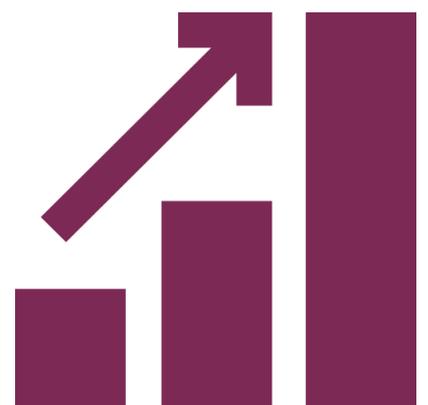


Leading Change Adding Value: a framework for nursing, midwifery and care staff

Year Two: Interim Evaluation Report



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2 Introduction

In November 2017 Edge Hill University (EHU) was commissioned to undertake an evaluation into Years Two and Three (final) of *Leading Change, Adding Value (LCAV): a framework for nursing, midwifery and care staff* (NHS England, 2016). An evaluation of the first year of LCAV was completed in March 2017 (Zubairu et al, 2017). The Year 1 process evaluation explored how LCAV had been received by key stakeholders from across the nursing, midwifery and care sector in its first year. Important aspects of establishing transformational change included how the framework had been disseminated, understood and embedded. The Year 1 evaluation report emphasised the continued engagement of frontline staff across health and social care as vital and that the co-implementation approach of LCAV supported all nursing, midwifery and care staff whatever their role, wherever they worked to embed the national framework as business as usual.

Following on from the year one evaluation, this interim report describes and evaluates the work undertaken in Year Two (May 2017- May 2018), building upon the foundations set within Year One (May 2016- May 2017) to continue to disseminate LCAV in a matrix fashion at national, regional and local levels and also to support its co-implementation as it moves towards an aim of being embedded as business as usual. The LCAV framework demonstrates strong partnership working, with senior representation from across nursing, midwifery and care organisations such as the Royal College of Nursing, the Royal College of Midwives, Care England and the National Care Forum, together with the Arms-length bodies, Health Education England, NHS Improvement and Public Health England, and other key stakeholders such as Unison, Queen's Nursing Institute and the Council of Deans of Health

all involved in the co-development and co-implementation approach of LCAV. This partnership approach, advocating matrix working, has ensured that the LCAV framework continues to demonstrate that the nursing, midwifery and care staff professions are key leaders within the transformational agenda, whose work supports successful change management across health and care.

This Year 2 evaluation report will be divided into three broad sections. Firstly, a qualitative narrative of the work that has been carried out under LCAV and its achievements within Year Two will be presented. Secondly, a focused analysis of a series of good practice case study examples led by nursing, midwifery and care staff will be outlined, identifying key themes. These case studies act as good practice examples to showcase work that demonstrates how LCAV has been put into practice, identifying and addressing unwarranted variation and the quantifiable contribution nursing, midwifery and care staff are making to the transformational work happening across health and care. There are also clear synergies with the Five Year Forward View (FYFV) priorities, which clearly reveal the vital contribution of the professions towards supporting services users with mental health conditions, advocating care closer to home with community nursing leadership amongst other notable parallels. The third and final section of this report will provide a summarised conclusion of the successes and ongoing progress of LCAV at the end of Year 2.

3 Key achievements in Year Two

The following section will provide an overview of the progress to date of the Leading Change, Adding Value framework during its 2nd year; from dissemination to the start of supporting implementation. This will include a description of resources and tools that have been developed and launched for nursing, midwifery and care staff; dissemination activity; partnership working; and supporting, as is relevant, the capacity and capability of staff; and digital analytics to demonstrate the communication outputs and successes in this period. This document is an interim report – it will not provide a quantitative review of the implementation of LCAV, these elements will be addressed at the end of the implementation phase, in the final year evaluation.

3.1 LCAV e-learning tool

Year Two of LCAV has seen the successful launch of the e-learning tool on the 26 March 2018, available at <https://www.e-lfh.org.uk/programmes/leading-change-adding-value/>. This tool was developed by Health Education England, NHS England and LCAV partners, working alongside e-learning for Healthcare. The e-learning tool aims to provide an opportunity to

build, or strengthen current knowledge and skills in the understanding of the impact of 'unwarranted variation' on individuals and populations and then help lead the change required to address this. The tool consists of a 20-25 minute e-learning session for all nursing, midwifery and care staff to access. There is also the opportunity to complete a short quiz, gain a certificate of learning in addition to signposts for further reading and resources. By completing the e-learning tool nursing, midwifery and care staff are supported in their understanding of LCAV, which supports colleagues to implement LCAV in practice. To date (6 months post-launch; 26 September 2018), there have been 1201 launches for the LCAV e-learning tool (Figure 1). Early feedback has indicated that those who completed the e-learning tool found it informative and helpful, easy to use and understand. Recognising that not all nursing, midwifery and care staff might have easy access to online resources, the LCAV Operational Team has also ensured that a pdf version is available and this has been and will continue to be distributed to nursing, midwifery and care staff across health and care.

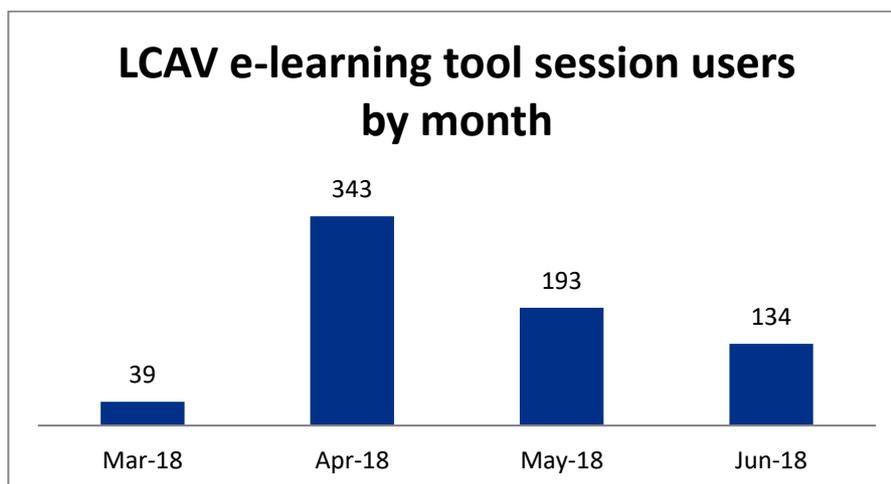


Figure 1: LCAV e-learning tool session users by month.

3.2 Embedding LCAV as 'business as usual': Digital analytics

There is significant evidence to demonstrate that communication and dissemination strategies for embedding LCAV as 'business as usual' have progressed over Year Two. LCAV key engagement and communications activity includes local and national LCAV events, twitter activity, publications, articles, blogs, LCAV films have been published online (LCAV webpages and an NHS England YouTube playlist) and other significant communications to continue to enhance nursing, midwifery and care staff understanding of LCAV.

