 2026

NHS
Barts Health
NHS Trust

Developing a Quality Management System
across Barts Health Group

WeImprove
Excellence and innovation in safe and compassionate care

At Barts Health, we have been on a seven-year improvement journey to embed continuous improvement (WeImprove) across the organisation, building quality improvement (QI) capability and capacity, through a ten-year dosing model, aligned to priority programmes and projects.

In 2025, we entered the next phase of this journey by developing a Quality Management System (QMS). The QMS provides an integrated, organisation-wide approach to continuous improvement, bringing together quality planning, control, improvement and assurance. Aligned to organisational priorities and the five NHS IMPACT domains, it strengthens cultural change and creates a consistent system that connects frontline improvement to strategic objectives.

The shift from isolated projects to a single, coherent system ensures that improvement activity is sustained, measurable and focused on what matters most. The QMS creates a visible 'golden thread' linking teams, services and leaders to organisational goals, supported by strong governance, leadership behaviours and data-driven decision-making.

While embedding a QMS takes time, early progress is already evident. Standardised quality planning aligns annual goals and improvement activity. Data-driven improvement has been strengthened through a trust-wide scorecard using Making Data Counts principles, and SPC analysis to prioritise focus. Over 4,400 staff have been trained in QI, alongside targeted leadership development in QMS principles. Visibility and connection have been enhanced through over 100 leadership 'Go and See' visits, and early implementer sites have demonstrated improved alignment, clarity and impact.

These early outcomes indicate positive cultural change, growing leadership capability and a robust foundation for sustained improvements in quality, safety and experience.

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NHS
Coventry and Warwickshire Partnership
NHS Trust

Movement 4 Improvement

How we're transforming curiosity into lasting culture change

Movement 4 Improvement (M4I) is Coventry and Warwickshire Partnership NHS Trust's strategic approach to embedding continuous improvement into everyday practice. Developed by our Improvement Team in response to workforce pressures, siloed services and variable understanding of quality improvement (QI), M4I reframed improvement from a specialist activity into a shared organisational movement, aligned to the People at Our Heart strategy.

At its core, M4I built a shared purpose and vision: to inspire curiosity, encourage creativity and build the courage to improve. A trust-wide rebrand, consistent messaging and visible senior sponsorship made improvement accessible and meaningful, helping staff connect improvement to patient experience, outcomes and wellbeing.

Investment in people and culture was central. Over 1,100 staff have been trained in QI, supported by Improvement Champions, coaching, guides and learning events. By prioritising psychological safety, celebrating success and encouraging experimentation, M4I fostered a culture where staff feel empowered to test ideas and share learning openly.

Leadership behaviours were critical to scaling improvement. Leaders at all levels were supported to role model curiosity, enable problem solving and remove barriers, embedding improvement capability within leadership development.

A structured yet flexible QI approach enabled over 200 projects, improved use of data for learning and stronger sustainability. By embedding improvement into governance and management systems, QI became business as usual. M4I demonstrates how the NHS IMPACT framework can translate curiosity into lasting cultural change, delivering safer, more effective and compassionate care across services and communities.

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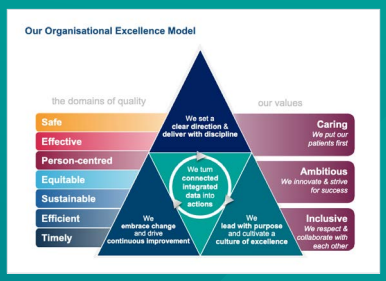
NHS
Guy's and St Thomas'
NHS Foundation Trust

Our journey toward organisational excellence at GSTT

At Guy's and St Thomas', we are creating a vision of organisational excellence that encompasses not only quality and collective improvement, but also integrates our strategy, governance, operational effectiveness and people development. This broader approach ensures that every aspect of our organisation is aligned, fostering collaboration and enabling us to deliver excellent care.



Through close collaboration with corporate, clinical and operational colleagues, we have standardised our definition of quality – i.e. excellence – and are aligning our methods for monitoring quality, setting priorities for change and we have developed consistent ways of delivering improvement, transformation and innovation.

Our Organisational Excellence Model is a visual representation of a purposeful and integrated framework. By establishing clear expectations, consistent tools, and a common language, we empower every team – whether on the ward or in the boardroom – to recognise the significance of their role in delivering safer, higher-quality, and more equitable care. This collective commitment to organisational excellence is vital for achieving sustained improvement.

Our ambition is simple: one trust, one definition of excellence, and one aligned way of improving care for our patients, our communities and each other.

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NHS
The Princess Alexandra Hospital
NHS Trust

Building improvement capability at scale

Applying QI methods to QI training

Princess Alexandra Hospital NHS Trust has taken a systematic approach to building improvement capability across the organisation, applying Quality Improvement (QI) methodology not only to clinical pathways but to the development of improvement culture itself.

Recognising that sustainable improvement depends on people and skills, we established a structured capability-building model combining accessible introductory QI training, leadership development, coaching, and practical support for teams to test and deliver improvements aligned to organisational priorities.

Since 2023, our beginner QI programme has enabled hundreds of staff across clinical and corporate services to develop practical improvement skills and apply them to real problems in their areas. This has been supported by an Improvement Partnership model, project tracking, coaching, and opportunities for teams to share and celebrate their work, helping improvement activity spread across the trust.

Using measurement and feedback to guide adaptation, we continue to refine our approach to ensure improvement becomes part of everyday work rather than a separate initiative.

Our journey demonstrates how applying improvement methodology to capability building can grow confidence, collaboration, and measurable improvement activity across a complex healthcare organisation, supporting the development of a sustainable culture of continuous improvement.

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Quality Improvement Project Summary

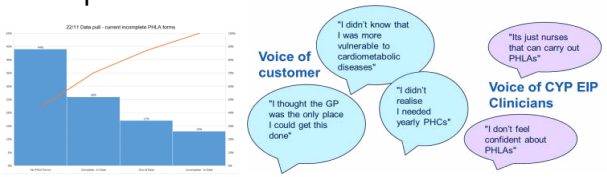
Project Title: **Children and Young People Early Intervention in Psychosis - Physical Health Checks**
Lead: **Georgina Poppa, Team Lead, Children and Young People Early Intervention in Psychosis**

Berkshire Healthcare NHS Foundation Trust

1) Background: People with a severe mental illness (SMI) are at a greater risk of poor physical health and have a higher premature mortality than the general population. Without a physical health and lifestyle assessment (PHLA), young people with SMI cannot be properly screened and offered appropriate physical health intervention.

2) Problem statement: A high percentage of young people on the Children's Early Intervention in Psychosis (EIP) caseload do not have a PHLA completed. In November 2023, 44% of young people on our caseload did not have a PHLA form.
We have a target within our national audit for 100% of our caseload to have a PHLA.
This improvement aim links to 'good patient experience' and 'harm free care' True North Goals.

3) Current State: In November 2023, 44% of the Children's and young people (CYP) EIP caseload did not have a PHLA form. A further 30% had a form that was either out of date or incomplete.

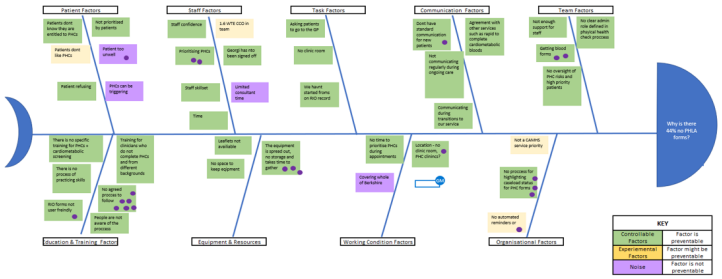


A process map of the current state was completed to demonstrate the flow of a patient through the system, and opportunities for improvement.

4) Vision: CYP EIP will have 100% of PHLA forms completed in date, by March 2025.

Goals: By the end of March 2024, the percentage of PHLA form completed will increase to 44% .
By June 2024, a further increase to 54% of PHLA completed.

5) Analysis, Root Causes and Countermeasures:

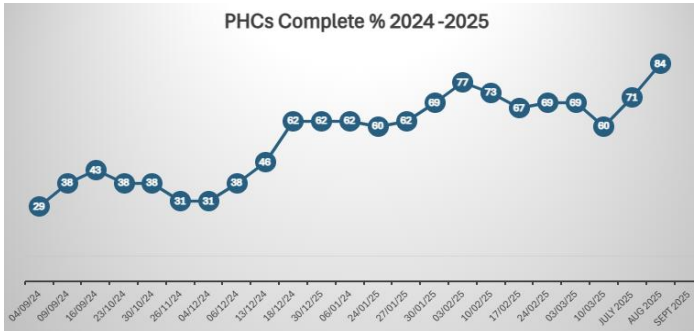


Following root-cause-analysis and prioritisation (above), three countermeasures where selected:
i) Creating a standard work as colleagues identified there was no standard process to follow
ii) Creating a 'grab bag' of equipment to make it easier for colleagues to carry out assessments
iii) Carrying out training for Care Coordinator colleagues.

6) PDSA: All three countermeasures were tested and adopted.
The grab bag has been used with all young people to complete physical health checks.
Standard work is available to clinicians, and training has been completed with the Care Coordinators.

The processes were tested for a longer period than planned to understand what was working and what wasn't.
Further countermeasures were also tested, such as physical health check audits, which were quick to implement as the structure was already in place.

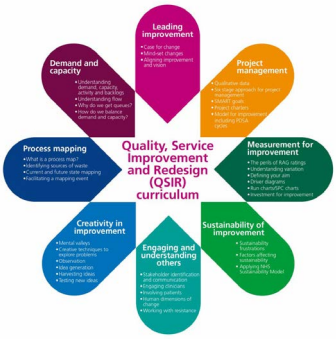
7) Outcomes:
As a result, the process of completing the physical health checks was quicker and smoother; the form was completed, and clinicians feel more confident.
As the process was quicker, young people noticed that there was more time to talk things through and complete PHLA form.



The percentage of young people on the Early Intervention in Psychosis (EIP) caseload with a PHLA completed increased to over 60% by the end of 2024 and to over 80% by September 2025.

8) Insights/Learning:

- All countermeasures were considered successful and will be sustained through monthly business meetings.
- There are already ideas of further countermeasures to be put in place, and the training will need to be repeated if there is a change of clinicians.
- Patients have already noticed a difference with the ease and timing of receiving PHCs. Clinicians feel more confident in this area too.
- I have really enjoyed looking at data and finding ways to present this to the team in a digestible way sometimes it is hard to engage the wider team in things they don't feel directly impact them.



