Innovation Project Application Form

Salford Innovation and Improvement Fund Locality Call 2022/2023

Each question in this application form is very specific about the information required. **Please ensure that you read the separate 'Application Guidance' document carefully, complete all sections of this form and provide all the information requested**. Please ensure that any abbreviations/acronyms are explained at the start of the application; they may then be abbreviated throughout the remainder of the application.

SUBMISSION DETAILS

SUBMITTED BY *(name, role, org.)*	Smeeta Sinha, Consultant Nephrologist, Deputy Director of Research & Innovation, Northern Care Alliance NHS Foundation Trust
CONTACT NUMBER	01612065710
EMAIL ADDRESS	Smeeta.sinha@nca.nhs.uk
SUBMITTING ORGANISATION	Northern Care Alliance NHS Foundation Trust
PARTNER ORGANISATION(S) *(if a joint bid)*	Nil
DATE SUBMITTED	31/8/22

Details of how to complete each section of this form correctly are found in the Application Guidance document. Please confirm that you have followed this guidance	☑ I have read and followed the Innovation Fund Application Guidance document

SECTION ONE: PROPOSAL OUTLINE

1) NAME OF YOUR PROPOSED PROJECT
RevOCE CKD – Revolutionising Outpatient Care for Patients with Chronic Kidney Disease

2) SUMMARY OF PROPOSAL

The Northern Care Alliance (NCA) has developed an integrated care dashboard that allows patients to be risk stratified at a population level and enables clinical staff to drill down to patient level data where there are specific concerns.

The programme has an initial focus on diabetic kidney disease (DKD) and aims to:

1) Identify patients with diabetic kidney disease and stratify by risk of progression using the validated Kidney Failure Risk Equation [1].

2) Target high risk patients for intervention: advice and guidance, invitation to specialist service, diagnostics

Benefits will include:

- Timely advice and guidance
- Medicines optimisation
- Earlier presentation of patients requiring specialist renal services input (GIRFT recommendation)
- Reduction in RTT and time from referral to outpatient review
- Reduction in hospital OPD appointments

The 2019 NHS Long Term Plan endorses the development of digitally-enabled services to replace the 'unsustainable' growth of the traditional outpatient model of care. NHS England has also commissioned the Renal Service Transformation Programme (RSTP) which aims to transform the care of patients living with chronic kidney disease (CKD) across the whole pathway including the primary and secondary care interface. The RSTP is clinically-led and delivered in partnership with commissioning teams and patients. It is working on recommendations from the Getting It Right First Time (GIRFT) report into renal services published in 2021 and is taking a whole person whole pathway approach to provide more joined up care to our patients with a strong focus on prevention through better disease identification in the population (e.g., earlier diagnosis with urine albumin testing). The delivery of integrated CKD care will be a key recommendation for April 2023.

Why is this important?

Chronic Kidney Disease affects approximately 6% of the population, and 80% of those patients have multiple long term conditions. £1 in every £77 of the NHS budget in England is spent on CKD. Diabetic kidney disease is a major cause of kidney failure. Supporting patients with end stage kidney disease costs the NHS >£50,000 per patient per year. Treatments are available to reduce the risk of CKD progression and cardiovascular events (renin-angiotensin system inhibition and SGLT-2 inhibitors), however, there is significant variation in medicines optimisation, in part due to the multimorbidity associated with this group of patients.

Despite NICE recommendations [2] analysis demonstrates that, since removal from QOF, achievement of CKD indicators has fallen below the lower process limit (**SPC charts, figure 1**) and below the lower 95% confidence limit (dotted line in bar charts, based on last 5 years of QOF data).

