High Impact Actions for Nursing and Midwifery
The Essential Collection
Created by a cast of thousands in the NHS

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Foreword

Nurses and midwives are the largest single profession within the NHS – and one of the largest workforces in the world. It is easy to see why we are so often considered to be at the forefront of leading improvement.

Providing high quality care for patients will always be a key priority for nurses; but so often doing the ‘day job’ can become all consuming, we can lose sight of the fact that part of that job is to identify and deliver improvements in care for our patients.

Everyday there is a palpable enthusiasm within the NHS to make care better for patients. Nowhere has this been better illustrated than when we launched the High Impact Actions for Nursing and Midwifery. Within three weeks, more than 600 frontline submissions had been received from nurses and midwives and organisations who were keen to share their successes.

From these submissions, a large group of experienced nurses and midwives identified the eight High Impact Actions that are outlined in this document. The Essential Collection incorporates detail about the scale of the opportunity for each High Impact Action in terms of improvements to quality, outcomes and patient experience. This is supported by case studies from frontline nurses and midwives who tell us, in their own words, how they have achieved the fantastic improvements in quality, patient experience and cost.

Nurses today recognise that cost and quality are not mutually exclusive and they also recognise that they have an important role to play. They know that higher quality care is often more productive and nurses and midwives are in an ideal position to lead on the work that will deliver both. Nurses can see how they can change things to make them better for patients. This often means reducing waste and removing unnecessary – and frustrating – repetition from the system.

Many organisations and their staff have been generous, not only with their time in helping to put this collection together, but also in sharing their ideas and materials for you to take away and transfer into your own local context.

It is clear from these case studies that there is no single recipe for success when it comes to improvement, but there are some key ingredients, such as highly engaged leadership and frequent, effective communication and measurement. We can also see that often it is small changes that have the biggest impact on patient care.

What is clear from this Essential Collection is that the opportunity is enormous; nurses and midwives are leading the way and this is already resulting in better care at lower cost. I am proud of what has already been achieved and confident that you have the commitment to continue to focus on what’s best for patients, spreading innovation and good practice across the NHS.

Dame Christine Beasley
Chief nursing officer
There’s no doubt that every one of the High Impact Actions is absolutely crucial. For me as a nurse, they are fundamental and we need to get them right; for most of us they are nothing new, but delivering them all the time is where people need the help and support; we need to get better at doing what we know is the right thing consistently, and at sharing what we are doing across other specialties and across other organisations.

People can become hung up on the need to come up with new ideas, but it’s often about doing the basic things right. Only then will we deliver the patient care we need to safeguard our patients, the profession and the NHS as whole.

Our profession has embraced technology and new responsibilities but we need to remember the fundamentals of what makes us nurses. That’s why being involved in, and leading this piece of work is important to me as a nurse and should be just as important to you.

This is a call to action for all nurses and midwives to be fully accountable for the care they give to patients – it could be your Dad.

Katherine Fenton  
Chief nurse  
Director of clinical standards and workforce  
NHS South Central

“I was familiar with the High Impact Actions programme and knew that it was possible to make a huge difference by introducing small, but significant changes…this sort of programme is fundamental to effective nursing care.”

Colin Iverson  
Tissue viability specialist, Kettering General Hospital NHS Trust
Nurses at all levels of the profession, from the most junior to the most experienced director, have the potential to bring new ways of working to the NHS to improve patient care. I am privileged to be in a position where I regularly see this happening as I work with frontline teams. The problem we have been grappling with is that, although throughout the NHS we see wonderful examples of good practice, this is not being systematically spread and adopted across all practice.

The High Impact Actions for Nursing and Midwifery has highlighted nurses and midwives as a group of passionate healthcare staff who have a unique ability to transform care for millions of patients by increasing quality, improving patient experience and reducing the cost of care. I want to call all nurses and midwives to do just this; learn from the case studies, adapt them for your local context and implement them into your practice. Go on, I know you can.

**Dr. Lynne Maher**  
Interim director for design and innovation  
NHS Institute for Innovation and Improvement

“I feel we are making a difference; sometimes it’s only a small difference, but to a young person that can be a big difference.”

**Claire Webber**  
Urgent care team leader, Sussex Partnership NHS Foundation Trust

“The High Impact Actions are a fantastic opportunity for nurses. They are a chance to show what a difference we can make. This really supports the quality agenda – that’s what this is really all about for me. Patient safety is not a nurse’s job or a doctor’s job, it’s everybody’s job. I am there as a resource to give advice, unblock any problems and help speed up the process.”

**Paula Showbrook**  
Chief nurse and director of infection prevention, Winchester and Eastleigh Healthcare NHS Trust
High Impact Actions for Nursing and Midwifery – The Essential Collection

Congratulations, you have taken the first step. It is great that you have been interested enough to get a copy of this Essential Collection and even better that you are reading it. We know you are incredibly busy, and we have tried to design this collection so that it works for you. The aim of The Essential Collection is to inspire you with some of the ways that staff – just like you – have transformed care for their patients. There are some brilliant examples of how really simple changes have made a big difference to the quality, experience and safety of patient care, how they have improved the experience of staff delivering that care and how they have saved money for the NHS.

The High Impact Actions are not brand new – they represent areas that we know often cause frustration to nurses and midwives as they strive to deliver the best quality care for their patients. They are areas for which there is evidence of inefficiencies in care provision and poor patient experience.

Nurses and midwives represent the biggest workforce in the NHS. We are closest to our patients on a daily basis, we are coordinators of care and are the patients’ advocate. We can make a difference. Whilst NHS organisations have been given a mandate to ensure that decisions are made at the right level in the system and this means as close to the patient as possible, nurses and midwives are central to achieving this agenda.

We all know that the NHS, like many other health care systems, is facing huge challenges. The economic situation means that, although the NHS is in a better situation than other parts of the public sector, making large cost savings is essential. Nurses and midwives are well placed to lead the changes that are required and to do this swiftly. A few nurses and midwives may still think that money is someone else’s business, but those that think this are, quite frankly, out of touch with reality - opting out isn’t an option. Addressing financial inefficiencies is a key personal, professional and moral responsibility.
Nurses and midwives regularly deal with the frustrations of waste and, in many instances, we have come up with innovative ways to get around these problems in our own clinical areas. Because of the scale of the current challenge, however, it is no longer enough just to come up with our own small innovations. The NHS needs these, but, in addition, we need ensure that they are systematically applied if we are to achieve the highest quality, most efficient standards of care that our patients need and deserve. It is not enough for individual wards or clinical areas to be high performing in a few elements of care. We need to be consistently high performing in all elements of care. The pockets of good practice we see in the NHS need to spread across and be adapted and adopted by all. Nurses and midwives are skilled coordinators of patient care – these skills need to be harnessed to coordinate and spread improvement and change. As leaders, we can mobilise other professions. This means stepping up to the challenges ahead, being recognised as influential leaders who can transform quality, patient experience and costs for the benefit of the NHS and its patients.

The case studies in this collection demonstrate the impact that innovations driven by frontline staff have already had. They show how the commitment, enthusiasm and determination of staff can deliver better quality care at a reduced cost. Leadership isn’t just about senior leaders, it is about everyday leadership provided by all levels of nurses and midwives. We all need to take responsibility in order to ignite collective action, mobilise others and inspire the changes we want to see. To safeguard the future of the NHS, we need to be willing to make a stand, to challenge the status quo and tackle these tough issues on behalf of all patients.
“Staff have developed an understanding of the impact of sickness absence. It’s not just about a shift, it’s telling people: ‘you do a good job here and we value you and we need you here and miss you when you are not here.”

Sally Hughes
Clinical team manager, Hertfordshire Partnership NHS Foundation Trust

“We have taken something that we are passionate about, but that can be seen as uninteresting to people, and made it interesting by getting people up and motivating people to think differently.”

Paula Tucker
Matron, Brighton and Sussex Hospitals

“The biggest impact we have seen on the ward is staff taking ownership of the issues, taking responsibility for addressing them and taking responsibility for improving them.”

Naomi Dickson
Modern matron, East Kent Hospitals NHS Foundation Trust
Getting started: how The Essential Collection will help

The High Impact Actions for Nursing and Midwifery were developed following a ‘call for action’ which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference. Nurses and midwives responded by submitting more than 600 examples in less than three weeks. The Essential Collection aims to highlight just some of the stories behind those submissions by providing details not only of what was done, but also ‘how they did it’. These examples are intended to provide illustrations of good practice which you may not already have seen. Most importantly they are examples of how real people have made a real difference. The Essential Collection is not designed to be tell you ‘how to’ make the changes; but it does signpost you to some of the many excellent resources already available that relate to the areas identified within the High Impact Actions.

Sometimes improvement needs to be radical, but often you can achieve radical change by taking small, simple steps which are then widely adopted. It is these two things together that can lead to massive improvements across the NHS.

With all of the case studies we think there is something interesting, whether it is the approach taken, the results that have been achieved or the way staff have been engaged. Often the improvements will be linked to other initiatives such as The Productive Ward: releasing time to care.

One of the most notable discoveries was the wide variation of measurement. Some had little or no tangible measures, some had measured the impact of their work on quality but hardly any of the case study submissions had combined these with cost benefit or return on investment data.

For some of the examples highlighted within this collection, we have worked with health economists to calculate and identify cost benefits. Now, perhaps more than ever in NHS history, we need to demonstrate a whole range of benefits from our improvement work including quality, patient experience and cost. The Essential Collection has been specifically designed to provide a range of material which we hope will help you to adopt and implement some of these improvements into your own local context. There is a separate section dedicated to each of the eight High Impact Actions. Within each of these sections you will also find:

- written and video case studies drawn from local staff across different health care settings. The videos are included as a DVD within this document and they are also viewable on the NHS Institute website; www.institute.nhs.uk/hia
- details of other useful resources that you can review if you want more information on any of the High Impact Actions
- a range of improvement tools and tips
- specific sections on measurement and return on investment calculations for some of the case studies.
There is a wide range of additional material that supports the essential collection at www.institute.nhs.uk/hia. This material includes:

- an online opportunity estimator that enables you to calculate the potential cost savings for your team or organisation related to making improvements in the High Impact Action areas
- additional resources provided by the case study sites that can be downloaded and shared
- further detail and the models for the return of investment calculations in 16 of the case studies.

To use the High Impact Actions: The Essential Collection please consider the following points carefully.

- Learn from what others have done, but remember that all organisations are different and one size may not fit all. Think about how you may need to tailor things to better suit your local circumstances.
- Sustainable change needs real commitment. Simply cherry picking ideas and trying to implement them without robust plans, support and alignment can lead to difficulties.
- Measurement is crucial in order to demonstrate the impact of your work – you cannot afford to miss it out.
- Remember ‘We all have something to give and we all have something to learn’.

Look out for these icons which will indicate where you can find further information and support.
Making it happen

Throughout the Essential Collection we have identified a range of improvement tips that link to all of the themes in the preceding pages. We have also provided details of where you can go to find more information.

In this section we are specifically highlighting two of those themes, communication and measurement, as they are critical components to success.

Within the time of our daily shift pattern we are often bombarded with information including reports, best practice guidance and research findings. It is indeed difficult for anyone to effectively wade through all of these and many just do not ‘hit the radar’ of busy people. The same can be said when a new improvement initiative or project is suggested. We often hear a sigh of dismay when staff, who are already working their hardest, hear the latest new idea that needs to be implemented.

However, in order to care for our patients effectively and efficiently, it is vital that we, as a profession, feel able to embrace the fact that in order to meet the needs and expectations of our patients we need to continually improve our services to them.

Sensitive and effective communication is vital to any improvement work and critical if you are to fully engage the people who currently deliver the service that is the subject of the change.

Most of the case studies featured within this collection have used good communication methods as a key theme of their success, often using several different methods. For example, one trust encouraged better urine measurement of patients by placing posters on the back of staff toilet doors; its infection control team carried out trolley dashes through the wards, giving out goodies to get people talking about catheter care; and another trust designed a giant floor game as a radical new way to communicate important information and to make learning fun. Elsewhere, staff briefing days run by the chief executive provide an opportunity to ‘ask the boss’.

Improvement tip

Learning from social movement

Social movement has been proven as a model that helps to focus on how to effectively communicate and engage people in change. The NHS Institute’s publication, Towards a Million Change Agents, provides a review of the social movements literature and implications for large scale change in the NHS. It also outlines how some of these different approaches can be used to support improvement. Social movement techniques are based upon collective and coordinated activity which results in a sense of shared identity and lasting change.

Further information available from the NHS Institute website
Social movements are very much about communication. ‘Frame to connect with hearts and minds’ means - think about how you are communicating the changes you want to see. We often describe our initiatives in very ‘technical’ language – yet most people are moved to act when they feel an emotional connection to what is being described. Think about how you use stories of patients when describing situations to friends or colleagues. Describing your improvement effort so that it engages with others at an emotional level is a powerful way to make change happen.

We can make communicating change part of the day job
Communication can be challenging, especially in large organisations. Many NHS staff are able to access a range of training and study days throughout the year which provide the essentials around communication methods. We are not able to reproduce all of the learning you may need within The Essential Collection but would like to highlight a few top tips.

- When communicating, think about how the people you are aiming the message at like to receive information. Do they prefer stories, graphical representation or text for example? Try to make sure that you use a range of methods or target your method towards a specific group with a focus on what style they prefer.

- Sometimes it is good to try something radically different just to gain attention as in the trolly dash example that we previously mentioned.
- Use a range of existing channels such as newsletter, notice boards and intranet alerts.
- Use different channels such as photography, a story telling session with patients or staff or a stall in a main corridor or staff area.

The content and message within any communication needs to be very clear. It can be helpful to think of describing the who, the what, the when, the where and the why you want people to get engaged with the work. Sometimes you can also add ‘how’ in terms of how they can contribute and how to make the change, although it is always good to leave room for staff to contribute with ideas about ‘how’ themselves.

Effective communication happens frequently and as a minimum before, during and after any initiative, however small. Creating energy and celebrating successes along the journey leads to a higher level of engagement.

The following case study shows how Leeds Teaching Hospitals NHS Trust has communicated effectively. It developed a patient care and safety day, bringing together senior frontline nurses with the chief and deputy chief nurses, divisional nurses and nurse consultants to focus on key issues of patient experience and safety.
Creating a communication pathway
Leeds Teaching Hospitals NHS Trust identified its frontline senior nurses as the key to disseminating the latest information about the trust. All senior sisters and charge nurses come together for a day with the chief and deputy chief nurses, divisional nurses and nurse consultants to focus on key issues of patient experience and safety twice a month.

Setting the scene
Leeds Teaching Hospitals NHS Trust is amongst the biggest trusts in the UK and includes the largest teaching hospital in Europe (St James’s University Hospital). The trust provides acute hospital services for the population of Leeds and the surrounding area and acts as a regional centre for a number of specialist services, such as cancer and cardiac surgery. In total, the trust employs around 14,000 staff across six main sites, treating more than a million patients every year, with a budget of around £930 million.

The approach
Patient care and safety days bring together the nursing director, her deputies and the senior nursing team to exchange information and work together to support continual improvement. The morning session consists of an update of things that have been happening including sharing important achievements. During the afternoon sessions, smaller groups work together on key areas of patient care, including infection control.

“...We needed good, consistent information, not a lot of disparate messages. We knew there were really good pockets of practice and areas that needed input. It’s about sharing practice, about everybody being on the same page at the same time. When you’ve got your head down working, you are not always aware of the drivers and don’t understand why audits are carried out and what happens to the results.”

Gill Chapman
Senior nurse
How they did it

A regular communication pathway not only keeps ward staff up-to-date with the latest practice, but it also fosters leadership, embeds consistency of care, identifies issues and concentrates efforts to rectify them.

In 2009, the senior nursing team introduced the patient care safety days programme. These bi-monthly events include senior nursing staff (band 7), matrons and allied health professional (AHP) staff. Subjects covered include: adult safeguarding, falls prevention, pressure ulcers, nutrition and leadership. Other subjects are often suggested by attendees and have also included non-clinical items.

The patient care safety days include a combination of lectures and group workshops. Each practical session is designed around the question: ‘What can your team walk out of here now and do?’ Staff have protected time and can do a range of different things on the same day, providing a real snapshot of where the trust is on a particular subject.

Staff take the learning and adopt it into their own working areas. Sometimes this includes also undertaking audits to help identify progress or challenges faced by the organisation. Matrons help with the formal monitoring process, help ward staff to plan and deliver the improvements and help to share and celebrate the successes widely across the organisation.

This idea was in response to a challenge the trust was facing with high rates of meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile infection (CDI). The trust is spread across six sites and 250 clinical areas and consists of around 6,500 nursing staff. It needed to develop a communication mechanism that could overcome the challenges that their environment posed and resulted in communication that was reliable, relevant, consistent and comprehensively delivered.

The trust recognised that the best way to communicate was to bring senior nurses together at the same time. But, there was resistance and concern that taking staff away from their clinical areas would lower quality of care. The answer was to ensure that those who attended learned something specific and worthwhile to take back to their clinical areas. “Band 7 staff – the team managers, sisters and charge nurses – are key to the delivery,” says Gill Chapman, senior nurse, who helped develop the days. “Improvement is about having targets and drivers, but if these staff are not on board at a local level, it’s not going to happen.”

“We wanted staff to see this as our investment in them – and make it a two-way communication. The day is very much about the senior nursing team being highly visible in the ward areas. It helps to show we understand the challenges they face and are working with them.”

Through the patient care safety days, the trust identified that staff knowledge of aseptic techniques was poor. It put 4,000 staff through training within three months to achieve competency. The days have also helped to introduce new tools and policies across the trust - a risk assessment tool was introduced for...
pressure ulcers virtually overnight. External speakers have included patients and carers, and the team is keen to harness the power of storytelling.

Chief nurse, Ruth Holt has been key to the success of the events. She attends and kicks off every event, sharing success stories, such as a specialist surgery reaching 100 days MRSA-free. She reports key statistics, for example zero cases of CDI in February, updates staff on trust board activities and asks for news to take back to the board.

Her session is designed to support and invigorate staff. Her visibility and familiarity with the nursing staff is inspiring. “The overall aim is communication,” she says. “We want to ensure that we are providing the ward teams with the information and messages they need to carry out their duties in the safest way possible. It’s about recognising where we have gaps.”

The days are constantly being reviewed to ensure success. Attendance is high, with days boasting upwards of 80 staff and many staff coming in from leave to attend. Emma Johnson, matron for endoscopy, breast care and gastroenterology, says: “It’s an opportunity to get senior nurses within the organisation together with the corporate nursing team, to focus on the key aspects within the organisation that will improve patient safety. The challenge for me, as a matron, is to release staff from the ward for two days a month so we do have to be creative.”

“For me, these days are about being able to find out what’s happening on a regular basis,” says ward sister, Sarah Harding. “I feed back to staff on the ward as fast I can, often on the same day. It’s great to put names to faces and know people are there to support you: you know who to get in touch with to ask questions and it doesn’t feel as formal.”

“The patient care safety day focuses on issues that effect patients in our organisation. It’s our opportunity to provide education and training, share ideas and speak to staff. It’s also a forum for people to ask difficult questions. It’s a vehicle for communication.”

Juliette Cosgrove
Lead nurse for patient safety
Measurment for High Impact Actions

Why measurement is important?
Nurses and midwives measure things every day, even though we probably don’t think of it in that way. We collect all kinds of data including clinical observations or test results to help diagnosis, hand hygiene audits to check compliance against protocols, and sickness and absence recording as part of operational management. We don’t just collect all this data, we use it to help us make decisions. This is the most important thing to remember whenever thinking about data and measurement, it can feel daunting and difficult but actually we do it all the time. Without having the appropriate data it can be impossible to make the decisions that are necessary. Good measurement in any situation enables better decisions to be made.

To help ensure the availability of quality information, from April 2010 onwards healthcare providers delivering services on behalf of the NHS, starting with acute trusts, will be required to publish quality performance in an annual ‘quality account’. These will include any additional information that will help to inform the public about the quality of the services provided.

NHS Operating Framework 2009/2010 for Quality

High Quality Care for All introduced the concept of reflecting quality in providers’ income. The Commissioning for Quality and Innovation (CQUIN) payment framework to ensure that quality improvement and innovation form part of commissioning discussions. Carefully considering what tools you need and using them with the right change approaches should help you to improve quality, allow you to spend quality time with your patients and show the impact you are having at the point of care.

The Nursing Roadmap for Quality
But we haven’t got time to collect more data...

Although we do routinely collect and use data in the NHS, we also collect lots of data that we never use. It can feel like we just keep measuring more and more things that are not useful to us in practice – but that just feed the ‘machine’. It often feels confusing and frustrating with a mass of changing directions and the endless annoyance of competing initiatives. The data that we do collect, is rarely given back to us in a useful way - so it can feel like a real burden.

In this brief section we want to help you to understand ‘measurement for improvement’, showing you how good measurement is an essential part of any improvement effort. It will also guide you to other sources of information that will help you in your practice. Measuring the services we deliver and the improvements we make is becoming even more important. Being able to understand both the quality and cost of patient care and the improvements you are making is essential.

This section on measurement is split into three parts. In part one we show you a tried and tested way of structuring the changes you want to make. It’s called the Model for Improvement. We also introduce you to the cause and effect diagram - often referred to as a ‘driver diagram’. This shows pictorially how all the changes you might want to make link together. In part two, we take you through the seven steps to measurement. Follow these simple steps and really get the benefit from your data. Finally, in part three, we ask you to consider the financial aspect of your work on the High Impact Actions. We show you how to go about calculating the return on the investment of your time and resources.

The guide concludes with a real-life example of how measurement is being put into practice along with references to further information.

Part one: The Model for Improvement

It is often also called PDSA (Plan, Do, Study, Act) or the ‘rapid cycle change’ approach. The concept was first used in the 1930s within manufacturing industries and began to be used extensively within health improvement programmes from about 1996. It is still one of the most simple but comprehensive approaches to use when thinking about making improvements to the services that you deliver for patients (see The Improvement Guide, Langley & Nolan for a detailed description). It assists teams to be really clear about what they are testing, being able to make and test changes quickly and understand if they actually work in practice. This means that staff do not waste time and effort designing changes that, when placed into the real world, don’t work as planned.
The three questions at the top of the model provide clarity of thought and the PDSA cycles provide a way of introducing changes successfully.

**What are we trying to accomplish?**
The first question guides teams to be very clear their aim. When establishing the aim you should ensure that it is: Specific, Measurable, Achievable, Realistic, and Timebound (SMART). Often people are not specific enough about what the aim is and then struggle to test and implement change. You need to think about the aim of the specific changes you are testing, not the broad aim of the overall improvement programme.

Each of the High Impact Actions has its own broad aim which will require adapting for your specific improvement work.

**How will we know that a change is an improvement?**
The second question relates to measurement. The seven steps to measurement described on page 25 will help you think about what you need to measure in order to understand if your changes are leading to improvements or not.

**What change can we make that will result in improvement?**
The third question asks what can be done in order to achieve the aim. Throughout this Essential Collection there will be various real examples of changes that have been made in the NHS. By all means think about using these ideas, but make sure you are clear about how they relate to your specific circumstances.

A useful device for helping to show how the different elements are connected - the aims, your interventions and the relevant measures is a ‘cause and effect’ – or ‘driver diagram’. Have a look at the driver diagram opposite. It is taken from the Patient Safety First Campaign for reducing harm from falls. In this example Measure 1 indicates the outcome they wanted to achieve. The other four measures indicate the process or interventions that are needed to get to that overall aim. You can use a driver diagram to help with your project. Go to www.institute.nhs.uk/hia to download a blank template.

The driver diagram links to the questions in the model for improvement as follows:

- Q1 is the aim
- Q2 are the measures shown
- Q3 are the interventions
Aim
What you want to achieve

Primary Driver
Key influences on the aim

Interventions
Practical steps to be taken to influence the driver

1. Reduce harm from falls

Leadership actions to reduce harm from falls

Board leadership: establish falls prevention group

Governance & risk leadership: improve analysis and learning from falls

Train and develop staff in falls prevention

Facilities & estates leadership: create a safe environment

Post fall protocols: care and secondary prevention

In depth assessment and multifaceted care plan

Ask about falls on every admission

Avoid unnecessary hypnotic / sedative medication

Ensure patients have appropriate footwear

Ensure call bell visible and within reach

High risk Patients

All patients
The four basics

1. Rate of patients harmed by a fall
2. % of staff who have received falls management training
3. % of patients with appropriate observations after a fall
4. % of high risk patients with an action plan
5. % of patients who received the four basics of falls prevention
Part two: The Seven Steps to Measurement

The **seven steps to measurement** is a process you can go through when thinking about measuring anything. Following the process will help you think about what you are measuring already and what you might need to measure in relation to the High Impact Actions. Use the seven steps to make sure you always know how you are doing. For each of the High Impact Actions you need to be collecting both outcome measures and process measures. This needs to continue even when you think you have made all the improvements that you can make. Why? Because you will need to ensure that you are sustaining the improvements that you’ve made.

An **outcome measure** reflects the impact on the patient. Many outcome measures relating to the High Impact Actions are already routinely collected as part of the overall performance management for your organisation. Relevant measures and definitions (if applicable) for each High Impact Action are given in the separate chapters on the ‘measurement’ page. An outcome measure might also be described as your local target. For example, to reduce falls by 50% in the next four months.

A **process measure** reflects the way your systems and processes work to deliver the outcome you want. For example, to achieve my overall aim of 50% reduction in falls I need to ensure that 90% of high risk patients have a falls risk assessment. It is important that the process measures have a clear link to the outcome measure - often this link is provided by published research. Some process measures will also be collected on an ongoing basis.

To help you see why both outcome and process measures are important think of this example…

When driving your car you will have an awareness of the speed that the car can go and approximately how many miles you can do before having to fill up with fuel. **Outcome** measures would be the maximum speed the car can go and the average miles per gallon. Because we know that fuel consumption is higher if you are doing short journeys around town, a **process** measure could be the % of short journeys compared to long journeys. So you could use these pieces of information to keep a check that your car is working as expected. If something happens to these figures e.g. you can suddenly not go faster than 50 mph, or you need to fill up with fuel more often and your ratio of short to long journeys has been the same as usual – you know there is likely to be a problem you need to fix. When you take the car into the garage – they will link it up to their computer diagnostics and measure lots of other things that will enable them to understand where the problem is. This is very similar to the measurement in the model for improvement – they measure a few key things that help them tweak the engine and fix the problem. It doesn’t make sense for you to be measuring all of the detail related to engine management all of the time, as you won’t understand it and will just become overwhelmed (imagine the number of dials on the dashboard!). You just need to be aware of the higher level measures so that you know when something may be going wrong.
The Seven Steps to Measurement

1. Decide aim
Whenever you think about collecting any data you need to be really clear about why you are collecting it and what is the aim. It is easy to collect data for the sake of collecting data and this just adds to the burden of frontline staff. Be really clear that the data will be valuable and will add to your knowledge and help you to make better decisions.

2. Choose measures
Once you have a clear aim you will need to think about what measures may be useful. Think about whether you want outcome measures, process measures, or measures that may relate to some specific changes that you are planning. Make sure you consider all the data that is already being captured and how it might be used. A useful thing to do is just look at any data that is put into a system, written in a book, displayed on the wall or produced in reports – it is easy to forget that you are already collecting something that will be useful. Think of other initiatives that may be happening in your organisation. For example: the Productive Series where good data collection is a key element. There may also be data being collected through Essence of Care work. Don’t forget to involve your information department. Often the information department don’t supply information unless we ask for it, but if they can understand how it will be used they will be happy to help by providing what information they can. Try creating a driver diagram to help you think through the relationships between different measures.

“We have 6,000 members of our infection control team – that’s every member of our staff.”

Duncan Selbie
Chief executive, Brighton and Sussex Hospitals
3. Define measures
Once you have decided what you are going to measure you have to carefully define all the terms so that everyone is clear what is included and what is excluded. Having clear definitions means that the collection and analysis of data will be comparable and consistent over time. In each of the High Impact Action sections we have tried to link to existing definitions that are being used. Adopt these definitions if you think they are useful, but also think about how you might need to adapt them for your local circumstances. It is important to get input from all the relevant people when defining the measures so that you get as much agreement as possible – but also remember that it is often very hard to get full agreement so make sure that you do not get bogged down in definitions to the point that you end up doing nothing. The most important thing is that the definition you use is commonly understood by everyone in your team or organisation who is collecting the data.

You will need to establish who is responsible for the data collection and what the process for collecting it is. You will also need to think about whether when collecting your data, you will collect just a sample or you will be trying to collect 100% of the data. This will depend largely on the amount of data involved and the time it may take collecting the data. If you are sampling, you have to ensure that you choose a sample which is representative of the overall population that you are measuring. For more information on sampling look at the Patient Safety First ‘how to’ guide for measurement for improvement. http://www.patientsafetyfirst.nhs.uk

4. Collect data
Before you make any big changes that relate to your aim, it is important to establish your baseline position. For many of the High Impact Actions you will already be collecting data and will have a good indication of your baseline. If not, you should start collecting straight away. It is important to think about how often you collect the data; are you thinking about the data on an hourly, daily, weekly or monthly basis. We tend to think about data in big chunks, but often (depending on what the data is) it is useful to collect and display the data daily.

“I can’t emphasise enough how much of a kick our nurses get out of this. It really goes back to what nurses come into nursing for: looking after patients.”
Nigel Broad
Charge nurse, Abertawe Bro Morgannwg University Health Board
5. Analyse and present
The type of presentation you use has a crucial effect on how you react to data. Using a run chart (line graph) to plot data over time is a very powerful way to determine how the systems and processes of care are performing. Constructing a run chart is simple and is often most effective when drawn by hand. Having a piece of paper displayed on the wall that everyone can see means that people get immediate feedback on the data they are collecting, so they know it isn’t just going into another ‘black hole’.

Run charts are incredibly useful because they show how much variation there is in your processes over time. This means that you can easily see if changes in the data are just random difference – natural variation, or is a change that might need to be investigated (or is the result of making some changes to improve things). As mentioned above – plotting the data often, maybe on a daily basis means that you can get a real feeling for the variation within the system.

If you want to get more technical, there is an extension to simple run charts called Statistical Process Control (SPC) – there are more details at http://www.institute.nhs.uk/innovation/innovation/measurement_tools.html

6. Review measures
It is a waste of time collecting and analysing your data if you don’t take action on the results. It is vital that you set time aside to look at what your measures are telling you. It is really important that you present your data to the right people. Even if there is a chart on the wall, you need to make sure that the chart is looked at whether that is at staff handover, a team meeting or any other time – make sure you know when the data is going to be reviewed. There is a useful review meeting template on page 21 of the Patient Safety First how to guide for measurement for improvement http://www.patientsafetyfirst.nhs.uk

You will need to decide how you are going to review and communicate your High Impact Action measures. Who needs to know about what the data is telling you will vary. For example, the board may only need to know about key outcome measures such as falls rates, but frontline staff will need to know about all the relevant process measures as well.

7. Repeat steps 4-6
Once you have completed the other steps this one is relatively simple but is often left out, which is a big mistake. You need to be continually thinking about what data you are collecting, making sure that it is useful and that you trust what it is telling you. Repeat steps 4, 5, and 6 continuously: Carry on collecting data, presenting it in a useful way and reviewing it. You will then be able to see how things start to get better as you make improvements to your service. You may want to consider stopping collecting
some data, or changing the way it is being collected (e.g. sampling) if you are very confident that improvements made have been sustained. However, remember that you always need to have some measures that will tell you if things start going off track.

We have created a checklist that will help you work through the seven steps for each measure you are using. It prompts you with some vital questions so that you don’t miss anything out. You can download it from the High Impact Action measurement section at www.institute.nhs.uk/hia

Assessing return on investment

When carrying out improvement work, you should also consider if the outcomes that you get are worth the cost it has taken to make the improvement. This can be achieved by creating a simple return on investment calculation. Showing you how the improvements that you have made have led to better quality care and are a better use of NHS resources is becoming increasingly important. Showing this information can also help win support for spreading an improvement more widely, and can help you to benchmark a range of different improvements against each other. Although writing robust and rigorous return on investment cases is a financial skill (and if you want help then the best place to start is your finance department) there are basic methods anyone can use to assess the benefits against the investment of time, effort and resources. Typically a return on investment (ROI) calculation is a type of cost benefit analysis that gives the net gains as a percentage of the costs. You can calculate a return on investment before or after an improvement but in this section we will assume you are calculating a simple return on investment before the improvement is made.

Costs

Usually, the main costs involved in making a service improvement will be staff time, training and materials. The project lead will be able to estimate the proportion of their time needed for the project as well as the input from other key staff. For example, the nursing staff of a ward who are provided with one hour’s training in an assessment procedure to minimise the risk of falls among older patients, or a steering group that meets for an hour on a quarterly basis.

“The most satisfying element is that we have raised the profile of infection control, and have focused on areas other than national targets. It was an area we identified and we improved patient care as a result.”

Lindsey Webb
Director of nursing and governance,
Birmingham Royal Orthopaedic Hospital
Record all those staff that will make a direct contribution to the project and get estimates of the time they will spend on the project. To calculate the costs, take the average salary for the staff pay band, divide it by the approximate number of working days in a year (this is usually around 220 days and takes into account weekends and annual leave) to generate a daily rate for each member of staff, and then again by dividing by 7.5 (i.e. hours in a working day) to get an hourly rate. You may also want to add something to cover the additional overhead costs of employing staff (pension and national insurance etc), a conservative estimate that is often used for this is 18%.

Add any other costs of training and estimate the cost of any materials that will be developed or purchased. For example, patient health information leaflets, posters, assessment documentation, equipment etc. Purchasing and finance managers within your organisation will be able to help you assess most material costs.

Benefits
The benefits that result from your service improvement project need to include, as a minimum, an assessment of any changes in quality, patient experience and cost. The main outcomes you are aiming to achieve should be tracked as part of the project’s measurement system (see the measurement information above). For example, service improvement initiatives aimed at reducing the number of falls or promoting early discharge will need to measure the status before the start, during and on completion of the work to understand what difference the improvement initiative has made. The number of falls is a relatively straightforward indicator, captured ideally along with the different grades of harm resulting from a fall (see falls section for more detail). As mentioned previously, much of the required information will be available from NHS trust information departments. Comparing outcome indicators before the service improvement initiative and after its implementation will give you an indication of the impact that has been made, or you can predict what impact you will have and see what the benefit will be. Remember there is always natural variation within any system so you need to make sure you have enough data to be really sure you have made a difference.

Once you are clear what the benefits are, it is then possible to start to calculate the costs. For example, the National Patient Safety Agency has calculated the direct costs of treating different types of fall according to their level of harm (see falls section). The Department of Health has conservatively estimated the daily cost of care for an individual awaiting hospital discharge to be £100. Therefore, if you are predicting that you can save 1.5 bed days per patient by reducing discharge delays, and treat 200 patients per year, your potential cost saving is 200 × 1.5 × 100 = £30,000. Not all outputs will be possible to quantify and assign costs to, such as enhanced quality of life for a patient or reductions in carer stress. Nevertheless, these are important quality and experience categories and must be carefully documented and reported as ‘categorical’ benefits that result from the service improvement.
Return on investment
By comparing the costs associated with the improvement with the benefits achieved (savings), it is possible get an estimate of your return on investment. For example, let’s say an initiative to reduce falls has cost £20,000 in staff time and materials but has saved £30,000 by reducing falls that would otherwise have happened. The return on investment* is: £30,000 ÷ £20,000 = £1.50. So for every £1 you spend you save £1.50.

Sometimes though, it will appear that savings achieved are less than the actual cost of making the change. In this case check your assumptions and calculations and always make sure you have identified and documented the quality gain.

Share the results
Once you have completed your return on investment analysis it’s important to share your results as the calculations can be very persuasive. It is important to always make clear the assumptions that underpin any cost calculation. For example, which costs have been included and which haven’t, which costs and benefits it’s been possible to cost and which it hasn’t, and very importantly the time period for which the calculation is made. Sharing this type of information with colleagues allows them to understand the basis of your calculation and provides opportunity to further enhance its accuracy through their ideas and suggestions.

For more advice and a more advanced approach visit the NHS Institute’s return on investment webpage: www.institute.nhs.uk/roi

The strict meaning of return on investment is (benefits – costs) divided by costs and given as a percentage but it is often not used in this strict way. The calculation given is actually a ‘benefits to cost ratio and a dividend. The dividend is simply the benefits minus the costs, in our example, £10,000, and the benefits to costs ratio is the benefits divided by the costs, in our example £1.50 will be saved per pound spent.

Further information available from the NHS Institute website
Case study: Stoke Community Health Services

Measuring success
One of the first things to go up on the walls at the newly built Haywood Hospital has been the matron’s dashboard, providing a visual reminder of performance for staff and patients alike.

Where we were
The dashboard was introduced by associate director of nursing and quality, Sarah Shingler, and is providing a range of benefits from improving quality of care to identifying funding opportunities.

The new 148-bed hospital run by Stoke Primary Care Trust houses six rehabilitation wards and is staffed by 200 nursing staff, many of whom have seen hospital closures and moves.

Driven by quality, the dashboard brings together nationally driven targets, locally agreed priorities and the trust’s dedication to improving patient quality, which drives everything they do. Staff fed into the measurements through a series of ongoing engagement events which set local priorities.

Using ‘Dashboards’ is another useful way of presenting data (Step 5 of the Measurement Process). Dashboards provide an overall view of how an organisation or ward is performing in key performance indicators which colleagues and managers can see: This helps identify when things are going wrong so staff can quickly address why and make improvements to their service.

“Staff can see how they are improving. This is a really visible tool. When we put the dashboard up, people could see how they were doing. For us it’s about saying: we know you do it, but this proves you are doing it. It’s no longer enough to just say: ‘I do a good job’.”

Angela Cole
Hospital matron
How they did it

Mandy Donald, managing director at Stoke Community Health Services believes the dashboard is improving – and proving – quality. “The dashboard enables us to put all these targets together into a visual design. It is really important that our staff see how they continue to improve in these key areas and share it with the public and patients who come into the ward.

“We need to quantify everything that we do financially, in doing so we understand the cost impact of getting things right first time, so we are becoming more efficient in what we do. For me the finance is an added bonus for us.

“The most pleasing thing is that on virtually every single ward, whatever the benchmark, there was an improvement. It provides me with the assurance, as the person heading up the organisation, that quality is paramount; not to just say that quality is important but show that it is being analysed.”

Each month, the dashboard is updated and is publicly displayed on wards using a RAG rating (red, amber, green) to identify improvement. The dashboard also features on a range of committee agendas, including the trust board. It forms a major part of progress reports presented to commissioners to highlight the work and progress of the organisation to them during contract meetings. The data for the dashboard comes from the ward managers and is collated and mapped onto the dashboard. “We knew most of the information was already there,” says Sarah. “We have also devised new documentation to support the dashboard.”

The dashboard has been designed to be responsive to each ward and features individual indicators pertinent to the ward or speciality, for example, drug monitoring within rheumatology.

Many staff welcomed the dashboard because the indicators spoke to core nursing values and features many of the High Impact Actions, such as falls reduction, infection control and tissue viability. In many cases the dashboards provide evidence of what staff are already doing and act as a visual tool to recognise these achievements. Where concerns are raised about performance, the matrons work with ward managers to develop action plans.

For those staff who were harder to convince, the trust identified development opportunities through a range of leadership programmes, designed to develop staff at all levels. “Once we started to share information, people’s competitive streak kicked in,” says hospital matron, Angela Cole. “Ward managers are absolutely key; they can do a lot of damage if they are obstructive to the process. But they are the unsung heroes.”

Ward manager, Nicky Dale said: “It’s important that we all work to improve patient care and the dashboard is a really useful visual aid to show staff how well they are doing. As long as it’s there for patient care, it can only be a good thing. I bring it up at every opportunity. If we do slip down that’s another reason to measure, so we can see it and address it.”
The next step is to add pound signs on to the dashboard to identify the savings being made to the trust – and across the local health economy. The team will map costs on to the work that is evidenced by the dashboard to provide a compelling argument for restructured funding.

The PCT has identified its impact across the health economy through a range of additional services. This includes cutting readmissions rate through reduction in falls and pressure ulcers. The role of care navigator has also been introduced into the acute hospital to reduce delayed discharge and the community services team has set up an IV antibiotics pathway.

Stephen Shallcross, was one of the first patients to stay on the wards following a stroke. He says: “The staff are absolutely brilliant. It’s unbelievable; the nurses can’t do enough for you. Everything is organised, you know what is going to happen when and it is a calm environment.”

The PCT remains very clear that the work is driven by quality, but recognise it is inextricably linked to finance. To build on the improvement work they will need to free up funding within the health economy. It is not about spending less, but spending it differently. “This is all driven by quality,” says Sarah. “But to do that we need to understand what these things cost.”

“Communication with staff is vital – making sure they are involved and understand the issues and that they are supported so they can act themselves. This goes from the healthcare assistants right through the grades – even the ward clerks have a role to play.”

Nicola Cerrulo
Ward manager, East Kent Hospitals University NHS Foundation Trust
Some key sources of information you can draw on:

The Nursing Roadmap for Quality:

This has been designed to help nurses and their teams understand the elements of the quality framework that relate to nursing practice.

The purpose of the document is to:

• inform nurses and their teams of their role in supporting quality improvements against the seven elements of the quality framework and provide a ‘one-stop shop’ for key resources which nursing teams can use to further demonstrate their added contribution to quality.

• reinforce the need for nurses to identify ways to reduce waste and repetition by contributing to the quality and productivity challenge.

Indicators for Quality Improvement:
http://tinyurl.com/lesm89

The indicators are:

• a resource of robust indicators to help local clinical teams select indicators for local quality improvement

• a source of indicators for benchmarking

• assured by clinicians for use by clinicians

• published with full metadata for transparency.

The indicators are not a new set of targets or mandated indicators for performance management. However it is possible that some of these may be specified as core indicators to be used in Quality Accounts. The initial indicators are mostly existing indicators which are supported by clinicians and NHS professionals as effective quality indicators.

Nurse sensitive indicators:
http://www.ic.nhs.uk/services/measuring-for-quality-improvement/what-is-happening-on-indicators-for

This first set of nurse sensitive indicators outlines the approach that has been taken to the development of the core definitions across nursing regardless of care setting. It also sets out it is proposed to measure these indicators in a consistent way, including consideration of the need to standardise and reduce the potential variation in measurement. They are intended to support improving quality in NHS provided care – in both the NHS and social care settings – and apply to anyone wanting to measure and demonstrate continued improvement regarding nursing care.

NHS Evidence- quality and productivity website:
www.evidence.nhs.uk/qualityandproductivity

This specific quality and productivity section acts as the national evidence base on how to improve quality while making cash-releasing saving. It is designed to be a national resource which is dawn on locally. The website contains a selection of the best evidence available with real examples, submitted by healthcare professionals, of how staff are improving quality and productivity across the NHS.
Patient safety campaign:
http://www.patientsafetyfirst.nhs.uk

Patient Safety First seeks to reduce harm to patients by changing practice in specific areas, based on existing evidence. To put it simply, Patient Safety First is about actively looking for examples of harm, examining the causes and learning from them to avoid future incidences. This campaign is different: it is delivered 'by the service, for the service' and is led by a core team of dedicated clinicians and managers from across England all experienced in, and passionate about, improving patient safety in their own field.

