Leading Change, Adding Value:
A framework for nursing, midwifery and care staff

A learning tool to support all nursing, midwifery and care staff to identify and address unwarranted variation in practice

March 2018

Foreword

Dear Colleagues,

We are delighted to formally present the first Leading Change, Adding Value (LCAV) learning tool.

LCAV is the national framework for nursing, midwifery and care staff within England. It builds on the success of Compassion in Practice with the 6Cs remaining as the core values. Following extensive consultation and feedback from the professions, LCAV was developed to support nursing, midwifery and care staff to apply equal importance to 'quantifying' and 'measuring' the outcomes of our work as we do to demonstrating the quality and compassion that we are recognised for.

We have therefore developed this learning tool to support all nursing, midwifery and care staff to identify and address unwarranted variation in practice, no matter what your role is, or where you work.

Many colleagues are doing this already as part of everyday practice, however, much of this essential work can often remain hidden or misunderstood, as some of it is not easily measured or captured, or shared. LCAV specifically looks at reducing 'unwarranted variation', where standards of care are not equal and how we can make sure that by seeing where inequalities exist and changing them, that everyone can receive the same highest standards of better outcomes, better experiences and better use of resources.

We recognise that for many, this may be a new way of working and that some of the language and principles may be unfamiliar. Therefore on behalf of Health Education England, NHS England and all LCAV partners, we have worked with E-learning for Healthcare to develop this tool to help explain and de-mystify the approach to identifying and addressing unwarranted variation in practice.

We appreciate your interest and participation in this work and ask that you encourage colleagues to also find out more about Leading Change, Adding Value. By doing so and putting LCAV in to action we can demonstrate our key contribution to the transformational work that is happening across the country, and showcase and share the positive outcomes of the work and the leadership of nursing, midwifery and care staff within both health and care sectors.

Best wishes,

Susan Aitkenhead
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Deputy Chief Nurse
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Contents

An online version of the e-learning tool can be accessed at
https://www.e-lfh.org.uk/programmes/leading-change-adding-value/

Session Overview

Description

This document will explore the Leading Change, Adding Value (LCAV) framework and support all nursing, midwifery and care staff to identify and address unwarranted variation in practice – recognising unequal standards of care and changing them.

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Duration: 40 minutes

Session Introduction

Learning Objectives

By the end of this session you will be able to:

- Identify the main elements of the LCAV framework
- Describe how nursing, midwifery and care staff can use the LCAV framework to identify and address unwarranted variation and strengthen the quality and outcomes of care
- Identify and address any examples of unwarranted variation in your workplace

Introduction

First launched in 2016, 'Leading Change, Adding Value' (LCAV) is a national framework for nursing, midwifery and care staff [1].

LCAV is aligned with the NHS Five Year Forward View [2] and positions nursing, midwifery and care staff as leaders in designing the future and using their influence to manage the challenges of today. LCAV gives England's nursing, midwifery and care staff a new opportunity to demonstrate the beneficial outcomes and impact of our work.

Nursing, midwifery and care staff (whatever their role, wherever they work) are invited to take a lead in narrowing the gaps facing those that work in health and care (see later).

The LCAV framework was launched in 2016 by Professor Jane Cummings, the Chief Nursing Officer for England.

Principles

It is important to ensure that we are not complacent and assume that our work and the resulting outcomes are always understood and recognised.

Why the LCAV framework matters

We need to clearly identify our positive contribution and demonstrate how we add unique 'value' to the new system going forward to 2020 and beyond.

The LCAV framework positions nursing, midwifery and care staff as leaders in designing the future (reproduced with permission from Science Photo Library)

The LCAV framework invites nursing, midwifery and care staff to use their influence to manage challenges (reproduced with permission from Science Photo Library)

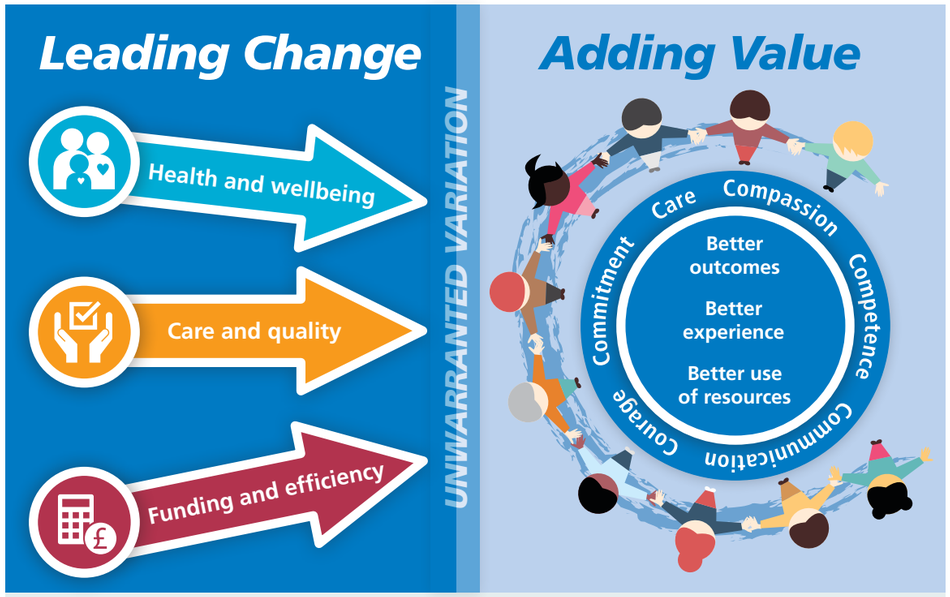
The LCAV framework encourages nursing, midwifery and care staff to demonstrate the beneficial impact of their work (reproduced with permission from Science Photo Library)

Elements

Before we proceed, let's explore the elements of the LCAV framework.

