



High Impact Actions for Nursing and Midwifery



Background to the High Impact Actions

Nurses and midwives care passionately about improving the care they provide to their patients. Proof of that ambition was demonstrated when nurses and midwives posted 600 submissions on the High Impact Actions web site in just three weeks. These actions, and the engagement of nurses and midwives throughout the country, have the potential to not only transform the care patients receive, but importantly, to also reduce costs. Nurses and midwives have seized the opportunity to lead the way in meeting the quality and productivity challenge.

A large group of experienced nurses and midwives have identified the eight high impact actions that are outlined in this document from the website submissions. In addition, a number of academic experts have provided references to best practice and some initial economic analysis has been undertaken. More detailed work will take place over the coming months to explore the good practice linked to these eight areas and to further quantify the potential impact if these actions were replicated throughout the NHS.

Each high impact action sets out the scale of the challenge and the potential opportunity in terms of improvements to quality and patient experience and reduction in cost to the NHS.

The good practice examples that we have highlighted demonstrate this. For each action the gains could be huge and nurses and midwives are able to lead on each of these actions which could have significant gains for the NHS.

Space only allows for a limited example from the website submissions for each high impact action. There were many submissions made for each of the areas and more examples can be viewed at www.institute.nhs.uk/hia.

For nurses and midwives working across a range of NHS provided care this is the opportunity to drive up quality and reduce costs in a difficult economic environment. Commissioners of services, strategic health authorities and regulators will want to see nurse leaders engaged in focusing on these high impact areas and demonstrate the outcomes we know can be achieved.

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This work is being led by the chief nurses from the 10 strategic health authorities in collaboration with the Royal College of Midwives, Royal College of Nursing, the Nursing and Midwifery Council, the NHS Institute for Innovation and Improvement and the Department of Health.



Your skin matters

Action

No avoidable pressure ulcers in NHS provided care.

Extent of the problem

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families. Even a grade one pressure ulcer is very painful. New pressure ulcers are estimated to occur in 4–10% of patients admitted to acute hospitals in the UK, with one study putting this as high as 20% (Clark M, Bours G, Defloor T; 2004). New pressure ulcers affect an unknown proportion of people in the community, as reliable data is not available, but it is estimated that up to 30% of patients may suffer and 20% of patients in nursing and residential homes may be affected.

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

Benefits for patients and benefits for NHS

The impact of pressure ulcers is psychologically, physically and clinically challenging for both patients and NHS staff.

Treatment costs vary depending on the grade of ulcer, from £1,064 for a grade 1 ulcer to £24,214 for a grade 4. The cost of preventing and treating pressure ulcers in a 600 bed acute trust has been estimated at between £600,000 and £3m a year (Touche R; 1993).

The total cost in the UK is estimated to be £1.4-£2.1 billion annually, comprising 4% of total NHS expenditure.

HIA Front-line Submission

The Tissue Viability Service at NHS Newham appointed a nurse to tackle the increasing incidence of pressure ulcers in nursing home patients, many of which resulted in hospital admission. This included increased frequency of visits for patient reviews and an educational programme for all nursing home staff. Data from acute providers showed a decrease in the number of patients admitted from the community with pressure ulcers by 50% for the period April-August 2008/09. Results show that in 2008 there were 25-45 admissions compared with 0-12 patients admitted in 2009. Based on admission costs of £199 per night with an average stay of 9 nights the cost saving is £59,100 based on the highest number of admissions.

References

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Staying safe - preventing falls

Action

Demonstrate a year on year reduction in the number of falls sustained by older people in NHS provided care.

Extent of the problem

Falls affect approximately 60,000 people per year in the UK and result in up to 14,000 deaths in total (Help the Aged; 2008). It was found that every day, 2,300 people in the UK fall. 28–33% of the population over 65 years, and 32–42% of the population over 75 years will fall each year. The National Patient Safety Agency (NPSA) found that in an average 800 bed acute hospital trust there will be around 24 falls every week and over 1,260 falls every year representing the highest volume patient safety incident reported in hospital trusts in England (NPSA; 2007). 28,000 falls were reported from community hospitals.

