Implementing the eight high impact actions to transform healthcare and boost efficiency

Patient care can be radically improved and healthcare costs drastically cut by rolling out a range of actions. The NHS Institute shows you how.

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Nurses and midwives could improve care and save billions of pounds a year by implementing the eight high impact actions unveiled by the chief nursing officer for England Dame Christine Beasley in 2009. We explore how staff can implement the actions through leadership and knowledge of change management processes.

INTRODUCTION

Imagine what a force for change over 400,000 nurses and midwives could be. Any actions performed by this group of passionate healthcare staff could truly transform care by increasing quality, improving patients’ experiences and reducing costs. This is the ambition set out for the high impact actions (HIAs) for nurses and midwives (NHS Institute for Innovation and Improvement, 2009a)(see Box 1).

THE HIGH IMPACT ACTIONS

Over 600 good practice submissions were posted in response to a call for action by chief nursing officer for England Dame Christine Beasley in a three week period during September 2009. In addition to the submissions, there were thousands of hits on the NHS Institute for Innovation and Improvement website from people reading and commenting on the case studies.

Submissions detailed actions that nurses and midwives felt they were already doing that, if implemented widely across the NHS, would make a massive difference to healthcare. A group of 70 nurses and midwives then came together and used a set of criteria to identify which of the submitted actions would make the biggest difference. They agreed on the following:

1. Your skin matters – ensuring no avoidable pressure ulcers.
2. Staying safe – preventing falls.
5. Important choices – where to die when the time comes.
6. Fit and well to care.
7. Ready to go – no delays.
8. Protection from infection.

Source: NHS Institute for Innovation and Improvement (2009a)

BOX 1. EIGHT HIGH IMPACT ACTIONS

- Your skin matters – ensuring no avoidable pressure ulcers.
- Staying safe – preventing falls.
- Keeping nourished – getting better.
- Promoting normal birth.
- Important choices – where to die when the time comes.
- Fit and well to care.
- Ready to go – no delays.
- Protection from infection.

These eight high impact actions cover a range of criteria to identify which of the submitted actions would make the biggest difference. They agreed on the following:

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1. Staying safe – preventing falls: achieving a year on year reduction in the number of falls sustained by older people in NHS care. Falls affect approximately 60,000 people per year in the UK (see Box 2 for information on how Ipswich Hospital has initiated a programme that will reduce falls by around 25%);
2. Keeping nourished – getting better: preventing inappropriate weight loss and dehydration in NHS care. Addressing this increases quality of life and reduces length of stay, as well as reducing associated risks of infections and pressure ulcers. Some £7.3bn could be saved each year by improving patients’ nutritional state (NHS Institute for Innovation and Improvement, 2009a);
3. Promoting normal birth: increased Caesarean section rates have not been accompanied by improved outcomes for mothers and babies. When midwives take up the lead role in the care of normal pregnancy and labour, normal birth is promoted and unnecessary Caesarean sections are reduced, leading to improved morbidity and faster discharge;
4. Important choices – where to die when the time comes: increasing the number of people who are able to die in the place of their choice rather than in hospital. More than half (55%) of people with cancer would...
prefer to die at home but only around 25% actually achieve this (Marie Curie Palliative Care Institute Liverpool, 2007); I Fit and well to care: reducing sickness absence in the nursing and midwifery workforce. Some 10 million working days are lost to sickness annually. Reducing staff sickness increases continuity of care, which has a positive impact on patient experience. If absence was reduced by one third, this would equate to savings of £3 million working days each year, saving £15.5m–£46.5m a year (National Audit Office, 2000); I Ready to go – no delays: increasing the number of patients in NHS care who have their discharge managed and led by a nurse or midwife. Timely, planned discharge means fewer delays, a more positive patient experience and a reduced risk of healthcare associated infections. A reduction in length of stay of 2–6 days per patient could save NHS trusts £15.5m–£46.5m a year (National Audit Office, 2000); I Protection from infection: drastically reducing the rate of urinary tract infections for patients in NHS care. Achieving this will reduce both length of stay and the risk of secondary bacteraemia, which is distressing and can be life threatening. Savings of an extra 798,000 bed days and £124m each year could be made (NHS Institute for Innovation and Improvement, 2009a).

**FUNDAMENTAL ASPECTS OF GOOD CARE**

Many nurses and midwives recognise the eight HIAs as fundamental to providing good clinical care. One significant point is that they are not new: each of the actions has already been implemented by some NHS organisations – but by no means all parts of the system.

If all of the changes were applied systematically across the NHS, to the high standards already being achieved in parts of the service, the experience of millions of patients would be transformed; hundreds of thousands of clinician hours, appointments and hospital bed days would be saved; staff satisfaction would be enhanced; and clinical quality significantly improved.

NHS staff are often celebrated for their inventiveness. Examples include: the development of the first hospice, providing excellent care and comfort for those needing end of life care; the MRI scanner that revolutionised diagnostic ability; and telecare that improved access to healthcare. However, it is recognised that the widespread adoption of new ideas and processes can be challenging. It can take many years for an idea to become mainstream within the NHS, even if there is a robust evidence base to support it. The good practice example on falls prevention submitted by Ipswich Hospital illustrates the difference the HIAs can make.

**ENSURING WIDESPREAD USE**

We know from evidence about the size of the problem in each of the high impact areas that good practice is not being systematically applied. Using our example of preventing falls, we know they affect approximately 60,000 people per year in the UK and can result in up to 14,000 deaths (Help the Aged, 2008). The National Patient Safety Agency (2007) found that, in an average 800 bed acute hospital trust, there are around 24 falls every week and over 1,260 every year. This represents the highest volume of patient safety incidents reported in hospital trusts in England.