- The three gaps
- Unwarranted variation
- The triple aim
- The 'six Cs'
- The ten commitments

We will now explore each of these five elements in more detail.

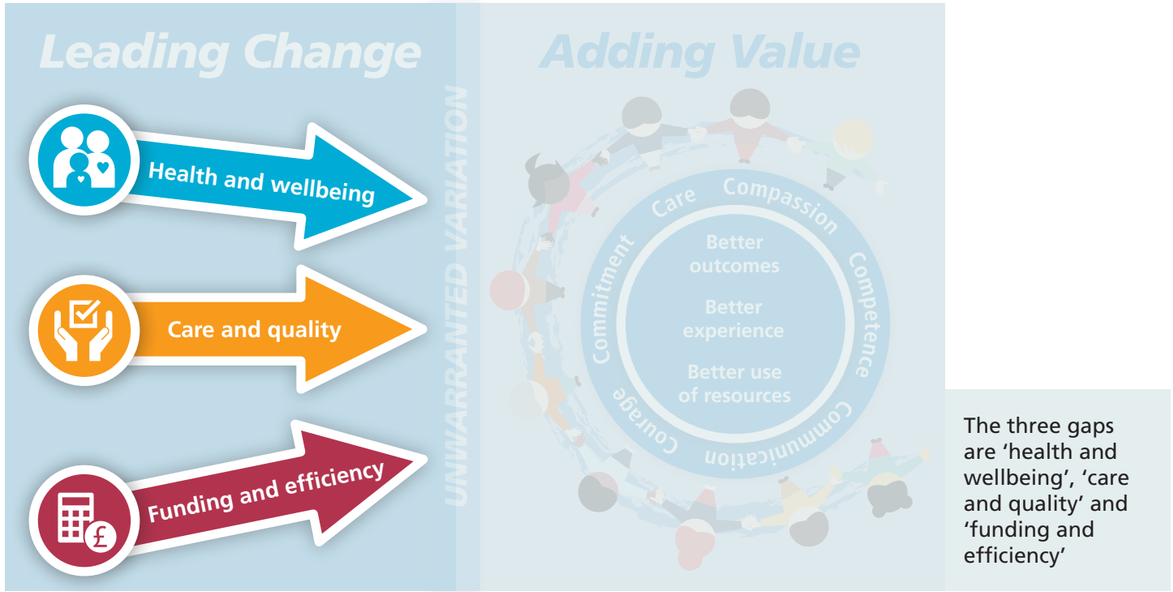


The final element of the LCAV framework is the 'ten commitments'

The Three Gaps

The FYFV report identifies three ‘gaps’ which impact on the health and care sector [2]:

- Health and wellbeing
- Care and quality
- Funding and efficiency



The three gaps are ‘health and wellbeing’, ‘care and quality’ and ‘funding and efficiency’

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.

***Question:* How can you help to close the health and wellbeing gap?**

Practise in ways which prevent avoidable illness, protect and promote health, wellbeing and resilience.

***Question:* Can you think of ways to narrow the health and wellbeing gap in your work and/or workplace?**

Care and quality

Health needs will go unmet unless we reshape care, harness technology and address variations in quality and safety.

***Question:* How can you help to close the care and quality gap?**

Practise in ways which provide safe, evidence-based care which maximises choice for individuals and population health.

***Question:* Can you think of ways to narrow the care and quality gap in your work and/or workplace?**

Funding and efficiency

Without efficiencies, a shortage of resources will hinder care services and progress.

***Question:* How can you help to close the funding and efficiency gap?**

Practise in ways which manage resources well including time, equipment and referrals.

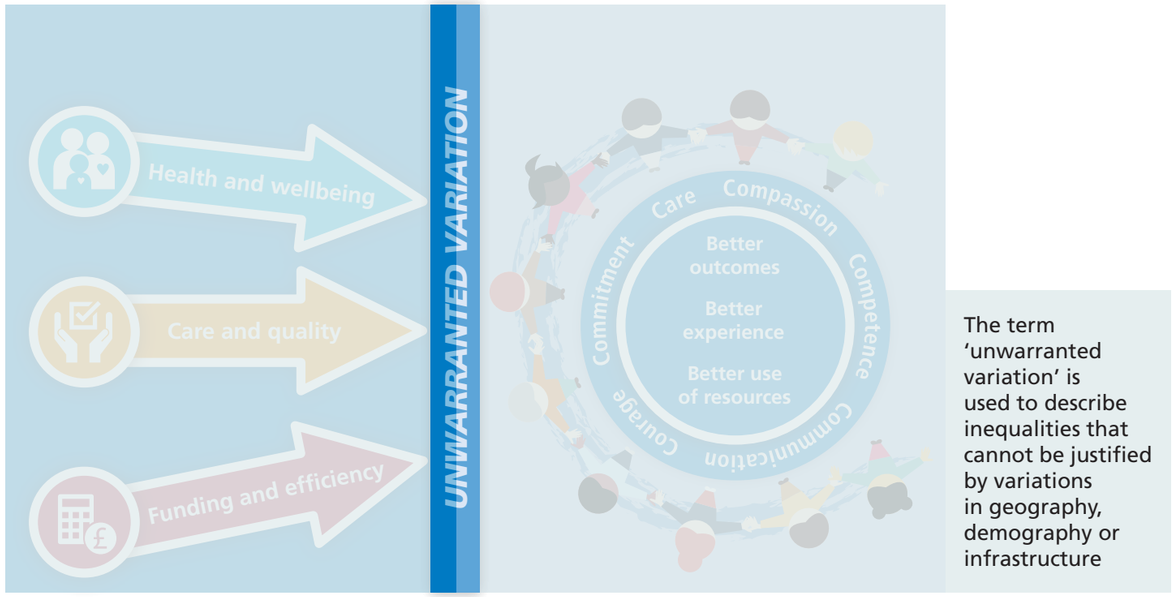
***Question:* Can you think of ways to narrow the funding and efficiency gap in your work and/or workplace?**