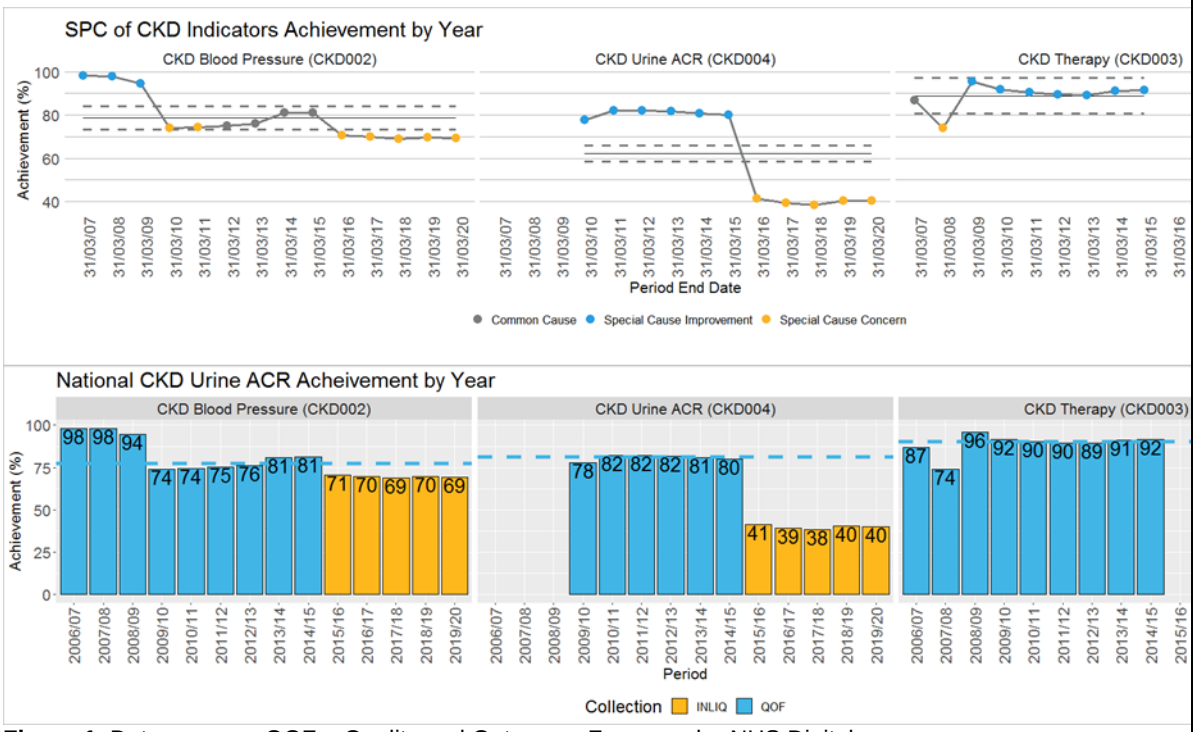


Figure 1: Data sources: QOF = Quality and Outcomes Framework - NHS Digital; INLIQ = PRODNHSESQL101, NHSE_UKHF.GP_Contract_Services_Eng.vw_Indicators_No_Longer_In_QOF1

Research has shown that high intensity, targeted interventions in patients with type 2 diabetes mellitus can have large benefits that are sustained more than ten years beyond the initial clinical optimisation [3-4]. Primary care does not have the capacity to provide more intensive care to this group of patients, while secondary has neither the capacity nor an appropriate funding model to deliver this care.

This project will build on and extend work carried out in a service established in East London, where the community service includes dashboard data on every GP registered patient with biochemical markers of CKD, not just those who have already been referred to renal services [5]. The emphasis is on upstream management of CKD in primary care. The changes made to services were highly successful in improving access to specialist advice and expanding the capacity available to assess patients with kidney disease. **The average waiting time for specialist advice reduced from 64 days to 5 -10 days.** Those patients who needed specialist investigation and follow up were able to access specialist services much more quickly.

Reducing health inequalities

Improving access to specialist advice also includes disadvantaged groups, such as care home residents, for whom traditional outpatient attendance poses the most difficulties. Between 15-18% of patients within the new RevOCE dashboard tool have data missing from their clinical records that makes it impossible to carry out risk calculations – this may be down to low engagement with health care services or poor coding of conditions. Those patients whose CKD diagnosis has not been coded have significantly worse outcomes than those whose condition has been identified and coded.

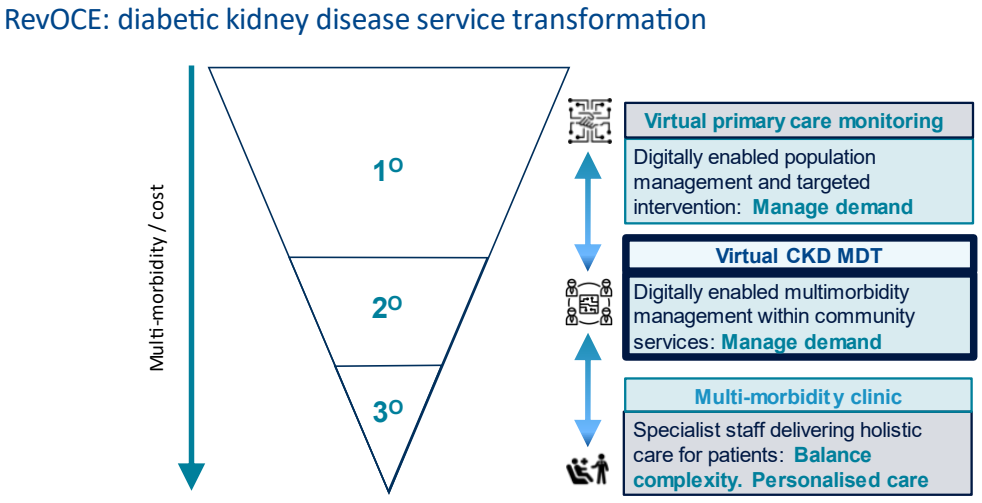
Patients from black and ethnic minority groups are disproportionately affected by CKD as they experience higher rates of hypertension and diabetes. These communities are also more likely to be diagnosed late and therefore present late to renal services. This in turn means they are more likely to experience poor cardiovascular health as well as the complications associated with progressive CKD; CKD is a major risk factor for cardiovascular disease.