Patient Safety First's cause is 'to make the safety of patients everyone's highest priority'.

Patient Safety First's aim is 'No avoidable death, no avoidable harm'.

The website contains a selection of “how to material”:

The how to guide for measurement for improvement:

Patient safety first measures definition paper:

The quick guide to implementing improvement:

How to guide for leadership for safety:

Measurement Tools: NHS Institute for Innovation and Improvement
http://www.institute.nhs.uk/innovation/innovation/measurement_tools.html

The measurement tools page is a one-stop shop for the resources available from the NHS Institute on the subject of measurement. The tools section lists all the interactive tools available to help you measure your progress. The resources section contains documents, toolkits and guides relating to measurement.

Other sources of information

“If we can make sure people are safe from avoidable harm, it's got to be worth doing. It reassures the patients' relatives, as they can see some form of documentation - which is quite prominent - that shows that their relative is being looked after.”

Sandra Gillingham
Ward matron, Ipswich Hospital NHS Trust
Your skin matters
The aim of the high impact action – Your skin matters is ‘no avoidable pressure ulcers in NHS provided care’ – but which ones are avoidable? We know that pressure ulcers represent a major burden of sickness and reduced quality of life for patients. They create significant difficulties for patients, carers and families, as well as increasing time in hospital and, therefore, cost to the NHS.

A practical summary
Most nurses will agree that the majority of pressure ulcers that develop in NHS provided care are avoidable. So why do they occur? Often it is the processes around their prevention that fail, for example not being able to get hold of the right equipment, or not finding the time to undertake an early assessment. Stopping pressure ulcers needs input from the multidisciplinary team that results in the creation of a simple process that works and that we all follow. As a nurse, why wouldn’t you want to lead on the work to stop your patients from developing pressure ulcers?

The problem
Pressure ulcers are quite common and are estimated to occur in between 4% and 10% of patients admitted to hospital. Figures for their occurrence in the community are more difficult to obtain, but it has been estimated that 20% of people in nursing and residential homes may be affected and up to 30% of the population in general. (Clark M, Bours G, Defloor T; 2004).

Pressure ulcers can occur in any patient but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or have continence problems, people with certain skin types and those with particular underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection and a two to four-fold increase in the risk of death in older people in intensive care units (Bo M, Massaia M et al, 2003).

The cost
The cost of treating all hospital acquired pressure ulcers in the UK is estimated to be between £1.4 – £2.1 billion each year, comprising 4% of total NHS expenditure (Bennett et al, 2004). Treatment costs vary depending on the grade of ulcer, from £1,064 for a grade one ulcer to between £10,551 and £24,214 for a grade four ulcer depending on complications. The same study estimated that the daily costs range from £38 to £196. Nurse or healthcare assistants time accounts for almost 90% of the costs, which increase with ulcer grade because the time to heal is longer and because the incidence of complications is higher in more severe cases.

What we can do
Prevention of pressure ulcers requires a collaborative inter-disciplinary approach requiring each member of the team to take responsibility for management, risk assessment and prevention of pressure ulcers.

Key areas to start with to help you to create the right processes and reduce pressure ulcers include:
- think about the high risk patients – we all know risk is predictable
- carry out timely skin assessments
- make sure the right equipment is available
• improve nutrition and hydration and initiate and maintain suitable measures of how you are doing
• use the expertise that is available to you: tissue viability specialists, medical staff, dietitians, physiotherapy, OT and the patient
• make sure that education and training focuses on the prevention as well as the treatment of pressure ulcers.

Remember: education is key; equipment can only do so much.

It is about more than just a mattress; patients need pressure relief when sitting, as well as lying down.

Consider the four key elements make up the SKIN bundle:
• surface
• keep moving
• incontinence
• nutrition.

Culture change is vital for embedding change. Pressure ulcers should be seen as avoidable adverse events not an inevitable fact of life. Root cause analysis of adverse events is crucial. Investigating incidents and comparing to best practice is essential. Ownership of the problem cannot be stressed enough - all too often it falls to tissue viability nurses who may struggle for several reasons (their/others knowledge, level at which they work, influence, trust priorities, culture, time and other priorities). It truly needs to be cross organisational, with investigations and actions performed/owned by all.

Pressure ulcers don’t just exist in acute hospital settings, but also within community, social care and home settings. A multi-organisational approach will help to reduce prevalence in the community and in hospital settings.

The case studies

East Kent Hospitals University NHS Foundation Trust – Ensuring the right equipment for the right patient led to a 9% reduction in the incidence of pressure ulcers.

Kettering General Hospital NHS Foundation Trust – focusing on continence care has helped reduce the incidence of skin damage by 80%.

Newham Primary Care Trust – working with nursing homes has reduced the number of pressure ulcers and saved £1.5m.

Abertawe Bro Morgannwg University Health Board (Wales) – a zero-tolerance approach to pressure ulcers has led to many wards having no pressure ulcers for several years.

“Quality is improved by empowering patients and empowering professionals. There must be a strong role for clinical leadership and management throughout the NHS.”

High quality for all-NHS Next Stage Review Final Report 2008
Where are the best sources of information?

The Royal College of Nursing (RCN) and National Institute for Health and Clinical Excellence (NICE) collaborated to develop clinical guidance on the management of pressure ulcers in primary and secondary care.
http://www.rcn.org.uk/development/practice/clinical_guidelines/pressure_ulcers

Tissue Viability Nurses Association
www.tvna.org

NPSA 1000 lives campaign

Saving 1000 lives campaign Wales
http://www.wales.nhs.uk/sites3/home.cfm?orgid=781

European and American Pressure Ulcer Advisory Panel
http://www.epuap.org/

Essence of Care

“Healthcare professionals should use their clinical judgment and consult with patients when applying the recommendations which aim at reducing the personal physical and social and financial impact of pressure ulcers.”

The management of pressure ulcers: a clinical practice guideline
The Royal College of Nursing and National Institute for Health and Clinical Excellence
Protecting our most vulnerable patients

Nursing homes were the focus for further improvement in reducing pressure ulcers in the community at Newham PCT, which recruited two specialist nurses to work with them on reducing the prevalence and impact of pressure ulcers among this vulnerable patient group.

Setting the scene

Newham PCT boasted a well-established and highly effective tissue viability service with an active education and training programme and a well-used wound formulary for routine care. But the service was receiving increasing numbers of calls from the eight nursing homes in its area for advice on tissue viability for residents. Referrals for nursing home patients were coming late, when pressure ulcers were advanced and often required hospital admission.

The approach

The tissue viability service appointed an additional nurse to tackle the increasing incidence of pressure ulcers in nursing home patients. This also helped to reduce hospital admissions. The service included an increased frequency of visits to review patients at risk of pressure ulcers and an education programme for all nursing home staff. The trust wound care formulary was introduced to the nursing homes to ensure dressing selection was appropriate for the wound type.

The team worked closely with staff in nursing homes to identify and acknowledge the extent of the problem and helped to audit the number of pressure ulcers in the nursing home population.

“...problems impact on the work of the NHS and on the patients’ lives I was finding quite horrendous pressure ulcers. By the time the referrals came in there was little choice but to admit them to hospital. I had to take a step back and think how could we change the culture?"

Caroline Dowsett
Nurse consultant for tissue viability
How they did it

Newham PCT felt the potential benefits of expanding its tissue viability support for nursing homes were clear, not only for the community health services, but across the health and social care economy. Developing the service would lead to better quality of life for patients by reducing the incidence and severity of pressure ulcers and, in turn, reducing the need for treatment, GP time and hospital admissions.

“Prevention is the most effective measure,” says George Souther, lead nurse. “Ultimately we are looking for a reduction in complex wounds – these are the patients that end up in hospital. This would mean we could pick up pressure ulcers at an early stage and work with the nursing home staff.”

Newham PCT had eight nursing homes in the area, with 480 beds, and Dr Caroline Dowsett, nurse consultant for tissue viability, recognised that providing real support would require more resources.

For Caroline, being a member of the professional executive committee was a critical enabler in securing support and, through a business case, the funding they needed. But it still took perseverance: Caroline lobbied commissioners over a three-month period.

“We knew we would need additional resources,” she said. “My success shows the importance of having clinical engagement in commissioning to drive up quality.”

In November 2008, practice nurse, Carole Taylor and district nurse, Bisi Oshinbolu were employed as clinical nurse specialists. Part of their role is to work closely with staff at the nursing homes. Routine monthly visits helped to establish trust and built up the skills of the workforce through training and education.

At times, the team has dealt with things head-on. “There is a duty of care,” says Caroline. “There was one nursing home that I was very unhappy with and then relationships broke down. There was a huge amount of relationship management needed to get them to trust us, so that we could work together.

“The problem might not be lack of knowledge, it might be about time or equipment. It is vital we listen not lecture. We are a guest in the nursing home and have to act accordingly.”

Education has been key to their success. It has given nursing home staff the confidence to make decisions, to work in partnership, to detect and intervene. The rate of staff turnover within nursing homes among unqualified staff means there is always more training needed. As well as organising dedicated training events. Bisi and Carole offer on-the-spot training in wound care.

Within six months, the team had moved away from being suspicious and not wanting us around to a position where we received daily calls for advice from a workforce invigorated by its role in improving their residents’ quality of life. The training is providing new skills to nursing home staff who are enthusiastic learners: an upcoming training course for healthcare assistants currently has a waiting list.
“The key to this is the education,” says Bisi. “The staff now have the confidence to make decisions and we support and encourage them, telling them they did the right thing. When we first went in, the staff thought we were checking up on them, they didn’t know how to take us. It’s about building trust and relationships; we are there to help them.”

“Support workers spend the most time with the residents, it’s important that they are trained so that they know exactly what to look for, making sure the cushions are okay, look at where the pressure areas are and also when dressing an ulcer, assessing the colour so they can do simple dressings.”

The role has provided its challenges, but Carole says it has tremendous job satisfaction. “We do impact more on people’s lives. I remember seeing one particular patient improving, and saying to the staff, it was the best Christmas present I could have had.”

“It was a very attractive outcome from a commissioning point of view. It improved quality of care, increased quality of life for patients and was cost effective by reducing incidence and severity and, with it, hospital admissions and treatment.”

George Souther
Lead nurse

“No, they will come to us and ask for training. It’s more of a partnership approach, not a doing ‘to’ but doing ‘with’.”

Bisi Oshinbolu
Tissue viability nurse specialist
Local results

Impact on quality of care
Data collection has shown a reduction in the number and severity of pressure ulcers in nursing homes.

Data from the acute providers has shown a decrease in the number of patients admitted from the community with pressure ulcers by 50% for the period April-August 2008/09.

The work has resulted in improved quality of care and improved quality of life through a reduction in incidence and severity (less category three and four) of pressure ulcers. The service has freed up GP time, and reduced costs through dressings and medicines. Caroline and her team are now able to concentrate on the more complex cases and provide more education which supports prevention.

The team carry out a root cause analysis for every patient admitted to hospital with a pressure ulcer, looking at what caused the admission and whether it could have been prevented. The local formulary for prescribing across the PCT has been rolled out voluntarily to nursing homes. Recent audits show 80% compliance.

Impact on patient experience
Patients remain in their own environment. Fewer patients developing pressure ulcers means less pain and a better quality of life.

Impact on staff experience
Nursing home staff feel empowered and their increased knowledge has improved their decision-making.

The tissue viability team has developed greater working relationships with local nursing homes.

Impact on cost reduction
In 2008 there were 25 to 45 admissions. In 2009 this reduced to between 0 and 12 admissions. Based on admission costs of £199 per night, with average stays of nine nights, the cost saving is £59,100 based on the highest number of admissions. Additional improvements in quality of life for patients who did not develop pressure ulcers.

Return on investment calculation
Costs of the following inputs were calculated for both the set up and roll out phases: dedicated time from the project lead to undertake the audit, develop the business case and provide ongoing management; employment of additional tissue viability nurses; delivery of education and support to the nursing homes; and travel costs. Impact costs were identified in terms of reductions in the number of patients being admitted to hospital for pressure ulcer care which, extrapolated over one year totalled 348. An average cost figure for treating pressure ulcers across the NHS at year 2000 prices was used to calculate cost savings. For every £1 spent Newham PCT generated £51.56 of benefits over a year. This calculation does not take into account the additional quality benefits that have not been monetised, nor any additional costs incurred by the nursing homes.
Managing relationships
The additional resource has allowed the tissue viability team to work with nursing homes, offering routine visits and training sessions, rather than simply responding to immediate needs via referrals. The time invested in building up a relationship with staff has more than returned that investment for the PCT.

Change can provoke different emotions and reactions in people. Understanding the human dimensions of change, and specifically the impact that your own personal approach has on others, can be invaluable. Many change projects fail because of lack of insight into why people may be reacting negatively to a proposed change.

"I like to give praise, to let the staff know it’s not me but they that have done it; giving them ownership is a great encouragement."
Carole Taylor
Tissue viability specialist nurse

"The key to this is the education. The staff now have the confidence to make decisions and we support and encourage them."
Bisi Oshinbolu
Tissue viability nurse specialist

"Quality improvement often takes longer than expected to take hold and longer still to become widely and firmly established within an organisation."
Sustainability

Providing ongoing and informal on-the-spot training to staff as the need arose, combined with regular more formal sessions, has created a better knowledge base. If change is hard, than sustaining it can be even tougher. The knowledge and skills training in Newham has been sustained, keeping skills up-to-date and keeping tissue viability at the front of minds and by quickly identifying new staff during visits and delivering training. The high level of involvement and training of staff have resulted in cost savings and all three of these means that the service continues to be effective and sustainable.

How can you avoid wasting money and time during change initiatives? One of the primary reasons why quality improvement is difficult to integrate into an organisation is that many of the changes that are put in place fail to survive in the longer-term. The sustainability model is an easy-to-use tool, which aims to help healthcare improvement teams think about the likelihood of the change sustaining throughout and beyond a project.

Improvement tip

The likelihood of a project sustaining is dependant on:
• staff
• processes
• organisation.

The sustainability model consists of 10 questions that you can score your project against to see how likely it is to lead to sustainable change. The accompanying guide gives lots of practical advice on how you can make it more likely to sustain.

www.institute.nhs.uk/sustainability
Case study: Kettering General Hospital NHS Foundation Trust

Change that’s not just skin deep
A programme of change focusing on continence care has helped reduce the incidence of skin damage by 80%. In the absence of a dedicated continence specialist, the tissue viability team worked differently to maximise the support they were able to give staff. A selection protocol for continence products was devised to ensure the right product is available and used.

Setting the scene
Kettering General Hospital had a high rate of Clostridium difficile infection (CDI) in 2006. A decision had been taken to open a new isolation ward to handle the high levels of infection and this prompted a request for ten extra air mattresses, each with a price tag of £3,000. The hospital believed that the mattresses were necessary to help combat the possibility of pressure ulcers, which is a constant risk in vulnerable patients with diarrhoea.

The approach
The tissue viability team recognised that moisture lesions are a preventable problem, primarily occurring secondary to incontinence, which leads to irritant dermatitis, maceration and excoriation. Avoiding compromised skin reduces the risk of pressure ulcers and potential subsequent infections.

The team worked on increasing their ability to recognise moisture lesions, and to select the best treatment options. This was first piloted in the isolation unit and then on three medical wards.

The team identified a range of products for skin care and protection and devised a selection protocol for their use, as well as providing staff education.

Improved access to a better range of incontinence management products, along with education on their selection and correct use, made a significant impact. The absence of a dedicated continence advisor meant that a different, collaborative approach was necessary to maximise the support available to staff.

“I was familiar with the High Impact Actions programme and knew that it was possible to make a huge difference by introducing small, but significant changes...this sort of programme is fundamental to effective nursing care.”

Colin Iversen
Tissue viability specialist
How they did it

The hospital’s tissue viability specialist, Colin Iverson identified that the potential skin damage in patients with CDI was caused by incontinence, rather than the type of mattress used.

“In my opinion, the solution was a human one, rather than something related to the equipment we were using,” he says. “Rather than getting pressure ulcers, patients with CDI – many of whom are elderly – are at risk of developing moisture lesions, which are caused by the exposure of skin to an irritant, such as diarrhoea.”

Colin campaigned for a return to the essentials of patient care. The key to preventing moisture lesions, or preventing pressure ulcers from becoming infected, is to keep fluid away from the patients’ skin. This meant that for this group of patients, using the correct incontinence products was more important than using pressure mattresses.

Colin worked with the hospital’s suppliers, reviewing available products and their suitability for different patients. Three different products were identified which would meet the needs of different categories of patient: velcro-based products for people who were immobile, integral pads with underwear for more mobile patients and lower absorbency products for those without acute diarrhoea. They also discussed barrier creams and products used for washing patients with compromised skin.

A training and education programme based on one-and-a-half hour drop-in sessions was designed for staff. Colin and the product supplier took staff through the fundamentals of how to measure patients, how to fit the products and how to recognise when the products needed changing. Within two weeks, all staff on the ward had attended the training.

Becky Mould says: “Nothing like this had been done before and it became part of the staff preparation for the new ward. Colin put together a skin guide, covering essentials like how to clean patients’ skin, what barrier products to use and which incontinence products were suitable for which patients and the supplier showed them how to use the products properly.”

Colin then spearheaded phase II of the programme, to roll it out across the hospital, with the medical wards next to be involved. “This time I was able to carry out an audit to give us a baseline figure to work from,” says Colin. “The supplier and I liaised with ward managers to draw up a patient profile and identify the sort of products that they might need. Then, as before, we held drop-in training sessions for staff.”

Colin believes that getting the right staff on board was crucial. Ward managers played a significant role and, without their buy-in, the programme would have been far less effective. “I have no authority and cannot compel staff to come along to the training,” he says. “However, the fact that the programme was given the backing of the ward managers meant that staff were keen to come along and, even though there was some resistance to the idea of removing bed squares, ultimately the results were very positive.”
“For the first two to three months, someone toured the wards every day to allow staff to ask questions, whether it was me, the supplier or Becky, the isolation ward manager. This was an important part of the change management process and helped to make sure the change became normal practice.”

The next stop was the surgical wards, where problems arose because moisture lesions weren’t recognised as a major issue with surgical patients.

“There was a low turnout, as staff felt the training was less relevant to them,” says surgical ward manager, Joanne Milton. “It is a limited problem on these wards but slowly practice is changing. I think you need experts on every shift to communicate best practice to others and it would have been helpful to have some training sessions for nightshift staff.”

“I plan to revisit areas that we have already approached to make sure the change is being sustained and I intend to re-approach the surgical wards,” adds Colin. “In retrospect, I would get staff to do their own audit so they can see for themselves what a difference their actions are making to patients. It is impossible to overstate how powerful this is as an approach.”

“A year after the ward opened, staff were proud of the fact that, even though they were looking after high risk patients, they had been able to prevent moisture lesions from developing by following a few simple procedures.”

Becky Mould
Ward manager
Local results

Impact on quality of care
No moisture lesions developed on the isolation ward over the course of a year.

An audit of numbers of moisture lesions on medical wards pre and post change showed there was a reduction of 80%; typically there were 5% of patients with moisture lesions pre-change. This was reduced to 1% or less post-change.

Impact on patient experience
Reducing lesions reduces pain and suffering for patients.

Impact on staff
The training sessions achieved 100% attendance for those staff on the isolation ward increasing both confidence and competence.

Impact on cost reduction
Product cost on the three wards: before change £5,023 per quarter and after, £4,830 per quarter. It is difficult to estimate the savings made by reducing hospital treatment and length of stay.

Return on investment calculation
Costs of the following inputs were calculated for both the pilot and roll out phases: dedicated time from the project lead to select products, develop the business case and provide ongoing management; and the delivery of education to staff on the pilot and roll out wards. Impact costs were identified in terms of reductions in the incidence of moisture lesions extrapolated over one year and savings made on the products used. For every £1 spent, Kettering General Hospital NHS Foundation Trust generates £3.84 of benefits over a year. This calculation does not take into account the additional quality benefits for patients that have not been monetised.

Further information available from the NHS Institute website
Project management: the importance of momentum and spread

Working in a busy high-pressure environment doesn’t leave much time for reviewing working methods. The lessons learned at Kettering General Hospital illustrate the importance of having a clear plan of what needs to be achieved but also of taking the time to make sure staff are supported through the change. It is important to be flexible in the way that new training is delivered to maximise the number of staff who are both able and willing to participate.

Training by itself will only get you so far. Staff also need continuing support and a constant, visible presence, so that they are reminded of the changes that are being made.

“Education and training were the foundation stones of this project and personalities, too, are a key to success. If you have ward managers or clinical champions who can positively influence their colleagues, then you are far more likely to succeed. In my opinion, you need at least 75% of staff on board to make a significant change. With 50% and an enthusiastic ‘champion’ you could still make a positive impact for patients.”

Colin Iverson
Tissue viability specialist

Improvement tip

Project management should help you start to pull together a practical plan for spreading and sustaining a project. Regardless of which project management approach you use, there are different tools that will enhance your project.

You do not always need a full-blown project management approach, but it is always good to use some of the basic principles in any project, however small. Try the following:

The Productive Series’ project guides
NHS Sustainability model and guide
Thinking differently resource guide
Commissioning to make a bigger difference

PRINCE 2 www.ogc.gov.uk

“As healthcare leaders we need the courage to make a personal stand for what is right. We need to make a profound connection with deep-seated values that brought us and our colleagues into healthcare in the first place.”

Helen Bevan
Chief of service transformation
NHS Institute
It is important not to underestimate the amount of time that it takes to get new ways of working fully up and running. There is no one way that always works in spreading good practice, it depends on what you are trying to spread and to whom.

Good project plans with aims and milestones are important, but equally important are the more informal aspects. We are all more likely to be influenced by our immediate network of friends and colleagues, and utilising these informal, social networks to get change to happen can be powerful. It is also important to remember that all clinicians want to deliver safe and effective care to their patients. Nobody wants their patient to develop a pressure ulcer. Tapping in to some of these fundamental values that are common to all clinicians is a good way of getting people involved and passionate about making the change.

**Understanding the problem**

In the NHS, innovative working can often have more impact than extra investment. At Kettering General, a plan to spend thousands on new mattresses to protect vulnerable patients with ‘CDI from skin damage seemed like the obvious answer. But, by really understanding the underlying problem, and asking ‘why’, the team ensured that the right solution was developed. Often we tend to jump in with a solution before really understanding what the problem is and then get disappointed when we don’t get the impact we want. In an improvement project, it is always better to spend more time really understanding the problem rather than just implementing a solution. Doing this is also a great way to involve and engage others early in the change process.

The Power of One, the Power of Many makes a powerful case for the way in which social movement thinking can be incorporated into existing health and healthcare improvement practice to create more effective, compelling, faster change for patients and the public. The publication demonstrates how social movement approaches – based on connecting with peoples’ core values and motivations to affect change – can deliver improvement at previously unseen depths.

**Improvement tip**

Identifying the root cause of the problem by analysing qualitative and quantitative information will help you understand the real cause and determine whether a symptom is actually the cause or effect of a problem.

Your improvement work needs to focus on the cause of the problem not the effect.

p40, The Handbook of Quality and Service Improvement Tools (NHS Institute)

**Using five whys**

This is a simple tool that can help you determine the relationship between different root causes of a problem.

Example – The new ward needs 10 mattresses

**WHY** The patients on this ward are at higher risk of pressure ulcers

**WHY** They are a potential risk for moisture lesions

**WHY** Because the skin is potentially compromised (due to poor continence)

**WHY** The root cause is that we need to prevent compromised skin by using appropriate continence products.
Case study: East Kent Hospitals University NHS Foundation Trust

Supporting those in need
Pressure relieving mattresses are considered to be an important tool in preventing and treating pressure ulcers – and this is why wards can be less than willing to part with them for fear of having a patient in need and no equipment to support them. East Kent introduced a range of measures to ensure they were available for those patients who were in most need.

Setting the scene
The trust recognised that safe, effective wound prevention and management is not only fundamental to high quality patient care but is inextricably linked to a number of health outcomes.

The approach
Support workers were employed to manage pressure-releasing mattresses. Their role was to help ensure that mattresses are available to those who need them.

The trust also implemented revised tissue viability guidelines and wound dressings/skin care formulary. This was undertaken in conjunction with a multidisciplinary education programme.

A tissue viability multidisciplinary foundation course was created in 2006 and is held regularly for staff. A project group was set up to review evidence, products and processes. An initiative that included all of these components was launched trust-wide to clinicians April 2009. To measure the impact of the work, a baseline wound audit was undertaken at the bedside in February 2008 prior to the intervention and one year later in February 2009.

“We had a problem with the management of mattresses across the trust. Not only finding them, but also storing them and decontaminating them. Since the introduction of the tissue viability support workers, the problem has been magiced away. Mattresses are available if we need them and the tissue viability support workers have raised the profile of what we need to do and got us thinking about what our patients need.”

Naomi Dickson
Modern matron for acute medicine
How they did it

Pressure relieving mattresses are an important component in combating pressure ulcers – but for many trusts, the management of these mattresses can be a big challenge.

East Kent Hospitals University NHS Foundation Trust has introduced tissue viability support workers as part of its work to reduce the risk and severity of pressure damage. These support workers have developed an equipment library, providing both safe storage and a reliable decontamination process.

Their first challenge was to instigate a mattress amnesty – to get wards to trust the system enough to part with unneeded equipment. Support worker, Corrina McMahon readily admits this was not easy. “My role is to make sure the equipment is with the right patient so that wards had it for when they needed it. An awful lot of equipment was being used on patients who didn’t need it. We had to build up confidence so wards no longer held onto mattresses they didn’t need. This took perseverance.”

Tissue viability nurse specialist, Judy Elliot admitted the roles were not easy to fill. “When we advertised we didn’t specify a nursing background. But it was vital the support staff had the right personality, as they would have to challenge staff in higher grades.”

The roles were taken on by seconded healthcare assistants. For the wards, it has been a revolution. Not only is there no longer a panic to find a mattress, patients are risk assessed by nurses within six hours of admission and sometimes arrive on the ward with the equipment they need with involvement from the support workers.

Liz Bonham, sister in the clinical decisions unit, coordinates admissions. She said: “Initially we didn’t know what the role (of tissue viability support worker) was, but it has become a lot easier with them in place. We can identify patients as soon as they come through the doors.”

Their achievements have been felt throughout the hospital. The support workers have the potential to become ‘the eyes and ears’ of the specialist nurses who work at the trust. Through visiting the wards, they can capture information on pressure ulcers and can give simple advice on wound care; all helping to improve care for patients and free up the tissue viability nurses to concentrate on more serious wounds.

The team also helps to improve the reporting and collection of reliable information on pressure ulcers. Having reliable information means that grade one ulcers can be targeted, and this helps prevent grade two ulcers from developing. “It’s generally accepted that there are some pressure ulcers we can’t prevent,” adds Judy, “We don’t see every pressure ulcer – some are wrongly graded and they can develop in hospital or in the community.”

The trust is considering how to develop the service further, but it is very definite about the value of the work the tissue viability support workers have done.
We are the champions!
The key to success for East Kent Hospitals in developing their High Impact Action work to reduce pressure ulcers has been its use of champions at all levels of the organisation. The tissue viability support workers are the most effective champions. Their work and success with wards has inspired ward staff to champion the programme themselves.

The introduction of new roles will only reap the full benefits when linked to a robust service redesign. This will only happen with strong clinical leadership and active engagement of clinical teams. This ensures that staff feel involved and are supported to act themselves. Involving people in the change means that they are less likely to resist the change.

Local results

Impact on quality of care
Significant improvements were observed in best practice and patient experience. In 2008, 42% of patients were considered to be receiving most appropriate wound care. This had improved to 65.7% in 2009, an increase of 23.7% prevalence of wound infection had reduced from 18% in 2008 to under 9% in 2009.

Impact on patient experience
This improvement means that less patients suffer pain, indignity and increased length of stay.

Impact on staff experience
Staff are demonstrating improved confidence and empowerment in their decision making regarding wound management. The tissue viability course is popular and often oversubscribed. There is improved communication with all staff groups throughout the trust and staff appear enthusiastic at taking best practice recommendations forward in their clinical areas.

Impact on cost reduction
In 2008, data analysis associated wound infection with longer length of hospital stay and a mean increased cost of £3,916.94 per patient with an infection. Using this calculation, in 2009, the reduction provided a total cost saving of £58,754.10.
Communication, communication, communication!

Any programme of improvement will fall at the first hurdle if no one knows what it is, how to do it and what the benefits are.

Successfully implementing the tissue viability equipment library has been about good communication, gradually building up trust and moving on to wholesale confidence. This is not just about telling people once, says tissue viability support worker, Corrina McMahon, but about perseverance. With some staff it has meant a gentle reminder, with others tackling their scepticism.

Investing in communication is vital to the work you are doing. Spending time in the beginning to understand how you will tell the ‘change story’ is important. If there are gaps in communication there will be layers of frustration and general nervousness around the change.

Improvement tip

Consider the type and extent of empowerment you want to encourage according to the nature of your organisation, its culture and the personalities and roles of the individuals involved.

There are three key areas to help you decide which empowerment approach to take:

area 1: six basic motivators
area 2: vision and directions
area 3: examine corporate actions.

Quality and Service Handbook (NHS Institute)

“Communication with staff is vital — making sure they are involved and understand and that they are supported so they can act themselves — this goes from the healthcare assistants right through the grades — even the ward clerks have a role to play.”

Nicola Cerrulo
Ward manager

“The support workers are an innovation. Nobody wants a patient to develop a pressure ulcer, we have to give frontline staff the knowledge, skills and empowerment to address it.”

Sally Moore
Deputy director of nursing
Improvement tip

Thinking about the change – identify your stakeholders

A good way to do this is to think about and list all the people and groups likely to be affected by the proposed change. One framework that can help you think about different people who may be affected is called the 9 Cs:

- commissioners
- customers
- collaborators
- contributors
- channels
- consumers
- champions
- competitors
- commentators.

Don’t worry too much exactly where people fit (and some people will fit under more than one ‘C’); it is just a way of identifying who you need to communicate with. Once you have your list, a good question to ask is: ‘what do I need from them and what do they need from me?’.

Quality and Service Handbook, NHS Institute

What are you squirreling away?

Keeping hold of things so they are there when you need them is something that happens a lot in the NHS. It may be anything: pressure-relieving mattresses, wheelchairs or specific medications; if there are things that you keep hold of – or squirrel away – then it indicates that the process around that item needs looking at. Holding on to things, although it seems a good thing to do for you, just makes the matter worse for everyone.

Think about what you squirrel away and think about how you can help to redesign the process around it.
I’d like to stay on the ward without the pressure ulcers, please
Nurses working in the plastic surgery unit were all too familiar with the dire consequences of pressure ulcers, so have developed a zero-tolerance approach to hospital-acquired pressure ulcers. The practice has spread throughout the trust and pressure ulcers are now an extremely rare event.

Setting the scene
The Abertawe Bro Morgannwg University Health Board provides primary and secondary care, serving more than 600,000 people across South Wales. It is part of the 1,000 Lives campaign, organised by NHS Wales, to save 1,000 lives and prevent 50,000 incidents of harm. An audit prior to the work showed a 13% pressure ulcer rate across the health board.

The approach
The health board adopted a zero tolerance approach to hospital acquired pressure ulcers. They introduced a SKIN bundle tool which stands for – surface, keep moving, incontinence, nutrition. In two years, the work has been rolled out across 92 wards in four acute hospitals.

Each ward has been empowered to introduce its own version of the SKIN bundle tool, but keeping the four key elements.

There has been a change in culture across the health board, from pressure ulcers being regarded as part of life, to being a serious incident and ‘nursing failure’.

“There was a feeling in many wards that pressure ulcers were part of life: what we have shown in the last two years is that they are avoidable. It took about a year to get the process right; it’s crucial to start small, to start on one area and get it right.”

Nicola Williams
Assistant director of nursing and quality
How they did it

Charge nurse Nigel Broad regularly sees the extreme harm and distress caused by pressure ulcers. His plastics and burns ward at Morriston Hospital regularly admits patients requiring surgery and skin grafts for severe pressure ulcers, many of which occurred in a hospital. So when his ward had the opportunity to develop a zero-tolerance approach, staff were keen to show it could work.

“We believe that the vast majority of pressure ulcers are preventable; they should not be happening. And that’s why we came up with the idea of zero-tolerance,” says Nigel. “In recent years, there have been a lot of targets to meet and we felt we were getting away from the quality aspects of nursing.”

In 2008, NHS Wales introduced its 1,000 Lives campaign, which aimed to save 1,000 lives and prevent 50,000 incidents of avoidable harm. Within months, the Angelsey ward’s zero tolerance approach to pressure ulcers had become a cultural norm with staff no longer feeling ‘pressure ulcers are part of hospital life’, instead viewing them as a ‘nursing failure’.

The ward itself started with a 4.5% rate for pressure ulcers. This is lower than the 13% average across the trust, and around half the national average, but Nigel and his team felt they could still do better and initially aimed for a 50% reduction.

The ward audited its rate of nutrition assessment and skin viability assessment on admission and found it needed improving. It also introduced a SKIN bundle (surface, keep moving, incontinence, nutrition) tool for those identified as high risk. This is a single sheet of paper that sits at the end of the bed and is used by all staff. The SKIN bundle acts as a contract between the staff and the patients – patients will shout ‘I need to be moved now!’

Within three months of starting the work, patients were getting properly assessed within hours of admission. Following the introduction of the SKIN bundle tool, the ward reduced the rate of pressure ulcers down to zero, a figure which they maintained for almost two years. When a grade two ulcer developed in January the staff, says Nigel, were devastated. A review found that the SKIN bundle had been used, but not fully maintained. This has further proved that the SKIN bundle works and redoubled staff efforts to ensure they are fully compliant. The ulcer healed within four days.

Key to its success was that the SKIN bundle was introduced slowly, starting with a single patient, and then growing throughout the ward. By April 2010, it had been spread throughout the trust’s four sites and 92 wards. Each ward uses the four elements of the bundle, but it is adjusted to suit the ward. The number of pressure ulcers are publicly displayed on ‘safety crosses’ in green. ‘Green’ days are quickly developing into green months and green years and have become a source of great pride among staff.
Hamish Laing, consultant plastic surgeon and associate medical director for performance and quality, helped lead the work. “As a specialty we care quite deeply about pressure ulcers – we see the pain, suffering and distress they cause. The story would often be the same, they came into hospital without one and develop one on a ward,” says Hamish. “We became increasingly convinced that they were avoidable. We started with what we thought would be an easy ward, got it right there and moved on. We now have dozens of wards that have gone 200 days or more without seeing a pressure ulcer, when they would have seen one or more a month.

“We are entering a period where budgets are going to be very difficult and everybody is worrying about how to save money. The obvious thing is to stop wasting it and every patient that gets a pressure ulcer costs the NHS thousands of pounds. Preventing pressure ulcers will stop harm and save a lot of money – it’s not surprising our director of finance is as excited about this as we are.”

They have had a high level of executive support: the director of nursing writes out to staff members when their ward reach 100 days free from pressure ulcers and the rate is regularly reported at trust board meetings. “If I went onto a medical ward and the sister said this is not that important, then the director of nursing would visit the ward and say this is a priority,” adds Nigel. “It has created a culture of change.”
Local results

Impact on quality of care
The health board changed the culture of staff to make pressure ulcers unacceptable. The pressure ulcer rate was reduced on Angelsey ward from 4.5% to zero; the ward went 638 days without any pressure ulcers.

Reduced pressure ulcers across the health board from 13% to zero. Many wards are now running up to a year without pressure ulcers.

Impact on patient experience
The work raised awareness of what pressure ulcers are and how they should be avoided; patients and families become partners in the SKIN bundle, requesting action when it is needed.

Impact on staff experience
The health board changed the culture of staff to make pressure ulcers unacceptable.

Impact on cost reduction
The work reduces length of stay through avoiding pressure ulcers.

The organisation is now looking at maintaining tissue viability in accident and emergency, looking at use of pressure relieving mattresses on A&E trolleys and modifying the method for use in the community to reduce occurrence of pressure ulcers in the home and in social care.
Key themes and methodology

Plan, Do, Study, Act
The trust introduced the changes in small areas, allowing rapid testing and evaluation. The Angelsey Ward piloted the SKIN bundle, introducing it for one patient, and then one bay and eventually onto the whole ward. This style has been adopted throughout the trust, spreading across 92 wards over four hospitals sites in two years.

Introducing these frameworks will benefit from the model for improvement known as Plan, Do Study Act (PDSA) approach: a simple structure for developing, testing and implementing changes.

The PDSA is a tool commonly used within improvement initiatives was first used in the 1930s within manufacturing industries and began to be used extensively within health improvement programmes from about 1996. One of the core benefits of this approach is that it advocates small scale testing which enables continual learning and adjustment of new approaches in order to achieve the most optimal change. It is still one of the most simple but comprehensive methods to use when thinking about making improvements to the service that you deliver for patients. (See Langley, G J Nolan, K M, Nolan, T W, Norman, L Provost, L P (1996) The improvement guide.)

Improvement tip
“Using a PDSA cycle enables you to test out changes on a small scale, building on the learning from these test cycles in a structured way before whole scale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don’t work. The process of change is safer and less disruptive for patients and staff.”
“The PDSA cycle is a never-ending cycle of learning and improvement that Deming developed, based on what he learned from his mentor, Walter Shewhart. Deming taught it to the Japanese in 1950. He called it ‘the Shewhart cycle’ and the Japanese call it ‘the Deming wheel’.

P33, The Leader’s Handbook – A guide to inspiring your people and managing the daily workflow
Peter R. Scholtes (1998)

“We did the SKIN bundle first with one patient, and then a bay of six patients and then two bays. We have spread it to the rest of the hospital and across four sites.”
Nigel Broad
Charge nurse
How to measure…Your skin matters

The national picture
A Nurse Sensitive Outcome Indicator has been developed for pressure ulcers. The indicator measures the number of newly acquired pressure ulcers in any given clinical setting per month. The measures are likely to be reported quarterly.

How are pressure ulcers defined?
“A localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.”

Nurse Sensitive Outcome Indicators:
http://www.ic.nhs.uk/services/measuring-for-quality-improvement/what-is-happening-on-indicators-for

Pressure ulcers are routinely measured by categories. The European Pressure Ulcer Advisory Panel (EPUAP) http://www.epuap.org/guidelines/Final_Quick_Protection.pdf guidelines categorises pressure ulcers as follows:

- **category one: non-blanchable redness of intact skin.** Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching

- **category two: partial thickness skin loss or blister.** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister

- **category three: full thickness (fat visible).** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Some slough may be present. May include undermining and tunnelling

- **category four: full thickness loss (bone visible).** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or Escher may be present. Often include undermining and tunnelling.

How do you define an ‘avoidable’ pressure ulcer?
The High Impact Action: ‘Your skin matters’ focuses on preventing avoidable pressure ulcers in NHS provided care. There is no consensus definition around what exactly an avoidable pressure ulcer is; the definition should be developed locally.

How do you define an ulcer as acquired in NHS-provided care?
The Nurse Sensitive Outcome Indicators have some advice around how to classify pressure ulcer that may develop in a healthcare setting:

“For patients admitted or transferred to a healthcare setting without any obvious signs or symptoms of pressure area skin damage, the development of a pressure ulcer of stage three or four within 72 hours is likely to be related to pre existing damage incurred prior to admission or transfer of care. For any pressure area damage arising thereafter, the most likely cause will be related to care within the healthcare setting the patient is are in; this must be regarded as a new event.”
How might pressure ulcers be recorded and measured locally?

Many organisations routinely monitor pressure ulcers at ward level. How this data is defined and used will vary, but you should consider using the principles of good measurement outlined in the measurement section (page 16). For example, display the information using a simple run chart so that the rate of newly acquired pressure ulcers over time is clearly visible to staff.

Some organisations might also benchmark their wards against one another and produce dashboards which show how the performances of wards compare. This can be useful as it can help to incentivise the spread of best practice, but care needs to be taken in how it is perceived to ensure that the focus is on improvement rather than judgement.

Pressure ulcer calendar

Another powerful way of displaying pressure ulcer data is to use a ‘safety cross’ which graphically shows how many days it has been since the last pressure ulcer in any given ward or organisation. If category one and two pressure ulcers are very common it may be better to start with showing how long it has been since the ward or organisation has had a category three or four pressure ulcer. Safety crosses are illustrated in The Productive Ward: releasing time to care programme www.institute.nhs.uk/productiveward.

As well as looking at the rate of newly acquired pressure ulcers, it is useful to have some ‘process’ measures that are related to the ‘outcome’ measure of pressure ulcers (see the measurement section (page 16) to understand more about process and outcome measures). Some examples of process measures that are suggested by the European Pressure Ulcer Advisory Panel are:

- % of high risk patients on pressure relieving mattresses
- % patients who are identified as high risk who have a dedicated repositioning strategy
- % of patients having a complete risk assessment including skin.

Measurement when making improvements

If you are starting to work on reducing pressure ulcers, you should begin by looking at what you and other teams in your department or organisation are already measuring. You might be able to use existing systems if appropriate and this will save a lot of time. Use the seven steps to measurement framework outlined in the measurement section (page 21) to link together what you are already collecting around pressure ulcers and to understand gaps where you might need to collect extra information.
Staying safe - preventing falls
Introduction

The aim of High Impact Action: staying safe – preventing falls is to demonstrate a year-on-year reduction in the number of falls sustained by older people in NHS-provided care.

However, patient safety must always be carefully balanced with patient independence and their right to make informed choices.

A practical summary

Every nurse knows there is no such thing as a simple fall. Even a fall where there is no injury can cause a level of psychological damage to the patient often resulting in a loss of confidence and independence. This can lead to the need for increased or extended support from the NHS. Nurses are aware that there are things that can be done to prevent patients from falling, or at least to minimise the risk. We all have a responsibility for ensuring that we try and take the appropriate action to keep our patients safe. To do this we need to have a coordinated approach with both organisational leaders and frontline staff playing their part.

There are many elements to falls prevention and the approaches featured in these case studies are not exhaustive. These organisations recognise that falls prevention is a complex area that has many layers, which means no one method will work alone. Falls prevention needs to consider the patient’s individual needs and the different environmental factors in different settings, including home, care setting and hospitals. All of this needs to be reviewed, while balancing patient safety, independence and rehabilitation.

The problem

The National Patient Safety Agency (NPSA) reported 152,000 falls in England and Wales in acute hospitals, 26,000 in mental health trusts and 28,000 in community hospitals (2009). Many falls are avoidable but the challenge of falls is one that is likely to grow alongside an ageing and more frail population who have more complex health needs then ever before. While the Social Care Institute for Excellence (SCIE) reports that care homes have a higher prevalence of falls, there appears to be a lack of comprehensive, recent data from the UK on the number of falls in care homes and other long-term residential settings (SCIE, 2004). It is generally accepted that around 30% of people aged over 65 living in the community fall each year (Gillespie, L. et al, 2009).