Unwarranted Variation

Overview

The term ‘unwarranted variation’ is used to describe situations where there are inequalities in health and care, patient and staff experiences and use of resources that cannot be justified by reasons of geography, demography or infrastructure.

By identifying and addressing such inequalities, everyone can receive the same high standards of care.



The term ‘unwarranted variation’ is used to describe inequalities that cannot be justified by variations in geography, demography or infrastructure

About unwarranted variation

Unwarranted variation can occur in many ways, e.g. between geographical areas, specialties or population groups.

Everyone would like to think they are offering the best value they can... but sometimes that just isn’t the case.

The framework specifically looks at reducing ‘unwarranted variation’, where standards of care are not equal and how we can make sure that by seeing where inequalities exist and changing them, that everyone can receive the same highest standards of better outcomes, better experiences and better use of resources.

Recognising unwarranted variation

Two areas within the same city and with similar demographics had differing rates of diagnosed type 2 diabetes.

Further investigation was required and nursing and care staff were well positioned to compare their practice with areas known to be successfully addressing the challenge.

This revealed that the more successful areas had educated practice nurses in the early identification of type 2 diabetes.

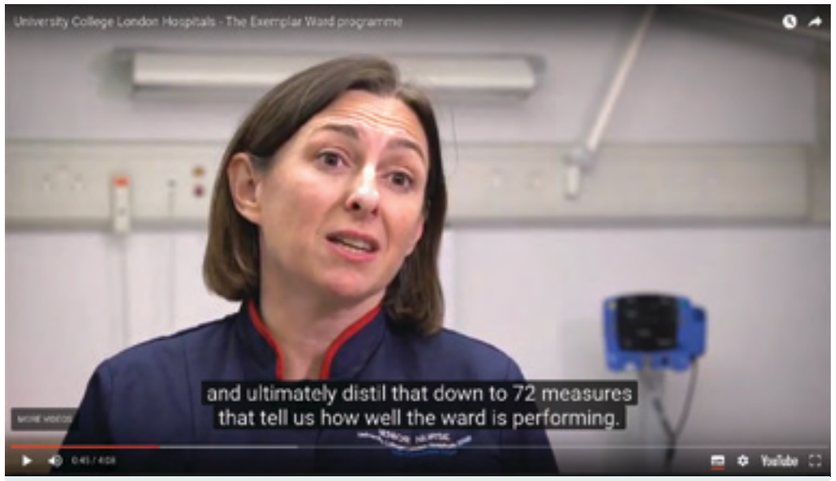
Those practice nurses then supported their patients with advice on nutrition, hydration and self-management and also become more proficient at recognising the signs of the condition and increased their detection rates.

This model was rolled out within the second area and the positive results were duplicated, leading to improved outcomes for both populations and reduced ratings on diabetes measurements.

Unwarranted Variation *continued*

Video

Consider this video clip showing how nurses at University College London Hospitals NHS Foundation Trust responded to unwarranted variation.



Nurses at UCLH NHS Foundation Trust explain how they developed an exemplar ward programme in response to unwarranted variation

Reflection points

Take a few moments to reflect on the content of the video clip.

Make some notes on the following questions:

- What was the nature of the unwarranted variation in this case?
- How did the staff at UCLH address the unwarranted variation?
- What were the outcomes of their intervention?
- Can you think of any unwarranted variation in your workplace?

Case study

University College London Hospitals (UCLH) have developed an Exemplar Ward programme that is designed to support clinical teams to implement standard processes, reduce unwarranted variation and deliver local quality improvement initiatives in their wards and departments. Data packs and monthly trend reports allow staff to view at a glance how their ward is performing, identifying what is being done well and what needs to improve. UCLH are aiming to move from reactive use of information towards a more proactive and preventative approach to its use, ensuring that patients receive quality care at all times and that staff work in a culture that supports and motivates them to engage in continuous improvement.

Feedback

To address unwarranted variation, we need to know where to look, what to change and how to change it. That means understanding the 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 make the necessary change. Now we need to measure it too, to demonstrate the value that we bring.