There are 23 films (circa 3-4 minute films) available on the LCAV webpages which are a combination of case study films and also key personnel providing an LCAV overview. For example, the film of Professor Jane Cummings introducing LCAV has had 10,766 views. A new film has been developed which provides an update on the framework’s progress and this was published on the LCAV landing page on 22 June 2018. There are also 11 ‘twitter clips’, these are shorter films – either snippets of the case study films or talking heads from events such as the LCAV Research Roundtable (described in the National Research Portfolio section of this report). In total, from these 32 short films, there have been 30,784 unique views between April 2017 and April 2018. The LCAV e-learning tool launch in March 2018 resulted in over 1.7m people reached via 423 tweets from 164 different participants. The #Lead2Add activity supported the national launch. Dissemination activity also included a published blog (Aitkenhead and Fenton, 2018) on the NHS England webpages and this was shared across the LCAV Partnership Board membership, with these key stakeholders invited to disseminate the e-learning tool to their own teams, networks and memberships.

A summary of the number of unique LCAV page views is included in Appendix One. There is an increase of unique page views in line with increased dissemination activity, as well as peaks in views when specific LCAV events have been hosted. Figure 2 depicts unique page views on the LCAV webpages between April 2017 and March 2018 as an exemplar.

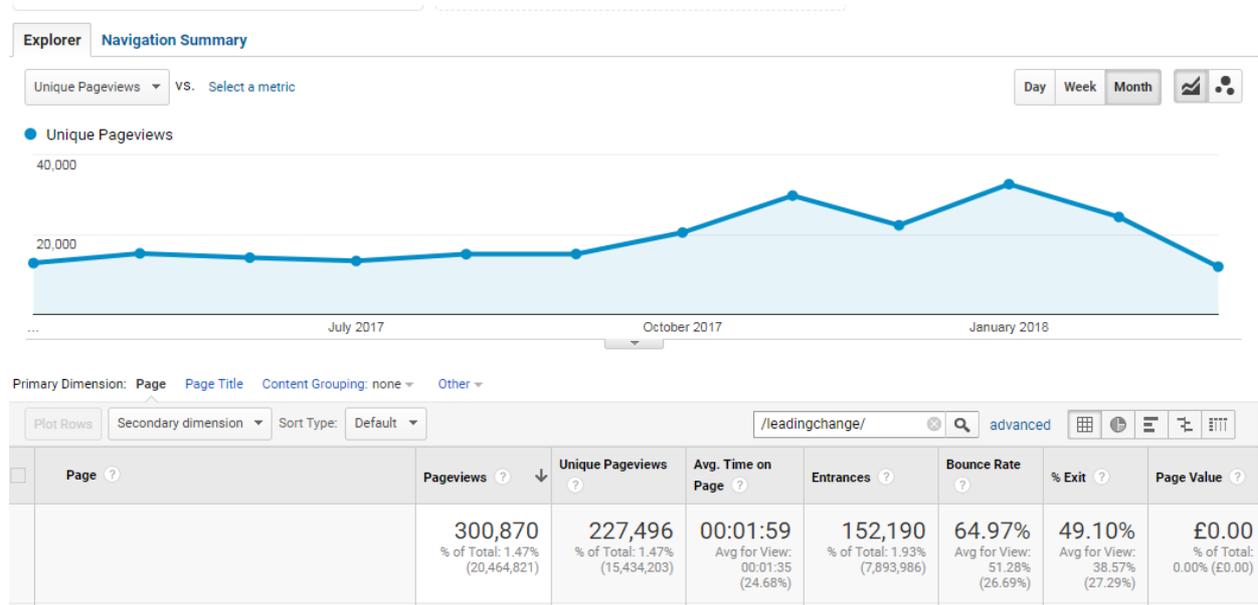


Figure 2: Unique page views on the LCAV webpages between April 2017 and March 2018.

3.3 Embedding LCAV as ‘business as usual’: Dissemination Activity

There has been extensive activity during the second year of LCAV to disseminate the framework and highlight it to nursing, midwifery and care staff. Part of this activity has been

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to publish a series of journal articles focusing on the key principles of LCAV. Appendix Two provides an overview of these outputs along with the current status in terms of the publication process. These include an overview of the first year evaluation of LCAV which is published in the British Journal of Nursing (Zubairu et al., 2018). A Nursing Standard Series to support the dissemination and understanding of LCAV amongst nursing, midwifery and care staff and to encourage them to lead change, wherever they work, whatever their role has been published. As a part of this series, profile pieces have been written by NHS Rightcare (Da Silva et al. 2017) NHS England (Aitkenhead, 2018a), NHS Improvement (Packman, 2018), Public Health England (Bosanquet, 2018) and Health Education England (Fenton et al., 2018), as well as a care sector profile (Blackburn & McCann, 2018) – all as key LCAV partners, each aligning their work to LCAV. There have also been a number of blogs outlining ongoing work within LCAV (Aitkenhead, 2017; Aitkenhead, 2018b; Aitkenhead, 2018c).

As previously mentioned, an LCAV Research Roundtable event was chaired by the British Journal of Nursing. Associated short narrative pieces have followed in the journal to support the promotion of Commitment 7 of LCAV “We will lead and drive research to evidence the impact of what we do” and to demonstrate nursing and midwifery research in practice, which aligns to LCAV. An article from the Editor in Chief at the British Journal of Nursing provided an overview of the LCAV Research Roundtable event along with the proposed process for moving forward (Peate, 2018).

The Chief Nursing Officer (CNO) monthly bulletin provides a specific feature on LCAV to update nursing, midwifery and care staff on recent developments and activities, continuing to disseminate LCAV. Registration numbers for the bulletin are at 1,314 at the time of writing this report illustrating its reach within practice. Recent feedback has reported that the bulletin content is well balanced, with an appropriate tone for staff wherever they work, whatever their role and includes a good balance of case studies. The most recent CNO bulletin had an open rate of 50 per cent (industry average is 26 per cent) and the click through rate was 52 per cent (industry average is 20 per cent). This information suggests that nursing, midwifery and care staff are engaging with the content and LCAV is resonating with frontline staff.

Year Two of LCAV has seen a targeted progression in the number and scale of dissemination events from Year One. These events have aimed and have shown an increased reach of the key messages within LCAV which in turn is increasing its’ ability to become embedded within the practice of nursing, midwifery and care staff. The following paragraphs will provide examples of this dissemination activity.

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The principles of LCAV have been presented as well as having had a stand presence at a number of national conferences. These include, but are not limited to the British Journal of Midwifery Conference, a specific LCAV hosted Care Workers Conference, Royal College of Midwives Conference, and the Royal College of Nursing Conference and the National Safeguarding Conference. Poster presentations on LCAV have featured in other conferences, for example the Hospice UK conference. LCAV was an integral theme at the CNO summit in 2018.