Using the QSIR Approach to Improve Ambulance Start of Shift Processes

NHS East Midlands Ambulance Service NHS Trust

By Andy Magee and Ali Watson

MODEL FOR IMPROVEMENT

What's the problem we're trying to solve?

In August 2024, across the organisation we lost more than 1100 hours (over and above the 15 mins allocated time) at the start of shift. That's over 98 x12-hour shifts.

What are we trying to accomplish?

AIM: To reduce the average time from start of shift to book on from a baseline of 32 minutes to the national standard of 15 minutes by September 2024 enabling us to respond to patients quicker.

How will we know that a change is an improvement?

Reduction in average time to book on.

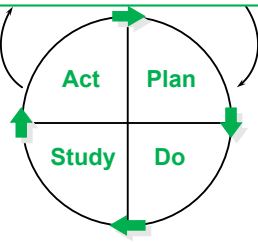
What changes can we make that will result in improvement?

- Change the dispatch process to ensure essential equipment and vehicle checks are completed prior to dispatch
- Improve clarity around what vehicle and equipment checks are needed.
- Improve data quality by developing a mechanism to capture the reasons for late log on's.

What are we trying to accomplish?

How will we know that our change is an improvement?

What changes can we make that will result in the improvement we seek?



QSIR APPROACH

Start out

- SRO identified and governance agreed
- Driver diagram developed
- SMART aim developed aligned to the National and EMAS strategy to deliver a response time of 30 mins to Category 2 calls.
- Stakeholders identified and project team including frontline staff developed

Define & Scope

- Defined current state through crew observations, data review, SOP review
- Fishbone (cause and effect) diagram completed - Key issues:
  - lack of clarity of what checks needed to be completed
  - confusion around what crews could be dispatched to in first 15 mins
  - Confusion at what point crews should book on to shift
  - Not clear what to do if there was no vehicle to book on to.

Measure & understand

- Outcome Measures agreed: Time to book on, hours lost to delays in start of shift
- Balancing measures identified: Hours lost to Vehicle off road (VOR) related to vehicle checks
- Benefits identified and mapped to trust objectives.
- SPCs used to monitor impact of the change

Design & Plan

- Action plan developed with key milestones for delivery.
- Safer Ambulance Check SOP amended and approved.
- Clarity of roles provided
- Comms materials and easy read summaries developed by frontline staff
- Late log on form tested with small group of crews
- PDSA testing of timings

Implement

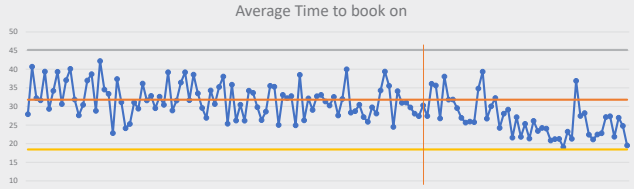
- Three key changes launched:
  - Introduced a five-minute restricted dispatch period.
  - Introduced a late log on form with link on the iPads
  - Priorities checks to be completed
- Clear comms with link to checks on the iPads.
- Monitored impact of the change

Handover & sustain

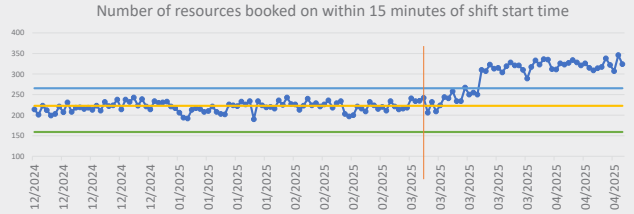
- Dashboard developed from the late log data.
- Lessons learnt completed
- Project closed

IMPACT

Reduction in the average time to book on from a baseline of 32 minutes to 25 minutes.



Increase in crews booking on <15 mins of their start of shift from 48% to 68%.



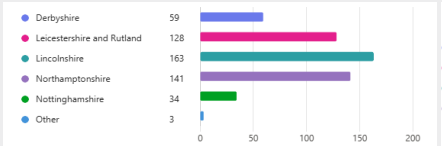
No significant change in Vehicle Off Road (VOR) time.

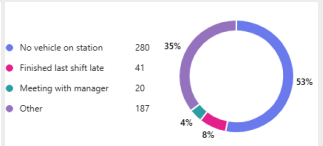
Since launch, of the 16,433 start of shifts, only 57 crews were dispatched to an incident within the first five minutes (0.3%). Of these 57, 30 were dispatched to a cat 1 call.

Since launch, of the 16,433 start of shifts, only 1,212 crews were dispatched to an incident within the first fifteen minutes (7%). 80% of these were dispatched to a cat 1 or 2 call.

Late log on forms submitted by all divisions and from most stations

The main reason for a late log on was "no vehicle on station":





LESSONS LEARNT

- Initial timescales underestimated the number of different staff groups involved in the start of shift process and the time needed to engage all groups
- Governance processes take time
- Proactively engage trade unions early
- Ask people from the target audience to write the comms

RESPOND | DEVELOP | COLLABORATE

South West Day Surgery Improvement Programme

Work in partnership

Improve health outcomes

NHS England South West

Background

In June 2024, the South West region prioritised a programme to improve day surgery rates across a range of procedures recommended by the British Association of Day Surgery (BADS), as well as improving length of stay (LoS) for ambulatory arthroplasty pathways. High day surgery rates are a reflection of clinical quality and improved elective surgery productivity. Furthermore, the release of surgical inpatient beds supports elective and emergency pathways and reduces waiting lists, ambulance waits and LoS. Regionally, there was a large variation in day surgery rates for key elective procedures and opportunities to improve.

The programme, led by the Clinical Improvement and Transformation team, closed at the end of June and the elective programme team will continue to monitor progress and provide any further support.

Aims

- To be the first region to achieve 85% day case rates by March 2025 by improving day surgery pathways
- Support and enable South West systems and providers to improve day surgery rates, targeting specific specialities and procedures where they are not meeting the BADS target
- Improve coding and data oversight to accurately represent day surgery activity,
- Improve ambulatory arthroplasty pathways and reduce LoS for hip and knee surgery.

Measurement

Model Health System (MHS) day case data was used throughout this programme, establishing a baseline for each Trust at the beginning, monitoring improvements during the programme and to evaluate the outcomes at the end. Data from MHS is transferred into a bespoke Tableau dashboard by the NHSE Insights and Intelligence team to enable Trusts to view timely data on the 21 specific BADS procedures that were focused on during the programme. LoS data was taken from Secondary Uses Statistics (SUS) Admitted Patient Care Spells (APCS) data.

Statistical Process Control (SPC) charts were utilised to identify and analyse any improvement trends. Surveys were sent to participants during and at the end of the programme to evaluate what went well, what could be improved and what work is in place locally to ensure sustainability.

Method/Design

- A data informed approach with bespoke data packs provided to each Trust ahead of, and reviewed in the meetings to support focus for improvement opportunities
- Initial and follow up visits completed for all Trusts (onsite and online)
- Reports sent with improvement actions following each visit (38 in total)
- Actions agreed and monitored regularly through follow-up meetings
- Sharing of good practice and presentation to clinical teams on successful day surgery pathways, e.g. in gynaecology, where the pathways are more challenging

Learning & Approach

Executive level agreement gained from each Trust prior to commencement of the improvement programme, supported engagement from all Trusts in the region.
Patient centred approach evidenced based pathway improvement work providing safe and high-quality outcomes.
A supportive learning system resources and contacts from Trusts shared to support peer to peer learning and improvement.
Clinically led improvement from the programme lead, Dr Mary Stocker and clinicians within each Trust department helped to drive change.
Tailored support to Trusts with meetings scheduled at intervals agreed with each organisation and further support offered, including visits where needed /requested. The two Trusts with the lowest rates at the start of the programme received a full visit and both have made steady improvement since then.
Variation in engagement from different stakeholders. Some Trust meetings had many participants indicating greater engagement and varying combinations of clinical/executive/programme leads.
Embedding complex ambulatory pathways is not simple to implement and takes time, but improvement was seen in LoS for many Trusts for these procedures.
Programme approach was effective and could be adopted for other areas.

Tools and/or Models Applied

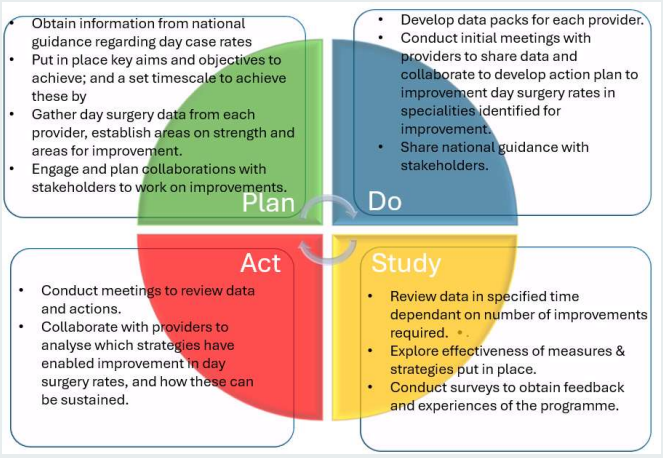


Figure 1: PDSA cycle illustrating the day surgery improvement programme through each of the stages (plan, do, study, act).

Figure 2

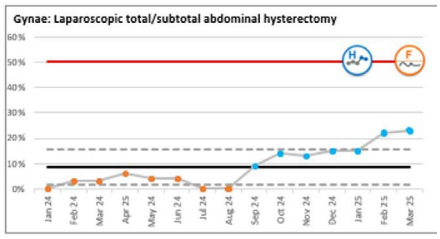


Figure 2: SPC Chart. Noting, in Sept 2024 the Trust day surgery leads and the NHSE day surgery programme team met and had a data led conversation. Gynae pathways were prioritised. Following this intervention, the SPC chart indicates a step change improvement in the rate of women having a laparoscopic total/subtotal abdominal hysterectomy.

Figure 3

Figure 3: Run chart demonstrating sustained improvement in day surgery rates since start of the programme.