Proposed innovation

This project will build on the proof-of-concept stage, where the dashboard was built and multimorbidity clinics were established. This project will implement the innovative CKD dashboard into clinical practice supported by virtual CKD MDTs to improve diagnosis, coding, and outcomes in patients with DKD.

The proposed integrated CKD pathway will aim to integrate digitally enabled population management, timely advice and guidance via virtual CKD MDTs as well as access to sub-specialty services for high risk patients, notably our established metabolic-renal-cardiac (MRC) clinic. The MRC clinic was established as part of a Joint Working Agreement with industry and is now established within the renal service. The MRC clinic has access to a diabetologist and heart failure MDT, thereby providing holistic care to patients living with multiple long term conditions. High risk patients with diabetic kidney disease can potentially by pulled straight into this clinic via the RevOCE platform and/or the Virtual CKD MDT (**Figure 2**).

Figure 2: Digitally enabled pathway for delivery of CKD care



CKD Dashboard

Greater Manchester was one of the NHS England regions to receive funding to develop a shared Local Health and Care Record [6]. This integrated care record provides an opportunity to develop a dashboard that uses system captured data to risk stratify CKD patients with poor outcomes or not receiving guideline recommended treatments. Salford Royal entered a Joint Working Agreement with industry to develop a proof-of-concept dashboard and multi-morbidity clinic.

An integrated CKD dashboard was delivered which enables segmentation of populations by KFRE as well as additional metrics. Risk thresholds can be segmented via KFRE score. Data presented within the representative dashboard (**Figure 3a**) highlights patients at very high risk of progression to ESKD in red (25% risk within 5 years). The dashboard allows further identification of patients that would be suitable for specialist advice as recommended by NICE NG 203 guidance (5 years risk >5%). The CKD dashboard can be drilled down to individual patient level to identify opportunities for improved management and potentially review within specialty services (**Figure 3b**).

Figure 3a: CKD dashboard - population level view. Risk thresholds can be segmented via KFRE score. Data presented below highlights patients very high risk of progression to ESKD in red (25% risk within 5 years).

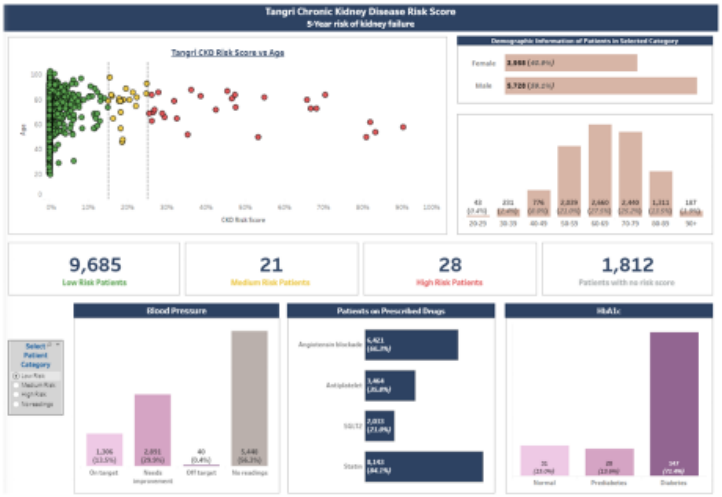
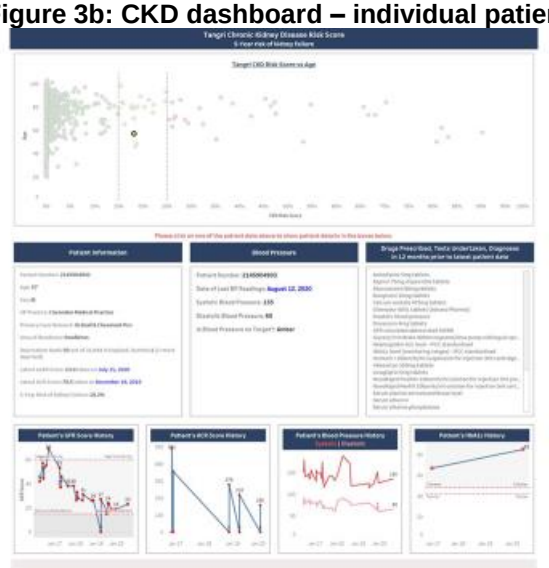