Falls are a major cause of disability and mortality for older people in the UK and the problem is likely to increase with an ageing population. 10% of all people that fall will die within a year according to Help the Aged (2008). However, research estimates that up to 30% of falls can be prevented.

Benefits for patients and benefits for NHS

According to the Royal College of Physicians (2008) falls present a huge problem for the health and independence of older people. The associated mortality and morbidity from a fall is high with individual consequences ranging from distress, pain, physical injury and loss of confidence to complete loss of independence which impacts on relatives and carers.

Financial costs can include extra home healthcare, social care or residential care. Research by the NPSA has found that even a fall (or falls related incident) that results in only minor injury is responsible for an extended patient stay of 1-2 days. Overall direct healthcare cost to the NHS is estimated at £15m every year representing a cost of £92,000 a year for an 800 bed acute hospital trust (NPSA; 2007).

HIA Front-line Submission

Ipswich Hospital has introduced the Seven Simple Steps Programme across its complex care wards. Multidisciplinary training and raising awareness were key to this programme and incorporated into mandatory training, junior doctor and pharmacy staff training. The pilot project demonstrated a 68% reduction of patient falls over first 3 months of implementation within a complex elderly care ward. The use of the seven simple steps will enable the trust to reduce falls by at least 25%, thus identifying savings of at least £32,891.

References

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- The Patient Safety First Campaign have recently issued a 'How to' Guide for reducing harm from falls. <http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf>



Keeping nourished - getting better

Action

Stop inappropriate weight loss and dehydration in NHS provided care.

Extent of the problem

Three million people are at risk of malnutrition in the UK; of these, 3% are in hospitals or other NHS settings (BAPEN; 2009). In 2006, it was found that around 10–40% of patients in the community (at home and in care homes) and in hospital have malnutrition (NICE 2006). Currently, 40% of patients admitted to hospital are undernourished. (British Nutrition Foundation, 2009).

Malnutrition is associated with poor recovery from illness and surgery (Stratton *et al* 2003). Yet NICE (2006) found that only about 1/3 of patients were screened for malnutrition on admission to hospital. Subsequently, patients at risk of malnutrition are not recognised and referred for treatment (Elia *et al* 2005).

Lack of adequate hydration has been noted by the NPSA, the RCN and Water UK (2007) as a common problem in hospitals. Dehydration increases length of hospital stay and is linked to a number of serious conditions, such as coronary heart disease (CHD) and stroke. In one study adequate hydration has been shown to reduce the risk of CHD by 46% in men and 59% in women. Conversely, dehydration increases the mortality of patients admitted to hospital with a stroke two-fold.

Benefits for patients and benefits for NHS

A study by the British Association for Parenteral and Enteral Nutrition (BAPEN) (2009) found that malnourished patients stay in hospital longer, succumb to infection more often, visit their GP more and require longer-term care and more intensive nursing care. They also identified additional consequences of malnourishment, such as muscle wasting, increased risk of infection, predisposition to falls and pressure ulcers, delayed recovery and reduced quality of life.

BAPEN estimated in 2005 that malnutrition costs the NHS £7.3 billion annually. Of this, 52% (£3.8 billion) relates to malnourished patients in hospital, and a further 36% (2.6 billion) to patients in long-term care facilities. Proper hydration alone could lead to savings of £0.95 billion (NPSA, RCN & Water UK).

HIA Front-line Submission

Enhancing Care for Vulnerable Patients is a new scheme to prevent dehydration at Milton Keynes Hospital NHS Foundation Trust. The red water jug scheme helps staff identify patients who require help with their fluid intake. Any patient who is vulnerable or at risk of dehydration is given a red jug and mug to highlight their specific hydration requirements. Devised and implemented by nursing staff, the scheme is helping ensure that patients are adequately hydrated. Results include: reductions in length of stay, earlier discharge for those patients involved in the scheme and reduction or elimination of the need for IV fluids. As patients are adequately hydrated the risk of contracting an infection, e.g. UTI, or as a result of intravenous access, is also reduced.