Hospital inpatients and older people in either hospital settings or care homes are more at risk of falling than non-hospitalised people, due to the increased incidence of confusion, confounding medical conditions and environmental factors (Fonda et al, 2006).

The cost

The average rate of falls in 2008 was 5.4 incidents per 1,000 bed days. This equates to 30 falls per week in an 800-bed acute trust.

Associated healthcare costs are estimated at a minimum of £92,000 per year for an average acute trust with an annual healthcare cost for treating falls in England and Wales of over £15 million. The direct cost of falls by harm category has also been calculated by the NPSA and range from £41 for a no harm incident to £2,289 for a fracture (excluding hip) and £3,981 for a hip fracture incident.
There are additional costs not included in these calculations such as the health and social care required after hospital discharge and any litigation claims made by the patient against the hospital. Litigation costs for falls, if sought, have been reported as resulting in a mean payment of £12,945 (based on data gathered between 1995 and 2006) (Oliver et al, 2008). Just under two thirds of these claims made by patients (60.5%) resulted in payment.

The NPSA (2007) calculated a potential cost saving of £16,560 each year for an average 800-bed acute hospital trust associated with reducing the number of falls by 18% through multifaceted interventions. This figure does not include savings associated with a reduced need for care after discharge from hospital or reduced litigation costs.

What we can do
Due to the complexity and nature of falls, we know there is no single preventative measure that will work. The sort of interventions identified as having an impact include: exercise programmes, identification bracelets, alarm systems and risk assessments. The range of interventions needs to be coordinated, to respond to the individual patient’s risk and be focused across the patient’s pathway. Contextual factors – those things that will be particular to your organisation (its systems and processes) and those things particular to groups of patients – are also important to consider when starting any work. There is much to gain by preventing falls, for example by keeping patients safe, independent and mobile means that patients spend less time immobile and bedridden and this lessens the likelihood of pressure ulcers. Additionally, examining the reasons for falls can lead to wider ranging interventions, such as improved nutrition, hydration, continence, privacy and dignity.

The case studies
East Kent Hospitals University NHS Foundation Trust introduced weighted alarm systems to alert staff when at-risk patients get out of bed or up from a chair unaided. They have tested its use alone and as part of a care bundle.

NHS Blackpool pre-empted falls by targeting very high intensity users and supporting them through case management provided by a community matron.

Colchester Hospital University NHS Foundation Trust introduced The Tiptree Box and cafe table style toolkit for staff in acute wards to provide distraction therapy for patients with dementia.

Ipswich Hospital NHS Trust developed a checklist observation tool of patient-centred activities across its complex care wards, designed to reduce falls in those at high risk.
Where are the best sources of information?

NPSA - Slips trips and falls in hospital guidelines
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59821

NICE- http://www.nice.org.uk/CG21

Prevention of Falls Network Europe www.profane.eu.org/

Patient Safety First – the How to Guide for Reducing Harm from Falls

Article – Strategies to prevent falls and fractures in hospitals and care homes and effect of cognitive impairment: systematic review and meta-analyses: http://www.bmj.com/cgi/content/abstract/334/7584/82

Age UK (formerly Help the Aged and Age Concern):
www.ageuk.org.uk/home-and-care/adapting-your-home/ways-to-make-tasks-easier-around-the-home/?dntshw=true

Effectiveness of a Multifaceted Intervention on Falls in Nursing Home Residents (Journal of the American Geriatrics Society)
www.americangeriatrics.org

Volume 51, Issue 3, Date: March 2003, Pages: 306-313)

Clemens Becker, Martina Kron, Ulrich Lindemann,
Elisabeth Sturm, Barbara Eichner, Barbara Walter-Jung, Thorsten Nikolaus

“Innovation (especially the widespread adoption of best practice) and prevention (in the medium term through secondary prevention, and, over the longer term, through primary prevention) will be key enablers for achieving quality and productivity gains.”

The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians
Case study: East Kent Hospitals University NHS Foundation Trust

Using a ‘falls bundle’ to reduce falls in hospital
East Kent Hospitals University NHS Foundation Trust looked at introducing weighted alarm systems, and piloted their impact against an intensive care bundle, which also incorporated staff champions, intensive support and education and regular access to specialist falls nurses. The care bundle helped to reduce falls on one ward from 18 to four over a period of three months.

Setting the scene
Most of the inpatient falls occurred on elderly care and stroke wards. The staff recognised the need to minimise the risk of falls.

The approach
The main focus of the project is to ensure that all patients over 65 are routinely assessed for risk of falling on admission to hospital, and appropriate measures taken to reduce falls both in hospital and post-discharge.

They piloted a range of different interventions as follows:
• a weighted alarm project on three wards
• a care bundle approach on two wards. This featured the weighted alarm along with the use of defined preventative care, screening tools and reporting of falls
• on a third ward, the care bundle was enhanced: the ward had a low-level bed, its own supply of hip protectors, intensive training, daily visits from specialist nurses, weekly practice audits and its own falls ‘champions’.

The team utilised every avenue of support, including working with the hospital trust’s League of Friends to fund a range of equipment.

“The biggest impact we have seen on the ward is staff taking ownership of the issues, taking responsibility for addressing them and taking responsibility for improving them.”

Naomi Dickson
Modern matron

Printable information from the NHS Institute website
DVD also on NHS Institute website
How they did it

Every nurse knows there is no such thing as a simple fall. Even a fall where there is no injury can do irreparable damage to the patient, increasing staff workload and stress.

One of the key interventions introduced by East Kent Hospitals is the sensor alarm project to alert nursing staff when a patient attempts to get up from their chair or bed. The alarms are used on patients identified as being at high risk of falls, following a risk assessment carried out on admission to hospital. Often, these are patients who don’t know they need help, or who don’t want to ask for it.

The sensor alarms were launched in April 2009, on three wards with a high incidence of falling. The hospital used two different approaches to measure the alarms’ effectiveness: the project team believed there was no single answer to the problem of falls. On two wards, the care bundle featured sensors, along with preventative care mechanisms, screening tools and reporting of falls. On the remaining ward – Bethersden Ward –, this was enhanced with other interventions, including a low level bed, a supply of hip protectors, intensive training and education and its own falls ‘champion’. On this ward, the enhanced care bundle has helped reduce the rate of falls by more than 60% within six months This result was made possible through intensive support which would need to be maintained.

“It’s about minimising the risk, we can never take the risk away completely,” says Debbie Janaway, osteoporosis and falls lead nurse, who led the work alongside modern matron, Naomi Dickson, and fellow specialist nurse, Joy Marshall. “People in hospital are most at risk if they don’t recognise the risks to their own safety. Most of the patients we are working with have some cognitive impairment.”

Embedding the use of sensor alarms and bringing staff on board was the ultimate challenge, but it only takes one patient to change practice, as healthcare assistant, Jane Evans, explains: “Initially, I thought it was just more paperwork, just another alarm to answer; but it just took one patient. Before the project, you accepted that if someone was going to fall, there was nothing you could do to prevent it. All you can do is put on hip protectors or take other measures to reduce the impact. But then we had one patient and he definitely would have fallen many, many times [without the sensors] and that’s what convinced me the alarms worked.”

“You have to commit yourself to keep up to date, to be able to say to staff you are coming from a good knowledge base, to do the research. We have to be credible.”

Naomi Dickson
Modern matron for acute medicine
Osteoporosis and falls nurse, Joy Marshall worked intensively with the ward, providing training on the use of the alarm sensors and falls prevention strategies. “Nurses are very busy and have many things to think about. I went onto the ward every day for a month.” she says. “Staff came to associate me with falls and the alarms and it acted as a reminder. I think this was a major part of its success.”

The sensor alarms were also introduced onto a neurology ward where patients were often younger but had cognitive problems, with conditions like Parkinson’s disease and Multiple Sclerosis, which affected their mobility. Patients considered to be high risk were grouped together and the alarms were used following an assessment in the clinical decision unit. Staff balanced their use as a safety tool against other important factors such as the dignity, privacy and rights of the patient. Deputy ward manager, Claire Langham says: “It offers piece of mind for nurses.”

Addressing the flow of information was also vital in developing the falls prevention programme. An assessment of the reporting systems revealed delays in reporting which made analysis difficult; timely responses were problematic and feedback to the wards was patchy. As a result, staff felt the incident reporting forms were just more pointless paperwork, increasing the risk of under-reporting. A new online reporting system is being introduced across the trust and will provide real-time data for managers, enabling a fast response. This web-based electronic form will allow the trust to analyse and feed back information through custom-made reports, identifying risk areas and appropriate interventions.

“Falls are a multi-factorial issue. The sensor alarms are just one element; you have to understand each patient is an individual, assess their risk and consider all the interventions available.”

Debbie Janaway
Osteoporosis and falls lead nurse
Local results

Impact on quality of care
The enhanced care bundle introduced on Bethersden Ward helped to reduce the rate of falls by more than 60% within six months.

The 60% reduction achieved on Bethersden Ward has been sustained since they were introduced in April 2009, indicating that the falls prevention strategies have become embedded in the usual care provided.

Use of the alarm systems as a single intervention did not reduce the incidence of falls on the other two wards, indicating that preventing falls requires multiple solutions.

Impact on patient experience
The sensors reduced the need for ‘specials’ – staff who can sit with the most vulnerable. As well as being an added cost, ‘specials’ can be difficult to recruit and patients often regard their presence as an invasion of their privacy.

Impact on staff experience
Teaching staff takes time and support for it to become embedded, but it improves staff satisfaction.

Understanding the issues with data and reporting means that the transition to a new hospital-wide information system can be tailored so that it collects and provides the information necessary.

Impact on cost reduction
There were 117 falls in the six months prior to the project starting, costing £6,944. Of these, three resulted in fractures at a cost of £9,924 - resulting in a total cost of £16,868 for these patients.

During the six-month project, 44 falls were recorded at a cost of £2,611. One of these resulted in a fracture at a cost of £3,308 resulting in a total cost of £5,919 for that patient.

During the six months following the project there were only 14 falls which cost £831 each, none of these resulted in a fracture.

As a result of this project the trust can report a £16,037 cost reduction in comparison with the period before this work started.

Note: An NPSA 2007 study reported the average cost of no harm to moderate/severe harm falls across the NHS is £59.35 and the average cost of a fall resulting in a fracture is £3,308.
Key themes and methodology

Senior level support
Executive support is vital for the success of any improvement work.

In this case it was evident that the programme was given high priority on the wards by frontline staff, matrons, directors of nursing and the trust board. This high-level, visible support, which included regular visits to the ward by senior leaders, directly influenced the success of the falls programme.

It is a responsibility of the board to both set strategic aims for improvement and support the local clinical teams to establish and agree a set of measures that will track progress towards the shared vision. It is important that this data is shared regularly with the board, along with details of progress, and any barriers to progress that are being faced.

Improvement tip
The appointment of an executive lead ensures that a reduction in harm from falls is represented as an integral part of the trust’s improvement agenda. They can provide a voice for the project at the board, have the leverage to remove barriers to progress and ensure that falls is included in the leadership walkarounds agenda.

In the How to guide for Leadership for Safety (available at http://www.patientsafetyfirst.nhs.uk), it is suggested that there be an executive lead for each workstream relating to patient safety, that this responsibility could be included in their job plan and the work’s progress form part of their appraisal process.

Slips, trips and falls
(National Patient Safety Agency)
"Falls are the leading cause of accidental death in people over the age of 75. In addition to suffering physical injuries, falls patients can experience psychological trauma. They can become socially isolated due to a fear of going out and this can lead to depression, anxiety and a loss of independence. Falls can be a real stigma for older people."

Lynn Sutcliffe
Falls matron

“Delivering high-quality care services means that local organisations should capture and understand information about their current level of quality performance and use this to make changes to improve care. Measuring quality and making comparisons with other clinical teams can drive significant improvements for patients.”

The Nursing Road Map for Quality – a signposting map for nursing
Case study: NHS Blackpool

Taking an holistic approach
Within the population of Blackpool PCT there is a high number of elderly residents, and it was spending £50,000 a month in ambulance call-outs to people who had fallen. Half of these people did not need clinical treatment, more often they physically needed help to get up with some reassurance. The PCT started a piece of work to reduce the number of these falls and focused on those patients who were very high intensity users. They aimed to pre-empt and prevent falls and did this by providing support through case management led by a community matron.

Setting the scene
Blackpool is a popular retirement destination, creating a high concentration of potentially vulnerable elderly residents at risk of falls in their own homes, hotels or residential and nursing homes. Around 6% of over 75s were identified as being at high risk of unplanned hospital admissions – equating to 800 people in the PCT area. In 2006, the PCT counted 250 ambulance call-outs a month to falls in the over-65s, costing around £200 each. Only half of these resulted in any kind of treatment beyond reassurance.

The approach
The falls team identified a number of best practice approaches:
- establish what the current level of service is across health and social care services and identify any opportunities for improvement
- inform GPs so that they are aware of the plans for improvement.
- distinguish between ‘falls’ and people collapsing or fainting
- be flexible, listen to feedback and, if necessary, act on it.

The PCT began by identifying very high intensity users (VHIUs) who would receive support provided by the community matron. These were people with one or more long-term conditions who were registered with a Blackpool GP and had had two or more falls over the last 12 months. Blackpool PCT identified 350 VHIUs with a range of conditions, including heart failure, COPD, cancer, asthma and diabetes.

From the outset, the PCT worked closely with the local authority, as well as other organisations involved in the care of elderly patients.

“It has changed my life completely. I can now live here independently. If I didn’t have this system, it would be very difficult for me to live on my own.”

Eileen Beaton
Telehealth user
How they did it

Lynn Sutcliffe was appointed as falls matron in 2006, spending half her time working as a community matron and the rest concentrating solely on falls, with 350 very high intensity users (VHIU) who had undergone frequent hospital admissions.

“The community falls team provides an holistic falls risk assessment service within the home of vulnerable adults, particularly those who, historically, have been unable or reluctant to access help. We then develop and deliver a patient-centred service that meets individual needs,” explains Lynn.

“Ultimately, our aim is to reduce the incidence of falls, thereby preventing unplanned admissions to hospital. This job is a great way to have a direct impact on older people’s health. I am passionate about it – the job description could have been written for me.”

The aim of the falls team is to work closely with VHIUs in order to reduce their chances of falling again. Lynn carries out around 10 falls visits per week and delivers training for anyone working with vulnerable elderly people, including the acute trust, social services and local council.

They work closely with a local social enterprise that provides telehealth and telecare for vulnerable people. The company received extensive training from the local ambulance service and now provides a lifting call-out service for people who have fallen. On average, they lift between 60 and 70 people every month – calls that otherwise, would go through to emergency services. The company has around 5,000 users, 3,000 of which are highly vulnerable.

“We are part of a much wider team,” says community falls case manager, Heather Hollowell, “that includes OTs, physios, chiropody, pulmonary / cardiac rehabilitation, district nurses and consultant geriatricians. I was a district nurse for six years, so I have a good understanding of the multidisciplinary team services that we can call on – that is crucial in this job.”

“At the outset, there were a number of dissenting voices, particularly among local GPs,” admits Lynn. “We got our main resistors on board by involving them in the implementation group and one, in particular, has now become a real advocate of the system.”

“It has also been important to learn as we have gone along,” says director of nursing and quality, Helen Skerritt. “Initially, our community matrons didn’t work at weekends, but analysis of hospital admissions showed that this was typically when a lot of referrals were made, so we have adapted the service to meet this demand. We have built up good relations with the local hospitals. Collaborative working is key for an approach like this to succeed.”

Another key challenge came in obtaining robust data to measure the impact of their actions. An external company carried out an audit of the PCT’s work and suggested how improvements in data collection could be made. The health informatics team now evaluates the work on an ongoing basis.

“Know your population, get the facts from the outset and make sure your staff have the right skills in place,” adds Helen. “We encourage a healthy competitive spirit between our community matrons by setting them improvement trajectories to achieve.”
“Due to Blackpool’s unique demographic, we believe it is important to have a community matron specialising in falls prevention. We have supported the falls agenda at the highest level from the outset and articulated our reasons to all of our stakeholders.”

Helen Skerritt
Director of nursing and quality
Local results

Impact on quality of care
Hospital admissions are reduced, saving money to be reinvested in healthcare. Patients feel reassured and better cared for. Lynn carries out around 10 falls visits per week, with each assessment taking between 60 and 90 minutes.

Impact on patient experience
Once assessed, between 50% and 75% of patients do not experience another fall within three months of the initial visit. Three years on from the launch, patient satisfaction surveys are glowing.

Impact on staff experience
The PCT is now recruiting a new case manager to deal with increasing referrals, staff say the approach makes them feel very valued and the service is joined-up, with the team acting as a coordinator of care provision.

Impact on cost reduction
Figures show that approximately six hospital admissions are saved every month – equating to a cost saving of around £18,000 per month for the current caseload. The latest matron analysis statistics show that 83 admissions have been deflected to date and £243,000 saved.

Return on investment calculation
Costs of the following inputs were calculated for the planning and implementation phases: dedicated time from the project lead and senior management support; development of the community matron model for falls; costs of the community matron falls team; staff training and travel costs. Impact costs were calculated in terms of fewer falls related hospital admissions each month. For every £1 spent the community matron falls programme generates £2.69 of benefits. This calculation does not take into account the additional quality benefits that have not been monetised or any of the additional levered costs through community services.

Further information available from the NHS Institute website
Key themes and methodology

Championing the cause
The falls team recognise that falls can not be prevented by a falls matron, or indeed a PCT alone. The team work closely with a range of organisations across the health and social care economy, including the acute sector, GPs and the local authority through to charities like Age Concern (now called Age UK), to identify gaps in provision. Taking a multi-organisational and multidisciplinary approach, the team was able to champion the cause with a wide group of people.

We need to start to understand the characteristics and the different ways of working required by the new system we are developing. If we are successful, the NHS in five years’ time will have more services closer to home and, therefore, less investment and activity in the acute sector. There will be much less variation, with the NHS pound increasingly spent on defined quality standards and patient pathways. Some of this will require new ways of organising services to deliver care in new ways, but we don’t have the luxury of prolonged debates.

Healthcare is complex, and working across both health and social care adds to the complexity. Anyone who works in the system will want to provide the best possible care for the user/patient, but often, the complexity means that this doesn’t actually happen. What we need to be aware of is that different parts of the system have different structures, processes and also patterns of behaviour. Working though these and understanding how the three elements interact will help if you want to make fundamental and transformational changes in a complex system to the common goal. Organisations need to work together to put patients’ interests first and manage risk across the system, rather than just within organisational boundaries.

“The local authority and PCT have always worked closely together to develop flexible and creative solutions to local issues. We share a building and have joint strategic planning groups and joint agendas. We ensure that our outputs benefit one another and we avoid duplication, wherever possible.”

Brenda Hargreaves
Head of nursing
Case study: Colchester General Hospital NHS Foundation Trust

Preventing falls
The Tiptree Box and café-style table is a toolkit for staff on acute wards to use to provide distraction therapy for patients with dementia. In an acute setting, patients with dementia often become more confused, feel displaced, have high anxiety levels and wander around the ward. The toolkit consists of familiar everyday items and a table where patients can sit safely and not be confined to their bedside.

Setting the scene
Ward sister, Carrie Tyler had been looking at how she and her team could better understand why patients feel the need to get up and wander around the ward and how to prevent the high level of falls in this group. She found that the end of the day was the highest risk time, recognising ‘sundowning behaviour’ or the regular activities that people do at the end of each day.

The approach
The Tiptree distraction tool – named after the ward it was first introduced on – consists of a café-style table with a red tablecloth, chairs, and a box of familiar items that keep patients engaged to the extent that they were less likely to wander but were happy to sit at the table in sight of the nurses’ station. The box includes food and drink to maintain energy and hydration.

The idea was presented to the Bright Ideas Competition at Health Enterprise East (HEE) in 2007 and the team won £3,000 to pilot it, as well as getting advice around Intellectual Property to protect their idea. An initial 12-week pilot was extended to a year. The team compiled tool boxes for nine areas, including elderly care, A&E, EAU, trauma and orthopaedics.

“It was the simplicity of the idea that intrigued me. Some simple initiatives and interventions don’t come at a huge cost and yet makes such an improvement to the patient experience. It’s important to nurture ideas and to give staff encouragement.”

Julie Firth
Director of nursing and patient experience
How they did it

Entering one of the acute wards at Colchester General Hospital NHS Foundation Trust, your eye is immediately drawn to the café-style table that plays a crucial role in the falls prevention work at the hospital, focusing on patients with dementia.

“At about 5pm, you wave goodbye to a core of doctors, physiotherapists and occupational therapists, but you still have care to provide and dispense suppers and drugs and this is also the main time for discharges,” says ward sister, Carrie Tyler. “It becomes a pressure point and staff often feel their stress levels go up. The patient doesn’t feel relaxed in a bed they don’t recognise, they get agitated and become more difficult to medicate. What they need is to sit in an area where they feel safe, have a cup of tea, some jelly babies to boost their sugar level, watch the world go by, and not feel threatened and made to feel that they’re in the wrong place with the wrong people.”

Understanding this, the team at Colchester started to make connections between the practical aspects of nursing dementia patients with what had been written in several different research articles. The idea for the distraction toolkit was born from a wide variety of interesting sources, one of which dated back as far as 1942 when the team found the first reference to sundowning within an institution. The team sought out more information which could help them. A programme by the King’s Fund, Enhancing the Patient Requirement, explained red is the colour that stimulates gastric juices as it is the most naturally occurring food colour, so the team used red for the tablecloth to encourage patients to eat and drink more. “I wanted to back up what I was saying so that people were more likely to say, ‘Yes, you know what, not only does it sound sensible, but we have the evidence there to put it into practice with confidence,” adds Carrie.

“It’s about marking the end of the day, which is referred to as sundowning behaviour,” explains Carrie. “For example, sundowning might involve cashing up your shop, so we include money, a calculator, wallet, purse, and envelopes in the box. Other examples include family albums, cards and dominoes. Patients might not use all of the equipment in the box but these are tactile and familiar objects, giving them a sense of safety. This makes the patient feel less restless and more likely to stay sitting in their chair where they will be safe and comfortable and ready to drink.”

“We compiled boxes for nine areas,” continues Carrie. “We chose A&E, EAU, trauma and orthopaedics. We were going to use a medical ward, but then an oncology ward asked if they could be included. They wanted to know if it would work with people who have brain tumours, because the behaviours I was describing were similar to it. The other five areas were care of the elderly wards.”

Carrie also developed 45-minute teaching sessions and worked with 98 nurses and healthcare assistants across the care for the elderly wards. She worked with ward managers on the remaining areas. “I spent a session with the managers and they rolled it out to their staff. Initially, we thought it would take 12 weeks, but there were barriers, such as workload so we decided to do a year long trial, which ended in September 2008.”
“I must admit, I thought, is it going to work?” says acting sister, Paula Whitehead. “But it was unbelievable. With 90% of my patients, you can give them one item out of that box, and it works a treat. It’s such a simple idea, easy to set up and cost-effective.”

“The activity box has made an incredible difference,” says ward sister, Helen Edwardson. “I saw the way it transformed the care on Tiptree Ward. It’s really changed the way we think about our patients who are confused or have dementia. The box is a focal point of the ward and has significantly reduced the wandering of patients from the ward, and reduced the rate of falls.”

The project had to overcome a number of obstacles to get off the ground, not least securing funding. Once Carrie and her colleague, Helen Langthorne, had completed the project trial, they presented the activity box to Health Enterprise East (HEE) in the Bright Ideas Competition, 2007. It won first prize of £3,000.

“The stress levels of both patients and staff have come down and the toolkit has reduced the number of the patients who are described as ‘difficult to care for’,“ says Carrie. “Even though it hasn’t worked in certain areas, like A&E, what has come out of that is the possibility of developing a delirium-screening tool that can be used at the front door to risk assess patients who are more likely to have delirium, with its associated risks of falling, so ward staff can be made aware of these behaviour types.”

“If we look back at how we coped with acute confusion and wandering states before, this toolkit has given the nurses more time and the patients a better experience. I didn’t realise that, behind the scenes, there are so many other organisations that can support your ideas. I’m happy to be part of something that helps other nurses realise this.”

“Supporting documents
Further information available from the NHS Institute website”

“Carrie Tyler
Ward sister

“The patients might not play the games, but the items in the box are tactile and familiar objects, giving them a sense of safety. This keeps the patient sitting, safe and comfortable and ready to drink.”

Carrie Tyler
Ward sister


Local results

Impact on quality of care
Staff feel they have more time to care and don’t feel like security guards following patients who are wandering. Patients are less likely to be seen as being ‘difficult to care for’. Patient stress levels are down and they are more likely to cooperate in taking their medication. This is especially important for patients who are prescribed antibiotics for urinary infections, which can be a contributing factor in delirium.

Impact on patient experience
When vulnerable patients are in a strange environment, it heightens their anxiety and makes it more likely that they will have a fall. Being in a calm environment, with familiar objects, means that patients feel more comfortable and their stay in hospital will be safer. When the box is in use, the café area becomes a communal area so that patients are less isolated.

Impact on staff experience
Because nurses had the idea and it was a very simple, cost-effective idea, everybody was really enthusiastic. Making the changes was not difficult and it did not mean big changes in processes or systems. The simplicity of the idea meant that it was straightforward and easy to implement, empowering staff and helping them deliver better care. Nursing patients with delirium can be challenging and stressful in any environment and busy acute wards are no exception – the distraction tool provided a positive way for nursing staff to manage this patient group therefore reducing staff stress.

Impact on cost reduction
The primary aim of the project was to improve care for a specific patient group, not to reduce the amounts of falls. Because of this the pilot cannot reliably quantify a reduction of falls to this piece of work. However the work and growing expertise of the staff became well known and Tiptree ward now receives more admissions from patient groups with a higher risk of falling.
Key themes and methodology

Leading by example
Nursing staff at the hospital had the permission and support of the organisation to develop ideas, be innovative, challenge current practice and make changes that could improve the quality of care and safety for their patients. Developing ideas in a demanding environment can be difficult. As nurses, we feel that we do not have the time to think. But, that very act of thinking differently and being creative steered this group of nurses to make real changes to the patient experience.

It is easy to carry on doing what we have always done and getting the same results we have had before, but we do need to try and build in some time to think about new ways of doing things.

Improvement tip

Thinking differently is the only real and sustainable bridge to get us from where we are now, to where we would like to be. Further, it is the extent to which we are willing to think differently that determines how great a difference we can really make. Use the tools for Thinking Differently and follow the three step process:

Phase one = stop before you start
Phase two = generate lots of ideas
Phase three = selecting and testing ideas to make a difference.

Further information available from the NHS Institute website
“I had supportive management and supportive staff and we had good rationale behind the idea. We had the evidence there to be able to put it into practice with confidence. If we look back to how we coped with acute confusion and wandering states before, this toolkit has given the nurses more time and the patients a better experience. I didn’t realise that, behind the scenes, there are so many other organisations that can support your ideas.”

Carrie Tyler
Ward sister
Case study: Ipswich Hospital NHS Trust

Seven Simple Steps – falls reduction programme
Ipswich Hospital NHS Trust developed a checklist observation tool of patient-centred activities across its complex care wards, designed to reduce falls in those at high risk. The programme was launched through a combination of staff training and support and is already delivering promising results.

Setting the scene
2,051 patient falls were recorded in 2008/09 within the trust, costing more than £131,000. The trust set an overall target to reduce falls by 25%.

The approach
Multidisciplinary training and raising awareness were incorporated into mandatory training for staff. Information packs have been developed to include information on medication that can increase the risk of falls and a flow chart identifying actions required in response to a patient fall. An initial baseline audit was carried out, looking at three months of inpatient falls data.

The Ipswich Hospital two-hourly falls prevention observation tool was developed through the identification of high-risk activities associated with inpatient falls, including both locally (identified via an incident reporting system) and nationally recognised elements of patient care.

The tool has seven simple steps:
• hydration – making sure the person has had something to drink
• checking toilet needs
• having the right footwear
• de-cluttering the area
• making sure things are in reach, like the call bell
• correctly fitted bedrail
• appropriate walking aid, if applicable.

The team used its experience of Leading Improvement in Patient Safety (LIPS) and The Productive Ward programmes.

“...If we can make sure people are safe from avoidable harm, it's got to be worth doing. It reassures the patients’ relatives, as they can see some form of documentation - which is quite prominent - that shows that their relative is being looked after.”
Sandra Gillingham
Ward matron

Improvement tip
The Leading Improvement in Patient Safety (LIPS) programme is about building the capacity and capability within hospital teams to improve patient safety. The programme aims to help NHS trusts develop organisational plans for patient safety improvements and to build teams responsible for driving improvement across their organisation.

www.institute.nhs.uk/safer-care
How they did it

Most nurses can spot the dangers for patients when it comes to falls. But having a ‘piece of paper’, providing a simple but essential reminder, ensures that those skills are used to their maximum for every patient, every day.

“We looked at all the tools we’d introduced over a period of about 18 months to see what the trends were and what we were missing,” says Julie Sadler, head of patient experience and adult safeguarding. “From that, we realised that when people fall they’re doing everyday activities, or trying to, and what we needed to do was look at how we could take the risk elements out of that.”

The result was a simple checklist observation tool. This is completed regularly throughout the day and covers seven fundamental elements of care, including nutrition and hydration. The tool was introduced with one nurse leading and training around 50% of staff on the ward. In addition, a healthcare assistant from each ward was nominated as a falls prevention champion and they received additional training to help them disseminate learning among their colleagues.

The programme was piloted on one ward for three months with mixed success. The ward had chosen to introduce it with one nurse trained to champion it among her colleagues. There was some resistance to filling in ‘yet another piece of paper’, but attitudes changed towards the tool as the fall rate dropped dramatically.

Healthcare assistant, Laura Byrne, admits she was one of the reluctant ones. “It was hard work to start off with, but it’s now become second nature. It’s a good idea because it keeps you on top of things and doesn’t take long. Filling in the form helps you care for the patient as an individual, and you become more aware of their needs.”

By the end of the pilot, the programme had demonstrated how a ‘piece of paper’ could release time to care, rather than add to the workload. When someone falls, there are a multitude of actions to carry out, which takes two nurses, perhaps 20 minutes. This includes managing the fall, checking for injuries, filling out a risk form and notifying the doctor and family. So, it quickly became clear that completing an observation form to prevent a fall was a better, and more productive, use of nursing time. It takes much less time and results in higher quality care if we carry out prevention work than post-falls management.

Patient experience facilitator, Linda Collins supports Julie in rolling out the falls programme through training and education. “Different areas will have different levels of reduction. We’re aiming for a 25% reduction overall,” she says. “At the moment, on the eight wards where we currently have the Seven Simple Steps programme implemented, we’re looking at a 19–20% reduction, so we believe that, by the time we get every ward onto the programme, we should be getting somewhere near our target, which is just fantastic. We’re in the process of rolling out The Productive Ward and we are releasing time to care so it fits and dovetails into that beautifully.”
In addition to reducing falls, the team has improved the way falls data is collected. They produced a guide with examples on how to complete their Datix form.

The seven simple steps pilot took place on Grundisburgh, a complex care ward. Matron, Julie Tomlin describes how it worked: “We had a high number of patients having falls. The pilot involved devising a checklist of very basic things that could be done to try to reduce falls for patients at risk. We engaged all the staff on the ward, particularly the care assistants. There was initial scepticism, as they thought it would be time-consuming, but after a while they could see the benefits of doing it and now it’s become part of the care that people receive. As a result of this pilot, some beds have been purchased that go right down to the floor, which has been a great help to patients and nursing staff. Reducing the number of falls on the ward has released more time for other aspects of care.”

“It really has made a difference,” continues Julie. “I could walk onto that ward and the environment felt calm, I could see that the nurses felt in control – that was the biggest difference for me. Linda once went to do some training, took the wrong turning and walked onto the wrong ward, one which had not be targeted for the programme as its rate of falls was low. But, they said they really wanted to do it, so we put them on the programme. It just shows that people want to do it.”

“These are fundamental, all very simple things. They’re normal to us, but we thought maybe we’re not checking them frequently enough. So every two hours we ask the nurses to check the patients at risk, using this tool.”

Julie Sadler, head of patient experience and adult safeguarding

“There was initial scepticism, as staff thought it would be time consuming but after a while they could see the benefits of doing it and now it’s become part of the care that people receive. Reducing the number of falls on the ward has released more time for other aspects of care.”

Julie Tomlin
Matron
Local results

**Impact on quality of care**
The pilot project demonstrated a reduction of nearly two-thirds within the first three months of implementation on a complex elderly care ward.

The programme has significantly reduced the number of falls, improved patient safety and released staff time. It has also led to other benefits, such as fewer complaints from relatives and improved staff morale.

Through the programme, the trust has improved the information provided via the risk reporting system. This has led to a greater understanding of where to target resources. The trust has developed a guide to completing the Datix form, which provides examples of the detail required when a fall has occurred.

**Impact on patient experience**
Results also identified that patients felt more confident and needed to use their call bells less. As a result of the pilot, some additional beds have been purchased that go right down to the floor to assist specific patient groups when getting in and out of bed.

**Impact on staff experience**
A staff evaluation after three months identified that time had been saved as fewer slips, trips and falls resulted in less need for reactive management. Overall, staff morale increased due to the staff’s improved knowledge and a sense of ownership and achievement.

Multidisciplinary training and raising awareness of falls and the seven simple steps programme was key to this programme. This was incorporated into mandatory training, including training for junior doctors and pharmacy staff.

**Return on investment calculation**
Costs of the following inputs were calculated for both the pilot and roll out phases. This included: dedicated time from the project lead; dedicated time from a system analyst to prepare information systems and feedback; training ward staff; cost of observation tool material and posters to present results to ward staff. Impact costs were calculated in terms of the savings made from reductions in the incidence of falls by harm category. For every £1 spent the seven simple steps programme generates £6.24 of benefits. This calculation does not take into account the additional quality benefits that have not been monetised. The ROI figure is also sensitive to the starting point (falls incidence baseline) of a ward. The pilot ward, which started from a much lower base than the additional seven wards was able to reduce its incidence of falls more significantly.

Further information available from the NHS Institute website
Key themes and methodology

Leading by example
Improvement work is inspired and driven by people, not things. The success of the paper based tool at Ipswich Hospital NHS Trust is all about the people using it. The programme was driven by senior nurses working at an individual ward level. On the ward, the familiarity and visibility of these nurses gave them the credibility.

Successful improvement works by managing the ‘human dimensions of change’. Having senior nurses demonstrating a commitment and promoting a ‘can do’ culture is absolutely core to good change management. Change leaders are people who really understand the work, who have an in-depth knowledge of the process and the ability to be passionate and involve others in making the change happen.

Improvement tip

What is trust?
If you have a good relationship and mutual trust between yourself and those you are working with, you are more likely to find them receptive to the new ways of thinking and the improvement methods you want to introduce. Find out more on human dimensions of change in the improvement leader’s guides ‘managing the human dimensions of change’.

The Improvement Leader’s Guide: managing the human dimensions of change

Further information available from the NHS Institute website
Improvement tip

Since improvements depend on the actions of people, ultimately, it comes down to winning hearts and minds. People are not machines. You cannot make others simple do as they are told, nor can you be everywhere at once in order to watch others to ensure compliance.

Command and control cannot work in a human-intensive system like health and social care because there can never be enough commanders and controllers to go around and none of us are willing to put up with the approach that would be required. So, we need to win the hearts and minds.

The Improvement Leader’s Guide: managing the human dimensions of change

“At the end of the trial period, I could walk onto that ward and the environment felt calm, I could see that the nurses felt in control – that was the biggest difference for me.”

Julie Sadler
Head of patient experience and adult safeguarding
How to measure...Staying safe - preventing falls

The national picture
Every fall that a patient has under your care should be recorded through your local risk management systems (LRMS). Certain incidents are required to be reported to the National Patient Safety Agency (NPSA) and certain important events that affect people who use their service submitted to the NPSA are required to be reported to Care Quality Commission (CQC). The National Patient Safety Agency produces quarterly data summaries which include all the patient safety incidents reported by NHS organisations in England and Wales.

How are falls defined?
The definition adopted by the Nurse Sensitive Outcome Indicators is “an unplanned/unintentional descent to the floor, with injury, regardless of cause (slip, trip, fall from a bed/Chair or other, whether assisted or unassisted fall). Patients ‘found on floor’ should be assumed as falls unless confirmed as intentional acts.”

http://www.ic.nhs.uk/services/measuring-for-quality-improvement/what-is-happening-on-indicators-for

In addition to defining a fall, you can categorise falls into different levels of severity.

The NPSA (http://www.nrls.npsa.nhs.uk/resources/?entryid45=59821) categorises falls into these categories with their respective definitions:

- **no harm** – where no harm came to the patients
- **low harm** – where the fall resulting harm that required first aid, minor treatment, extra observation or medication
- **moderate harm** – where the fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital
- **severe harm** – Where permanent harm, such as brain damage or disability, was likely to result from the fall
- **death** – Where death was the direct result of the fall.

How might falls be recorded and measured locally?
As well as reporting falls to the National Reporting and Learning Service (NRLS), many organisations will be monitoring falls on a more regular basis and at ward level. How this data is used will vary but you should consider using the principles of good measurement outlined in the measurement section. For example, display the information on a simple run chart so that the rate of falls over time is made clear to all staff.

Some organisations might also benchmark their wards against one another and produce dashboards which show how one ward is performing compared to another. This can be useful as it can help to incentivise the spread of best practice, however there is always the danger that those wards that are specifically targeting falls start to record them more accurately – and this can make it look like their performance is poor. Whenever making comparisons it is vital do it in the spirit of improvement and understand the wider context.
Another powerful way of displaying falls data is to use a ‘safety cross’ which graphically shows how many days it has been since the last fall in any given ward or organisation. Safety crosses are an approach that are illustrated in The Productive Ward – releasing time to care www.institute.nhs.uk/productiveward programmes.

**Falls calendar**

As well as collecting falls rates, it is useful to think about what process measures may be useful (see measurement section page 16 for information about process measures). Some examples, of process measures taken from the Patient Safety First Campaign’s ‘How to Guide for reducing harm from falls’ are:

- % of staff who have received falls management training
- % of patients with appropriate observations after a fall

**Measurement when making improvements**

If you are starting to work on falls, you should begin by looking at what you are already measuring and what other teams in your department or organisation may be collecting, so that you save time and use existing systems if they are appropriate. You should use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting around falls and also see gaps where you might need to collect additional information.
Keeping nourished - getting better
Introduction

A practical summary
Malnutrition is a cause and a consequence of disease leading to worse health and clinical outcomes in all social and NHS care settings. Yet most patients, carers, healthcare professionals, commissioners, senior managers and chief executives do not realise how common it is in the UK and so it goes unrecognised and untreated (BAPEN, malnutrition matters, 2010). Nurses and midwives have a responsibility to make sure people under their care are appropriately nourished and hydrated – they need to have food and drink. This is a basic human requirement and fundamental to the care and recovery process. To support and improve nutritional care we need to have an approach that is inclusive and ensure we have a joined up approach which crosses pathways in both acute and community settings. Clinical leadership and effective management structures in addition to robust multidisciplinary care is essential in order to provide nutritional care that is focussed on each individual and is comprehensive and seamless across all care settings.

The problem
Malnutrition in the population has a massive impact on health and social care, with spending on disease-related malnutrition being estimated to be in excess of £13 billion per year (BAPEN, 2009). Approximately one in four patients in NHS hospitals are either malnourished or at risk of malnutrition and as much as 70% of malnutrition in acute hospital admissions is unrecognised and unmanaged (NICE, 2006). Patients in hospital have a low body mass index (BMI) compared to the general population, with 20-25% of patients having a BMI of less than 20 kg/m² which indications that they are malnourished this can be compared to 5% of the population with a BMI of less than 20kg/m² (British Nutrition Foundation, 2009).

Age UK (formerly Age Concern and Help the Aged) reports that patients over the age of 80 admitted to hospital have a five times higher prevalence of malnutrition than those under the age of 50. The risks also rise in certain diagnostic categories.

Although the vast majority of people who are malnourished are living in the community, malnutrition and dehydration are clearly key challenges for all NHS organisations. Well-hydrated and nourished patients get better more quickly and have a shorter length of stay. Feeling nourished is also key to a positive patient and carer experience - one of the most frequent issues raised with Age UK by the relatives of older people who have been in hospital is the lack of appropriate food and help with eating and drinking for people who are unable to manage this for themselves. Patient surveys of older people who said they needed help to eat their meals reveal that 18% feel they do not get enough help and 21% said that they only got enough help ‘sometimes’.

The cost
The length of stay for malnourished patients is, on average, 1.4 days longer than better-nourished patients (NICE, 2006b). Malnourished patients also succumb to infection more often, visit their GP more frequently (NICE, 2006) and require longer-term and more intensive nursing care. Better nutritional care has been shown to result in substantial potential cost savings to the NHS with a saving of just 1% of the annual health care cost of malnutrition amounting to £130 million annually.

An estimated 40% of hospital food is wasted, which results in patients receiving only 70% of their energy and protein requirements, contributing to the risk of malnutrition (British Nutrition Foundation, 2009).
There is little data available on the costs of poor hydration, but the Hospital Hydration Best Practice Toolkit reports that tap water is available at around one tenth of a penny per litre and, therefore, as much as one thousand times cheaper than less healthy, sugary and caffeinated drink options. It concludes that the costs of implementing good hydration and nutritional practice are more than balanced by the lower maintenance costs of healthier people.

**What we can do**

For nurses to introduce good nutrition and hydration practices, it is necessary to know the patients at risk. NICE (2006) found that only around a third of patients are screened for malnutrition on admission to hospital.

Patients may arrive in a relatively healthy nutritional state but their status may change, so regular measurement, particularly for long-stay patients, is vital. Once patients are identified as being at risk, appropriate interventions should be introduced and monitored.

Dietitians are the experts when it comes to calculating nutritional requirements for patients. It is the nurses who are responsible for the day to day nutritional care. It is vital that both professions work together to ensure their patients get the right amount of nutrition and hydration they need for a speedy recovery.

Providing a nutritionally adequate diet, i.e. providing patients with all of the nutrients that they need is fundamental to the delivery of good nutritional care. In patients who are malnourished or at risk of becoming malnourished, it may be necessary to offer fortified foods and/or oral nutritional supplements. Dietitians can work with nursing and catering staff to develop a programme of food fortification. There is good evidence that oral nutritional supplements are effective in improving patients’ nutritional intake. It is important to make sure that these are used appropriately to minimise wastage, taking account of the patient’s preferences regarding choice of flavours.

**The case studies**

**Lancashire Teaching Hospitals NHS Foundation Trust** holds daily multidisciplinary ward rounds for all patients with TPN (total parenteral nutrition).

