Leading Change, Adding Value

A framework for nursing, midwifery and care staff

May 2016

Contents

NHS England publications gateway approval number: 05247

This information can be made available in alternative formats such as easy read or large print and may be available in alternative languages upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

Foreword

Professor Jane Cummings, Chief Nursing Officer for England

It is four years since I took on the role of Chief Nursing Officer for England and it remains a huge privilege to work with and lead the nursing, midwifery and care staff within this country.

I remain immensely proud of our professions, the way in which we continue to strive to improve care experiences and outcomes, adapting our approach as needed to ensure we do our very best in each situation. I want to particularly thank you all, for what has been achieved over the last three years through Compassion in Practice and I want each one of you to be proud of how we have together restored public confidence and pride in our professions. 2016 sees the conclusion of Compassion in Practice and with your help its legacy and the learning gained from it, has helped to shape this new framework.

As Chief Nursing Officer for England and on behalf of other senior professional leaders in England, I am delighted to launch Leading Change, Adding Value. It is a framework every nursing, midwifery and care professional, in all settings, can use to ensure that we achieve the best quality of experience for our patients and people, the best health and well-being outcomes for our populations, and use finite resources wisely to get best value for every pound spent.

We are a huge community of practitioners who make a difference to people's lives, health and wellbeing every day. We have just over 543,000 registrants in England. 50,000 of these registrants work in adult social care alongside their 1.1 million care assistant colleagues.

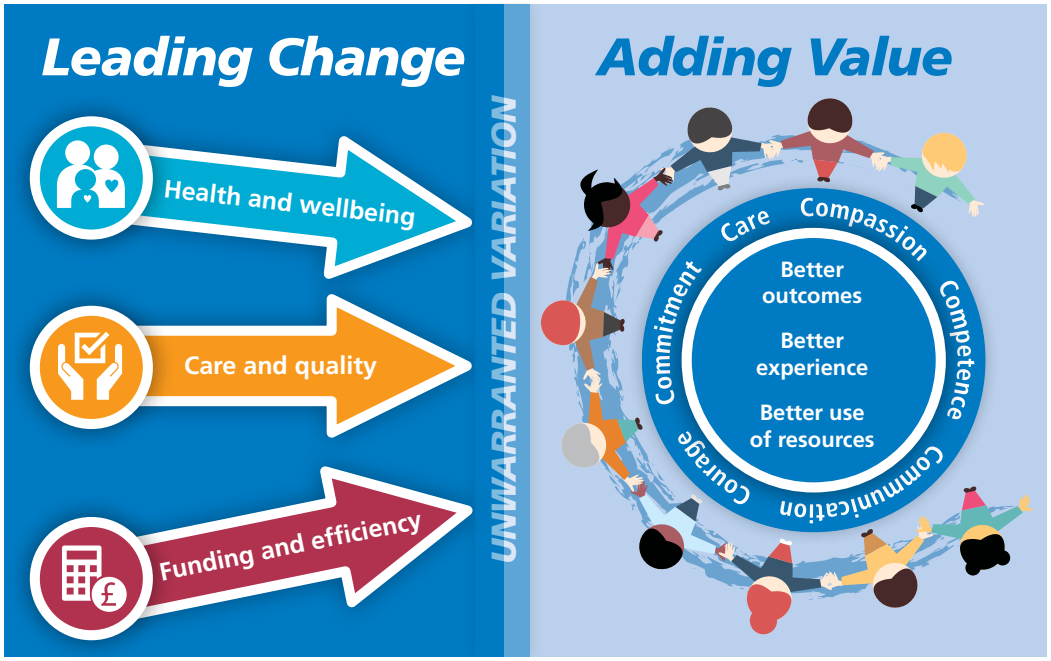
The impact and leadership ability of our workforce is phenomenal. Together we need to recognise the potential to manage the challenges of today and shape the future.

Everyone can influence and lead improvement, whether in the 3,500 care homes in England or when delivering care and support to the 1 million people who are treated every 36 hours within NHS funded services.

This framework encourages us all to reach further both individually and collectively. To do this we need to focus on what is important and connect with each other so we achieve more for patients and people and also for our professions.

The key leadership contribution of nursing, midwifery and care staff is crucial to maintaining high standards and delivering change. Leading Change, Adding Value sets out our shared ambitions and commitments that demonstrate our leadership potential and the role we can and must play. I am excited about what this new framework will help us achieve in the coming years.

Professor Jane Cummings,
Chief Nursing Officer for England



Part One
Towards the future

Part One
Towards the future

We live in a changed world - technologically, socially, environmentally - from that inhabited by our parents and grandparents. The pace of change is sometimes so great it is hard to imagine what the future will look like.

Though the world has changed, our values haven't. As nursing, midwifery and care staff we know that compassionate care delivered with courage, commitment and skill is our highest priority. It is the rock on which our efforts to promote health and well-being, support the vulnerable, care for the sick and look after the dying is built.

In just 20 years from now, the UK's population will include 3.5 million people over the age of 85, and many will be over 100 (Office for National Statistics). Technology will assist us in caring for this ageing population, by measuring vital signs, indicating when individuals need to exercise more, eat less, take medication or seek help - often from their own homes, without needing to cross the threshold of the GP surgery or hospital department.

The digital technology underpinning the health and care system will have developed significantly. The health and care system will look very different. People's confidential health records will be held securely but remain accessible, with the individual's consent, to professionals directly involved in their care; quickening response times and improving emergency care. At the same time, anonymised information from those records will help shape services, chart the spread of disease and contribute to the development of bespoke services for individuals and communities.

Children and adults will have their genomes sequenced to help predict the likelihood of inherited disease and preventive treatments selected to prolong life.

A skilled workforce, proficient in areas seen as the domain of the specialist today, will be essential. All staff will need to be confident practitioners of behaviour change, dementia care and management, and the care of people with mental health problems and learning disabilities. They will need to understand peoples' needs and be familiar with coaching and mentoring approaches considered the norm, and be comfortable working in partnership with individuals and communities.

It will be a workforce proud of its opportunities for development, that provides clear career pathways and encourages ambition, to maximise the potential of each individual and of the professions they represent. It will also be sensitive to generational differences, encouraging younger and older staff to learn from and support each other.

There will be a new emphasis on team work where nursing, midwifery and

care staff will co-operate together across traditional boundaries in integrated teams.

Leadership will be shared - including with people who use services, local communities and the public - and focus on maintaining consistent practice and values.

A key goal will be to promote health and well-being by working alongside people in towns and neighbourhoods, supporting them to prevent illness, look after themselves and remain independent in their own homes. We want to create a population of skilled, knowledgeable, confident individuals able to self-manage their conditions and control their own personal health budgets so they can choose how, when and from whom they receive their care.

These are some of the ways in which caring in the future will differ from the past. It is essential that we carry the workforce and the population we serve with us. Over the past nine months we have asked more than 9,000 people to tell us what matters to them and what ambitions they have for the transformation in the health and care sector that is required. We have presented their responses as 10 commitments that will underpin our leadership today and help us to shape provision in the future.

In addition to the 10 commitments, we found overwhelming support for the 6Cs - compassion, care, commitment, courage, competence, communication identified in Compassion in Practice - as the foundation of our value base. While compassionate care flourishes today and its beneficial impact is seen widely on individuals and populations, we must never be complacent and ensure that as our work changes our values remain aligned, recognised and understood.

The 10 commitments and the 6Cs are vital elements of the work that we do. We now need to focus on a new dimension - the need constantly to improve the quality of the care we deliver. That means measuring what we do, for it is only through measurement that we can demonstrate improvement.

The biggest threat to our capacity to deliver high quality care is shortage of resources. Public services are under pressure. We know that short term financial solutions cannot sustain them. There are no quick fixes.

But there is a way forward, set out by the Five Year Forward View (FYFV). With the right changes, the right partnerships and the right investments, we can put our health and caring services on a financially sustainable footing. To do this, we need to focus on achieving what the FYFV called the 'Triple Aim': better outcomes, better experiences for people and better use of resources.

The Triple Aim means closing three gaps identified in the FYFV - the health and wellbeing gap, the care and quality gap and the funding and efficiency gap (see Part Two) Nursing, midwifery and care staff have a crucial role in this drive.

This will require us to focus on activities that create 'high value' whilst having the courage to phase out activities that contribute 'low value'. In particular

we need to investigate and correct unwarranted variations in health and social care, which will often reveal lower value activity.

The notion of unwarranted variation is a helpful way to focus on delivering the right care in the right place at the right time. There are some reasons why health and care outcomes may vary over which we have no control. Unwarranted variations are those which we could change if we chose to. They can be a sign of poor quality care, missed opportunities and waste and can result in poorer outcomes, poorer experience and increased expense.

The new focus on the Triple Aim will require a shared understanding of the resources available and a commitment to use them for high value care, driven by local health needs and the choices of local people and users of services.

Nursing, midwifery and care staff form the largest proportion of the health and care workforce will work with individuals and communities of all ages and across all sectors. Evidence shows that new models of care lead to cost-effective, people-centred services with better outcomes, according to Health 2020, the policy framework for health and wellbeing in the World Health Organisation (WHO) European Region.

Leading Change, Adding Value gives England's nursing, midwifery and care staff a new opportunity to demonstrate the beneficial outcomes and impact of our work.

Part Two
Explaining the framework

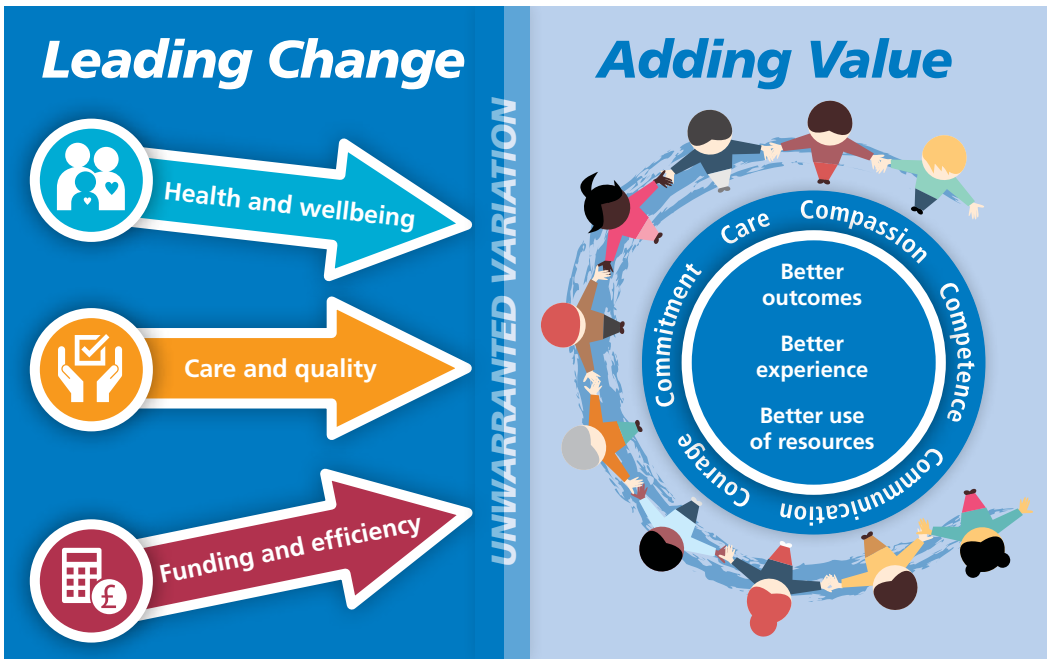
Part Two
Explaining the framework

Leading Change, Adding Value is a framework for all nursing, midwifery and care staff, whatever our role or place of work. Throughout the document, we use the terms "we" and "our" to represent all nursing, midwifery and care staff.

It builds upon Compassion in Practice and is directly aligned with the Five Year Forward View (FYFV) in seeking to develop new ways of working that are person-focused and provide seamless care across the boundary that has traditionally separated health and social care.

It aims to target three crucial gaps identified in the FYFV. These are:

- **Health and wellbeing:**
  without a greater focus on prevention, health inequalities will widen and our capacity to pay for new treatments will be compromised by the need to spend billions of pounds on avoidable illness.
- **Care and quality:**
  Health needs will go unmet unless we reshape care, harness technology and address variations in quality and safety.
- **Funding and efficiency:**
  Without efficiencies, a shortage of resources will hinder care services and progress.



Nursing midwifery and care staff have a crucial role to play in closing these gaps, by ensuring the activities we undertake are of high value. This framework aims to help achieve that by:

Closing the gaps

Closing the health and well-being gap:
practising in ways which prevent avoidable illness, protect health and promote well-being and resilience.

Closing the care and quality gap:
practising in ways which provide safe evidence- based care which maximises choice for patients.

Closing the funding and efficiency gap:
practising in ways which manage resources well including time, equipment and referrals.

The overall objective is to develop a high quality, financially sustainable service that delivers the objectives set out under the Triple Aim:

Triple Aim

Achieving:

- Better outcomes
- Better experiences
- Better use of resources

The Triple Aim was first described in 2008 by Berwick, Nolan and Whittington and was later developed by the US Institute for Healthcare Improvement which showed that measurement of the three dimensions - outcomes, experiences and use of resources - provided a benchmark for the quality of services.

Leading Change, Adding Value provides a framework to apply the principles of the Triple Aim to the work that nursing, midwifery and care staff do. We have already proved our value by embedding the 6Cs as central to everything we do. Now we need to bring the same focus to measuring the outcomes, experiences and use of resources involved in our work. In that way we will be able to demonstrate an extra dimension of our value.

What is adding value?

There has been much discussion about the meaning of value in health and social care, for example, Realising the Value, a programme supporting the FYFV.

By using this framework, nursing, midwifery and care staff have the opportunity to demonstrate the value they bring in a new way - by realising the goals of the Triple Aim.

To do this, we need to apply the right standards and create the conditions for consistent behaviour. We know we can create an environment where choice and partnerships flourish, care is personalised to individuals and support is provided to people and communities to improve their health and wellbeing. The 6Cs form the value base that guides all our behaviour and are vital to reducing unwarranted variation. Now we need to show how we can narrow the gaps that the Triple Aim seeks to close.

We have a diverse, multi-ethnic workforce and nursing, midwifery and care staff have a key, leadership role in valuing the positive impact this can have on care and outcomes. For example, supporting organisations to meet their equality duties by ensuring the Workforce Race Equality Standards (WRES) are reflected in the leadership and delivery of care can improve patient experience and staff satisfaction.

There is strong evidence that registered nurses and midwives deliver safer, higher quality, care and are more productive. We need to demonstrate that appropriate registered nurse staffing levels are associated with lower rates of serious incidents, including medication errors, falls, poor nutrition and hydration and failure to rescue.

Unwarranted variation

One of the key tasks required in achieving the Triple Aim is the reduction of unwarranted variation - between geographical areas, between specialties and between population groups.

We need to know where to look for unwarranted variation, what to change and how to change it. That means understanding differences in how services are provided, the outcomes they achieve and what they cost.

The process may start with a conversation with a colleague. We often benchmark ourselves against colleagues, informally, without even realising it. They may highlight a new practice that is reducing the number of falls which starts us thinking about our own practice.

Or it may start with a conference on infection control that triggers local debate and sets us looking at what we might be doing differently.

Care home colleagues comparing catheterisation rates in their homes may learn about improvements in care that lead to reduced use of catheters - and reduced infections, reduced costs and greater comfort for residents.

Improving outcomes requires us to reflect on our practice. It is not easy and we often need support to the make the necessary change. Now we need to measure it, too, to demonstrate as nursing, midwifery and care staff the value that we bring.

Closing the gaps:

10 commitments to support action of nursing midwifery and care staff

The framework offers 10 aspirational commitments to help us focus on narrowing the three gaps, address unwarranted variation and help demonstrate the Triple Aim outcomes. They are designed to be applied locally in any environment and at any level.

Commitment	Health and wellbeing	Care and quality	Funding and efficiency
1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff	✓	✓	✓
2. We will increase the visibility of nursing and midwifery leadership and input in prevention	✓	✓	✓
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health	✓	✓	✓
4. We will be centred on individuals experiencing high value care	✓	✓	✓
5. We will work in partnership with individuals, their families, carers and others important to them	✓	✓	✓
6. We will actively respond to what matters most to our staff and colleagues	✓	✓	✓
7. We will lead and drive research to evidence the impact of what we do	✓	✓	✓
8. We will have the right education, training and development to enhance our skills, knowledge and understanding	✓	✓	✓
9. We will have the right staff in the right places and at the right time	✓	✓	✓
10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes	✓	✓	✓

Commitment 1

We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.

Commitment 1

We have responsibilities for health and wellbeing as set out in our professional regulatory Code and Standards. We also have opportunities through 'public trust' and 'individual professional relationships' to have significant impact on improving health and reducing health inequalities - practising in ways which prevent disease, protect health and promote wellbeing and resilience.