Conclusion and Next Steps

As of March 2025,10/13 Trusts achieved the 85% day surgery target, including two trusts with the lowest rates at the beginning of the programme. The three Trusts who did not meet the target achieved 82.5%, 84.5% and 84.7%. LoS for ambulatory arthroplasty pathways improved from 754 to 997 day case spells, with mean average inpatient LoS reducing from 2.2 to 2.1 regionally.

Handover packs have been produced and sent to each Trust to include Trust and regional data trends from April 2023 to March 2025, a remaining Trust actions to progress and a list of supportive resources.

Contacts: Mary Stocker, Lisa Brown, Nicola Mitchell, Sharn Hooper, Rebecca Bridges, David Richmond, Jo McSweeney & Hayley Moule

Transforming Integrated Urgent and Emergency Care in London: Increasing uptake of digital services

> **Minor messaging changes grounded in the EAST framework can yield significant operational impacts and foster sustainable system transformation.**

Efejiro Ashano[1], Kate Lambe[1], Helen Sheldon[1], Andrew Cox[2]

Health Innovation Network South London[1], NHS England[2]

High call volumes strain London's NHS 111 telephony service. While digital options are offered for low-acuity needs, such as dental care or prescriptions, uptake remains low, and a more substantial shift is required to manage call volumes effectively. The Health Innovation Network (HIN) South London was commissioned to support digital transformation of NHS 111. This project was delivered by a multidisciplinary team using data-driven behavioural science and system modelling to optimise entry to the Integrated Urgent and Emergency Care (IUEC) system.

Aims

The project sought to increase digital service uptake by optimising Interactive Voice Response (IVR) messaging. Additionally, we utilised system dynamics to evaluate the key drivers of long-term sustainability and the intervention's impact on health equity across different age demographics.

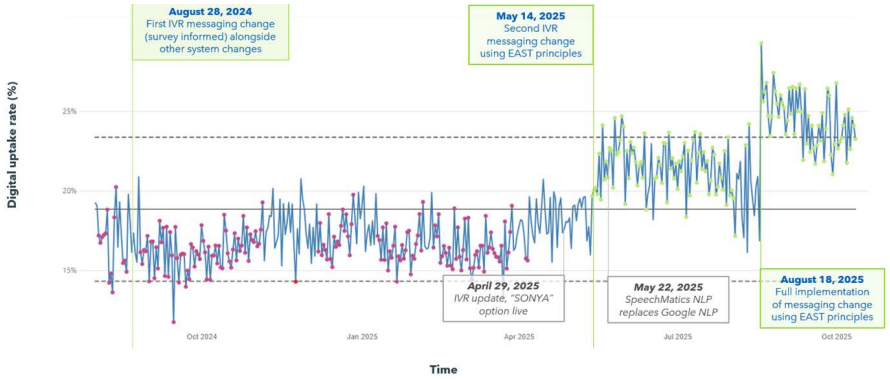
Execution Theory

The project followed four stages:

1. Identifying caller barriers through public engagement
2. Developing messaging variants using feedback and EAST principles
3. Evaluating variant performance via Statistical Process Control (SPC) and Randomised Controlled Trials (RCT), and
4. Implementing the most effective IVR message variant across London. This was supported by technical upgrades, including enhanced SpeechMatics Natural Language Processing (NLP).

Theory of Change

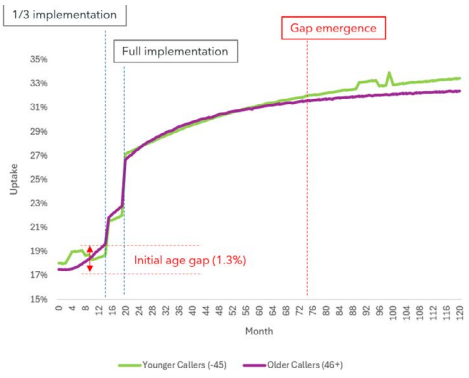
Based on behavioural change theory, we anticipated that improved IVR messaging would increase service uptake. Messaging was framed around the EAST (Easy, Attractive, Social, Timely) framework. We hypothesised that making the digital offer more "Easy" or "Social" would reduce barriers for callers to transition to a digital pathway.



Digital uptake trends in 346,954 callers triaged to the dental, repeat prescription, emergency medication and other low-acuity pathways (sourced from IVR utilisation data between August 1, 2024, and October 12, 2025).

24%

Final digital uptake achieved after full implementation in August 2025, compared to a 17% baseline.



Projected trends for performance in uptake of the digital offer in "younger" (green) and "older" (purple) callers triaged for dental reasons.

Results

Prior to the message change (the intervention), digital uptake remained below 17% up until April 2025.

Improvement: While testing the intervention in May 2025, uptake increased to 21%. After full implementation in August 2025, digital uptake rose to 24%.

Sustainability: System dynamics modelling over a 10-year horizon validated digital uptake as sustainable. The intervention proved five times more influential than word-of-mouth or a caller's prior experience for uptake.

Equity: The intervention bridged a digital divide by eliciting a stronger increase in uptake from callers above age 45, closing a 1.3% uptake disparity when compared to callers aged 45 and below.

>24,000

The number of callers shifted from telephony to digital services based on the 7% increase in uptake across the study population

Conclusions

Minor messaging changes can yield significant operational impacts. Combining RCTs and SPC provides robust evidence, though operational buy-in remains vital. Nudges at digital entry points can reduce health inequities. Next steps involve monitoring potential age-gap re-emergence as service reuse patterns evolve.

Contact Details

healthinnovationnetwork.com
hin.southlondon@nhs.net
@HinSouthLondon

NHS
Hertfordshire Partnership University
NHS Foundation Trust

Faster access to psychiatrists through data-driven and systematic quality improvement methodologies

Daniel Cohen, Dr Sarah Cohen, Dr Katherine Smart, Linzi Barnes & Kelly Dale
Community Perinatal Team, Hertfordshire Partnership University NHS Foundation Trust

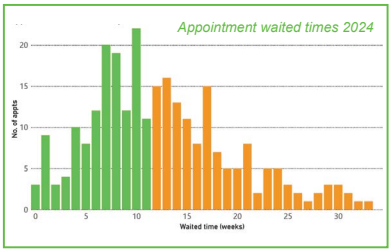
Introduction

The Hertfordshire Community Perinatal Team is a specialist multi-disciplinary team that supports women who are experiencing, or are at high risk of experiencing, moderate to severe mental health difficulties when they are pregnant and after having their baby.

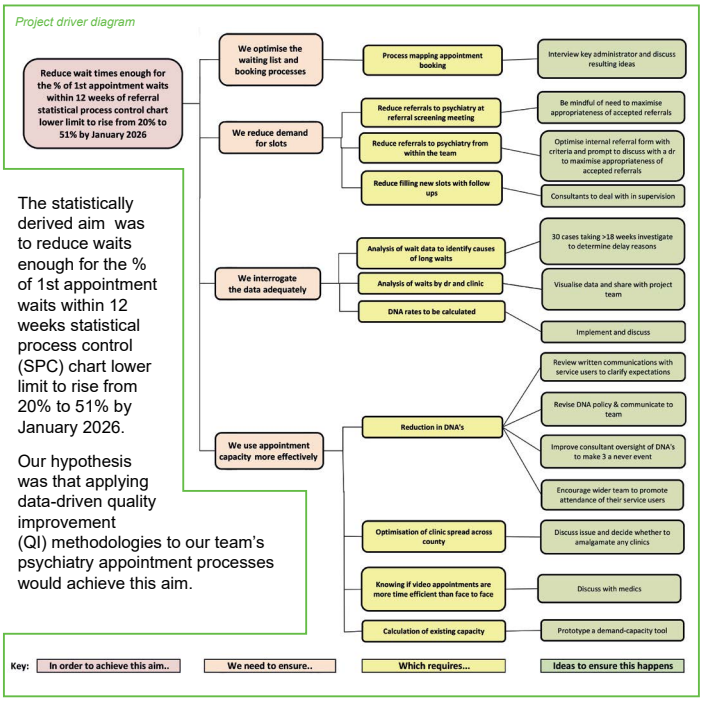
This poster summarises a project that started in the autumn of 2024 and is ongoing.

Our vision for the project was that timely expert psychiatric supervision of care can prevent deterioration and promote recovery.

In the 6 months July to December 2024 only 45% of the 200+ attended 1st psychiatry appointments were within 12 weeks of referral. See below barchart of 2024 waits.



Project driver diagram



The statistically derived aim was to reduce waits enough for the % of 1st appointment waits within 12 weeks statistical process control (SPC) chart lower limit to rise from 20% to 51% by January 2026.

Our hypothesis was that applying data-driven quality improvement (QI) methodologies to our team's psychiatry appointment processes would achieve this aim.

What supported the project's success?

- Forming a working group of a range of roles who met regularly.
- The support of team leadership.
- Consulting people who had previously done projects with similar aims.
- Exploring the data by doctor and clinic to tease out differences.
- Applying QI methodologies.
- Brainstorming solutions with doctors and a key administrator.
- Engaging with the wider team.

What did we learn?

- Collaboration is key.
- To embrace failure as part of a delivery plan.
- To have faith that the project will succeed when things feel messy and uncertain.
- Applying QI methodologies really works.
- Focusing on improving one area (1st appointment wait times) can have a positive knock-on effect on others (DNA rates for all psychiatry appointments).
- There are anecdotal reports of staff feeling more contained knowing doctors' appointments are happening sooner, and of improvement to clinical outcomes.

What might we do again or differently next time we make an improvement?

- Use a project plan to ensure aims of project are clearly understood by key stakeholders from the outset.
- Have more face to face meetings with stakeholders from the outset.

Conclusions

- Applying data-driven QI methodologies can significantly reduce wait times and DNA rates, and lead to significant productivity gains.
- We have sustained the improvements by monthly monitoring and auditing cases waiting more than 18 weeks.
- Other services could benefit by implementing some of our solutions and/or following similar processes in a project of their own.

Methods

Systematic QI methodologies with collaborative multi-disciplinary work including service user co-production, data interrogation and learning from other teams.

Root causes for delayed appointments were identified through process mapping, a driver diagram and the '5 why's'.

Clinical and administrative staff worked together to review current practices and identify improvement.

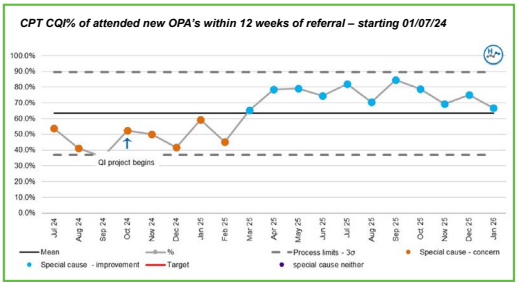
Team-wide engagement was achieved via presentations and an online questionnaire. A Did Not Attend (DNA) rate of around 20% was identified.