**NHS County Durham and Darlington** has dramatically reduced the amount of supplements being used – and thrown away – in its community hospitals by developing a food fortification programme and encouraged better eating by using dining rooms.

**Hereford Hospitals NHS Trust** developed a scoring tool to monitor fluid balance to speed up interventions. It uses volunteers to ensure those who need help eating get it.

**Salford Community Health** worked across the health community to reduce the inappropriate use of supplements by ensuring its dietitians were the frontline to accessing nutritional supplements in the community.
Where are the best sources of information?

10 Key Characteristics of Good Nutritional Care Toolkit.
http://www.nrsl.npsa.nhs.uk/resources/?entryid45=59865

Nutrition Action Plan (DH)

British Association for Parenteral and Enteral Nutrition (BAPEN)
http://www.bapen.org.uk/

Characteristics of good nutritional care National Patient Safety Agency (NPSA)
http://www.npsa.nhs.uk/

Malnutrition Universal Screening Tool (MUST) (This takes you to the BAPEN site. Click on MUST)
http://www.bapen.org.uk/musttoolkit.html

The Productive Series Meals module
http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

RCN Nutrition Now website
http://www.rcn.org.uk/newsevents/campaigns/nutritionnow/tools_and_resources/workshop

“No NHS or social care organisation can claim it is delivering quality care to patients and residents, if it does not have appropriate nutritional policies in place and nutritional care and treatment embedded into everyday professional practice. Quality NHS care is defined as flexible, patient-centred, safe and effective. Best practice nutritional care and treatment delivers against all these quality markers. We know there is some way to go before all NHS and social care organisations fully implement nutritional policies and practices, but are heartened by the Care Quality Commission’s confirmation of its focus on nutrition as a cross-cutting indicator of quality.”

Dr Mike Stroud, Chair of BAPEN speaking at the opening of the BAPEN conference (2009)
Case study: Salford Community Health

Food First – weighing up the cost of supplements
Salford’s community nutritional support dietitians worked across the health economy to ensure the appropriate use of supplements by implementing a nutrition screening policy and ensuring a consistent dietetic approach across acute and community services.

Setting the scene
Salford is a diverse community with high rates of deprivation. It is thought to be the second most deprived area in Greater Manchester and the 12th most deprived in the country. Salford has an ageing population, with approximately one in six of every household consisting of a pensioner living alone. Life expectancy is lower than the national average and Salford has high rates of mortality from circulatory diseases and cancer. Therefore, the PCT anticipated high incidence of malnutrition in the community.

Since 2006 the trust has witnessed a considerable rise in the cost associated with prescribing supplements; prior to the project, expenditure had increased by 49% to over £725,000 a year. GPs believed this was due to patients being discharged from hospital on sip feeds.

The approach
Consultant dietitian, Kirstine Farrer, secured £50,000 from the PCT’s best value project to evaluate the use of supplements and launch a nutrition screening policy in the community. Two community dietitians were seconded to the project, Laura Mash and Alison Levy.

The team also worked with Salford Royal NHS Foundation Trust to stop sip feeds being routinely added to TTOs (drugs to take home) unless the patient was under the care of a dietitian.

Sue Duffield, from the medicines management team, NHS Salford, identified the top 10 GP practices for prescribing supplements and another three practices requested assistance. In total, 512 patients were identified as having supplements on repeat prescriptions. Those patients who were unknown to the dietetic service were invited to a clinic for review or, if housebound, the team offered a home visit. If patients opted out of the dietetic service their prescriptions were discontinued. The team also provided training on the new screening policy which advocates the use of the malnutrition universal screening tool (MUST) for Salford GPs and 10 nursing homes in and around Salford.

“We looked at how many people were on supplements, what type of supplement they were on and the reason it was prescribed.”

Laura Mash
Senior dietitian
How they did it

The project to improve the use of nutritional supplements in the community has transformed the culture of prescribing, saving £238,000 across Salford in just five months - including £49,000 within GP practices taking part in the project. Salford Community Health also saw a 349% rise in referrals to the community dietitians service.

Working with ten GP practices, identified by the PCT as high prescribers, and three volunteer practices, the project team spent four months identifying patients on supplements. Of the 512 identified, just 21% were known to the community dietetic service. “We were shocked,” says senior dietitian, Laura Mash. “We knew there would be a proportion of the population unknown to us, but didn’t expect it to be that many. We offered 312 nutritional assessments – 176 ‘opted out’, which meant their prescriptions for supplements were discontinued. The team reviewed 136 patients, with some patients being seen up to five times. Only two patients stayed on the same regimen throughout the project.”

They found that the vast majority of the supplements were prescribed by GPs, with no indication of weight loss or actual weight. More than half had been prescribed for reasons given as ‘other’ or ‘unknown’, according to the audit. Further research found supplements had been given to patients with a range of conditions for which the supplements were inappropriate, including reflux, or for patients suffering reduced appetite due to bereavement.

The GP practices were given training in using the MUST tool and the team highlighted the PCT policy on prescribing supplements.

Along the way, the team was able to transform the quality of life of a number of patients. Alongside patients who were receiving the wrong supplements with the wrong combination of nutrients, they came across one elderly woman who had stopped eating and drinking for two years after being diagnosed with a hernia. “For some reason, she had been told she couldn’t eat and had been surviving on supplements,” says Laura. “She had got used to not eating; she no longer had a social interaction with food. I went through with her how she could enjoy food again, finding out what her favourite foods had been; counselling was key. It was about convincing her that I was there to help her, not take something away. I saw her five times and managed to reduce the number of supplements she was receiving and wean her onto a soft food diet.”

Fellow dietitian, Alison Levy, met one patient who had been receiving double the necessary dose of supplements – costing around £5,000 a year. Alison says: “He was receiving eight supplements a day. His weight suggested he wasn’t taking them all, but he did say he couldn’t afford food. We found a place he could get a three course meal for 70p and reduced his supplements to two a day. We have since advised his GP to stop prescribing any supplements.”
Key to the success has been the work with nursing homes. A total of 10 nursing homes were identified as having patients on supplements and the team visited each one. A series of training sessions were delivered, looking at the appropriate use of supplements and the concept of ‘food first’, which means fortifying foods as a first-line treatment. “We went into the homes and spoke to patients and staff about weight measurement, the risk of malnutrition, eating and drinking, and formulating a nutritional plan,” says Laura. “We looked at how and when they should be referring patients to a dietitian.”

“It made me feel much more confident,” admits Bridget Lawler, acting manager of Avondale nursing home. “Knowing I could phone them if I had a problem I didn’t know how to solve. It really has made a difference to staff. We don’t have to say to staff ‘make a milky drink’ anymore, they will say ‘I’ve put cream into the porridge’ and they are so proud. Our cook will be attending the next course.”

An additional training day was organised for GPs. It attracted more than 60 GPs, practice nurses and practice managers, and focused on explaining the MUST tool, updating them on local policy for the use of sip feeds and encouraging GPs to refer patients to the dietitian service for assessment as an alternative to prescribing supplements. Local GP, Dr Peter Budden, from St Andrews Medical Centre in Eccles, is prescribing lead for medicines management at NHS Salford. He says: “The provision of this service has allowed GPs rapid access to expert advice in an unfamiliar field. It has delivered quick, authoritative guidance, which has improved clinical and financial effectiveness and left a legacy of better knowledge amongst care home staff; an invaluable resource.”

Although the project has now finished, the team is committed to maintaining the training, and further sessions are booked with GP practices. “Reducing cost was a key driver,” says Francine Thorpe, head of integrated adult and therapy services, who sponsored the work. “But, the improvement in quality of life and patient experience has really shone thorough. My hope is that it becomes part of what the dietitians do routinely rather than a stand-alone project.”

“The programme of assessment with appropriate nutritional fortification, without the need to medicalise the situation with expensive prescribing of inappropriate protein replacement drinks, was a refreshing experience. The cost saving to the NHS of this valuable team is a ‘no brainer’ must-have.”

Nigel Hyams
Salford GP
Local results

Impact on quality of care
The project has improved access to dietetic expertise for a wide range of healthcare professionals, including nursing home staff and GPs.

The number of sip feeds being prescribed has decreased by 39.8% in the 12 GP surgeries which took part in the project, with a 58% increase in the proportion of patients known to the nutrition service. In addition, they saw a 30% reduction in supplements placed on repeat prescription.

The work reduced the use of ‘other/not known’ as the recorded reason for supplement prescription from 52% to 19%.

Impact on patient experience
Patients were able to meet and speak to dietitians, discussing alternatives to sip feeds. There was an average of 2.6 contacts per patient through the project, with a variation of between one and six contacts. All but two patients saw changes to their supplement regime. In many cases, this meant stopping it entirely or changing the type or the dose to something more appropriate.

There has been a 349% increase in referrals to the community dietetic service.

Impact on staff experience
Nursing home staff and GPs have much improved access to dietetic expertise. Training means that staff are more informed and confident in nutritional assessments. A questionnaire given to nursing home staff post-training showed the average confidence ratings increased across those areas that were covered by the training sessions.

Impact on cost reduction
A reduction in the overall cost of supplement prescriptions was seen for 124 patients (91.2% of cases).

Suggested annual savings of £151,224: total costs across Salford were calculated as £298,202 between September 2008 and January 2009, prior to the project. During the same time period in 2009-10, following the project, the expenditure reduced to £235,192 – indicating a cost saving of £63,010 in five months.

Further information available from the NHS Institute website
Key themes and methodology

Finding out the facts
With different stakeholders having different pre-conceived ideas of who was responsible for the increase in sip provision and why it was happening, the only way to understand its was to obtain the facts, based on current processes. At the beginning of this piece of work, the medicines management team identified the 10 GP practices in the area with the highest expenditure on sips feeds. Following this exercise, the team was armed with a wealth of information which helped to diagnose and understand the problems and identify opportunities for improvement with key stakeholders.

Improvement tip

Measurement for improvement
The handbook of quality and service Improvement tools (NHS Institute) provides a section with tools that help organisations, directorates, teams and individuals understand the importance of measurement.

All too often, we are busy collecting data or formulating reports that don’t give us the true picture in relation to service performance. In addition, we don’t always connect this work to the key service deliverables and performance.

These tools can help you to use data to identify areas for improvement and, when used with other tools, like mapping the process, they support service improvement for cost and quality.

The handbook of quality and service Improvement tools (NHS Institute)
“I was fortunate to attend a primary care update given by the Salford dietetics team. I was amazed at the advances in patient assessment and management, especially in the field of malnourishment (a group of patients often overlooked, due to the obesity epidemic the western world has brought upon itself). The level of expertise brought a resounding vote of confidence from my primary care colleagues, as we learned just how little we all knew!”

Nigel Hyams
Chair and Salford secretary, Salford and Trafford local medical committee
Case study: Lancashire Teaching Hospitals NHS Foundation Trust

Multidisciplinary ward rounds
Staff at Lancashire Teaching Hospitals NHS Foundation Trust have cut the use of total parenteral nutrition (TPN) and improved care for this vulnerable group of patients, through a specialist nutritional nursing service and daily ward round.

Setting the scene
An audit within the trust showed that around half of patients given TPN were prescribed it inappropriately. NICE guidance (2006) recommends that all hospitals should have a lead nutrition nurse. A lead nurse role was funded at the trust in 2001.

The approach
The trust set up a nutritional nursing team led by a consultant nurse, supported by two specialist nurses. The team focus on ensuring patients get the most appropriate artificial feeding device for their condition, and full support for their nutritional requirements. Along with a pharmacist and dietitian, the team carry out a daily ward round focusing on TPN patients. An extended multidisciplinary team ward round is held on Mondays and Fridays, with the addition of a consultant gastroenterologist, a biochemist and a microbiologist. The ward rounds are used to discuss all patients with artificial feeding devices.

The trust introduced a central referral system for the nutritional nursing team. Inpatients are assessed within 24 hours and the team holds a rapid referral, nurse-led clinic for patients in the community with nutritional devices.

Patients with an naso-gastric (NG) tube are now routinely discharged with a nasal bridle to reduce the need for them having to attend the clinic to have it refitted. An education and training programme was developed, focusing on prevention of central line infections.

“Total parenteral nutrition (TPNs) carries a range of health risks, including infection and liver damage, and it can cause death. We've reduced hospital admissions and prevented the use of many unnecessary devices.”

Tracy Earley
Consultant nurse in nutrition
How they did it

It is a term that has been used to denote good practice throughout the NHS for many years, but true ‘multidisciplinary’ working takes real effort. At Lancashire Teaching Hospitals NHS Foundation Trust, senior staff across disciplines have come together to hold multidisciplinary ward rounds focusing on their most vulnerable patients – those unable to eat and receiving total parenteral nutrition (TPN).

The team includes a consultant gastroenterologist, a nurse consultant in nutrition, two nutrition nurses, a senior dietitian, a biochemist and a pharmacist. The seniority of the members has helped to create a stable team that has sufficient influence and recognition to enable it to work across all the hospital’s wards, covering a wide range of specialties, to take on the nutritional care of appropriate patients.

Dr Philip Shields, consultant gastroenterologist, carried out a notes audit on his arrival at the hospital in 2001. As well as identifying several preventable TPN and central line complications, he found that based on international guidance, half of total parenteral nutrition (TPN) referrals were inappropriate. He demonstrated a potential saving of £40,000 on TPN – enough to fund a nutrition nurse post. A nutrition nurse was first funded in 2001. Nurse consultant in nutrition, Tracy Earley, came into post in 2003. Since then, the nutrition team has grown to incorporate two additional nurses.

Before the introduction of the nutrition team, TPN bags were available ‘off the shelf’ and were used as a short-term measure, or given to patients at risk of refeeding syndrome and leaving them at risk of having symptoms of metabolic disturbances as a consequence of reinstitution of nutrition following starvation or severe malnourishment. Now, patients who may need a nutritional device are referred to the nutrition team, who will assess them within 24 hours to decide if a device is required and what the optimal method is. TPN is now only used as a last resort in those with true intestinal failure.

“This is a very vulnerable group of patients, who can’t eat or drink,” says Dr Shields “We ensure there is an early assessment, making sure TPN is given appropriately. As a nutrition team, we are able to offer an alternative. For anyone with a functioning GI tract, for example, we can offer solutions, such as nasogastric (NG) or naso-jejunal tube feeding.”

The multidisciplinary nutritional team takes over the nutritional care of patients while they recover, regardless of the underlying condition. The team’s involvement begins when a nutritional device is considered. This could be due to a range of conditions including bowel surgery, intestinal failure due to Crohn’s disease or swallowing difficulties caused by stroke. On Monday and Friday mornings, the multidisciplinary team, led by a consultant physician, reviews care and sets a care plan for the next few days. From Tuesday to Thursday, the core members of the team continue to review care and make appropriate changes. The ward round typically lasts for around 90 minutes, and the team see around four to six patients on the wards.
The dietitian ensures the patient receives the correct amount of calories and nutritional supplements, the biochemist monitors biochemical blood results, while the consultant and nutrition nurses develop the care plan. The team is also supported by an interventional radiology team who can insert feeding devices. Feedback from patients has shown they feel well-supported. “Nutrition is a basic human need,” says specialist nurse, Thelma Shaw, who has been with the team for three years. “We get to know the patients and they get to know us.”

“The team is designed to make sure the patient is fed through the safest and most appropriate route,” explains specialist dietitian, Pam Coulthurst, who spends around two days a week working within the team. “It’s important that we don’t work in isolation from each other.”

The team is now seeing rising numbers of people needing TPN – in 2009 they saw 56 patients, compared to just 17 patients in 2005. Figures for 2010 are expected to rise again. This is as a result of increasing emergency admissions, the development of a new upper GI cancer centre and an increased level of complex surgery being undertaken. The nutrition team is helping to influence how surgeons work, knowing a team is there to provide a high level of dedicated care and support, influences the type of surgery they carry out. The nutrition nurses train ward staff to insert NG tubes and are called to assess patients where other types of feeding devices are being considered, such as PEG or a nasal bridle (magnetic clips used to insert thread around the nasal septum, to secure NG tubes). The nutrition nurses also run a rapid access service for patients in the community, and they are continuing to innovate. The rapid access service provides high quality day case care, treatment, replacement of failed feeding tubes and advice for patients who are artificially fed in the community. This reduces the need for hospital readmissions.

“It’s great to see the difference in patients once they are referred – they feel they are being looked after and that they matter,” says nutrition nurse specialist, Thelma Shaw.

“Patients get the right amount of support and the appropriate artificial feeding device for their condition, considering their short and long-term needs. TPN is only given when it’s the right thing to do and there is no other way.”

Tracy Earley
Consultant nurse

“The team is designed to make sure the patient is fed through the safest and most appropriate route.”

Pam Coulthurst
Senior dietitian
Local results

Impact on quality of care
A multidisciplinary team approach has meant better quality care, with early recognition of problems and fewer complications. It ensures that patients receive optimal nutrition through the safest and most appropriate route.

To date (April 2010) more than 1,000 nasal bridles have been fitted, preventing accidental removal.

Impact on patient experience
The high level of expertise within the team ensures that patients receive the right nutritional support. Patients receive expert care and feel more supported at home, meaning they can be discharged sooner.

Impact on staff experience
Expert ward round takes over nutritional care of the patient, regardless of speciality and the nutritional team responds to referrals within 24 hours of admission, providing an expert assessment of the nutritional needs of their patients. The team provide training on wards for NG insertion so staff feel both more supported and more capable. The team has contributed to NICE reviews on feeding devices.
Key themes and methodology

Multidisciplinary working
Realising the benefits of true multidisciplinary working takes real effort. Working in the NHS and delivering care along a patient pathway means we need to work closely with all members of the multidisciplinary team. This needs to continue whilst making improvements to the patient’s pathway. It is essential that any change process involves all those who have an interaction with the patient, and that it focuses on integrated working and improving communication between the multidisciplinary team wherever possible. Nurses and midwives cannot just change and make improvement to one element of the process, without it impacting on others. Remember that when working with groups of healthcare professionals, the common ground is that everyone is trying their best to make things better for the patient?

Improvement tip

When working in a group, it is important to understand some of the relationships and dynamics within the group. Groups will often go through a series of stages before becoming really effective and are able to have the biggest impact on the cause. Understanding where a group or team may be in their development can help to minimise some of the risks that may occur, particularly in the ‘storming’ phase.

The stages of group development

Forming  Storming  Norming  Performing  Adjourning

To find out more please see NHS Institute’s Improvement Leaders’ Guide – working with groups:
www.institute.nhs.uk/improvementleadersguides
“Although they get general care from the ward staff and medical staff, these patients have a particular problem and it is really important that it is managed in an expert way because the problems they face are unique.”
Katie Swarbrick
Associate nursing director

“Hope is not only audacious, it is substantial. Hope is what allows us to deal with problems creatively. In order to deal with fear, we have to mobilise hope. Hope is one of the most precious gifts we can give each other and the people we work with to make change.”

Why Stories Matter -
The art and craft of social change
Case study: NHS County Durham and Darlington Primary Care Trust

A comprehensive approach to patient nutrition in community hospitals

Staff working in Durham’s community hospitals have dramatically reduced the amount of supplements being used – and thrown away – by developing a food fortification programme that, along with other changes, enables staff to ensure their patients are well-nourished.

Setting the scene
The trust has three community hospital sites, providing continuing care, palliative care, rehabilitation and stepdown/step-up care, with an average length of stay of two weeks. The trust was chosen as a pilot for the Royal College of Nursing ‘Nutrition Now’ Campaign. The hospitals used ‘Regen’ food: regeneration trolleys designed to accept chilled or frozen food, keep it chilled during transport, then heat it back up to a safe and pleasant serving temperature close to the point of service. The wards had no 24-hour access to hot meals prior to the improvement work so were unable to offer hot food to patients outside of meal serving times.

The approach
The trust developed a programme using standardised food fortification so that supplements became a last resort. The programme was supported with training for staff in how to fortify foods. The trust now uses the malnutrition universal screening tool (MUST) on admission, with staff undergoing a two-hour MUST training session.

The trust worked with Age Concern (now part of Age UK) to collect patient stories and experience of the hospital food. This helped them to redesign their food provision. Staff worked with contractors and food suppliers to ensure menus met patient tastes. A range of equipment was installed to enable staff to respond better to patients’ requests. This included freezers, microwaves, toasters and fridges. Staff can now provide patients with hot meals at any time. Mealtimes have been improved by implementing a protected mealtimes standard operating plan.

“When it’s hospital food you don’t expect too much – it is invalid food – so we just put up with it because we want to get well.”

Community hospital patient
How they did it

At NHS County Durham and Darlington’s three hospitals, food fortification is a central part of nutritional care. It starts with identifying those patients in need of additional nourishment using MUST (the Malnutrition Universal Screening Tool). The screening tool is used on admission and triggers if and when an intervention by a dietitian is required. It also helps to identify obesity.

For patients on the wards who need additional nourishment, there is a range of different ways that this is supported. In the ward kitchens, there are recipes for making supplemented milkshakes, cream is available to add to porridge and there are protein powders to sprinkle into foods. There are scones and teacakes, which can be freshly toasted in the ward kitchen and tinned foods, such as beans, ham, corned beef, tuna and soups. Staff can also make up sandwiches or salads, and a range of microwavable hot food is stored in the ward freezers, which includes meals appropriate for special dietary requirements, e.g. soft for those with swallowing difficulties or choices for diabetics.

As well as making these additional foods available, the trust also worked on the main menus. They worked with Age UK (formerly Age Concern and Help the Aged) to collect patient stories on their experience of the food they were served. Age UK sat down with patients on the wards to interview them, both before and after the changes. They found many of the items on the menu were unappetising and some of them were inappropriate for the patient group. Crunchy vegetables, whole carrots, curries, chilli and spaghetti bolognese, along with anything from the gourmet menu received low votes from patients. By reducing unwanted items on their menu, as well as ensuring patients are better nourished, they have cut waste.

“At the end of the day, if patients don’t like the food, they won’t eat it,” says modern matron Karen Dyson, who led the work. Patients also felt that fortified drinks were ‘forced’ on them.

Not all of the comments that came back were on the menu or the quality of the food. One patient commented: “I don’t feel that I am being encouraged to eat or that anyone is taking any notice of whether I am eating or not.”

“Where we felt we were doing a really good job, some patients felt we weren’t interested,” says Sedgefield Hospital matron, Jan Conner. “The patients felt that there wasn’t staff focus or interest at mealtimes, and that was one of the things we worked on.”

The staff encouraged patients to use the dining rooms, where they can sit at a table to eat rather than at their bedside. Each table has its own menu and a nurse is allocated to sit at each table where they can monitor food intake and be on hand to give any help. This minimises the need for the red tray system, which is commonly used in acute hospitals to signify where a patient requires help eating. Patients had reported feeling conscious of the tray and what it meant, feeling that it affected their dignity. “In an acute hospital, I can see that you need to know at a glance, but in a community hospital you know the patients. We also have a board in the kitchens where we list the patients who require help,” says matron, Julie Walton.
A major benefit has been in making eating a sociable occasion. This has encouraged better eating and improved general wellbeing, including the exercise necessary to go to the dining room and back. “Encouraging patients to walk to the dining room is a form of rehabilitation,” says Karen. “Patients do eat much better when they are sitting away from their beds.”

The MUST screening tool enables any staff member to see how the patient is responding to their diet and reveals patterns or other issues that can be addressed, “It’s not just about monitoring – you might have a patient with leg ulcers and find they aren’t getting enough protein,” says Jan. “With all this, there is an element of common sense that runs through the work, you join up the patient’s diagnosis and what we know about them.”

Better monitoring brings comfort to families. Confused patients will often tell their visitors they have had nothing to eat or drink all day. Now, staff will know what their patients had for breakfast, lunch and tea, even if they are on a late shift. “If somebody comes to me and asks if her mum or dad has eaten today, I can say they had a full breakfast this morning – and I can say it with confidence,” says Jan. “As nurses, we do things that doctors used to do. We have got to invest in those people delivering the care. If you invest in your healthcare assistants, then what you want to happen will happen.”

The hospital kitchens have diaries so staff can record patient comments on the food, helping ensure continuing improvement. The introduction of The Productive Ward’s meals module has highlighted the need to spend £25,000 on extra housekeeping staff, which would release 41 hours of nursing time a week from plating up food to actually caring for patient nutrition.

Community dietitian, Catherine McShane, runs mandatory training sessions for staff, looking at the MUST screening tool and how to fortify foods – including taste tests comparing milkshakes with supplements. The training is supported by recipe books, posters and guidance on calorie intake. A new policy has been launched to embed this further.

“Under-nourishment costs the UK £13 billion a year – that’s double the cost of obesity,” says Catherine. “Under-nourishment increases hospital stays, GP visits and social care visits. It increases infections and pressure ulcers and it can have severe impact on people in terms of mobility and dependency. The course has empowered staff. People have got more confident, knowing what to do, rather than going to the dietitian or just introducing supplements.”

Supporting documents
Further information available from the NHS Institute website
Local results

Impact on quality of care
Patients in need of additional nourishment are identified and supported. More attention on mealtimes and food intake means that patients are more likely to be well nourished.

Impact on patient experience
Patients are now asked about their dietary requirements as part of the admission process, and the MUST tool is also used to identify those who may need additional nutritional support. Staff used patient experience as a driver to make the changes and continue to collect patient experience to monitor the situation. Since the new menu – designed based on patient feedback – was introduced, no negative comments have been received.

Impact on staff experience
Staff have a clear role at mealtimes and have received additional training in fortifying foods and developed a closer relationship with the dietitian. They are able to confidently interact with family members who may be concerned about their relatives’ food intake.

Impact on cost reduction
This High Impact Action has reduced costs in a number of ways. More appropriate menus that patients enjoy have reduced food waste and substituting nutritional supplements with food fortification which is up to 89% cheaper. Nutritional supplements can cost per portion from 27 pence to 61 pence (2000 prices).

The reduction in waste was as a result of quicker turnaround on standard orders, for example one ward has 34 beds but they may not always all be full. It used to take 2-3 weeks to change the order size (so, if there were only 10 patients in during this time, there would be 24 sets of meals wasted for 2-3 weeks). Now it takes only 24 hours.
Key themes and methodology

Using patient experiences to influence improvement

Much of the improvement work at NHS County Durham and Darlington began with the survey of food carried out by Age UK (formerly Age Concern and Help the Aged). Comments from patients helped inform their decisions when it came to making menu decisions, and improved their engagement with patients at mealtimes.

Every day, nurses come into contact with patients and listen to their experience with regards to illness or treatment and how they are feeling. But does this mean they have an understanding of the patient’s experience of the services provided? Nurses receive some feedback on the piece of the jigsaw that directly involves them, but what about the whole pathway or journey?

The ever changing reforms of the health service gives new structures and different points of focus, but the one, consistent factor is that, to deliver quality care that is productive and safe, we need to better understand the patients’ interactions with the service.

Improvement tip

The ebd approach

The ebd approach (experience based design) is a method of designing better health services for patients, carers and staff. The ebd approach encourages staff to work together with patients and carers, firstly to understand their experiences and then to improve them.

Further information available from the NHS Institute website
“Why bother to go to such trouble trying to understand experience? Why not stick with behaviours which at least are observable, or attitudes which are measurable? Simply for the reason that all of our judgements, attitudes, sentiments, feelings, sensation, opinions, memories, action and reactions are coloured and shaped by our experience and it is, therefore, only by understanding and, ultimately, designing experience that we can influence and begin to understand and create the very essence of life itself."

Bringing user experience to healthcare improvement – the concepts, methods and practices of experience-based design, Paul Bate and Glenn Robert
Case study: Hereford Hospitals NHS Trust

Water works!
Hereford Hospitals NHS Trust developed a scoring tool to monitor fluid balance, to speed up interventions and improve mealtimes, introducing volunteer helpers who ensure those who need help eating get it.

Setting the scene
A vital signs audit in July 2009 revealed many patients had inadequate fluid documentation. Staff appeared to be unaware of the importance of adequate hydration and the implications of poor fluid balance and awareness of the importance of good basic observations was low. In addition, the trust found mealtimes were not being prioritised by staff as one of their vital care giving tasks.

The approach
The trust introduced the amber scoring tool, an early-warning scoring tool, which measures the amount of urine produced each hour. Staff also redesigned the fluid balance chart to enable them to total fluid intake and output every 12 hours, at midday and midnight, instead of every 24 hours. In addition, patients admitted to ITU are reviewed to ensure that fluid balance monitoring is of the highest standard. Critical care outreach staff can then raise concerns with the ward sister and, together, review each case to see if poorly managed fluid balance had an influence on the patient’s deteriorating condition.

Staff introduced a ‘Forget-me-not’ form which records hourly visits to patients in side rooms to check they have everything they needed including visits to the toilet and drinks within easy reach. This helped to reassure patients and their families that they had not been forgotten thus reducing feelings of isolation. An ‘all hands on deck’ approach was introduced at mealtimes, with staff available to help patients eat supported by a team of volunteers. Better hydration awareness was encouraged through the red jug system where red-lidded jugs are used to identify, at a glance, which patients need help to drink.

“My agenda was: what things will make a difference and what do we need to do? What makes a patient’s experience better? In reality, it is high quality basic care, delivered efficiently and effectively. If we get that right, you get a huge amount of benefit. A well-nourished patient will heal better, have better skin integrity, they are less likely to fall and if they are hydrated they are less likely to develop UTIs: for me nutrition is the lynchpin of good care.”

Tim Tomlinson
Director of nursing and operations
How they did it

Nurses know that poor hydration and malnutrition can have serious consequences for their patients. Something as simple as too little to drink can cause already weak patients to end up in intensive care. Mealtimes can be the time of the day that patients look forward to, but they may also need help and encouragement to eat appropriately and stay well hydrated. Hereford Hospitals NHS Trust wanted to design better nutrition and hydration across their wards.

Linda Kehoe, ward sister and previously clinical nurse trainer, and Caroline Maguire, junior sister in the critical care outreach team, led the work. Both had witnessed the severe health consequences of poor hydration, which include kidney failure, coronary heart failure, and stroke. Their work began after an audit identified fluid documentation was poor. Both of them recognised staff didn’t see the importance of this, or the importance of good hydration for their patients’ wellbeing. “Staff didn’t understand the importance of basic observation,” says Linda. “We had to get them over the sense that because ‘the patient is not too ill’ they don’t need to be measured and documented.”

While healthcare assistants are often the frontline in catheter care, the team targeted ward sisters to ensure the documentation was recognised as a priority. A laminated poster highlighting key points can be found on every ward and posters have been widely distributed: they have become a familiar sight on the back of staff toilet doors!

She adds: “Measuring at 24 hour intervals was too long – once the problem was identified it was too late. We began totalling up patients’ output at 12-hour intervals – midday and midnight. This allowed action to be taken and fluids given to address the fluid balance quickly and avert any health consequences. We have upset people along the way, but they are now fully on-board.”

All patients are amber scored (using the early warning scoring tool), based on the amount of urine produced each hour. The target is more than 30ml per hour and staff are also encouraged to monitor patients who use the toilet. This is done by asking the patient: “have you been to the toilet, was it normal for you?” Staff now total up fluid input and output every 12 hours, at midday and midnight. An increase in the amber score triggers immediate action; all staff are able to call the nurse in charge who will then make the decision either to call the critical care outreach team or, where concern for the patient is greater, the adult emergency team to review the patient.
Measuring success through auditing has been a key tool to improvement. The team found one ward where 100% of their documentation was up-to-date, but it had all been totalled incorrectly. Since then, the team has worked with the ward to harness that enthusiasm to do the job properly – and they have made great improvements.

Emphasis on hydration and reviewing individual patients has been key. The work is supported by the red water jug system on wards, where red-lidded jugs are used to identify, at a glance, which patients need help to drink.

Mealtimes have been transformed to ensure that patients are given every opportunity to eat well, using The Productive Ward as a key improvement tool. Ward sister, Pauline Ellis observed mealtimes on her ward: “We thought we were doing a good job, but when I sat and watched what happened, I saw nurses leaving the wards and the ward clerk going for lunch, which meant nurses had to leave their patients so they could answer the phone. There were patients being taken off the ward for tests, doctors and other staff coming on to the ward to see patients. The red trays were being used, but we needed to make changes.”

Now, protected mealtimes prevent patients being disturbed, and staff negotiate with clinical staff coming on to the ward. Patients requiring assistance are identified and staff are assigned to help them. Volunteers go on to the wards at lunchtime and tea time to help. There are 20 volunteers, of which 14 have been trained and are now helping to feed patients – and there is a waiting list of more volunteers wanting to join.

Ward sister, Carol Harrison, estimates as many as half of the patients on her ward will need assistance at mealtimes instead of help with feeding – this could be as simple as needing the top taken off the yoghurt. “Just having the red tray has made everyone aware of the need to ensure patients eat well. Doctors and other colleagues are told to leave the patients to eat in peace.”

“The volunteers feel they are doing a great job in helping to feed patients and patients are more than grateful,” says Jane Derry, voluntary services coordinator.
Local results

Impact on quality of care
Better documentation and screening of patients at risk of dehydration means earlier intervention. There is greater awareness of the importance of eating and drinking and more help and encouragement on hand for patients at mealtimes.

Impact on patient experience
Better nutrition and hydration means better health and faster healing. As a result of the changes that have been introduced, patients receive the help they need and the food and drink that they want.

The Forget-me-not forms provide reassurance to patients and families that they are not isolated and have not been forgotten by staff.

Impact on staff experience
Staff have more clarity over expectations and have clear processes and documentation. There is a change in culture with staff understanding the importance of good hydration and mealtimes. Staff feel empowered to challenge others who may be interrupting the protected mealtimes. There are clear guidelines and permissions that mean junior staff can immediately step-up care for high-risk patients.

Impact on cost reduction
The trust has saved 7.5 hours per month per ward by developing a standard operating plan at mealtimes. It is difficult to show in cost terms how the work has reduced the severity of dehydration, but there are potential savings in length of stay and reduction in need for critical care stays.

Return on investment calculation
Costs for the following inputs were calculated: staff time for mealtime audit, development of standard operating procedures and introduction of protected mealtimes; ‘vital signs’ audit and development of new materials; materials to support mealtime-specific activities (red jugs, green aprons etc.) and improved observation work (‘Forget-me-not’ charts, information posters for staff etc.). Impact costs were calculated in terms of reducing the staff time that has to be spent on mealtimes (in minutes saved from each staff members’ time). For every £1 spent Hereford has generated £15.74 of benefits over a year. This calculation does not take into account the additional benefits that have not been monetised, nor any additional costs incurred in delivering the trust-wide culture change on which this work was founded. It is also important to acknowledge that these returns do not automatically result in direct cash savings since staff salaries are fixed costs. However, they do allow the staffing resource to be directed to other care priorities, e.g. pressure area care. For some services the savings may allow a reduction in the use of agency staff.
Key themes and methodology

Nurses on the board
Director of nursing and operations, Tim Tomlinson has supported his staff throughout their work. His presence as a board member means he can provide that all-important nursing perspective and ensure the impact of basic nursing care is felt at the highest levels. Part of his role is to understand the national and regional priorities and translate them for frontline staff. His ability to do this has an impact on the quality of the service provided to patients.

Having key objectives and messages and then advocating them is easy, but when the workforce see lack of commitment or even a lack of adoption from the executive team, then things will fail and staff will be reluctant to join future initiatives.

Having a senior level manager, or executive, to act as a champion for an improvement project is an important way to ensure consistency of message and an element of leadership by example.

Simple ways for senior staff to lead by example are to involve them as active participants in training and facilitation. Rewarding and celebrating the achievements of improvements that have been made and simple acts of recognition are invaluable for generating support and commitment.

"Something goes wrong and we get all of these initiatives come in and we can’t treat them as 10 separate entities, you take a few and use them as a single spearhead. You have to be consistent and supportive. Innovation is about small things."

Tim Tomlinson
Director of nursing and operations
Improvement tip

How a person behaves and the ability to communicate is the substance that will bring about change. The new leadership competencies are:

• the ability to think in terms of systems and knowing how to lead systems
• the ability to understand the variability of work in planning and problem solving
• understanding how we learn, develop and improve, and leading true learning and improvement
• understanding people and why they behave as they do
• understanding the interdependence and interaction between systems, variation, learning and human behaviour. Knowing how each affects others
• giving vision, meaning, direction and focus to an organisation.

The Leader’s Handbook: a guide to inspiring your people and managing the daily workflow

“It is the ultimate management conceit to believe that we can motivate people. Motivation is not some substance we can infuse from the outside, like a bone marrow transplant.”

The leaders handbook – a guide to inspiring your people and managing the daily workflow
Peter R. Scholltes
How to measure...Keeping nourished - getting better

The national picture
There are a variety of national frameworks and requirements for measuring the performance of nutritional care: Meeting nutritional needs is one of the 16 aspects of quality that by law that must be registered with the Care Quality Commission; the Essence of Care benchmark for food and drink provides guidance that has been developed to ensure quality in person focussed outcomes; Food and hydration services are part of the annual self-assessed Patient Environment Action Teams (PEAT) Assessments. The measurement focus is often around the process of nutritional care; ensuring that there is a good practice for example:

- information provision of a nutritionally adequate diet and the importance of maintaining a healthy weight/preventing individuals becoming malnourished
- training of all healthcare professionals in the importance of nutritional care
- raising awareness of the importance of fluid balance as an integral part of the nutritional management of individuals
- that the environment is conducive for eating and that there is a variety of food available
- patient are not unnecessarily kept nil by mouth for extended periods.

How is malnutrition defined?
Malnutrition is defined as a state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome. (BAPEN Toolkit www.bapen.org.uk)

How do you define inappropriate weight loss in NHS provided care?
The High Impact Action, Keeping nourished - getting better is about identifying individuals at risk of being malnourished, providing good nutritional care and stopping inappropriate weight loss and dehydration in NHS provided care.

Using screening and risk assessment in all hospitals, community and other care settings will identify patients who are malnourished and at risk of malnutrition. Validated screening tool, such as the malnutrition universal screening tool (MUST) that meets NICE guidance. and is evidence-based which can be used by all care workers.

Within all care settings management of those patients identified to be malnourished or at risk means ongoing assessment and care planning. This ongoing evaluation of nutritional intake and status is an indicator of improvement to patient wellbeing and for all these patients maintaining documentation and ensuring nutrition screening. Of course, assessments with action and treatment plans should be transferred with the patient when admitted to any other care setting.
How malnutrition might be recorded and measured locally

Your organisation will be using some form of nutrition screening tool either the MUST or a locally designed tool. This will be the way you identify the patients at risk of malnourishment. Monitoring throughout the whole patient journey is important so it is essential to ensure that when patients leave your care setting all of the documentation goes with them to aid continual and effective measurement. Your organisations may have systems in place that indicate patients who require assistance at mealtimes. Food served on a red tray provides an effective signal to staff.

The red tray needs to be part of initial and continuing assessment. This may also be part of, and linked with, the protected mealtimes where during periods of time over breakfast, lunch or supper all non-urgent activity will stop. (All essential and urgent care needs will still be met.) This is to prevent unnecessary interruptions to mealtimes and enable nurses, housekeepers and volunteers to focus on serving the food and providing assistance to patients who may need help. How these processes are defined and used will vary, but you should consider using the principles of good measurement outlined in the measurement section (page 16). Having clear information, using a simple run chart of the number of patients at risk of malnutrition that had their screening assessment completed within agreed local time frames over a time period, is a great start.

As well as looking at the patients identified at risk or patients that are actually malnourished, it is useful to measure the processes that affect this sort of outcome. Think about the processes in your care setting (see measurement section page 16 for information about process measures).

Some examples of process measurement can be found within the NICE guidelines: Nutrition support in adults http://www.nice.org.uk/nicemedia/pdf/cg032quickrefguide.pdf. For example:

- % of patient screened for malnutrition or the risk of malnutrition
- All hospital inpatients on admission and all outpatients at their first clinic appointment or people in care homes should be screened on admission and when there is clinical concern
- % of patients who are malnourished provided with Nutrition support
- % of patients who are considered at risk should have nutrition support
- % of healthcare professionals (directly involved in patient care) should receive education and training, relevant to their post, on the importance of providing adequate nutrition
- % of patients who receive nutrition support via coordinated care from a multidisciplinary team.
Measurement when making improvement
If you are starting to work on nutrition and hydration care, you should start by looking at what you are already measuring, and also what other teams in your department or organisation may be collecting so that you save time and use existing systems if they are appropriate. You should use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting around nutrition and hydration and also see gaps where you might need to collect extra information.

The most important factor we found in all of the case studies was the passion, energy and commitment of individual nurses and midwives who wanted to make a difference.
Promoting normal birth
Introduction
The aim: to increase the normal birth rate and eliminate unnecessary caesarean sections through midwives taking the lead role in the care of normal pregnancy and labour, focusing on informing, educating and providing skilled support to first-time mothers and women who have had one previous caesarean section.

A practical summary
Maternity services in England offer care for mothers and babies that is the envy of many other countries. However, there are concerns that intervention rates are rising. The proportion of births by Caesarean section (c-section) has steadily increased in England over the past twenty years.

Clinicians currently working in services with low c-section rates believe that maternity units applying best practice to the management of pregnancy, labour and delivery can achieve consistent rates below 20% (NHS Institute 2006, Focus On: Caesarean Section).

A focus on normalising birth results in better quality, safer care for mothers and their babies with an improved experience. Increasing normal births and reducing c-section deliveries is associated with shorter (or no) hospital stays, fewer adverse incidents and admissions to neonatal units and better health outcomes for mothers. It is also associated with higher rates of successful breastfeeding and a more positive birth experience.

These changes benefit not only women and their families but also maternity staff. Midwives are able to spend less time on non-clinical tasks and more on caring for women and their babies.

The problem
The most recent data (2008/09) reports a national c-section rate of 24.6%, a significant rise compared to 12% in 1990. There is significant variation in the c-section rate across maternity units, ranging from 12.5% to 34.6% (NHS Institute, 2007). Many units have a rate significantly higher than the World Health Organization recommended rate of 15%. Higher rates of c-section appear to be associated with older mothers and women from certain ethnic groups but even when these factors are taken into account, they do not explain the differences between trusts (Healthcare Commission, 2008). It has been suggested that this difference is influenced by cultural and organisational factors within trusts (NHS Institute, 2007).

Many women who have already had a c-section do not necessarily need to have another one for their next baby. The Royal College of Obstetricians and Gynaecologists (RCOG) suggests that around three-quarters of women should be able to have a vaginal birth after caesarean section (VBAC). However, of those trusts able to supply figures, on average only 32% of women had a vaginal birth following a previous Caesarean, with rates ranging from less than 10% to more than 60% between trusts (Healthcare Commission, 2008).

The cost
Savings can be made by increasing the number of vaginal birth and by improving the efficiency of care after Caesarean section. Depending on complications, a c-section costs between £1,370 and £1,879 (NHS Institute, 2009). The typical length of stay is three to four days. By contrast, a normal delivery will cost
between £735 and £1,097 per birth. A cost study by the NHS Institute has calculated that a potential £65.5 million could be saved by reducing the national caesarean rate by 4% and by reducing the length of stay for a c-section without complications from 4 to 2.5 days (NHS Institute, 2009). This equates to a saving of £510,000 per trust.