Turning intention into actions

In summary, when faced with unwarranted variation we need to:

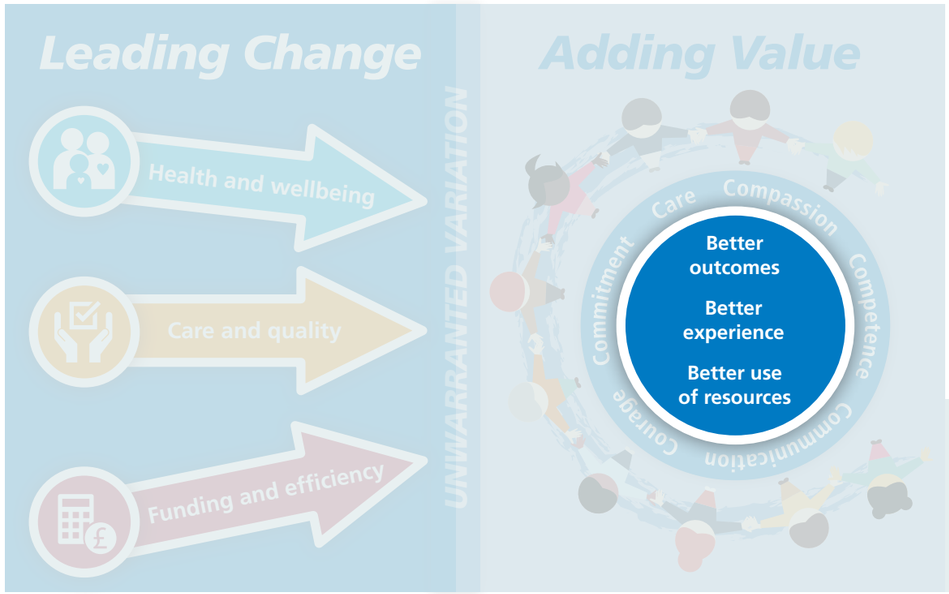
- Take a closer look at what we do
- Uncover activities that we need to change, add or take away
- Challenge established practice because we understand that service can be delivered in a better way
- Strive for high value care
- Use the ten commitments to provide focus (see later)

The Triple Aim

Overview

To meet the ‘triple aim’ of better outcomes, better experience and better use of resources, colleagues across the system need to be equipped with the knowledge and capability to deliver the framework within the context of their roles.

LCAV provides a framework to apply the principles of the triple aim to the work that nursing, midwifery and care staff do. It builds on the successful Compassion in Practice [3] with the 6Cs remaining as the inherent core values. However, LCAV was developed to enable nursing, midwifery and care staff to also apply an equal importance to ‘quantifying’ and ‘measuring’ the outcomes of their work as they do to demonstrating the quality and compassion that the professions are recognised for.



The triple aim is focused on ‘better outcomes’, ‘better experience’ and ‘better use of resources’

Better Outcomes

Let’s investigate how addressing unwarranted variation can result in ‘better outcomes’.

Hampshire Hospitals NHS Foundation Trust found unwarranted variation amongst older people admitted to an acute unit.

Staff noticed how some older people lost their independence and raised concerns about the effects (e.g. prolonged rehabilitation).

Nurses, physiotherapists, occupational therapists and doctors received health coaching training from the Health Foundation.

The staff work in partnership with patients and families to increase engagement in their care and recovery.

Improvements in activities of daily living of patients and self-efficacy have been observed alongside reductions in the length of stay and the need for care home placements.

The Triple Aim *continued*

Better Experience

Next, let's consider how addressing unwarranted variation can lead to 'better experience'.

Staff at James Paget University Hospitals (JPUH) NHS Foundation Trust identified unwarranted variation in the uptake of certain vaccinations.

Antenatal influenza and pertussis vaccinations were available from local GP services but uptake was poor (below 40%).

Maternity staff at JPUH led a pilot offering women the vaccinations at their 20-week anomaly scan appointment.

Uptake rates increased (to 76% for influenza and 80% for pertussis) and feedback confirmed that the pilot was more convenient.

This change in provision resulted in a better experience for patients at no additional cost to the trust.

Better Use of Resources

Now, let's explore how addressing unwarranted variation can encourage 'better use of resources'.