We focused on reducing DNAs, aiming to make three DNAs a 'never event'. Referral processes, communications, and policies were revised. Psychiatry cover for MDTs was improved, and staff were encouraged to promote outpatient attendance.

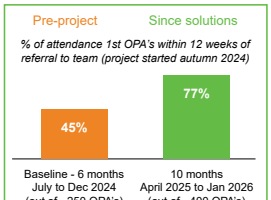
Results

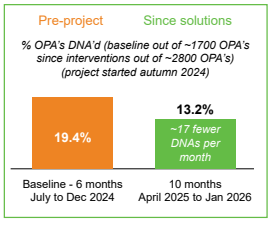
The proportion of attended 1st appointments within 12 weeks consistently increased from 45% to average 77%. ►

The Statistical Process Control (SPC) chart shows this increase in detail. The blue dots indicate improvement due to specific cause or causes rather than chance. ▼



The mean waited time consistently reduced from 16 weeks to average 9½, and the median from 13 weeks to average 7½.





▲ Though the focus of the project was on 1st psychiatry appointments, the DNA rate for all psychiatry appointments reduced from 19.4% to 13.2%.

The productivity gain from project savings in psychiatrists' time alone has been estimated to be £5000 per year, with additional gain through administration time savings.

Acknowledgements

Community Perinatal Team clinicians and administrators, and Trust-wide Improvement and Innovation, Communication and Finance Teams.

Bibliography

National Institute for Health and Care Excellence (2020). Antenatal and postnatal mental health: clinical management and service guidance. Accessed on 17/02/2026 at https://www.nice.org.uk/guidance/cg192

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). The improvement guide : A practical approach to enhancing organizational performance. John Wiley & Sons, Incorporated.

Institute for Healthcare Improvement (2023a). Science of Improvement: Setting Aims. IHI - Institute for Healthcare Improvement

NHS Institute for Innovation and Improvement (2010). The Handbook of Quality and Service Improvement Tools. Accessed on 17/02/26 at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/44/2017/11/the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf

as One

Our Values
Welcoming Kind Positive Respectful Professional

Connecting Innovation, Research and Improvement across Humber and North Yorkshire

Global aim

To better connect **Innovation**, **Research**, and **Improvement** across our HNY system, to support the development of a unified culture that enables accelerated change to happen.

- To co-produce an explainer animation
- To co-design practical pathways
- To co-design a shared language
- To grow and development Communities of Practice

Introduction

Across health and care systems, **Innovation, Research, and Improvement (IRI)** activities are often undertaken in parallel but remain largely siloed. Despite shared aims and overlapping personnel, each domain typically operates with distinct processes, terminology, and entry points. This fragmentation limits collaboration and creates barriers when initiatives move between dom ains.

Demand for IRI activity continues to grow while resources remain constrained. Expectations of what can be achieved with those resources are increasing, and the consequences of inaction are substantial. These challenges highlight the need for stronger integration and alignment across IRI domains.

This project is funded through the Q community's Supporting Q Connections programme.

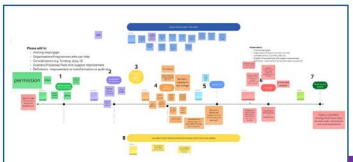
Find out more here:
hnyicb-ery.iris@nhs.net

Timeline

Improvement Methods

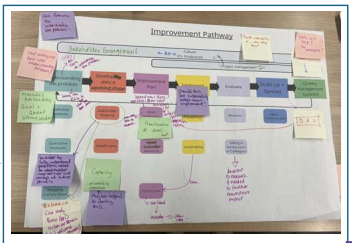
The work so far has used a mix of the Model for Improvement (PDSA cycles) along with the Double Diamond Design model: Discover, Design, Develop and Deliver taking complex ideas, language and pathways and simplifying with stakeholders from across Health and Care organisations in Humber and North Yorkshire (both within and external to the NHS). This process has taken place across three CoPs with a collective membership of over 300colleagues, building relationships and trust across Organisational boundaries as the work progresses.

Progression of the pathways

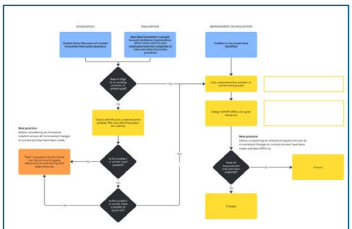


Each CoP co-produced an initial pathway; a high-level attempt at explaining the steps we go through when completing a IRI project.

At each stage, further detail was added including examples of tools, measures and support services within HNY.
We linked with external partners: the Q Community, Health Foundation and NEY Network.



An in-person session made further iterations on the pathways and was used to understand where IRI interconnect.



The pathway is being developed into practical decision trees, which a design agency will be working on.

Measuring Success

As this work is predominantly about building and changing culture which takes time; our measures are mainly qualitative through questionnaires, please see below for some measures: (as we are yet to launch our co-produced tools, we are unable to share data at this point)

- Increase in Research, Innovation, and Improvement work shared across organisational boundaries
- Increase in Communities of Practice membership and participation
- Increase in the number of cross organisation/ joint work in Innovation, Research, and Improvement
- Decrease in the number of "stuck" pieces of work

Feedback from the CoPs

'A great opportunity to connect and learn from each other'

'I value meeting new people and potential stakeholders for future projects'

Innovation CoP

Average Usefulness Rating: ★★★★ 4.48/5

Likely hood of a conversation after this: **Somewhat likely**

Research CoP

Average Usefulness Rating: ★★★★ 4.75/5

Likely hood of a conversation after this: **Somewhat likely**

Improvement CoP

Average Usefulness Rating: ★★★★ 4.31/5

Likely hood of a conversation after this: **Somewhat likely**

The Animation

An amination is currently being created by a design agency it has been voiced by members of the design group who represent members of our system. It demonstrates how **curiosity**, **openness** and **collaboration** are essential foundations of working together to make a lasting, positive impact on lived in Humber and North Yorkshire.

Impact

Through the work we have done so far, we have seen colleagues come together from and build new trusting relationships with one another. We know that building stronger connections across IRI as well as across organisational boundaries will help to change the dial in the way we work together and help to accelerate more transformational change. This work is about building and fostering these strong connections. In the words of Margaret Wheatly we know that creative solutions come from new connections and that to save a failing system we must connect it with more of itself. We hope to demonstrate more of the Impact as our co-produced products launch and we progress with the work.

Anja Jensen, Hannah Parker, Becky Bibby, Callum Schofield, Amanda Lilley –Kelly, Juan Winter, Karen Lucas, Tracey Daniels, Gemma Kierczuk, Tracey Wartnaby, Marie Girdham

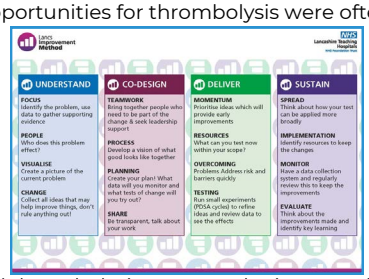
CLOSING THE DOOR TO NEEDLE GAP; EMBEDDING IMPROVEMENT METHODOLOGY FOR SUSTAINABLE CHANGE IN STROKE THROMBOLYSIS

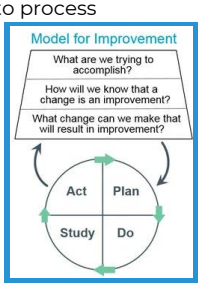
Ben Morris - Head of Improvement Programmes - ben.morris@lthtr.nhs.uk
Dr Clare Gordon - Consultant Stroke Nurse LTH & Senior Research Fellow, University of Lancashire - clare.gordon@lthtr.nhs.uk
Stroke Big Room Colleagues
Laura Nicholson - Stroke Specialist Nurse Team Lead - laura.nicholson@lthtr.nhs.uk

UNDERSTAND

Aiming to double thrombolysis rate from 7% to 14% as defined by NHS Elect using the Lancashire Improvement Methodology

Despite a committed stroke team and established pathways, the Trust's thrombolysis rates for eligible patients lagged behind the national average 7% vs. 14% target. This gap was reflected in SSNAP (Sentinel Stroke National Audit Programme) performance and, more importantly, in patient outcomes, delays in thrombolysis are associated with increased disability and mortality. Analysis of baseline data revealed that delays occurred at multiple points: pre-hospital notification, ED triage, imaging, and treatment decision-making. Missed opportunities for thrombolysis were often due to process variation,
communication gaps, and resource constraints, particularly during out-of-hours periods.



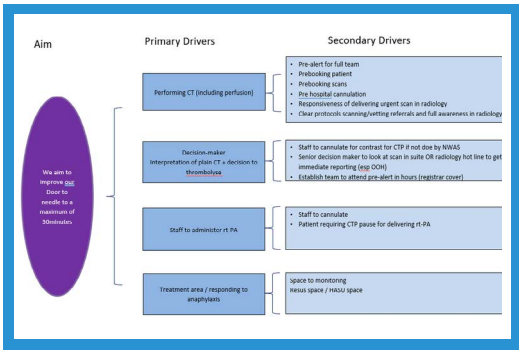


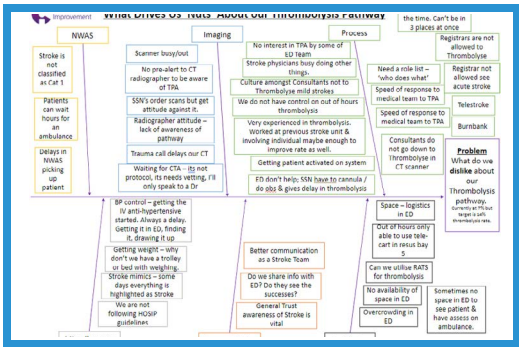
- Thrombolysis is a time-critical stroke treatment for acute ischaemic stroke - blockage of the blood supply to the brain lading to damage to the brain
- Delays in thrombolysis are associated with increased long-term disability and mortality
- Established local pathways and a dedicated 24hour stroke team were already in place
- In 2023, NHS England review of local population and stroke admission data identified thrombolysis rates can be improved to 14%
- Baseline data analysis identified multiple contributing factors to delays: ambulance pre-hospital notification, ED triage, brain imaging and treatment decision-making
- Reasons for missed thrombolysis opportunities were due to: process variation, communication gaps, resource constraints (particularly out-of-hours)

CO-DESIGN

The improvement team designed a multifaceted intervention, informed by the Model for Improvement and PDSA (Plan-Do-Study-Act) cycles. Key components included:

- Standardisation of direct-to-CT protocols for all suspected stroke arrivals, with clear criteria and roles for each team member.
- Introduction of a pre-alert system, enabling ambulance crews to notify the ED and stroke team of incoming patients, allowing for early mobilization of resources.
- Pilot of Harris Flex pre-arrival functionality, enabling rapid booking of CT scans and prioritization of stroke patients in the imaging queue.
- Consultant-led assessment for all suspected stroke cases during in-hours, with escalation protocols for out-of-hours cases.
- Regular feedback and learning sessions, using SPC (Statistical Process Control) charts to monitor performance and identify special cause variation.
- Implementation of the Samuel machine learning tool to analyse missed opportunities and benchmark performance against other stroke centres.