All Our Health is a 'call to action' to healthcare professionals individually and collectively, to contribute to the Five Year Forward View's vision, through prevention, improving population health and being champions of developing the 'social movement for health' (as quoted in the All Our Health guidance).

All Our Health provides resources that enable nurses, midwives and care staff to access evidence and metrics for developing practice and demonstrating impact (see Public Health Outcomes Framework).

The range of roles and settings in which nursing, midwifery and care staff work creates major opportunities to make a difference to health - whether one person at a time or across whole populations.

We will meet this commitment by:

- Contributing to and influencing 'place based' programmes to improve services and outcomes (including Sustainability and Transformation Plans).
- Understanding our responsibilities and opportunities to make a difference to population health, as set out in the national programme All Our Health.
- Applying extended skills and roles in prevention and health promotion.
- Responding effectively to local population needs and wider factors affecting health and people's ability to make healthy choices for example, employment and housing.

Key messages

Nursing, midwifery and care professionals have privileged relationships with individuals and communities and high trust from the public which enables us to have a significant impact on improving health and reducing inequalities.
The All Our Health programme gives us the resources to extend and embed practice and services that improve the public's health.
The public health work and prevention roles of nurses, midwives and care staff are vital and need to be more visible in leading and providing services which simultaneously support personalised care and improve population health.

Commitment 2

We will increase the visibility of nursing and midwifery leadership and input in prevention.

Commitment 2

We can demonstrate our role as a vibrant force for change by leading, shaping and implementing innovative and targeted prevention programmes, with the aim of promoting health gain for individuals, families and communities.

We will meet this commitment by:

- Championing and extending our prevention and health promotion responsibilities.
- Collectively supporting a 'social movement for health' including social media, national campaigns and local action.
- Maximising the leadership of specialist community public health nursing, especially in the health of children and young people.

Key messages

Health promoting practice with a focus on prevention is essential if we are to create better health outcomes for people (individuals, families and communities).
Primary and community care nurses and midwives have a role in working with families and communities to enhance their capability to manage and improve health, especially of babies, children, young people and families.
High levels of public trust enable us to lead the 'social movement for health'.

Commitment 3

We will work with individuals, families and communities to equip them to make informed choices and support them to manage their own health.

Commitment 3

People are living longer but are at risk of spending their extended years in poor health as a result of obesity, poor diet, lack of exercise, smoking and excessive alcohol consumption. We need to support people to adopt healthier lifestyles. This includes having a place based approach, involving local partners and communities in delivery.

We will meet this commitment by:

- Understanding the wider health and social care issues that affect people's decisions about their health and ability to self-manage.
- Consistently applying the principle of 'making every contact count'; providing timely advice to people about their health and wellbeing.
- With partners (including state and voluntary sector), working with communities to build healthy places (Asset Based Communities Development ABCD).

Key messages

Working with people (individuals, families and communities) through a range of interventions including 'Making every Contact Count' provides important opportunities to influence their health choices and behaviours.
Strong communities (people and environments) where people feel socially connected and that services are responsive to their needs are more likely to foster better health and well-being in the people who live there.
Understanding and building on strengths that exist in local communities is vital to build healthy places.

Commitment 4

We will focus on individuals experiencing high value care.

Commitment 4

We will ensure that individuals are always supported to influence and direct their own health care decisions, so that they are confident that 'no decision is taken about me without me'.

Care planning should involve the development of a personalised plan for each individual who is entering, leaving or transitioning care environments whether within a hospital, in their own home, care home or rehabilitation unit.

Children with long- term health conditions transitioning to adult care need good, strengths-based transition support rather than support based on a pre-determined set of transition options.

People with mental health problems may also have physical health conditions in need of treatment, and vice versa.

We need to encourage people to take more responsibility for their health by focusing on personalised care planning, self-management and behaviour change.

We will meet this commitment by:

- Putting people, their families and carers at the centre of developing and delivering all aspects of their care.
- Providing equal importance to both meeting the physical and mental health needs of individuals.
- Continuing to facilitate safe, responsive and culturally sensitive care with the ambition to enable women to have the choices of where to have antenatal, birth, and post-natal care, and to receive continuity of carers.
- Enabling the services to be designed through listening to the voices of users, especially vulnerable people with complex needs.

Key messages

Truly putting people receiving care, their families and carers, at the centre of all we do when developing and delivering all aspects of their care; so that what matters to them always informs our actions and judgement such as end of life choices.
Person centred care is central to improving the lives and health of the increasing number of children, young people and adults who live with long term conditions.
Truly getting to the core of what matters to individuals by the use of 'I-Statements' for example - "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Commitment 5

We will work in partnership with individuals, their families, carers and others important to them.

Commitment 5

We will ensure that individuals and their families are at the heart of their care and decisions are made with them by recognising the assets they bring, and working collaboratively as care navigators to signpost easily-accessible support systems.

We will work to reduce our reliance on specialist inpatient units to support people with a learning disability and/or autism who display challenging behaviour.

We will support people to live at home by leading the development of integrated health and social care services, delivering new care pathways and working to specific standards.

We will work with new "Healthy New Towns" housing developments to take an ambitious look at improving health through the built environment.

We will seek to integrate into our work the crucial roles of carers, volunteers and the local community.

We will meet this commitment by:

- Recognising the assets which people and their families bring to maximising the health and wellbeing of those in our care.
- Integrating volunteers and communities into our work;
- Facilitating the involvement of individuals and their carers in co-designing and providing care services.
- Embracing the 'six principles' of the People and Communities Board for developing new care models. These are personalised care, community partnership, equality, valuing carers, volunteering and social action.
- Recognising and promoting the role of maternity services liaison committees in improving maternity care for women and their families.

Key messages

Always valuing and integrating into our work the crucial roles of carers, family members, volunteers and the local community in maximising the health and wellbeing of those in our care; always recognising that those in receipt of care are often experts by experience.
Listening and responding to the voice of individuals and their communities by engaging with local self-interest and advocacy groups, HealthWatch and health and wellbeing boards, paying particular attention to vulnerable and marginalised groups.
We will be champions against institutional discrimination in mental health, acute and emergency services to recognise and treat the physical health needs of people with a learning disability. Mental health and learning disability nurses will use their knowledge, skills and expertise to improve access across the health system and lead improvements in physical health care for people with complex mental health and/or learning disabilities.

Commitment 6

We will actively respond to what matters most to our staff and colleagues.

Commitment 6

Better staff health and wellbeing is associated with improved outcomes and experience for those individuals and populations that we serve.

However, working in health and social care whilst rewarding can be demanding. We must show the same care and consideration to ourselves and our colleagues, as we do to those we serve.

We have a responsibility to protect our own health in order to practise safely and effectively. Providing an appropriate culture, terms and conditions will mean we gain the most from our staff.

We will meet this commitment by:

- Embedding the key question 'What matters to you?' alongside the delivery of consistent compassionate leadership.
- Ensuring staff health and wellbeing is promoted as a priority, such as considering the role of mental health first aiders.
- Supporting staff to take responsibility for their own health in order to maximise impact for individuals and populations.
- Creating environments that are conducive to health and well-being such as reshaping the working environment, providing healthy food choices, and opportunities for other lifestyle changes for example exercise and stopping smoking services.
- Ensuring the right staff support systems are in place, such as regular appraisals, mentorship, coaching, preceptorship and midwifery supervision; and identifying and supporting those who may work in professional isolation.
- Developing an effective way of assessing and triangulating the impact of good staff engagement and wellbeing on productivity, safety and the outcomes and experience of those receiving care.

Key messages

Embedding the importance of consistent compassionate leadership as the cornerstone of a people-centred approach, in a shared ambition to achieve excellence, which includes recognition of the contribution of all nursing, midwifery and care staff, across all the sectors.
Highlighting the importance of speaking up for safety and promoting and using the statutory Duty of Candour and the need to always act in an open and transparent way.
Recognising the need to foster improved staff engagement, commitment and morale through more positive, strengths based approaches, and the need to evaluate improvements, so that we can evidence the impact of investment in staff on outcomes and experiences for patients and on reducing unwarranted variation.
Understanding our own responsibility to ensure that our health allows us to practise safely and effectively, meeting the requirements of revalidation that enable us to remain on the professional register.

Commitment 7

We will lead and drive research to evidence the impact of what we do.

Commitment 7

There is a wealth of evidence based practice to help us improve our work. However, there remains a need for robust evaluation, embedded from the outset, so that we can demonstrate our positive impact.

We must routinely capture and analyse data which accurately measure the impact of our work.

In research, education and practice, clear outcome measures will give us a greater understanding of what we achieve and the public a greater understanding of our role.

We will meet this commitment by:

- Celebrating and showcasing achievement and success.
- Building competence and capability to identify unwarranted variation.
- Using the relevant metrics and outcome measures, to increase productivity and efficiency whilst driving up quality.
- Sharing our findings both nationally and internationally.

Key messages

Using learning from our research to innovate and improve care and define our contribution and value.
Recognising the value of collecting data electronically where possible at the point of care using modern technologies.
Establishing international partnerships to mutually support learning on global best practice.
Participating in networks that will help drive the uptake of innovation across the sectors such as Academic Health Science Networks.

Commitment 8

We will have the right education, training and development to enhance our skills, knowledge and understanding.

Commitment 8

Education, learning and training are vital for the provision of high quality care. We will support a culture of life-long learning and self-reflection.

We will ensure that we are prepared for professional revalidation which will promote good practice and strengthen public confidence.

We will encourage partnership working across health and social care, which provides opportunities to share understanding and skills, new career options and new roles.

We will seek to widen access and develop new roles and more flexible routes to graduate education.

Developing a successful workforce depends on providing the necessary motivation, skills, behaviours and opportunities, as set out in the 2015 review by Lord Willis, Raising the bar - Shape of caring; a review of the future education and training of registered nurses and care assistants.

We will meet this commitment by:

- Having and providing training, research and career progression opportunities.
- Developing clinical academic careers for nurses and midwives to build the nursing and midwifery evidence base.
- Embedding a culture of life-long learning by making the education and training of staff a priority.
- Providing clinical placements in all settings for learners to help them work flexibly, such as establishing shared professional learning across health and social care, including the sharing of knowledge and skills through the creation of rotational posts traversing the health and social care landscape.

Key messages

Recognising the importance of building up the future workforce and, through talent spotting, building future leadership capability at local, regional and national level.
Making the education, learning and training of staff a priority.
Act as mentors, teachers, coaches and role models; ensuring that this becomes a predominant and consistent style of care, help and support.

Commitment 9

We will have the right staff in the right places and at the right time.

Commitment 9

Our staffing must be safe, sustainable, efficient and able to provide competent and compassionate care to our patients and people we care for. Better workforce planning and management of staff resources are needed to improve quality of care, staff productivity and financial control.

As recognised within the Lord Carter Report, we can improve workforce efficiency by ensuring we have good workforce practices in place for, the recruitment and retention of permanent staff, better deployment and rostering of staff, for reducing sickness absence and for matching work patterns to patient need and reducing dependency on agency staff.

We can drive new ways of working across organisational and professional boundaries. We have the knowledge, skills and experience to play a lead role in vanguard and other innovative projects, which are developing new models of care.

We must be aware of the differing needs of older and younger staff and ensure all caring roles are fulfilling and ones in which staff are supported, have a positive experience and want to stay.

We will meet this commitment by:

- Ensuring the right staff are in the right place at the right time to provide safe, compassionate and effective care.
- Ensuring that decisions about staffing are based on available evidence, take account of the wider multi-professional team, and there is a proactive approach to delivering improved outcomes and productivity.
- Ensuring staffing decisions take account of the local context so local improvements can be made.
- Developing an e-learning package on safe and sustainable staffing for frontline leaders to include establishment monitoring, workforce planning and workforce development.

The forthcoming National Quality Board document, supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time will complement this commitment.

Key messages

Ensure sufficient capacity and capability in order to provide safe, compassionate and effective care, making the best use of resources at all times.
Ensure a proactive approach to improvement of staff retention, sickness absence and deployment of staff, to reduce the need for bank and agency staffing.
To attract new staff to health and care roles, we will provide flexible routes into education at pre-degree and post-registration levels, and develop post-registration education standards transferable across teams and sectors.

Commitment 10

We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

Commitment 10

Technology has helped transform care and our roles in providing it. We need to continue to be at the forefront of innovation, enabling individuals to access information, use diagnostic tests, record their own health data and live more independently and safely in their own homes.

Technology can enhance our clinical decision making by providing access to the relevant information at the point of care and enable us to reach out to communities in sparsely populated areas.

We need to be prepared for routine tasks we currently undertake to be replaced by technological developments and to use the advances to improve outcomes, promote self-management and increase efficiency and productivity.

We will meet this commitment by:

- Developing the skills needed in a technology-literate workforce.
- Advocating technologies that may assist in reducing unwarranted variations in care.
- Leading as early adopters of technology to improve health and enhance efficiency.
- Empowering and supporting individuals to improve health and self-manage care.
- Using technology to manage workflow more effectively such as mobile working.

Key messages

Ensuring that the ambitions of relevant nursing, midwifery and care staff are reflected in Local Digital Roadmaps, and helping build a national picture of IT capability.
Ensuring that local digital roadmaps take forward the ambitions from national digital nursing roadmap work.
Ensuring that the user experience is as seamless as possible between primary care and specialist services, and across health and social care.

Part Three

How the framework can be used to deliver the Triple Aim and reduce the three gaps

Part Three

How the Framework can be used to deliver the Triple Aim and reduce the three gaps

Section 1

Within NHS funded services

As nursing, midwifery and care staff working in today's NHS we are expected to deliver high quality care and be skilled in managing resources and leading change. But we also have influence over the individuals and populations whom we care for, whether as hands-on care givers or as executive directors and educators.

By using the framework we can work to identify and reduce unwarranted variation, ranging from small scale interventions up to large scale transformational change.

Understanding unwarranted variation

Two areas within the same city had differing rates of diagnosed Type-2 diabetes. Both had similar demographics suggesting that there was unwarranted variation. Further investigation was required and nursing and care staff were well positioned to compare their practise with areas known to be successfully addressing the challenge. This revealed that the more successful area had educated practice nurses in the early identification of Type 2 diabetes. Those practice nurses then supported their patients with advice on nutrition, hydration and self-management and also become more proficient at recognising the signs of the condition and increased their detection rates. This model was rolled out within the second area and the positive results were duplicated, leading to improved outcomes for both populations and reduced average rates of HbA1c measurements.

At a Trust Ward Manager meeting it was noted that the staff sickness rate was substantially higher in one Trauma and Orthopaedic Ward than in the Trauma and Orthopaedic Ward on the opposite wing. Both wards admitted the same type of patients, had the same staffing establishment and skill mix, and were identically set out. The ward managers suggested that this was unwarranted variation and asked their nursing and care staff to investigate. The investigation revealed that the second ward was piloting a new type of manual handling equipment which avoided potential strain and injury to staff when lifting patients and was well liked and well used, reducing their sickness absence levels. The first ward successfully bid for the same equipment and the sickness absence levels fell.

Understanding unwarranted variation

An organisation running two large NHS funded care homes discovered that one had a greater incidence of pressure ulcers than the other, despite being in the same neighbourhood, having the same number of beds, the same staffing and the same client group. This suggested that there was an unwarranted variation in care, which might have been due to a number of factors, including poor clinical practice, a lack of training, poor leadership or even human error. Nursing and care staff were ideally placed to investigate and they discovered that a member of care staff at one home had attended a tissue viability conference, after which the home had introduced intentional rounding and was assessing their residents at high risk of pressure ulcers more frequently. This had reduced the incidence of pressure ulcers. The practise was shared with the other care home which saw a similar fall in the incidence of pressure ulcers, reducing harm, improving outcomes, and making more effective use of resources.

Initial areas of NHS funded care to be supported

As a starting point, work is planned on programmes where nursing, midwifery and care staff can take the lead in addressing unwarranted variation in areas that straddle the NHS, independent care sector and local authorities. The intention is to encourage similar efforts in other areas, such as in care homes where staff can use the approach for both small scale projects and large ones.

There is a huge opportunity for nursing, midwifery and care staff to lead this work.

Area	Subject	Proposed area of unwarranted variation to be addressed
Health and care sector nursing	Wound care	A project will consider a national approach to wound care management which aligns to a specific component such as diabetes care.
Safeguarding in health and social care	'Looked After Children' (LAC) Annual Health Assessments	Guidance is available that sets out the requirements of assessments that are undertaken in relation to 'Looked After Children'. These measures alongside those set out within statutory guidance and aligned tariff arrangements should be used to ensure a quality assessment for all LAC. Variation has been identified in relation to both quality and payment processes and there is an opportunity to identify whether this is unwarranted variation and should be addressed.