Importantly, there have been many local and regional events across England to also disseminate, explain and promote LCAV in addition to the national events outlined above. This has also been a targeted approach to present at national events and to reach nursing, midwifery and care staff across the country in their local organisations. These events have reached significant numbers of nursing, midwifery and care staff within their local settings and the traction is reflected in the previously described analytics demonstrating increased footfall on Twitter and the LCAV Webpages. This activity has aligned to the principles of matrix working which has underpinned delivery from the start, particularly with the agreed approach that LCAV would be driven at a regional level.

These dissemination activities are important tools in increasing awareness and moving towards embedding LCAV as business as usual – particularly as there is a focus on the dissemination to not only support nursing, midwifery and care staff to help understand the key principles of LCAV (e.g. signposting to the e-learning tool), but also to support staff to implement the framework in their own workplace and to share the success of this work within the AoSL via a good practice case study example. Evidence for this success is clear from the evaluation of the LCAV Care Workers Conference held in October 2017. Of the 250 attendees, over 90% of delegates reported that they felt the conference had improved their understanding of the framework generally and in terms of their capacity to lead change. Figures 3 & 4 provide an example of the delegate feedback.

To support the dissemination of LCAV to frontline nursing, midwifery and care staff, as well as students, a new national partnership using LCAV to improve care has been embedded into events attended by Thomas Whitelaw, a well-respected patient and carer advocate, UK Project Lead for Dementia Carers Voices, Health and Social Care Alliance Scotland. Events are held across England to local and national audiences about LCAV. The links between

Thomas Whitelaw's work and LCAV can be seen here

<https://www.england.nhs.uk/blog/turning-pledges-and-intentions-into-actions/>.

An aim to increase dissemination activity is additionally being addressed via the network of Care Makers who are being offered an opportunity to be supported to spread the message and principles of LCAV; as champions of LCAV. Resources (e.g. presentations) have been developed to reinvigorate the Care Maker network to support dissemination and embedding of LCAV in practice. This has included identifying active Care Makers, arranging regional events, establishing the support that might be needed and enhancing communication channels through means of a bi-monthly e-mail update, and direct communication with the LCAV Team Coordinator to share LCAV resources to support their work (e.g. LCAV badges, lanyards, summary documents and .pdf versions of the learning tool). Figure 5 demonstrates the impact of activity when an LCAV specific event is held. This was the Twitter activity in October – with particular note to the LCAV Care Worker Conference on 17 October 2017.

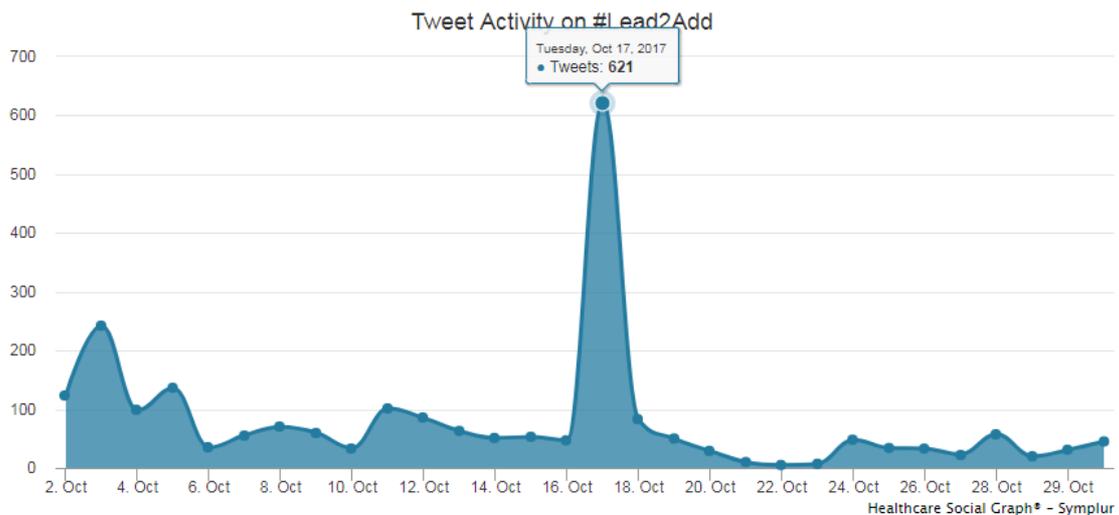


Figure 5: A demonstration of Twitter Activity associated with LCAV following an event aligned to the framework.

It is too early to determine whether the strategy for dissemination is effective with regard to embedding LCAV as business as usual at this stage, but it certainly seems to gather traction and widen the reach of LCAV to nursing, midwifery and care staff.

3.4 Partnership working

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During the second year of LCAV, as it has moved from launch and landing, towards embedding and implementation in practice, the LCAV framework continues to demonstrate strong partnership working.

The Leading Change, Adding Value Framework was published after key stakeholder engagement and endorsement for a framework that demonstrates the key contributions nursing, midwifery and care staff make in the delivery and support of health and care within a challenging and complex system. Based on this whole system endorsement, the foundation that LCAV was built on – in co-development and now co-implementation is crucial. This is a shared national publication for nursing, midwifery and care staff where there is no LCAV 'mandate', there is a shared professional accountability of the LCAV Partnership Board and LCAV Regional Support Group members to showcase the professions' contribution and to demonstrate key leadership opportunity and responsibility, wherever they work, whatever their role.

An intrinsic component of the co-development and now co-implementation of LCAV, was matrix-working, with the framework being delivered regionally, to ensure that the work is bespoke to local needs but is also supported to maturity to be disseminated nationally. A concerted effort of the LCAV Regional Support Group, which is rotationally co-chaired with ALB partners, is to support this framework as regionally led. With all of the above taken into consideration, it is clear that the implementation phase has been intentionally gradual, and that it is recognised and supported as being a way of working which can subsequently be embedded as business as usual across England rather than seen as being potentially a time-limited piece of work. Throughout this narrative, there are implicit examples of the structured, matrix-working approach to disseminate the framework and the development of resources to support and enhance understanding of LCAV.

Additionally, the Council of Deans of Health is co-chairing the Task and Finish Group set up to develop the *National Research Portfolio*. The Council of Deans of Health are members of the LCAV Partnership Board and co-hosted a research roundtable event focusing on LCAV. Together this partnership strengthens the academic rigour of LCAV and supports in advocating the research and evidence based commitment of LCAV. There is a clear ambition and focus within LCAV to work with academic colleagues to have true academic rigour in the approach. This is most clearly apparent in the evidence based style that is advocated throughout the framework, with a clear steer towards improvement methodology and parameters. LCAV advocates research capacity and academic leadership across nursing and midwifery and considers how nursing and midwifery staff can be optimised in their roles,

all with a focus on evidence-based practice. The framework may also act as a vehicle to support the huge appetite from nursing and midwifery clinical academics to provide a gateway to integrated health education, research and clinical practice.

3.5 National Programmes of Unwarranted Variation in Practice

In the LCAV framework document, a series of national pieces of work are presented, signposting to large-scale programmes of change, which have a component of alignment to LCAV, notably in terms of identifying and addressing unwarranted variation. This section provides a brief summary of activity in these programmes which showcase nursing, midwifery and care staff leadership at a national and regional level.