DELIVER

A robust measurement framework was established, incorporating both quantitative and qualitative data:

- Thrombolysis rates were tracked monthly using SPC charts, with data stratified by time of day, day of week, and patient demographics.
- Door-to-needle times were monitored for all thrombolysed patients, with a target reduction of at least 10 minutes.
- The number of missed eligible cases was reviewed quarterly, with root cause analysis conducted for each.
- Staff confidence and satisfaction were surveyed quarterly, with results shared transparently.
- Patient and carer satisfaction was assessed through structured interviews and feedback forms.
- The intervention was designed to be reproducible, with detailed protocols, training materials, and checklists developed for each component. Staff were trained through simulation exercises, shadowing, and peer-to-peer learning.

SUSTAIN

The interventions led to measurable improvements in both process and outcome metrics:

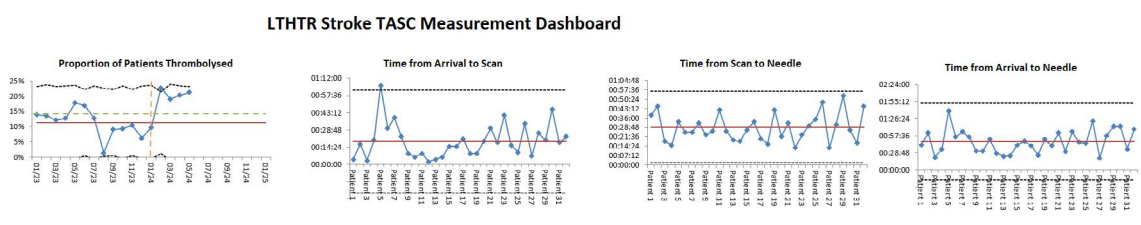
- Thrombolysis rates increased from 7% to 12% over 9 months, with a sustained upward trend.
- Median door-to-needle time decreased by 8 minutes, bringing the Trust closer to national best practice.
- The number of missed eligible cases declined, with root cause analysis informing further process refinements.
- Staff confidence and satisfaction improved, as measured by quarterly surveys.
- Patient and carer satisfaction increased, with positive feedback on communication and involvement.

Challenges encountered included sustaining consultant cover, embedding new technology, and maintaining momentum during periods of operational pressure (e.g., winter surges).

RESULTS

Analytical methods included run charts, control charts, and benchmarking against national data. Preliminary results showed an increase in thrombolysis rates from 7% to 19.5% over 9 months, with a median door-to-needle time reduction of 8 minutes.

The Samuel tool identified additional missed opportunities, guiding further improvement cycles.



Gloves off

Utilising KRFT's Improvement Journey to deliver a successful and sustainable QI project

Authors: Dr Samantha Maisey, Perrine Dhaisne, Emma Stinton, Jonathan Grellier

NHS Kingston and Richmond NHS Foundation Trust

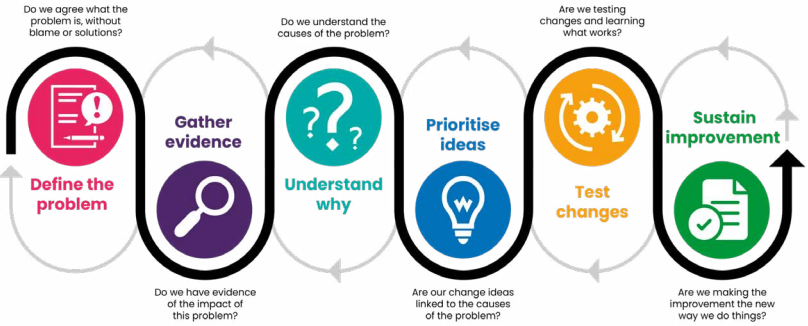
Background

- Environmental Sustainability is a priority for the NHS, with a commitment to reach **Net Zero for all emissions by 2045**.
- Aligned with this ambition, at KRFT we have committed to act sustainably, aiming to deliver high quality care whilst achieving co-benefits for the **3Ps: Our People, Our Planet and Our Pounds**. Considering the 3Ps adds sustainable value to improvement work.
- Our Infection Prevention Control (IPC) team and Clinical Leads for Environmental Sustainability (CLES) embarked on introducing the nationally endorsed **sustainable healthcare initiative: The Gloves Off Campaign.**
- This campaign aims to promote compliance with national infection control guidance by stopping non-sterile gloves being worn unnecessarily, whilst delivering **co-benefits for the 3Ps** (Table 1).
- When planning this campaign, we linked with teams from other Trusts who had already launched it and discovered that it **had varying success**. We felt this was down to different approaches used.
- As such, we opted to start afresh and follow a systematic **QI approach, utilising our KRFT improvement journey** (Image 1) to address the unnecessary overuse of non-sterile gloves at our Trust.

Table 1: Benefits of reducing unnecessary non-sterile glove use

People	• Reduce the potential for cross-contamination & transmission of healthcare associated infections amongst patients & staff • Reduce the level of hand dermatitis amongst staff • Improve patient experience as gloves can be perceived as a barrier preventing interpersonal care provision
Planet	• Reduce the number of non-sterile plastic gloves that we use and therefore reduce our carbon footprint & unnecessary waste
Pounds	• Reduce the number of non-sterile gloves we are using & optimise stock management of these, therefore saving money

Image 1: KRFT Improvement Journey



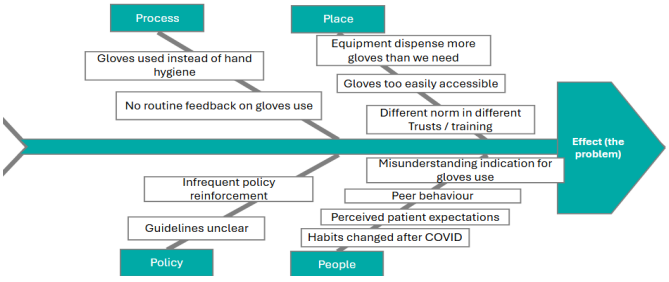
Gloves off at KRFT Improvement Journey Summary:

Define the problem:

Non-sterile gloves have been observed to be used unnecessarily across multiple clinical areas at KRFT in acute and community settings. This can negatively impact the 3Ps.

Understand why: Fishbone Diagram

We used a fishbone diagram to explore what was causing the problem.



Gather evidence:

No. Gloves ordered & associated cost: data collected & analysed to establish a baseline.

31% increase in gloves ordered between 23/24 - 24/25

Observational surveys completed in 3 pilot areas to establish pre-intervention compliance with IPC standards.

Unnecessary use of non-sterile gloves 52 – 61 %

Prioritise Ideas: Our change ideas focused on People – Behaviour change campaign

Adaptation and design of **bespoke education materials** for our staff and patients. Including posters (clinical & non-clinical), staff education pack, whatsapp message, readout for handovers, presentation for departmental meetings, newsletter item, quiz, noticeboard pack, patient information leaflet.

Test Changes:

- 3 pilot wards selected (acute medical, acute surgical, community).
- Different approach for acute vs community (led by IPC and Team leads).
- Engaged with team leads. Agreed pilot to trial materials and approach.
- Developed and shared education materials.
- Feedback from staff on effectiveness of materials & campaign approach.
- Regular meetings with team leads for feedback.
- Patient leaflet developed with patients and patient experience team.
- PDSA cycles within pilot period to adapt materials and approach.

Measures:

Average reduction in unnecessary glove use of 58%

Post intervention observational surveys (after 1 month promoting the campaign)

Data collection (Apr-Oct 2024 vs Apr-Oct 2025) for acute wards:

NB: community data from 2024 not available for comparison

295,650 less gloves
£7713.65 less spend
approx. 887kg plastic saved

Sustain Improvement:

Phased roll out at KRFT. 1 month of support for each department launch & 6 monthly data feedback

Ongoing 1-month PDSA cycles in each department (e.g. materials adapted for specialist teams). Teams have ownership of the materials and how they are used for their staff. Teams guide the support required from IPC/CLES. Data fed back at 6 monthly intervals at team meetings.

Conclusion: By using a systematic QI approach to address the overuse of non-sterile gloves, we were able to address specific drivers of the issue within our local system and tailor the campaign approach to suit the needs of our staff, resulting in a positive behaviour change. This project demonstrates the importance of following a QI approach when engaging staff in sustainable QI initiatives, even if already established elsewhere.

Acknowledgements: With thanks to the KRFT IPC teams and data analyst for co-leading this campaign. The QI team, the staff & patients from our pilot wards, communications team and patient experience team in shaping this campaign. Additional thanks to the IPC/sustainability teams from GOSH and UCLH for sharing their experience and materials to help us when prioritising ideas.

NHS
North West Anglia
NHS Foundation Trust

FRAILTY SAME DAY EMERGENCY CARE

Transforming urgent care for older pepole

We redesigned the frailty front door by introducing a Frailty SDEC model that provides rapid, multidisciplinary assessment and same-day decision-making, reducing delays, avoidable admissions and supporting older people to remain at home.

THE 4S MODEL

Scope: Identifying the project area, setting aims, and understanding the problem.
Shape: Designing the change, mapping processes, and planning the intervention.
Shift: Implementing the change through small-scale tests, often using PDSA cycles.
Sustain: Monitoring, auditing, and embedding the improvement into daily work.

WHAT DID WE DO?