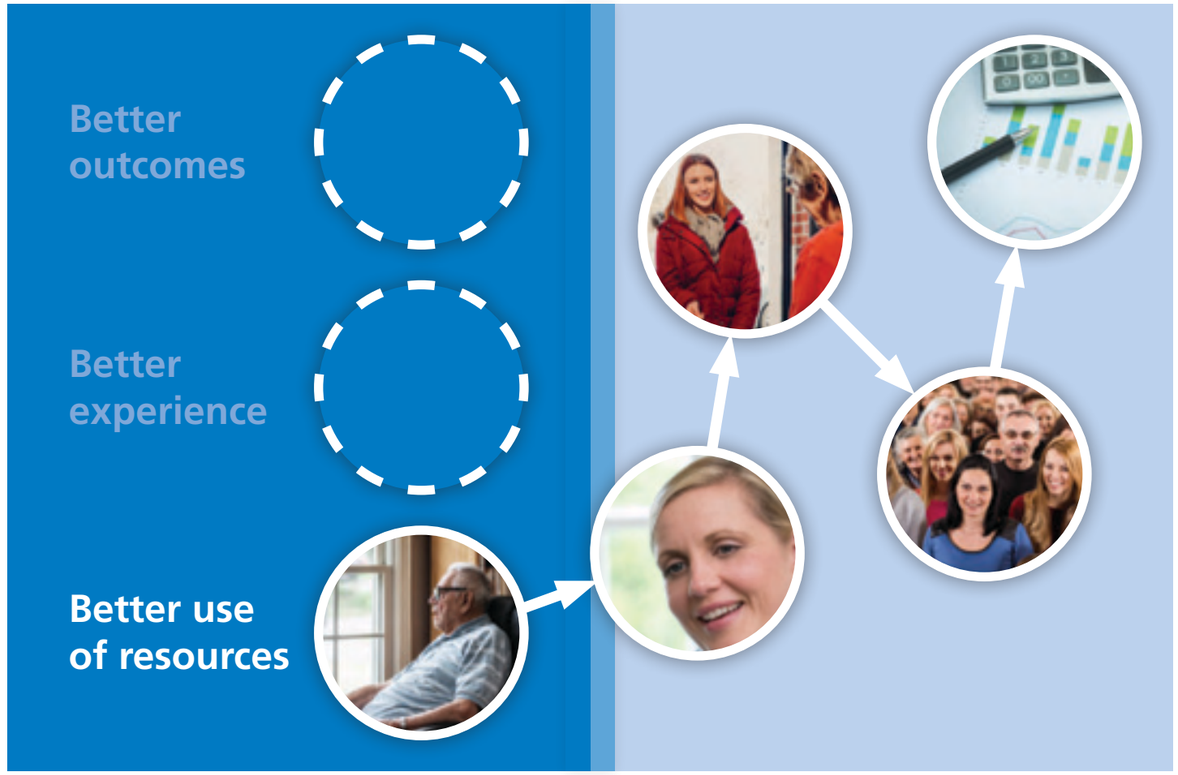
Cornwall Partnership NHS Foundation Trust found unwarranted variation in support for vulnerable people with long-term conditions.

Working with Age UK and Volunteer Cornwall, nurses co-designed and led a pioneering programme called 'Living Well'.

Volunteers visited vulnerable people, establishing new partnerships and engaging with individuals to understand their goals.

The 'Living Well' project now supports 2,500 vulnerable people in three different parts of Cornwall.

A recent assessment reported a 40% reduction in hospital admissions and care packages by 8%, improving wellbeing by 23% and raising staff morale by 87%.

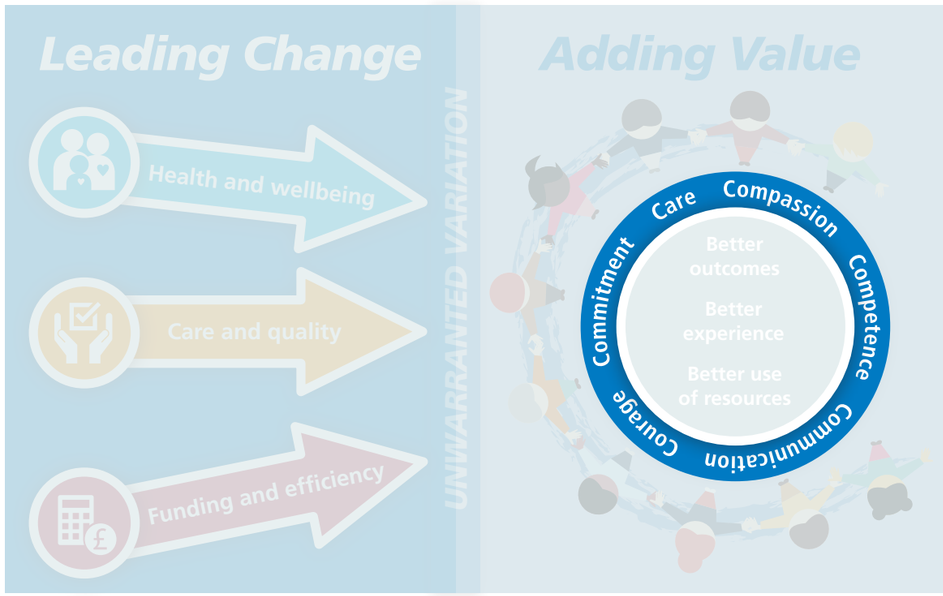


The Six Cs

The ‘six Cs’ were first introduced in ‘Compassion in Practice’ [3] and represent the value base for LCAV.

They are central to identifying and addressing unwarranted variation.