In 2008, the NHS Institute started a rapid improvement programme to promote normal birth and reduce c-section rates. Nineteen out of the twenty participating sites have reduced their c-section rates, with some trusts achieving reductions as high as 6% (NHS Institute, 2009).

**What we can do**

Focusing on VBAC can have a massive impact on c-section rates. By targeting skills and support for women following a c-section and during pregnancy, this rate can be reduced substantially – in one trust it dropped by 300%. Many women and their health professionals lack accurate information on the benefits of VBAC so that this option is not offered or supported even when it is the most appropriate choice.

The recent consensus statement Making Normal Birth a Reality suggests a realistic objective of 60% as the rate of normal births, that is, births without interventions such as epidurals or episiotomies but according to the Healthcare Commission’s review of maternity services, the median trust reported only 40% of births as normal and a quarter of trusts reported 32% or less (Healthcare Commission, 2008).

Women with a low risk pregnancy should be able to benefit from the philosophy of normal birth and receive midwife-led care, even in an obstetric unit.

**The case studies**

**Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust** introduced massive organisational change that has had a significant impact on how maternity care is delivered.

**Luton and Dunstable Hospital** reduced their c-section rate from 31% to 23% in a year, through top to bottom cultural change and a commitment to normalising births.

**Stockport NHS Foundation Trust** focused on providing support and building the confidence of women who had previously had a c-section.

**The Western Sussex Hospitals NHS Trust** increased its rate of successful VBAC by more than 300% through a wide-ranging programme designed to normalise birth.
Where are the best sources of information?

NHS Institute for Innovation and Improvement (2006) Delivering Quality and Value: Focus on: High Volume Care Executive Summary

NHS Institute for Innovation and Improvement (2006) Delivering Quality and Value: Focus on: Caesarean section


Healthcare Commission review of maternity services: Towards better births (2008)
www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

Department of Health, Maternity Matters: Choice, access and continuity of care in a safe service


Better Birth Environment Toolkit

NICE Clinical guidelines: Caesarean section
http://www.nice.org.uk/guidance/CG13

Royal College of Obstetricians and Gynaecologists – Standards for maternity care


RCM campaign for normal birth.
http://www.rcmnormalbirth.org.uk/

NICE- Intrapartum guidelines: www.nice.org.uk/guidance
Case study: Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust

Doing it the Blackpool way
In recent years, Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust turned its fortunes around as a result of massive organisational change, which has been dubbed The Blackpool Way. No department better illustrates the impact of the Blackpool Way than maternity.

Setting the scene
The trust has approximately 2,800 births a year and had the highest c-section rate in the North West (28%).

The approach
The trust introduced a series of projects designed to improve care and support women through natural birth. These include:
- developing formalised handover
- a weekly incident review meeting
- disseminating learning throughout the hospital at all levels
- open and accessible appraisals and training for staff
- learning from other hospitals.

“We realised that the answers to our problems lay with our staff. By changing the management culture, we have released the potential of staff to make changes. The board was keen to see an improvement in c-section rates, both from a patient experience perspective and also from the perspective of quality of care and cost. We made a high level commitment to reducing c-section rates and have taken a keen interest in the work that the maternity team is doing.”

Aiden Kehoe
Chief executive
How they did it

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust had the highest c-section rates in the North West. Now, as a result of sweeping changes in the organisational culture and a focus on normalising births, it has dropped to around 22%.

The trust has introduced a wide range of measures, including weekly incident review meetings, open and accessible appraisals and training, a formalised handover using the latest improvement techniques and systems to ensure learning is disseminated throughout the hospital at all levels.

The formalised handover uses situation, background, assessment and recommendation (SBAR), a structured method for communicating critical information that requires immediate attention and action. “We have developed an SBAR sticker which we stick into the patient’s notes, and then we formally sign to say that we are handing over care from one person to another,” says consultant midwife Nicola Parry. “It is a way of making us stop and think about how we are communicating from one shift to the next, or from one ward to the next.”

The incident review meeting is one of the trust’s key improvements. Facilitated by the clinical governance lead, this weekly meeting provides an opportunity to review any incidents. This presents a learning opportunity for the benefit of the whole team. The meetings are open to anyone who wishes to attend including consultants, midwives, healthcare assistants, paediatricians, special care nurses and colleagues from other disciplines. The atmosphere is relaxed and informal – people can come and go as they wish and anyone can contribute.

“Previously there had been a culture of mistrust,” explains consultant obstetrician, June Davies. “Incident reports were looked at in isolation by me, as the risk lead, and it took a long time for information to be fed back to the staff. Now, any incident is discussed within 24-48 hours of its occurrence and information is fed back to staff within a week. By looking at things in real-time, incidents are fresh in people’s minds and we have developed a no-blame culture so that people are willing to speak out about what happened. That way we can all learn from each other.”

Each meeting begins with a discussion of further actions from the previous week. Minutes from the meeting are disseminated both horizontally to staff on the wards and vertically to the divisional board, and to governance and clinical meetings. This ensures that the learning that comes from these sessions goes right through the hospital.

A two-way appraisal system enables junior members of staff to comment on the performance of senior staff, and vice versa. It proves very beneficial in identifying improvements that individuals can make, tackling problems before they develop and improving the sense of teamwork. Training, too, is delivered in an open and accessible way. Dates are posted on notice boards and anyone linked to maternity can attend, from healthcare assistants through to paramedics. People are put into multidisciplinary teams and asked to re-enact emergencies.
“It’s a good way of building teamwork and ensuring that people are speaking the same language,” says practice development midwife, Moira Broadhead.

The multidisciplinary training is part of an improved package of training for midwives in Blackpool that includes normal birth study days, education about vaginal birth after Caesarean section (VBAC) and improved Cardio TocoGraph (CTG) training. The hospital has set up a weekly VBAC clinic to explain to women that a previous c-section does not preclude them from having a normal delivery next time and has also worked hard to normalise the birth environment. “We have taken away the bed and put in birthing couches and beanbags instead,” adds Moira. “En-suite showers have been replaced with baths that women can use for pain relief in the early stages of labour. It is a more intensive approach and harder work for staff so we have increased staffing levels to enable us to offer more one-to-one care.”

Shift leader, Lisa Dunkley has been active in introducing aromatherapy as part of the drive to reduce pharmacological pain relief. “There is evidence to support the positive effect of aromatherapy on women in labour,” she explains. “I worked in another local trust prior to this one where aromatherapy was found to have a hugely positive effect on mums and midwives. I am delivering aromatherapy training to all of the midwives. Initially it will be offered to all low risk mums, before being rolled out across all deliveries.”

Having achieved a reduction in c-section rates and an increase in successful VBAC – up from 50% to 65% – there is a palpable sense of pride in their achievements among the staff. “Over the last few years, the maternity department has made huge leaps forward,” says chief executive, Aiden Kehoe. “We appreciate that this has taken a massive effort from everyone but the results are worth it. Feedback from patients is more positive, we have a better approach to risk management and the patient experience is far better than it was a few years ago.”

“Confidence has increased amongst the staff, particularly more junior staff. We all use the same approach and there is a clear understanding between us about the history, expectations and plan of care for each woman. The way we promote normal birth is not regimented but we make clearly-documented decisions. The midwives are buzzing from the changes and there has been a huge rise in job satisfaction. We have moved from a culture of anxiety to one which is proactive in encouraging VBAC but that also accepts that intervention is necessary in some instances.”

Lisa Dunkley
Shift leader
Local results
The trust saw its c-section rate drop from 28% to 22% and increased successful VBAC from 50% to 65%. The trust developed a process to ensure a faster response to incidents involving whole multidisciplinary teams.

Impact on quality of care
The overall aim of the work is to provide the support and information mothers need in order to make an informed choice about the place and method of birth.

Impact on patient experience
A normal birth means mother and baby go home sooner after birth. Improvements in care include offering aromatherapy to all low risk mums, with plans to roll out the service to all women.

Impact on staff experience
Multidisciplinary training includes normal birth study days, where staff are put into multi-professional teams and asked to re-enact emergencies. A two-way appraisal system enables junior members of staff to comment on the performance of senior staff, and vice versa. The work has increased team working and removed the culture of mistrust.

Impact on cost reduction
The trust has reduced its rate of c-sections by one-fifth. A 5.4% reduction equates to 162 c-sections fewer than in the previous year. Taking the c-section without complication cost of £2,198 this generates a cost reduction of £356,076 but must be balanced with the costs of an alternative method of delivery, which, if we assume is normal birth without complications at a cost of £996, would cost £161,352 for the 162 births.

So actual cost saving is £356,000 minus £161,000 = £194,724
Key themes and methodology

Using SBAR to improve communication
A key change in Blackpool has been the introduction of the patient safety tool: Situation, Background, Assessment and Recommendation (SBAR). Derived from the aviation industry, SBAR is a structured method for communicating critical information that requires immediate attention and action.

The trust has developed an SBAR board on which midwives and obstetricians write information relevant to each woman in the delivery suite. It provides a structured system for communicating, particularly amongst multidisciplinary teams and it gives more junior staff a vehicle for making themselves heard in a way that everyone will listen to. The system was adopted over the August bank holiday in 2009. Initially, it was greeted with some shock and scepticism. Within 12 hours everyone was on board and no-one wanted to go back to the previous system.

Find out more at:
www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_situation_background_assessment_recommendation.html

The NHS Institute Safer Care webpage (www.institute.nhs.uk/safer_care/safer_care/sbar_resources.html) features resources on SBAR including SBAR presentations, prompt cards, posters and an e-learning module.

Further information available from the NHS Institute website

Improvement tip

SBAR: Situation, Background, Assessment, Recommendation

SBAR is an easy to remember method that you can use to frame conversations, especially critical ones, requiring a clinician’s immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety. The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition. The tool helps staff anticipate the information needed by colleagues and encourages assessment skills.

Using SBAR prompts staff to formulate information with the right level of detail.
“The SBAR board gives us an easy way of identifying which women are likely to require intervention or review and who is high and low risk. The scheme has now been extended to handover between shifts and between wards as it provides a consistent way of communicating which everyone understands. Other parts of the hospital are following maternity’s lead and adopting SBAR as a communication tool.”

Dr June Davies
Consultant obstetrician

“This has only become possible as a result of cultural change. No one department can change the culture of an organisation; it must be led from the top.”

Nicola Parry
Consultant midwife
Case study: Luton and Dunstable Hospital

Top to bottom culture change delivers outstanding results

When c-section rates peaked at 31% in April 2009, it was a wake-up call for Luton and Dunstable Hospital’s maternity department. A year later, rates are averaging around 22% – well below the national average. The hospital has achieved this through top to bottom cultural change and a commitment to normalising births.

Setting the scene
The trust has approximately 5,500 babies born each year and had a c-section rate of 31% in April 2009.

The approach
The trust introduced a midwife lead for normality, to champion normal birth with staff and pregnant women and developed a birth option clinic for women who had previously had a c-section.

Normality study days were designed for community staff and ‘skills books’ created for maternity care assistants which detailed training and competencies for each individual.

“Luton is a deprived area and we had lost our focus on normal birth due to the large numbers of high risk women coming onto the unit. Since 2009, we have succeeded in turning that around with a change in culture towards making birth a normal experience. Women now remain under the care of a midwife throughout their pregnancy unless there is a good reason to do otherwise.”

Katie Chilton
Delivery suite matron
How they did it

“Like all hospitals, we were concerned by the rising c-section rate,” says head of midwifery, Helen Lucas. “We are a level three neonatal unit and there was generally a perception among staff that this made us a ‘high risk’ unit. In 2008, we started using the maternity dashboard to give us a month-by-month picture of the number of c-sections taking place. The following year, we employed a midwife to lead on the normalising agenda. Since that time, there has been a drive to change attitudes and behaviours. We are now seeing c-section rates coming down and normal deliveries, particularly VBAC (vaginal birth after Caesarean) rising significantly.

“We have introduced a daily multidisciplinary review meeting to look at all of the deliveries over the preceding 24 hours and staff at every level are encouraged and empowered to speak out and give their opinion – even challenge senior staff,” she continues.

Consultant and lead obstetrician, Bright Gympoh, has acted as a champion for the normalising births agenda. He believes this is the key to achieving organisational change. Bright comes from Ghana, where Caesarean sections are rare and he was disturbed by the rising rate of c-sections when he joined the hospital 12 months ago. “My advice to anyone embarking on this type of work is to get a midwife who is keen on normal births together with an equally keen consultant and leave them to drive any changes,” he says.

Midwife Heidi Beddall trained within a low risk unit and joined Luton and Dunstable to gain experience of working in a high-risk environment. When the post of midwife lead for normality came up, she was keen to go back to her roots and pursue her passion for normal birth. She has been instrumental in introducing a range of training and support initiatives, including a birth options clinic for women who are requesting a c-section after a previous section or a traumatic birth experience. “Women come along to the clinic after they have seen the consultant if they are requesting a c-section,” says Heidi. “We discuss all of the issues and talk about the physical, social and emotional impact of different birth choices. Even if women don’t ultimately choose a VBAC, I want them to feel fully debriefed and counselled before they make their birth plan.”

While it is impossible to measure the impact of this work on every woman’s experience, feedback has been extremely positive. In a recent audit, 80% of women who had spoken to Heidi or Bright about their birth choices went on to attempt a VBAC and around half were successful.

“I can pick up the phone to Heidi at any time if I have a question and I know I can refer any woman to her for support in normal birth.”

Marianne Musemeci
Midwife
Luton and Dunstable has been careful to ensure that its philosophy on normalising birth extends to every staff level. Training is provided for maternity care assistants, coordinated by senior midwife, Karen Billington. “We want maternity care assistants (MCAs) to feel part of the team and to be involved in discussions about normalising birth,” she says. “MCAs are the first point of contact for women coming onto the unit and they set up the rooms for birth, so it is important that they understand the impact of the birth environment on outcomes and are fully on board with the idea of normalising birth. As well as training MCAs on how they can help women to have a normal birth, we make sure they understand the nature of emergencies so they can respond appropriately when a situation is urgent. Now, when we receive thank you cards they often mention the MCA by name and thank her for the care she gave.”

All maternity care assistants are given information cards when they join the hospital explaining terminology and providing a list of key contacts and telephone numbers. Karen introduced the concept of skills books for maternity care assistants from elsewhere in the hospital. The books provide detail on training and competencies for each individual.

Community midwives are also regarded as crucial to promoting normal births and can now attend normality study days, held on Saturdays. “Normality starts in the community,” says Helen. “It’s important that community midwives feel supported.”

New mum Charlotte Barnett recently had a successful VBAC, thanks to the support she received from Heidi and her team. “My first baby was 9lb 11oz and was delivered by emergency Caesarean,” she says. “I assumed my next baby would be big and I didn’t think I could have a natural birth. Heidi said she could coach me and I kept in contact with her throughout my pregnancy. She even came with me to see the consultant. She showed me how to get the baby into the right position, how to cope with the contractions and what positions would help me to have a normal delivery. Robert came within 50 minutes. It was a good experience. I wanted to have a natural birth for the health of the baby and I was home the same afternoon. The baby was relaxed because I was relaxed.”

More improvements are planned, including a pre-birth clinic, which will advise women on the process of early labour and provide information on self-care. In May 2010, a new midwifery-led birthing unit will open, providing four ensuite rooms and a birth environment geared towards normalising birth.

“This is what midwifery is all about,” says Helen. “Giving birth is natural.”

“I am proud of the fact that we have built a fantastic team and everyone is working together much better than they did a year ago. We have successfully implemented and maintained the daily review meeting and we now run a regular birth options clinic, which will soon be expanded to cover pre-natal care. It has been absolutely fantastic – this is a great place to work.”

Bright Gympoh
Consultant and lead obstetrician
Local results

Impact on quality of care
80% of the women who attend the birth options clinic to discuss their birth choices went on to attempt a VBAC and around half were successful.

The unit plans now to open a pre-birth clinic, designed to advise women on the process of early labour and encourage self-care.

Impact on patient experience
Women now have a wider range of options and more information to make a choice that is right for them.

They also have greater opportunity to discuss their concerns with staff.

Impact on staff experience
The trust focused on improving staff skills through targeted training programmes, including normality study days for community midwives, which are held on Saturdays to improve access.

In addition, all maternity care assistants are given information cards explaining terminology and providing a list of key contacts and telephone numbers. Skills books provide details on training and competencies for each individual.

Return on investment calculation
Costs of the following inputs were calculated for the project: staffing for the birth options clinic; daily case note review sessions; and normality study days. Impact costs were calculated in terms of money saved as a result of more babies being delivered by normal birth rather than by Caesarean section. For every £1 spent Luton and Dunstable generated £1.11 of benefits over a year. This calculation does not take into account the additional quality benefits that have not been monetised including mothers’ increased satisfaction with care nor any additional costs incurred in community midwifery.

Further information available from the NHS Institute website
Key themes and methodology

Learning from human factors
Luton and Dunstable hospital has introduced learning from human factors as part of the drive towards safer birthing and promoting normality. This approach recognises that the majority of substandard care can be attributed to human factors. The trust uses a range of communication tools, particularly SBAR (situation-background-assessment-recommendation), to ensure that everyone on the team feels able to speak out in the interests of patient safety. Work at the trust focusing on human factors is in its infancy but is already contributing towards a change in culture.

Human factors encompass all those factors that can influence people and their behaviour. In a work context they are the factors relating to the work environment, the job itself and the organisation and the individual characteristics which influence people’s behaviour at work.

Healthcare professionals are human beings and, like all human beings, are fallible. In our personal and working lives we all make mistakes in the things we do, or forget to do, but the impact of these is often non-existent, minor or merely creates inconvenience. However, in healthcare there is always the possibility that the consequences could be catastrophic. It is this awareness that often prevents incidents as we purposefully heighten our attention and vigilance when we encounter situations or tasks we perceive to be risky.

Some of the common human factors that can increase risk include:

• mental workload
• distractions
• the physical environment
• physical demands
• device/product design
• teamwork
• process design.


Visit the NHS Institute or Patient Safety First websites for a video of a story which illustrates human factors issues. In ‘Just a Routine Operation’, Martin Bromiley, an airline pilot, discusses his personal experience of healthcare.

Other sources of information
“Human factors are all the things that make us different from logical, completely predictable machines. How we think and relate to other people, equipment and our environment. It is about how we perform in our roles and how we can optimise that performance to improve safety and efficiency. In simple terms it’s the things that affect our personal performance.”

Clinical Human Factors Group (CHFG)
http://www.chfg.org

“We have introduced a daily multidisciplinary review meeting to look at all of the deliveries over the preceding 24 hours. Initially, the idea was greeted with some scepticism as people expected it to be all about blame, but we use a human factors approach to say ‘what did we do well?’, ‘what could we have done better?’ and ‘if we encounter this situation again, what would we do differently?’ Staff feel empowered and happy to come to the meetings. The hierarchy has diminished and junior staff are happy to liaise with senior colleagues. I was delighted when a junior colleague spoke out and corrected me recently. We are also using human factors to interpret CTGs in a more uniform way.”

Bright Gympoh
Consultant and lead obstetrician
Case study: Stockport NHS Foundation Trust

Empowering clinicians to optimise opportunities

Stockport NHS Foundation Trust has a strong tradition of working to promote normality in childbirth. In 2008, the trust began focusing on reducing the rate of Caesarean sections focusing on building confidence and support in women who had previously had a c-section.

Setting the scene

The trust had 4,000 births a year, with a c-section rate of 24%. The trust was chosen as a pilot site for the NHS Institute’s Focus on Normal Birth and Reducing Caesarean Section Rates toolkit.

The approach

Stockport established its first service users’ forum to involve parents in developing services. These developments include:

• a weekly VBAC clinic after women’s 20 week scan
• VBAC workshops where women talk about their experience and answer questions
• a post-natal debrief in response to feedback
• a ‘Choices’ DVD, outlining delivery options for women, now available on the trust’s website
• facilitated ‘time-out’ sessions for delivery suite coordinators.

In addition, the trust hold a weekly audit of c-sections and a daily review of emergency c-sections to monitor what is happening in real-time. The trust set a target for 20% of births to take place outside the delivery suite by March 2010.

“Like everywhere, our c-section rate was rising and in 2007 we decided this was a good time to go back to basics and look at how we were supporting women in achieving a normal birth. We introduced a Normal Birth campaign looking at parent education. The programme was changed to include an active birth workshop for all parents and we established a triage system to encourage women to stay at home in early labour. When the NHS Institute for Innovation and Improvement introduced its Focus on Normal Birth and Reducing Caesarean Section Rates toolkit, we were delighted to be chosen as a pilot site. We chose to focus on VBAC as we have always been keen to avoid unnecessary interventions and to allow women to give birth as they are designed to.”

Julie Estcourt
Head of midwifery
How they did it

Women who have undergone a c-section are less likely to give birth naturally in future pregnancies, even when the pregnancy is normal. Maternity staff at Stockport recognises these women often simply need support and information to have a natural birth.

One of the trust’s first actions was to establish a weekly vaginal birth after Caesarean (VBAC) clinic, giving women the opportunity to talk face-to-face with either a consultant midwife or obstetrician. “Women who have had a previous Caesarean have a lot of unanswered questions and, often, a high level of anxiety,” says consultant midwife, Debbie Garrod. “We were keen to introduce a service that would allow them to talk about what had happened and to make a plan for their next delivery. We offer parents the opportunity to come to a VBAC workshop, which focuses on practical preparation for birth, but we find that many women, and often their partners, need the opportunity to sit with someone face-to-face and tell their story. We make sure that the woman either talks to a supervisor of midwives or consultant so that we can support her if she requests care outside normal guidelines.

“This is a very powerful process and the women often say they feel better just to be able to talk about what happened to them in their last pregnancy,” adds Debbie.

Women attend the clinic at between 20 and 24 weeks of pregnancy and the discussion is documented in the medical notes using a pro forma. Consultant obstetrician, Claire Candelier says: “It is useful for women who may be worrying about their birth options to be able to come to the clinic some time after their 20 week scan. Previously, discussions didn’t take place until around 36 weeks which was too late. Depending on the complexity of their previous c-section, either Debbie or I spend half an hour with each woman, asking her to identify her issues. Our role is to give her the right information and to offer reassurance. We send a letter to the woman’s GP summarising our discussion.”

After being seen in the VBAC clinic, women and their partners are invited to attend an evening VBAC workshop where they can hear women talk about their own experience and answer questions. “When I had my second pregnancy, I wanted to deliver normally,” says Claire Blankley, who leads the workshop. “I was given the opportunity to talk to midwives and clinical staff but what I really would have liked was to talk to someone who’d been through that experience. It’s great to feel that I am helping, and this section of the evening is generally evaluated highly by the women who come along.”

The trust is now developing a post-natal debriefing in response to feedback from the VBAC work. Staff have collaborated with service users to design a letter that will go out to women who have had a c-section, with a copy sent to the GP explaining the reasons for the intervention. It has been important to get the language right, replacing medical terms with user-friendly language, translating terms like ‘failure to progress’ into ‘slow progress in labour’.
The team is analysing the number of inductions of labour in relation to the number of c-sections and, from this, agreeing to review and update the guidelines on induction. A new service users’ forum held a series of five ‘talkback’ events, including events for fathers, teenagers and members of the Muslim community. Among the suggestions from the events were that all women should be given the contact details of their own midwife to overcome occasional problems in getting through to the triage department, and that information should be made available online for women to download when they want it.

Stockport maternity service places a high priority on promoting choice regarding the place of birth, including home and birth centres for ‘low risk’ women. There are two birth centres and a delivery suite for higher risk deliveries. VBACs take place in the delivery suite and some women are making informed choices to use the pool for labour and birth following a previous c-section. The team set a target for 20% of births to take place outside the delivery suite (i.e. in the birth centre or at home) by the end of March 2010 and is close to achieving this.

Since choosing to focus on the VBAC pathway, the work being done in Stockport to normalise births has broadened out to encompass all aspects of the maternity service. In fact, planning for VBAC now starts with the letter that will go out to women immediately after a c-section. Debbie comments: “Using women’s stories to go back and explore what you are doing is far more powerful than any audit. It makes you wake up. The working relationship between midwives and obstetricians is key. You need the right interventions at the right time. As we take this work forward, working in partnership will be the most important contributor to our ongoing success.”

“In normalising births, it is important to start at the very beginning as we have done and to look at the core basics,” adds Julie. “Fundamentally, that’s what is at the heart of good midwifery.”

“We recognise that this needs to be a multidisciplinary approach, involving everyone who has contact with pregnant women. A chance comment can make all the difference to a woman’s confidence in her ability to deliver normally, so we all need to do whatever we can to build the parents’ confidence.”

Debbie Garrod
Consultant midwife
Local results

**Impact on quality of care**
Women are more prepared for their birth experience.

The VBAC service is being evaluated and audited, from local data resource Euroking, along with feedback from parents.

There is an increased opportunity for homebirth.

**Impact on patient experience**
Women are invited to attend a weekly VBAC clinic following their 20-week scan to help reduce any anxiety.

The trust set up a service user’s forum to feedback and learn from women’s experiences.

Using more simple language enables women and their families to understand complex information.

**Impact on staff experience**
Staff morale has improved as they become confident that they are providing a high quality service.

**Impact on cost reduction**
The trust continues to monitor the c-section rates and although it has not yet recorded a drop in the rate it is confidence that the improvement is continuing to have an impact on patient experience and on the quality of care they provide.
The power of women’s stories

Stockport maternity service promotes choice regarding the place that women would like to give birth, including home and birth centres for ‘low risk’ women. Key to their improvement work has been listening to women talk about their experiences, which provides insights into how things can work better. Staff recognised that often women and their partners simply needed to sit face-to-face with someone and talk about their previous experiences and their concerns for future birth.

In designing the new birth centre, the team spoke to women to get their views on the physical design and the pathway through the unit.

It goes without saying that childbirth should be viewed as a positive experience, with no unnecessary interventions, where the women and family feel empowered in making decisions with support from staff.

One of the ways that can help to achieve the above is using the actual experiences of women and their families to design services and care environments.

Stockport used the Better Birth Environment Toolkit when improving their birth environment for women and families. The toolkit enables staff to research women’s perspectives on their local birth environments and to benchmark feedback against a UK wide survey on what women said was important to them.

The NHS Institute’s ebd approach (experience based design) provides a method for working with patients and staff to capture and improve their experiences. For more information, see:

http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_(experience_based_design).html

Healthcare organisations have demonstrated that they have significant skills in improving the performance and reliably of services but they have not always placed equal focus on the aesthetics of experience – how it feels to use or be part of the service. The ebd approach provides the opportunity to build on previous successes by focusing more attention on this third component – the experience of care.
“This is the first time we have systematically involved service users and we are very pleased with the results. As well as suggesting minor improvements they have played a key role in redesigning the birth centre using the National Childbirth Trust’s ‘Better Birth Environments’ toolkit. It is a really homely environment with subdued lighting, birthing balls and beanbags. Women are encouraged to mobilise and the bed is no longer the primary focus of the room. We have three birthing pools, as well as one on the delivery suite.”

Mandy Green
Delivery suite coordinator
Case study: Western Sussex Hospitals NHS Trust

Reclaiming birth for women and midwives

The Western Sussex Hospitals NHS Trust has increased its rate of successful vaginal births after Caesarean section (VBAC) by more than 300% and continues to reduce its overall Caesarean section rate through a wide-ranging programme designed to normalise birth.

Setting the scene

In 2007, the trust had a c-section rate of 27% and a rate of vaginal births after Caesarean section (VBAC) of 26%.

The approach

A new birth centre for low risk births opened in 2009 at St Richards Hospital in Chichester.

The trust was an early adopter site for the NHS Institute’s Focus on Normal Birth and Reducing Caesarean Section Rates toolkit, identifying VBAC as their priority pathway. This led to the introduction of the VBAC lead and midwife counsellor role.

Every woman who leaves hospital following a c-section is given a letter explaining the reasons for the intervention and outlining her choices for next time. The birth afterthought service provides women with a telephone number for support from the midwife counsellor.

Other improvements in care include a new weight management in pregnancy clinic for women with a raised BMI, and an initiative inviting service users to ward rounds so staff can hear, firsthand, what women are saying about their experience. COOS Cards: The trust added a section for comments on its service cards and this information is fed back to staff.

A band five midwives’ ‘club’ provides staff development through protected time for study days and a more robust preceptorship programme.

“I am delighted that normalising birth is one of the High Impact Actions. It puts the focus back onto making services safe and pulls back the over-medicalisation of birth. It has put maternity onto the agenda at last and reclaimed birth for women and midwives.”

Carole Garrick
Head of midwifery
How they did it

When the newly merged Western Sussex Hospitals NHS Trust opened a new birth centre for low risk births in 2009, it was the ideal opportunity to focus on normalising births. The trust introduced a wide range of improvement measures focusing on the experience of women using the service.

The trust has increased its rate of successful vaginal births after Caesarean section (VBAC) from 26% in 2006 to 84% in 2009. Overall, c-section rates have come down from a peak of 27% in 2007 to 25% in 2009, and the numbers are continuing to fall.

The new birth centre at St Richards Hospital in Chichester was developed in consultation with service users, and has two birthing pools and an environment to encourage normal birth, including Bradford birthing couches and mood lighting. Community midwives work alongside hospital midwives, enabling them to bring their experience of home birthing onto the unit, and staff wear everyday clothes rather than uniforms. Alongside the birth centre sits a consultant-led unit, which also has its own birthing pool. The hospital recently reported its first successful VBAC in the pool for a woman who had previously had twins by c-section.

“Two or three years ago, this unit was threatened with closure,” says consultant obstetrician and gynaecologist, Matthew Jolly. “However, following the appointment of a new head of midwifery and the refurbishment of the labour ward, we were given the opportunity to redesign the service for women. We have recruited more consultants with a profound interest in obstetrics but who are also competent gynaecologists. We have introduced a day assessment unit where we can see women with antenatal problems. And we have developed an open culture, with shared ownership of problems and challenges. There is still more to do but we have made a positive start. The key is to take a holistic approach, looking at both the culture and the organisation of the service.”

“How, every woman who leaves hospital following a Caesarean is given a letter explaining the reasons for it and outlining her choices for next time,” says Annie Hamilton, the VBAC lead and midwife counsellor. “This begins the normalisation process even before her next pregnancy. In addition, we have introduced the birth afterthought service. Women are given my telephone number as part of their post-natal information and they, or their partners, can ring me at any time to discuss the birth experience. I am a trained counsellor and, alongside their GP and health visitor, I can support women who may be suffering from post-partum post traumatic stress and discuss their future birth options.”

Healthy women who would like a VBAC are not required to attend a hospital clinic unless they reach 41 weeks of pregnancy without going into labour. A daily handover meeting now takes place on the labour ward, providing an opportunity for the team to review all of the c-sections from the preceding 24 hours. Midwife Anita Clarke says: “The meetings are an opportunity to make sure we are evaluating our practice and that everyone is following the guidelines correctly. We all have a voice: the consultants and registrars are happy for the midwives to have an input; there is a lot of respect on both sides. It is a better place to work and I feel as though my opinion is valued.”
The trust has also changed the competency pathway to improve skills training for newly qualified midwives. “We have revised our competency document so the focus is on normalising birth,” explains clinical skills facilitator Jill Hutchings. “In addition to medical skills, such as cannulation and suturing, we want our midwives to develop competencies in water birthing and normalising birth as part of a more holistic approach to childbirth. Initially, some midwives were in awe of the process of normal birth, while others thought they didn’t need any of this information. Now, they are elated by the process. It is all about enabling midwives and banging the drum for normal birth long and loud enough so that people will listen.”

Practice development midwife Sarah Bolger invited normal birth champion, Dennis Walsh, to speak at a recent two-day training workshop attended by 40 midwives, doctors, paramedics and neonatal staff. “The challenge in this type of training, which is not mandatory, is in motivating people to attend,” she says. “Everyone wants to give the best care they can and by showing them how much better their working environment would be if we could facilitate normal birth, we demonstrate that it is in the best interests of both staff and service users to promote normality.”

Obesity is one of the biggest risk factors linked to maternal morbidity and poor outcomes. Community midwife, Lisa Cosgrove helped to establish a weight management in pregnancy clinic for women with a raised BMI. “Initially, it was quite a negative experience for women coming for their 15-week appointment to be told they have a raised BMI,” says Lisa. “Now, we are doing something more positive. Women are invited to come along and receive advice on diet and exercise, as well as being given guidelines on what is a safe level of weight gain during pregnancy. Women with a BMI over 30 have an increased risk of diabetes and women with a BMI over 35 are more likely to have a c-section, so this is contributing to the normalisation agenda at the same time as making women healthier and improving their birth outcomes.”

“We are committed to normalising all births, even those that are considered high risk. Ours was one of the first high risk labour wards to install a birthing pool and we are all delighted by the recent successful VBAC using it. The consultant-led delivery suite offers the same type of care as is available in the birth centre, but with additional back-up, if required.”

Kelly Pierce
Senior midwifery manager

“The involvement of service users is crucial. Often, women will get involved in the maternity services liaison committee when they have experienced a problem themselves. We want them to performance manage us and let us know how we’re doing.”

Carole Garrick
Head of midwifery and associate director
Local results

Impact on quality of care
The trust increased its rate of successful VBAC from 26% in 2006 to 84% in 2009. Water births now account for 5% of all births and c-sections reduced by 2% and are continuing to fall.

Impact on patient experience
There is much greater emphasis on normal birth, particularly following a Caesarean section and women have a greater range of birth environments to choose from. Women can attend ward rounds so they can hear, firsthand, from other women about their experience. They also have access to a midwife counsellor who can provide debriefing and support following a traumatic birth experience.

Impact on staff experience
Staff can gain additional feedback from women through a new comments section on comments on our services (COOS) cards and have access to a range of training and development opportunities focused on normalising birth.

Impact on cost reduction
A 2% reduction in c-section rates equates to savings of £96,285.80 per annum. These savings are set against the high capital costs (new birth centre and labour ward refurbishment) in year one, which together with staff costs are greater than the 2% saving in c-section rates. However, these capital costs will not recur in year two and assuming equivalent staff costs and c-section reductions for the second year these High Impact Actions move toward a positive return on investments. There are also benefits that it has not been possible to monetise within the model such as increased home births and VBAC, plus earlier discharges for those who have hospital births.

Further information available from the NHS Institute website.
Focusing on both the culture and the organisation of the service was the key to success for the team. Using normalising birth as the driver, the team worked on changing the culture and on how they organised services.

By prioritising the VBAC pathway, the trust was able to discuss the principles of care in the management of their patients. One of these new processes was a discussion and a post-discharge letter given to women following a Caesarean, which explained the reasons for the c-section and outlined her choices for her next birth. This was seen as an important step to ensure women had the right information about the event of their labour and birth and how these may affect their future births, including the possibility of a VBAC. This might be seen as a fairly minor change – but it gave the clinicians the opportunity to use their skills and experience to support women and, hopefully, increase the likelihood of a vaginal birth in the future.

Looking at both the culture and organisation of services is not easy, but the NHS Institute’s self-assessment workshops that will help maternity services to explore their current practices relating to c-section and help the team work through changes in culture and behaviours and processes what are the cultures, behaviours and processes for your future services. The tool also outlines a pathway of organisational characteristics where changes in culture and practice might have the greatest benefit in reducing c-section rates. Each pathway lists the principles of care underlying each stage of a women’s progress through it and illustrates the behaviors and practices that trust’s believe have contributed to their success.

NHS Trust used the NHS Institute’s Delivering Quality and Value Pathway to Success a self-improvement toolkit: Focus on normal birth and reducing Caesarean section rates. In the toolkit, there are 3 clinical pathways: keeping first pregnancy and labour normal, vaginal birth after Caesarean (VBAC), elective Caesarean section. The tool also outlines a pathway of organisational characteristics where changes in culture and practice might have the greatest benefit in reducing c-section rates.

Improvement tip

Further information available from the NHS Institute website.
“Women now feel that they can exert more choice and tell us what they would find helpful. The dialogue between us has improved. It is all part of a wider approach to monitoring the effectiveness of care, which includes talking about performance, involving doctors and midwives in audits and analysing and acting on statistics.”

Carole Garrick
Head of midwifery and associate director
How to measure...Promoting normal birth

The national picture

National statistics concerning the method of delivery are published yearly by the Information Centre using Hospital Episode Statistics (HES) however HES data can be unreliable for mode of birth because it misses out births in the catchment of a maternity service that occur outside hospital. Maternity services usually keep detailed statistics from an information system or manual recording based on birth registers. Comparator information can be obtained from the annual returns to the Royal College of Obstetricians and Gynaecologists and from the LSA annual reports published for each SHA. The Care Quality Commission is currently monitoring maternity data quality.

Hospital episode statistics Link:
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1024

Please note that Operating Procedure Codes (OPCs) and Healthcare Resource Groups (HRGs) two coding system used in hospitals are differently defined and are not interchangeable.

How is normal birth defined?
The Information Centre (IC) defines a normal birth as: “A normal delivery is one without induction, without the use of instruments, not by Caesarean section and without general, spinal or epidural anaesthetic before or during delivery. Procedures related to assisted deliveries are excluded, except repair of laceration.”

Although the above defines a normal birth if a Caesarean section is replaced by an assisted birth or by a spontaneous vaginal birth even if any of the exclusions above are not met, it is seen as a success, even if not the gold standard.

What is an “unnecessary” Caesarean section?

A c-section is ‘unnecessary’ if it is unlikely to provide any benefit to mother and/or baby. At the point of deciding on an emergency c-section, very few operations are ‘unnecessary’. However, there are ways in which we can avoid reaching that decision point.

- Selective use of admission Ctg (% low risk women who have admission Ctg)
- Skills in assisted birth (% assisted births)
- External cephalic version services (% singleton breech where ECV was attempted)
- Timely use of oxytocic drugs (women with ‘delay in labour’ that was diagnosed and treated according to NICE guidelines).

Elective c-sections may be considered ‘unnecessary’ when they are performed in the absence of a medical indication or for reasons outside the parameters of best clinical practice.
How might normal births be recorded and measured locally?

Normal birth registers in birth units collect normal birth information via local information systems; however, you may also want to measure some process measures as well:

- % of women who contribute to their birth plan
- % of clinical staff who are aware of monthly c-section rates and trends

Measures you might consider for VBAC:

- % women giving birth vaginally who have had (one) previous c-section

Interim measures for VBAC:

- % of women who have had (one) c-section choosing VBAC at time of booking
- % of women who have had (one) c-section choosing VBAC at 37 weeks’ pregnancy
- % of women who receive a verbal debriefing within 48 hours of c-section
- % of women who receive written information within 48 hours of c-section.

Measure when making improvements

If you are starting to work on increasing normal births and reducing c-sections, you should begin by looking at what you are already measuring, and also what other teams in your department or organization may be collecting, so that you save time and use existing systems if they are appropriate. Use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting around pressure ulcers and to understand gaps where you might need to collect extra information.
Important choices
- where to die when the time comes
Introduction

The aim: to increase the numbers of people who are able to die in the place of their choice and avoid inappropriate admission to hospitals.

A practical summary

Improvements in medical interventions and treatments are advancing at a great pace, which means that populations are living for longer.

The Gold Standards Framework (2004) states that many people who are nearing the end of life, or who are known to need end of life care, are admitted to hospital rather than supported to die at home. The National Care of the Dying Audit (Marie Curie Cancer Care; 2007) notes that 55% of people with cancer would prefer to die at home but in fact only around 25% actually achieve this wish.

Sometimes, in our society, we still find it hard to talk about the subject of death. However, unless we discuss issues around the care of the dying, the NHS will not be able to respond to the challenge of reducing the existing level of variation in the care it currently provides and therefore it will not be able to improve the experience of patients and their families at this very important time.

The problem

Around half of the annual 500,000 deaths in England currently occur in acute hospitals, with people spending an average of 18 days as inpatients during the last year of their life, often spread over several admissions. Research suggests that 40 per cent of those who die in hospital have no medical need to be there (National Audit Office; 2008b).

This is not only expensive but also is often inappropriate and unsatisfactory for patients and their families. Indeed, approximately half of all complaints made to acute trusts relate to an aspect of end of life care.

People in the UK are now living longer which means that people increasingly have more complex care needs at the end of life. Of the half million people who die each year in England alone, two-thirds, around 350,000, are over 75 years old. In addition, the ability for people to choose where they die varies across the country. This is often influenced by factors such as where people live and the medical conditions they have.

The cost

An ageing population means that the number of deaths each year is expected to increase and, with it, the cost. For cancer patients alone, the National Audit Office (NAO) calculates that, by reducing hospital admissions by 10% and the average length of stay by three days, £104 million could be redistributed to meet people’s preferences for where they want to be cared for at the end of life. For patients with organ failure the NAO has made a similar calculation, which has the potential to release £67 million.

Economic modeling for the NAO by RAND Europe (2008) reports that palliative care hospital bed days are more expensive for the NHS than home care: hospital care = £222 per day; community care (own home or nursing home) = £28 per day.
A subsequent analysis of Marie Curie Nursing Service data estimates a £2 saving for every £1 spent on home palliative and supported care (cited in RAND Europe 2008).

**What we can do**

Preparation is vital to getting end of life care right and to providing a seamless service for people and their families. Identifying people who are nearing the end of life is vital to unlocking the end of life pathway. Being able to discuss end of life care issues while patients are ‘well’ enough can greatly enhance their experience and that of their loved ones by helping them at this stage. Discussions with patients should include anything the person thinks is important including decisions about preferred place of death and do not attempt resuscitate (DNACPR) orders. Practical aspects such as providing equipment and anticipatory medication can be key to making the patient’s journey easier and avoiding crisis calls and emergency hospital admissions.

Community nursing teams already carry out a lot of end of life care – recognising this and providing support and robust systems to help provide care that is important. All staff working with people at the end of life need good levels of support to maintain high morale, which is key to reducing staff turnover and ensuring that patients receive a high quality service.

We need to expand the current focus of end of life care beyond cancer. The organisations featured in the case studies within this section include people who have long-term conditions and dementia and are planning for the end of their life.

**The case studies**

*Community Health Oxfordshire* worked with Sue Ryder, a specialist palliative organisation within the third sector, to develop a shared specialist central role: a community matron for supportive and palliative care.

*NHS Leeds Community Healthcare* has introduced a service delivery framework for integrated end of life care. The district nurse plays a pivotal role in providing end of life care, supported by a flexible and responsive continuing care service, which provides complex and palliative care.

*Solihull NHS Care Trust Community* ensures that patients who want to die at home are given every support, focusing on anticipatory drugs being ready and available to relieve symptoms if they are needed.

“I love my job and at the end of each shift I feel that I have accomplished something worthwhile and have learned something new every day.”

Joan Shaw
Healthcare assistant, Leeds
Where are the best sources of information?