References

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Promoting normal birth

Action

Increase the normal birth rate and eliminate unnecessary caesarean sections through midwives taking the lead role in the care of normal pregnancy and labour, focusing on informing, educating and providing skilled support to first-time mothers and women who have had one previous Caesarean section.

Extent of the problem

Maternity statistics for 2008/09 show that, in England, around 60% of women who had their baby in hospital had a normal birth (HES Online; 2009). In the past 15 years the proportion of births by Caesarean section (CS) has been increasing steadily in England. In 1989/90 the rate of CS accounted for 12% of all births in England, whilst by 2005/6 the rate had doubled to 24%. Currently the rate stands at 24.6% for 2008/9.

The rate has remained largely static for the past three years and, whilst the fact that there is no significant increase is positive, the challenge remains that there is no active national reduction in CS rates.

The overall increase in babies born by CS has not been accompanied by a measurable improvement in outcomes for the baby and has been shown to carry an increased risk of morbidity for the mother when compared to normal delivery.

Benefits for patients and benefits for NHS

For women, the benefits of a normal birth include improvements in morbidity rates and a quicker return home to their families. The reduction in the level of unnecessary interventions also results in a reduction of unnecessary complications.

In the UK, Caesarean sections have been found to cost an average of £1,701 while a vaginal delivery costs an average £749. The Audit Commission has estimated that a 1% rise in Caesarean section rates costs the NHS £5m per year (Parliamentary Office of Science and Technology ; 2002).

Women with spontaneous vaginal deliveries spend on average 1 day in hospital after delivery, women with instrumental deliveries 1 or 2 days and CS deliveries is 3 or 4 days (Hospital Episodes Statistics; 2004).

HIA Front-line Submission

The ambition at Kettering General Hospital NHS Foundation Trust is to promote normal childbirth and reduce the Caesarean section rate. They did this by providing information to enable mothers to make a more informed choice. One of their focus areas was to spend time with mothers who had previously given birth by Caesarean section. They were able to highlight the rationale for normal birth and provide advice about the mother's choices for their next pregnancy. The results of this effective intervention have been impressive: a reduction in costs as Caesarean sections have been reduced by 2.2% for 2009 demonstrating an overall saving of £820 per case and the average in-patient stay has been reduced by 1 day equalling £2,630 per month. Total annual savings amount to £101,030.

References

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The Royal College of Midwives have published 10 top tips for normal birth available at: <http://www.rcmnormalbirth.org.uk/> these pull together the actions most likely to promote a normal birth.

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Important choices – where to die when the time comes

Action

Avoid inappropriate admission to hospital and increase the numbers of people who are able to die in the place of their choice.

Extent of the problem

People in the UK are now living longer. Of the half million people who die each year in England alone, 2/3 are over 75 years old and the number of annual deaths is forecast to increase from 512,000 in 2005 to 585,000 in 2030 (Hatzian Andrew; 2008). 50-60% of deaths currently occur in acute hospitals with patients experiencing an average of 18 days as an inpatient spread over 2-3 admissions in the last year of life.

Evidence from the National Audit Office shows that many people wish to be cared for and die in a location other than hospital (NOA 2008a). The study found that in one locality, 40% of patients who died in hospital did not have medical needs which required them to be in an acute setting and could have been cared for elsewhere such as their own home or other appropriate setting (NOA; 2008b).

The ability for people to choose where they die varies across the country. It is often influenced by factors such as where people live and the medical condition they have. The National Care of the Dying Audit (Marie Curie Cancer Care; 2007) notes that 55% of patients with cancer would prefer to die at home but in fact only around 25% actually achieve this.

The Gold Standards Framework (2004) states that people who are nearing the end of life or known to be needing end of life care are admitted to hospital rather than supported at home. This is not only expensive but is often inappropriate and is preventable. People at the end of life and their families should be able to choose to have this care closer to home.