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

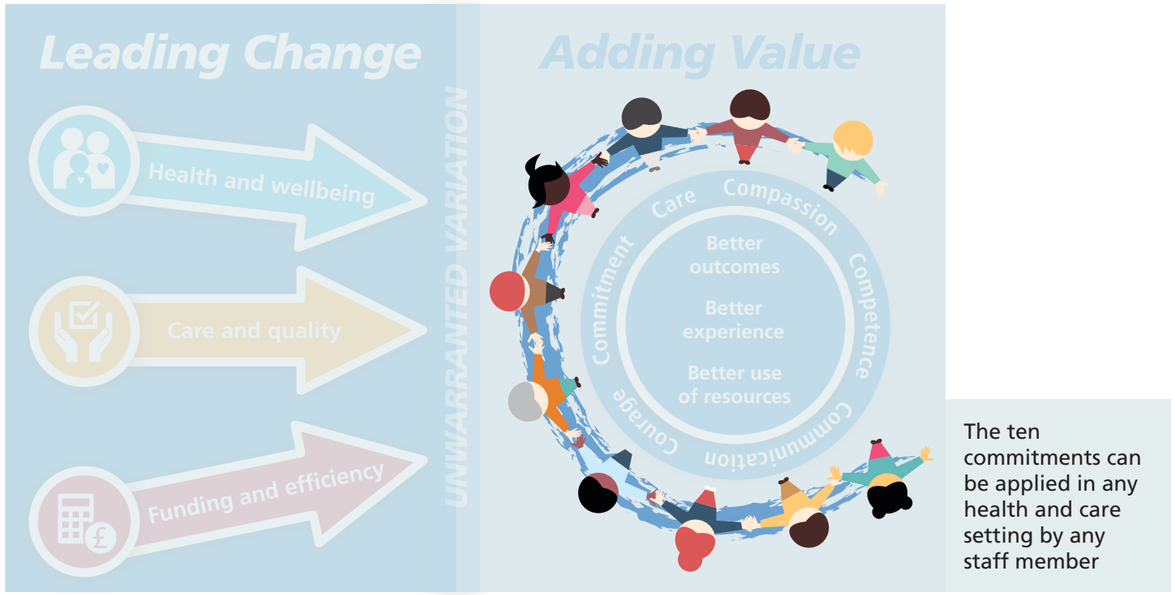


The ‘six Cs’ represent our value base and are central to identifying and addressing unwarranted variation

The Ten Commitments

The LCAV framework also includes ten aspirational commitments.

These commitments can be applied in any health and care setting by any member of staff. Collectively, they can help us to narrow the three gaps, address unwarranted variation and achieve the triple aim.



The ten commitments can be applied in any health and care setting by any staff member

1

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.”

The public health and prevention roles of nursing, midwifery 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.

We have opportunities through ‘public trust’ and ‘individual professional relationships’ to have significant impact on improving health and reducing health inequalities – practicing in ways which prevent disease, protect health and promote wellbeing and resilience.

Case study

An enhanced practice nursing programme in Harrow transformed their integrated care system to reduce the unwarranted variation in the provision of home-based support to patients with significant healthcare challenges.

A nurse-led implementation of a ‘virtual ward’ allowed practice nurses to provide home-based support, preventing the need for hospital admissions and for acute healthcare challenges by promoting a positive health culture (commitment 1).

The Ten Commitments *continued*

2

Commitment 2

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

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.

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.

Case study

'Respiratory Futures' is an example which demonstrates nursing leadership in respiratory care. They identified that across Leeds, there was unwarranted variation with regards to respiratory care and it was one of the worst places in the country for respiratory outcomes. This was identified through the NHS Atlas of Variation.

Practice nurses established the Leeds Respiratory Network to try and reduce variation in respiratory care through education of healthcare professionals. The network organise evening educational meetings as well as other respiratory events with national speakers attending. They disseminate information via different forms of social media and blog accounts and disseminate new guidance and resources to their colleagues. Their work is centred on clinical effectiveness and the nursing leadership in working with patients in primary care is having a preventative function and reducing the demand on hospitals and unplanned admissions. Through collaboration with nursing staff and patients, they are improving respiratory care.

3

Commitment 3

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

People are living longer, but are at risk of spending their extended years in poor health as a result of smoking, poor diet, alcohol consumption and other lifestyle choices.

We need to support people to engage in healthier lifestyles and encourage people to take more responsibility for their own health.

Understanding and building on strengths that exist in local communities is vital to build healthy places.

4

Commitment 4

"We will be centred on individuals experiencing high value care."

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 without them'.

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

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.

Case study

A General Practice Nurse in Durham led a piece of work with nursing colleagues after recognising profound difficulties for their patients to engage in weight management programmes. They also identified that their weight management consultations were not satisfactory according to their CQC preparatory work. In an area of the country where input is needed, weight loss was not being achieved. They developed evening groups (nurse led) for a structured, evidence based weight loss programme that made the groups more accessible to their population and they used these groups to objectively monitor weight, lifestyle and diet. Flexible sessions in remote areas proved influential, peer support was also popular. They found better outcomes, experiences and use of resources through targeting commitment 3 (amongst others). This work has the potential of being rolled out across other rural practices that may be faced with similar issues – especially given concerns over obesity.

Case study

An example to showcase commitment 4 is work at the Royal Marsden NHS Foundation Trust, where they worked to improve patient experience through a patient and nurse collaborative redesign of the prostate cancer follow-up pathway. Evidence suggested that numbers of patients being discharged from hospital care following curative treatment for localised prostate cancers were potentially low. 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. Nurse leaders 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. After making changes to the care pathway based on these discussions, the number of patients successfully discharged from the service rose from 0 to 73 in the first year. Patients were able to move into survivorship care as a result of earlier discharge with appropriate support. 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'.

The Ten Commitments *continued*

5

Commitment 5

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

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 support people to live at home by leading the development of integrated health and social care services.

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

Tommy Whitelaw from the Dementia Carer Voices campaign talks about the value of working in partnership

6

Commitment 6

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

We have a responsibility to protect our own health in order to practice safely and effectively.

Providing an appropriate culture, terms and conditions will mean we gain the most from our staff.

Embedding the key question 'What matters to you?' alongside the delivery of consistent compassionate leadership will help us to meet this commitment.

Case study

'Teaching Care Homes' was a programme conducted by Care England. 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. This is an ongoing piece of work which will create the foundations for a framework of learning; becoming pioneer centres from which the whole sector can learn. A digital platform was launched (commitment 10) to share learning about the development and social care nursing for use across the care sector as well as the NHS. 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 existing care home staff and managers. 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'.