The Improving Wound Care programme led by the Regional Chief Nurse in the North has provided supporting evidence that the number of full wound assessments being provided in line with the guidelines is approximately 40% (ranging from 0 – 100%) which is in line with the published research evidence. Continued improvement targets have been laid out for the coming months. Workshops have been held with the aim of developing ideas to support providers increase the number of wound assessments being completed. A national wound care strategy is being developed and is in initial planning stages.

Within the Public Health England-led 'Smoking reduction in mental health' programme, there has been significant development of a series of resources to support mental health trusts to go smoke free. Fifteen mental health trusts have completed the smoke-free tool so far (June 2018). These resources are soon to be added to the LCAV webpages for colleagues to access and utilise in their workplace – providing continued support for nursing leadership across the country.

The NHS England led Continuing HealthCare programme has conducted a review of the skills and confidence of continuing healthcare staff. The programme has provided recommendations, and examples of good practice which will continue to be shared as a resource for CHC teams and staff. These recommendations and examples will inform their 'pathway tool box' which is in development and has supported the update of the CHC learning tools.

The LCAV Learning Disabilities Unwarranted Variation programme prioritised four health conditions for 2017-2018: diabetes, dysphagia, epilepsy and heart disease. Within each of

these areas guidance has been updated to improve the quality of care and support evidence-based adjustments to mainstream pathways.

The Unwarranted Variation for Looked After Children (LAC) project has sought to address the unwarranted variation in health outcomes for LAC across England. Work within area this focussed upon standardising the approach to commissioning and delivery of statutory LAC health assessments, providing 16 and 17 year old care leavers with Health Summaries, strengthening communication pathways between regional and national LAC forums along with the provision of resources for professional and young people regarding Unaccompanied Asylum Seeking Children.

Within maternity services developments can be seen in the *Continuity of Career programme*, in terms of aiming to increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally. Progress has been made in terms of the development of national guidance and educational material for midwives in the form of a learning module.

Midwifery services have also seen a *new system of midwifery supervision (A-EQUIP)* being developed and disseminated with its implementation phase nearing completion. This has been an excellent example of work being rolled out for larger scale change.

3.6 Atlas of Shared Learning

One of the key products of LCAV is the *Atlas of Shared Learning (AoSL)*. The foundation of the AoSL was published in July 2018 and will continue to be populated with case studies throughout the remainder of the framework with an aim of including at least 200 examples of nursing, midwifery and care staff identifying and addressing unwarranted variation in practice. This resource will demonstrate this transformational change at national, regional and local levels, and particularly the quantifiable contribution to the FYFV and other national, regional and local initiatives. To share best practice and help inspire similar work there is a dropdown function to allow users to not only search using a keyword search, but also to search for case studies that reflect the setting they themselves work in across health and care.

This AoSL platform will be hosted on the LCAV webpages, on the NHS England website which also provides a library of resources to support nursing, midwifery and care staff to understand how to identify and address unwarranted variation as well as other key principles

of the LCAV framework. These LCAV case studies demonstrate how nursing, midwifery and care staff have led change to address these principles, including how they have measured the impact of their work, tackling the triple aim outcomes and narrowing the three gaps described within the Five Year Forward View. This will showcase the transformational change and quantifiable contribution which nursing, midwifery and care staff have provided as leaders of change and aims to strengthen the evidence base of the professions' contribution. These exemplars are in the form of written case studies and short films, and while recognising the multi-disciplinary nature of work highlight the leadership of nursing, midwifery and care staff. Over 100 case studies have already been received and are being quality assured by the LCAV Operational Team to ensure that they do map across to the principles of LCAV. Case studies are presented in more detail later in this report. To support users, a settings search function is available, as well as geographical search function and a free-text key word search. By using a geographical reference point, regional and local initiatives can be identified and shared, as well as providing a national picture of leadership and addressing unwarranted variation in practice.

3.7 National Research Portfolio

LCAV has a strong research focus running concurrently through it and there is a specific research commitment – number 7 – “We will lead and drive research to evidence the impact of what we do”. LCAV was developed to help nursing, midwifery and care colleagues truly consider the outcomes of their work and question whether their actions always make a measurable difference to experience, outcomes and the use of resources. The National Research Portfolio is being developed in close collaboration with the Council of Deans of Health and other relevant partners. A short-term Research Portfolio Task and Finish Group has been established to support the development of the portfolio. As has already been firmly established through the case studies and the Atlas of Shared Learning, LCAV asks that the same importance is applied to quantifying and measuring the outcomes of the work of nurses, midwives and care staff, as is applied to demonstrating quality and compassion. Applying both together should not be mutually exclusive and LCAV was developed to look at reducing unwarranted variation, and help nursing, midwifery and care staff to truly consider the outcomes of their work and question whether their actions always make a measurable difference to experience, outcomes and the use of resources. Through showcasing nursing and midwifery led work that have utilised research principles, the National Research Portfolio provides a clear demonstration of academic rigour and a platform on which to advocate clinical academic pathways.

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The portfolio aims to support the implementation of Commitment 7 and to further increase the visibility and impact of nursing and midwifery research. This resource aims to help raise the profile and disseminate examples of completed nursing and midwifery research in practice. It will also aim to signpost colleagues to any gaps in nursing and midwifery led research which addresses the priority areas of the FYFV (NHS England, 2014) and other national, regional and local initiatives. This work is in its infancy, but will be a key product of LCAV.

In December 2017, a Research Roundtable was held, and co-hosted with the Council of Deans of Health to discuss key priorities for nursing and midwifery research in England. During the roundtable, colleagues reflected on a shared interest in increasing research and academic leadership across nursing and midwifery and considered how nursing and midwifery staff can be supported in their roles, all with a focus on evidence based practice. The research roundtable focused on how these components directly align to Leading Change, Adding Value as the national framework for nursing, midwifery and care staff. This work recognises an ambition of LCAV in increasing research capacity and academic leadership across nursing and midwifery and considered how nursing and midwifery staff can be optimised in their roles, all with a focus on evidence-based practice; this objective is pivotal in undergraduate and post-graduate discussion and understanding.

4.0 Case Studies aligned to LCAV Principles

This section outlines the progress made in developing the evidence base for the quantifiable contribution of nursing, midwifery and care staff in terms of identifying and addressing unwarranted variation to deliver the Triple aim outcomes. The evidence presented here consists of a series of case studies and moving into year three this will be supported with additional examples of the quantifiable contribution of nursing, midwifery and care staff.

The LCAV Operational Team continues to seek case study examples from nursing, midwifery and care staff for the Atlas of Shared Learning. A case study template is used:

<https://www.england.nhs.uk/publication/leading-change-adding-value-case-study-template/>.

Following any submission to the LCAV Operational Team, there is a rigorous quality assurance process in place to truly demonstrate the leadership and quantifiable contribution of nursing, midwifery and care staff to transformational change across health and care and how this work aligns to the key principles of LCAV such as identifying and addressing unwarranted variation and tackling the triple aim outcomes.