We redesigned the front door for frailty. In response to rising demand, long waits and avoidable admissions, we created a Frailty Same Day Emergency Care (SDEC) model that delivers rapid assessment, stabilisation and same-day decision-making for older people with frailty. Built through strong clinical leadership and deep partnership working, the model brings together geriatricians, ACPs, nurses, therapists, pharmacy, social care, Virtual Ward and community IV teams to provide integrated, multidisciplinary care from the moment a frail patient arrives.

Using structured quality improvement methodology — daily huddles, PDSA cycles, real-time data dashboards and process mapping — we redesigned pathways to reduce delays, prevent social admissions and keep people where they want to be: at home. The model embeds a shared Comprehensive Geriatric Assessment (CGA), therapy-led decision-making and early senior clinical input, ensuring safe, timely and person-centred care.

This work has also begun to build the evidence base for a left shift of frailty care into the community, demonstrating that early assessment and stabilisation can safely happen outside the acute hospital and aligning directly with the ambitions of the NHS 10 Year Plan.

WHAT WAS THE IMPACT? THE IMPACT WAS IMMEDIATE, MEASURABLE AND TRANSFORMATIVE.

58 BEDS RELEASED ANNUALLY THROUGH BETTER UTILISATION

READMISSIONS REDUCED FROM 22% TO 10%, DEMONSTRATING SAFER, MORE EFFECTIVE CARE

50%

LENGTH OF STAY HALVED (12.6 HOURS VS 28.2 HOURS)

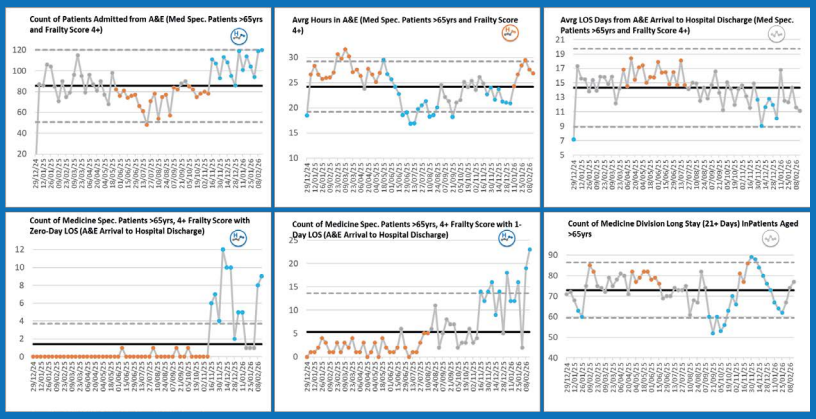
ED TIME REDUCED BY 5–10 HOURS FOR FRAIL PATIENTS STREAMED TO SDEC

SOCIAL ADMISSIONS AVOIDED THROUGH EMBEDDED THERAPY AND SOCIAL CARE

STRONGER **COMMUNITY INTEGRATION**, ENABLING SAME-DAY IVS, VIRTUAL WARD MONITORING AND RAPID FOLLOW-UP

94% **POSITIVE PATIENT EXPERIENCE**, WITH FAMILIES PRAISING SPEED, KINDNESS AND DIGNITY

The model didn't just improve metrics — it changed culture. Staff confidence grew, MDT working strengthened and the system saw what is possible when frailty care is redesigned around the needs of older people. The evaluation demonstrated that frailty admissions are often driven by system design rather than clinical need, and that early MDT intervention can safely prevent escalation.



Top: Counts of A&E Admissions and their Journey time in A&E and in Hospital for Frail Patients aged >65yrs.
Bottom: Counts of patients turned over in 1-Day and 2-Days (from A&E arrival to Hospital Discharge) and the Count of Long Stay patients aged >65yrs across all Medicine Base wards.

WHAT WERE THE OUTCOMES?

- Safer, faster, more dignified care for older people
- Fewer avoidable admissions and reduced deconditioning
- Improved flow and winter resilience
- Better continuity through integrated community follow-up
- A consistent, high-quality frailty pathway
- A strong foundation for shifting activity into the community

Patients experienced quicker decisions, earlier therapy input and smoother transitions home. Staff reported improved morale, clearer pathways and stronger relationships across acute and community teams. The model demonstrated that when the right MDT is available at the right time, many frailty admissions can be safely avoided.

WHAT HAPPENS NEXT?

Our future vision includes:

- Relocating Frailty SDEC into a community hub, closer to where people live
- Shifting activity and workforce upstream, enabling earlier assessment and stabilisation
- Strengthening seven-day therapy, social care and senior decision-making
- Building a single integrated frailty operating model across acute, community and primary care
- Digitising the CGA and improving shared records

We are now ready for the next phase: **moving frailty care into a community setting.**

- Expanding Virtual Ward and community IV capacity
- Aligning commissioning to outcomes, supporting the left shift

This is the next evolution of the model: a proactive, preventative, community-based frailty service that keeps people independent, reduces hospital demand and delivers the ambitions of the NHS Long Term Plan.

Working together to provide **outstanding care** for our local communities

Improving the Sheffield Psychiatric Decisions Unit (PDU)

Jenny Morton, Clare Glossop and Dr Raihan Talukdar

Contact: Jenny Morton, *Jenny.Morton@sheffieldpartnership.nhs.uk*

Background

This work took place within Sheffield Health Partnership University NHS Foundation Trust (SHPU), home to one of only six PDUs currently operating across the country.

The PDU is a specialised, short-stay facility (typically <48hrs) designed to provide rapid assessment, stabilisation, and treatment planning for individuals experiencing a mental health crisis who do not need physical health interventions.

The PDU can offer a more suitable and timelier alternative to Accident and Emergency (A&E) departments by delivering targeted mental health support in a less chaotic environment. Also, by diverting appropriate patients away from A&E, the PDU can help to reduce pressure on emergency departments, allowing emergency services to focus on acute physical health needs.

Despite these benefits, it was noted that the PDU was underutilised.

Aims

The project started in November 2024 with baseline data identifying the average monthly occupancy of the DU was 43%. Our aim was to increase this by 30% by July 2025. Additionally, it was identified that an average of 6% of referrals were declined by the service user.

Qualitative feedback from Experts by Experience (EbE) and staff identified that service users declining referrals to the PDU only included those who had been formally referred, and informal declines were not recorded, and that some staff were not confident in the referral criteria for the PDU. These findings were used to design a driver diagram for the project (see Figure 1).

Reduce service users declining the PDU – Coproducing information with Experts by Experience

Aim: Increase the usage of the PDU by improving the quality and accessibility of information on its website for service users, carers and referrers.

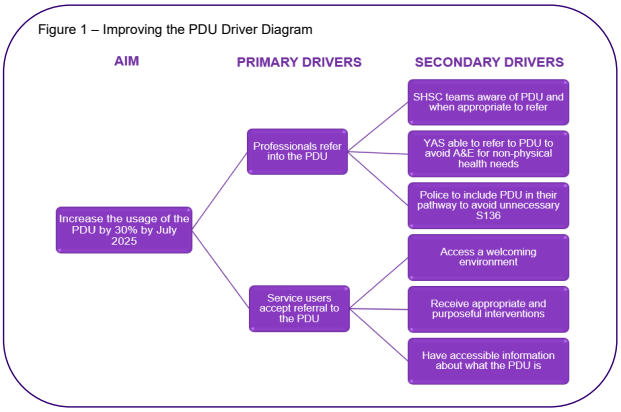
Rationale: Initial feedback highlighted a disconnect between service user expectation and experience of the PDU, and some referrers reported being hesitant to signpost service users to the website due to limited or unclear information.

Measures: Website engagement (hits), online surveys, feedback from EbEs and referrers, and accepted referral rates.

PDSA 1: Feedback was collected through surveys and an EbE focus group, leading to the creation of a Frequently Asked Questions (FAQ) section and included more photos of the PDU. Website ratings improved significantly (EbEs: 2.4 → 4.2; Referrers: 3.25 → 4.0).

PDSA 2 (in progress): A video is being coproduced with EbEs to enhance website accessibility and encourage greater use of the PDU.

Figure 1 – Improving the PDU Driver Diagram



Increase referrals to the PDU – Collaboration with South Yorkshire Police

Aim: Work with South Yorkshire Pollice (SYP) to increase the usage of the PDU by redirecting individuals experiencing mental health distress to this less restrictive service instead of detaining under Section 136 (S136) where appropriate.

Rationale: Police officers have a duty to consult with a mental health professional before using S136 powers where practically possible.[1] An audit of S136 data between Jan-Feb 2025 revealed that only 40% of incidents involved a consultation between police and mental health professionals before the S136, and that 52% of S136 cases did not result in formal detention under the Mental Health Act (MHA). This suggested that some individuals could have instead been supported via less restrictive options, such as the PDU, if the consultation had taken place, potentially easing pressure on police and A&E services.

Measures: Monthly S136 incidents, proportion leading to MHA detention, and police time spent on S136 cases.

PDSA 1 – Approved Mental Health Professionals (AMHPs) were the first point of contact for police to discuss a potential S136, but AMHPs confirmed they were often unavailable to take police phone calls due to being out of the main office. The SYP pathway was revised to replace the primary contact from AMHPs to a dedicated phoneline at the PDU. After a 10-week pilot period, the percentage of consultation calls prior to S136 increased from 40% to 85%. There was no significant decrease in the percentage of detentions post-S136, however, this assured the group that the process was not negatively impacting S136.

Results

The average monthly occupancy at the PDU increased by approximately 68%, from an average of 2.5 to 4.2 (see Chart 1) and the percentage of referrals declined by service users reduced by approximately 47% from an average of 7.8% to 4.1% (see Chart 2).

Chart 1 – Monthly average occupancy at the PDU

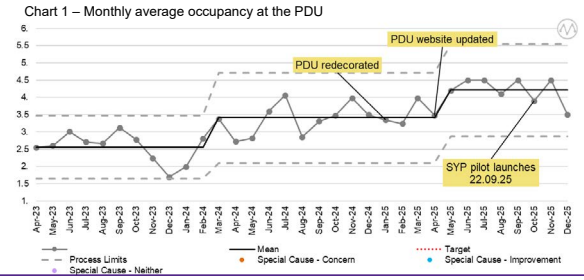
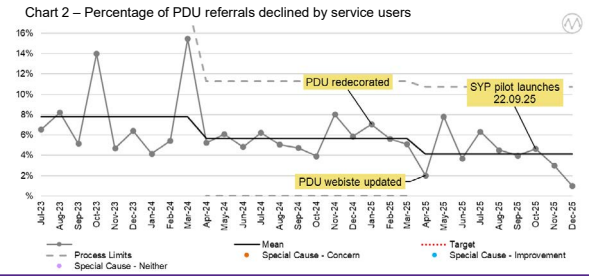


Chart 2 – Percentage of PDU referrals declined by service users



Conclusion

This project demonstrates how collaboration and co-production can significantly improve a service. By improving information about the PDU to both service users and SYP, the average occupancy of the PDU increased and the rate of service user declining the service reduced. These findings highlight the value of accessible information, shared understanding, and multi-agency working, and provide a sustainable model for further service improvement.