Area	Subject	Proposed area of unwarranted variation to be addressed
Continuing healthcare (CHC) in health and care settings	Commissioning of care packages for individuals eligible for NHS CHC; Application of the National Framework for NHS CHC	NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding individuals have to be assessed by Clinical Commissioning Groups (CCGs) according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'. It is proposed that there may be differentials in approaches to commissioning and application of the framework and this may be unwarranted variation.
Maternity	Midwifery supervision	Following a review of statutory supervision in 2015 the recommendations were made that the Nursing and Midwifery Council (NMC) should have direct responsibility and accountability solely for the core functions of regulation. The legislation pertaining to the NMC is being revised to reflect this. By spring 2017, a new model of supervision will be developed that will: support the provision of woman centred safe care that improves outcomes for women and their families and supports a framework of sustainable clinical supervision for midwives in England. It is proposed going forward to consider any unwarranted variation that may arise from this.
Spotlight on maternity	Improving outcomes in maternity care	Contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030 sets out five high-level themes which are known to make care safer.

Area	Subject	Proposed area of unwarranted variation to be addressed
Maternity	National Maternity Review recommendations	The National Maternity Review (2016) set out wide-ranging proposals designed to make care safer and give women greater control and more choices, to be implemented over the next five years. It will enable women to choose a provider based on their maternity offer, for example, continuity of carer throughout pregnancy, birth and postnatal care. Improving continuity is linked to improving quality of care and is expected to reduce unwarranted variation.
Mental health	Improving the physical health and wellbeing of people with mental health problems	The Five Year Forward View for Mental Health (2016) highlighted that people with mental health problems have poorer physical health than the general population and are often unable to access the physical healthcare they need, contributing to avoidable health inequalities. People with severe mental illness are particularly at risk and die on average 15-20 years earlier than the general population.
Learning disabilities	Premature mortality in individuals with learning disabilities	The Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD), published in March 2013, set out the extent of the health inequalities suffered by people with a learning disability and showed, through case studies, how annual health checks would have made a difference. The Mencap report Death by Indifference also included case studies showing where health checks might have contributed to preventing premature deaths. Using the 'Right Care' approach, the new focus will be to improve the quality of care to reduce premature deaths in the following key areas: epilepsy, diabetes, cancer and heart disease.

Section 2

To address public health challenges

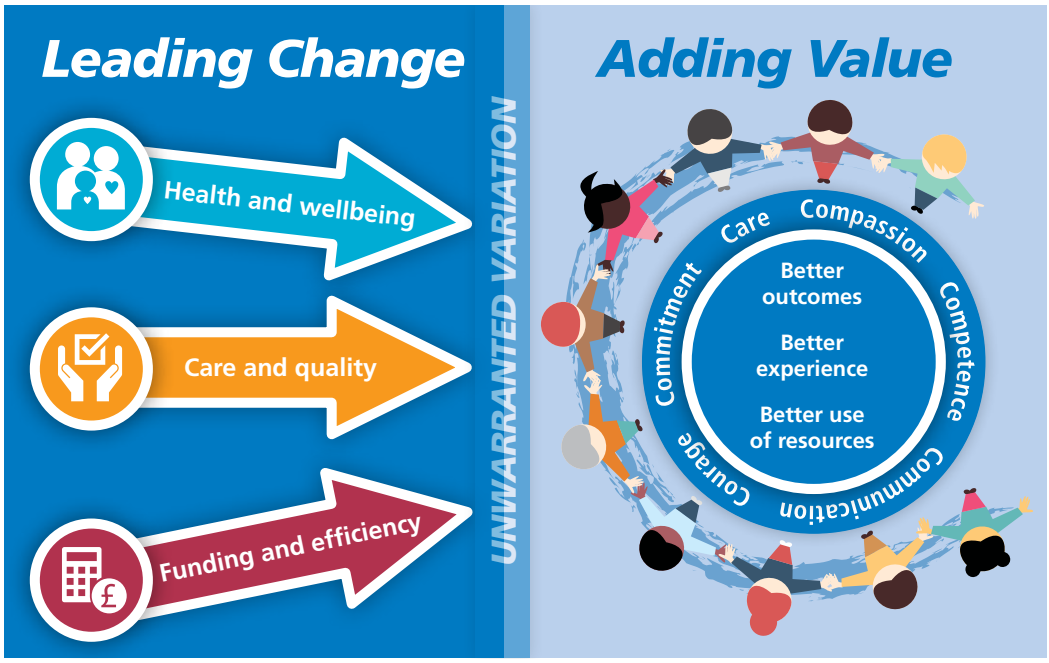
Closing the health and wellbeing gap by increasing the focus on prevention is vital to creating sustainable health and care service. The framework shows how nursing, midwifery and care staff can contribute to this effort, both individually and as a collective force for change.

Three of the 10 commitments set out previously have a primary focus on health and wellbeing:

- **Commitment 1**
  We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff
- **Commitment 2**
  We will increase the visibility of nursing and midwifery leadership and input in prevention
- **Commitment 3**
  We will work with individuals, families and communities to equip them to make informed choices and support them to manage their own health

To meet these commitments we need to practise in ways which prevent avoidable illness, protect health and promote wellbeing, self-care and resilience (as described in All Our Health).

The next section sets out how, by taking action on the 10 commitments outlined in the framework, nursing, midwifery and care staff can help tackle two of the major challenges to our population's health - antimicrobial resistance (AMR) and obesity.



Anti-microbial resistance (AMR)

Resistance to all antimicrobials, including antivirals and antifungals, is increasing, but of greatest concern is the rapid development of bacterial resistance to antibiotics.

Antibiotic consumption is a major driver for the development of antibiotic resistance in bacteria. The 2015 English Surveillance Programme for Antimicrobial Utilisation and Resistance report found that 74 percent of antibiotics were prescribed in primary care in 2014 and antibiotic consumption in England has increased by 6.5 percent over the last four years. Across England, the 2013 Atlas of Variation shows a 1.3-fold variation in prescribing antibiotics and in the highest prescribing area there is 40 percent more prescribing in general practice compared to the lowest prescribing area. It is vital to reduce the unwarranted variation in the prescribing of antibiotics across England to the safest level possible while still ensuring quality of care and focus on the 'patient' experience.

Meeting the challenge of antimicrobial resistance

Promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.

- Understand the causes and actions needed to address AMR including Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS).
- Recognise variation in antibiotic prescribing and promote understanding in prevention and self-care so that antibiotics are only used when clinically relevant (AMS).
- Be a positive role model and champion for AMR/AMS/IPC so that ownership is seen as everybody's responsibility.

Increase the visibility of nursing and midwifery leadership and input in prevention.

- Become an Antibiotic Guardian and support changing attitudes (social movement).
- Be aware of, and promote, the annual European Antibiotic Awareness Day and International Infection Prevention and Control Week.
- Lead by example with infection prevention and control including hand hygiene.
- Report any concerns regarding breeches in standards through the quality assurance route.
- Be aware of the local 'place based' cross system partnerships such as Health and Wellbeing Boards, AMR Sustainability and Transformation Plans (STPs).

Work with individuals, families and communities to equip them to make informed choices and manage their own health.

Work with individuals, and at community or population level protecting health and promoting wellbeing and resilience through:

- Educating that flu and colds are caused by viruses that cannot be treated by antibiotics.
- Promoting messages about preventing the spread of respiratory illnesses by covering the mouth when sneezing or coughing, discarding tissues after use and washing hands after sneezing, coughing and using a tissue.
- Educating the public to complete the course of prescribed antibiotics or other medication as directed.
- Educating individuals and the public about the importance of hydration in the elderly to prevent urinary tract infections.
- Educating individuals and carers on where to get support and further information about antibiotic resistance.

Centred on individuals experiencing high value care.

- Promote good infection, prevention and control practices - an infection prevented is one that does not require treatment.
- Support the uptake of all immunisation, vaccination and screening programmes and health checks to optimise health, reduce complications and avoidable infections and hospital admissions.
- Work in partnership with individuals and communities to enhance their experience of care and to feel a sense of control.

Work in partnership with individuals, their families, carers and others important to them.

- Promote antimicrobial stewardship across your practice.
- Promote empowerment and community resilience by increasing individual/patient activation (PAM) with their care.
- Be aware of and promote the needs of vulnerable and underserved groups.

Actively respond to what matters most to our staff and colleagues.

- Know where to get further advice for your organisation, i.e. Director of Infection Prevention and Control (DIPC)/Director of Nursing/Lead Nurse for IPC/IPC Champion/Health Protection team.
- Know where and when to refer or escalate concerns raised with you (Duty of Candour).

Lead and drive research to evidence the impact of what we do.

- Celebrate and showcase success and good practice.
- Review and share current content from the national health profiles AMR portal on fingertips.
- Be aware of any local reviews of practice and suggest areas for improvement.
- Take a lead in using evidence based tools and audits.

The right education, training and development to enhance our skills, knowledge and understanding.

- Be aware of and promote a culture of compliance with the Health and Social Care Act Code of Practice on the prevention and control of infections and related guidance.
- Follow NICE guidance NG15 and good practice guides to promote better outcomes, experiences, use of resources, and better value in AMR and promoting standardised practice and reduce unwarranted variation in prescribing.
- Know and understand the signs of infection (including sepsis) and the immediate actions to take.
- Be aware of and promote antimicrobial resistance awareness and infection prevention and control training.
- Mentor learners and ensure they have the right skills for their level of training.

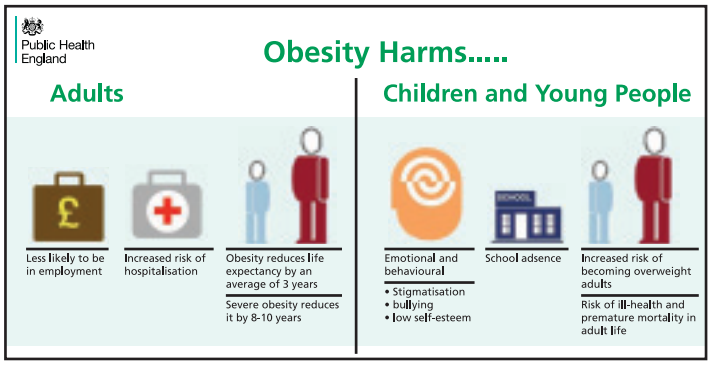
The right staff in the right places and at the right time.

- Protect the health of the workforce including through promoting immunisation and safe infection control practice thus reducing sickness absence.

Champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

- Work with others to review outcomes in the point prevalence survey on healthcare associated infections (HCAI) and antimicrobial usage in England in order to address areas for improvement.
- Work with others to evaluate and assess the Antimicrobial Stewardship Programmes that exist within acute hospitals using the Antimicrobial stewardship: an evidence-based, antimicrobial self-assessment toolkit (Start Smart Then Focus).
- Work with others to adapt the indicators in the Royal College of Nursing Infection Prevention and Control Commissioning toolkit to meet local needs and support on-going improvement.
- Work with others to benchmark antimicrobial consumption against the English surveillance programme antimicrobial and resistance report.

Obesity



The rise in obesity in the UK is a major challenge. Two thirds of adults are overweight or obese, according to the Health and Social Care Information Centre. 1 in 5 children are overweight or obese when they begin primary school increasing to 1 in 3 by the time they leave. Obesity in children is closely linked to deprivation and obese children are more likely to become obese adults.

Tackling the challenge of obesity

Promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.

- Be informed about the complex interactions of individuals, communities and population and how behaviour is influenced by the 'obesogenic environment'.
- Understand the physiological causes of excess weight and importance of energy balance.
- Develop knowledge re evidence based activities which can help reduce obesity.
- Identify areas and communities with high levels of obesity to target interventions and resources.

Increase the visibility of nursing and midwifery leadership and input in prevention.

- Incorporate prevention and management of obesity in planning for health and wellbeing.
- Make preventing and managing obesity a priority at both strategic and delivery levels. Champion good practice, including in the work place.

Work with individuals, families and communities to equip them to make informed choices and manage their own health.

- Use the available resources to support behaviour change training through the Making Every Contact Count initiative.
- Discuss weight, diet and activity with people at times when weight gain is more likely, such as before, after and between pregnancy, the menopause and while stopping smoking.

- Be involved in development and delivery of support programmes for families of children and young people identified as being at high risk of obesity and those identified as overweight or obese and be confident in raising excess weight as an issue, sign posting people to help and advice.
- Advise people on diet, weight and activity.
- Advise individuals to use the Eatwell Guide, and how to control portion sizes, reduce consumption of energy dense high fat, sugar, salt foods, and increase consumption of fruit and vegetables.
- Encourage individuals to set targets - health benefits can be achieved from modest amounts of weight loss.

  Promote active lifestyle and exercise - encourage people to build activity into their daily lives, gradually increasing the amount and intensity of activity.
- Advise parents that children over five should engage in at least 60 minutes of moderate to vigorous intensity physical activity every day.

Centred on individuals experiencing high value care.

- Signpost to the Healthy Start scheme which provides vouchers to families on low-incomes that can be exchanged for fresh or frozen fruit or vegetables, milk and infant formula and vitamins for mother and baby.

Work in partnership with individuals, their families, carers and others important to them.

- Promote the Start4Life and Change4Life information service which provides evidence based information to families.
- Work with schools to support whole school approaches for taking action on obesity and related issues.
- Ensure parents, children, young people, families and front line staff are involved in the design of interventions.

Actively respond to what matters most to our staff and colleagues.

- Play a leadership role by creating environments that are conducive to health and well-being, such as reshaping the working environment, providing healthy food choices, weight management support and exercise.
- Be aware of staff health and wellbeing opportunities and participate and encourage participation.
- Celebrate and showcase success and good practice.

Lead and drive research to evidence the impact of what we do.

- Audit and share activities in 'health promoting practice'.
- Understand how to access research support and grants.
- Generate new knowledge on health promoting practice in nursing midwifery and care.

The right education, training and development to enhance our skills, knowledge and understanding.

- Be aware of and follow of NICE guidance and good practice guides to promote healthier eating and physical activity to tackle adult and childhood obesity.
- Understand how NICE guidance and good practice guides will also promote standardised effective practice and reduce unwarranted variation in approaches.
- Participate in and promote brief intervention training through the Making Every Contact Count initiative.
- Be aware of and promote recognised training and development on healthy eating, activity and obesity.

The right staff in the right places and at the right time.

- Be a positive role model for a healthier diet and active lifestyle and encourage others. This benefits individual wellbeing and resilience and can reduce staff absence rates.

Champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

- Share appropriate data between health, education, social care and community organisations to target prevention activity and co-ordinate interventions.
- Provide peer support mechanisms for engaging the public, such as use of digital apps for young people.
- Measure outcomes against indicators in the Public Health Outcomes Framework which relate to obesity.
- Measure outcomes against the indicators in the Health and Social Care Information Centre (HSCIC) that relate to obesity.
- Use child obesity data from the National Child Measurement Programme (NCMP) 2006/07 - 2014/15 in their online tool.
- Use key health indicators in Child Health Profiles, to enable comparison locally, regionally and nationally.

See Appendix A for further resources: documents, tools and references.

Section 3
Within social care

There are 49,500 nurses working in Social Care, 85 percent of whom work in care homes with nursing. They are part of an overall workforce of 1.55 million people. As we move towards greater integration, it is vital that the important contribution those nurses and care staff within social care make to managing complex care needs for thousands of people every day is recognised.

Nurses and care staff providing social care apply their specialised knowledge and skills within the context of a relationship. They deliver relationship-centred care and are essential partners, both with colleagues and with people using services, in providing a consistent and high quality experience.

In embracing the framework and the ten commitments, they can drive essential change to improve their own and their team's abilities to create new ways of working and build a strong foundation for the future.

For people using social care the commitments in the framework together with the 6Cs ensure that people can say:

- I can live the life I want and am supported to manage any risks;
- I have choice and control and feel safe;
- I have the information and advice I need to stay healthy and as independent as I want;
- I am still connected to my local community through friends and family;
- I have a voice to control the planning and delivery of my care and support;
- I have caring compassionate support delivered by competent people;
- My family is supported to care which helps us all to cope.

People who use services should experience better outcomes as a result of this framework. However, improving outcomes requires us to reflect on our practise, for which we often need support and that can make it difficult to demonstrate value. This is where the ten commitments, set out in the framework, can help - by focusing our attention on reducing unwarranted variation.

A complementary document to this section is available at www.england.nhs.uk/leadingchange

Teaching care homes

Care homes are among the most established nurse-led services amongst the many sub-specialities.

Care homes are well positioned to help drive the transformation needed around out-of-hospital and personalised care. But as in NHS-funded services, the amount of unwarranted variation in quality of care, experience of staff and use of resources, needs addressing.

The 'Teaching Care Homes' programme will support the development of 5 centres of excellence in social care. Pioneer centres will provide a framework from which the whole sector can learn, helping us to reduce unwarranted variation.