NHS End of Life Care Programme www.endoflifecare.nhs.uk

Marie Curie Delivering Choice Programme deliveringchoice.mariecurie.org.uk

The National Council for Palliative Care www.ncpc.org.uk/

Liverpool Care Pathway for the Dying Patient (LCP) www.mcpcil.org.uk/liverpool-care-pathway/

Gold Standards Framework (GSF) www.goldstandardsframework.nhs.uk/

End of Life Care section on Department of Health website www.dh.gov.uk/en/Healthcare/IntegratedCare/Endoflifecare

NICE Supportive and Palliative Care Guidance www.nice.org.uk/guidance/index.jsp?action=byID&o=10893

Department of health - End of Life Care Strategy Promoting high quality care for all adults at the end of life (Department of Health) http://www.cpa.org.uk/cpa/End_of_Life_Care_Strategy.pdf
Case study: Community Health Oxfordshire

Getting it right
Community Health Oxfordshire worked with Sue Ryder, a specialist palliative organisation outside of the NHS, to develop a shared specialist central role: the community matron for supportive and palliative care. This role supports people with complex needs during acute episodes, with particular focus on long-term conditions.

Setting the scene
The primary care trust (PCT) wanted to reduce admissions and looked at creating a new role which would help them to achieve their ambition but recognised the need for support from a specialist organisation.

The focus of this role is for those patients who are frail, may have multiple long-term conditions and health issues and need to be supported to continue to live at home.

The approach
Community Health Oxfordshire developed a specialist community matron role to provide supportive and palliative care. The role was piloted in 2006 and jointly funded by Sue Ryder and the PCT. Following its extensive success, it was made permanent in 2009.

The PCT reviewed existing end of life care services and identified a number of areas for improvement. The community matron now provides a comprehensive end of life care advice service throughout the county and is also supported by the local hospice.

Patients are referred from a variety of sources including the acute trust, specialist nurses, the respiratory team, community hospitals and from speech and language therapists.

The role consists of clinical, training and strategic elements and helps to build links between the primary, community and acute sectors and with social care and other organisations.

“We don’t think emergency care interventions are the best interventions for people at the end of their life.
“There are 6,000 emergency admissions for patients in the last year of their lives - some patients have many, many admissions, as many as 20 and have long-term conditions. What we must do is make sure these patients have got pathways of care as patients without malignancies.”

Val Stangoe
End of life care services development manager in commissioning

“We can’t make them better we can’t cure them, but we can support them where they want to die.

As a district nurse, I felt the support wasn’t there and the equipment wasn’t there and family couldn’t cope and the patient had to go to hospital. For relatives there is a huge bereavement issue if they feel they have let their loved one down.

We should be able to get it right - why can’t we?”

Liz Clement
Community matron for supportive and palliative care
How they did it

Community matron Liz Clement has a unique role within end of life care.

Liz Clement took on the role of community matron for supportive and palliative care in 2006 as a pilot jointly funded by Community Health Oxfordshire and the Sue Ryder hospice. It was made permanent in 2009.

Liz’s background as a district nurse and Gold Standard Framework (GSF) facilitator made her a good choice for this unique role. As a district nurse she had experienced the frustrations of providing end of life care in the home first hand. As a GSF facilitator and end of life lead, she had a wider grasp on the complexity of end of life care for those with long term conditions. This new dual role traverses the divide of NHS services and those traditionally provided by the local hospice.

Her responsibilities include prescribing of medicines, providing frontline clinical care, providing expertise and education, and working in partnership with a range of organisations. She has an active clinical caseload, covering South Oxfordshire, works in an advisory capacity in the north of the county, and provides strategic advise within the local primary care trust.

“The acute sector is extremely busy and their core role is to provide treatment and care for people who are admitted with an acute illness or episode of their long term condition. In this setting the knowledge required about the patient’s home setting or local services is not always available. A major aim of Liz’s role is to coordinate a range of support for patients and their families in order to prevent unnecessary admissions to hospital; in addition to this Liz often see patients in hospital who want to go home and she is able to coordinate their discharge as rapidly as possible.

“I feel privileged that I do the job I do,” she admits. “It’s very rewarding to have the ability to put everything in place to make sure someone gets home and you know that without your input that may not have occurred.”

Vital to Liz’s success is the support that she receives through a special relationship with the local hospice. “If I visit a patient and need further advice, I can contact a consultant to discuss things. This support reduces the isolation I would have felt otherwise as the only community matron in this area,” she admits.
Achieving a diagnosis of dying can be complex, particularly in non-cancer patients, says Dr Maeve McKeogh, consultant in palliative care, based at the Sue Ryder Nettlebed Hospice. “It involves a full assessment of that person to establish whether we are at the point where the side effects of the illness and any treatment are worse than the benefits.” she says. “At that point the medical input is very important. We have to ask ‘is this patient on the right pathway?’.

For example, someone with cardiac failure can be extremely unwell, get treatment and go home again but at the next admission they might not make it. So should we be looking at alternative ways of managing this? It’s about making sure that people have all the options.”

Alongside her clinical caseload, Liz is reviewing existing services and identifying areas for further improvement. She is also a member of the end of life group for Oxfordshire and part of the strategic health authority’s clinical leader’s network looking at dementia – one of her passions. “I am able to work clinically and be involved at strategic level. It’s good when clinicians have a voice,” she adds. “I know what’s happening.”

Dementia is often not recognised as a palliative condition, and is instead seen as simply a mental health issue. Liz has already been instrumental in developing local services, working with nurses from the community hospitals across Oxfordshire to develop an assessment tool to measure pain and distress for people who have dementia.

“A lot of patients will have multiple conditions but the dementia takes precedence and people relate any behaviour changes to the dementia rather than exploring other reasons, such as pain, for changes in their behaviour.” says ward manager Pam Treadwell. “We were relying on verbal scoring for pain and we had to do something about it to help educate staff to more accurately assess patients. We have now designed a formal scoring system tool for use in our community and are quite hopeful that it will make a real difference in the quality of care. Liz was a real catalyst in this work.”

“Often we will have a patient that will come to us with multiple conditions and we may struggle to find the right support that puts them and their families in touch with the right agencies,” says Nettlebed ward manager Fiona Manning. “When we refer to Liz we have a proper conversation, we know that she will meet the patient and family and we can work together to form a proper plan which meets all of their needs.”

“Liz is there to support them, whatever their decision is. The relatives appreciate the support that Liz gives – it is their journey as well, because the memory of the last days of a loved one such as your mum or dad is precious and will be with you for the rest of your life. If the last days are calm, dignified and comfortable that ultimately makes a difference.”
Local results

Impact on quality of care
49 out of 51 people under Liz’s care achieved their wish to die in the place of their choice.

Impact on patient experience
The work, including anticipatory care, has helped to reduce inappropriate hospital admissions for patients at the end of their life. Many more patients with complex needs are now referred to the community matron service and all of their needs are met.

Impact on staff experience
The service has improved staff understanding of the importance of good end of life care and has increased their ability to access continuing care funding. The trust is now agreeing a model for expanding these services which may further develop the role of community nursing staff in end of life care.

Impact on cost reduction
During the first year the role of end of life matron prevented 25 admissions within a caseload of 50 patients, saving an estimated £41,000.
Key themes and methodology

Redesigning roles
Community Health Oxford recognised the expertise available within the third sector and worked with Sue Ryder to develop and jointly fund this important role. The community matron works alongside existing end of life services, including Macmillan nurses who offer specialist symptom control management.

A joint survey, undertaken by the Department of Health and the National Council for Palliative Care in 2005, indicated that around 5,500 staff work in specialist and palliative care services. This specialist workforce cannot and should not provide all the care needed by people approaching the end of life. However, they do have a vital role in providing care for people with the most complex problems and in providing education for staff who are not specialists in palliative care.

Improvement tip
Role redesign can be described in a variety of ways: job redesign, new ways of working, reallocation of tasks, workforce redesign and skill mix. Changing a role or the way work is done aims to make an improvement for the care and experience of those that use the service.

Redesigning roles, Improvement Leaders’ Guide (NHS Institute)

Further information available from the NHS Institute website
“I think the end of life strategy has ensured our focus is on all patients that are approaching end of life. They should all have the same level of care; it’s about expanding it from cancer patients. People are living longer and on their own and need proper end of life care.

“Every human being deserves proper end of life care and they need the opportunity to say in advance what they want.”

Dr Maeve McKeogh consultant in palliative care

“There is widespread agreement on the importance of workforce development to the overall success of this End of Life Care Strategy and an acknowledgement that there are major deficiencies in the knowledge, skills, attitudes and behaviours of staff groups who come into frequent contact with people at the end of their lives. The focus, therefore, relates more to training and development issues across all the statutory and independent sectors involved in end of life care services, than on an expansion in the workforce.”

End of Life Care Strategy Promoting high quality care for all adults at the end of life (Department of Health)
Case study: NHS Leeds Community Healthcare

A service delivery framework for integrated end of life care
The district nurse is the lynchpin to end of life care for patients in Leeds. This role is supported by a flexible and responsive Complex and Palliative Continuing Care Service (CAPCCS) providing vital support and essential care as part of a service delivery framework designed to offer integrated end of life care.

Setting the scene
The trust has 500 district nurses covering a city with a population of 750,000. Two local hospices provide end of life care.

The trust recognised the existing care pathway for people at the end of life was inconsistent and was dependent on the geographical area that the patient lived in and the expertise available through the community nursing team.

The approach
NHS Leeds Community Healthcare began by recognising that the recognised measure which identified the number of community nursing visits was not an adequate indicator of quality of care, especially for those who required end of life care. They designed a framework to clearly outline the responsibilities of district nursing and joint care management in caring for patients at the end of their life.

The new service, supported by the Marie Curie Delivering Choice Programme, prevents unnecessary admissions to hospital and facilitates patients to die in their preferred place of care.

Once the framework was agreed, all staff carrying a clinical caseload were trained in how to provide the new way of working. 500 district nurses including up to 100 case holders participated in workshops on the new service. The community nursing service expanded its availability from 22 to 24 hours, ensuring patients are always able to contact somebody when they need to. The whole team uses the same paperwork to ensure clear communication.

The PCT has worked with the local ambulance service to ensure that crisis calls from end of life patients or their families are referred to the district nursing service as the first point of call.

“We are providing a spectrum of end of life care. It’s not just a ‘two days to live’ approach.”
Paul Morrin
Director of operations
How they did it

District nurses in Leeds are delivering a framework of care for people reaching the end of their lives, helping 80% of these patients die at home.

The framework has three key levels of care delivery: support, intermediate and intensive, which covers the range of patients’ needs. The end of life pathway begins once a patient has a prognosis and when it is recognised that at some stage they will need end of life care. A district nurse makes contact with the patient soon after the prognosis to discuss the range of interventions and support which can improve their quality of life and prepare them for the time when they become less well. Along the patient’s journey, decisions over preferred place of death and DNRCPR orders are agreed and preparations, such as the prescription of anticipatory drugs, are made.

The main focus of the framework is to avoid unnecessary hospital admissions and to ensure that people die where they want to die. The district nurses can anticipate and prevent crises occurring and ensure the dying person’s journey runs smoothly. The framework also enables district nurses to better plan their workload around the demands of dying people. “District nurses are key to the palliative care pathway,” says clinical services manager Liz Eastman. “They plan, decide and evaluate care.”

The district nurses are supported by the CAPCCS service, which provides personal care and social support for people who are dying. This can range from simply sitting with someone who lives alone and keeping them company, to practical tasks such as taking care of the laundry, making a cup of tea or fulfilling final wishes like a fish and chip supper. For staff providing the service, these simple requests are evidence that they have built a worthwhile relationship with the patient, and so made a difference to their last days.

“The CAPCCS service is essentially a support service for district nursing,” explains Ann Robertson, manager for adult services. “It provides the full range of health and personal care. When someone is at the end of life, there’s no difference in what is nursing care and what is social care. At the end of the day, the patient needs the care. You don’t get a second chance with end of life patients. We don’t think about whether anybody else should be paying for it, we think about the patient.”

The CAPCCS team includes 20 support staff and three clinical nurses. Staff work in specific geographical areas, so, as far as possible, there is continuity of care with individual patients seeing the same members of the team. Of 540 end of life referrals, 65% receive one-to-one care, 9% receive more general support, 8% receive support through night visits from the ‘roaming’ team and 18% are signposted to other services.

“I think district nurses have always delivered palliative care and this means we are all working to the right standards,” says practice teacher Karen Rudys, who’s role is to deliver training. “It’s important to remember that the district nurse is the caseholder and CAPCCS is an extension of the team.”
The training of support staff has covered communication, dignity, privacy, hygiene and nutrition. The whole role is around building up those competencies and two of the support staff have gone on to nurse training.

“At interview it was made very clear that life experience was also taken into account and, as I had nursed my parents when they had both been diagnosed with terminal cancer, I had the qualities that they were looking for,” says healthcare assistant Joan Shaw. “At first I was quite overwhelmed with the amount of training involved but enjoyed being part of a close-knit team whose first priority was the patient.”

The service is highly regarded by the families and the district nurses who refer patients to them. Support staff can refer to district nurses if they identify any issues outside their remit and the district nurse still calls on the patient at least once a day.

“We have a daily handover about all the patients,” says Corina West, senior nurse with the CAPCCS team, which is currently caring for 28 people. “30% of our caseload live alone. Nursing assistants will sit in on a one-to-one basis overnight. Three roaming teams of two carers will do 10 visits a night for patients that are very poorly. We now have a referrals coordinator and that’s made a big difference.”

The trust has worked with the ambulance service to ensure that they contact the district nursing service if they receive a crisis call from an end of life patient or their family. The district nurse will respond within ten minutes and visit within an hour to make the patient comfortable and manage the situation.

The success of the end of life framework is measured by a range of indicators, including place of death, number of contacts and verification of death.

Carer Ann Rotherham looked after her husband Tony for many years with a range of illnesses and always did everything for him. He died at home in September 2008, supported by the team. “Taking him into hospital would have been like tearing us apart,” she says. “I never had to explain anything twice and they thought of things I never would have.”

“I love my job and at the end of each shift I feel that I have accomplished something worthwhile and have learned something new every day. It is sad when a patient passes away but we know that we have made them as comfortable and pain free as possible and that they have spent their last weeks at home surrounded by their family.”

Joan Shaw, healthcare assistant
Local results

Impact on quality of care
Discharge planning has become more responsive for patients wishing to die at home. Monitoring of implementation and feedback show significant improvements in the prescribing of anticipatory medication and utilisation of the Leeds Care of the Dying pathway.

The CAPCCS teams provide 1,500 contacts each month in support of district nursing. The sitting service provided 5,000 nights of one-to-one care in a year.

The palliative care discharge facilitator, who works across the acute and community trust, has collated a number of case studies which demonstrate successful outcomes, with patients dying in their chosen place.

Impact on patient experience
More than 80% of patients are now achieving their wish to die at home.

Impact on staff experience
The CAPCCS team has high levels of job satisfaction and a low staff turnover rate.

Impact on cost reduction
The service has achieved a 5% reduction in admission to hospital due to improved symptom control at home. They have also reduced the number of crisis calls from carers.

Return on investment calculation
Costs for the following inputs were calculated across the life of the project: workshops to develop the model and share it with district nurses; meetings with community equipment services; cascade training to community teams; cascade of information to hospital and hospice staff; palliative care component of the CAPCCS team; focused work with DN, joint care managers and continuing care services; and review workshops. Impact costs were not monetised in terms of the quality improvements achieved by Leeds Community Healthcare. Instead this calculation reports the costs of developments to achieve a standard of care by which 80% of patients secure their preferred place to die, significant improvements in anticipatory prescribing are realised, communications between staff, patients and their families are rated highly and fewer end of life patients are admitted to hospital. The costed components of this programme of work indicate that these quality standards have been achieved with an investment of £415,744.

Further information available from the NHS Institute website
Key themes and methodology

Listening to the experts
Both the trust, and the nurses themselves recognised that district nursing plays a pivotal role in end of life care. The trust used them as the experts. District nurses helped to redesign the end of life care pathway, and chose to be the coordinators of care rather than hand over to a new end of life team.

Clinical staff play a vital role when designing care pathways. Their clinical expertise and their knowledge of the strengths and weaknesses of the services they work with help to identify any opportunities where improvements can be made. Non-clinical staff also provide important insights and ideas for improving the processes and systems that support care delivery.

We also need to remember to listen to the other experts: patients. Patients, along with their families and carers, all have unique expertise in their own lives and how their condition, treatment and experience of care affect them. Consulting with patients and families, and involving them in the design of care pathways, is crucial to ensuring that we develop and deliver responsive, high quality services that will meet their needs.

(For more information on working with patients, carers and families, see the NHS Institute publication, ebd approach http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_(experience_based_design).html

Improvement tip
Using listening skills is an important element in any part of the improvement process and at any point within in a project. These skills are vital when working with any stakeholders, including staff, patients and families. They help to identify problems and to recognise and understand concerns or uncertainty. Listening skills are key to successfully implementing and sustaining improvements.

Listening – importance of this skill
Staff involved in organisational change may have questions, concerns and grievances they want to air. Open and sensitive discussion can help resolve areas of potential conflict before they impact on the improvement process. It is important that you promote understanding, involvement and constructive discussion throughout the change process.

5-step tool, The Handbook of Quality and Service Improvement Tools (NHS Institute)
“The district nurse is the lynchpin to all of it. We have a very good district nurse service and needed to give them the support and tools to do it. The one thing the district nurses wanted from me was a bit of permission.”

Paul Morrin
Director of operations

“...Death is awful enough as it is - we need to make death as comfortable as possible and the Just in Case box and Comfort Care box help do that. They don’t always get used, but I think the big thing is that they are there if they are needed. I don’t really care if they are not used, they are there for people in pain or so we can make people more comfortable.”

Louise Perry Macmillan nurse specialist in palliative care
Case study: Solihull NHS Care Trust

Be prepared: just in case
Community nursing staff in Solihull are developing their end of life services to ensure that patients who want to die at home are given every support. They are preparing care packages to provide a seamless service for those at the end of life, focusing on supportive care and anticipatory needs.

Setting the scene
The trust implemented the Gold Standards Framework which was introduced in 2003.

An audit in 2005 revealed a range of issues within community services, including poor documentation, poor recording of do not attempt resuscitate (DNACPR) and patients not identified as being in the end of life phase. They found isolated areas of good practice within the community nursing teams. 31 general practices had developed their services in line with the Gold Standard Framework (GSF) by 2007.

The approach
Solihull NHS Care Trust undertook an audit to get a baseline of what was happening in the community around end of life care. Following this the trust developed new documentation to standardise the approach to end of life care. Alongside the implementation of the GSF, the community nursing team set up a series of improvements including:

• just in case box, featuring anticipatory drugs for common side effects including pain, nausea, restlessness and respiratory problems
• comfort box, featuring regularly used items such as continence products, mouth care, skin care and pressure relieving mattresses that can be used on a patient’s own bed for several days
• a purpose-designed intranet site for palliative care
• patient/carer information leaflets addressing practical aspects of end of life, such as registering a death.

In addition, the nursing team provided training on an annual basis with support from MacMillian nurses and those working in the local hospice. Staff now map the patient’s journey, using green, amber or red to identify the stage they are at. Supportive care documentation for patients on the GSF register is being used to facilitate proactive nursing care.
How they did it

Community nurses working in Solihull have developed special ‘boxes’ to provide anticipatory care, offering immediate relief for symptoms and averting inappropriate end of life hospital admissions.

Staff say the just in case box has revolutionised how patients are cared for at home. The box contains standard pre-prescribed medication which district nurses can administer to relieve common side effects facing patients at the end of their lives, including pain, nausea, respiratory problems and restlessness.

Its fellow comfort care box includes items used regularly by nursing staff, including continence products, syringes, equipment for mouth and skin care, catheters and lilo-style roll-up pressure relieving mattresses that can be used on a patient’s own bed, allowing patients to sleep with their spouses. Additional items can be added to suit individual patient’s needs.

The work was inspired following the introduction of the Gold Standards Framework, when end of life care was recognised as a core part of NHS provision. In 2005, staff reviewed what was happening across the trust and found pockets of good practice but also many areas where care was being provided but was poorly documented.

The first step was to improve documentation, developing pilots to establish what good documentation should look like. The aim was to ensure that when staff visited a patient, they had full access to all the relevent information about the patients circumstances including whether they were on the support care pathway and knowledge of the patient’s wishes at end of life, including their preferred place of death and whether a DNACPR order is in place.

Audits in 2007 found documentation had improved massively and to build on this success a series of additional improvements were developed including the just in case box and comfort care box.

“The just in case box has made a huge impact,” says Macmillan nurse, Louise Perry. “Previously, the district nurse had to contact the GP or out of hours service to come and see the patient to prescribe medication and then we would go out and find a pharmacy. The patient could wait many hours for the drugs.”

District nurse Jeannette Smith adds: “Before the concept of anticipatory drugs, the district nurse would have to leave the patient to go an get the required medication, this caused a lot of distress for the patient – and the nurse as well. It gives relatives confidence in the nursing service and confidence in caring for them at home. The just in case box means we are being proactive for this patient. We can deal with the whole episode of care without unnecessarily getting other professions involved.”

“Ten years ago, the response for end of life care was ‘the hospice does that’. It’s taken time to get palliative care into the language of what we do,” says Helen Meehan, lead nurse palliative care. “We have raised the profile of district nurses and their role in palliative care and supported interdisciplinary working to support patients. What we have done is make the system robust, it’s not dependent on who you see at what time.”
“We are supporting people to die in the place of their choice,” says Vanessa Stuckey, deputy director of community services. “There are also financial gains to be achieved in caring for people in the appropriate environment at home rather than admitting them to hospital.”

District nurses say that they are caring for a growing number of people at the end of life and with more complex needs. This figure is expected to grow as Solihull Care Trust has set targets to increase the number of end of life patients cared for by the service by 50% over the next year. The supportive care documentation gives structure and direction to the nursing visit, enabling nurses of all levels to deliver the best possible care in, what can often be, difficult situations. Its simplicity and ‘tick box’ format means less time writing notes and more time for contact with the patient.

“As part of the pathway, we discuss with the patient and their carers where they would like to be cared for at the end of life. For the majority it will be home and it’s a goal for the nursing team to achieve that with the carers,” says district nurse Ann White. It’s not always possible but there’s usually a good reason where it’s not achieved.

“Most are grateful that the patient can be at home in their own environment and can avoid hospice or hospital admission, especially if this has been agreed with the patient early on in their diagnosis, which in turn helps family deal with bereavement.”

“It’s a cost saving for the trust and it’s quality of care for the patient,” says community matron Cecily Harper. “I think every area should be taking this on board and anticipatory drugs should be the norm.”

“One felt very safe that should anything happen, everything was going to be there,” says Sue Worley, carer for her 95-year-old mother, Marjorie, who died in March 2009. “It was very comforting to know that everything was there. The box came at the right time.”

“Without anticipatory medication, patient wouldn’t have so much care planning. Before we would be running around for perhaps six hours for drugs to relieve someone’s pain, nausea or agitation – that wasn’t good nursing. This is what the carers would remember and that was so sad. It has changed our lives in looking after these patients and from what the carers say it has changed their lives; they have been able to see their loved ones die at home peacefully, without the symptoms that often send them to hospital.”

Cecily Harper
Community matron
Local results

Impact on quality of care
The anticipatory drugs in the just in case box have dramatically reduced delays in administering medication to ease side effects: district nurses can administer drugs within 30 minutes instead of six hours or more.

The number of patients identified as being in the end of life phase has increased and the trust now documents routine recording of DNACPR orders, identification and recording the patients’ preferred place of death has increased.

Community nurses looked after almost 600 patients at the end of life in 2009, with a target to increase this by 50% in 2010.

Impact on patient experience
The work has helped reduce the anxiety of patients and carers through clear planning. A ‘My Life’ book has been piloted for patients using the Gold Standards Framework. This provides information about care and more personal reflective information, and enables patients to record consultations and contacts with staff. The Motor Neurone Disease society plans to use the ‘My Life’ book nationally, which is an excellent example of spread and will benefit a wider group of patients.

Impact on staff experience
The change in culture means that if a just in case box is not available, this is now treated as an incident. Standardised documentation ensures better quality of care for patients regardless of who they see. There have been no prescribing errors for anticipatory drugs for four years. Staff have access to a programme of training in palliative and end of life care.

Impact on cost reduction
Crisis calls to emergency services have reduced.

Return on investment calculation
Costs of the following inputs were calculated across the life of the project and included: dedicated time from the project lead to steer the work and provide ongoing management; staff costs of the pathway and anticipatory prescribing groups; intranet and staff training costs; and product costs. Impact costs were identified in terms of a 5% reduction in the number of end of life patients dying in hospital between 2006/07 and 2008/09 from an annual death rate of 1700. An SHA average cost figure was used for this purpose. For every £1 spent Solihull Care Trust has generated £2.23 of benefits. This calculation does not take into account the additional quality benefits that have not been monetised, nor any levered costs through additional use of Marie Curie health care assistants (HCAs) and hospice palliative care doctors.

Further information available from the NHS Institute website
Key themes and methodology

Getting it right first time
All NHS organisations have to achieve targets even though they sometimes feel as if they are competing for focus. Lead nurse Helen Meehan recognised that to make lasting improvements, she and her team needed to ensure that end of life care was kept a priority. The introduction of the Gold Standards Framework in 2003 helped her to lead change and she has continued to seek out any policy documentation or support or new work that prioritises end of life care. These include the Next Stage Review and the High Impact Actions for Nursing and Midwifery.

Using a framework like GSF helps teams focus their efforts and provides a tried and tested approach to developing good practice. It gives organisations that are providing end of life care a foundation on which to build their own processes, utilising some of the best available research evidence and the experience of clinicians working in this area.

The Department of Health’s End of life care strategy – Promoting high quality care for all adults at the end of life recognises that The NHS End of Life Care Programme (2004–2007) has contributed significantly to the rollout of programmes such as:

The Gold Standards Framework (GSF)
Liverpool Care Pathway for the Dying Patient (LCP)
Preferred Priorities for Care (PPC)
"Over the past few years the concept of a care pathway has been found to be useful for the planning, contracting and monitoring of services across a wide range of conditions... individuals differ in many ways as they approach the end of life. No two people will have an identical end of life care pathway. For each individual many different factors will impact on their needs and preferences for care."

End of Life Care Strategy – Promoting high quality care for all adults at the end of life (Department of Health)

"You become savvy about language and using buzzwords like quality, innovation, productivity, prevention (QIPP) and applying end of life to priorities like keeping people out of hospital and reducing hospital admissions if that’s the priority for your organisation at that time, so it stays on the agenda. I think QIPP has a big part to play."

Helen Meehan
Lead nurse palliative care
How to measure...Important choices - where to die when the times comes

The national picture
There are many sources of information for end of life care, some of the information available includes: cause and place of death by age and gender and locality found at the Office for National Statistics (ONS), information on deaths in hospital (e.g. duration of final admission, specialty, type of admission by age, gender and NHS trust) from Hospital Episode Statistics (HES). The Quality Outcomes Framework (QOF) has helped to establish end of life care registers in general practice. South West Public Health Observatory (SWPHO) is a national lead public health observatory for end of life care. It was commissioned by the National End of Life Care Intelligence Network (NEoLCIN) to develop a set of indicators to help identify and understand variation in end of life care across England. The first wave of indicators focus on place and cause of death. This is broken down by age and sex, and by local authority area in England. However, there are plans to present the indicators by primary care trust and these will be added to the website in the future.

http://www.endoflifecare-intelligence.org.uk/profiles/overview/atlas.html

How is end of life care defined?
As is pointed out in the End of Life Care Strategy there is no simple way of defining when the end of life care pathway begins but a working definition of end of life care established by the National Council of Palliative Care is that it, “helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.”


How might end of life care be recorded and measured locally?
End of life care spreads across various settings and so there are a number of different things that you may want to be measure by different people working in the different settings.
One of the easiest things to measure is the actual place of death, but this does not give a measure of quality. In primary care you could measure the number of patients on a practice Gold Standards Framework (GSF) or palliative care register, which would indicate the number of patients identified as having end of life care needs and being reviewed as part of a quality framework. You could also measure the number of patients on an end of life pathway such as Liverpool Care Pathway (LCP) dying in hospital or community setting. These are a practical ways of measuring the aim of this High Impact Action (to avoid inappropriate admission into hospital and to ensure patients can choose where they die) but will only provide process measures. However, both service improvement tools (GSF and LCP) also offer more detailed audit tools which can provide information on patient outcomes in end of life care.

Another key measure is whether patients are offered the opportunity to discuss their preferred place of care as part of an advance care planning process, whether they have a recorded preferred place of care and whether this is achieved when the patient dies. This information can be collected if the patient has an advance care plan recorded in the patient’s care plan or recorded using the Preferred Priority for Care (PPC) document.

A more accurate way of measuring how well patients choose where they die would be to look at how many people died where they wished to. This information can be collected if the patient had a Preferred Priority for Care (PPC) plan or advance care plan which stated a patient’s wishes regarding their death, but is difficult to do so otherwise.

One of the key processes is that patients on an end of life care pathway have a PPC plan or ACP and to measure this you could, for example, measure the number of end of life care patients dying divided by the number of those patients who had a plan. This could be taken as a sample.

The After Death Analysis (ADA) is a web-based audit and improvement tool based on the Gold Standards Framework (GSF) and in complete alignment with the Department of Health draft quality markers. It measures key factors in primary care or in care homes, such as:

- unscheduled hospital admissions
- advance care planning
- place of death
- patients dying in their preferred place
- Level of GSF implementation.

For more information: http://www.goldstandardsframework.nhs.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=03985562-C786-4E2B-97C3-D4F6094231DE&mode=link&guid=434965a3f67a45d18dcf87b64918692b

**Measure when making improvements**

If you are starting to work on end of life care you should start by looking at what you are already measuring, and also what other teams in your department or organisation and teams from other organisations that are key to the delivery of end of life care may be collecting, so that you save time and join up the work you are doing. Use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting around pressure ulcers and to understand gaps where you might need to collect extra information.
Fit and well to care
Introduction

The aim of this High Impact Action is to reduce sickness absence in the nursing and midwifery workforce to no more than 3%.

A practical summary

Without fit and well staff, how can we ensure quality? As a caring profession, we should ensure that we have strategies to ensure that staff are fit and well. Caring for our staff means supporting our staff, trying to understand what is causing levels of sickness absence and providing an environment that lets them know the positive impact they have by delivering patient care. It means ensuring staff feel valued and missed when they’re not at work and that they realise their health and wellbeing is important to us.

Staff spend a lot of time at work and they need to feel that they are really contributing. Hardly any nurses would disagree with the suggestion that having more regular and consistent staffing therefore requiring fewer bank and agency requests results in enhanced team work and better care provision.

Having a focus on ‘fit and well to care’ will, without question, have an impact on quality and cost reduction, but more importantly needs to ensure that NHS staff feel valued and supported in their work.

The problem

10.3 million working days are lost in the NHS in England each year (CIPD Annual Survey of Absence Management). This is the equivalent of 45,000 whole time equivalent (WTE) staff or 4.5% of the current workforce. The proportion of working days lost to sickness absence varies widely between trusts, from 1.75% to 7.42% (Health and Social Care Information Centre (2009)). Within nursing and midwifery, the average rate of sickness absence is 4.96% - the third highest group behind healthcare assistants and ambulance staff. There is a wide variety between wards, grades and specialities, with those wards that look after older patients being the hardest hit (NAO 2006). There is a direct relationship between the quality of care provided, as measured by a range of factors, and the levels of sickness absence within departments and wards.

The cost

The annual direct cost of absence in the NHS is £1.7 billion a year (DH, 2009). The indirect costs (i.e. the use of agency and other temporary staff to cover staff absence) adds an additional £1.45 billion a year. The NHS Health and Wellbeing report found that if absence was reduced by a third, this would equate to savings of 3.4 million working days a year, equating to an extra 14,900 whole time equivalents and direct cost savings of £555 million a year.

What we can do

Other large organisations such as BT and the post office have demonstrated that aiming to reduce absence by a third is a realistic and achievable target. Communication is the key to most areas of improvement and never more so than in staff wellbeing. It is important to empower staff to lead change and to make individuals matter. It is vital to empower ward managers and team leaders so they
can provide support and information to staff about health and wellbeing. This group should also be able to recognise signs of stress and anxiety especially when any change is happening. Whenever change is happening, staff need to be involved and be active participants in the decision-making process, inclusion helps people to feel more in control. Regularly set aside time to review how the day went, a simple ‘what went well’ and ‘even better if’ approach helps to draw out both the positive and less positive aspects following a particularly difficult shift, training day and so on. Physical activity can also improve health and wellbeing, so you may want to organise and encourage joining existing schemes or develop new activities and support staff to take part.

Measurement is a vital part of all change. Ensure your reporting systems are accurate, transparent and visible to all staff in your area. Make sure that everyone knows the desired goal for reducing sickness absence and get the message right: focus on the positive aspects of improving health and wellbeing rather than the punitive messages around reducing sickness absence.

**The case studies**

**Homerton University Hospital NHS Foundation Trust** used the impending 2012 London Olympics and its status as the official Olympic hospital to embrace the positive elements of physical health and encourage staff to get out there and exercise. It used sponsorship money to appoint an Olympic athlete to lead the work and champion physical health.

**Leicester City Community Health Service** asked its staff: ‘What can we do to improve your health and wellbeing?’ It used staff wellbeing as a tool to create change within the organisation.

**Hertfordshire Partnership NHS Foundation Trust** introduced The Productive Mental Health Ward and used measurement as a prompt to develop staff health and wellbeing.

"We need to encourage nurses to care for themselves as much as they do for their patients...for their own sakes."

The Queen’s Nursing Institute
Where are the best sources of information?

www.nhshealthandwellbeing.org/FinalReport.html

NHS Health and Wellbeing review- Interim Report:


Frontline care: commission on the future of nursing and midwifery in England:

Occupational health clinical effectiveness unit:

NHS Evidence: www.library.nhs.uk/qualityandproductivity/SearchResults.aspx?optID=37138

Health work and wellbeing website:
http://www.workingforhealth.gov.uk

NHS Constitution: http://www.nhs.uk/choiceinthenhs/rightsandpledges/nhsconstitution/Pages/Overview.aspx
Case study: Homerton University Hospital NHS Foundation Trust

An Olympic effort
As the official Olympic hospital for London 2012, Homerton Hospital wanted to embrace the positive elements of physical health and encourage staff to get out there and exercise. The trust used funds provided by Olympic sponsors to employ an Olympic athlete to lead the work and champion physical health.

Setting the scene
Homerton is a district general hospital with 500 beds, serving an area with a transient population. More than 62 languages are spoken in the area and there are high rates of obesity. The hospital has 2,000 staff whose health reflects the surrounding area. In 2008 the trust had sickness absence levels running at 4.4%.

Homerton was named as the official Olympic hospital for the 2012 games. The Olympic park, including the flagship 80,000 seat stadium, is 3km from the hospital.

The approach
The trust wanted to build on the legacy of the Olympics as a once in a lifetime opportunity. It was approached by Olympic sponsors with the offer of funding to engage with the hospital’s staff.

The trust engaged with staff through external, agency-run focus groups to ask how they should spend the money. They funded a part-time coordinator to champion the work. Shani Anderson is a personal trainer and Olympic athlete and, so, is the perfect role model for staff. Shani coordinates a growing number of regular classes and short workshops, to fit around both shift patterns and family life.

The trust developed its occupational health service in response to the feedback from staff and worked with a local heart charity to measure staff health and fitness levels.

“I was a track and field athlete for 19 years and in the Great Britain team for 11 years. As a personal trainer, I know what works and what doesn’t. My position here, as a member of staff, means they have access to me a lot more - I can run workshops, and work with people one-to-one and engage with more people.

I take a running class and we run with the new Olympic stadium in the background - that’s good encouragement!”

Shani Anderson
Lifestyle coordinator and Olympic athlete
How they did it

To access a star personal trainer is beyond the reach of most NHS staff so, when Olympic athlete Shani Anderson joined Homerton University Hospital Foundation NHS Trust as its lifestyle coordinator, the response was enthusiastic, to say the least.

The launch event attracted more than 800 staff, with half of them signing up for a growing list of activities, including: Nordic walking, ballroom and salsa dance classes, pilates, running classes, circuit training, as well as short workshops with Shani as a personal trainer.

The programme of events began early in 2010, but the work to develop it started much earlier.

Homerton hospital is in Hackney. It serves a deprived and diverse area of London and the staff groups reflect that, with more than 62 different languages spoken among staff and patients. The hospital is destined to become the hospital for the 2012 Olympic athletes, so, when one of the sponsors contacted the hospital with a view to working with them, Cheryl Clements, director of workforce and education, wanted to ensure they left an Olympic legacy that would touch all of the hospital’s 2,000 staff.

"We work in partnership with other organisations to address the health inequalities of our area. We have high levels of obesity in the population and our staff, and the fitness levels of our staff are quite poor," explains Cheryl.

Over a year, an external company held a series of focus groups to gather staff views on what could improve their health and wellbeing. Activities were a popular choice and it soon became clear that employing a champion who could coordinate the range of activities was the best use of sponsorship money.

Enter Shani, a commonwealth bronze medal holder and participant in the 2000 Sydney Olympics. Her part-time role as lifestyle coordinator at the trust, which she fits in around her own business as a personal trainer, includes setting up and running activities and offering one-to-one sessions with staff to improve their health and physical fitness.

"The whole point is that, hopefully, everyone can have a go," she says. "The main challenges have been awareness, and shift patterns, but we have set up mini workshops for groups of nurses, looking at how to train at home, and healthy eating. It’s little changes, but they make a difference; one clinician here came to the launch event, found out his blood pressure and BMI were too high and that was enough to spur him on: he now goes to the gym three times a week and has lost a lot of weight. I had a session with one midwife about nutrition and she has now lost 25lbs."

Alongside classes, staff have access to supported gym membership, which is free for the first 16 weeks and discounted afterwards. The hospital has also invested in gym and sports equipment for team sports, such as
football and cricket. One of the key successes has been to build a full netball team, from a base of just two members. The team has competed against – and beaten - local teams that were once forced to merge due to lack of numbers.

“It’s not a one-size fits all programme. Every single staff group has become involved – we have clinicians doing football, managers running and administrative staff doing activities,” adds Cheryl, herself a regular member of the lunchtime running sessions. “We have a fun run in May, so it’s good to have a target to aim for.”

Already staff are starting to see the benefits, feeling fitter, more energised and losing weight. The success of the programme is being measured by Heart Research UK, which carried out some initial health assessments with staff, looking at eating habits, exercise levels and BMI measurements.

There have also been other benefits, with staff from different levels and professions within the organisation coming together to socialise - whether on the football pitch or on the dance floor - helping to engender a team spirit throughout the organisation. This has also led them to become a trust with one of the highest levels of staff engagement, as measured by the staff survey.

Plans are already underway to safeguard the future of the programme as sponsorship money dwindles, with funding being identified from charities to continue the champion role. They also hope to start offering complementary therapies, including aromatherapy and massage.

“Getting the fresh air and doing an activity means you go back to work feeling refreshed and ready to work again,” says PALS officer, Linda Farrell, who takes part in the Nordic walking classes. “In my post, I don’t meet a lot of people and getting out is really sociable.”

“I feel better and I sleep better at night,” adds fellow Nordic walker and midwife, Bev Scantlebury. “Shani is very encouraging and those who take part feel happier and healthier.”

“We started the team up 15 years ago and we never had enough members,” says netball team stalwart and medical secretary, Adlene Hickson. “It’s exciting to get new members – and we are now top of the league!”

“The key objective is to keep staff engaged, keep them healthy and keep them happy. And, that will help to reduce sickness absence. The key outcome of whether this is making a difference is the next staff survey.”

Cheryl Clements, director of workforce and education
Local results

**Impact on quality of care**
Staff sickness absence has dropped from 4.4% to 3.4% in a year.

**Impact on patient experience**
The hospital has created a better working environment, with happier and more engaged staff. Lower staff sickness absence leads to improved continuity of care across shifts. All of this in turn, has created an improved environment for patients and their families.

**Impact on staff experience**
Almost half the workforce attended the launch event, illustrating the interest and potential of the idea. Engagement is across all staff groups and at all levels of the organisation. Anecdotally, the trust recognises improved health and wellbeing among staff and increased goodwill towards the trust.

**Impact on cost reduction**
Start up costs estimated at around £50,000 including setting up focus groups and employing a lifestyle coordinator for 16 hours per week. Following the initial success the Trust also accessed charitable funds to buy new sporting equipment. Sickness absence levels reduced by one per cent and for Homerton this equates to £1 million saving. We cannot attribute all reduced sickness to the physical health programme. However, many employees have confirmed its benefits. If a very conservative estimate is adopted and we consider that 50% of the reduced sickness is due to the programme, i.e. £500k savings, then, for every pound spent, the trust has achieved £10-worth of benefits in terms of staff being present for work who would otherwise have reported sick.

Further information available from the NHS Institute website
Key themes and methodology

Going with the ‘pull’
Homerton used its role in the 2012 Olympics as the ‘hook’ to tap into staff interest in physical fitness. This gave the programme energy and purpose, which has been further embedded by employing an Olympic athlete as its lifestyle coordinator.

Sometimes when we think about making changes and improvements, we make things over complicated. We become wedded to particular approaches and ways of doing things. Although structures and processes are important, even more important is to tap in to the energy of individuals, groups or the organisation. Starting by asking people what they are passionate about and committed to provides a really good understanding of what needs to follow and is always much easier that constantly battling to get people to engage in a change that they do not feel engaged with. Every organisations has champions or activists who have a real passion for leading changes. It is important that this energy is harvested by the organisation so that it can be channelled into action and impact. So…. ‘go where the energy is’.

Improvement tip
Social and normative factors
Key points for healthcare improvement leaders:
- An NHS improvement movement is more likely to succeed if its stated aims and values are widely shared and supported by society as a whole.
- Pre-existing networks of people within the NHS have a key role to play in mobilising sufficient staff to join a movement.
- Individuals are much more likely to engage in improvement activities if their colleagues, friends and peers are already doing so.
- Finding those at the centre of these networks, who are committed to improvement in the NHS, is a critical first step in developing the self-sustaining communities of practice that can provide mass and energy to improvement activities.

(Paul Bate, Helen Bevan, Glenn Robert)

Million change agents
Further information available from the NHS Institute website
“Organisational energy is about the extent to which an organisation is able to harness the effort, speed and stamina of its workforce. From that perspective, the key task of an NHS leader is to unleash the energy of the organisation and channel it towards strategic goals.”

(Bevan, 2007)
Health Service Journal

“Sickness absence was coming down but we looked at what else we could do that would benefit staff. At that time, we were approached by an external sponsor of the Olympics who wanted to work with us. We wanted to create an Olympic legacy for staff. Your champion has got to be believable and has to be a good role model.”