Figure 3b: CKD dashboard – individual patient view



Virtual CKD MDT/Academic Detailing

Community MDTs have been established to support the care of patients living with diabetes [7]. This model enables hospital-based specialists to engage more effectively with primary care colleagues in the community. This model has not been widely adopted for the management of CKD, however, we have reported that improved partnership working and educational outreach can improve response times to AKI alerts. In 2015, Salford renal services received Salford innovation funding to evaluate the impact of AKI e-alerts and educational outreach on response times to AKI events. The combination of AKI alerts and educational outreach improved response times and was well received by primary care colleagues [8]. The programme was subsequently rolled out to other CCGs.

There are parallels with the introduction of AKI alerts and educational outreach and the introduction of the KFRE and CKD education. This project will bring together learning from the AKI work successfully delivered in 2014 – 2016 and develop a sustainable virtual CKD MDT model. In addition to educational outreach the CKD MDT will provide access to individual patient level advice and guidance supported by the dashboard.

This project will achieve the aims as follows:

1) Identify patients with diabetic kidney disease (DKD) and stratify by risk of progression using a validated kidney failure risk equation

- Application of the kidney failure risk equation across Salford ICP population (irrespective of primary care coding)
- Identification of patients with appropriate CKD coding and variation across the ICP for targeted intervention

2) Target high risk patients for intervention: academic detailing/virtual CKD MDT review

- Develop cross-boundary partnerships to facilitate specialist review (potentially directly via secondary care) for high-risk patients thereby reducing workload for primary care
- Develop models of integrated care utilising the RevOCE dashboard for low and medium risk patients e.g., virtual CKD MDTs/academic detailing as described above, additional advice and guidance services or neighbourhood kidney ‘champions’.

References

1. Major RW, Shepherd D, Medcalf JF, Xu G, Gray LJ, Brunskill NJ (2019) The Kidney Failure Risk Equation for prediction of end stage renal disease in UK primary care: An external validation and clinical impact projection cohort study. PLoS Med 16(11): e1002955

2. The National Institute for Health and Care Excellence N. Chronic kidney disease: assessment and management NICE guideline. 2021. Accessed at https://www.nice.org.uk/guidance/qs5

3. Gaude P, Vedel P, Larsen N, Jensen GVH, Parving H, Pedersen O: Multifactorial interventions and cardiovascular disease in patients with type 2 diabetes. N Engl J Med 2003;348:383–393

4. Gaude P, Vedel P, Larsen N, Jensen GVH, Parving H, Pedersen O: Effect of a Multifactorial Intervention on Mortality in Type 2 diabetes. N Engl J Med 2008;358:580-591

5. Hull, S.A., Rajabzadeh, V., Thomas, N. *et al.* Do virtual renal clinics improve access to kidney care? A preliminary impact evaluation of a virtual clinic in East London. *BMC Nephrol* 2020;**21:**10 https://doi.org/10.1186/s12882-020-1682-6

6. Understanding Patient Data. 2018. Local health and care record exemplars announced. Available at https://understandingpatientdata.org.uk/news/local-health-and-care-record-exemplars-announced. Access date: June 2022

7. NHS Right Care Pathway – Diabetes https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2018/07/nhs-rightcare-pathway-diabetes.pdf Access date: August 2022

8. Tollitt J, Flanagan E, McCorkindale S, Glynn-Atkins S, Emmett L, Darby D, Ritchie J, Bennett B, Sinha S, Poulikakos D. Improved management of acute kidney injury in primary care using e-alerts and an educational outreach programme. Fam Pract. 2018;35(6): 684 - 689

3) KEY OBJECTIVES: WHAT ARE YOU TRYING TO ACHIEVE?

(Key things that need to happen for the project to be considered successful)

These objectives need to be **SMART (Specific, Measurable, Achievable, Realistic and Timed).** Project objectives and associated payments need to be completed within the 12 month period after the agreed project start date.

If the project has more than five objectives, please list additional objectives in the comments section.

Objective 1:	Establish integrated care model of DKD care delivery including virtual CKD MDTs including physician satisfaction
Objective 2:	Improve outpatient response times as part of restoration and recovery of services - Reduction in 18-week breaches - Reduce time from referral to outpatient review
Objective 3:	Earlier presentation of patients requiring specialist renal services input (core GIRFT recommendation) - Reduce late presentation for RRT
Objective 4:	Improve urinary ACR measurement and risk stratification to > 75% (pre-QoF withdrawal levels)
Objective 5:	Increase proportion of patient on outcome modifying (renoprotective) agents and BP targets to >85% (pre-QoF withdrawal levels)

Comments:

4) WHICH CITIZENS / PATIENTS / COMMUNITIES / VULNERABLE GROUPS WITHIN SALFORD WILL SEE A BENEFIT AS A RESULT OF THIS PROPOSAL?