A digital platform, launched in March 2016, will provide a community hub for nurses working in the sector and enable care providers to share best practice.

Section 4

An introduction to the RightCare Programme

One of the major programmes currently being implemented to tackle unwarranted variation is the Right Care programme, which seeks to obtain the best value care in line with patient expectations by comparing spending across areas and specialties.

It has been developed to demonstrate, through using a range of tools, where unwarranted variation exists and how to address it.

The programme will assess the value that the individual patient derives from their care as well as its value to the population. It will assess how funds are allocated between different specialities, such as cancer and mental health, between different areas of the country and between different groups, such as BME populations.

It will compare the use of resources between areas and between specialties, to ensure they deliver maximum value and to minimise waste, using reports such as the Atlas of Variation, which details differences in disease incidence, care resourcing and outcomes in different parts of the country.

RightCare shares best practice by providing local examples of innovations published through a series of Right Care Casebooks.

A three-stage approach to drive improvement is set out:

- **STEP ONE: 'Where to look'**
  The Atlas of Variation is an ideal starting point for making comparisons and identifying quickly which local services are outliers.
- **STEP TWO: 'What to change'**
  This typically involves a 'deep dive' into a particular care pathway to gain more detailed insight into what is working well, and what is not, informing the case for change.
- **STEP THREE: 'How to change'**
  This involves proving the viability of the proposed change and then implementing it. It requires programme management, stakeholder engagement, analysis of the potential impact on service providers and a sound business case.

The key to success is that the right people work together to articulate and drive the case for change. As nursing, midwifery and care staff, we have a vital leadership role in driving this search for clinical excellence, working in partnership with colleagues, trade unions and professional organisations.

Addressing unwarranted variation can be tackled by anyone, by looking carefully at the care we deliver and comparing it with our peers. We can drive the promotion of health and wellbeing and we can be pivotal in designing and delivering new integrated models of care.

Developing a Right Care Programme for nursing, midwifery and are staff to reduce unwarranted variation

The Leading Change, Adding Value framework encourages everybody to focus on searching for unwarranted variation to release resources to help reduce the three gaps and achieve the Triple Aim outcomes.

Most of this work will be undertaken locally. But over time and where appropriate, we will build a Right Care programme for nursing, midwifery and care staff. It will be supported nationally but will be interpreted locally, and will include provision of a range of resources to build competence, capacity and capability in using the programme.

Underpinned by the 6Cs, the programme will create the right culture and help us demonstrate that we are narrowing the gaps and adding value whilst providing individuals and populations with the best possible care.

Involving individuals, clinicians and care colleagues in designing new care pathways will be challenging. However with national and regional support we can lead this new way of thinking, working and transforming our practice. There will be clear links with other emerging care models, such as the vanguard sites.

This approach will ensure that our core values are preserved. Person-centred care will remain fundamental to all transformation and redesign.

Part Four
Message from the Editorial Board

Part Four

Message from the Editorial Board

Nursing, midwifery and care staff have worked in partnership to co-produce Leading Change, Adding Value.

We have listened to staff, patients and the public who have told us why it is important that we have a framework that supports us to be leaders of change, that helps us make a difference and that helps us demonstrate the added value we contribute to the health and well-being of individuals and communities.

- More than eight months of engagement with over 9000 people, across the health and care system
- More than 11,000 pieces of evidence and data
- Almost 4,000 contributions from 900 people specifically at the Chief Nursing Officer's Summit to test the initial draft.

We are jointly committed to Leading Change, Adding Value which is specifically aligned with the Five Year Forward View. We will continue to work together, alongside all nursing, midwifery and care staff colleagues, to lead with confidence and demonstrate the difference that we can make.

Editorial Board Members: (in alphabetical order):

- Gail Adams, Head of Nursing, Unison
- Obi Amadi, Lead Officer, Unite
- Professor Viv Bennett CBE, Chief Nurse, Public Health England
- Sharon Blackburn CBE, Policy and Communications Director, The National Care Forum
- Dr Philip DaSilva, Co-founder, RightCare Programme
- Janet Davies, Chief Executive, Royal College of Nursing
- Liz Fenton, Nurse Advisor, on behalf of Professor Lisa Bayliss-Pratt, Chief Nurse Health Education England
- Dr David Foster, Head of the Nursing, Midwifery and Allied Health Professions Policy Unit, Department of Health
- Hilary Garratt, Deputy Chief Nursing Officer England /Director of Nursing, NHS England (Chair),
- Paulette Lewis MBE, for the CNO BME Advisory Group
- Carmel Lloyd, Head of Education and Learning, and Dr Jacque Gerrard, Director England, Royal College of Midwives; on behalf of Professor Cathy Warwick CBE, Chief Executive, Royal College of Midwives
- Ruth May, Executive Director of Nursing, NHS Improvement/ Deputy Chief Nursing Officer, England
- Jacqueline McKenna MBE, Deputy Director of Nursing, NHS Improvement
- Tracy Paine, Operations Director, Belong (on behalf of the National Care Forum)
- Suzanne Rastrick, Chief Allied Health Professions Officer
- Professor Deborah Sturdy, Nurse Advisor, Care England

Engagement timeline

Leading Change, Adding Value has been directly informed by extensive engagement.

June-November 2015

In depth national engagement including events, workshops, staff surveys, social media conversations, webinars, presentations and targeted engagement with individuals and organisations.

November 2015

Professional analysis undertaken, working with emerging themes with subject matter experts from health and social care, and organisations representing the public. This included a facilitated 'Think Tank' event of stakeholders across the system. A potential strategic framework emerged from early analysis highlighting a set of priorities and three ambitions; adding value to the professions, to individuals and to populations.

December 2015

Interactive workshops at the Chief Nursing Officer's Summit tested the evolving strategic framework and priorities. More than 500 attendees and several hundred 'virtual' attendees at twelve locations around the country used an online platform to review, vote and comment on ambitions and priorities.

An independent company analysed all the data. The feedback from the engagement suggested:

- A strong desire for follow-up to Compassion in Practice for nursing, midwifery and care staff;
- A demonstration of distinctive values across nursing, midwifery and care staff, whatever the role;
- The '6Cs' to remain as the value base guiding the next phase of development;
- The need to work with a strong evidence base, with a firm indication of what success will look like and how it will be measured;
- Nursing, midwifery and care staff to be the primary agents of transformation and request support to work together to prepare for the future.

January-March 2016

Consolidating work to date. A virtual feedback group of over seventy members scrutinised and commented throughout production of the framework.

Part Five
Tools to support the framework

Part Five

Tools to support the framework

In order to further support local implementation, a number of additional resources are included within the appendices of this framework. These include a range of case studies and examples of where change is happening or has already happened; and signposting to national resources which can also support your work.

Appendices:

A National resources: documents, tools and references

B Case studies

C Impact Measurement Framework

Complementary versions:

- **Leading Change, Adding Value:**
  A framework for nursing midwifery and care staff - summary document
- **Leading Change, Adding Value:**
  What it means for nurses and care staff working in social care

Appendix A

National resources: documents, tools and references

Appendix A
National resources: documents, tools and references

Information to help further understand:

Unwarranted variation:

Unwarranted variation adversely affects outcomes, experience and resources, resulting in care of lower value. These resources will help you to identify unwarranted variation and understand how to address it. These resources are relevant across all 10 commitments.

- NHS RightCare, (2016), Programme overview.
- NHS Right Care, (2015), The Atlas of Variation in Healthcare.
- Wennberg, JE, (2010), Tracking Medicine: A Researcher's Quest to Understand Health Care, Oxford University Press.
- NHS RightCare Casebooks.
- Lord Carter of Coles (2016) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations independent report for the Department of Health, Crown Copyright.

The National Picture:

These resources will provide you with information on the context of the health and care system that we work in. These resources are relevant across all 10 commitments.

- RCNi (2015) A guide to economic assessment in nursing, RCN Publishing Company Limited.
- Department of Health, (updated 2015), The NHS Constitution.
- Department of Health, (2016), NHS Mandate.
- NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE) (2014) Delivering the Forward View: NHS Planning Guidance 2016/17 - 2020/21.
- NHS, (2015), Five Year Forward View.
- Lord Carter of Coles, (2015), Review of Operational Productivity in NHS Providers interim report.

- NHS Improvement, (2016), Implementing the Forward View: supporting providers to deliver.
- The Mental Health Taskforce, (2016), The Five Year Forward View for Mental Health.
- HM Treasury and The Rt Hon George Osborne MP (2015) 2015 Spending Review.
- NHS England, (2016), General Practice Forward View.
- NHS England, (2014), New care models - vanguard sites.
- Department of Health (2016), Corporate report: Shared delivery plan 2015 to 2020.
- Department of Health and NHS Commissioning Board, (2012), Compassion in Practice.
- NHS England, Compassion in Practice, website.
- The Health and Social Care Act 2012.
- Stiefel M, Nolan K, (2012). A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.
- Donald M. Berwick, Thomas W. Nolan and John Whittington (2008) The Triple Aim: Care, Health, And Cost Health Affairs, 27, no.3: 759-769.
- Living Longer, Living Better, website.
- NHS England, (2016), Our 2016/17 Business Plan, NHS England.
- Gov.uk, Report a problem with a medicine or medical device, website.
- Department of Health, (2016), NHS Outcomes Framework: at-a-glance, Department of Health.
- NHS England, Health as a social movement, website.
- Association of Directors of Adult Social Services, (2015), Distinctive, Valued, Personal - Why Social Care Matters: The Next Five Years.
- NHS England (2016), Local Digital Roadmaps, website.
- NHS England, Harnessing the Information Revolution, website.
- NHS England, Digital Maturity Assessment, website.
- NHS England, Sustainability and Transformation Plans, website.
- NHS England, Primary Care Web Tool, NHS England.
- Department of Health, Health Education England and Public Health England, (2014), Healthy Lives, Health People: update on the public health workforce strategy, Department of Health.
- Public Health England, Public Health Outcomes Framework.
- National Voices (2015) A new model of partnership with people and communities: key principles, National Voices.

- Care Quality Commission (2015), Regulation 20: Duty of candour, CQC.
- Healthcare UK, Department of Health and UK Trade & Investment (2016) The UK: your partner for digital health solutions, Crown Copyright.
- Department of Health (2012) National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (Revised), DH.
- Public Health England, Public Health Profiles.
- Public Health England (2012) Healthcare associated infections (HCAI): point prevalence survey, England.
- HSCIC, Statistics on Obesity, Physical Activity and Diet.

Productivity:

The information in this section will support nursing, midwifery and care staff to further understand the productivity and efficiency agenda. These resources are relevant across all 10 commitments.

- Lord Carter of Coles, (2015), Review of Operational Productivity in NHS Providers interim report.
- NHS Improvement, (2016), Implementing the Forward View: supporting providers to deliver.
- NHS UK, Making People Count, Future Focused Finance, website.

Work on Mental Health and Learning Disabilities:

More emphasis needs to be placed on improving outcomes and experience for people who have a mental health illness or learning disability. These resources will support us to understand how we can improve care for those individuals with a mental health illness or learning disability and ensure parity of esteem. These resources are relevant across all 10 commitments.

- NHS England, Department of Health and Public Health England (2016), Improving the physical health of people with mental health problems: Actions for mental health nurses.
- Department of Health, (2011), No health without mental health - a cross-government mental health outcomes strategy for people of all ages.
- Improving Access to Psychological Therapies, website.
- Department of Health and Home Office, (2014), Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis.
- The King's Fund, (2015), Mental health under pressure, The King's Fund.
- University of Manchester, (2015), The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales, University of Manchester.
- NHS Choices, (2015), Care Programme Approach, website.

- Time to Change, (2016), website.
- NHS England and Department of Health, (2015), Future in Mind.
- Department of Health, (2005), Delivering race equality in mental health care.
- Mental Health Act, (2007), The Stationery Office.
- Think Ahead Programme, website.
- Health and Social Care Information Centre (HSCIC), Mental Health Services Data Set, website.
- Care Quality Commission, (2015), Right Here, Right Now, CQC.
- The Mental Capacity Act, (2005), The Stationery Office.
- The Mental Health Taskforce to NHS England, (2016), The Five Year Forward View for Mental Health.
- Association of Directors of Adult Social Services, Care Quality Commission, Department of Health, Education England, Local Government Association and NHS England, (2015), Transforming Care for People with Learning Disabilities, NHS England.

Children and Young People:

There are over 15 million children and young people in England, making up 25 percent of the population. There are also an estimated 700,000 young carers who are not only seeking to build their health literacy skills, but also require these skills to advocate for those they care for. These resources are relevant across all 10 commitments.

- Care Quality Commission, (2015), Children and young people's inpatient and day case survey 2014 - Key Findings, CQC.
- Department of Health, (2015), Children and Young People's Health Outcomes Forum: 2014 to 2015, Department of Health.
- Department of Health and NHS England, (2015), Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing.
- National Institute for Health and Care Excellence (2016) Transition from children's to adults' services for young people using health or social care services, NICE.
- Department for Education and Department of Health (2015) Promoting the health and wellbeing of looked-after children, Crown Copyright.
- Public Health England, National Child Measurement Programme.

Maternity services:

These resources outline the future direction for maternity services and the role we can play in leading those changes. These resources are relevant across all 10 commitments.

- Maternity Services Liaison Committees, website.

- Baroness Julia Cumberledge, (2016), Better Births; improving outcomes of maternity services in England. A Five year forward view for maternity care, NHS England.
- Royal College of Obstetricians and Gynaecologists (RCOG), Each Baby Counts, website.
- NHS England, (2016), Saving Babies' Lives - A care bundle for reducing stillbirth, NHS England.
- NHS England, Maternity Review, website.
- NHS England (2016) The National Maternity Review, NHS England.
- Royal College of Midwives, Better Births Initiative, website.
- The Royal College of Midwives (RCM), (2015), Caring for women with Mental Health problems, RCM.
- Leadsom, A., Field, F., Burstow, P. and Lucas C., (2013) The 1001 Critical Days: the Importance of Conception to the Age of Two Period, Best Beginnings.
- The All Party Parliamentary Group for Conception to Age 2, (2015) Building Great Britons.
- RCM/SANDS, Bereavement network, website.
- NHS England, (2016), Spotlight on Maternity: Contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, NHS England.

Equality and Diversity:

These resources will help you understand how to safeguard workforce equality, to ensure that all individuals are treated fairly and equally, specific to their needs. These resources are relevant across all 10 commitments.

- NHS England (2014) NHS Workforce Race Equality Standard, website.
- Department of Health (2005) Delivering race equality in mental health care, Department of Health.
- Department of Health, Equality and Diversity Act 2010, website.
- Equality and Human Rights Commission, Protected Characteristics, website.
- Mencap (2007) Death by Indifference, Mencap.
- CIPOLD Team (2013) Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD), Norah Fry Research Centre.

Population Health and Prevention:

These resources will help you to understand how to place a greater emphasis on prevention and self-care to reduce health inequalities and meet the population health challenge, of the rising number of people living with a long

term condition, practising in ways which prevent disease and protect health and well-being. These resources are particularly relevant to commitments 1, 2 and 3.

- Gov.uk, All Our Health; About the Framework, website.
- Public Health England and Health Education England, (2016), Making Every Contact Count.
- Public Health England, NHS England and Health Education England, (2016), Making Every Contact Count (MECC): consensus statement, Public Health England.
- Public Health England, (2014), A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals, Public Health England.
- Department of Health, (2011), Cancer framework, Department of Health.
- Public Health England, (2014), From evidence into action: opportunities to protect and improve the nation's health, Public Health England.
- Public Health England, (2013), Public health contribution of nurses and midwives: guidance, Department of Health.
- National Voices, People and Communities Board, website.
- NHS England, Realising the Value, website.
- Suzanne Wood, Health Foundation, and Annie Finnis, Halima Khan and Johanna Ejbye, Nesta, (2016), At the heart of health - realising the value of people and communities, Nesta.
- National Voices (2015) How should we think about value in health and care? Nesta.
- Gov.uk, Health matters: antimicrobial resistance, website.
- The review on Antimicrobial Resistance, (2015), Chaired by Jim O'Niell, HM Government/Welcome Trust.
- Antibiotic Guardian, website.
- Gov.uk (2016) The Eatwell Guide, website.
- NHS, Healthy Start, website.
- NHS, Start 4 Life, website.
- NHS, Change 4 Life, website.
- NICE, Diet nutrition and obesity.
- NHS England (2016) Healthy New Towns.
- The King's Fund, The new NHS: health and wellbeing boards.
- Gov.uk, Population screening programmes, website.
- Gov.uk (2014) Immunisation against infectious disease, website.
- NHS Health Check, website.