Cheryl Clements
Director of workforce and education
Case study: Leicester City Community Health Services

Finding out what works
Leicester City Community Health Services was a new organisation, facing new challenges but with a jaded staff group who were experiencing yet more change and uncertainty. Its answer was to initiate a research project with a difference, aimed at answering one simple question: ‘what can we do to improve your health and wellbeing?’

Setting the scene
Two primary care trusts covering the city of Leicester merged in 2006. This led to a number of redundancies and resulted in low staff morale. In 2007, the trust board was unhappy with the results of the staff survey and made improving staff wellbeing and raising morale a corporate objective.

The approach
The trust did a range of preparatory work to gather evidence on staff health and wellbeing. This included commissioning an external researcher to work with focus groups and look at what makes a difference to staff sickness and absence. The trust also carried out a staff survey specifically aimed at health and wellbeing. The trust set itself targets and introduced a range of projects including new policies, IT solutions and a middle management leadership programme. The focus of the work was on staff wellbeing, not staff sickness.

“Staff health and wellbeing is crucial. If we can’t look after our staff, how can they look after their patients?”

Anne-Maria Olphert
Associate director of children’s community health services
How they did it

When it comes to understanding how to improve staff health and wellbeing, there is a very good place to start - why not ask the staff?

At Leicester City Community Health Services, the trust did just that. It invested £15,000 in an external research project which looked at various interventions and measured the potential impact of these interventions on the trust’s objective: to reduce staff sickness and absence. Through a series of focus groups, staff were questioned on around 85 different elements of their work, with the aim to find the few key things that if changed would make the biggest impact on staff sickness and absence.

This meant looking at different elements of working life and measuring whether these actually had an impact on staff sickness. For example, while frustration with car parking was high, there were no measurable links to staff health. However, unsurprisingly, the researchers found that psychological and physical violence increased staff absence.

The research found that rewarding staff and giving them recognition were the most important factors for reducing staff sickness. This meant reviewing management behaviour with a view to maximising the positive. The research also found that inter-personal relationships (between colleagues) were critical for health. Other findings showed that where staff turned to family and friends for support, sickness and absence increased, whereas support from line managers had the opposite effect on absence levels, with a noticeable decrease.

“It was amazing to discover what things actually impact on staff stress and what we can do to reduce them,” says head of human resources, Kshama Srivastava. “We could guess what might affect staff stress levels, such as lack of key equipment, but this provided the evidence.”

The trust has set up a £50,000 fund to spend over the next two years on improving health and wellbeing, using the research to target interventions which will have the most impact.

The research was a key part of a comprehensive programme designed to improve health and wellbeing among staff, with a view to reducing sickness and absence. Management responsibility – specifically giving clinical leads and managers clear responsibilities to ‘manage’ staff sickness and absence in their areas was another key component.
An ongoing programme was launched to coach managers in the necessary skills of managing sickness. “We didn’t give managers the choice to opt out,” admits deputy associate director for human resources, Kam Kotecha. Alongside the rolling training programme, the trust developed additional two-hour sessions looking at specific issues like returning to work.

Once managers were trained, they needed better tools to do the job and attention shifted to IT. The HR team had identified that staff were returning to work after a few days but remaining ‘off sick’ on the system: this would only be questioned when their pay was affected. New IT systems have now been introduced that provide real-time bespoke reporting on staff sickness by area, which managers can check to ensure staff absence is up-to-date. The reports also give managers figures on how much staff absence has cost them in sick pay. This has fostered some friendly competition to keep the figure low, signalling ownership of the issue. The organisation has also updated its staff sickness and absence policy to reflect a 3% target, agreed locally as part of the early work. Staff awareness sessions have been set up to ensure everyone in the organisation understands how all the elements fit together.

“We feel valued, so we value the organisation,” says manager, Jayne Talman, who is part of the health and wellbeing working group. “The trust has raised the profile of health and wellbeing and how important it is.”

The trust put the programme to the test when it introduced the new nursing strategy which required new shift patterns. Staff wellbeing was used as a tool to develop community nursing into a 24-hour service with managers and team leaders being targeted via a series of leadership sessions.

“A lot of the research is very clear that this managers and team leaders have a huge impact,” says Dorothy Gillespie, service manager for Diana children’s community nursing. “There are really key leadership behaviours for managers to use with staff: feeling valued, managing effectively and being the best they can be for themselves and the organisation.”
Local results

Impact on quality of care
There is a clear link between levels of staff sickness and a range of quality measures, so reducing sickness improves quality of care.

Impact on patient experience
Having less staff sickness means better continuity of care and enhanced patient experience. Lower levels of stress means better communication with patients and improved liaison with partners an example of how the work has directly impacted patient experience is with the newly-introduced 24-hour community nursing which reduces the need for GP out-of-hours services.

Impact on staff experience
Higher level of engagement with staff has empowered all staff groups to lead change and innovate within their own areas. There are better training opportunities for staff and there is more support and acknowledgement for efforts. A number of interventions have been introduced that will make a real difference to their working lives. Key processes such as appraisals are carried out much more reliably. Staff recognise the need to maintain and improve their own health in order to care for patients and will take time to debrief with colleagues to reduce stress.

Impact on cost reduction
The trust has achieved a 4.04% sickness and absence rate (January 2010), which has contributed to a reduction in the use of agency and locum staff. Improved staff morale has increased retention of experienced staff, reducing the cost of advertising and releasing management time from the burden of recruitment.

Further information available from the NHS Institute website
Key themes and methodology

Let staff lead the change
There are lots of different ways that staff views can be captured to understand their experience of delivering care, specifically what affects their health and wellbeing. As well as focus groups or workshops, think of different ways of both capturing staff experience, but also engaging staff in the change process. These might include diaries, ‘what annoys you’ lists, or simple visual displays of how people are feeling. Often just doing this helps staff to feel more involved. Getting staff groups together helps them to share thoughts and ideas on subjects, such as staff wellbeing – although it is important that there is a clear action plan at the end of the meeting so that people can see that there is definite action and it doesn’t just become a moaning session. As well as identifying the problems, this approach gets staff to participate in coming up with solutions which, in turn, helps with overall sign-up to the project.

Improvement tip
The Handbook of Quality and Service Improvement Tools describes a number of ways in which you can learn about staff perceptions to help inform service improvement. Change that is initiated and supported by staff is generally more successful.

“Understanding how staff view the organisation can help service improvement work by identifying issues that need to be addressed and by monitoring views of change.”

The Handbook of Quality and Service Improvement Tools (NHS Institute)
Every person matters

Principles: staff are the most important asset and their wellbeing is, therefore, recognised as vital to the organisation.

The focus on getting staff wellbeing right is also based on the concept that the patient’s experience will improve as a result.

Measures of success:
• year-on-year improvement in staff satisfaction through national and local surveys
• year-on-year improvement in patient satisfaction surveys, national and local
• reduced sickness absence
• staff report an increased feeling of being valued and involved in service improvement work
• a reduction in the number of vacancies.

Leicester City Nursing Strategy, available on the High Impact Actions website
Case study: Hertfordshire Partnership NHS Foundation Trust

How was your day?
The new Cassio Unit at Hertfordshire Partnership NHS Foundation Trust merged two teams, this led to a level of uncertainty and increased stress levels as a result of temporary re-deployment of staff. The trust used tools from The Productive Mental Health Ward to measure staff wellbeing and introduced support and supervision mechanisms as part of efforts to reduce staff sickness levels.

Setting the scene
Hertfordshire Partnership NHS Foundation Trust is a large mental health and learning disability trust, with more than 44 separate units and a wide geographical spread. It had recently merged services from two existing units, into one 10-bed, short-stay assessment and treatment unit for people with learning disabilities and additional mental health problems. The unit has a staff of 25 nurses and healthcare assistants.

The approach
The trust began introducing the Productive Mental Health Ward throughout its units, choosing the Cassio Unit as one of the first. It decided to measure staff wellbeing through; clinical supervision, staff stress levels, staff sickness (via bank agency use). In addition, the trust developed a wellbeing tool for newly-registered nurses.

“Staff have developed an understanding of the impact of sickness absence. It’s not just about a shift in attitudes, it’s telling people: “you do a good job here and we value you and we need you here and miss you when you are not here.”

Sally Hughes
Clinical team manager
How they did it

It’s often the small things that make the difference. Within the NHS, this can mean feeling that you are important and not just an anonymous pair of hands needed to cover a shift. At the same time, when you are ill, you want to feel supported rather than someone who has caused a problem for the shift that needs covering.

Recognising this is key to the approach adopted by Cassio Unit in improving staff wellbeing. After opening as a new unit, merged from two others, staff felt insecure. They had faced significant change when the two teams amalgamated and had experienced temporary re-deployment and they were facing new ways of working.

Using the NHS Institute’s The Productive Mental Health Ward programme, wards and units were asked to choose at least one measure from the ‘improving staff wellbeing’ area of the measurement ‘jigsaw’. The Cassio Unit chose three measures: clinical supervision, staff stress levels and staff sickness which is measured using bank and agency use as a proxy.

The measurements are displayed visually where everyone can see them and staff stress levels are recorded at every shift, with all staff being asked to indicate how they feel at the end of their day. They marked a measurement chart with different coloured crosses which are very easy to distinguish. The use of agency/bank staff and clinical supervision is recorded in a similar manner. These visual displays then provide an instant ‘temperature check’ for managers. “Our service can be quite stressful to work in,” says Sally Hughes, clinical team manager. “We can have an 18-year-old with autism and psychosis and an 82-year-old with a learning disability and dementia,”

“What’s important to us?” asks Oliver Shanley, director of quality and safety. “We want to try and provide a high quality care environment and the opportunity for staff to develop themselves, with full support.”

“At the end of every shift, we check with all the staff and ask each individual if they felt stressed; green is no stress, amber is moderate and red is high,” explains healthcare assistant, Dani Robbins, who led the programme on the Cassio Unit, supported by The Productive Mental Health Ward facilitators. “It’s a mechanism for letting off steam. If someone is stressed, I ask them why and from there, we can talk about it.”

The trust has also found that regular clinical supervision – the aim is one session every four to six weeks per member of staff – also helps to reduce stress. They have also found that there is a link between stress levels and other indicators, such as high bank or agency use.

“If your staff are happy and relaxed, then it’s a better atmosphere for service users,” says improvement lead, Liz Haskins. “Because staff are aware of sickness absence and the fact that it is monitored, they have ownership and pride in the unit – they don’t want the measurement to go down.”
“We need to value our staff and invest in our staff,” says Jacky Vincent, lead nurse for learning disabilities and forensic services. “The staff are in control, they dictate to us the agenda and what they want to focus on.”

The unit has had recognition both across the trust and nationally, as more wards and units – 17 at last count – begin their Productive Ward journey. Visits from the chief executive and trust board were over-shadowed by a planned visit from chief nursing officer Christine Beasley – something which so far holds the record for increasing stress levels according to the visual displays!

“At the end of the day it’s all about interaction with the service users. If there are any issues that staff carry around with them it’s going to impact on that relationship. There’s a recognition that we won’t achieve all our aspirations around quality until we make sure the most important part of our workforce is looked after emotionally and physically. If that’s not looked after then that impacts on quality of care.”

Oliver Shanley
Director of quality and safety
Local results

Impact on quality of care
Lower staff sickness and a less stressed workforce means better quality of interaction with patients and better continuity of care.

Impact on patient experience
With this challenging patient group, interaction with staff is key. Continuity of care is also important and is maintained through reduced sickness absence.

Impact on staff experience
Staff report a better working environment, they are given the opportunity to discuss concerns and unload any stress. They have an active training programme through well-planned and monitored clinical supervision.

Impact on cost reduction
Reduction of the amount of nursing workforce hours lost due to sickness. From August 2009 to January 2010 the average number of hours lost was 96 per month the team are now recording an average of 59 hours per month from January 2010 to May 2010.
Key themes and methodology

The Productive Mental Health Ward
Focusing on the Knowing How We Are Doing module of The Productive Mental Health Ward (NHS Institute), has helped the Cassio unit to develop its new staff into a team. The measurements used within the module focus heavily on staff wellbeing and agreed, consistent measures for the effectiveness of staff health and wellbeing programmes, which can be used at board and national reporting level.

At all times, the staff felt supported by the trust board, with senior leaders being visibly supportive of the programme and keen to put staff health and wellbeing at the core of the organisation. Resources were provided, with a clear understanding that the work represents investment that will deliver both long-term savings and improved patient care.

Using The Productive Mental Health Ward programme has helped the team to focus on what really matters to them. Through the Knowing How We are Doing module, the team has built a vision and aspiration of what they want for themselves and the care that they deliver to their service users.

They identified that staff wellbeing was key and what really mattered were the three components that they knew were the drivers to reduce staff sickness – staff stress, availability of clinical supervision and bank and agency use. Find out more at The Productive Mental Health Ward:

www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_mental_health_ward.html

“The NHS needs to support and improve the health and wellbeing of its workforce if it is to meet the challenge of delivering high quality care without excessive cost. The health and wellbeing of its staff should no longer be a secondary consideration, but needs to be at the heart of the NHS mission and operational approach.”

NHS Health and Wellbeing Review (interim report)

“The Productive Ward has been really helpful. It has given us something tangible to use. I think people are genuinely keen. The reality is that we don’t live in a world of infinite resources and we have to maximise them. Things like Productive Ward enable is to do that; to change our thinking and to do things more effectively and efficiently but, ultimately, to provide a better quality of care for our service users: our staff get that.”

Oliver Shanley
Director of quality and safety
“There are other benefits for the NHS from tackling health and wellbeing issues for its staff. Firstly, and most obviously, the NHS employs more than one million people. Improving their health, and that of their families, will make a significant contribution to the overall goal of improving the health of the population. Secondly, improving NHS workplace health and wellbeing will help to embed the concept of prevention as a core skill for all NHS staff. Finally, effective action to improve the health and wellbeing of NHS staff will help to make them champions of a proactive and committed approach to health improvement.”

NHS Health and Wellbeing Review (interim report)
How to measure...Fit and well to care

The national picture
The NHS Information Centre (www.ic.nhs.uk) publishes a quarterly statistical bulletin relating to sickness absence rates for staff in NHS organisations captured from the Electronic Staff Record (ESR). At present this has only been published for three quarters and as such is still experimental. In these published statistics, sickness absence rates are grouped by organisation, organisation type, staff group or SHA.

The sickness absence rate used by the Information Centre is calculated by dividing the sum total sickness absence days by the sum total days available per month for each member of staff.

How is sickness absence defined?
Generally speaking, sickness absence is self-explanatory. It is the time when a member of staff who is contracted or has agreed to work but doesn’t work due to sickness. When thinking about measuring sickness absence you need to be clear what unit of time you will use. The measure used by the Information Centre has days as the unit of time, which may well suit your needs, but it may also be useful to measure hours or whole time equivalent (WTE) hours.

Another important definition that will need to be established is what exactly constitutes the ‘nursing and midwifery’ workforce (for example are HCAs included) and you may also want to analyse nursing and midwifery separately.

How might sickness absence be recorded and measured locally?
Sickness absence will invariably be recorded in the same way across most NHS organisations, via the ESR. How this data is used and at what level it is accessed will depend on your role in your organisation. If you are in a supervisory role for a team, you will be interested in your team’s absence rate overall and also the absence rate for individuals within the team. This information should be available, but we are aware that some do not routinely review this data or focus on improving it. You may also be interested in the sickness absence rates of similar teams in your organisation (benchmarking) so that you can understand whether your absence rate is typical, or higher or lower than average.

What is collected in terms of ‘process measures’ could be other components related to the health and wellbeing of staff. You can use the results of the NHS staff survey to get an indication of elements of staff wellbeing as these will relate to sickness absence rates. Other process measure might include:

- % of staff that received professional development plans annually
- % staff stress rate over agreed time period
- % of staff receiving clinical supervision over agreed time period.
In November 2009 the NHS Health and Wellbeing Report by Dr Steve Boorman was published in which a set of recommendations for improving health and wellbeing of NHS staff were made. These may also help you to think about potentially useful process measures.

www.nhshealthandwellbeing.org/FinalReport.html

**Measurement when making improvements**

If you are starting to focus on sickness absence, you should begin by understanding your current baseline. Use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting and also see if there is any further information that might be useful.
Ready to go - no delays
Introduction

The aim: to increase the number of patients in NHS provided care who have their discharge managed and led by a nurse or midwife where appropriate.

A practical summary

In recent years, discharge initiatives which aim to free up hospital beds have become common-place within hospitals. However, the development of new systems and roles, such as bed management, can leave nurses feeling disengaged from the proactive management of patient admission and discharge. And the increasing focus on bed capacity and turnover of patients can result in nurses feeling pressurised into speeding up discharge and removed from their role of caring for patients.

While new roles and initiatives can be valuable, changing the way nurses engage with discharge is key. Proactive management of patient discharge and embracing of nurse-led discharge will have a major impact on the flow of patients, faster discharge and less frustration for patients that are ready and waiting to go home.

Increasingly, nursing staff need to respond to this issue and increases in nurse-led discharge will meet the needs of patients and deliver the quality from admission to discharge that we inspire to.

The problem

There are a number of ‘myths’ relating to discharge that contribute to delays in many simple discharges from hospitals. Perhaps the most common belief is that some elements of the process that often cause obstacles to timely discharge are unavoidable.

Other myths include:
- effective discharge is less important than admission
- discharge led by nurses or allied health professionals is risky and can cause problems with patient safety
- clinical management means that estimated dates of discharge are not possible
- discharge is wholly the responsibility of one group of healthcare professionals.

Most nurses will have experienced, if not agreed with, some of these myths, which can be exacerbated by unclear roles and responsibilities within the multidisciplinary team. However, nurses can take a lead in overcoming these obstacles and develop clear systems and processes for the smooth and timely discharge of patients.

The cost

It is estimated that an average patient on an NHS surgical ward costs up to £400 per day, indicating real financial benefits to reducing length of stay (Webber-Maybank & Luton; 2009). It is estimated that a reduction in length of stay of between two and six days per patient could save NHS trusts £15.5m to £46.5m a year in total (NAO; 2000).

For the NHS as a whole the Select Committee of Health has calculated that, assuming the average cost of an acute bed to be £120,000 per year, and assuming that nationally there are some 6,000 beds occupied by patients who should be discharged, this represents an annual cost of £720 million.
A more conservative estimate was reported by the Department of Health in 2002 based on the cost of care for an individual awaiting discharge to be £100 a day and with 5,000 delays per day. This total annual costs to the NHS of £180 million per annum.

What we can do
The benefits of nurse-led discharge include a more timely planned discharge for the patient with fewer delays leading to a more positive patient (and family) experience as well as a lower risk of healthcare associated infections.

Nurse-led discharge does not necessarily require additional roles and investment, but it should be recognised as an extended role that should be voluntary for staff, come with training and be supported by clear guidance and policy.

To make nurse-led discharge work the whole process of discharge needs to be evaluated. The best place to start is to reflect on your own organisation’s effectiveness. By using the ‘Ready to Go?’ – 10 key steps to achieving safe and timely discharge you can have an idea of your own practices and where changes are required to improve outcomes.

Discharge planning should begin on admission, with visual cues, such as information boards or within notes, of the patient’s journey used to ensure efforts remain focused. The savings that can be made occur across the health and social care economy, not just within the trust. But money isn’t everything: don’t underestimate how much senior leaders value improvements in quality of care as well as cost savings.

The case studies
Cambridge University Hospitals NHS Foundation Trust neonatal unit has developed discharge and extended outreach services to get babies home safely and in a timely manner.

Cambridge University Hospitals NHS Foundation Trust paediatric nurses are now discharging their patients on the day case unit at Addenbrooke’s hospital, helping to reduce the time spent on the wards by children and parents, reduce staff time chasing a doctor to discharge and reduce anxiety and frustration for all.

NHS North Staffordshire Community Healthcare has developed a culture of continuing care with new discharge facilitator roles to support a new way of working centered around estimated days of discharge.

Sussex Partnership NHS Foundation Trust has created a new urgent help service designed to provide intensive home treatment to adolescents with acute mental health conditions, dramatically reducing the need for inpatient admissions and reducing length of stay.
Where are the best sources of information?

Department of Health: Ready to go?
Planning the discharge and the transfer of patients from hospital and intermediate care

Department of Health: Achieving timely ‘simple’ discharge from hospital. A toolkit for the multidisciplinary team
Community Care (Delayed Discharges etc.) Act 2003.

NHS Institute The Productives Series Admission and Discharge modules:
http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

National Audit Office: Ensuring the effective discharge of older patients from NHS acute hospitals


Department of Health (2002b) Health and Social Care Joint Unit and Change Agent Team, Discharge from Hospital: a good practice checklist
Department of Health, London.


**Case study: Cambridge University Hospitals NHS Foundation Trust**

**Home sweet home**

Neonatal cots are at a premium and long stays in hospital can have major impact on the families. Cambridge University Hospitals NHS Foundation Trust neonatal unit has developed discharge and extended outreach services to get babies home safely and in a timely manner.

**Setting the scene**

As a tertiary centre the unit takes babies from 23 weeks old and has 33 cots, including 17 ITU and 16 special baby care and eight beds extra care. The unit cares for 950 babies each year, including post-surgery.

There is increasing demand on services: more pre-term babies are surviving, with one in eight babies needing some form of neonatal input.

Staff were facing bottlenecks and length of stay was increasing and the role of the existing ‘transitional’ care unit lacked clarity. At the same time, the unit needed to find savings through the capacity improvement programme (CIP).

**The approach**

The unit designed a specific discharge coordinator role. They also invested in an outreach team for an extended community service to support babies with naso-gastric (NG) feeding tubes.

The outreach team has the overall view of the service and maintains clinical skills. The nursery nurses complement is being expanded within the team to carry out some of the visits and routine activities such as weighing.
How they did it

Getting babies home with their parents is a priority for the team in the neonatal unit. Early discharge prevents parents becoming dependent on NHS care and evidence shows that the sooner babies are home with their parents as a family unit, the better.

The team has combined two key elements: a discharge coordinator who can focus efforts on getting babies home, and an extended outreach service for patients who no longer need active care but who need support. “There was a community team but something was missing: the community team were out doing the visiting, however what needed to happen beforehand wasn’t taking place,” says Tina Pollard, clinical services manager for neonatal services.

The answer came in the form of discharge coordinator Sara Harris, who supports Julie May, lead nurse for the neonatal outreach team. The pair share an office and work closely together.

“There is a lot of focus on preparing, so they are ready to go home,” says Sara, a trained neonatal nurse and former health visitor. “Our involvement can start from admission. For most babies we look at a discharge date around their term date but most babies go home before that now because of the outreach team.”

Parents are empowered to provide special care with support from the outreach service. Without input from the outreach team, babies can stay up to five or six days longer. Parents keen to get their babies home are more likely to turn to bottle feeding to reach the discharge criteria of two feeds within 24 hours.

Thanks to the outreach team, babies from the local area can go home with their NG tube in situ. If the tube does come out while at home, the outreach team will visit the family to re-insert the tube, without the baby requiring readmission to hospital.

“As soon as a baby is admitted to the special care baby unit or intensive care, we identify who’s in that area that we can take home and we start a set of notes and map their journey through the unit,” says Julie.

“Initially when the idea of discharge is first put to parents, they are worried. Some parents don’t want to go home and we respect that. They will usually change their minds as they become more confident.”

There are enormous benefits in preparing parents for early discharge. In addition to the emotional trauma of having a baby in intensive care, many parents live far away from the hospital, facing difficulties with jobs, relationships and the associated costs of daily travel to the unit.

The discharge system has been designed to form part of the ‘normal working day’ on the ward. Julie is a key member of the morning ward round, where she will identify who is a special care baby. She will then work with the outreach team and the parents to facilitate early discharge. The outreach team typically cares for 10-15 babies at a time and is seen as a core part of the patient pathway. New staff to the unit will spend time with the outreach team on their visits as part of their training.

Alongside the new services, the team has redesigned the whole of the patient’s journey through the unit. In designing their new ways of working, the team found
there were few existing neonatal discharge pathways and so developed their own. The first step was to change the vague term ‘transitional care’ to ‘extra care’ and develop a service with clear criteria for entry. The extra care unit is designed for a maximum three-day stay for babies receiving IV antibiotics and requiring some help with feeding. If a baby needs more than three days, they are reviewed by a paediatrician and may be moved back into the more supportive environment of the high dependency unit.

“You can’t do it without the staff. I can say we need to do this, but if they don’t take it forward it doesn’t happen,” says Tina. “It’s a big thing to start to change the culture of the staff who have been here a long time. It’s about getting staff to do things a lot earlier.”

As a result, any success has been recognised as a team effort. Challenges remain, particularly when it comes to returning babies home from outside Cambridge, where outreach teams, if they exist, are not developed to provide a more intensive level of care. Here, Julie and her team have begun to develop a national reputation and now deliver training to staff from outside the trust, bringing in revenue.

“They really have developed the initiative locally and run with it locally and we have supported it as an organisation,” says Angela Thompson, deputy chief nurse and a former neonatal nurse from the unit. “We have had community nursery nurses for a long time but where we are now different is how we send babies home with gastric feeding. We have a very good success rate.”

“The parents can’t wait to be at home with their babies. They want to feel the baby is theirs and we are facilitating that.”
Sara Harris
Discharge coordinator
Local results

Impact on quality of care
A faster and more timely discharge with greater planning and closer working with the community team.

Impact on patient experience
Babies are being discharged home earlier with better planning and preparation as a result of the discharge date.

Discharge planning documentation is being revisited to allow parents to take charge of documentation, in line with the ‘red book’ held by parents.

Now identifying teenage mums for extra support.

Looking at end of life care pathway, working with hospice; traditionally end of life babies will die in hospital.

Impact on staff experience
Clear pathway through the neonatal unit, with closer working in the community.

Working towards standardisation through aligning criteria for outreach tertiary referral.

Impact on cost reduction
The work has saved 1.4 cots per day in special care baby unit, costing £450 a day.

The team is earning money through delivering a national training course. The outreach team also prevents readmission by reinserting NG tubes in the home.

Further information available from the NHS Institute website
Key themes and methodology

Moving care closer to home
The cost of the extended roles of the outreach team and the discharge coordinator is offset by the savings made through shorter hospital stays. The work of the team has secured support at the highest levels including its commissioners, who recognise the savings being made throughout the health economy.

Delays continue to occur where babies are waiting to go home to areas covered by other PCTs where no extended outreach service exists. This difference highlights the impact the service makes on length of hospital stay.

It is more than evident that commissioners need to deliver unprecedented levels of improvement in quality and cost of care that their communities experience. With challenges of variation in clinical practice and the difficulties of health inequalities present in each and every health economy, these testing challenges require commissioners to ask for different innovation to ensure we have different results that will deliver against the rising expectations.

Commissioners will receive different ideas from providers. To ensure that these ideas are beneficial commissioners have a responsibility to examine these. To understand what framework commissioners will work to, which will help with development of your idea as a provider, look at the guide Commissioning to make a bigger difference – a guide for NHS and social care commissioners on promoting service innovation (NHS Institute).

Improvement tip
“While incremental change remains highly desirable, at perhaps no other time in its history has the NHS and its partner public services needed innovation – step-changes in what we do and how we perform – more than now.”

Commissioning to make a bigger difference – a guide for NHS and social care commissioners on promoting service innovation (NHS Institute)

“Without innovation, public services costs tend to rise faster than the rest of the economy. Without innovation, the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder.”

Innovation in the public sector (Mulgan G. & Albury D.)
A useful framework for thinking about impact is the domains of quality. This framework below examples some of the indicators to consider under each dimension.

**Improvement tip**
**Tool: Seven dimensions of performance**

**Effectiveness**
For example…
Population health/wellbeing
Clinical outcomes
Improved functional status, quality of life, or independence
Free from complications

**Efficiency**
For example…
Cost
Consumption of provider time or resources
Consumption of time or resources of people (or carers) who use service

**Safety**
For example…
Absence of errors
Prevention of harm
Conformance to standards

**Timeliness**
For example…
Reliability
Waiting time
Time required completing a task
Influence fit to lifestyle or needs
Choice experience of care (including experience of carers)

**Timeliness**
For example…

**Equity**
For example…
Greater access and availability to all
Cultural sensitivity
Closing the gap in inequalities

**Coordination (across the whole system)**
For example…
Flow across whole journey/system
Integration of care plans
Shared information or assessments

**People-centredness**
For example…
Ease of use/ease of understanding
Convenience/engagement/involvement in care
Portability self-management

Commissioning to make a bigger difference – a guide for NHS and social care commissioners on promoting service innovation

Further information available from the NHS Institute website
Case study: Cambridge University Hospitals NHS Foundation Trust

Happy for patient to go
Paediatric nurses are now discharging patients on the ward, helping to reduce the time spent by children and parents in hospital, and reduce staff time chasing doctors to complete discharge – cutting anxiety and frustration for all.

Setting the scene
Children were facing long waits to be discharged by the consultant or a member of their team on the ward, usually at the end of the day. Some parents wanted to leave without seeing the doctor, resulting in a note of ‘left without medical advice’ in the child’s notes.

The trust had considered introducing of a discharge lounge, where patients can wait to be discharged to free-up beds.

A retrospective audit of 646 patients, carried in May to September 2007, found 39% of discharges were ‘delayed’ by more than four hours, 21% more than six hours and 11% by more than eight hours.

Within the trust, the paediatric service covers more than 80 different specialties, therefore nursing staff needed to consult with a wide range of medical consultants.

The approach
A literature search revealed there were no existing examples of paediatric nurse-facilitated discharge on which to base the new system.

A pilot of nurse-led discharge was set up on the day case unit in April 2008 and quickly became embedded into normal practice.

The nursing team set up a project group in September 2007, giving all medical colleagues the opportunity to comment.

The trust designed an education programme, including competency training and supportive documentation for nurse-facilitated discharge.

The paediatric team developed a nurse-facilitated discharge policy and procedures, which was ratified in May 2008.

They created an information leaflet for children and their families.

“We had considered using a discharge lounge, at the start of the project but we recognised that a major block was waiting for doctors to come and discharge patients, therefore we felt nurse-led discharge would be a useful tool.”

Corrina Hulkes
Senior clinical nurse/ modern matron (project lead)
How they did it

Children and their parents were facing delays of up to eight hours on paediatric wards at Addenbrookes hospital to see a doctor in order to confirm that they could go home.

The nursing team felt their young patients were getting a raw deal, waiting around for a routine discharge, which they, as nurses, could easily facilitate themselves. Long delays meant children often became fractious and parents frustrated. Because they had already seen the surgeon in recovery and been assured that the operation went well, most were happy to go home and wait until the follow-up appointment to see the surgeon again.

The wards have up to 80 different visiting specialties and some children would have to wait until the end of the day, when the surgeon or a member of their team was free to visit. As well as spending time having to reassure families, nurses were also regularly chasing doctors to request a discharge.

A retrospective audit of around 650 discharges enabled nurses to identify probable delayed discharges: those cases where the patient was fit for discharge but was waiting for confirmation by a doctor. “From the audit, we knew that 39% of discharges were four hours plus, 21% six hours plus and 11% eight hours plus,” says Corrina Hulkes, senior clinical nurse and modern matron, who led the project. “We realised we would have to engage consultants and explain the project; we sold it to them by saying that consultants would still have ultimate responsibility and that they would devolve some of that to nurses, within agreed parameters.”

The paediatric department established a project steering group and mapped improvement work to the trust’s key priorities: improving patient experience, patient care and patient safety. The project group developed a nurse-facilitated discharge policy, which was sent for ratification by consultant groups and the trust’s senior nurse. Few consultants responded but the policy was approved in May 2008.

“The nursing staff has really led it. The evaluation is where they have needed support,” says Angela Thompson, deputy chief nurse. “For the last two or three years, improving patient discharge has been one of the priorities and this fits with our strategic objectives of patient safety and patient experience, so they have had the support of the board and the senior nursing team.”

Engagement with the many consultant teams who had patients on the ward was gradual. Nurses regularly asked consultants if they were happy for the child to go home, and they quickly began to respond positively. Nurse-led discharge has now become an accepted part of the culture on the day case ward. Medics can write in the notes ‘okay for discharge’, enabling nurses to complete discharge, without requiring a doctor to make a further visit to the ward.

“It is really good that nurses are empowered to make decisions for their patients,” adds Corrina. “Doctors need to support and trust them and this has encouraged the nurses to look at other initiatives.”
Other initiatives include patient group directives (PGD) to allow nurses to administer oral sedation to children attending the ward for a scan. This enables a nurse to admit the child, administer the sedative and discharge them following their scan. The whole visit will no longer require input from a doctor.

Supporting staff through running and development has been key to success. Discharge is recognised as an extended skill only appropriate for experienced nurses, and staff can choose to opt out. For most staff the process feels like a natural extension of the care they already provide and, because they have spent the time caring for the patient, they believe they are able to give a better quality discharge providing more information. In addition, nurses are now able to write discharge letters. “It’s often the junior doctor that comes on to the ward to discharge patients, whereas the nursing staff have got a lot of experience with children in that specialty and they are often more familiar with the procedure and after care required than the junior doctors,” says Corrina.

Staff who felt that nurse-led discharge would be an additional burden, only needed reminding that, while it adds to the nurse’s workload, it reduces time spent reassuring patients that the ‘doctor is on their way’ or chasing a doctor to carry out a discharge.

“The nurses could see the benefit for the children and the parents: staff weren’t running around trying to find doctors to discharge patients or dealing with exasperated parents who want to go home.”

Cathy Barnard
Senior sister

“Nurses feel more empowered and valued: we have spent all day with that patient, we know when they are feeling better,” adds Carley. “It’s a dramatic improvement to the patient experience: families feel they get more information and more attention and it’s a higher quality discharge. A lot of our families travel a long way and it can make a huge difference to their day.”

“For patients it means a much more seamless service,” says Cathy Barnard, senior ward sister on the day unit. “Parents respect the nurses who have been looking after their children all day and trust that we know when they are ready to go home.”

“By the end of the pilot period of six months, 95% of discharges were nurse-led and we have maintained that,” says Carley Gibbens, paediatric practice development nurse. “We always ask if they would like to see a doctor and they rarely do, maybe one a month they will say yes. The parents are happy with the clinic follow-up appointment.”
Local results

Impact on quality of care
Of 588 discharges between April and September 2009, 410 were nurse-led.

The team has developed a patient group directive, which enables nurses to administer an oral sedative to children undergoing scans on the ward. Patients attending hospital just for a scan now no longer need to see a doctor.

Nurse-facilitated discharge is now being introduced in several adult wards.

A pro forma has been developed to allow nurse-led post surgery wound review for patients who come onto the ward.

Impact on patient experience
Children and their parents now experience a faster and better quality discharge, led by nurses who have looked after them during their stay.

Impact on staff experience
Senior members of the nursing staff now have an extended role, while junior medical staff spend less time on the ward after carrying out surgery.
Key themes and methodology

Leading for improvement
In Addenbrookes hospital, nurses led the programme to develop their extended role from the outset. They identified the issues, gathered strong evidence, generated solutions, consulted with colleagues and changed traditional ways of working. Nurse-facilitated discharge was quickly embedded on the wards and overwhelmingly accepted by consultant staff and their teams.

The success of improvement work is often down to frontline leaders and change agents. In order to change the way teams operate, the staff who do the work need to be empowered to identify and develop improvements themselves. A leader of improvement needs to move from a mindset of controlling and firefighting to one of devolving decision-making and empowering others.

A good improvement leader does not only need to be a good leader but to standout as able to deliver excellent care or enable other to do so.

High quality care for all: NHS Next Stage Review (2008) highlighted the importance of effective leadership in the system and, in particular, the need for greater involvement of clinicians in leadership. Incorporating leadership competences into education and training for all clinical professions will help establish a stronger foundation for developing high-level leadership capability across the health service.
“Achieving safe and timely discharge or transfer from hospital is a complex activity. The pressure to discharge or transfer patients and release beds, together with a trend towards shorter lengths of stay means that there is less time for assessment and discharge or transfer planning.”

Ready to go? planning the discharge and the transfer of patients from hospital and intermediate care

Department of Health

“Making change actually happen takes leadership. It is central to our expectations of the healthcare professional of tomorrow.”

High quality care for all: NHS

Next Stage Review (DH 2008)
Case study: NHS North Staffordshire Community Healthcare

Community hospital care for those who need it

NHS North Staffordshire Community Healthcare faced growing demand for their beds within a developing culture of continuing care, which meant discharge had become rare. The trust introduced discharge facilitators to support a new way of working centred around using lean methodology.

Setting the scene

There were 180 beds across three community hospitals which took GP admissions, provided rehabilitation and end of life care. Many patients were being admitted for continuing care and had an average length of stay six weeks.

The trust identified delayed discharge as a problem: one hospital site was being used as a nursing home, with some patients staying for up to five years.

In addition, there were waiting lists in the acute trust for transitional care and plans to reduce acute beds by 300 across the local health economy.

The approach

An external agency carried out an initial review to identify blockages in existing discharge processes ahead of the trust introducing The Productive Ward.

The trust developed services to provide sub-acute and active rehabilitation and appointed a discharge planning lead to expedite patient discharge. Under the new system, an estimated date of discharge was established within 48 hours of a patient’s admission to hospital and there were daily updates on discharge plans across the three hospitals.

All ward managers attended development days for intensive training in good practice around discharge and principles of lean.

Patients now receive an assessment by occupational therapy within 24 hours of admission with home visits and hospital-based social care practitioners were introduced to expedite home care.

The trust has also worked with social care services to design a single assessment process (SAP), reducing the original 14-page documentation down to five. It also developed a leaflet for patients, which explained the new discharge process, helping to manage patient and carers expectations.

“In two years, the length of stay has significantly diminished. In one area it was 13 weeks and it’s now down to 3.8 weeks. Trust-wide it was ten weeks two years ago and is now four. Staff are much more aware of the discharge process and it’s a key performance indicator for me.”

Kathryn Ramage
Matron
How they did it

Around half of the inpatients cared for by NHS North Staffordshire Community Healthcare require social care, with many facing moves into nursing or residential homes.

To introduce lean methodology into their discharge and admissions process, the trust began work to close gaps within the patient pathway between the acute and community hospitals, and between community hospitals and community health and social care services ahead of their work on The Productive Ward. The first step was to identify those patients who no longer needed to be in hospital by being very clear that an inpatient stay was for active rehabilitation. “Our length of stay was longer than it needed to be,” says managing director, Derek Pamment. “People were used to providing a nursing home type of facility; for some that’s been a difficult transition. The Productive Ward has helped and given us a lot of encouragement – it has helped lift our heads up out of the sand.”

Plans to reduce acute beds across the local health community meant increasing demand for rehabilitation in the community sector. This meant the trust needed to respond by developing a sub-acute service. However, the trust needed to change the culture of continuing care that had developed among both staff and the local community. One site was effectively providing a nursing home within a hospital setting, with resident patients who had been there for several years.

The trust recognised that staff were key to the success of any changes but that they couldn’t do it alone. Nursing staff remained the case managers for patients, while new discharge facilitators provided an overview and developed discharge packages. Patients are now seen and have their discharge package reviewed on a daily basis.

Under the new system, every patient has an estimated date of discharge, set within 48 hours of admission. The date is widely publicised via discharge boards and acts as a goal for all clinical interventions and other elements of care. The trust uses a traffic light system within their documentation: red is used when the patient is admitted into hospital and needs an assessment with the multidisciplinary team for an estimated date of discharge and amber indicates the rehabilitation phase, with specific actions to be taken prior to discharge in relation to social care needs.

“It is better for patients to go out of hospital in order to reduce their risk of infections and keep their independence,” says Rose Goodwin, associate director of nursing and quality. “There was a reluctance to use estimated dates of discharge because of the fear that bed managers would come back and harass wards. Now we have a date and we work towards it.”

“We are here to look at what causes delays and solve problems and find solutions,” says discharge coordinator, Sue Brewster. “We liaise with social workers and the intermediate care team. Lines of communication need to be in place to keep the information going. The delays are often because of patient choice: families want the best for their loved one and we can offer a lot of discussion and negotiation and support to come to a satisfactory solution. Sometimes people believe the best place is hospital, but it isn’t. Patient care has to be paramount.”
“We are looking at the progress of patients every day,” says Liz Smallwood, facilitator at Leek Hospital. “Half of our patients are a delayed discharge risk. They are elderly, with long-term conditions and require social care or nursing care.”

Discharge has become a core responsibility for ward staff. Nurses are the discharge coordinators, with ultimate responsibility resting with the senior sister, backed up by the matron, to ensure it takes place effectively. “When I first came two years ago, it was very much continuing care and that has changed to an intermediate rehabilitation focus,” says matron Kathryn Ramage. “I would walk onto a ward and ask staff to tell me about discharges that day and they would look at me blankly. Now I can walk onto a ward and know what’s going on. The discharge boards on the walls tell me what’s happening and where the blockages are. There’s been a lot of development of staff and that’s where we have seen the benefits. Staff have been given the tools to do the job,” she adds. “It is the senior sisters on the wards’ responsibility. Staff will ask for my advice and assistance if they encounter blockages in the system.”

“The discharge process is part of the admission process,” says ward sister Sue Morgan. “It’s nice to have facilitators there just to concentrate on discharge as their main role. Our facilitator will link with social services, link with the family and organise referrals.”

Ward-based social care assessors, funded by the local authority have been key to the success of the new system. Cynthia Rigby and Wendy Goodwin, both assessors, help ensure a seamless discharge. They assess patients’ social care needs and help patients and their families, as well as NHS staff, to navigate the, often bewildering, range of social care packages. In December 2009, it was taking up to three months for staff to complete a patient social care assessment. By April that had reduced to four to six weeks. The social care assessors work with patients during their hospital stay and for up to six weeks following discharge into the community. “The majority of patients require some element of social care,” says Cynthia. “Some patients are frail and most patients don’t know what is out there and what services are available.”

Working as a close-knit team has helped staff make discharges more dynamic and responsive. Through planning and preparation, staff are now well-versed in procedures as patients come to the last few days of a hospital stay. People are not overloaded with information but are prepared for their transition as they leave the hospital ward. “There is really good teamworking; there is no ego and is everyone is equal within that team,” says ward-based occupational therapist Elizabeth Dodd. “The discharge team can involve OTs, physios, the named nurse, social care, a discharge facilitator, a consultant and, outside of hospital, primary care, district nurses, and specialist organisations. We all work really well together.”

“We are with the patient 24 hours a day and we have more say as to whether they can cope at home,” says staff nurse Kerrie Smith. “If a discharge is planned then I don’t think there’s pressure. We know we have to get them home safely.”
Local results

**Impact on quality of care**
60% of patients now leave hospital on their estimated date of discharge. Any delays are usually caused by funding issues.

The trust has reduced length of stay from six weeks to four and has achieved 98% bed occupancy.

With the new system, individual hospitals own and manage their waiting lists.

**Impact on patient experience**
The team reports that readmissions for patients with chronic obstructive pulmonary disease (COPD) has substantially reduced from eight or nine per year to two or three.

**Impact on staff experience**
The skill mix on wards is being reviewed to ensure it matches the growing acuity of the patients.