References

[1] UK Parliament (1983) *Mental Health Act 1983*, Section 136 (as amended). Available at: https://www.legislation.gov.uk/ukpga/1983/20/section/136

Acknowledgements

This project is funded through Q Exchange by the Health Foundation and NHS England. Special thanks to the Q Community for their support in this project, and to all PDU staff for engaging with this work, particularly Team Manager, Tom Milner, and Deputy Manager, Claire Butler. Thank you to SYP colleagues Superintendent Richard Hammond, Force Mental Health Coordinators Karen Hockley and Jo Carver, and Police Sergeant Sarah Stevens. We appreciate the support of our EbEs, and our Sheffield colleagues who have taken the time to provide feedback for this project. We also express thanks to our Communications team for their support.

SaTH Improvement Hub

NHS The Shrewsbury and Telford Hospital NHS Trust

A Quality Improvement project to redesign the Orthodontic-Oral Surgery pathway at the Royal Shrewsbury Hospital

Theme| Pathway redesign. Digital. Sustainability. Waiting time reduction. Patient safety

Case Study Date | January 2024-February 2026

Produced by | Leonie Seager

Acknowledgements: SaTH Patient Experience Team, SaTH Improvement Hub, OMFS and Orthodontic colleagues

REASON WHY?

The Shrewsbury and Telford Hospital NHS Trust (SaTH) Orthodontics and Oral & Maxillofacial surgery (OMFS) teams, identified prolonged waits (up to two years) for orthodontic patients requiring oral surgery. These significant delays carried clinical risk, such as the development of root resorption occurring in adjacent teeth, cyst formation, increased clinical complexity and orthodontic treatment delays. Rework, often caused by changes in clinical presentation due to the timescales involved was frequently required, resulting in additional appointments and patient complaints. Stakeholders included consultants, specialty doctors, dental nurses, admin staff and patients/families. A clinically led Quality Improvement (QI) project to address these long waiting times and inefficiencies in the care pathway for patients requiring combined orthodontic and oral surgery management was therefore undertaken at The Royal Shrewsbury Hospital led by the Orthodontic and OMFS teams.

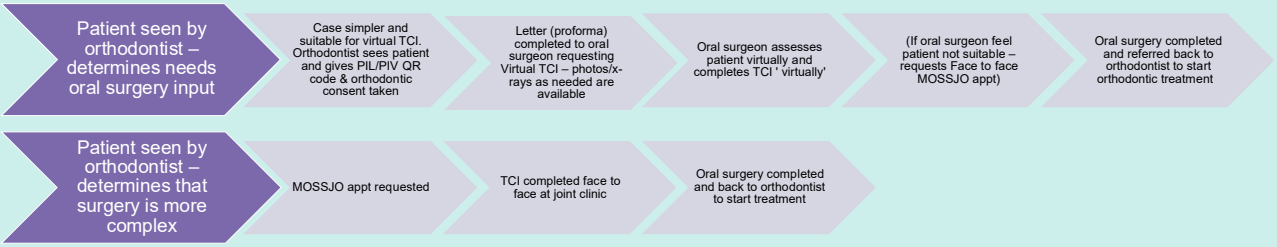
SMART AIM

- Reduce referral-to-OMFS assessment to ≤3 months by January 2026
- Reduce overall pathway to ≤52 weeks by January 2026
- Improve patient experience and safety as evidenced by audit data
- Standardise information and consent by August 2025

PLAN

- In early 2024, clinicians and managers met to discuss the waiting list as a recent audit showed that on average patients were waiting 39-52 weeks for an OMFS assessment (longest wait 104 weeks), and an average of 104 weeks from referral to completion of their oral surgery.
- To address these system pressures, the Consultant Orthodontists and Consultant Oral & Maxillofacial Surgeons worked collaboratively using structured QI methodology to redesign the pathway. The new pathway comprises the planning of three key components:
- **Virtual assessment clinics for straightforward cases**
  - Virtual clinic enables remote triage using shared imaging and standardised criteria, increasing overall assessment capacity by 50% (12 vs 8 per session), reducing the number of face-to-face attendances, and accelerating initial decision-making.
- **Joint Orthodontic–OMFS multidisciplinary clinics (MDT) for complex patients**
  - These clinics allow patients to be reviewed by both specialists in one appointment, facilitating real-time decision-making and reducing clinical rework.
- **A Standardised patient information leaflet and QR-linked video**
  - To improve the quality and consistency of preoperative communication, support the delivery of informed consent and strengthen the safety of the pathway by ensuring patients have access to clear and accessible information.

DO

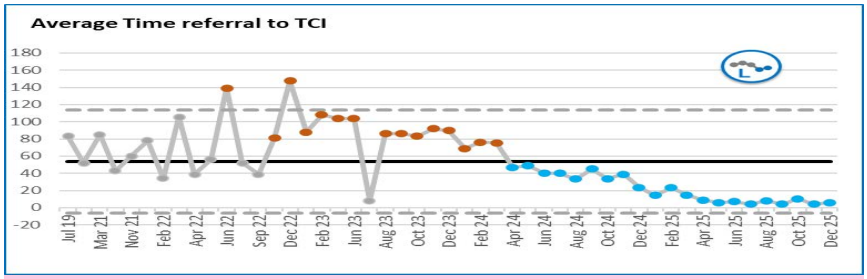


Following implementation of the newly designed pathway, continual assessment using audits, SPC charts, and patient questionnaires has taken place. Through a series of Plan, Do, Study, Act (PDSA) cycles, the pathway has been refined, including correction of virtual clinic alert settings, development of standard letter templates and the adoption of Multidisciplinary Team (MDT) request proformas for clinical assurance. These iterative improvements have ensured reliability and safety throughout the redesigned process. To maximise clinic utilisation, the team also implemented nurse-led pre-clinic calls and clinic checks to support joint clinic utilisation with the aim of protecting valuable clinical capacity and delivering value in each clinic.

STUDY

The redesigned pathway has delivered measurable improvements in waiting times, patient experience, clinical risk reduction, and productivity.

- **Significant reductions in waiting times**
  SPC data to December 2025 shows sustained and continuing improvement, with the most recent patients referred into the redesigned pathway experiencing the greatest benefit.
- **Increased assessment capacity and reduced face-to-face appointments**
  More patients can be assessed on a virtual clinic, enabling the team to clear the waiting list backlog during this case study period by assessing more patients in the same clinical time. Reducing patient travel also links to key strategies in the NHS sustainability plan.
- **Improved clinic efficiency and financial viability**
  The nurse-led pre-call system has delivered a 98% attendance on the MDT clinic since its inception. This compares to a 91% rate of clinic utilisation of the same joint clinic at a different site which doesn't employ nurse-led pre-clinic calls and checks. This improvement enables full use of clinical time and supports the cost-effective delivery of multidisciplinary care.
- **Enhanced patient experience and improved safety**
  The patient information video and leaflet were evaluated using a questionnaire approved by patient experience, with results showing that 97–100% of pre as well as post-treatment patients asked found the video to be helpful, clear, and that they would recommend it to other patients. An audit of the first 20 virtual pathway completers also confirmed no reported safety concerns, further supporting the reliability of the redesigned approach.



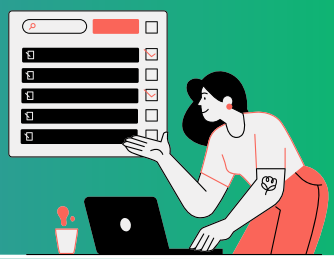
ACT

The re-designed pathway has eliminated the historic two-stage separate assessment process for complex patients, removing repetitive appointments and reducing changes in treatment decisions caused by long delays and the inability to treatment plan in real time with MDT partners in complex cases. In reducing repetition and variation, and streamlining the pathway for more simple cases, improved clarity for both patients and staff has been achieved as well as a reducing in waiting time and the clearing of a significant backlog of patients. Ongoing governance oversight through the application of continuous audit, and the continued application of QI methodology will ensure that this adopted pathway remains responsive. Sustainability will be further strengthened through strategic consultant recruitment, supporting future capacity planning and continuation of the redesigned pathway. Learning has been shared to support adoption by other departments and services. The project has been presented at the Shropshire/Staffordshire Orthodontic Managed Clinical Network meeting as well as the SaTH Moving to Excellence forum. Patient information resources have also been shared with local orthodontic providers as well as with the second Trust site with the aim of establishing further virtual clinic capability if needed.

Improving Effectiveness of MDTs with a Structured Communication tool (RADAR)

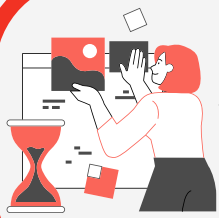
Dr U Nasser, Dr M Pecover, Dr K Durmaz, Dr E Okonji, T Forsyth, J Taylor

NHS Surrey and Borders Partnership NHS Foundation Trust



Risk, Actions, Discharge, Assign Review (RADAR):
Using a structured communication tool to improve the reliability of daily multidisciplinary team (MDT) meetings across inpatient psychiatric wards.

BACKGROUND



The **Surrey and Borders Partnership (SaBP) NHS Trust** inpatient meetings varied in quality, frequently overran, and lacked a consistent structure. Information risks, and discharge dates were frequently missed.

AIM

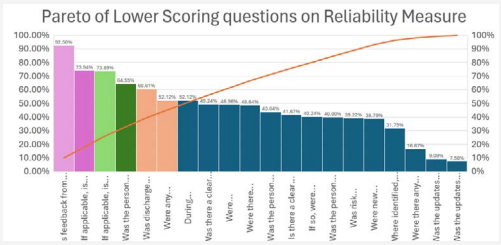
Baseline reviews showed low reliability against MDT meeting terms of reference (TOR) (average 53%).