Group/s	What benefit/s will be realised for this particular group?
Patient with diabetic kidney disease	Early diagnosis and management of DKD
Underserved communities	Patients who are unable to attend specialist clinics will still be able to access specialist care closer to home as well as improved diagnosis and management.

5) HAVE YOU PREVIOUSLY SUBMITTED ANY APPLICATIONS FOR FUNDING TO DELIVER THIS PARTICULAR INNOVATION WITHIN SALFORD?

Please tick the relevant box, and provide details where necessary

		Details
☐	**No**	
☐	**Yes** – and it was **not funded**	
☒	**Yes** – and it **was funded**	The proof-of concept CKD dashboard was delivered as part of a joint working agreement with a commercial partner.

6) HAS YOUR PROPOSED IDEA BEEN IMPLEMENTED OUTSIDE OF SALFORD PRIOR TO THIS APPLICATION?
(If yes, please state where, when and provide details of the impact of this in the comments section below) ☐ Yes ☒ No ***Comments:***

7) PLEASE EXPLAIN HOW THIS PROPOSAL IS "INNOVATIVE"
RevOCE is a digitally enabled integrated care system for the management of DKD. The incorporation of an established risk-prediction tool to segment populations and identify high risk patient has not previously been delivered in clinical practice and will facilitate identification and early management of at-risk populations without increasing workload in over-stretched primary and secondary care services. The RevOCE dashboard is an innovative approach to improving population health. Whilst this project will focus on diabetic kidney disease there is scope to further develop the platform for other disease areas.

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SECTION TWO: ALIGNMENT WITH SALFORD LOCALITY PRIORITIES

8) WHICH OF THE 2022-23 INNOVATION PRIORITIES DOES YOUR PROPOSAL ADDRESS?

*(This year's Innovation Priorities are summarised below. Please tick the **ONE** most relevant box for the priority area your proposal aligns with.)*

	2022-23 Innovation and Improvement Themes
☒	Neighbourhood based care
☐	Safer Salford Care Homes and Domiciliary Care
☒	Workforce Transformation
☐	Sexual Health
☐	Frailty and ageing
☐	Screening
☐	Tackling vaccine / immunisation hesitancy

A full breakdown of these themes is available in the separate Application Guidance document.

NONE / OTHER	☐	*Please select this option if your proposal does not clearly align to any of the above priority topics, but you believe it addresses a current un-met need*

9) WHICH OF OUR CORE INNOVATION PRINCIPLE/s DOES YOUR PROPOSAL EVIDENCE?

(Please tick all that apply)

☒	*Exploiting the use of **Technology and Digital** Innovation*
☐	***Partnership Working** - Developing links between Health & Social Care and external organisations that are looking to test and evaluate innovative solutions in this field*
☒	***Neighbourhood Working** - Developing, delivering and structuring Health & Social Care within the 5 Salford Neighbourhoods / GP Networks*
☒	*Addressing **Health Inequalities and Wider Determinants of Health***
☐	*Improving the **Environmental Sustainability** of care*

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SECTION THREE: PROJECT DELIVERY

10) KEY PROJECT TIMESCALES

(What is expected to happen, when?)

Month 1	Steering committee finalised and project processes agreed
3 months:	Primary care engagement, baseline line data collection, roll out of new processes with ongoing data collection
6 months:	Mid-project check-in on data collection and progress
9 months:	Completion of implementation phase, commence write up of evaluation
12 months:	Evaluation of implementation phase completed, including health economics and future business case/ Share outputs with national teams (if approved by steering committee)

11) HOW IS THE PROJECT GOING TO BE MANAGED?

A steering committee will be established with representation from Salford ICP and the NCA Research & Innovation team (for oversight of the innovation processes, contracting arrangements etc.) and the renal clinical service. A patient representative will also be a key member of the steering committee.

12) HOW WILL YOU MEASURE AND EVALUATE YOUR PROJECT?

A) Does your proposal involve an external / independent evaluation?

☒ Yes
☐ No

B) Who will be carrying out the evaluation of this project?

The NIHR ARC will support this evaluation in collaboration with the RevOCE research & innovation team.

C) Please outline your plan for measurement and evaluation of the project

The evaluation plan will be agreed with the NIHR ARC at the start of the project, to facilitate ongoing data collection. In addition to quantitative outcome measures and health economics, the understanding of professional attitudes to the changes, particularly in primary care will be key.

13) WILL THE PROJECT REQUIRE A CHANGE TO AN ESTABLISHED CARE PATHWAY?

