1.0 INTRODUCTION

1.1 The local project High Impact Actions for Nursing and Midwifery (HIAs) was established in June 2010 as a cross health economy project. It continues to focus on improving the delivery of essential care. The project was developed nationally in autumn of 2009 under the leadership of the Chief Nursing Officer (CNO) for England in conjunction with Directors of Nursing. The aim of the work is to re-focus the nursing profession on delivering basic nursing care and develop measurable indicators to demonstrate improvement in care provided. HIA identifies eight areas where Nurses and Midwives can be instrumental in quality improvement using a set of Sensitive Outcome Indicators. The approach promotes wellbeing, demonstrates improved patient care, reduced duplication, removes delays, improves knowledge and measurably benefits patient care and experience.

2.0 RECOMMENDATION

For the Board to:
- Continue to support Nursing and Midwifery teams in delivering this initiative,
- Receive within the Quality and Safety report outcomes against Nurse Sensitive Indicators and quarterly nursing reports on progress with delivery of the HIA project.

3.0 MAIN BODY OF REPORT

3.1 The HIAs were launched at the annual CNO conference in November 2009 with a request to gather examples of good practice with measurable outcomes. This resulted in the publication of “The Essential Collection” from The NHS Institute for Innovation and Improvement and this document provides case studies and examples on how to improve nursing practice. Nursing standards at Hereford Hospitals NHS Trust were recognised in the development of this document through our work on hydration and nutrition initiatives.
3.2 HIA covers eight areas of practice which directly impact on patient care, these areas focus on direct care and indirect care for example improving the working life of staff delivering care. (Appendix 1)

3.3 Historically, the measurement of nursing and midwifery interventions has been variable, subjective and lacking in a National Standard approach. Two Nurse Sensitive Indicators have been developed and published, with the remaining indicators currently in consultation with agreement expected early in 2011

3.4 The Trust Quality and Safety Department has commenced data collation for the two areas of HIA where indicators have been agreed, these are:
   (i) patient falls and
   (ii) pressure ulcers (appendix 1)
   These will be reported in future in the patient quality and safety report.

3.5 Project groups for each of the high Impact Actions have been established across the health economy and work is underway to establish processes, working relationships and begin introducing improvement ahead of further the indicators expected in 2011

3.6 As part of scoping activity a review of current improvement work was carried out to avoid duplication and integrate this project with other work in progress. The links established are:
   • Productive Ward-Releasing Time to Care;
   • NPSA-Patient Safety First Campaign;
   • Essence of Care, Energising for Excellence;
   • Safety Thermometer
   • Leading in Patient Safety programme.

3.7 Additional Action taken to date includes:
   • Participation in events led by the SHA on HIA providing increased knowledge and opportunities to network.
   • Countywide group from acute, PCT and Provider arm focusing on six areas of HIA which have provided a focus to develop cross organisational working to improve quality of patient pathways particularly care of the older patient pathway.
   • Raising the profile of nursing has included interviews by local radio and nursing road shows which has travelled to venues across the county to promote importance of hydration and nutrition. Regular stands in HHT promoting HIA
4.0 POLICY AND BUSINESS PLAN CONSIDERATIONS

High Impact Actions links to the following Trust Objectives:

Objective 1 – To enjoy a reputation for and be able to evidence exceptional quality, safety and customer service.

Objective 4 – To be seen by staff and potential employees as an excellent employer and have in place the systems to recruit, develop and retain staff we need to realise our vision.

5.0 IMPLICATIONS

5.1 Value for Money

Reducing acquired pressure ulcers and patient falls contributes to improved safety, reduction in length of stay, improved patient experience and cost reduction.

5.2 Healthcare /National Policy

High Impact Actions link to focus on improved delivery of nursing care as seen in recent health policy.

6.0 CONCLUSIONS

6.1 Local people require assurance that the nursing care they will receive will be of the highest standard. HIA provides a framework to deliver this assurance. The first step has been the production of inpatient falls data using Nurse Sensitive Indicators and the process for highlighting pressure ulcers. As further indicators are published local data will be produced.

6.2 A key element to this work is the early inclusion of this work stream in the development of the Integrated Care Organisation and establishment of a county wide approach to the introduction of HIAs with a particular link to the older peoples pathway. Regular update reports will be presented to provide assurance on standards of nursing and midwifery care delivered within the organisation.

References:

Chief Nursing Officer’s Bulletin July 2010- www.dh.gov.uk/cnobulletin

High Impact Actions for Nursing and Midwifery-The Essential Collection-NHS Institute for Innovation and Improvement 2010
Appendix 1

<table>
<thead>
<tr>
<th>High Impact Action</th>
<th>Links</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Skin Matters</strong></td>
<td>Tissue Viability group-link nurses</td>
<td>Local Data base developed. Awareness training weekly Nov/Dec Daily review of all pressure sores in HHT Cat 3&amp;4 pressure ulcers reporting to Quality and Safety and requiring director of nursing to personally review Safety Thermometer Cat 4 SERI report requirement embedded.</td>
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<tr>
<td></td>
<td>Project team established</td>
<td></td>
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<tr>
<td><strong>Staying Safe-preventing falls</strong></td>
<td>Falls Group – NPSA</td>
<td>National Clinical indicators produced and operational in each Business Unit Incident reporting Safety Thermometer</td>
</tr>
<tr>
<td></td>
<td>Productive Ward-module and monthly data</td>
<td></td>
</tr>
<tr>
<td><strong>Keeping Nourished</strong></td>
<td>Productive ward nutritional Steering Group</td>
<td>Definitions not at this time agreed nationally MUST Audit Productive Ward Measures</td>
</tr>
<tr>
<td><strong>Promoting Normal Birth</strong></td>
<td>Patient Safety Week</td>
<td>Promoted in pre natal counselling. Database developed and shared monthly with Midwifery staff</td>
</tr>
<tr>
<td></td>
<td>Promoting Normal Birth Group</td>
<td></td>
</tr>
<tr>
<td><strong>Important Choices – Where to die when the time comes</strong></td>
<td>Palliative Care Strategy</td>
<td>Local data collection completed earlier this year as part of Three Counties Cancer Network. End of life pathway developed cross county</td>
</tr>
<tr>
<td><strong>Fit and Well to care</strong></td>
<td>Productive Ward monthly data Workforce Data-presented Finance and Performance meeting</td>
<td>Sickness Absence Data produced monthly</td>
</tr>
<tr>
<td><strong>Ready to go no delays</strong></td>
<td>Productive Ward module</td>
<td>Patients staying more than 10 days reviewed daily and a report</td>
</tr>
</tbody>
</table>
| Protection from Infection | Saving Lives initiative Productive Ward | Data produced monthly for Quality and Safety and published in clinical areas
Board reports
Point Prevalence Survey
Safety Thermometer | produced weekly |