7

Commitment 7

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

There is lots of evidence based practice which can help us improve our work.

However, to demonstrate our positive impact, we need to use robust evaluation, from the beginning when we can.

We should routinely capture and analyse data which measures the impact of our work – placing the same importance on quantifying as we do to quality.

Case study

Rising numbers of acute admissions and Emergency Department (ED) attendance from care homes, which could lead to unnecessary distress and avoidable hospital stays were identified in this case study. Colleagues at Airedale recognised that telemedicine used successfully in prison healthcare could be applied to support care homes. The Critical Care Outreach team had skills in assessment and treatment of deteriorating patients and led work to deliver a telemedicine service in 27 local care homes. A 24/7 telemedicine hub was established to support the staff and carers of frail elderly residents in care homes, using remote video consultation.

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. The telemedicine system of assessment is now in almost 500 care homes across the UK. Care home residents can now access remote consultations reducing their need to attend GP surgeries and the need for GPs to visit care homes. 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 Ten Commitments *continued*

8

Commitment 8

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

Education, learning and training are important for the provision of high quality care. This commitment encourages us to support a culture of life-long learning and self-reflection.

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

Case study

Improving infection control in nursing care homes (Doncaster and Bassetlaw NHS Foundation Trust). Unwarranted variation in infection prevention and control (IPC) standards in care homes suggested that consideration should be given to ensuring the environment always supported safe care. IPC nurses worked with the care homes and set up a nursing forum for communication and education.

The team in Bassetlaw has focused 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. Improvements were seen in all areas of infection prevention and control.

9

Commitment 9

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

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 is needed to improve quality of care, staff productivity and financial control.

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.

10

Commitment 10

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

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.

Case study

The ESTHER model of care is based on a real person who became unwell with serious heart failure and was admitted to hospital. There were delays in diagnosis, treatment and care planning. Overall the experience that Esther had was not good and somehow typical of a lot of patients and service users. The health and social care staff involved in Esther's care recognised that there was a different way of doing things that would lead to better outcomes, higher quality care and efficiency.

This work has shown that evidence based work has allow care staff to lead on the care and the care plans, and ensuring patient/resident care was optimal but the new element of this process was that care staff worked to ensure residents wishes (e.g. in terms of support wanted) were listened to and represented and this practice improves outcomes and experiences. It has led to more personal care, better mood among the residents and staff time is saved, not having to ask each other or the resident the same questions over and over again. Quality of care has improved alongside this through the approach.

Case study

Releasing nursing time while providing safer care is a case study which exemplifies how technology can support health and social care. 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. The project was led by nurses and midwives who acted as local champions deciding on areas for implementation and leading the introduction of bedside vital signs monitors.

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 consistency in the delivery of safe patient care and reducing the time of completing paper records.

This provides a 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).

Conclusions

As we near the end of this session, take the opportunity to reflect on the following key questions.

Firstly, is there ‘unwarranted variation’ where you work?

Secondly, is there something you do every day that makes you think ‘we could do this differently’?

Finally, how can you show your great work and share it with colleagues around the country?

Key questions to consider

Next steps

Visit the LCAV website [4] and download a copy of the framework.

Explore the case studies and think about the work you are doing that the LCAV team would love to hear about.

If you would like to discuss the framework, or to hear more, contact the LCAV team via: england.leading-change@nhs.net

Questions and Answers

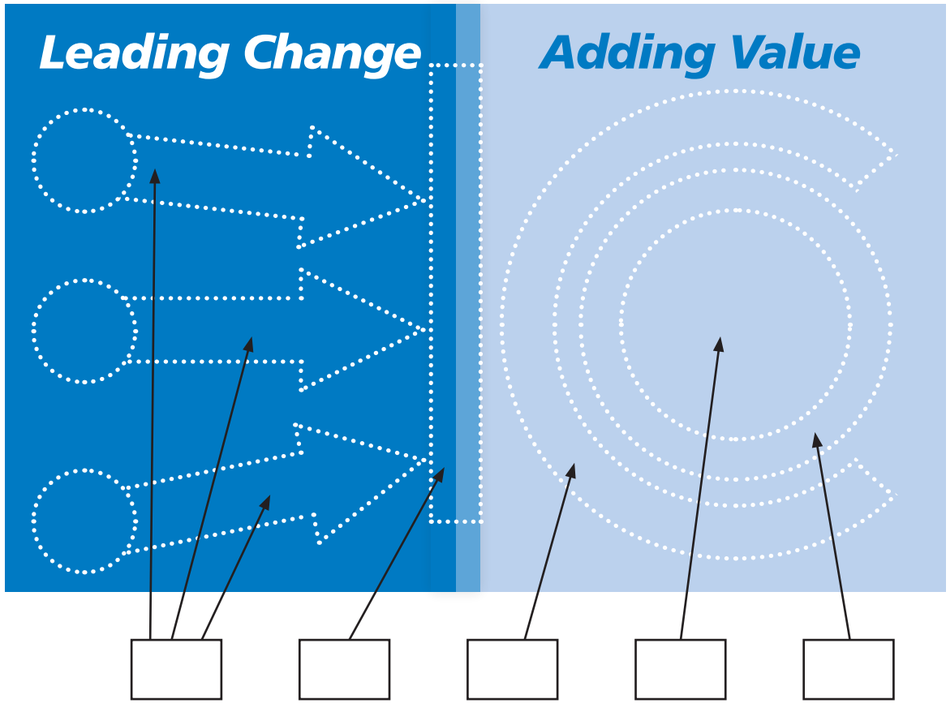
Self Assessment Questions

1. **Which of the following statements on the Leading Change, Adding Value (LCAV) framework are true?** (please tick)