Our aim was to increase MDT reliability from 53% to 90% in 7 inpatient wards across SaBP by April 2025.

UNDERSTANDING THE PROBLEM

We engaged with teams using tools like TRIZ (liberating structures) and process mapping to support understanding of the process on 3 wards that signed up for testing.

Weekly workshops reviewed the baseline data. Pareto analyses were completed to identify the areas that needed improvement. Overall compliance was tracked using SPC charts. All 3 of the testing wards found common issues in MDT reliability.



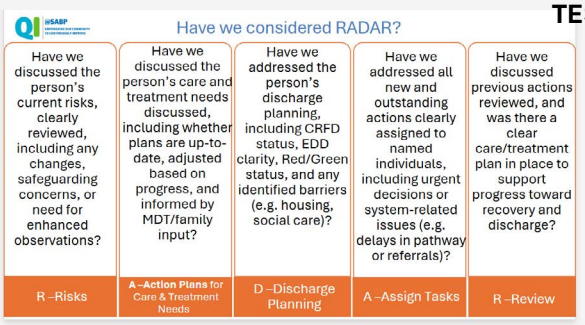
RISK

Failure Mode Effective Analysis (FMEA) tools were were used to walk through potential risks associated with the reliability measures scores captured in the Pareto analyses.

DEVELOPING A STRATEGY AND CHANGE IDEAS

Teams developed change ideas on the areas underperforming against the TOR. These included a nursing checklist and a structured communication tool,
RADAR.

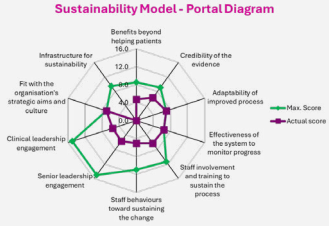
TESTING IDEAS



The test wards supported rapid testing of the different ideas. The structured communication tool RADAR from Rowan ward, showed the most improvement. The key was thought to be its use as a summarised verbal prompt for each patient during MDT.
"is RADAR covered for this patient"

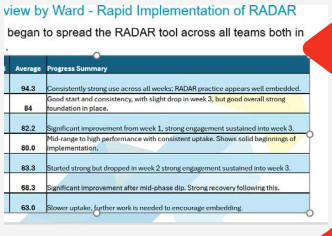
IMPLEMENTING AND SUSTAINING THE GAINS

Tools, including a sustainability model, were used to identify gaps in areas of spread across the remaining 4 wards.



CONCLUSION

After spreading, 5 of 7 wards scored over 80% in reliability, with some showing a 40% increase.



Theatres Utilisation Improvement Programme

Spotlight on Pre-Op: *to optimise efficiency and ensure increased numbers of patients on our waiting lists were cleared for surgery*

Wirral University Teaching Hospital NHS Foundation Trust

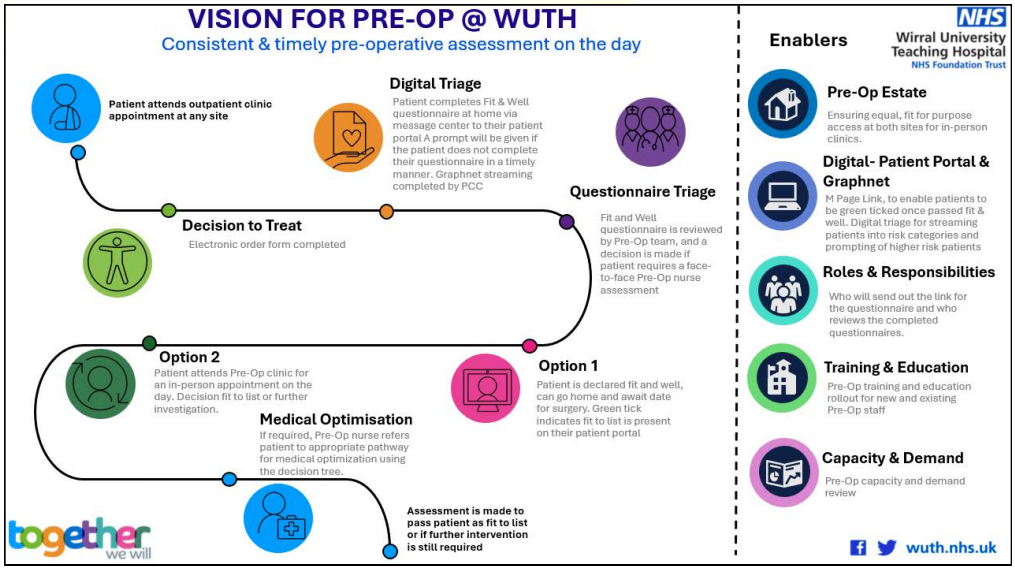
Background:

The Theatre Utilisation Improvement Programme was initiated in 2024 in response to underutilisation of the Trust's surgical hub site at CGH.

Aligned with the NHS Elective Recovery Plan and informed by Getting It Right First Time (GIRFT) standards, the programme aims to maximise theatre efficiency, productivity, and capacity to support the reduction of elective backlogs.

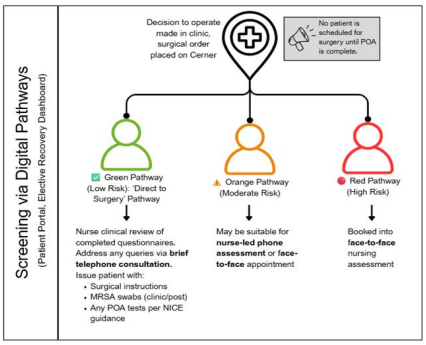
Problem Statement

To address challenges in our pre-op processes which were impacting on theatre utilisation.



Aim

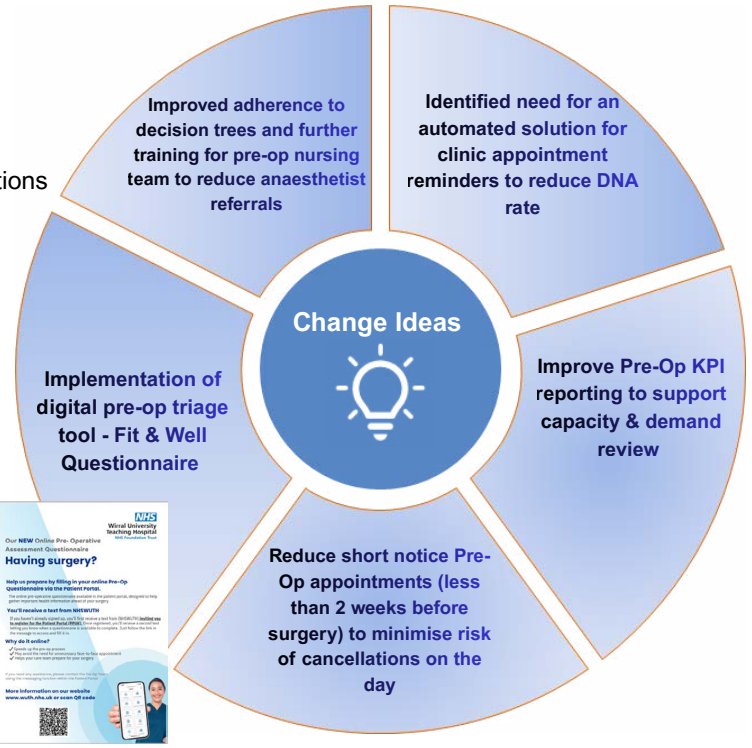
- To provide assurance on sustained improvement to pre-operative processes
- Supporting increased theatre utilisation
- Improved patient readiness and alignment with GIRFT recommendations



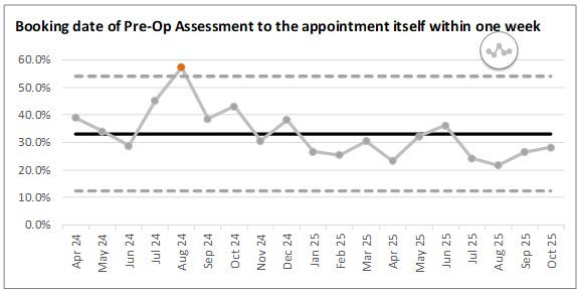
Measures

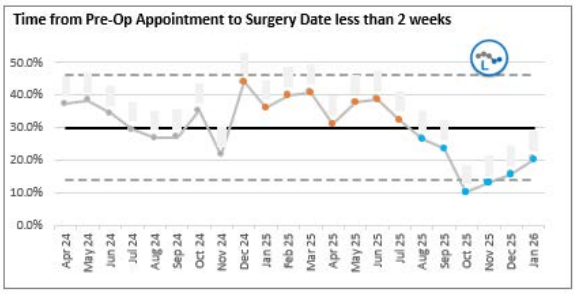
Key metrics for the the Pre-Op workstream focused on the following areas:

- % of patients cleared for listing
- % of patients where anaesthetist consulted
- Pre-Op Assessment DNA rate
- Short notice Pre-Op Assessments



SPC Charts





Reflection & Learning

Improved triage, reduced unnecessary face-to-face appointments and released capacity for complex patients following the implementation of the Fit & Well questionnaire and Graphnet

- ICB funding enabled the establishment of a Perioperative Care Coordinator (PCC) role, which has been fundamental in improving questionnaire return rates and utilising Graphnet to ensure patients are streamed onto the correct peri-operative pathway. An extra 258 assessments have taken place over a 7 month period due to the efficiency of the PCC role.
- Questionnaire return rates are significantly higher for patients identified by the PCC as suitable for the low-risk 'green pathway', driven by proactive PCC telephone follow-up
- As a result of robust patient streaming, a Clinical Support Worker (CSW)–only pathway has been enabled to triage patients and complete observations and swabs.
  - ***251 patients have been managed via this route***
  - ***No cancellations or issues reported***
  - ***Pre-operative nursing capacity released***

PCC Streaming (green & amber patients)	Total questionnaires targeted	Completed total following PCC prompt	Conversion rate
	890	620	70%
Automation	Total questionnaires sent	Total completed overall	Conversion rate
	13548	1544	11%

"From a Pre-Op perspective we have well and truly moved the dial and that is down to the collective effort of the team. I'm excited to see how Pre-Op develops over the coming weeks / months, it's an exciting space and the impact on patients is going to be huge".

GIRFT Implementation Lead - Theatres & Perioperative Medicine

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