If you are currently unable to assess if the activity will require a change to an established pathway, please indicate so using the Don't Know option. Applications selected to progress will be able to work with their sponsor to establish this.

☒ Yes
☐ No
☐ Don't Know

If Yes, please provide details of the existing care pathway and explain how your project will require a change to this.

The direct identification of patients via a digital dashboard, using risk stratification methods, represents a change to the current practice of GP referral but aligns with a key recommendation within updated NICE CKD guidance (August 2021). This project will therefore bring Salford referral pathways in line with NICE NG203 guidance which recommends adults with CKD should be referred for specialist assessment (taking into account their wishes and comorbidities) if they have a 5-year risk of needing renal replacement therapy of greater than 5% (measured using the 4-variable Kidney Failure Risk Equation). This replaces the previous CKD 4 referral criteria.

The integrated CKD model will be developed as part of the project. This in turn may lead to a more sustained change in an existing pathway in line with recommendations within the Long Term Plan and Renal GIRFT. This will also ensure that Salford ICP is able to deliver an integrated CKD model of care which will be recommended to commissioners in April 2023 as part of the RSTP.

The proposed pathway will also increase access to specialist advice via virtual CKD MDTs and provide direct access to renal services for patients with high risk CKD. This will potentially reduce the burden of work in primary care.

14) IS THIS A DIGITAL HEALTH TECHNOLOGY (DHT)?

☐ Yes
☒ No

***IF YES**, please answer the below questions:*

A) How would you categorize the function of this Digital Health Technology (DHT)?

*(tick **ONE** option only)*

	Functional Classification	Description	Examples May Include
☐	**System service**	Improves **system efficiency**. Unlikely to have direct and measurable individual patient outcomes.	Back office systems, Electronic prescribing, health record platforms, Ward management systems.
☐	**Inform**	Provides **information and resources** to patients or the public. Can include information on specific conditions or about healthy living.	DHTs describing a condition and its treatment. Apps providing advice for healthy lifestyles (such as recipes). Apps that signpost to other services.
☐	**Health Diaries**	Allows users to record health parameters to create health diaries. This information is **not shared** with or sent to others.	Health tracking information such as from fitness wearables. Symptom or mood diaries. No data transmitted.
☐	**Communicate**	Allows **2-way communication** between users and professionals, carers, third party	Instant messaging apps for health and social care. Video conference-style consultation

		organisations or peers. Clinical advice is provided by a professional using the DHT, not by the DHT itself.	software. Platforms for communication with carers or professionals.
☐	**Preventative behaviour change**	Designed to improve **health behaviours** to prevent ill health consequences associated with smoking, eating, alcohol use, sexual health, sleeping and exercise. Based on accepted behaviour change theories	Smoking cessation DHTs and those used as part of weight loss programmes. DHTs marketed as aids to good sleep habits.
☐	**Self-manage**	Aims to help people with a diagnosed condition to **manage their health**. May include symptom tracking function that connects with a healthcare professional	DHTs that allow users to record, and optionally to send, data to a healthcare professional to improve management of their condition.
☐	**Treat**	**Provides treatment** for a diagnosed condition (such as CBT for anxiety), or **guides treatment** decisions.	DHTs for treating mental health or other conditions. Clinician-facing apps that advise on treatments in certain situations. Electronic prescribing systems that provide patient-level advice on prescribing.
☐	**Active Monitoring**	Automatically records information and **transmits the data** to a professional, carer or third-party organisation, without any input from the user, to inform clinical management decisions.	DHTs linked to devices such as implants, sensors worn on the body or in the ward/home/care setting. Data automatically transmitted through for remote monitoring.
☐	**Calculate**	Tools that perform **clinical calculations** that are likely to affect clinical care decisions.	DHTs for use by clinicians, professionals or users to calculate parameters pertaining to care, such as early warning system software.
☐	**Diagnose**	**Uses data to diagnose** a condition in a patient, or to **guide a diagnostic decision** made by a healthcare professional.	DHTs that diagnose specified clinical conditions using clinical data. AI systems making diagnostic or triage decisions.

Functional Classifications from NICE Evidence Standards Framework for Digital Health Technologies (April 2021)

B) Does the Digital Health Technology have a CE mark?

☐ Yes
☐ No

C) Is the Digital Health Technology classed as a medical device?

☐ Yes
☐ No

If yes, please state classification and whether currently approved by MHRA

15) WILL YOUR PROPOSED PROJECT ACTIVITY REQUIRE ACCESS TO, CHANGES TO, OR INTEGRATION WITH, EXISTING IT SYSTEMS TO ENABLE DELIVERY?