- Gov.uk, Find your local health protection team in England, website.
- Public Health England (2015) English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) 2010 to 2014.
- Royal College of Nursing (2015) Infection prevention and control commissioning toolkit: Guidance and information for nursing and commissioning staff in England, RCN.
- E-Learning for Healthcare, Reducing Antimicrobial Resistance.
- Public Health England (2015) Start Smart - Then Focus, Antimicrobial Stewardship Toolkit for English Hospitals.
- European Antibiotic Awareness Day.
- Department of Health (2015) The Health and Social Care Act 2008: code of practice on the prevention and control of infection and related guidance.
- NICE, Antimicrobial stewardship, NICE.
- Gov.uk (2014) Antimicrobial Resistance (AMR), website.
- Public Health England (2015) Start Smart - Then Focus.

Workforce:

These resources provide information on how we can develop and strengthen the nursing, midwifery and care staff workforce. These resources are particularly relevant to commitments 6, 7, 8 and 9.

- Health Education England, (2015), Raising the Bar - Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants, Health Education England.
- Jones, K, Warrren A, Davies, A, (2015), Mind the Gap - Exploring the needs of early career nurses and midwives in the workplace, Birmingham and Solihull Local Education and Training Council.
- The Point of Care Foundation (2014) Staff Care: How to engage staff in the NHS and why it matters, The Point of Care Foundation.
- NHS Employers, Health and Wellbeing Toolkit, website.
- Primary Care Workforce Commission, (2015), The future of primary care, Creating teams for tomorrow, Health Education England.
- Health Education England, Transforming nursing for community and primary care, Health Education England.
- Cavendish C, (2013), The Cavendish review; An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, Department of Health.
- Skills for Care, (2016), Registered nurses in the Adult Social Care sector, Skills for Health.
- Department of Health, (2016), Corporate report: Department of Health: shared delivery plan 2015 to 2020, Department of Health.

- Health Education England, Framework 15, Health Education England, 2014-2029, Health Education England.
- Skills for Care and Skills for Health, (2013), National Minimum Training Standards for Healthcare Support Workers and Adult Social Care Workers in England, Skills for Care and Skills for Health.
- Royal College of Nursing, (2012), An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation, Royal College of Nursing.
- The Queen's Nursing Institute, (2015), The QNI/ONIS Voluntary District Nursing Education Standards, The Queen's Nursing Institute.
- Health Education East Midlands, (2014), Quality Standards for local training and education providers, Health Education East Midlands.
- National Quality Board, (2013), How to ensure the right people, with the right skills, are in the right place at the right time, NHS England.
- National Quality Board (2016), Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.
- Department of Health, (2011), NHS Staff Management and Health Service Quality, Department of Health.
- Lord Willis (2015) Raising the bar - Shape of caring; a review of the future education and training of registered nurses and care assistants, Health Education England.
- Academic Health Science Networks, NHS England.

Experience of Care:

These resources will help better understand how we can ensure care is centred on individuals and their carers; supporting them to make decisions relating to care planning and self-management. These resources are particularly relevant to commitments 3, 4 and 5.

- Department of Health, (2015), Voice choice and control; how registered nurses, care and support staff in the care sector can support people to achieve these aims, Department of Health.
- Think Local Act Personal and National Voices, (2013), A Narrative for Person-Centred Coordinated Care, National Voices.
- Public Health England and Department of Health, (2014), A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals, Public Health England.
- NHS England, (2015), Improving Experience of Care through people who use services, How patient and carer leaders can make a difference, NHS England. Patients as leaders.
- Self Care Forum, The Self-Care Continuum.

- Hibbard, J, & Gilbert, H, (2014), Supporting people to manage their health. An introduction to patient activation, The Kings Fund.
- NICE, (2014), Behaviour change: individual approaches, NICE.
- NHS Scotland, (2010), Long Term Conditions collaborative, NHS Scotland.
- NHS England, (2014), Commitment to Carers, NHS England.
- Institute for Healthcare Improvement, (2011), Always Events®, Institute for Healthcare Improvement.
- National Palliative and End of Life Partnership, (2015), Ambitions for End of Life Care, End of Life Care Ambitions.
- NHS England, Supporting patients' choices to avoid long hospital stays, NHS England.
- NHS England, Quick Guide: Clinical input into care homes, NHS England.
- NHS England, Quick Guide: Better use of care at home, NHS England.
- NHS England, Quick Guide: Identifying Local Care Home Placements, NHS England.
- NHS England, Quick Guide, Technology in care homes, NHS England.
- NHS England, Quick Guide: Sharing patient information, NHS England.
- NHS England, Patient Online, website.
- NHS England, Digital Primary Care, website.

Professional Standards:

Leading Change, Adding Value is for implementation by all nursing, midwifery and care staff across the health and care sector. For those with a professional registration, these resources provide information relevant to that registration. These resources are relevant across all 10 commitments.

- Nursing and Midwifery Council, (2015), The Code – Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council.
- Nursing and Midwifery Council, (2012), Midwives rules and standards, Nursing and Midwifery Council.
- Nursing and Midwifery Council, (2007), Standards for medicines management, Nursing and Midwifery Council.
- Nursing and Midwifery Council, (2010), Standards for pre-registration nursing education, Nursing and Midwifery Council.
- Nursing and Midwifery Council, (2015), Revalidation: Your step-by-step guide through the process, Nursing and Midwifery Council.
- Nursing and Midwifery Council (2015) Review of midwifery regulation, NMC.

International work and policy:

Nursing, midwifery and care staff can demonstrate how we lead innovation and change both nationally and internationally. These resources highlight opportunities for addressing health care challenges today and in the future. These resources are relevant across all 10 commitments.

- World Health Organisation Regional Office for Europe, (2015), European strategic directions for strengthening nursing and midwifery towards Health 2020 goals, World Health Organisation.
- World Health Organisation Regional Office for Europe, (2011), The new European policy for health - Health 2020:Vision, values, main directions and approaches, World Health Organisation.
- World Health Organisation Regional Office for Europe, (2014), implementing Health 2020; 2012 - 2014, World Health Organisation.
- Australian College of Nursing, (2015), Nurse Leadership - A White Paper by ACN 2015, Australian College of Nursing.

Leadership and culture:

It is well recognised that the link between leadership and positive culture leads to better outcomes. These resources will support us to influence the culture required to achieve better experience and outcomes. These resources are relevant across all 10 commitments.

- The Health Foundation, (2011), Measuring Safety Culture, the Health Foundation.
- Working together, A partnership to deliver high quality, efficient patient care, website.
- National Nursing Research Unit (2015), Culture of Care Barometer, NHS England.
- 6Cs - Our Culture of Compassionate Care, (2012).
- NHS England, (2014), Building and Strengthening Leadership, Leading with Compassion, NHS England.
- Care Quality Commission, (2015), Regulation 20: Duty of candour, Care Quality Commission.
- Future Focused Finance, (2016), Crossing professional boundaries: a toolkit for collaborative teamwork, future Focused Finance.
- NHS England, Sign up to safety, website.
- NHS England, (2014), Building and strengthening leadership - Leading with Compassion Field Guide, NHS England.
- West, Michael, Eckert, Regina, Steward, Katy and Pasmore, Bill (2014), Developing collective leadership for health care, The Kings Fund.
- West, Armit, Loewenthal, Eckert, West, and Lee, (2015), Leadership and Leadership Development in Health Care: The Evidence Base. London: Faculty of Medical Management and Leadership/The King's Fund.

Further reading

Minogue V, Wells B (2016) Reducing waste in the NHS - an overview of the literature and challenges for the nursing profession.
Nursing Management. 2016 Jul;23(4):20-5. Date of submission: 13 October 2015; date of acceptance: 22 April 2016.

Minogue V, Wells B (2016) Managing resources and reducing waste in healthcare settings.
Nursing Standard.30, 38, 52-60. Date of submission: October 2 2015; date of acceptance: December 23 2015.

West M, Eckert R, Steward K and Pasmore B, (2014), Developing and enhancing teamwork in organizations: Evidence-based practice and guidelines. (pp.331-372). Jossey-Bass, San Francisco.

Appendix B
Case studies

Appendix B
Case studies

There is much more to addressing unwarranted variation than just an improvement methodology. This is an exciting opportunity to better understand the culture of care delivery, look at the evidence and understand how the care that we deliver can be benchmarked with peer organisations, and across different health and care settings. So that when unwarranted variation occurs, we can challenge the status quo and start to do things differently.

To demonstrate work that has already been undertaken or is in progress we set out below a number of case studies and examples of best practice. This document is live and will be updated with additional studies.

If you would like to know more about the work included in this Appendix please contact the named person on the case study. Collaborative working and sharing ideas are essential to demonstrating how we can lead change and add value.

Case study 1

Diabetes training programme: The management of insulin administration in the community by non-registered practitioners

Organisations:
Shropshire Community Health NHS Trust, Shropshire Partners in Care (SPIC)

Contact:
Angela Cook, Head of Nursing and Quality, angela.cook@nhs.net

Case study 1

Diabetes training programme: The management of insulin administration in the community by non-registered practitioners

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Variable levels of diabetes care were identified in the community and residential care homes, with increased demand for district nurses to administer insulin in these settings.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Diabetes specialist nurses worked with community nurses and staff in residential care homes to deliver a training programme for care staff, to provide them with the competencies to administer insulin. The team in Shropshire have highlighted a systematic issue with poor medicine support. This is particularly important for individuals with long term conditions. As leaders the nursing team will now work with GPs and other colleagues to coordinate a wider approach to medicine support. In doing so the team will "increase the visibility of nursing leadership and input in prevention" (commitment 2).
How was unwarranted variation identified?	An MSc project looking at the diabetes knowledge levels and its management in the community showed that care was not of the standard expected. The variation was identified through data which included increased demand /referrals, incident reports and the experience of nurses visiting care homes.			
How did nursing, midwifery or care staff lead the change?	Diabetes specialist nurses, community nurses, non-registered practitioners from the independent sector and a non for profit organisation from the third sector worked in partnership to deliver change. The nurses identified suboptimal care, potential patient safety concerns and the opportunity to influence how diabetes care is provided in the community and care homes. They worked together to deliver this change.			
What action was taken?	A training programme was developed to upskill both community nurses and non-registered practitioners in diabetes care. A diabetes mentorship programme for community nurses was also started. A robust policy for the delegation of insulin administration to non-registered practitioners was developed and a core set of diabetes competencies written to support this. In addition a register and recall system was set up with a third party organisation - Shropshire Partners in Care, to administer the annual recall and review of delegation and competency assessment and to manage the administration of the programme.			

Case study 1 continued

Diabetes training programme: The management of insulin administration in the community by non-registered practitioners

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• Attendance levels and demand for programmes. • Assessment of knowledge levels pre and post course - this showed an improvement of 40%. • Competency assessment in terms of a practical and viva framework.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	Care is often provided to people in the community by a number of different staff from different organisations and teams. The team in Shropshire have worked to remove the mismatch between the administration of insulin by one team and help at meal times provided by another. In doing so they have been able to improve the control of blood sugar levels and reduce the risk of hypoglycaemia. Better control and less intervention by nurses and care staff has resulted in more time for people with diabetes to undertake other activities improving their quality of life. This approach to personalising care has reduced the risk of the complications of diabetes for these individuals as well as improving the health of this population (commitment 1). The team are challenged with how to evaluate their work from the perspective of the patients they care for many of whom have complex care needs. They will be able to use the framework and commitment 3 to "work with individuals, families and communities to equip them to make informed choices and manage their own health". This may lead them to look at the satisfaction of those they care for, admissions to hospital due to the complications of diabetes or to work with individuals to define the measures of success as they see them.
What were the successful outcomes?	Access for elderly residents in care homes to high quality care and diabetes reviews by community nurses; improved knowledge levels by non-registered practitioners relating to diabetes care and management. The correct identification of hypoglycaemia and the correct management of it. The identification of hyperglycaemia and when to seek help. Improved diabetes care planning with the use of non-registered practitioners to support their own clients in residential care home settings, reducing the need for frequency and number of district nurse visits required especially in rural locations. This work has the potential for reducing admissions for medication errors and hypoglycaemia.			

Case study 2
Improving outcomes for people living with dementia

Organisations:
Belong

Contact:
Phil Orton, Head of People Management and Development, phil.orton@clsgroup.org.uk

Case study 2

Improving outcomes for people living with dementia

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Variation in the amount and quality of time staff felt they could spend sitting with residents, due to cultural and workload factors.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Nurse leaders at Belong wanted to ensure that they were consistently providing a high standard of care and to do this they needed to know what "good" looks like. One of the lessons learned in leadership from the team was that to make a change, engagement needs to happen at a local level and be something that everyone buys in to.
How was unwarranted variation identified?	Nurse leaders wanted to ensure that they were providing consistently high standards of care and that training and evaluation of staff performance was not just a "tick box" exercise.			
How did nursing, midwifery or care staff lead the change?	Belong developed an initiative that highlights staff knowledge, understanding and confidence to act appropriately using a dementia best practice framework. This encourages learning and reflective practice and ensures continuous improvement.			
What action was taken?	Individualised approach to staff training; Staff were provided with their own feedback report and development plan. Assessment through scenarios evidenced learning.			

Case study 2 continued

Improving outcomes for people living with dementia

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• Clearly identification of skills needs within teams. • Improved confidence and greater understanding of dementia and being able to challenge practice.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	Commitment 8: "the right education, training and development to enhance our skills, knowledge and understanding" are the focus of this case study. Staff stated that they feel more confident in providing specialised person centre care and feel time spent with residents is of better quality. Improved staff is one way in which we can demonstrate that we have met commitment 6 and "actively responded to what matters most to our staff and colleagues". Resident satisfaction will be measured; where residents are unable to provide feedback, this can be collected through relatives and the care village staff. Leading Change, Adding Value will support Belong to demonstrate how they have added value under each of the 3 headings. In doing so staff will be "centred on individuals experiencing high value care" (commitment 4).
What were the successful outcomes?	• Improved skills and confidence in providing specialised person centred care. • An improved care experience for residents living with dementia. • Career progression as a result of the learning, development and training opportunities.			

Case study 3

Liberating the voices of all - recovery coaching in an older persons acute rehabilitation ward

Organisations:

Hampshire Hospitals NHS Foundation Trust and The Health Foundation

Contact:

Beverley Harden (Associate Director of Education and Quality) beverley.harden@thamesvalley.hee.nhs.uk

Case study 3

Liberating the voices of all - recovery coaching in an older persons acute rehabilitation ward

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	A loss of independence was identified in older people often evident within 48 hours of admission to an acute unit. This often meant prolonged rehabilitation and care needs and increased care required after discharge.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Health coaching is a model used by the team (widely used in the USA and Australia) developed a person centred approach to care - working with patients to identify their goals and through a coaching model to help them achieve these. Commitment 3 "we will work with individuals, families and communities to equip them to make informed choices and manage their health" is particularly relevant to the work in Hampshire Hospitals Foundation Trust.
How was unwarranted variation identified?	Nursing staff were concerned about the way in which older people could quickly lost their independence and were concerned about the potential short and long term effects of this.			
How did nursing, midwifery or care staff lead the change?	Funding was obtained from the Health Foundation to support nurse leaders make the change consisting of a team of nurses, physiotherapist and occupational therapists.			
What action was taken?	• Nurses, physiotherapists, occupational therapists and doctors were taught health coaching skills. • Staff work in partnership with patients and families to increase engagement in their health care and recovery.			

Case study 3 continued

Liberating the voices of all - recovery coaching in an older persons acute rehabilitation ward

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• Activities of daily living. • Length of stay. • Economic analysis. • Staff satisfaction.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The team in Hampshire have shown significant achievements in a range of metrics and will be looking to evaluate the patient outcomes over a longer period of time. This will demonstrate that the work contributes to improving the health of this population of elderly people on a sustainable basis. Commitment 8: "the right education, training and development to enhance our skills, knowledge and understanding" is particularly important. Staff stated that they feel more resilient as a result of this work. It will be possible to measure this through staff satisfaction and sickness absence rates. Improved satisfaction at work is one way in which we can demonstrate that we have met commitment 6 and "actively responded to what matters most to our staff and colleagues".
What were the successful outcomes?	• Improvements in the Barthel index (an ordinal scale used to measure performance in activities of daily living) of patients, activities of daily living and self-efficacy mean scores. • Length of stay was reduced. • 60% of patients went home with the same level of care as at admission. • Reduction in care home placements. • Estimated savings of up to £4,973.43 per patient by reducing length of stay and care placement. • Staff felt it gave them the additional skills needed to work in partnership with patients. • Improved job satisfaction.			