To date, a total of one-hundred and twenty one (121) case studies have been submitted by nursing, midwifery and care staff across England. A quality assurance process is ongoing by the LCAV Operational Team, to ensure the examples align to LCAV and have demonstrable outcomes. The following sections of this report will comprise of a review of 50 of these case studies including common themes being identified, highlighting key constructs of LCAV. The themes are: LCAV in action; nursing, midwifery and care staff leadership; Working across traditional boundaries; Developing quality improvement methodology; and Developing the evidence-base. Verbatim quotes from the case studies will be used for illustrative purposes.

4.1 LCAV in action

In the following section the depth and breadth of LCAV achievements is illustrated by identifying a number of specific case studies from across the nursing, midwifery and care professions and across the field of practice within nursing. These specific case studies have been summarised below:

Improving vaccination uptake by changing the way pregnant women were offered and accessed services

The midwifery team at James Paget University Hospitals NHS Foundation Trust created a process which increased the number of pregnant women being vaccinated against influenza and pertussis (whooping cough), providing vaccinations at services they were already accessing. Vaccination rates have achieved 76% coverage for influenza and 80% for pertussis, a significant increase in the rates achieved in primary care (both previously below 40%). Feedback from women was positive. By being offered vaccines at a time when they would be at an important appointment in their pregnancy anyway, they received an enhanced care option with no further need to access other services for their care. Midwives were able to offer an improved service within existing resources provided. The key shift was reorganising the way services were delivered to these women.

An urgent call communication checklist and training package for care homes

Nurses within South Norfolk CCG supported residential and nursing homes to reduce avoidable hospital admissions. They developed a checklist and trained care staff in its use, to help them when making urgent calls to other services. There are fewer urgent calls as a result, as the care staff feel better equipped in making decisions on which services a resident needed – meaning calls were only made when appropriate to do so. Initial ambulance data indicates that following the training package, call volumes in two of the CCG areas reduced by 30% and 50% respectively. An A&E audit over one weekend confirmed that 100% of care

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home calls were made appropriately, from those who had received the training. It also showed that 15% of the actual admissions were considered avoidable and was linked to those care homes who were yet to receive the training package. Care home staff are being surveyed to assess any changes in their experience and confidence. Training has also been given to informal carers at a local GP practice with very positive feedback supporting the model of care closer to home. Unplanned emergency admissions have fallen by 22% in South Norfolk, with smaller reductions in the other two local CCGs. This is encouraging, but should be viewed within the broader context of other admission avoidance work.

Introducing a Dementia Support Service' in Somerset Partnership NHS Foundation Trust

Led by their team manager and working closely with the Project Lead, mental health nurses at Somerset Partnership NHS Foundation Trust set up a new community-based Intensive Dementia Support Service (IDSS). It has had a significant positive impact on patients, carers and colleagues – providing interventions at point of crisis in the person's usual place of residency, with the aim of reducing admissions to an older person's mental health ward. Feedback has been positive from community mental health colleagues, care home staff and from patients and carers. Previously likely hospital admissions have been prevented and a small number of early discharges have been facilitated. Carers have also benefited from regular advice and support. Patient stories have been captured which tell how the IDSS has made observable differences, particularly noting the reduction in number of services needed and minimising the number of 'moves' a patient makes in their journey of care, streamlining their care. Patients and carers have reported an improved experience as a result of IDSS involvement, frequently citing the extended operating hours that enable visits at convenient times, and that people can stay in their usual place of residence. Staff have quickly adapted to their new roles and there has been a noticeable improvement in partnership working across the teams involved in providing care. Reducing hospital admissions is a more effective use of NHS resources. Referral processes have been streamlined. All staff now have mobile phones and laptops to use for work and to assist them to operate remotely and make timely, accurate records of visits and have had community return on investment (RIO) training.

'Increasing neonatal palliative care support', Rainbows Hospice and Cope Children's Trust, Leicestershire

A Children's Nurse at Rainbows Hospice has created a new service to help and support families across the East Midlands region who experience the death of a baby before, during or shortly after birth – forging links across services and raising the awareness of the end-of-

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life-care services available from Rainbows. Following a successful pilot project, a Children's Nurse at Rainbow's Children's Hospice, developed the Neonatal Link Nurse role – which has already received 40 referrals in the first 12 months (to December 2017) across the East Midlands. Close collaboration has been established with several of the hospitals across the East Midlands, including University Hospitals of Leicester NHS Trust. Communication with regional services across health and care has improved to make them more aware of what the hospice can offer. An increase in neonatal hospice referrals has given families greater choice about place of care, both at Rainbows and at home – notably given the earlier presented figures, this is often out of hospital. Families have more options in how they are supported to care for their baby at the end of their life, and after death. The new care pathway is also expected to bring major benefits in streamlining the experience of the families involved. The strengthening of the partnership and joined-up working between the NHS and third sector is creating a more robust and flexible neonatal palliative care system.

All of these examples, plus others, feature in the Atlas of Shared Learning (launched July 2018). The case studies demonstrate that there are a multitude of examples which showcase LCAV in action across nursing, midwifery and care, representing different fields of expertise and geographical regions across England. There are examples of case studies within a multitude of settings including but not limited to midwifery led care, including 'Improving vaccination uptake to protect mother and baby' from midwives at St James Paget University Hospital and care staff led care by developing 'An urgent call communication checklist and training package for care homes' in South Norfolk.

Equally, different fields of practice within nursing are represented in the case studies. For example, mental health nurse led care through 'Introducing an intensive Dementia support service' in Somerset Partnership NHS Foundation Trust and neonatal nurse led care via 'Increasing options for neonatal palliative care support', Rainbows Hospice and Cope Children's Trust, Leicestershire. Focus on children's services was seen in examples of change such as 'Let's get kids fit- an integrated targeted intervention to prevent obesity in infants, Black Country Partnership Foundation Trust. The field of Adult nursing provided examples such as 'Share your Dialysis' aiming at increasing patients understanding of their condition and treatment, Nottingham University Hospitals Trust.