Occupational therapists based in the hospital can now refer directly to the intermediate care team rather than having to go through a staff nurse.

**Impact on cost reduction**
Between August and November 2009, a pilot of occupational therapy assessment of patients within 24 hours reduced the length of stay by 19.5 days, saving £3,276. Among patients with complex care needs their length of stay has reduced by half from three months to six weeks. A return on investment calculation was undertaken in respect of patients with complex needs. Costs of the following inputs were calculated: staffing to develop the Lean Discharge Programme; staff training across seven wards, progress audits and material costs in terms of a whiteboard for each ward. Impact costs were calculated in terms of money saved in reduced length of stay for those patients with complex needs across one year. For every £1 spent NHS North Staffordshire Community Healthcare generated £5.34 of benefits over a year. This calculation does not take into account the additional quality benefits that have not been monetized including improved patient and family experience and fewer COPD readmissions.

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"From admission we talk about discharge so patients are not coming into hospital for a long stay, they are working towards rehabilitation from the minute they get here. If that’s not possible there’s a process for allocation of continuing care, whether that’s residential care, nursing home or a home care package."

Sue Brewster
Discharge coordinator
Key themes and methodology

Make everyone part of the change
NHS North Staffordshire Community Healthcare recognised the benefits of their investment, not only for the trust but for the whole health economy. They have become expert at keeping the focus on the end goal of an estimated date of discharge and ensuring that changes to that date occur only through clinical necessity. Ward staff work across professional and organisational boundaries, with ward-based social care staff becoming part of the care team.

Using lean to transform services
The term lean was developed from motor manufacturers and how they organise their production processes. This approach can be described by:

Five principles of lean thinking enhance the quality of healthcare by improving flow in the patient’s journey and eliminating waste.

- Specify value
- Identify the value stream or patient journey
- Make the process and value flow
- Let the customer pull
- Pursue perfection

“Lean thinking, developed from the Toyota Production System, has been applied in many competitive sectors. Tesco, for example, is one of the biggest and most successful lean companies in the world.”

Kathryn Ramage Matron

“Make everyone part of the change”

“It’s about seeing things from a health economy perspective; if we don’t discharge our patients, the acute sector can’t access our beds.”

Kathryn Ramage Matron

Improvement tip

Further information available from the NHS Institute website

Going lean in the NHS (NHS Institute)
There are a variety of tools that can be used to support the lean approach, and some of these tools are common in many other approaches of improvement. Some of the common approaches are:

- Ohno’s eight wastes (p216 The Handbook of Quality and Service Improvement Tools)
- The 5S: sort, set, shine, standardise, and sustain (The Productive Series)
- Value stream mapping (p101 The Handbook of Quality and Service Improvement Tools).

Although lean is fundamentally recognised for its tools, it is the whole process and approach of applying the principles rather than just applying the tools.

Lean thinking identifies the least wasteful way to provide better, safer healthcare to patients with no delays.

Using the principles of lean and having the emphasis on discharge planning helps the multidisciplinary team really focus on the patient journeys, which means that everyone knows what needs to happen to get that patient discharged. There are some common key elements when planning discharge – regardless of whether the patient is emergency or elective. Using the lean approach helped NHS North Staffordshire Community Healthcare team address the issues and make these processes stick within their organisation.

There is a range of discharge planning tools and guidance available:

- British Association of Day Surgery, Ready to go Home 2002
- Achieving Timely Simple Discharge from Hospital: A Toolkit for the Multidisciplinary Team
- Discharge from hospital pathways, process and practice (Department of Health)
- Ready to go? (Department of Health)

"Health care professionals, and nurses in particular, spend a disproportionate amount of time managing the mismatch between when a bed is needed (patient admitted) and when it is available (patient discharged)... This leads to frustration for the whole team and poor quality care for patients and carers."

Achieving Timely Simple Discharge from Hospital: A Toolkit for the Multidisciplinary Team
Case study: Sussex Partnership NHS Foundation Trust

Developing a CAMHS crisis resolution and home treatment service
With the opening of a new purpose-built adolescent unit, Sussex Partnership NHS Foundation Trust developed a new urgent care service designed to provide intensive home treatment to adolescents in order to dramatically reduce the need for inpatient stays and cut the length of stay.

Setting the scene
The trust set up a community outreach team eight years ago. In 2009, it opened a new purpose-built adolescent unit with 12 beds catering for 12 to 18-year-olds and has around 60 admissions a year. Half of patients in the unit are admitted with eating disorders.

The average length of stay was typically two to three months and longer for certain conditions.

Consultant-led admission meant that patients required assessment in clinic, which resulted in waiting lists.

The approach
The trust re-designed the existing outreach team by engaging key stakeholders, including local CAMHS services, Tier 4 services, commissioners, young people and families. Clarity about the service model was important to ensure that it added value to existing services.

The trust developed an urgent care service, led by mental health practitioners, to provide intensive support available to patients within hours.

They invested in five additional people and now have 15 staff across three localities in Sussex.

The multidisciplinary team includes nurses, occupational therapists and support staff.

Speeding up discharge has been part of an overall approach to reduce hospital admissions.

Length of stay has reduced from two to three months to six to eight weeks.

The urgent care service supports weekend leave for patients nearing discharge.
How they did it

For young people experiencing a severe mental health condition, being removed from everyday life into hospital can have lifelong repercussions and can be detrimental to long-term recovery.

Sussex Partnership NHS Foundation Trust launched its urgent care service, named by the young people for which it cares, in 2010. The service has received enthusiastic reviews from patients and families alike.

The trust’s ethos is to provide a single journey of integrated care for patients. For urgent care patients, this means introducing a short spell of intensive home treatment into that journey wherever it is needed, either before or after discharge from hospital, as well as working with patients for whom admission can be avoided entirely.

Home treatment translates into several visits a day, when needed, for a period of up to eight weeks. Three clinical teams work across Sussex, involving mental health practitioners, nurses, psychologists, support workers and other therapists.

“The urgent care team often get involved before admission and will continue to see patients during their admission, planning discharge,” says service manager, Anna Guildford. “Access for families has changed dramatically and some families who may have thought their child needed to be in hospital now have confidence in the service and feel they are supported enough to get through it at home.”

The urgent care service works across professional boundaries, with clinical involvement and support at the deepest level. As a result, the teams have extended their role into areas traditionally carried out by doctors, freeing up medical time to be more responsive to patients and to the teams themselves when they need support. “We are able to use our medical staff in a consultative way rather than as the first line of intervention. It’s been crucial for us to be able to ask for help,” adds Anna.

Dr Tim Gillett, consultant child psychiatrist, supports the new system that has transformed his working day. He has led training for staff to enable them to assess risk, utilising his expertise when needed. “Our length of stay has reduced. An acute admission would often
take a long time to discharge. Now, if we are not sure if a young person can manage fully in the community, we stagger discharge so we keep a bed open for them should they need to come back or go home for extended periods of weekend leave.”

“Often the work that goes on before admission will influence how long that stay needs to be, and may actually avert it completely,” says general manager Peter Joyce. “It’s important for patients to see that we are all working together as a team for their outcomes.”

“It’s a different way of working,” says Paul Mazzer, ward manager at Chalkhill. “We are supporting young people back home as quickly as possible. We are discharge planning from the outset. It’s good for the young person and families and for the rest of the team to be aware so we can work towards the same goals. It’s better to have a short, effective stay, so they don’t lose their social networks. We have been fortunate because most of the staff on the urgent care service have come from the ward and are aware of how we work in the unit and what we are trying to achieve.”

“There’s always an awful lot of informal support between colleagues,” says team leader Claire Webber. “The skill base within the team is such that people are able to learn from each other’s practice. In my team we have support workers, we have nurses, we have psychologists and I am an occupational therapist. That gives us a good skill mix because people have not only their professions but also the range of experience.

“We are able to get involved right from the outset and engage with the young person and family and work closely with them and provide the best possible care. The out-of-hours working has had the biggest impact and we are working much more intensely for a much shorter period. The benefit for the families is to be able to access our team at a time when they need to. There’s no such thing as a typical day: I could be doing two, three or four visits a day to a young person with their family. That could be sitting down in the kitchen and talking with the family or going out for a walk in the park. I do feel we are making a difference.

“Sometimes it’s only a small difference, but to a young person that can be a big difference.”

“A long hospital admission erodes self-confidence, so the briefer the period of time away from the family, home, school and friends, the better for the service users. It’s a much more exciting way of working, breaking away from those traditional roles is better for patients and their families.”

Dr Tim Gillett
Consultant psychiatrist
Local results

Impact on quality of care
The trust now has a more streamlined referral process, offering support to 80 families.

Urgent care teams are exceeding their target of 15 contacts per clinician per week.

Impact on patient experience
The urgent care teams respond to all urgent referrals within four hours.

The Royal College of Psychiatry is now exploring their intensive home treatment model.

The team adds three to five contacts a week into the patient’s existing care plan – support provided for up to six weeks with regular reviews to ensure services meet the patient and families needs.

Impact on staff experience
Wards now have a greater concentration of complex patients in their most acute phase. This has prompted a review of the staffing establishments to match clinical need.

Impact on cost reduction
Length of hospital stay has reduced from 12 weeks to 6-8 weeks.
Key themes and methodology

Stop before you start
Sussex Partnership NHS Foundation Trust wanted to create a new service that would sit seamlessly within the existing services available. It needed to fit within the newly built adolescent unit, where the focus was on intensive, effective, short treatments. They began with feedback from families and young people about what they valued about the services already available in order to help identify the elements they needed to keep. Working across disciplines and with senior support and clinical involvement, they created the new urgent care service.

The Thinking differently guide from the NHS Institute uses a framework to guide you through the process from identifying and challenging an issue through to making ideas into reality. These phases are:

- stop before your start
- generating lots of ideas
- selecting and testing ideas to make a difference.

Sussex Partnership NHS Foundation Trust stopped before they started by getting other people’s points of view, with this knowledge the team were able to see the issues in a different light which helped them to generate lots of ideas of what they need to keep and what they needed to change.

There are many tools that are tried and tested for coming up with new ways of working some of these may be first order or second order change. Everyone likes to think they are creative and are able to think differently about problems and solutions but to really move from first order change to second order change you need to make three deliberate mental activities, attention, escape and movement. Find out more information about this tool in the Thinking differently book at www.institute.nhs.uk

“Creative ideas have no value until they are put into action.” Paul Plsek

“We are working with young people with high levels of risk in the community. For us to be able to manage these people at home, we need good multidisciplinary team back up with medical staff.”

Claire Webber
Team leader
Improvement tip

Tools for generating ideas
That’s impossible!

We often take it as read that something is impossible. Maybe we weren’t able to do it in the past and haven’t recently reconsidered the possibilities. But, if you really think about it, you should find it possible to do (or at least come close to doing) many ‘impossible’ things. That’s impossible! is a tool that you can use to raise expectations and jolt people into believing that extraordinary things really can be achieved.

Thinking differently book at www.institute.nhs.uk

“Change is a pre-requisite for survival amongst individuals and even more so in organisations which they create and in which they work. Put simply, if an organisation does not change what it offers the world – its products or service – and the ways in which it creates and delivers those offerings, it may not survive.”

John Bessant
High-involvement Innovation
How to measure…Ready to go – no delays

The national picture
Hospital Episode Statistics (HES) captures delayed discharge as the date when a patient is medically ready for discharge from a hospital bed but couldn’t be discharged.

Questions 59, 60, and 61 of the Care Quality Commission’s Adult Inpatient Survey are centred on delayed discharge and results from this survey are used to benchmark trusts performance in this area with other trusts.

How are nurse-led discharges defined?
Nurse-led discharge has revolved around promoting nurses managing ‘simple discharges’. The Department of Health defines simple discharges as: “those patients who can be discharged to their own homes and who have simple health care needs which can be met without complex planning”.

It is important to remember that although nurse-led discharge is commonly associated with simple discharge it can also be appropriate for patients with agreed criteria as part of a medical plan and for patients with acute on chronic episodes of illness where their chronic/complex needs have not altered during the admission. It is also recognised that nurse-led discharge can be applicable to both unscheduled and elective admissions with the right support and discharge planning processes.

You will need to agree local definitions and guidelines that describe when and when it is not appropriate to have a patient’s discharge managed by a nurse or a midwife.

How might nurse-led discharge be recorded and measured locally?
Nurse-led discharge is actually a process measure – the outcome measure is the number of patients who have a delay in their discharge. Evidence and experience tells us that having nurses leading the discharge process is an effective way of influencing the outcome measure. It is important to understand that there are also other things that need to be done to influence to outcome measure, and also that it is possible to reduce discharge delays without implementing nurse-led discharge. It would be especially useful to create a driver diagram (see measurement section) to help understanding in this action.

Many organisations routinely use patient administration systems (PAS) to record the outcome of discharge of the patient. Although the person managing the discharge of any given patient will be recorded it is less likely that the data regarding the number of patients having the discharge managed by a nurse will be actively monitored and analysed (although some systems will do this). This information could be expanded to include other options such as whether the discharge was simple or complex. You need to use the principles of good measurement outlined in the measurement section (page 16) for to make sure all of the measures are agreed ad defined appropriately.

As well as looking at the amount of nurse-led discharges it is useful to have some additional ‘process’ measures, some examples of process measures are:
• % of nurses and midwives competent to be nurse/midwife led discharge practitioners
• % of simple discharges daily
• % of patient with a expected discharge date and how many are reviewed daily.

Because discharge is a complex process with a number of different steps, it is important to be really clear about which of the steps you are trying to improve. It is possible to fully implement nurse led discharge, but to have no impact on the outcome measure of the number of patients who experience a delayed discharge (although again experience tells us this is unlikely). Measurement should focus on the components that need to come together to enable the discharge.

Measurement when making improvements
As with any improvement work, you should start by looking at what you are already measuring, and also what others, either in your organisation or elsewhere, are measuring so that you save time and learn from others experience. You should use the seven steps to measurement framework outlined in the measurement section (page 21) to link together what you are already collecting also see gaps where you may need to collect extra information.
Protection from infection
- urinary tract infections
Introduction

Urinary tract infections (UTIs) make up a large proportion of healthcare-associated infections (HCAIs) in the UK – and four out of every five can be traced to indwelling catheters (Health Protection Agency, 2009). This means there is massive scope for both improving the quality of patients’ lives and saving precious healthcare resources by reducing the occurrence of UTIs.

A practical summary

It is clear that, if we want to reduce the number of catheter-associated urinary tract infections, then one simple thing that we can do is to catheterise patients only when absolutely necessary and, also, minimise the time that a catheter is in place. While catheterisation can be necessary for certain symptoms, such as acute retention and for monitoring urinary output, it should be the last resort for managing incontinence.

Catheterisation carries many risks. Tissue damage, bladder damage, infection, encrustation and blockage of catheters are just some of the potential problems – and all of these risks increase the longer the catheter is in situ. Responsibility for ensuring that there is a clinical need for catheterisation lies with all clinicians performing the procedure. Ongoing catheter care is the responsibility of nursing staff and forms part of basic nursing care provided for patients.

The problem

Patients with indwelling urinary catheters, patients undergoing urological manipulations, long-stay elderly male patients and patients with debilitating diseases are at high risk of developing nosocomial UTIs (Kalsi et al, 2003). Those with indwelling urinary catheters are most at risk as 80% of UTIs can be traced to indwelling urinary catheters (National Audit Office, 2004).

The cost

There is a lack of up-to-date cost information around UTIs. It was estimated that the 1994/5 costs of treating UTIs in the NHS were in the order of £124 million for the year (Plowman et al; 2000). The main elements of the cost burden come from the numbers of UTIs, and the increased length of stay associated with them. From this same study it has been estimated that the additional cost of treating an inpatient with a UTI is £1,327 per patient. If this 1994/5 figure is corrected to take account of inflation it equates to circa £1,968 at today’s prices (using the Bank of England inflation calculator).

What we can do

There has not been as much focus on UTIs as other healthcare-associated infections, such as meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (CDI). In many trusts, the number of catheter-acquired urinary tract infections (CAUTIs) is not routinely measured. Where audits have taken place, the rate of UTI was shown to be as high as 32%. In addition, there was variation in the type of catheter available; type of catheter used; systems for stock management and clinical identification of which patients required catheterisation.
In the following case studies a combination of approaches were undertaken including:

- a programme to reduce the number of catheters used
  standardisation of equipment, insertion protocols and optimal catheter care
- a continuous programme of education and training to improve catheter care
- a policy of early removal.

Healthcare assistants are a key group in relation to improvement work in this area and the case studies show that they have responded enthusiastically to training resulting in increased confidence and competence in providing catheter care. They have also been given the support – and permission – to challenge the necessity of a catheter for patients.

The case studies

**Birmingham Royal Orthopaedic Hospital NHS Foundation Trust** has maintained a zero rate of catheter-acquired urinary tract infections a year after bringing infection control services in-house in 2008/09.

**Brighton and Sussex University Hospitals NHS Trust** has made learning fun with its giant Bladders and Ladders board game, focusing on reducing catheter use and improving care for patients.

**Winchester and Eastleigh Healthcare NHS Trust** introduced Urinary Catheter Assessment and Monitoring forms to record and document all insertion and ongoing urinary catheter care. The process supports a daily review of patients with a catheter to support early removal.

“Arrangements to prevent and control HCAI should be such as to demonstrate that responsibility for infection prevention and control is effectively devolved to: all professional groups in the NHS body clinical specialties and directorates and, where appropriate, support directorates or other similar units.”

The Health Act 2006
Code of Practice for the Prevention and Control of Health Care Associated Infections

The recommendations on standard principles provide guidance on infection control precautions that should be applied by all healthcare personnel, and other carers, to the care of patients in community and primary care settings.

Prevention of healthcare associated infection in primary and community care NICE June 03
Where are the best sources of information?


Department of Health – Saving lives
www.clean-safe-care.nhs.uk
Department of Health – High Impact Intervention 6 – urinary catheter care bundle

Infection control nurses association – Core competences for infection control http://www.ips.uk.net/icna/Admin/uploads/Competencies2ndeditionpdf.pdf

NHS Quality Improvement Scotland – Urinary catheterisation and catheter care best practice statement

Department of Health – The Health Act 2006 - Code of practice for the prevention and control of healthcare-associated infections
www.dh.gov.uk/assetRoot/04/13/93/37/04139337.pdf


http://www.cdc.gov/ncidod/dhqp/dpac_uti_pc.html

National Institute for Health and Clinical Excellence; 2006; Clinical Guideline 40: Urinary Incontinence: the management of urinary incontinence in women; NICE; London
http://www.nice.org.uk/nicemedia/pdf/CG40NICEguideline.pdf

National Institute for Health and Clinical Excellence; 2006; Clinical Guideline 40: Urinary Incontinence in Women: costing template; NICE; London


Scottish Surveillance of Healthcare Associated Infection Programme; 2005; Surveillance of Catheter Associated Urinary Tract Infections: Annual Report; Health Protection Scotland; Edinburgh

Wound, Ostomy and Continence Nurses Society Clinical Practice subcommittee; 2009; Indwelling Urinary Catheters: Best practice for clinicians; WOCN; New Jersey
Case study: Birmingham Royal Orthopaedic Hospital

Think link
Birmingham’s Royal Orthopaedic Hospital has maintained a zero rate of catheter-acquired urinary tract infections for the past year after bringing infection control services in-house – a far cry from the 32% rate revealed in an audit in 2008.

Setting the scene
The hospital has 150 beds and carries out in excess of 16,500 procedures each year – mostly elective hip and knee replacements. The average length of stay is around five days. Infection prevention and control was provided by an out-of-house service. Low rates of meticillin resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile infection (CDI) meant there was a general perception that there was no infection problem. The rate of catheterisation was 21% and this was considered appropriate due to nature of the patient group.

An audit revealed a 32% rate of catheter-acquired urinary tract infections compared to a national average of 7.3%.

A catheter stock audit discovered that many different types of catheter were being used, with no standardisation across the hospital. There were around 660 catheters in stock, including 137 that were out-of-date.

The approach
The team standardised catheters by selecting only one type to be used throughout the organisation. They worked with suppliers that offered a ‘money back’ approach to using more expensive silver-coated foley catheters: if the catheters failed to reduce infections by a third in six months, suppliers would refund the cost or replace all the old stock. Stringent stock control was introduced, so that wards now only stock a total of 10 catheters in two sizes (three sizes in HDU and theatres). Alongside these changes, mandatory clinical skills courses and on the ward training provided skills in aseptic non-touch techniques.

The work was carried out as part of the ‘Think Link’ programme, which brings together the five elements of good infection prevention into the chain of prevention. These are:
• cleaning
• universal precautions
• hand hygiene
• communication
• patient power.

Regular snapshot audits were carried out into catheter use.

“The most satisfying element is that we have raised the profile of infection control, and have focused on areas other than national targets. It was an area we identified, and improved patient care as a result.”

Lindsey Webb
Director of nursing and governance
How they did it

When the Royal Orthopaedic Hospital brought its infection control services in-house, it knew its patient type meant rates of meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile infection (CDI) were very low, so staff considered other areas where they could improve patient care.

“Government targets were focused on MRSA bacteraemia and CDI, which didn’t really affect us. Our priority was to get a baseline on everything to decide where our priority should be,” says Sarah Mimmack, infection prevention and control lead. “Our surgeons kept saying, ‘we have really low infection rates – why do we need an infection control team?’”

The audit revealed a 32% rate of catheter-acquired urinary tract infections (CAUTIs), compared to national estimates of just over 7%. This provided a focus for their work, as part of the ‘Think Link’ programme. This has five elements that support infection prevention, the idea being that the chain of these five elements should be unbroken in order to maintain high levels of prevention.

The trust reviewed the types of catheters available and wanted to use silver-coated foley catheters – which report a lower risk of infection, but are more expensive. The suppliers came up with a novel idea: reduce CAUTIs by a third – or your money (and stock) back.

“It was very difficult to argue with when our CAUTI rate was so high – that gave us ammunition – and the trial change to the new catheter wasn’t going to cost us any money,” says Sarah.

Around two-thirds of staff have undergone aseptic non touch technique (ANTT) training, which has been provided in clinical areas through practical demonstrations and as part of the clinical skills and mandatory training. The basis of the technique is that the only way to truly reduce the risk of infection is not to touch key areas, even if you are wearing sterile gloves.

“Equipment is only as good as the people operating it,” says infection prevention specialist nurse, Laura Ludman, who delivers the training alongside clinical skills tutor, Karen Hughes. “It’s quite complicated to do something trust-wide: it takes a lot of time to give the
training. The staff were a little bit reserved about the concept of ANTT initially. However, the more we have become visible, the more interest there is; people are now asking for training. It feels very relevant to the nurses involved.

“The idea behind the technique is that it doesn’t matter if you are wearing six pairs of sterile gloves, you should not touch what you can avoid touching.”

Within six months the CAUTI rate was down to 5%. For the past year, it has remained at zero. “I would say that both the introduction of standard catheter stocks and the ANTT training have been vital to making this work,” adds Sarah.

She admits a big part of the work was to address the complacency caused by having low infection rates for the higher profile targeted areas, such as MRSA and CDI. Some even blamed the infection prevention team for ‘increasing the infection rates’ as a result of better reporting. “We have forced through various changes over the past three years, not least the perception that we didn’t have an infection problem.”

Lindsey Webb, director of nursing and governance, says: “We have incidentally reduced our catheterisation rate, but the work was focused around reducing infections. Reducing the catheterisation rate was an added bonus to us. I am fortunate enough to have a very committed board. My main role has been about helping them to understand the national targets and that there’s lots of other work we can do. Training has been absolutely crucial.”

The team work closely with Pauline Jumaa, consultant microbiologist at Birmingham University Hospitals. She says: “There is ignorance over what a CAUTI is. Diagnosis of urinary tract infections is key. Around half of women aged over 65 will have asymptomatic infection and it’s not clinically significant unless there are symptoms.”
Local results

Impact on quality of care
Reduced CAUTI means no additional length of stay for patients.

Impact on patient experience
Reduced risk of urinary tract infection and the associated discomfort and worry. The reduction in the catheterisation rate also means that fewer patients have the discomfort and inconvenience of a catheter.

Impact on staff experience
Aseptic non-touch technique training programme now used in other invasive procedures, such as canulas. A new catheter tray is being introduced, which will save around eight minutes per catheter insertion. The work continues, with a rolling programme of training and education.

Impact on cost reduction
The team has estimated savings of £185,000, by reducing the need to treat CAUTIs.

The increased cost of the new catheters was covered by reducing over-stocking and preventing waste through standardised catheter use and stock control.
Key themes and methodology

Get sponsored
The team secured £9,000 funding to support the project through the trust’s 3Ds committee, which invests £80,000 a year in new devices and dressings on the basis of business cases submitted by staff. Demand for funding far outstrips the committee’s budget. This made it crucial that the team developed a strong business case – and identified key individuals who would support their case.

Clinical services manager, Lynn Davies, sponsored the business case, applying her clinical knowledge to convince her fellow committee members. She admits it was very satisfying to feed back that their funding of around £9,000 had saved £185,000.

“Putting together a business case is crucial to improvement programmes and it is important to have a sponsor, to collect as much evidence as you can and as much advice as you can.”

Lynn Davies
Clinical services manager

“Communication is absolutely fundamental and has to happen on lots of different levels. It is a serious issue, but that doesn’t mean we shouldn’t make it memorable. We produce a newsletter, called Talking Dirty, which has jokes and information that’s accessible to everyone.”

Laura Ludman
Infection prevention

“Nursing and midwifery fellows should be appointed as champions of change and leaders of transformational peer review teams that raise standards and embed innovation and excellence.”

Front line care: report by the Prime Minister’s Commission on the Future of Nursing and Midwifery in England (Ann Keen)
It’s not just what you say, but how you say it
Getting the message across has been vital in reducing CAUTI rates. First, the team had to address the perception that there was no infection issue and then they had to publicise their improvements to show that they were having an impact and to get others on board. The team used ‘neuro-linguistics’ to maximise their message, ensuring staff understood their work was about infection prevention – not control, prompting a stronger response and leading to more action.

Communication style, language and the visual tools we use are very important in providing the glue to help you engage and mobilise groups to assist in telling the story of change. Using different ways of communicating, for example with a newsletter called ‘Talking Dirty’, is a simple prop that supports the message and encourages participation. This is, often, the very thing that will bring it to life for the audiences; these then become the vehicles that help convey the core message.

“Once individuals have decided to join a movement, their personal experience of participating in that movement play an important role in determining how long, and how much they personally contribute to its activity.”

Towards a million change agents
A review of the social movements literature: implications for large scale change in the NHS.
Paul Bate, Helen Bevan.
Case study: Brighton and Sussex Hospitals

Ladders and Bladders
Making learning fun was the aim of the game for nursing staff at Brighton and Sussex hospitals, where playing Ladders and Bladders is helping to reduce catheter usage and rates of catheter-associated urinary tract infections by educating staff in best practice approaches with regards to catheter care.

Setting the scene
The work began more than three years ago, when the trust began looking at introducing new catheter products which claimed to lower infection rates.

Before investing in new products, the trust carried out an audit to look at catheter use throughout the two sites that make up the trust. They found catheters were being used too often and for too long, sometimes without clinical need, and that the standard of catheter care was varied.

The approach
The team developed a comprehensive trust catheter action plan that aimed to ensure:

- catheters are only inserted if there is a clinical need
- need is monitored daily
- the incidence of CAUTIs is measured
- staff competency
- integration between primary and secondary care
- the use of standardised catheters in the trust and a discontinuation in the use of short-term and female length catheters – through a catheter amnesty.

The board game, ‘Ladders and Bladders’ supports the overall objectives and helps to educate staff in a different, fun and engaging way.
How they did it

Matron Paula Tucker wanted to improve knowledge of catheter use and care at Brighton and Sussex University Hospitals NHS Trust but needed something attention-grabbing to capture the imagination of busy ward staff.

Her answer was Ladders and Bladders, a giant floor game which gets staff into teams to compete against each other’s knowledge of good catheter care. The new game was piloted in its original format (as a giant snakes and ladders game) with healthcare assistants in 2009, as part of a comprehensive programme to reduce catheter use – and reduce catheter-acquired UTIs.

This work has helped reduce catheter usage from 24% to 16.7% in three years and cut the incidence of CAUTIs from 18% to 13.3% over the same period. This data was collected from several wards across the trust, including wards of different specialities, age and gender. They have also seen an improvement in evidence-based care of urinary catheters. With the assistance of NHS Innovations South East (NISE), Ladders and Bladders is now in commercial production and will be on sale in 2010 for use by other hospitals and healthcare settings. An electronic version should be available in 2011. The game comes with 70 questions, including: “What solution do you use to inflate a catheter balloon?” (The answer is sterile water/saline).

“The questions don’t have ‘yes’ or ‘no’ answers, but have been designed to invite discussions every time you ask a question,” explains Paula. “Other players can challenge the answer or, if it’s wrong, it is up for discussion. You can make the game as long or short as you want.”

The game was piloted at a senior nurses meeting in August 2009 and a second session took place at the trust’s healthcare assistants’ conference in October – with more than 50 people taking part. Once the new design is available, it will be accessible for every ward/department to use as a teaching tool.

“Healthcare assistants (HCAs) are so important, we can teach them, empower them to take information back to the ward, undertake audits and challenge practice,” says nurse specialist, Sally Goodman. “Their knowledge base is fantastic and they are enthusiastic about becoming catheter champions.”

Chief nurse, Sherree Fagge – who teamed up with chief executive Duncan Selbie to play (and win) the game – said: “We are starting to see reductions and that will be improving both the quality and the experience and care of our patients.”

In addition to the game, the trust has developed a comprehensive range of material to support the delivery of excellent catheter care. Catheter care bundles are in use throughout the trust, aiming to ensure evidence-based practice is maintained for the insertion and ongoing care of urinary catheters. A protocol has been developed by nurse specialist, Sally Goodman, to ensure the correct medical and nursing management of male patients that present with acute retention of urine. The trust has created a referral form for patients discharged with a catheter and these patients were also discharged with a catheter diary.
This is supported by improved patient and carer information, and making sure patients had adequate supplies to enable them to self-care when discharged, if appropriate.

“It’s accepted that anybody with an indwelling catheter is more likely to get infection, but CAUTI can be difficult to diagnose,” says Angeline Boorer, lead infection control nurse. “This programme broadens awareness and makes everyone responsible.”

“Staff have limited time to read pages and pages of policies. People were attending training sessions and the feedback was that they were too long and uninspiring. I listened to what nurses were saying and I thought we could do something to make the learning more fun. So, I bought a big mat, an inflatable dice and got people up out of their seats and, so, developed Ladders and Bladders. It’s informal and good for a big group and we play the game and give prizes.”

Paula Tucker
Matron
Local results

Impact on quality of care
This work has helped reduce catheter use from 24% in 2007 to 16.7% in January 2010 and cut incidence of CAUTIs from 18% to 13.3% over the same period. The trust has also seen an improvement in care, adherence to storage policies, antibiotics use and discarding of disconnected bags.

There has been a reduction in A&E attendances and trust admissions with catheter-related problems. The interface between primary and secondary care has improved by the use of a discharge proforma and patient diaries.

Impact on patient experience
Improved patient care, satisfaction and dignity by reducing invasive interventions and infection rates. Empowered patients and staff to challenge practice.

Improved overall communications and documentation in primary/secondary care.

Impact on staff experience
Empowered staff to challenge practice, particularly lower grade staff. Improved communication between secondary and primary care. A catheter champions programme is due to be launched in May 2010 and an e-learning modular programme is also being designed (currently under contract with NISE, with a view to commercialise). This will form part of the mandatory training requirements within the trust.

Impact on cost reduction
Research carried out into the incidence of A&E admission related to catheters, identified a small number of high users who could be treated in the community. The work reduced admission rates by around 15% – an estimated saving of £50,000 across the health economy. Added to this are reduced A&E attendance costs, which are estimated to save another £64,000, as well as costs saved from not having to treat CAUTIs.
Key themes and methodology

Ownership
The trust changed the culture and what had been seen as acceptable ways of working in relation to the care of catheters. The team worked with staff and used the Ladders and Bladders game to create a sound knowledge base. This made all staff on the wards responsible, not only for catheter care, but also for the decision-making process on whether catheters are appropriate for individual patients on a continuing basis. The trust sent out a strong message that EVERYONE was a part of the infection control team, providing them with the skills, knowledge and permission to discuss and challenge decisions through a wide range programmes, including Ladders and Bladders.

Actions speak louder than words; this is never more true than when the message comes from senior leaders within an organisation. When encouraging the adoption of new ways of thinking and working, it is important that action follows words. This can be done by ensuring that staff have the necessary skills, knowledge and support to enable them to change their behaviour.

Translating values into behavioural actions that are clear and convey a consistent message will inspire and motivate teams.
“Define the simple rules for the culture you want and say what is required, what is forbidden and what is allowed.”

Improvement Leaders’ Guide (NHS Institute)

“We have 6,000 members of our infection control team - that's every member of our staff.”

Duncan Selbie
Chief executive

You can make a difference - this is about better care for your patients.
Case study: Winchester and Eastleigh Healthcare NHS Trust

When ‘catheter care done’ is not enough
Urinary Catheter Assessment and Monitoring (UCAM) forms were introduced trust-wide in October 2009 to record and document all insertion and ongoing urinary catheter care. It was developed following a three-month trial with nursing staff, the infection control team and specialist urology team. The UCAM forms prevent unnecessary catheterisation and prompt a daily review of patients with a catheter to support early removal.

Setting the scene
The infection control team recognised UTIs as one of the most common hospital-acquired infections, often associated with the insertion of urinary catheters. The team had two goals: to reduce inappropriate catheterisation and where a catheter is necessary ensure reliable catheter care and prompt removal, when clinically appropriate.

The approach
UCAM (Urinary Catheter Assessment and Monitoring) is a form used to record and document all insertion and ongoing urinary catheter care. This idea was developed following the results from a trust-wide audit on urinary catheter care. The UCAM form was developed and refined through contributions from nursing staff, the infection control team and the specialist urology team. The plan for measuring the success of implementation includes weekly assessment through the nursing quality indicators audit.
How they did it

In October 2009 the infection control team introduced the Urinary Catheter Assessment and Monitoring (UCAM) form across the trust. The launch was supported by a month-long awareness campaign, which used a ‘trolley dash’ through wards by infection control nurse, Sheryl Lucero, to deliver the message via quizzes and giveaways. The work is challenging the perception that catheters are a routine procedure to address continence issues, instead encouraging staff to view them as an invasive and potentially dangerous intervention.

The UCAM form was designed to make it as easy as possible to monitor catheter use and govern the catheter care provided by staff. A single sheet provides an at-a-glance 28-day history of the patient’s catheter, recording when the bag is changed and whether daily hygiene has been carried out. It also prompts staff to review whether the catheter is still required. This is supported by weekly audits measuring compliance.

“When we audited, it became obvious that doctors thought it was the nurse’s responsibility to remove the catheter, and the nurse thought it was the doctor’s.” says Sue Dailly, lead nurse for infection control. “The reality is that anyone can make the decision to remove a catheter.”

Initially, nurses voiced concerns that the UCAM form was simply more paperwork that would take them away from the patient’s bedside, but clinical assistant, Andy Racktoo believes it has improved patient care and may actually save time. On his gastroenterology ward, he estimates around 10% of patients will have a catheter.

“Our ward has three shifts and a patient could be checked three or four times a day. Now it is done once and documented, helping to protect the patient’s dignity by reducing invasive reviews.”

Avril MacDonald, consultant stroke nurse, said her staff were encouraged to see the UCAM form being introduced across the trust. On her 24-bedded stroke unit, up to half of patients could arrive on the ward catheterised, often in response to compromised continence caused by their level of consciousness. As a result of the raised awareness the ward staff assess each patient over 24 hours using a bladder scanner and all other possibilities will be exhausted before a catheter is introduced.
“Today on the ward we have only two patients with catheters in,” she says. “These patients will be assessed regularly to ensure the catheters are removed once they are no longer needed. It’s a myth that catheterisation is an easy answer to continence issues. Alongside the cost to the patient in terms of future continence and the risk of infection, it doesn’t reduce workload.”

The UCAM streamlines catheter care and has clarified staff responsibilities regarding the use and care of catheters. Nursing staff now routinely challenge whether a catheter is appropriate, particularly where the issue relates to continence. The trust is supporting staff to ensure all other options have been considered, including a full continence assessment.

Urology specialist nurse, Roisin Hart believes the UCAM form is raising awareness throughout the hospital. “If it prevents one UTI we are heading in the right direction,” she says.
Local results

Impact on quality of care
The work helps to prevent unnecessary catheterisation. It also helps to prompt a daily review of patients with a catheter and encourages removal of catheters as soon as possible. The UCAM form helps to provide evidence of quality of patient care.

Impact on patient experience
The UCAM form impacts on patient experience by preventing catheter-associated urinary tract infection, reducing pain and discomfort and preventing extended hospital stay.

Impact on staff experience
Reduction in catheterisation has reduced workload and helped staff to deliver high quality care to their patients.

Impact on cost reduction
The projected impact on cost reduction is through contributing to the prevention of catheter-associated urinary tract infections (CAUTI). Trust staff acknowledge that it is difficult to determine precisely the contribution UCAM has made to the reduction and an alternative proxy indicator is the number of patients who are catheterised. Between 2007 and 2009 this figure fell by 23% (n=20 patients). If it is assumed conservatively that 25% of these patients would have acquired a CAUTI then the reduction in catheter usage has released a little under £10,000. Other savings accrue from patients not being catheterised and a reduced use of specialist urology nurses. In the latter respect urology nurses confirm they are required on the wards less and now see less complicated cases as nursing practices nip CAUTIs in the bud.

Key themes and methodology

Visible leadership
Paula Showbrook, chief nurse, and director of infection prevention and control, ensured the staff introducing UCAM were fully supported, and she provided both advice and a direct line to the trust board. Her support and belief in the programme ensured all staff at the trust recognised that it was a core part of the care they provided and this really helped to embed the new process.

But engaging leadership is not enough. Without visibility of that leadership on the wards, helping to support the change process, the process will be less effective. Frequent visits by senior leaders to teams and areas involved in the work is essential for engagement, credibility and sustainability. It also provides fantastic opportunities for teams to show off their hard work.

“The High Impact Actions are a fantastic opportunity for nurses. It’s a chance to show what a difference we can make. This really supports the quality agenda – that’s what this is really all about for me. Patient safety is not a nurse’s job or a doctor’s job, it’s everybody’s. I was there as a resource to give advice, unblock any problems and help speed up the process.”

Paula Showbrook, chief nurse, and director of infection prevention and control
Empowering staff
A high proportion of catheter care is carried out by healthcare assistants. The trust recognised that they were a key group and ensured they were equipped with the necessary skills and training to be able to support safe catheter care. This gave them more confidence and the permission to challenge more senior staff or medical staff on behalf of their patients.

Many organisations have taken steps to raise awareness of patient safety across their organisations. However, there are still barriers that exist: blame cultures, lack of ownership and lack of reporting of risk and incidents. These variations in awareness and understanding among staff groups mean that it is important that all individuals, at all levels and in all roles, are aware of patient safety and its relevance to them and their patients.

Improvement tip
Staff across the NHS work very hard to care for their patients. Yet, despite their efforts and good intentions, many patients inadvertently suffer harm whilst under their care. The same is true in healthcare systems the world over. Increasingly, staff and patients are demanding action. The NHS Institute has a programme of work in safer care that provides education and training to build capability and capacity.

www.institute.nhs.uk/safercare
Improvement tip
Seven Steps to Patient Safety is an overview of patient safety with practical action points applicable to whole organisations and teams.

Seven Steps to Patient Safety for primary care NHS (NPSA 2006)
Seven Steps to Patient Safety in general practice NHS (NPSA 2009)
Seven Steps to Patient Safety in mental health NHS (NPSA 2008)
Seven Steps to Patient Safety full reference guide NHS (NPSA 2004)

“It empowers more junior staff to have that conversation with the medical team; to discuss whether a catheter is needed, or appropriate.”
Tracey Leddington
Ward manager
How to measure…Protection from infection - catheter associated urinary tract infections (CAUTI)

The national picture
The focus on healthcare associated infections in recent times has been on infections such as meticillin resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile infection (CDI) which are part of the list of Indicators for Quality Improvement (IQI). Measurement of catheter associated urinary tract infections (CAUTI) has received less focus. However, there will be an indicator on the IQI list related to CAUTIs as part of the Nurse Sensitive Outcome Indicators.

http://www.ic.nhs.uk/services/measuring-for-quality-improvement/what-is-happening-on-indicators-for

The indicator will measure the incidence of indwelling urinary catheters in situ for less than 28 days and the number of catheters being used as a proportion of all the patients being cared for.

How are catheter associated urinary tract infections defined?
Establishing a nationally agreed definition for a urinary tract infection associated with catheterisation is difficult. Any medical device that is inserted in to the body can become colonised with bacteria, increasing the risk of infection.

This is partly the reason why the Nurse Sensitive Indicator looks at the incidence of catheters being used as opposed to incidence of UTIs or CAUTIs.

The Department of Health's Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection have advised that given the problems with the interpretation of urinary isolates for patients with indwelling catheters and the difficulty of establishing an agreed standardised definition, routine surveillance of catheter associated urinary tract infections is not recommended. However, it is recommended that organisations undertake ongoing assessment of urinary catheters with a view to minimising inappropriate use.
How might incidence of indwelling urinary catheters be recorded and measured locally?

Your organisation may be measuring the amount of patients with a urinary catheter and implementing strategies to reduce this to a minimum and/or introducing best practice care principles for their management. For example, HII Bundle 6 will have an impact of the amount of CAUTI.

How this information is defined and used will vary, however you should consider using the principles of good measurement outlined in the measurement section (page 16). Some organisations might benchmark their wards against one and another with regards to number of patients and the incidence of indwelling urinary catheters to show how performances of wards compare. This can be useful as it can help incentivise the spread of good practice, but care needs to be taken in how this is implemented to ensure that the focus is on improvement. It is important to establish a definition of what is an inappropriate and appropriate catheterisation and to ensure it is clearly communicated to all healthcare professionals.

Some process measures which may be useful to measure locally are:

- the number of indwelling catheters in situ as a proportion of all patients
- the amount of time the catheter is in situ
- % of staff trained, confident and competent in their knowledge of infection control standards
- percentage of staff demonstrating competence in the management of urinary catheters
- compliance to the High Impact Intervention for urinary catheters (HII6).

Increasing the number of nursing and medical staff who receive appropriate training and demonstrate competence in the insertion and management of urinary catheters will support a reduction in the incidence of CAUTI's and in turn may also support cost savings by reduction in treatment costs.

**Measurement when making improvements**

When starting to work on reducing catheter associated urinary tract infection, you should begin by looking at what you and other teams in your department or organisation are already measuring. Use existing systems if they are appropriate as this will reduce the time and effort you spend on gathering data. You should use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what information you are already collecting and also see gaps where you might need additional data.