☐ Yes
☒ No
☐ Don't Know

Please only select the 'Don't Know' option if you are currently unable to assess whether the activity will require access or changes to IT systems or infrastructure. If selected for progression, you will need to engage the relevant IT departments of pilot sites to complete this assessment and establish any requirements prior to achieving final sign-off for funding.

If Yes, please answer the below questions:

A) Which system/s or infrastructure will you require access to, changes to, or integration with?

B) What changes / integrations are required, and the timescales needed for this?

C) Who owns or manages this system / infrastructure?

D) How have you engaged with the relevant system owners / managers / IT departments so far to determine the feasibility of making these necessary changes?

16) WHAT RISKS HAVE YOU IDENTIFIED FOR THIS PROJECT, AND HOW WILL YOU MITIGATE THEM?

1. Primary Care Engagement – we have already engaged with the Salford CCG Long-Term Condition lead and the Salford ICP CCIO and both are supportive of the RevOCE dashboard. The RevOCE programme also has support from Health Innovation Manchester and the GM Primary Care Cell. We will also present the project and engage with neighbourhood teams. We recognise the impact of workforce challenges, vaccination programmes and COVID19. We have attempted to mitigate this by creating a project which will share workload across the pathway and can be delivered by AHPs.
2. Secondary care renal capacity – current waiting times for outpatient renal review are > 14 weeks. The volume of referrals increases risks that secondary care clinicians may not be available to engage with virtual MDTs. This has been mitigated by requesting dedicated support for the service and support from renal directorate operational leads. We also envisage that the successful delivery of an integrated model will enable increased numbers of patients to be reviewed more efficiently than current models of secondary care outpatient services.

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SECTION FOUR: BUDGET & FINANCE

18) PLEASE PROVIDE A FULL BREAKDOWN OF HOW THE REQUESTED FUNDS WILL BE UTILISED

Please include a comprehensive ~~budget, ensuring you~~ include VAT where applicable.

£109,936

Payment schedules for successfully funded projects will be finalised prior to sign-off. The typical arrangement is to pay 50% of awarded funds up front, with the remaining 50% released upon receipt of a successful 6-month project update report. If you would require any different payment schedule or arrangement, please give details below

- Renal consultant time to review dashboard £12,478
- Renal consultant time to develop and deliver virtual MDT £12,478
- Administrative support £2980
- Research fellow £12,000
- Business Intelligence support £2,599
- Health economic evaluation £10,000
- Primary care engagement and input £60,000 – funding will be provided to primary care teams who will participate in virtual MDTs and development of the integrated CKD pathway

19) HOW WILL THE PROJECT ACHIEVE A RETURN ON INVESTMENT / COST BENEFIT?

- Improved access to renal services and medicines optimisation will ultimately improve management of DKD leading to attenuated progression of CKD and reduced utilisation of expensive renal replacement therapy as well as reducing hospitalisation in this cohort of patients, as shown in clinical trials.
- Renal specialists will also identify those underserved populations in primary care that require more support and guidance with the management of diabetic kidney disease and provide targeted support.
- Reduce time to specialist advice
- Deliver an integrated CKD service and achieve NICE guideline recommendations

20) WHAT COMES NEXT AFTER THIS FUNDING? HOW WILL YOU ENSURE THAT ACTIVITIES, OR RESULTS, ARE SUSTAINABLE AFTER THE 12 MONTH FUNDED PERIOD HAS ENDED?

The aims of this project align with Renal GIRFT and the Long Term Plan. The project itself will enable renal services and Salford ICP to deliver national recommendations whilst supporting recovery and restoration from COVID-19. Prof Sinha is also the NHS England National Clinical Advisor for CKD for the Renal Service Transformation Programme (RSTP). The development of integrated CKD services (such as the RevOCE programme)

will be a key recommendation for commissioners and regional networks. Improved access to specialist advice is also a core aim of the wider NHSE Outpatient Transformation Programme. As a result. alignment with commissioning and transformation programmes, as well as buy in from renal services and primary care, provides a mechanism to embed the outputs of this project into routine clinical care.

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SECTION FIVE: DATA PRIVACY IMPACT ASSESSMENT

21) WILL THE PROJECT COLLECT / USE / PROCESS PERSONAL CONFIDENTIAL DATA?

☒ Yes
☐ No

If 'yes', please tick below which of the personal and sensitive data items the asset / system /project will process.

Personal Data Items

☒ Forename(s)
☒ Surname
☒ Address
☒ Postcode
☒ Date of Birth
☒ Home Telephone Number
☒ Mobile Telephone Number
☐ Other Contact Number
☒ GP Name and Address
☐ Legal Representative Name (Next of Kin)
☒ NHS Number
☐ National Insurance Number
☐ Photographs / Pictures of persons
☐ Other – please state below:

Sensitive Data Items

☒ Gender
☐ Religion
☒ Ethnic Origin
☒ Medical Information
☐ Occupation / Employment
☐ Other – please state below:

A Data Privacy Impact Assessment (DPIA) form will need to be completed if your proposal is shortlisted to Interview.