This is not just an acute hospital problem; community hospitals report around 28,000 falls per year. Falls are a major cause of disability and mortality for older people and the problem is likely to increase because the population is ageing.

According to Help the Aged (2008), 10% of all older people who fall die within a year, yet research estimates that up to 30% of falls can be prevented. We need to consider and address how we can help every organisation in the NHS to adopt the sort of good practice that is evident in Ipswich Hospital and other organisations. The fundamental question is: how can we help every organisation in the NHS to adopt good practice that is evident in some organisations and that we know can make a massive impact? This is the main theme of a discussion paper setting out ideas to support large scale change in the NHS (Bevan and Pislek, 2009). The authors concluded: I There is sufficient will among leadership for change; I There are plenty of ideas about what to do to close the cost and quality gap (although there is always room for more innovation); I The weakest aspect is execution, that is, the ability of leaders across the system to fully implement changes and release sufficient cash benefits while maintaining or improving quality.

**FOCUS ON IMPLEMENTATION**

A critical issue for the next stage of the health service improvement journey is executing or implementing work proven to be good practice.

In Does Improving Quality Save Money?, Øvretveit (2007) suggested thinking about successful improvement can be summarised with the following formula:

Evidence of effective change + supportive environment + effective implementation = improvement

There is a strong evidence base for each of the HIAs as well as evidence from the NHS that these problems can be tackled and improvements made or substantial harm reduced.

Creating a supportive environment for change requires leaders at every level of the organisation and system to be engaged. Effective implementation depends on frontline nurses and midwives grasping the nettle and making things happen in wards, communities and people’s homes.

The focus of the next two phases of work on the HIAs is on harnessing the evidence from the NHS and putting it into practice in every organisation every day. This requires a new approach to implementation.

The aspiration is to encourage widespread uptake to achieve good practice in each of the HIAs. This can only be done by nurses and midwives themselves, who need to be supported and enabled to prove their own services. This support will include providing knowledge and making connections at national level to aid local leaders to champion and support implementation.

The leadership challenge cannot be overestimated. Marshall Ganz, a civil rights
campaigner who said knowledge of mass mobilisation during the Obama election campaign in the US, suggests that leaders need to start “accepting responsibility for enabling others to achieve purpose in uncertainty”.

In discussing leadership, we are focusing not only on senior leaders but also on leadership at every level of the NHS. We need all 400,000 nurses and midwives to feel enabled to adopt and implement the HIAs in their own area.

In addition to leadership, what else will help or hinder implementation of the HIAs? Research and evaluation on quality improvement helps us understand what enables improvement and also, importantly, what prevents it. Box 3 summarises some of the most important elements.

Every organisation in the NHS – local, regional and national – needs to assess its contribution to implementing the HIAs and to ensure that the conditions are right for large scale action.

To become a part of mainstream service delivery, rather than a separate project, a combined bottom up and top down approach to implementation is needed. The bottom up approach needs to harness the enthusiasm and will of nurses and midwives to put these changes in place. The top down approach must ensure that any barriers to implementation are removed and that the right conditions exist across the health system to support a focus on these improvements.

**ELEMENTS OF LEADERSHIP**

The following are all elements of good leadership:

- Clinical engagement: this involves talking about the HIAs in a way that captures both hearts and minds. Nurses and midwives want to provide high quality care – ensuring that the HIAs are “the way we do things around here” is a route to securing that care.
- Having the right information: practitioners will need to understand whether each particular action is a priority in their organisation. How much work has already been undertaken on each of these areas? What is the rate of harm in the organisation, for example, the number of falls or avoidable pressure ulcers? This information will help to prioritise and begin to build a baseline from which to track improvement.
- Change management skills: many nurses and midwives have learnt these skills through working on other improvement programmes (such as the Productive Series from the NHS Institute for Innovation and Improvement). These skills are vital in implementing the HIAs and measuring their impact, as well as ensuring the whole team is involved in the changes.
- Time for implementation: putting in place each of the HIAs requires dedicated effort. The Productive Ward – Releasing Time to Care programme highlighted the importance of the “change facilitator” role in supporting improvement (NHS Institute for Innovation and Improvement, 2010).
- Financial flexibility, rewards and incentives: these will not always be within nurses’ control; discussions may have to be held in other parts of the system to remove barriers to change. There may be a “spend to save” requirement because of set up costs for some of the HIAs in some organisations. Alternatively, for those trusts already working on these areas, a change in focus or methodology may be all that is necessary.

**MOVING FORWARD**

We have seen how nurses and midwives have engaged with this programme and are encouraged to learn how they are already planning to build the HIAs into their local improvement plans.

We know that each local community or organisation that adopts one or more of these changes will draw on the knowledge and case study examples provided and will develop the improvements to fit their own context and situation.

This is not a one off launch of eight high impact actions. It is an ongoing process of working together in a different way to transform health services. Over the coming months, we will be sharing information and experience from a number of case study sites that are demonstrating success in implementing the HIAs. We will also focus on obstacles: what are the barriers and setbacks that have to be overcome – and how can leaders in organisations really support nurses and midwives to make these changes?

In addition, we are interested in nurses’ and midwives’ views about what they believe would support them in their organisation to implement the HIAs. We urge you to visit www.institute.nhs.uk/hia and help us to build the right conditions that will ensure mass action.

**REFERENCES**


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