Case study 4

Improving patient experience through stratification of the prostate cancer follow up pathway

Organisations:
The Royal Marsden NHS Foundation Trust

Contact:
Netty Kinsella, Uro-oncology Nurse Consultant, netty.kinsella@rmh.nhs.uk

Case study 4

Improving patient experience through stratification of the prostate cancer follow up pathway

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Evidence suggested that numbers of patients being discharged from hospital care following curative treatment for localised prostate cancers were potentially low.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Nurse leaders at the Royal Marsden NHS Foundation Trust (RMH) reflected that it is easy to think you are doing a good job but you cannot be sure unless you ask patients what matters to them. The RMH has therefore taken the opportunity to look at how their clinics run and to obtain the input of patients into the redesign of these. Treatments and expectations change and the team at the RMH will be demonstrating their leadership role by seeking the views of patients on an ongoing basis and making changes to their service to reflect these. Their work will include "work in partnership with individuals, their families, carers and others important to them" (commitment 5).
How was unwarranted variation identified?	Increasing numbers of referrals led nurses to look at the way in which clinics were held and the way in which patients were being discharged from hospital care despite the success of their treatment.			
How did nursing, midwifery or care staff lead the change?	Nurses, working with physiotherapy and dietetic colleagues, established a patient reference group to define a new pathway for patients.			
What action was taken?	Urology stratified care pathways were developed, which enable an individualised approach to follow-up care. Early adoption of a 'Recovery Package' has optimised patient experience and reduced variation. Pre-treatment preparation, opportunity for re-assessment, care planning and supported self-management liberates patients from a potential burden of unmet needs, whilst safely reducing what was identified as often unnecessary secondary care use.			

Case study 4 continued

Improving patient experience through stratification of the prostate cancer follow up pathway

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• 2015/16 saw a 16% (1781) increase in the number of prostate cancer patients treated at the Royal Marsden NHS Foundation Trust. • Integrated follow-up and supportive care. • Self-management strategies. • Safe discharge to establish closer to home care with primary care follow up. • Release of clinical capacity.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The pathway will continue to be reviewed on a 3 monthly basis including interviews with patients, demonstrating commitment 4 "we will be centred on individuals experiencing high value care". Regular staff satisfaction surveys demonstrate commitment 6 "we will actively respond to what matters most to our staff and colleagues". The pathway supports early discharge and streamlines and focuses on follow-up and supportive care. This aims to prevent unnecessary readmission to hospital, with follow-ups taking place in primary care. Clinical teams now have increased clinical capacity to manage new patients and treatment outcomes. The leadership skills demonstrated in developing this new pathway might have the potential to be extended to other areas such as physiotherapy and dietetics. This "promotes a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1).
What were the successful outcomes?	The number of patients successfully discharged from the service has risen from zero to 73 in the first year. Patients were able to move into survivorship care as a result of earlier discharge with appropriate support.			

Case study 5
Collaborative working across care sectors to improve patient safety

Organisations:
Ipswich Hospital NHS Trust

Contact:
Lisa Sutherland, Tissue Viability Lead, lisa.sutherland@ipswichhospital.nhs.uk

Case study 5

Collaborative working across care sectors to improve patient safety

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	A high number of patients were admitted to hospital from care homes in the locality with pressure damage, which was often very significant.	Leading Change	Health and wellbeing, Care and quality, Funding and efficiency	Nurses at Ipswich Hospital have worked closely with colleagues in care homes responding to concerns about the number of residents developing pressures ulcers. In doing so they have "increased the visibility of nursing and midwifery leadership and input in prevention" (commitment 2). The team used their leadership skills to focus on bringing about change through learning and created an open learning environment in which this could occur. By listening to and understanding the needs of care home staff, hospital and care home teams have worked together to meet commitment 8: "we will have the right education, training and development to enhance our skills, knowledge and understanding".
How was unwarranted variation identified?	The number of patients admitted with damage was collated every month and provided to the local CCG. Numbers were seen to be high and a Commissioning for Quality and Innovation (CQUIN) scheme introduced to reduce these numbers.			
How did nursing, midwifery or care staff lead the change?	The Tissue Viability Nurse and Patient Safety Lead worked with colleagues and identified a lack of education and knowledge on the prevention of pressure ulcers. They used their leadership skills to provide an open access study event for local care homes.			
What action was taken?	• Data was analysed of the incidence of pressure. • Study days including resources to be taken away for in-house training by care homes. • Follow up communications regarding use of resources. • Provision of a support service by clinical photography to enable advice by Tissue Viability Nurses.			

Case study 5 continued

Collaborative working across care sectors to improve patient safety

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	Data was analysed nine months after the initial recording of pressure ulcer numbers. This showed a reduction in both the numbers of patients with pressure damage and a reduction in severity of damage. Evaluation of study days and follow up feedback showed that the study day and resources provided were of value and were being implemented.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The work is in early stages but the evaluations are showing positive results and the team are intending to extend the education and skills development programme further to look at infected leg wounds. In doing so they will continue to "promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1). Future measures of improvement may include length of stay in hospital which should reduce as care homes feel more confident in managing with pressure ulcers. Similarly with a greater skill base it will be possible to care for residents who develop pressure ulcers in their own home.
What were the successful outcomes?	• Reduction in harm and improved knowledge of impacting factors. • Reduced pressure damage or severity, impacting on equipment and resources. • Reduced risk from septic pressure ulcers.			

Case study 6
The role of the Enhanced Practice Nurse in Harrow

Organisations:
Harrow CCG

Contact:
Sue Young, Project Manager - Virtual ward & enhanced practice nursing whole systems integrated care, sue.young@nhs.net

Case study 6

The role of the Enhanced Practice Nurse in Harrow

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Variation in the provision of intensive home-based support to patients who present with significant health care challenges.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Senior and enhanced practice nurses have a variety of professional backgrounds as practice nurses, district and specialist nurses. Education programmes and investment in the new roles has helped to ensure that we "have the right staff in the right places at the right time" (commitment 9). This new way of working has been used to "promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1). The team have "championed the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes" (commitment 10). Specifically technology has been used to provide access to assessments and treatment plans for staff in the community, primary care and the acute sector.
How was unwarranted variation identified?	Data relating to hospital admissions was analysed and showed higher numbers of admissions from nursing homes and some geographical areas, and a higher number of admissions at the weekend.			
How did nursing, midwifery or care staff lead the change?	Distributed leadership brought together nurses from different employers to learn together, develop decision making and methods of communication. The skills of nurses were enhanced to provide uniform and effective support.			
What action was taken?	Implementation of the 'virtual ward' within which practice nurses provide intensive home-based support to patients with significant health care challenges. An integrated assessment system allows access by acute and community staff.			

Case study 6 continued

The role of the Enhanced Practice Nurse in Harrow

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• Reduction in GP and A & E attendances. • Reduction in hospital admission and facilitation of rapid discharge to home-based care. • Improved recovery times. • Reduced prescribing costs. • Evidence of greater clinical effectiveness; enhanced patient/care experience; greater compliance and competence to self-manage.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	Improving the intensive support for patients at home has resulted in adding value in all of the three areas. Nurses involved in the programme have extended their skills, are managing their own caseloads and referring to multidisciplinary colleagues where additional input is required. The programme was established in 2015. Data will continue to be collected as the work progresses to other areas of Harrow CCG and North London.
What were the successful outcomes?	Identifying and meeting the needs of those requiring home based intensive support enables patients to live at home enhancing their quality of life and reducing the reliance on hospital services.			

Case study 7
Improving infection control in nursing care homes

Organisations:
Bassetlaw CCG, Doncaster and Bassetlaw NHS Foundation Trust, Nursing home providers in Bassetlaw

Contact:
Denise Nightingale, Chief Nurse and Executive Lead for Quality and Safety, d.nightingale@nhs.net

Case study 7

Improving infection control in nursing care homes

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Variation in infection prevention and control standards in care homes suggested that consideration should be given to ensuring that the environment always supported safe care.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	The team in Bassetlaw have focussed on having the "right education, training and development to enhance skills, knowledge and understanding" (commitment 8). The Infection Prevention and Control nurses have increased the visibility of nursing and midwifery leadership and input in prevention (commitment 2) and have done so while working in partnership with staff in care homes supporting them to become more knowledgeable leaders and practitioners in the field of infection prevention and control. Commissioning leaders have the opportunity to develop the model further and into relevant care homes outside of the Bassetlaw area.
How was unwarranted variation identified?	An internal investigation and subsequent audits by the Infection Prevention and Control team identified a knowledge gap in respect of infection control in a number of care home settings.			
How did nursing, midwifery or care staff lead the change?	Infection Prevention and Control (IPC) nurses worked with the care homes and set up a nursing forum for communication and education.			
What action was taken?	The Bassetlaw Quality Improvement Tool (BQIT), an online tool devised to help care home staff develop and sustain best practice in infection prevention and control, and ensure a safe environment for residents was launched in September 2014.			

Case study 7 continued
Improving infection control in nursing care homes

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	After the launch of the BQIT tool, improvements were seen in all areas of infection prevention and control.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The BQIT tool will show how practice is improving and metrics can be used to demonstrate the numbers of people trained with the opportunity to further test their knowledge. Care home residents and their families and visitors could potentially contribute to the assessment of standards and become champions for improvement. The team will be working "in partnership with individuals, their families, carers and others important to them" (commitment 5) to identify what is important to them in respect of infection prevention and control and use this within their evaluation.
What were the successful outcomes?	Through the audits it is possible to show that practice in infection prevention and control has improved thus reducing the risk of infection.			

Case study 8
The changing face of modern nursing - "Living Well"

Organisations:
Cornwall Partnership NHS Foundation Trust, Age UK and Volunteer Cornwall

Contact:
Lucy Clement, Integrated Community Care Team Manager North and East Cornwall, lucyclement@nhs.net

Case study 8

The changing face of modern nursing - "Living Well"

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	The support offered to vulnerable people with long term conditions was variable.	Leading Change	Health and wellbeing, Care and quality, Funding and efficiency	Colleagues in Cornwall recognised the importance of looking outside of the NHS and networking with colleagues in the community and voluntary sectors to find solutions. One of the lessons in leadership from the team is that to make a difference you have got to do something different, which will help to create leadership capacity. The model is now being used with 2,500 people and the intention is to extend this further to look at other groups of vulnerable people including young people with enduring mental health needs and children with continuing care needs. The "Living Well" team "will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1).
How was unwarranted variation identified?	Variation was identified as part of a project during the "Nurse First" leadership course. Community nurses were undertaking visits with very few step down processes and not consistently addressing what really mattered to patients. Overlooking the importance of isolation and loneliness.			
How did nursing, midwifery or care staff lead the change?	District nurses from Peninsula Community Health worked alongside co-ordinators funded by Age UK, GPs and a range of other professionals to map services available and then worked with the voluntary sector to enable access.			
What action was taken?	Nurses and Age UK have co-designed and led the pioneering Living Well programme with volunteers recruited to visit and support vulnerable people with long term conditions. Establishing a new working culture based on partnerships and focused on reducing dependency. Engaging with individuals through guided conversations to understand their personal goals.			

Case study 8 continued

The changing face of modern nursing - "Living Well"

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	The project looked at the number of patients admitted to hospital and those who required care packages. Individual well-being was also measured.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	Those who have entered the programme have had two or more long term conditions, The team would like to look at whether they can be more proactive with their interventions and use this approach to prevent ill health. This may lead the team to "lead and drive research to evidence the impact of what we do" (commitment 7). In order to see how sustainable this programme is, an example research question might be "12 months post intervention, how many of the sample size have been re-admitted into hospital compared to their previous year's admission profile?"
What were the successful outcomes?	Living Well now supports 2,500 people in three parts of the county. Assessment of the pilot has shown a 40% reduction in hospital admissions and 8% in care packages by 8% Improving wellbeing by 23% and raising staff morale by 87%.			

Case study 9
Teaching care homes

Organisations:
National care homes

Contact:
Deborah Sturdy, Nurse Advisor Care England, deborah.sturdy@btinternet.com

Case study 9
Teaching care homes

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Care homes are some of the most established nurse-led services yet there can be often a lack of understanding of this as a professional career pathway. There is often a challenge in the recruitment of registered nurses to work in care homes and a need to demonstrate the career options in the sector and bring nursing colleagues together to network and develop a community of practice.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	The sector wants to be at the forefront of offering consistent high standard learning experiences for pre-registration students and to do this they are articulating and disseminating what "good" looks like. Commitment 8: "the right education, training and development to enhance our skills, knowledge and understanding" is a core focus of this case study. The programme aims to provide excellent education and training to pre-registration students, to encourage and embed a future workforce of care nurses. It aims to further develop current care home staff and managers. The programme will maximise opportunities to use technology (commitment 10) by developing an online digital platform to share best practice and learning; this will contribute to reducing unwarranted variations in care. It will also allow care home nurses to connect with others and avoid any potential isolation in their work.
How was unwarranted variation identified?	Data and experience of lead professionals working within the sector.			
How did nursing, midwifery or care staff lead the change?	The Department of Health Taskforce for Social Care Nursing Workforce has influenced the development of this work, recognising the need for good clinical experience and supporting care home nursing to flourish as a speciality. Five pilot sites will support nursing and care staff to consider their culture and practice.			
What action was taken?	The work will be launched in May 2016 and support the development of five centres of excellence in social care. The Teaching Care Homes project will create the foundations for a framework of learning; becoming pioneer centres from which the whole sector can learn. A digital platform was launched in March 2016 to share learning about the development and social care nursing for use across the sector and NHS. This will provide a community hub for nurses working in the sector, and provide an opportunity for care homes and care providers to share best practice. The participating homes will come together to learn and develop a new approach through a learning set, be supported with coaching to help them lead and deliver changes in their home and be a project for the sector to share and learn from.			

Case study 9 continued
Teaching care homes

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	The programme will be evaluated in March 2017, focussing on staff learning and resident and family experience.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	An aim to improve satisfaction with work would demonstrate that the meeting of commitment 6 and "actively responded to what matters most to our staff and colleagues". Leading Change, Adding Value will support care homes to demonstrate how they have added value under each of the three headings.
What were the successful outcomes?	Work in progress and results will be updated as available.			

Case study 10

The First Response service - a 24/7 integrated model for urgent mental health care

Organisations:
Bradford District Care NHS Foundation Trust and The Bradford Metropolitan District Council

Contact:
Sarah Deacon, Clinical Manager, sarah.deacon@bdct.nhs.uk

Case study 10

The First Response service - a 24/7 integrated model for urgent mental health care

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	The provision of 24/7 mental health crisis services and the option of out of hours crisis requiring attendance at the local Accident and Emergency. This included considering the use of Section 136 of the Mental Health Act (MHA).	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	The team in Bradford established strong partnerships and worked closely with colleagues in voluntary services, the police and social care to bring about change. First Response Service is listed as a local inspiration on the Crisis Care Concordat website. An education programme is being developed so that emergency department staff can identify and signpost mental health service users experiencing a crisis. In doing so the team is enacting commitment 8: "we will have the right education, training and development to enhance our skills, knowledge and understanding".
How was unwarranted variation identified?	Consideration of the number of service users being admitted to out of area placements, the capacity of acute wards and partnership working with police colleagues. It was suggested that an unwarranted variation in service provision was evident in the comparison of 'in' and' out' of hours.			
How did nursing, midwifery or care staff lead the change?	The project led by a Nursing Deputy Director with Senior Nurse Managers and the service is led by advanced nurse practitioners. Change required the development of strong partnerships with colleagues external to the NHS.			
What action was taken?	The Trust looked at other crisis models elsewhere in the country and the local CCG agreed to fund a pilot for the First Response Service to provide a 24/7 crisis assessment service. The Trust redesigned their Acute Care Pathway and brought the acute mental health services together under one structure.			

Case study 10 continued

The First Response service - a 24/7 integrated model for urgent mental health care

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	There were reduced admissions to inpatient beds leading to zero out of area beds being used. This saved £1.8 million in 12 months. There was a reduction in attendances to the emergency department and in Section 136 MHA detentions (25 in August 2015 and 8 in January 2016).	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The team has shown significant reduction in the use of out of area beds to demonstrate an improved client experience. The project team could potentially develop the project evaluation further by asking clients to use their experience to shape pathways. In doing so they would be working "in partnership with individuals, their families, carers and others important to them" (commitment 5).
What were the successful outcomes?	• Improved access to crisis care avoiding escalation. • A consistent and responsive approach to crisis care. • Savings on the cost of out of area beds. • A more client focussed service with a consistently higher response 24/7.			