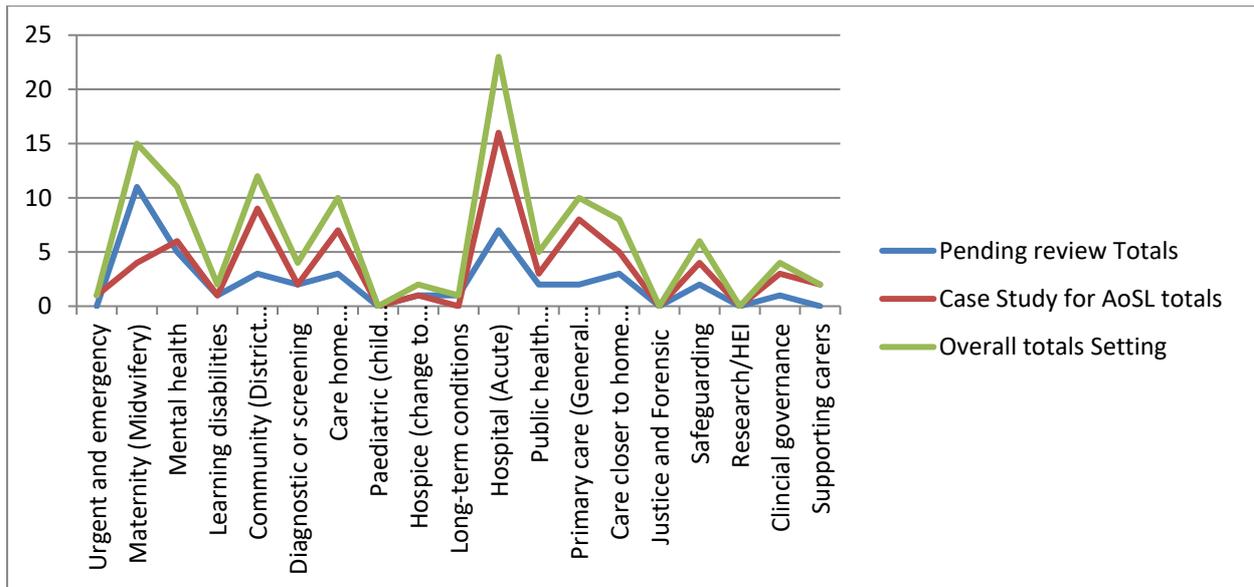


Figure 6: Overall totals of case studies split by setting (those under review as well as selected for the Atlas of Shared Learning, to date, June 2018).

Case studies also represented a wide geographical representation across England with those meeting the criteria for publication in the Atlas of Shared Learning showing work at both a regional and local level. Furthermore, there were exemplars truly demonstrating joined-up partnership working across different organisations, disciplines and services which is extremely positively received. This could be seen in examples of working across traditional role boundaries such as setting up new multi-disciplinary teams and developing partnerships between organisations and across sectors, for example, Higher Education institutes and health service providers. The value of developing partnerships and working across traditional boundaries was recognized, within and across health and care sectors which aligns to Sustainability Transformation Plans and demonstrates the synergies to the national transformation agenda:

'The importance of partnership work cannot be underestimated in improving patient care.'
Falls Prevention Team Lead, West Yorkshire.

The case studies also illustrated examples of partnerships and new closer working practices being developed between different professional groups within an organisation, for example between nursing staff and pharmacy staff within a Trust. Taken together, the case studies show LCAV in action across traditional professional boundaries and across professions. It also shows how LCAV has landed in the health and care system and the implementation by way of examples of improvements from across England at a national, regional and local level. This is a testament of the success of the LCAV framework, so far – the clear synergies

with national, regional and local priorities and approaches and how the framework advocates leadership at all levels to implement change when unwarranted variation is identified.

In reviewing examples of LCAV in action, the extent to which they align to key principles within other national policy documents and initiatives was important. Specifically, the case studies reviewed gave examples of how they are explicitly aligned to LCAV and the FYFV in terms of narrowing the three gaps of health and well-being, care and quality and funding and efficiency, by identifying and addressing unwarranted variation in the workplace.

Unwarranted variation was clearly referred to all of the case studies reviewed, although there was variability as to how this was identified and defined within the case study description. In the case studies which provided a clearer account of their link to unwarranted variation reference was made to an evidence base, or an evaluation that had completed, a small number had utilised the NHS RightCare *Atlas of Variation* (accessed [here](#)) to provide evidence for the unwarranted variation and the need for change.

Working in partnership, the synergies between NHS RightCare and LCAV encourage nursing, midwifery and care staff to lead change, driven by a focus on reducing unwarranted variation in practice, and in this particular example, to redirect resources towards better quality care. Betty's story is an early LCAV example of truly 'quantifying' nursing practice with robust data and is a product of the Improving Wound Care Programme.

Successful partnership working can be well observed in 'Betty's story', which demonstrates an equal evidence of not only the personal but the strong economic case for change and the subsequent benefits in line with the triple aim outcomes. For further information:

<https://www.england.nhs.uk/rightcare/wpcontent/uploads/sites/40/2017/01/nhs-rightcare-bettys-story-narrative-full.pdf>

4.2 Nursing, midwifery and care staff leadership

As LCAV continues to be disseminated and embedded in practice, the case studies are becoming more sophisticated and stronger, often utilising a quality improvement methodology and employing quantifiable metrics in order to demonstrate success. This could be an indicator of enhanced understanding and a move towards LCAV being embedded as business as usual – all showcasing nursing, midwifery and care staff leadership.

There were many different examples of nursing, midwifery and care staff leadership, including but not limited to:

- setting up new services or pathways
- establishing new team structure or working practices;

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- conducting further staff training;
- developing new risk assessment tools and clinical pathways.

Larger scale examples of change had been rolled out across NHS Trusts, provider and commissioner organisations or geographical regions, whereas smaller scale implementations of LCAV included in the case studies was confined to a particular clinical area or site. Both small and large scale change are seen as equally important under the LCAV ethos.

It is beyond the scope of the process evaluation and the parameters of LCAV work generally to be aware of all of the work aligned to LCAV and nursing, midwifery and care staff led work embedding LCAV in practice. However, the work presented here is extremely positive and demonstrates that both small scale and large scale change is being effectively implemented. As depicted by the wide-spread examples, there are regional priorities being tackled and are they showcased in the Atlas of Shared Learning. This is a key strength of LCAV being delivered regionally as it can support dissemination nationally, but the matrix-working approach ensures that by being regionally led, the framework can be a vehicle for change, locally too. It is considered that this approach will enhance the opportunity for LCAV to be embedded as business as usual with the regional leads and other key stakeholders identifying case studies for the Atlas of Shared Learning.

Similarly, the role of staff leading the case studies varied which immediately depicts an overarching ethos of LCAV; anyone can lead change, whatever their role, wherever they work. There were examples of unwarranted variation being identified and addressed, led by a variety of staff both registered and non-registered staff at a range of levels in their organisations and at varied stages in their careers; healthcare assistants, student nurses, staff nurses and specialist nurses amongst others.

A key feature of many of the case studies was the ‘snowball’ effect of the change. Many case studies described how the change was going to be, or already had been, rolled out to other local organisations and neighbouring areas – often piloted and then due to demonstrable quantitative success in achieving better outcomes, better experience and better use of resources, was scaled up and made mainstream clinical practice:

*‘It is possible to achieve significant positive change from comparatively small beginnings.’
Neonatal link nurse, Rainbows Hospice and Cope Children’s Trust, Leicestershire*

These examples continued to show synergy with the ethos of LCAV in terms of transformational leadership and the opportunities that can develop from small changes growing and gathering momentum to affect larger change, particularly by measuring the impact the change has made. This will be further investigated in the year 3 evaluation for a more detailed review. Within the case studies, reference was made to the impact that either being involved in leading the change or working within the environment had on the working experience of staff:

'one of the most rewarding aspects of this project has been the positive involvement of staff who have felt both engaged and empowered to make successful changes which have achieved better outcomes for patients and an improved sense of well-being for staff.' Project Manager (Nurse), NHS North Tyneside Clinical Commissioning Group

The importance of compassionate leadership and the commitment of staff to improve patient care and contribute to a culture for innovation and high quality care is well recognised (West et al, 2017). In other case studies, positive feedback provided by individuals regarding an improved experience as a result of the work undertaken to reduce unwarranted variation was also described to contributing to a better staff experience. Whilst much of the evidence of positive impact on staff within the case studies was anecdotal in nature, it is vitally important to recognise nonetheless.