Benefits for patients and benefits for NHS

Patients and families would benefit by having an opportunity to discuss preferences and choices of where to die and have this supported and recorded.

Of the 1.8 billion spent annually on treating cancer patients in the last year of their life the National Audit Office calculates that £104 million could be redistributed to meet people's preferences for place of care by reducing hospital admissions by 10% and the average length of stay following admission by three days. There is also scope to extend this kind of best practice to other conditions (NAO; 2008a).

Approximately half of all complaints made to acute trusts relate to an aspect of end of life care.

The estimated cost for a complaint of average complexity is just under £2,500. It is calculated that a typical acute trust will have total complaint costs of £2,220,300 per year of which around £1,110,150 will be associated with end of life care.

HIA Front-line Submission

The City Healthcare Partnership in Hull, has established a health and social care team to complement end of life care provided by community services.

The responsive team is specifically skilled in providing essential end of life care, offers instant access, and is able to provide support multiple times a day if needed, or 'round the clock' through working in conjunction with other care services. In the four months the service has been operating data indicates that 76% of end of life care patients referred to the team die at home. The death at home rate prior to the service introduction was less than 20%.

References

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Fit and well to care

Action

Reduce sickness absence in the nursing and midwifery workforce to no more than 3%.

Extent of the problem

The CIPD Annual Survey of Absence Management highlighted that more than 45,000 NHS staff call in sick every day resulting in the loss of over 10 million working days (CIPD; 2009). The proportion of working days lost to sickness absence varies between trusts from 2.8% to 6% (NHS Employers; 2009). The National Audit Office (2006) found that in 2004-05 the average rate of sickness absence for nursing staff is 7.5% (16.8 days per year)

There is wide variation in absence rates for nurses by wards, specialties and grades. The CBI (2007) found the greatest levels of absence are within services that have a high proportion of older patients such as stroke units, rehabilitation units, geriatrics and general medicine. There is less sickness absence in departments that provide specialist services, such as coronary care units, cardiothoracic surgery, intensive therapy units and paediatrics although rates are still comparatively high.

Benefits for patients and benefits for NHS

Reduced sickness absence results in increased continuity of staff which leads to increased continuity of care and has a positive impact on the experience of patients and their relatives. Sickness absence also has a major impact on the stress levels of those staff who are working to cover absent colleagues.

The average acute trust (800 beds) spends £2.5 million on agency staff, which is equivalent to 5.1% of its staffing costs. This has risen rapidly from 2.9% just seven years ago (Health & Safety Executive; 2007). There is a large variation in the level of nursing hours lost, for example the variation within acute Trusts is between 5% and 10%.

The NHS Health and Wellbeing report found that if absence was reduced by a third this would equate to savings of 3.4 million working days a year equating to an extra 14,900 WTEs and a cash figure of £555m (DH; 2009).

HIA Front-line Submission

Leeds Partnerships NHS Foundation Trust, a mental health trust, reviewed its skill mix and focused on strengthening the leadership on wards in response to a survey on sickness absence. The result has been: a reduction in sickness, a reduction in bank/agency costs, a reduction in patients going AWOL which has also impacted on use of police service resources - and overall reduction in errors which in turn has reduced the time investigating these errors. This has clear benefits for the quality of care and overall integrity and financial balance of the organisation.

References

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Ready to go - no delays

Action

Increase the number of patients in NHS provided care who have their discharge managed and led by a nurse or midwife where appropriate.

Extent of the problem

Simple discharges make up approximately 80% of all discharges (Lees; 2004). The Department of Health (DH 2004) states that changing the way in which discharge occurs for this large group of patients would have a major impact on patient flow and effective use of the bed capacity. This will in turn both reduce delays and improve patient experience by helping to ensure that patients are fully informed about the process for leaving hospital.

The move towards nurse led discharge has been, in part, a response to an overall shift in discharge activity brought about by shorter lengths of stay, increasing patient throughput and the increasing acuity of patients admitted to hospital. The importance of nurse led discharge has been highlighted in government plans to overhaul the NHS discharge process (Chatterjee 2004).

