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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.

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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

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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.			

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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.			

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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

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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.			

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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.			

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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

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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.			

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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.			

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Case study 4

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

Organisations:
The Royal Marsden NHS Foundation Trust

Contact:
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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.			

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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.			

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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

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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.			

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

<table>
<tr><th colspan="2">Case study</th><th colspan="3">Using Leading Change, Adding Value</th></tr>
<tr><td>What metrics were used to measure/ demonstrate success?</td><td>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.</td><td rowspan="2">Adding Value</td><td rowspan="2">Better outcomes, Better experiences, Better use of resources</td><td rowspan="2">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.</td></tr>
<tr><td>What were the successful outcomes?</td><td>• 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.</td></tr>
</table>

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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

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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.			

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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.			

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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:

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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.			

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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.			

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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

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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.			

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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%.			

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Case study 9
Teaching care homes

Organisations:
National care homes

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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.			

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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.			

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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:
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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.			

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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.			

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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

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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			

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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.			

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Case study 12

Releasing nursing time while providing safer care

Organisations:
Imperial College Healthcare NHS Trust

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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.			

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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.			

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Case study 13

Telemedicine in care homes

Organisations:
Airedale NHS Foundation Trust

Contact:
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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.			

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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.			

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Case study 14

Using social media for reaching women and families in healthcare services

Organisations:
Western Sussex Hospitals NHS Foundation Trust

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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.			

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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.			