- *If Yes is selected, a full DPIA will need to be completed*
- *If No is selected, the DPIA only needs to be completed up to Screen 5*

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SECTION SIX: SOCIAL VALUE, EQUALITY AND INCLUSION

22) EQUALITY & DIVERSITY POLICY AND COMPLIANCE

A) Do you have an up-to-date Equal Opportunities (or equivalent) Policy in place?
☒ Yes
☐ No

B) Have you been involved in any Equality Act 2010 litigation breaches in the last 3 years?	
☐ Yes	*If Yes, please give details here*
☒ No	

23) PLEASE DESCRIBE HOW THIS PROJECT WILL ENSURE THE RIGHTS OF PROTECTED CHARACTERISTICS IN PARTICIPANTS, AND CONTRIBUTE TOWARDS TACKLING HEALTH INEQUALITIES IN SALFORD?

This project will ensure the rights of all patients, by providing equal access to high quality services, based on risk. Patients from black and ethnic minority groups are particularly at risk of CKD.

24) ADDED SOCIAL VALUE: WHAT OTHER SOCIAL, ENVIRONMENTAL OR ECONOMIC BENEFIT/s WILL SALFORD RECEIVE THROUGH THIS PROJECT?

This project aligns with the aims of the Sustainable Kidney Care programme which is part of The Centre for Sustainable Healthcare and is supported by the UK Kidney Association. Delivery of virtual MDTs and digitally enabled CKD care have the potential to reduce progression to end-stage kidney disease and the costs associated with RRT as well as travel to and from hospitals for face-to-face consultations.

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SECTION SEVEN: OPERATIONAL DETAILS

25) REGISTERED DETAILS OF BIDDING ORGANISATION/s

Name of Organisation	Registered Address	Organisation Type
Salford Care Organisation. Northern Care Alliance NHS Foundation Trust	Stott Lane Salford, M6 8HD	NHS Trust

26) WHICH ORGANISATION WOULD THE GRANT FUNDS BE PAID TO?

Salford Care Organisation, Northern Care Alliance NHS Foundation Trust

27) WHO WILL BE THE INDIVIDUAL/s RESPONSIBLE FOR THIS PROJECT?

(Please complete all sections)

SENIOR LEAD *(overall accountability and oversight of project)*	
Name	Prof Smeeta Sinha
Job Title	Consultant Nephrologist & Deputy Director of Research & Innovation
Organisation	Northern Care Alliance NHS Foundation Trust
Email Address	Smeeta.sinha@nca.nhs.uk
Telephone Number	0161 206 5710

OPERATIONAL LEAD *(day-to-day delivery of project)*	
Name	Ms Victoria Fox
Job Title	Renal Business Manager
Organisation	Salford Care Organisation, Northern Care Alliance NHS Foundation Trust
Email Address	Victoria.fox@nca.nhs.uk
Telephone Number	0161 206 0806

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SECTION EIGHT: APPLICANT AGREEMENT

28) PLEASE CONFIRM THAT IF YOUR PROPOSAL IS ACCEPTED YOU ARE AWARE OF, AND AGREE TO, THE FOLLOWING CONDITIONS:

Applicants must tick all boxes to indicate that they agree to all conditions

☒	Bidding organisation must be able to confirm a commencement date for the project within 2 months of receiving funding approval or approval may be withdrawn
☒	Completion of a 6 month (mid-point) project update report, presented to the Innovation and Research Oversight Group (IROG) and relevant Sponsoring Strategy Group
☒	Completion of a 12 month (final) evaluation report, presented to IROG and the relevant Sponsoring Strategy Group

29) PLEASE CONFIRM THAT YOU HAVE READ AND ACCEPT THE TERMS AND CONDITIONS

☑ I have read and accept the Salford Innovation & Improvement Fund Terms & Conditions

End of Application

Your completed application form, along with any requested additional information, should now be submitted via email to innovation.salfordccg@nhs.net

You will receive confirmation of receipt within three working days, along with a unique Bid Reference for managing your application and for on-going communication regarding your proposal.

Applications can be withdrawn at any time, for any reason, by contacting innovation.salfordccg@nhs.net with your Bid Reference

MAILING LIST

Want to be notified when we release new Innovation & Improvement funding opportunities?

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All of the data you provide will be treated in accordance with the General Data Protection Regulations 2018 and will be stored securely. You may unsubscribe at any time by contacting innovation.salfordccg@nhs.net