Case study 11

Reacting to Red - Developing a whole health and social care economy approach to preventing and reducing pressure ulcers

Organisations:
Nottinghamshire Healthcare NHS Foundation Trust, Bassetlaw CCG, NHS England - North Region

Contact:
Phyllis Cole, Senior Nurse Manager, phyllis.cole@nhs.net

Case study 11

Reacting to Red - Developing a whole health and social care economy approach to preventing and reducing pressure ulcers

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Variation in the reporting of pressure ulcers both in relation to safeguarding and care practice.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	"React to red" relies on a collaborative approach achieved by inspiring, engaging nurses and care staff to work towards a common goal. The team developed a collaborative and have demonstrated how they have worked to improve the health of the population by promoting "a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1) and have acted to "increase the visibility of nursing and midwifery leadership and input in prevention" (commitment 2). The leadership skills demonstrated in developing and delivering the goals of the collaborative could be transferred to other areas of practice providing the framework for collaboration in other key aspects of patient safety including, for example, infection prevention and control, nutrition and hydration or dementia care.
How was unwarranted variation identified?	Tissue viability nurses raised concerns that the focus of care was on the treatment of pressure ulcers rather than on prevention. This was supported by anecdotal evidence of nurses are alerted by carers at the point pressure damage has already occurred.			
How did nursing, midwifery or care staff lead the change?	Tissue viability nurses used a collaborative approach across acute, community and care home services. Change in practice was brought about by a bottom up as well as a top down approach.			
What action was taken?	• Development of a good practice protocol • Development of a training resource and competency assessment			

Case study 11 continued

Reacting to Red - Developing a whole health and social care economy approach to preventing and reducing pressure ulcers

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	Development of a data collection tool which demonstrated a reduction in the incidence of pressure ulcers. This included an improvement of data quality.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The collaborative intends to collect more quantitative data to show the impact of the work they have been doing. This will include looking at whether the education programmes and information produced by the collaborative have made a difference to the knowledge of individuals and their practice. Patient satisfaction will be measured; this will include focussing on patients who are unable, due to their cognitive ability, to provide feedback and will be collected through relatives and carers including care home staff. In doing so staff will be "centred on individuals experiencing care" (commitment 4).
What were the successful outcomes?	Data collection tools demonstrated a 55% reduction in pressure ulcers within the first year. The evaluation of the tools to date has shown them to be very empowering for frontline staff, patients and carers. By identifying people who are at risk of developing pressure ulcers and intervening early the incidence of pressure damage has been reduced.			

Case study 12
Releasing nursing time while providing safer care

Organisations:
Imperial College Healthcare NHS Trust

Contact:
Gerry Bolger, Imperial Trust Nurse Informatics Lead for Clinical Systems, gerry.bolger@imperial.nhs.uk

Case study 12

Releasing nursing time while providing safer care

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	The practice of documenting patient information on paper often resulted in a fragmented approach to the recording, visibility and access of information and ease of escalation of patients at risk of deterioration.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Patient safety is an essential element of patient care. Through the introduction of the electronic system for the recording of National Early Warning Scores (NEWS) at Imperial College Healthcare NHS Trust, the Executive Nurse Director and Nurse Informatics Lead have "actively responded to what matters most to our staff and colleagues" (commitment 6) ensuring a consistency in the delivery of safe patient care and reducing the time of completing paper records. This provides a really good example of how it is possible to "champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes" (commitment 10).
How was unwarranted variation identified?	Through audits, case reviews and feedback from the Critical Care Outreach Team.			
How did nursing, midwifery or care staff lead the change?	The project was driven by nurses and midwives. Nurses and midwives have provided leadership as local champions deciding on areas for implementation and leading the implementation of bedside vital signs monitors.			
What action was taken?	Implementation of the electronic patient record, supported by a handover page showing the patient's latest National Early Warning Scores (NEWS) score. Hand held devices have been used to reduce documentation time with decision support at the bedside.			

Case study 12 continued
Releasing nursing time while providing safer care

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	• Length of time to document patients NEWS scores. • Reducing readmissions to ITU. • Increasing timely SBAR (Situation, Background, Assessment, Recommendation) notifications to Critical Care Outreach and medical colleagues.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	As an IT based solution there is significant opportunity to look at the data produced and measure the impact this is having on patient outcomes. The information goes directly into the patient record reducing the incidence of transcription errors and therefore increasing the accuracy of information. This is the start of a journey for staff at Imperial College Healthcare NHS Trust who will use the experience to date to identify areas in which technology can be used to provide decision support and further increase the speed at which corrective action can be made.
What were the successful outcomes?	Improved patient safety as a result of earlier and consistent referral to critical care outreach and medical colleagues.			

Case study 13
Telemedicine in care homes

Organisations:
Airedale NHS Foundation Trust

Contact:
Rachel Binks, Nurse Consultant, rachel.binks@anhst.nhs.uk

Case study 13

Telemedicine in care homes

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	Rising numbers of acute admissions and Emergency Department (ED) attendance from care homes, which could lead to unnecessary distress and avoidable hospital stays.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Using the learning from the prison healthcare work, nurse leaders developed the care home model, supported by specialists in the acute trust, in order to avoid potentially unnecessary trips to ED and hospital wards. In doing so the team "increased the visibility of nursing leadership and input in prevention" (commitment 2) Commitment 5 "we will work in partnership with individuals, their families, carers and others important to them" is particularly relevant to the work in Airedale NHS Foundation Trust. Residents and carers are empowered to be involved in decision making around their care, ensuring the best possible outcomes and what matters to them. Patient benefits are already being realised as clinicians in secondary and primary care can view shared data such as medication, clinical notes and begin to blur organisational boundaries by initiating community actions from secondary care, and vice versa. This improves patient experience and also improves overall service efficiency. The telemedicine hub is staffed 24/7 by acute care nurses with access to specialists as required, meeting commitment 9 "we will have the right staff in the right places and at the right time."
How was unwarranted variation identified?	Consideration of rising number of admissions and Emergency Department attendances in hospital statistics.			
How did nursing, midwifery or care staff lead the change?	Colleagues at Airedale recognised that telemedicine used successfully in prison healthcare could be applied to support care homes. The Critical Care Outreach team who had skills in assessment and treatment of deteriorating patients led work to deliver a telemedicine service in 27 local care homes.			
What action was taken?	This team were supported to use their assessment skills via video link. A 24/7 telemedicine hub was then established to support the staff and carers of frail elderly residents in care homes, using remote video consultation. The Digital Care Hub now employs 18 WTE nurses and therapists with skills and experience to deliver care remotely. The hub also hosts a GP triage service, a 24/7 end of life telephone and video service, an intermediate care hub where health and social care work in partnership.			

Case study 13 continued
Telemedicine in care homes

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	Early data showed a reduction in avoidable ED attendance (14%) and acute admissions to hospital (5%) from care homes. Residents are triaged through the telemedicine system and where possible their issues are addressed by nurses working in the hub.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	The telemedicine system of assessment is now in almost 500 care homes across the UK. This is a significant achievement but also allows an evaluation at scale to demonstrate the value of this work and an opportunity for nurses to "lead and drive research to evidence the impact of what we do" (commitment 7). The team at Airedale NHS Foundation Trust will "champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes" (commitment 10) and are planning, as part of the national Vanguard programme, to develop a virtual training room for care homes to deliver remote training sessions.
What were the successful outcomes?	Care home residents are now able to access remote consultations reducing their need to attend GP surgeries and also the need for GPs to visit care homes.			

Case study 14

Using social media for reaching women and families in healthcare services

Organisations:
Western Sussex Hospitals NHS Foundation Trust

Contact:
Cate Bell, Head of Research, cate.bell@wsht.nhs.uk

Case study 14

Using social media for reaching women and families in healthcare services

Case study		Using Leading Change, Adding Value		
What was the unwarranted variation?	The maternity department had developed a number of initiatives to support women with additional needs, however there were still many women who were not fully engaged and not able to access important information and support during their maternity care.	**Leading Change**	Health and wellbeing, Care and quality, Funding and efficiency	Midwives at Western Sussex Hospitals NHS FT realised that the traditional methods of support for women were not reaching all who needed them. The team are "centred on individuals experiencing care" and having identified the unwarranted variation the team have worked with women to find a solution to this. By improving the support and information available to this group of people they have demonstrated how they have "worked with individuals, families and communities to equip them to make informed choices and manage their own health" (commitment 3). While the work to utilise social media is primarily based on support and information for women, the team have embraced this method of communication and are using similar methods to communicate with staff who work in the unit. Good communication is important to effective team working and this is one way in which the team can demonstrate that they have "actively responded to what matters most to our staff and colleagues" (commitment 6). In developing the use of social media the team have "championed the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes" (commitment 10).
How was unwarranted variation identified?	Local performance data identified a discrepancy between the numbers of women who might benefit from the Weight Management in Pregnancy (WMIP) programme (and other specialist services) and those actually attending the face to face sessions showing that a significant number of women were not accessing available services.			
How did nursing, midwifery or care staff lead the change?	Midwives talked with women to explore why they were not accessing the information and support available to them through their pregnancy. These included ability to attend due to time, work or family commitments and travel as well as social aspects. The drivers to explore the use of social media to support care came from feedback from women.			
What action was taken?	To widen participation and address the barriers of time and accessibility plans to use social media were developed. Facebook was chosen as an accessible format with which many women may already be familiar and is free to use. A pilot Facebook page was set up by women and midwives involved with the Weight Management in Pregnancy Programme (WMIP), and was trialled for three months. Group permissions and membership were monitored and rules and best practice guidance collaboratively developed. After successful piloting, participation was widened to all women who might benefit from the WMIP programme and other group pages developed to support women and their families.			

Case study 14 continued

Using social media for reaching women and families in healthcare services

Case study		Using Leading Change, Adding Value		
What metrics were used to measure/ demonstrate success?	Facebook group membership numbers were monitored and qualitative information on women's satisfaction with the service and level of engagement with the WMIP programme and other services were measured.	**Adding Value**	Better outcomes, Better experiences, Better use of resources	Midwives in Western Sussex have used two different methods of evaluation - data from social media (numbers accessing) and qualitative data including the use of the guest book. Local data with regard to the WMIP programme showed a significant outcome benefit for women who attended. The team are currently formally evaluating outcomes and experience in a research project. The ethos is "promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff" (commitment 1).
What were the successful outcomes?	• Significant increase in the level of engagement and communication with women and families. • Peer to peer support provided for women and feedback demonstrates the benefit of this to improving their experience of maternity care and early parenthood. • Enhanced staff engagement and improved cross site working.			

Appendix C

Impact Measurement Framework

Appendix C
Impact Measurement Framework

Leading Change, Adding Value is a framework for all nursing, midwifery and care staff, wherever we work and whatever role we might have.

It builds upon Compassion in Practice and is directly aligned with the Five Year Forward View (FYFV) and its vision to integrate health and social care services, improve the adoption of preventative measures and narrow three crucial gaps in:

- **Health and wellbeing:**
  A greater focus on prevention is needed to enable health improvements to continue and to counter pressure on services
- **Care and quality:**
  Health needs will go unmet unless we reshape care, harness technology and address variations in quality and safety
- **Funding and efficiency:**
  Without efficiencies, a shortage of resources will hinder care services and progress

This framework encourages us to go one stage further in demonstrating our value. We have already demonstrated our value in the work we have successfully undertaken in embedding the 6Cs as central to everything we achieve and the excellent work that was achieved within the individual action areas of Compassion in Practice.

We now need to apply the same importance to how we quantify and measure the outcomes of our work, as we have done to making those values and behaviours the cornerstone of all that we do.

The combined measures of the Triple Aim allow us to place better outcomes, experience, and use of resources as central to the design, delivery and measurement of everything that we do and by doing so allows us to demonstrate the use of resources wisely and efficiently.

This Impact Measurement Framework proposes how we can demonstrate success.

Commitment 1

We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff.

Impact Statement:

Nursing, midwifery and care staff have the responsibility to improve the quality of life and wellbeing for people and populations and do so in a variety of ways - with individuals, carers, families and communities. Public confidence is at the heart of all we do and by building partnerships and relationships we have the opportunity to support individuals to make a real difference to their health and social wellbeing.

Commitment 1

Frontline Staff

1. Act as role models to encourage those we work with to adopt a healthy lifestyle;
2. Enable people to manage their health by sharing information about healthy choices;
3. Support people to make informed decisions, providing information that enables understanding of the impact of choices and aims to improve quality of life, resilience, independence and add years to life;
4. Be open and willing to change in response to evidence/research about best practice.

Organisational Leaders

1. Provide staff and community champions with evidence and guidance to assist them to deliver health promoting programmes and guided activities;
2. Develop and commission services which provide evidence of effective and efficient outcomes;
3. Ensure that up to date management information is collected, collated and used to influence the use of resources;
4. Provide management information that informs decisions about the use of resources. Informed decisions are made based on best available evidence and research of what works.

Educators and Trainers

1. Develop and deliver programmes with a public health focused curricula;
2. Create a culture of co-production in the design and delivery of programmes;
3. Ensure that learners are offered a range of experiences that expose them to health promoting and community development initiatives to inspire engagement;
4. Enable engagement in research and development activity that responds constructively to population health and social care challenges and service improvement programmes.

System Influencers and Commissioners

1. Ensure that local knowledge informs health promoting programmes that are robustly evaluated;
2. Ensure compliance with sustainability and transformation plans that seek to improve population health and reduce unwarranted variation;
3. Influence policy on lifestyle choices based on evidence that informs design and implementation of campaigns and creates a culture that promotes health and wellbeing;
4. Ensure that impact measures are integrated into health and social care programmes; maximising compliance and demonstrating improvement.

National and Local Quality Metrics and Measures

All OurHealth programme; Public Health Outcome Framework domains; Right Care metrics; NHS Outcomes Framework - key inequalities metrics; Slope index of inequality in life expectancy at birth; Reducing inequalities in life and healthy life expectancy. NHS Mandate.

Commitment 2

We will increase the visibility of nursing and midwifery leadership and input in prevention.

Impact Statement:

Nursing and midwifery leaders have the opportunity to make a measurable and sustained contribution that reduces health inequalities through an evidence-based approach to preventing ill health and improving the social conditions that contribute to its manifestation.

Commitment 2

Frontline Staff

1. With individuals and communities promote culturally appropriate systems of prevention and health development designed to instil sustainable change;
2. Close the gap between lifestyle and healthy living, enabling people to take responsibility for lifestyle choices and behaviours;
3. Make every contact count equipping people with the knowledge and confidence to make the informed choices that empower and sustain change;
4. Design and implement innovative health protection and prevention programmes, aimed at reducing the harm that inappropriate actions may have on health and wellbeing.

Organisational Leaders

1. Working with communities engender actions to tackle inequalities and increase the motivation and capability to promote health improving behaviours;
2. Ensure health prevention programmes evidence impact, creating partnerships that enable self-directed sustainable change;
3. Implement and monitor achievement of health gain and evidence improvement in the health of the local population;
4. Demonstrate the value of local programmes through systematic review against population data and trend analyses;
5. With the local authority and health and wellbeing boards develop and implement health impact plans that build capability and reduce inequalities.

Educators and Trainers

1. Enable purposeful enquiry that identifies prevention and health protection systems that make a difference allowing learners to interpret and implement best practice;
2. Enable the acquisition of skills, knowledge and competencies that enable a responsiveness to population need;
3. Evidence learning objectives focussed on health protection and prevention and include strategies to reduce social inequality;
4. Educate to protect the public health by improving surveillance skills and prevent and control infection.

System Influencers and Commissioners

1. Demonstrate the leadership required to implement and monitor the impact of research/ evidence based interventions;
2. Work with health and wellbeing boards to identify priorities and commission for health promotion and ill-health prevention;
3. Develop the information infrastructure and governance to support the implementation of prevention measures, informed by local priorities, capacity and capability;
4. Develop healthy community programmes bringing leaders together and build the trust required to develop sustainable healthy living environments; supporting investment in those systems that prevent ill health and respond to the diverse needs within communities.

National and Local Quality Metrics and Measures

All Our Health programme; Public Health Outcome Framework domains; Right Care metrics; NHS Outcomes Framework - key inequalities metrics; Slope index of inequality in life expectancy at birth; Reducing inequalities in life and healthy life expectancy; Shared delivery plan targets; HMSR and Mortality Ratios; Board quality scorecards; Goal attainment scores; Triple Aim metrics.

Commitment 3

We will work with individuals, families and communities to equip them to make informed choices and manage their own health.

Impact Statement:

Nursing, midwifery and care staff work with individuals, families and communities to help them maximise their involvement and engagement to acquire behaviours that improve health and social wellbeing while adding years to lives. We can communicate and engage in a range of ways providing accessible information which enables self-management, supports decision making and respects generational and cultural difference.

Commitment 3

Frontline Staff

1. Encourage, engage and motivate individuals to self-manage and understand the benefits of healthy choices;
2. Co-design personalised care plans designed to support measurable goal-oriented action;
3. Work within communities to identify priorities and harness the potential of voluntary and self-help groups to direct action and improve health and wellbeing;
4. Share the skills and knowledge that improve self-management, self-esteem, social contact and build networks and personal resilience.

Organisational Leaders

1. Develop a stakeholder engagement strategy that supports co-design and engenders action to tackle inequalities;
2. Utilise information and intelligence to promote health, reduce inequalities and add value to health and social wellbeing;
3. Encourage collaboration within communities to release social capital and assist in maintaining health and wellbeing;
4. Oversee and measure the impact of community engagement avoiding duplication of effort between statutory and informal care provision, identifying gaps in service and ways to improve experience and use of resources.