4.3 Working across traditional boundaries

Nursing, midwifery and care staff leaders as to be expected involved others in the work. This may have been engaging staff to support the implementation of the work, seeking support and guidance from a senior colleague to put the work into action, or to formally collaborate with other team members to ensure the work could be rolled out – linked to national encouragement for integrated and joint working practice (e.g. Care Quality Commission; CQC, July, 2018). For instance, this proved important in terms of initiating conversations with others; both within the clinical/practice setting and / or reaching out to other settings in the care pathway:

'another learning outcome was the importance of finding allies. Like-minded staff within clinical areas who would work with us as champions to promote the new way of working. Keep finding allies and you quickly build an army to help change the culture.' Lead nurse, Sandwell and West Birmingham Hospitals NHS Trust.

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This model helped in terms of benchmarking good clinical practice and sharing the evidence-base and need for change:

'It is important to listen and understand the concerns of both staff and carers. Each ward had to come up with their own way of implementing the change so they feel some ownership of it.' Carer Lead, Patient and Carer experience, Lister Hospital, East and North Hertfordshire NHS Trust.

Approaching change in this manner also encouraged ways in which the change could be communicated between staff to help ensure an increased awareness and understanding of the change and in turn help its sustainability and continued improvements in the quality of care. This was illustrated within the case studies:

'Staff involvement in all stages from designing to implementation is crucial as at the end of the day they are the ones who are going to need to drive the change and deliver it' The Transformation Team, James Paget Trust, East Coast.

It was recommended to have:

'Early engagement with staff in the process as it was such a large change within their working practices; this created anxieties which could have been avoided. Engage as early as possible with all stakeholders, this can avoid any potential barriers to the change.' Medicines Management Pharmacy Nurse, Leeds Teaching Hospitals NHS Trust.

Central to involving others in the change was gaining support from management and leadership within the local organisation and beyond. In many cases this was supported by providing evidence of the unwarranted variation and how addressing the variation could lead to improvements.

4.4 Developing a quality improvement methodology

The case studies illustrate evidence of aspects of an emerging quality improvement methodology. One example of this is that some case studies have commenced with a pilot. After piloting the change was reviewed in order to evaluate its impact. The value of this approach was emphasised within the case studies:

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'it is important to involve all the stakeholders, and to complete small scale pilot which can be reviewed, audited and then changed if necessary'. Tissue Viability Specialist Nurse, Tissue Viability Team, East Coast Community Healthcare Norfolk

Other case studies highlighted that prior to introducing the change and in order to gain further intelligence on where and how the change needed to be made an audit was completed. This resulted in a clear rationale to support the change and establish the evidence of what the change might need to address. Further examples of engagement to support this information gathering process included conducting surveys and holding focus groups and open events.

A number of case studies were able to provide a set of objectives which were used to base an assessment of measuring success. There were also examples of those leading the change reviewing key documents such as quality assurance frameworks from other sectors to identify what key points might or might not be relevant in their change. This indicates an awareness of wider perspectives and consultation beyond traditional frames of reference.

Particular models of establishing change were referred to in some case studies, for example:

'using the listening into action approach of involving staff in problem-solving and transformation.' Clinical Lead Red2Green, Leicester NHS Trust

Further examples included the use of Plan, Do, Study, Act (PDSA) cycles within the change. In that case there was emphasis on the:

Importance of following a quality improvement tool to test the innovation and change in practice, allowing time to assess its impact and effectiveness before making a change on a larger scale' Practice Development Matron, Nottingham University Hospitals NHS Trust.

The importance of evaluation of change is key in terms of developing a quality improvement methodology. This will be explored further within the theme, 'Developing the evidence'. The practice of conducting an evaluation of the change to provide supportive evidence as to its impact can be seen in several ways. Examples within the case studies reviewed include audits, focus groups, surveys to assess changes in staff experience and levels of confidence. The value of evaluation was explained:

'Making a continuous evaluation has helped the project to be more flexible and adaptable to the results being achieved. It also provides regular opportunity to celebrate and promote the project and get more people engaged.' The Transformation Team, James Paget Trust, East Coast.

There were several examples of methods of evaluation being carried out before and after the change to try and establish its impact, for example 'Let's get kids fit'- an integrated targeted intervention to prevent obesity in infants', Black Country Partnership Foundation Trust and the 'Introduction of flexible visiting', Aintree University Hospital NHS Trust. Support for these stages of work is provided by the LCAV Framework. The practice of a baseline audit which is repeated after the change is introduced can provide useful evidence of its impact, notwithstanding the difficulty of accounting for other variables. The progress of the changes reported within the case studies varied; some examples were still at the piloting stage whereas other had progressed further and were more established within the clinical area which allowed more opportunity for evaluation. There is recognition in the LCAV framework that this would be the case, given the implementation of many of these pieces of work will be longitudinal in nature. There is a suggestion within these examples that LCAV has supported staff to view information and data differently and this will continue to be explored at LCAV is further embedded in practice.

4.5 Developing the evidence base

A variable within the case studies examined was the level of quantifiable evidence available to support the identification of unwarranted variation at the outset as well as the subsequent success and outcome of the change, particularly in relation to the Triple Aim outcomes.

The case studies which provided greater evidence to support a demonstrable contribution did this by referencing impact on areas such as:

- referral rates,
- increased uptake in vaccination numbers,
- numbers of screening and assessments carried out,
- reduced lengths of hospital stay,
- reducing bed occupancy rates and reduction in admissions.

In these case studies, they were able to provide data to provide support the results and commentary on where improvements had been made. A number of case studies were then able to translate their impact to better use of resources, for example in relation to re-allocating services to more appropriate times / locations for patients or signposting

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individuals to the right care at the right time by way of streamlining a care pathway. However, other case studies did refer to these improved variables but did not provide any quantifiable figures to show the extent of the improvement, for example, that there was a reduction in hospital admissions or length of stay but with no quantification of that contribution – it may be that the results were not yet evaluated and this information was more anecdotal. However it would be warranted to return to these case studies to hear more about their improvements as things progress. It is also accepted that the key principles in LCAV is a new way of working for many and that this change in culture is difficult to quantify in terms of data and will be a gradual shift in practice. Of course, many colleagues already do this as part of their everyday practice, however, much of this essential work can often remain hidden or misunderstood, as some of it is not easily measured, captured or shared.