- ☐ The LCAV framework was first launched in 2016
- ☐ The LCAV framework is aimed exclusively at hospital nurses
- ☐ The LCAV framework is aligned to the Five Year Forward View

2. **Consider the five main elements of the LCAV framework.**
(Number the five boxes below the diagram)

1 - The six Cs
2 - The ten commitments
3 - The three gaps
4 - Unwarranted variation
5 - The triple aim



Self Assessment Questions *continued*

3. **Consider the purpose of each element of the LCAV framework.**
(match the description to the element)

Element	Description
Unwarranted variation	Impact on the health and care sector and result in unwarranted variation.
The ten commitments	Inequalities that cannot be justified by differences in geography, demography or infrastructure.
The three gaps	Achieved through better outcomes, better experiences and better use of resources.
The six Cs	Represent our value base and help us to identify and address unwarranted variation.
The triple aim	Ten aspirational statements that can help us to narrow the three gaps.

4. **Which one of the following does not represent an example of the 'six Cs'?** (please tick)

- ☐ Care
- ☐ Commitment
- ☐ Compassion
- ☐ Communication
- ☐ Courage
- ☐ Creativity
- ☐ Competence

Answers on page 30...

Session Key Points

- 'Leading Change, Adding Value' (LCAV) is a national framework for nursing, midwifery and care staff
- It supports nursing, midwifery and care staff to take a lead in promoting health and wellbeing, improving care and quality, and using resources efficiently
- It encourages nursing, midwifery and care staff to identify and address unwarranted variation, measuring the impact of their work and using the ten commitments
- Consider if there is unwarranted variation or something that makes you think 'we could do this differently' where you work
- Contact the LCAV team to show the great work you do and share it with colleagues around the country

Session Summary

Learning Objectives

Having completed this session you will now be able to:

- Identify the main elements of the LCAV framework
- Describe how nursing, midwifery and care staff can use the LCAV framework to identify and address unwarranted variation and strengthen the quality and outcomes of care
- Identify and address any examples of unwarranted variation in your workplace

Further Reading

Refer to the following text for additional information:

- NHS England. Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff. London: NHS England, 2016.
- NHS England. Five Year Forward View. London: NHS England, 2014.
- Department of Health. Compassion In Practice: Nursing Midwifery and Care Staff – Our Vision and Strategy. London: Department of Health, 2012.

Next Steps

Having completed this session you may now wish to:

- Visit the LCAV programme webpage.
- Think about the work you are doing that the LCAV team would love to hear about
- Contact the LCAV team via: england.leading-change@nhs.net and request your Leading Change, Adding Value badge!

References

1. Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff. London: NHS England, 2016.
2. NHS England. Five Year Forward View. London: NHS England, 2014.
3. Department of Health. Compassion In Practice: Nursing Midwifery and Care Staff – Our Vision and Strategy. London: Department of Health, 2012.
4. Leading Change, Adding Value. https://www.england.nhs.uk/leadingchange/

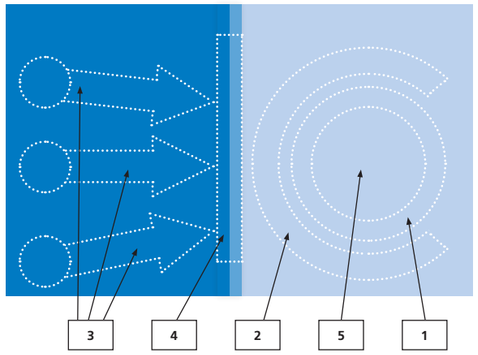
Self Assessment Answers

1. **Which of the following statements on the Leading Change, Adding Value (LCAV) framework are true?** (please tick)

- [x] The LCAV framework was first launched in 2016
- [ ] The LCAV framework is aimed exclusively at hospital nurses
- [x] The LCAV framework is aligned to the Five Year Forward View

2. **Consider the five main elements of the LCAV framework.**
(Number the five boxes below the diagram)

1 - The six Cs
2 - The ten commitments
3 - The three gaps
4 - Unwarranted variation
5 - The triple aim



3. **Consider the purpose of each element of the LCAV framework.**
(match the description to the element)

Element	Description
Unwarranted variation	Impact on the health and care sector and result in unwarranted variation.
The ten commitments	Inequalities that cannot be justified by differences in geography, demography or infrastructure.
The three gaps	Achieved through better outcomes, better experiences and better use of resources.
The six Cs	Represent our value base and help us to identify and address unwarranted variation.
The triple aim	Ten aspirational statements that can help us to narrow the three gaps.

4. **Which one of the following does not represent an example of the 'six Cs'?** (please tick)

- [ ] Care
- [ ] Commitment
- [ ] Compassion
- [ ] Communication
- [ ] Courage
- [x] Creativity
- [ ] Competence

Leading Change, Adding Value:
A framework for nursing, midwifery and care staff

NHS England Publications Gateway Reference: 05247