Benefits for patients and benefits for NHS

Benefits of nurse led discharge include a more timely planned discharge for the patient with fewer delays leading to a more positive patient (and family) experience as well as a lower risk of healthcare associated infections.

The 2009 Annual Health Check, published in October 2009 by the Care Quality Commission, has revealed the proportion of hospitals failing to hit a target to reduce delayed transfers has increased by 12% in the past two years. Nearly a quarter of trusts (24%) failed to meet the required standard for delayed transfer of care, up from 21% in 2006-07
<http://www.cqc.org.uk>.

It is estimated that for an average patient on an NHS surgical ward it costs up to £400 per day, indicating real financial benefits to reducing length of stay (Webber-Maybank & Luton; 2009). It is estimated that a reduction in length of stay of between two and six days per patient could save NHS trusts £15.5m-£46.5m a year in total (NAO; 2000).

HIA Front-line Submission

The establishment of THREADS (Taunton Hospital Early Assisted Discharge Scheme) has meant that patients admitted to hospital with an exacerbation of chronic obstructive pulmonary disease (COPD) are discharged home early and cared for by a dedicated team until well. Patients are educated comprehensively about their disease and they are offered pulmonary rehabilitation. The national average length of stay in an acute bed is 6 days. THREADS reduces this to 0-3 days (60% of patients of which 25% less than 2 days) 4-7 days 33%. Over a year period taking into account all costs and the reduction in bed days resulted in a cost saving of £42,550.

References

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Protection from infection

Action

Demonstrate a dramatic reduction in the rate of Urinary Tract Infections (UTIs) for patients in NHS provided care.

Extent of the problem

In 2000 the Public Accounts Committee estimated that there were at least 100,000 cases of hospital-acquired infection annually – (The NAO (2009) stated that this remains the best estimation of costs available). Urinary tract infections are the second largest single group of healthcare associated infections in the UK and make up 20% of all hospital acquired infections (Health Protection Agency; 2009). In primary care, UTIs make up between 1-3% of all GP consultations with the condition affecting women significantly more than men at a ratio of 50:1 in the age group below 60 years. 80% of urinary tract infections occurring in hospital can be traced to indwelling urinary catheters (Kelsi *et al*; 2003).

Benefits for patients and benefits for NHS

UTIs lead to longer stays in hospital for patients. Up to 5% of hospital acquired UTIs develop into secondary bacteraemia; this is often painful and can be life-threatening. For pregnant women the development of a UTI can be especially problematic leading to pre-term delivery, anaemia and a low birth weight baby.

Adults with hospital acquired infection stay in hospital 2.5 times longer, incur hospital costs 3 times higher and incur higher general practitioner, district nurse and hospital costs after discharge than uninfected patients.

UTIs have been found to extend the average length of hospital stay by 6 days (NAO; 2004) UTIs may account for an extra 798,000 bed days annually (Memorandum by Bard Limited to the Select Committee on Science and Technology (2003)).

It was estimated that the 1994/5 costs of treating UTIs in the NHS were in the order of £124 million (Plowman *et al*; 2000) and the extra financial cost of urinary infection has been estimated at £1,122 per patient (UTI Care Bundle).

HIA Front-line Submission

Winchester and Eastleigh Healthcare NHS Trust has developed UCAM care. UCAM stands for urinary catheter assessment and monitoring. It is a form used to record and document all insertion and ongoing urinary catheter care. This proposed idea was born out of the results from a trust wide audit on urinary catheter care. The approach aims to: prevent unnecessary catheterisation, prompt daily review of patients with catheter and removal of catheter ASAP, and provide evidence of quality of patient care (insertion & ongoing care) as per High Impact Intervention No.6 catheter care bundle*.

The projected impact on cost reduction is prevention of costs from treating catheter associated urinary tract infections.

**The urinary catheter care bundle (DH 2006, DH 2007), as part of the DH Saving Lives programme, summarises best practice in relation to urinary catheter care and has an accompanying compliance tool. It has been developed for use both in primary care and the acute sector.*

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