Educators and Trainers

1. Promote a culture within which improving the health of people and communities is a core component of learning;
2. Create online and social media networks to share information and support self-management and community partnerships;
3. Encourage creativity and focus research in areas that relate to healthy community partnerships, social capital and health promotion;
4. Provide professional learning to facilitate understanding of the wider determinants of health and the principles required for self-management.

System Influencers and Commissioners

1. Build community alliances that encourage co-design and delivery of services aimed at reducing unwarranted variation;
2. Establish alliances within communities that enable identification of investment priorities, avoiding duplication and fragmentation;
3. Commission innovative community action that seeks to generate principles and models of good practice to stimulate local action;
4. Align evidence of improvement through commissioning and procurement strategies that demonstrate the impact of health promoting investment.

National and Local Quality Metrics and Measures

All Our Health programme; Public Health Outcomes Framework; Right Care metrics; NHS Outcomes Framework - key inequalities metrics; Reducing inequalities in life and healthy life expectancy. NHS Mandate; Five Year Forward View; Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMs).

Commitment 4

We will be centred on individuals experiencing care.

Impact Statement:

Nursing, midwifery and care staff provide personalised, co-ordinated care to ensure effective support and transition between services. Individuals can be empowered to exert influence to self-manage, make choices and direct all aspects of their physical, psychological and social care in order to maximise value for themselves and for their local communities.

Commitment 4

Frontline Staff

1. Enable individuals, carers and families to influence all aspects of co-ordinated care and planning, ensuring culture, difference and vulnerability are respected;
2. Create time to listen and respond to the actual needs of individuals to truly inform shared decision making and action;
3. Develop curiosity to identify and address unwarranted variation;
4. Adapt care provision and delivery to meet the needs of individuals in whatever 'place' care is provided.

Organisational Leaders

1. Ensure that individuals and populations are engaged in all aspects of service design, delivery and evaluation;
2. Promote an environment within which co-ordinated multi-professional leadership and service delivery is encouraged;
3. Support staff to 'speak up' while creating a culture within which staff are encouraged to speak out in exercise of their duty of candour and ensure that lessons are learned and shared;
4. Ensure that unwarranted variations in care are identified and addressed by using evidence to inform quality improvement, user and staff experience and the effective use of resources.

Educators and Trainers

1. Provide a focus on health literacy and the education of individuals, carers, and their families to support self-management;
2. Engage and empower local communities and populations to address unwarranted variation;
3. Educate to encourage positive engagement to improve health and social care outcomes and to reduce social inequalities;
4. Embed a partnership to co-design education and training programmes enhancing understanding of self-management and shared care.

System Influencers and Commissioners

1. Ensure that personalisation forms the central focus of future service design and transformation;
2. Exert influence to create the national, regional and local culture required to promote self-management, self-care and service improvement;
3. Provide and disseminate evidence of innovative and transformational leadership to facilitate person-centred care;
4. Possess vision and foresight to lead, drive and support the personalisation agenda.

National and Local Quality Metrics and Measures

Person centred care - care measures (patient feedback measure); Patient satisfaction surveys; PROMS and PREMS; Care Quality Commission (CQC) ratings; Dementia well being metrics; Complaints and compliments, Friends and Family Test.

Commitment 5

We will work in partnership with individuals, their families, carers and others important to them.

Impact Statement:

The support that matters most to people is within their family, friends, carers and communities. Nursing, midwifery and care staff form part of that network, sharing the skills and knowledge that support the best care possible. This requires us to integrate care and support plans empowering individuals to exert choice and control over their lives and achieve their full partnership potential in care design and delivery.

Commitment 5

Frontline Staff

1. Co-design plans that enable care to be self-directed, providing support at the right time, in the right place and in accordance with agreed outcomes;
2. Build the trusting relationships that prevent social isolation, enable support and engender the confidence to make informed decisions;
3. Co-ordinate care ensuring those involved are engaged and informed avoiding any negative impact on health and social wellbeing;
4. Coach individuals and families to meet care in ways that work for them and utilise support to maximum effect.

Organisational Leaders

1. Enable co-ordination of care including implementation of inter-professional care plans, shared electronic records and care navigation systems;
2. Communicate effectively with local advocacy and user groups to build sustainable partnerships to support collaborative care for individuals and carers;
3. Facilitate effective and responsive support to enable individuals and carers to self-manage and achieve optimal health;
4. Organise and co-ordinate care to ensure continuity and avoid unwarranted variation.

Educators and Trainers

1. Provide inter-professional training to build the knowledge, trust and behaviours required for effective care co-ordination;
2. Support staff to gain the knowledge and confidence that will reduce reliance on hospital-based care and support adjustment to new working practices;
3. Ensure involvement of individuals and carers in the design and delivery of programmes;
4. Facilitate opportunities for staff to consider how new models of user engagement can be implemented.

System Influencers and Commissioners

1. Provide leadership to develop whole system solutions that respond effectively to care needs;
2. Work closely with service user groups to identify system resource gaps and seek solutions that empower individuals;
3. Champion early adopters to evidence the benefits that innovative care solutions can have for individuals, carers and communities;
4. Develop innovative alliances to identify responsive supported living solutions for people who might otherwise be dependent on care.

National and Local Quality Metrics and Measures

All Our Health programme; Public Health Outcome Framework domains; Right Care metrics; NHS Outcomes Framework - key inequalities metrics; Reducing inequalities in life and healthy life expectancy; Reduced admission and reduced transfer of care metrics; Evidence of completed inter-professional care plans; Patient satisfaction surveys; PROMS and PREMS; CQC ratings; Dementia well being metrics; Five Year Forward View.

Commitment 6

We will actively respond to what matters most to our staff and colleagues.

Impact Statement:

Nursing, midwifery and care staff possess the skills, knowledge, values and aspiration to deliver world class health and social care services that respond to the needs of individuals and communities across a range of settings. There is a responsibility to provide compassionate leadership, ensuring that staff can understand what is expected of them and that they are supported and educated to fulfil their roles.

Commitment 6

Frontline Staff

1. Share learning to ensure that services are delivered efficiently and effectively;
2. Listen to our colleagues to make the best use of skills and resources to ensure we deliver the best outcomes;
3. Listen to colleagues to identify and create opportunities to implement new ways of working that improve the way in which individuals experience and receive the care we give;
4. Seek feedback in order to improve the quality of our services.

Organisational Leaders

1. Raise awareness of how the data collected is analysed and used to inform decisions at organisational and board level;
2. Work collaboratively, with other professionals and organisations, to reduce fragmentation and duplication to optimise best outcomes and use of resources;
3. Listen to the workforce to address and improve retention, working lives and wellbeing with the aim of building workforce skills, capacity and capability;
4. Provide opportunities for the workforce to maintain innovation in the ways in which they work through coaching, personal development, compassionate leadership, appraisal and supervision.

Educators and Trainers

1. Facilitate programmes that develop the skills, capability and resilience in multi professional and sectoral teams;
2. Provide flexible and innovative learning that maximises skills and builds the confidence and capability to embrace new ways of working;
3. Support the delivery of sustainability and transformation plans, including workforce planning;
4. Promote a learning culture that facilitates change, builds resilience and confidence enabling a purposeful contribution to service transformation.

System Influencers and Commissioners

1. Support the delivery of sustainability and transformation within local settings and across services;
2. Provide collaborative system leadership to ensure there is a shared vision across providers, commissioners and regulators;
3. Put in place effective and responsive systems of work and resources to enable organisations to deliver safe and sustainable workforce plans;
4. Promote the conditions required for organisations to construct and deliver safe and effective workplaces that promote personal motivation, fair and just employment practice and wellbeing.

National and Local Quality Metrics and Measures

Friends and Family Test; Staff survey; recruitment, retention, sickness, absence, appraisal, vacancy, training rates; duty of candour.

Commitment 7

We will lead and drive research to evidence the impact of what we do.

Impact Statement:

Nursing, midwifery and care staff are well placed to make every contact count and improve the care we give. It is essential to use research, evidence and evaluation to measure the impact of our interventions. We have a responsibility to individuals, the communities we work with and to our professions to actively to assess the effectiveness of our work. We can identify and address unwarranted variation, demonstrate effective use of resources and invest in those areas where our time, commitment and services are most needed to achieve sustainable improvement.

Commitment 7

Frontline Staff

1. Effectively manage resources to reduce duplication and waste and maximising the value of every intervention;
2. Develop understanding of the local care system within which care is given to direct support to meet the needs of individuals;
3. Act as an 'agent of change' to shape care and demonstrate value for individuals and communities;
4. Listen to individuals to determine what is important to them and use evidence and information to direct care in ways that results in measureable impact.

Organisational Leaders

1. Promote a culture that places the concept of 'adding value' and impact measurement at the heart of all we do;
2. Use intelligence (such as user feedback, audit and benchmarked data) to identify where time, skills and resources can be targeted to maximise the impact of investment and innovation;
3. Identify outcome measures for those things that really matter locally. Deliver value-based care that aligns to agreed expectations, resource allocation and service improvement;
4. Provide staff with constructive feedback on their performance and access to information to enable them to add value and make an active contribution in their local communities.

Educators and Trainers

1. Encourage the use of tools to maximise the efficient and effective use of resources and the measurement of impact for individuals and across care pathways;
2. Support the development of effective leadership enabling quality improvement;
3. Enable peer support, coaching and action learning to build resilience, innovation, capability and capacity to improve the ways in which care and resources are deployed;
4. Provide the learning space required to enable critical inquiry, research and development to flourish.

System Influencers and Commissioners

1. Develop a shared narrative on how systems of health and social care can add value to inform care and identify evidence-based metrics against which improvement can be measured;
2. Support organisations to deliver new models of care, recognising where unwarranted variation can be addressed to enable resources to be directed towards optimal care;
3. Develop and implement strategies that define outcomes and quality indicators to encourage a focus on continual improvement;
4. Focus on outcomes and the identification of gaps in service provision, particularly those that lead to unwarranted variation.

National and Local Quality Metrics and Measures

NHS Right Care (optimal care pathway) metrics; NICE; Five Year Forward View; Triple Aim measures; Consumer Assessment of Healthcare Providers (CAPHS); Care Management Service (CMS); National Committee for Quality Assurance (NCQA) measures.

Commitment 8

We will have the right education, training and development to enhance our skills, knowledge and understanding.

Impact Statement:

The delivery of effective and sustainable health and social care is linked to a culture of lifelong learning that equips, enables and nurtures talent and innovation. Nursing, midwifery and care staff require time to learn, reflect and update their practice in response to individual and service need, enabling a culture in which learning, reflection and improvement promotes engagement and safe and effective care delivery.

Commitment 8

Frontline Staff

1. Recognise the value of reflection and learning from experience in support of lifelong learning and facilitates revalidation;
2. Seek constructive feedback and share learning opportunities with colleagues;
3. Participate in team and action learning to share experiences and acquire the skills, knowledge and confidence to challenge inappropriate practice;
4. Acquiring the right skills, knowledge and behaviours to measure our impact.

Organisational Leaders

1. Enable staff to identify and maximise a variety of learning opportunities;
2. Promote a culture of continuous improvement and leadership within which all are encouraged to contribute to and evidence improved experience, effectiveness and productivity;
3. Build an improvement culture, informed by the evidence base and benchmarked best practice aimed at promoting best practice and innovation;
4. Making learning a priority and part of a transparent and open career development framework to encourage all staff to commit to the organisation's values, to maximise retention, and encourage life-long learning and professional revalidation.

Educators and Trainers

1. Deliver responsive education and leadership programmes, provided as close to the workplace as possible and based on credible experience;
2. Enable staff to embed learning in their workplace; encouraging individuals, carers and professionals to share learning;
3. Enable placement experiences for learners that build the requisite knowledge, skills and behaviours and that encourage learning across professions and sectors;
4. Promote a culture of professional enquiry.

System Influencers and Commissioners

1. Support a 'whole system' learning plan to inform educational commissioning and workforce projections;
2. Design transformational education programmes to ensure that the workforce is supported to develop the skills, competencies and behaviours required to meet service demand;
3. Develop new roles and ways of working and inform future commissioning intentions and contract specifications;
4. Provide an environment within which career development and aspiration is encouraged, talent is identified and nurtured and opportunities for learning are evidenced.

National and Local Quality Metrics and Measures

Statutory and mandatory training figures; Recruitment and retention; Cavendish certificate attainment; Placement capacity; Revalidation; Recruitment and retention, sickness/ absence, appraisal, vacancy, training rates.

Commitment 9

We will have the right staff in the right places and at the right time.

Impact Statement:

There is strong evidence that good workforce practices can deliver improved productivity and outcomes. Nursing, midwifery and care staff respond to immediate demand and forward plan to meet complex staffing requirements, simultaneously managing resources in a cost-effective and productive way. Workforce methodology, implemented successfully, can provide evidence of achievement of the 'Triple Aims' of better outcomes, patient and staff experience and use of resources.

Commitment 9

Frontline Staff

1. Engage in development and training to ensure skills and practices are current and flexible and meet the changing needs of service delivery;
2. Facilitate new ways of working safely and innovatively to give the right care to individuals and groups;
3. Consider flexible patterns of work to deliver optimal care outcomes;
4. Contribute to making each workplace a beacon of excellence within which people wish to work, develop their skills and abilities.

Organisational Leaders

1. Provide oversight and scrutiny to ensure safe and effective staffing and that optimal standards are delivered consistently;
2. Facilitate workforce planning and allocation systems that enable deployment of the workforce to enable continuity of care, reducing the inconsistency and fragmentation that leads to unwarranted variation;
3. Engender a culture of 'wellbeing' that enables staff to reach their potential and achieve the objective of value driven care;
4. Identify the productivity and efficiency opportunities that exist such as reducing reliance on temporary staffing to achieve consistency and quality in care delivery.

Educators and Trainers

1. Support the delivery of care that is safe and sustainable such as using e-learning and work-based learning to support planning and deployment;
2. Design and deliver programmes that develop resilience, emotional intelligence and build the human factors required to accommodate change with confidence;
3. Support organisations to enable staff to evidence the skills, values and behaviours to work flexibly;
4. Facilitate flexible access to programmes maximising recruitment, facilitating career progression and mobility.

System Influencers and Commissioners

1. Demonstrate the system leadership required to create a culture that attracts and retains the best staff to deliver safe and productive care;
2. Lead the design of innovative and new ways of working that challenges any outdated practice;
3. Support whole system workforce planning, modelling tools and systems that seek to reduce fragmentation and duplication;
4. Consider workforce recruitment trends to take account of different generational needs and changing requirements to ensure an adequate and 'fit for purpose' supply of new talent to sustain and deliver care services.

National and Local Quality Metrics and Measures

Carter Review indicators; Staff survey; Staff recruitment, retention, sickness, absence, appraisal, vacancy, training rates; whistleblowing, Speaking Up outcomes; safer staffing metrics.

Commitment 10

We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

Impact Statement:

Technology impacts on every aspect of our lives and we must strive to recognise the potential that advances in technology can make on how we provide effective and consistently high standards of care.

Commitment 10

Frontline Staff

1. Embrace technology and informatics to improve care, self-management, health and social care outcomes;
2. Develop understanding of the benefits of technology and informatics for practice increasing time to care;
3. Use technology to support effective coordination between care givers and teams;
4. Connect through digital messaging and social media to disseminate information, particularly for difficult to reach groups.

Organisational Leaders

1. Share best practice to engender understanding of how technology and informatics can assist in reducing unwarranted variation, inform quality improvement and enhance practice;
2. Promote the use of technology and information systems that seek to coordinate and share information;
3. Ensure that performance and outcome data is utilised to improve local understanding of unwarranted variation and informs mitigation;
4. Promote a culture within which smart working practice reduces the dependence on administrative time that takes time away from care delivery.

Educators and Trainers

1. Provide learning that enables staff to maximise the benefits of innovations in technology and informatics;
2. Construct training and education to build the knowledge and confidence to utilise technology;
3. Raise awareness of the benefits that telehealth, telecare and information management can bring to improve effectiveness;
4. Consider developing new roles in the leadership of informatics such as a career pathway for nurse informaticians leading to chief nurse information officer roles.

System Influencers and Commissioners

1. Improve inter-professional learning and working practices with the development of a culture within which data and evidence is shared;
2. Encourage the widespread adoption of digital solutions to reduce the impact of social inequality and illness;
3. Consider the picture of local and national IT capability to develop strategies to encourage a culture that shapes systems to improve value and productivity;
4. Seek to reduce inefficiencies and enhance the wellbeing of service users and staff by the effective use of technology.

National and Local Quality Metrics and Measures

Five Year Forward View; National Information Board (NIB) data; Health and Social Care Information Centre (HSCIC) metrics; National Institute for Health Research (NIHR) 'Big Data' metrics.