Other case studies were able to refer to evaluations which have been conducted that focused on the change. There were examples of more longitudinal evaluations over a six-month period and also examples of case studies which were able to measure their impact on a month-to-month basis, as well as some evaluations demonstrating added value at one-time point and not yet followed up thereafter. Those case studies who provide this level of 'hard data' were able to more definitively support the impact of the change from a quantifiable perspective and LCAV advocates this robust approach, applying the same importance to quantifying the contribution of nursing, midwifery and care staff as is done to the quality and care that is provided.

Several examples utilised a qualitative research methodology such as focus groups and qualitative questionnaires in addition to quantitative measures, or indeed in place of which is positively received. These appear to have been primarily used to review experience of staff or patients in relation to the change. However, anecdotal evidence is referred to within many of the case studies such as gaining positive feedback from colleagues, patients and carers for the change. Reference was made in many case studies to an increase in understanding of aspects of care from the individual's perspective along with that of their family/carer/friends/significant others. There was also an acknowledgement as to how the change had helped, and how a positive difference had been made, however further data is needed to substantiate this claim. The LCAV framework recognizes that this will be a new way of working for many and that some of the principles, such as using evidence to identify and address unwarranted variation, may be unfamiliar to some using the framework. The resources such as the e-learning tool described earlier in this report have been developed to provide an opportunity to build, or strengthen current knowledge and skills in the understanding of the impact of unwarranted variation on individuals and populations and then

help lead the change required to address this and moving forwards will continue to support nursing, midwifery and care staff to lead change, and add value.

In a number of case studies it is difficult to account for the different variables which may affect patient outcomes, use of resources and patient and staff experience. Here, clinical outcomes might need to be reviewed over the longer term and will be multi-faceted. In addition, the nature of some of the changes, particularly those which focus on prevention, before people access a service, might experience difficulties in providing quantitative data to demonstrate the impact that they have made – but qualitatively they are able to share the success of the implementation.

5 Conclusion

This interim report has illustrated the commendable ways in which nursing, midwifery and care staff have started to adopt the LCAV framework and the varying nature in which LCAV has progressed during the second year, since the May 2016 launch. It is clear that there have been positive advances in terms of LCAV being translated as 'business as usual' within clinical practice. This has been evidenced by an increase in the quantity and range of dissemination activities within the LCAV programme. Journal publications, bulletins and other media outlets have supported the dissemination of LCAV to a range of clinical audiences; all nursing, midwifery and care staff wherever they work, whatever their role. Social media and LCAV webpage activity have supported this dissemination and advocated the implementation of LCAV in practice. The use of digital analytics provides the evidence of the impact this has made over the second year.

There have also been significant developments in terms of key end products LCAV, such as the LCAV e-learning tool (launched March 2018); the Atlas of Shared Learning (currently being populated with LCAV case studies, launched Summer 2018) and the National Research Portfolio (in development with a task and finish group, to be launched Spring 2019). From a research perspective, the National Research Portfolio presents an opportunity to showcase and support the development of nursing and midwifery led research to identify and address unwarranted variation. As these vehicles of change become established, their reach and impact on nursing, midwifery and care staff in terms of support to implement LCAV as business as usual will amplify. From reviewing the LCAV activity within Year Two, it is evident that strong partnership working and supporting frontline staff in understanding the key principles of LCAV have presented opportunities to progress and establish the framework, both ensuring reach to a wider audience and also in implementing these

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principles in practice. As LCAV moves forward within today's complex system of modern healthcare, the value of having a single framework that works across professions providing a clear vision is valuable.

The case studies reviewed illustrated valuable examples of LCAV in action and provided evidence of changes made, aligned to the LCAV framework, across the country, led by nursing, midwifery and care staff in many different roles and settings. There was evidence of a developing quality improvement methodology included within the case studies which links to the more general service improvement agenda as well as a key element advocated in the LCAV framework. It would be warranted to continue to provide nursing, midwifery and care staff with signposting to the [National Atlas of Shared Learning](#), [LCAV e-learning tool](#) and the National Research Portfolio to support them to identify and address unwarranted variation using an evidence base.

An important principle of LCAV, which was showcased well within the case studies, was the leadership of nursing, midwifery and care staff. One area in which the case studies were more variable was how the evidence of unwarranted variation and the quantifiable measurement of success was collated and presented. Overall, the case studies provided some useful examples of how nursing, midwifery and care staff have translated the framework into practice, by establishing improvements in patient outcome, patient experience and better use of resources. Moving forward, establishing how this impact might be evidenced consistently is an important next step.

The developments within Year Two have provided a background for the next phase in the evaluation of LCAV in terms of further qualitative and quantitative methodology. Year Three will focus on evaluating LCAV from the perspective of staff within four case study sites to provide a picture of how LCAV is understood, implemented and can be embedded by nursing, midwifery and care staff on the frontline, including primary care and community care as well as care sector colleagues. This final stage in the evaluation will gain important perspectives from clinical staff working within those sites and provide further insight as to the impact, evidence and sustainability of the key principles of Leading Change, Adding Value: a framework for nursing, midwifery and care staff.

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7 Appendices

7.1 Appendix One: Dissemination: List of publications

Title	Journal	Accessed by:
Exploring unwarranted variation through the RightCare programme	Nursing Times	https://www.nursingtimes.net/clinical-archive/leadership/exploring-unwarranted-variation-through-the-rightcare-programme/7022339.article
Nursing Standard Series to support the dissemination and understanding of LCAV amongst nursing, midwifery and care staff and to encourage them to lead change, wherever they work, whatever their role:		
Framework for change: supporting you to drive improvement	Nursing Standard	https://rcni.com/nursing-standard/features/framework-change-supporting-you-to-drive-improvement-125076
National framework for nursing, midwifery and care staff will ensure our contribution is recognised	Nursing Standard	https://rcni.com/nursing-standard/opinion/comment/susan-aitkenhead-national-framework-nursing-midwifery-and-care-staff-will-ensure-our-contribution-125111
A clear vision of health promotion for nurses and midwives	Nursing Standard	https://rcni.com/nursing-standard/opinion/comment/joanne-bosanquet-a-clear-vision-of-health-promotion-nurses-and-midwives-127101
A team approach to reducing inpatient falls	Nursing Standard	https://rcni.com/nursing-standard/opinion/comment/zo%C3%AB-packman-a-team-approach-to-reducing%C2%A0inpatient-falls-127141
Variations in healthcare: how you can help close the gap	Nursing Standard	https://rcni.com/nursing-standard/opinion/comment/variations-healthcare-how-you-can-help-close-gap-133766
Leading Change, Adding Value releases the potential of care workers	Nursing Standard	https://rcni.com/nursing-standard/opinion/comment/sharon-blackburn-and-stacey-mccann-leading-change-adding-value-releases-potential-of-care-workers-127171
A process evaluation of the first year of Leading Change, Adding Value	British Journal of Nursing	https://www.magonlinelibrary.com/doi/10.12968/bjon.2018.27.14.817
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