National Stop the Pressure programme: One year on − our focus for improvement

November 2017

Pressure ulcers are an avoidable and costly harm. In the NHS in England from April 2015 to the end of March 2016, 24,674 patients were reported to have developed a new pressure ulcer (according to NHS Digital) while the average length of stay in hospital for patients with pressure ulcers is 25 days. Furthermore, progress on improving this situation has stalled since 2015, despite the work that has been done.

Our national 'Stop the Pressure' programme launched in November 2016 aims to create a significant culture shift and eliminate avoidable pressure ulcers in acute, community and mental health provider settings. We are working with partners, particularly frontline staff, NHS England and the Academic Health Science Network to deliver this.

In support of our improvement work, 172 trusts submitted improvement plans earlier this year that highlight great work being done at trust level across the regions and good evidence of partnership-working across health and social care settings. They also signpost areas for more exploration, alongside the work of the programme. Below we outline some common themes that emerged from this work.

Leadership

Trust improvement plans prioritised an executive-level sponsor for the work and multidisciplinary (MDT) team input at local and trust levels, supporting the programme drive that this is an MDT patient safety issue; individual clinical areas were taking forward improvement work, tissue viability services providing specialist input for almost all plans, and, importantly, the involvement of patients in learning events.

Quality improvement

Trusts used a range of quality improvement (QI) approaches including the Sign up to Safety Framework, the Institute for Healthcare Improvement (IHI) approach, safety huddles, interventional rounding where staff proactively check on their patient's condition at regular times, use of improvement collaboratives and staff as clinical champions.

Data measurement

There was a strong focus on getting the basics right, including making sure that local reporting of pressure ulcers is accurate and consistent alongside improving Serious Incident reporting. Trusts are working to make better use of data for frontline teams to support improvement and better organisational learning from incidents.

Documentation

Trusts are focusing on improving the standard of documentation through the patient pathway, particularly ensuring accurate assessment and documenting within 24 hours of admission, sometimes by designing local forms to meet need.

Clinical focus

Clinical focus was on preventing the more severe grade 3 and 4 ulcers and rolling out the SSKIN framework to support changes in practice at the bedside. Supporting learning from local clinical incidents and use of leadership panels to review cases were also important and learning from these was used to inform the development of new clinical pathways. They also prioritised managing non-concordance with treatment and supporting patients where mental capacity was a factor. Timely access to equipment was also a factor.

Education

Priorities for trusts were supporting frontline staff at all levels and students, ensuring temporary staff have the right skills, tackling training capacity challenges and providing outreach education to local care homes following individual Serious Incidents.

There were some topic areas we know are important in tackling avoidable pressure ulcers that were less visible in trusts' improvement plans. These include the link between nutrition and development of pressure ulcers; incontinence management and the development of pressure ulcers; patient feedback about their experience, and interventions in relation to bariatric patients.

National programme work and priorities

Our national programme has been leading a range of work related to the trusts' activity in the last 12 months including:

- Definition and measurement: frontline and academic colleagues are working to deliver a single approach to how we define pressure damage; how we report and measure at local and national levels to ensure we are tackling long-term inconsistency in practice, that we fully understand what harm is occurring, and that our QI work is focused appropriately. We plan to implement a new framework for practice in April 2018.

- Education for students and other staff: We are developing a curriculum expanding SSKIN to support student and newly qualified staff in practice.

- Improvement capacity: We launched a national Stop the Pressure collaborative in October 2017 with 25 trusts and 90 trusts in total have applied to join it over the coming months. We have also worked on the link between nutrition/ hydration and pressure ulcers and are developing resources for launch early 2018.

- Supporting the delivery of more productive pressure wound care: we are working with our operational productivity team to collect data that will help us understand ‘what good looks like’ in this area.

In the future we will develop patient and carer information on preventing pressure damage, and look at how to get better feedback on patient experience and the treatment of pressure ulcers, alongside our work on prevention.

With the support and enthusiasm of everyone in practice we are working to create sustainable improvement actions.

For more information

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