



Improvement

National 'Stop the Pressure' Programme

Update: May 2017

We are delighted to write to you to highlight some of the outstanding work supporting improvements in care for your patients through the Stop the Pressure campaign, and to highlight future developments for pressure care. You have all achieved so much with your continued passion and commitment to good outcomes for patients that we would like to thank you personally for this. We are always inspired visiting your organisations and engaging with staff to learn about the innovations in practice and improved outcomes for patients: please keep this up. We are always keen to celebrate your great work.

The last few months since the relaunch of the Stop the Pressure programme have been exciting and busy. This is to update you on those developments, highlight improvement drives with which we will support you with over the next year and tell you how you and your teams can be involved.

Developments in the 'Stop the Pressure' programme likely to affect you in the coming months are:

- a revised approach to reporting and measuring pressure ulcers
- use of the Patient Safety Thermometer
- a pressure ulcer national audit tool
- the launch of an improvement collaborative
- active support in sharing of good practice
- a new pressure damage curriculum.

Other work will emerge from the programme too. This update also contains feedback on your improvement plans, which we have shared with our regional quality teams.

We relaunched the 'Stop the Pressure' programme in November 2016 as a national improvement initiative building on work in the Midlands and East region in 2012: despite progress since 2012, performance had reached a plateau. The new programme includes acute and community settings in collaboration with partners in social services and care homes.

Definition and measurement workstreams

Evidence shows there is not a consistent approach across England to defining and measuring pressure ulcers, so data is inconsistent. Our definition and measurement workstreams aim to correct this. We held a consensus event in May to share their results so far and get views from 150 staff, and we will soon issue a survey to gather views more widely. We expect to implement a revised framework during Quarter 2 of 2017/18, and will support you during the implementation.

The **Patient Safety Thermometer** is an important quality improvement tool when used with other data. It is linked directly with the Model Hospital, and we wish trusts to continue to use it, although it is used inconsistently.

The programme is developing a **national audit tool** for trusts. This is for trusts to use alongside data from the National Reporting and Learning System and from the Patient Safety Thermometer, so they can better understand how their pressure ulcer management is working in practice. We are setting up a working group to lead this work and will support a national audit to be carried out by the end of 2017.

Your improvement plans have provided important feedback on this. Many of you are working towards effective, consistent reporting in practice and focusing on using data to drive improvement, particularly with frontline colleagues. Learning from incidents was a core theme. We are keen to help share good practice while working with those still facing these challenges.

Driving improvement in practice workstream

Driving improvement in practice is a major aim of the national programme, complementing regional and local programmes that you are all involved in. Our focus continues on eliminating harm as far as possible across all clinical settings. At this time we have not indicated nationally a specific reduction target for pressure ulcers,

because of the work on definition and measurement but we are closely monitoring improvements in performance.

Your plans contained a wide range of clinical initiatives, many connected with learning from incidents and many part of a formal quality improvement plan. The approach to programme management was varied, with some programmes led at board level.

A common theme was improving the management of patients who are non-concordant with treatment and those with mental capacity challenges, this work with a clear link to safeguarding. Another theme is the link between equipment and the development of pressure damage. We will consider how the national programme can help in these areas.

We are setting up an **improvement collaborative** for between 15 and 20 trusts, modelled on our falls and end-of-life care collaboratives. We will circulate details soon with a view to launching in July. We will also share good practice through the national Stop the Pressure website.

Supporting education in practice

To decide how we can best support education in practice we reviewed the evidence and your improvement plans, and spoke to colleagues. A great deal of activity in this area aims to support both staff and patient education.

Much is focused on bedside nursing roles, so our work must reflect changes here, such as the introduction of the nursing associate. We will also support other professional frontline roles. For some organisations, ensuring temporary staff have sufficient knowledge about pressure damage is evidently a key objective.

Many of you are focusing on outreach education for local partners – for example, in care homes – to address issues arising from care pathways across organisations. We are working with the NHS England team that is leading work in the North region testing ‘React to Red’ – an educational framework designed to improve pressure ulcer care in care homes.

We will soon start to develop a **curriculum** for preventing, managing and healing pressure ulcers. We intend to link this with existing curriculum work for pre-registration students and others in key roles. It will be available to providers to use in practice: for example, using a Skills for Health approach. We will address the

problem of staff knowing what they should do but failing to apply it – a complex issue but one we should try to address collectively.

Other workstreams

The programme will support research and partnership working to maximise public health promotion on pressure damage. We need to acknowledge the opportunity to reduce unnecessary expenditure by improving clinical practice and reducing harm. The programme will try to quantify that benefit.

We will provide regular feedback about the progress of these workstreams and alert you to any proposals that will affect you.

We thank you and your teams for your support in this important patient safety issue. If you have any questions about the programme, then please contact Jennie Hall: jennie.hall1@nhs.net.

Dr Ruth May
Executive Director of Nursing

Professor Mark Radford
Director of Nursing (Improvement)

Professor Jennie Hall
Strategic Nurse Adviser