

# **Leading Better Care and Releasing Time to Care**

Implementation and progress to date:  
a briefing paper

## Contents

<b>FIVE KEY MESSAGES .....</b>	<b>3</b>
<b>Abstract .....</b>	<b>4</b>
<b>1. Context and background.....</b>	<b>5</b>
Leading Better Care .....	5
• Framework for the SCN role.....	5
• The Clinical Quality Indicators.....	6
• eQIPS .....	6
Releasing Time to Care.....	7
<b>2. Measuring impacts .....</b>	<b>7</b>
Progress reporting template .....	7
Progress reports.....	8
• LBC.....	9
• RTC.....	12
• Education and development.....	14
<b>3. Integration/synergy with other key initiatives .....</b>	<b>15</b>
<b>4. Other related activities .....</b>	<b>15</b>
<b>5. Challenges.....</b>	<b>16</b>
<b>6. Implications.....</b>	<b>16</b>

## FIVE KEY MESSAGES ...

- Senior charge nurses, empowered, supported and developed through *Leading Better Care* and Releasing Time to Care, are acting as clinical leaders and guardians of safety and quality in their wards and departments and are engaging explicitly with efforts to meet strategic objectives at organisational and national level. This contribution is supporting the achievement of key outcomes in areas such as healthcare associated infection and improving the patient experience and is delivering considerable benefits at organisational level.
- All NHS boards have made a commitment to achieve implementation of the senior charge nurse role framework by the end of 2010. Current data indicate that all are on target to achieve their goals by the **end of 2010**.
- Emerging evidence suggests that application in wards of the Clinical Quality Indicators, part of the *Leading Better Care* initiative, is resulting in benefits for patients in terms of enhanced safety, better experience of services and improved outcomes.
- Releasing Time to Care is building on the existing strengths of the nursing workforce to develop new patterns of working that are enabling improved patient care and better patient experiences. Indications from progress reports on *Leading Better Care* and Releasing Time to Care implementation suggest that alongside an increase in direct patient care time, staff are seeing:
  - improved leadership ability
  - greater efficiency
  - enhanced morale and team-working
  - the development of a care environment that is safe and secure.

Releasing Time to Care is about changing working practices within wards over the long term. There is consequently no specific deadline for its implementation, and NHS boards have developed their own roll-out plans to reflect local needs.

- *Leading Better Care* and Releasing Time to Care comprise part of wider, cross-professional approaches to quality, which are encapsulated in the *Healthcare Quality Strategy for NHSScotland*. Senior charge nurses have a huge contribution to make in leading and delivering on the quality strategy, and *Leading Better Care* and Releasing Time to Care provide vehicles through which the contribution of the nursing and midwifery professions can truly be demonstrated.

## Abstract

This paper has been prepared on behalf of the *Leading Better Care* Steering Group to update NHSScotland chief executives, NHS boards, human resources directors and professional and clinical leads on progress to date on implementation of the *Leading Better Care* (LBC) and Releasing Time to Care (RTC) initiatives in Scotland.

LBC is the report of the review of the senior charge nurse role in Scotland. It has put in place a new role framework for senior charge nurses with a supportive education programme developed by NHS Education for Scotland. LBC also encompasses the Clinical Quality Indicators (CQIs) now being used by senior charge nurses in all NHS boards as part of quality improvement methodologies.

RTC is a quality improvement initiative that aims to support nurses to identify how they can be more productive and effective and to increase the amount of time they spend providing direct patient care. An education package has been developed to support participating staff.

This paper briefly describes the aims, drivers and facilitators of the initiatives before reporting on key indicators of impacts in clinical areas. Impact evaluations are carried out through a specially designed progress reporting template, which is also described in the paper. Successes and challenges in achieving the Scottish Government's target of full implementation of LBC in all NHS boards by the end of 2010 are noted.

**All NHS boards have made a commitment to achieve implementation of the role framework by the end of 2010. Data received through the progress reporting template indicate that all boards are on target to achieve their goals by the end of 2010.**

Where possible, the impacts on quality of care delivered are also being measured, and it is clear that the combination of the revised senior charge nurse role, the development of the CQIs and the introduction of RTC are producing tangible and measureable benefits for patients and staff.

Data from individual NHS boards are available from executive nurse directors and local LBC facilitators.

# 1. Context and background

## Leading Better Care

**Leading Better Care (LBC)**,<sup>1</sup> launched by the Cabinet Secretary for Health and Wellbeing in July 2008, is based on the recognition that NHSScotland will require effective leadership at all levels of service, including senior charge nurse (SCN) level, to meet the population's needs now and for the future.

The nursing and midwifery literature emphasises that SCNs<sup>2</sup> are largely responsible for determining the culture of care within wards and departments and have a significant impact on staff job satisfaction, the quality of patients' experiences and the outcomes of care. The LBC report envisions SCNs who are the "visible embodiment of clinical leadership in NHS settings", the "arbiters and guarantors of patients' experiences", and the "guardians of clinical standards and the quality of care patients receive".

## Framework for the SCN role

Central to the measures LBC put in place is the **Framework for the SCN Role** in hospitals across NHSScotland. The framework is built on four key areas of responsibility:

- ensuring safe and effective clinical practice
- enhancing patients' experiences of care
- managing and developing the performance of the team
- contributing to the delivery of the organisation's objectives.

A series of development opportunities, spearheaded by the NHS Education for Scotland (NES) **Education and Development Framework for Senior Charge Nurses**,<sup>3</sup> has been put in place to ensure all SCNs have the right knowledge and skills to fulfil their new roles. The framework was published in 2008, shortly after the launch of LBC. It consists of four main parts:

- capabilities, key knowledge and skills
- planning learning and development
- learning and development options
- education provision.

The LBC facilitators have been central to disseminating the framework to SCNs in their areas through the LBC development programmes they have in place.

Transition of SCNs to the revised role framework is a phased process that has strong endorsement from the Cabinet Secretary for Health and Wellbeing and

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<sup>1</sup> <http://www.scotland.gov.uk/Publications/2008/05/30104057/0>

<sup>2</sup> The term "senior charge nurses" is intended to encompass all nursing and midwifery roles that describe the nurse or midwife who leads a team of staff within an NHS setting. Other titles may include charge nurse, sister, team leader or ward manager.

<sup>3</sup> <http://www.nes.scot.nhs.uk/about-nes/publications/education-and-development-framework-for-senior-charge-nurses>

the Chief Nursing Officer, and which has executive-level support from NHS board nurse directors across Scotland. It is overseen by a national steering group.

Implementation at NHS board level has been supported by a funding package provided by Scottish Government, the NES education and development framework, a national programme leader, LBC steering groups and a board-level clinical facilitator network.

**All NHS boards have made a commitment to achieve implementation of the role framework by the end of 2010.**

### **The Clinical Quality Indicators**

Part of the LBC report focuses on the **Clinical Quality Indicators (CQIs)**, which were developed in response to an Audit Scotland recommendation that NHSScotland should create nursing-specific measures of clinical care quality that focus on continuous improvement.

The CQIs are evidence-based process indicators that measure aspects of nursing care and which support nurses to continually monitor and improve the quality of care they provide. They do this by identifying nurse-specific measures that have an impact on the quality of care and patient experience.

A **core set of CQIs for nursing** has been developed, consisting of:

- food, fluid and nutrition
- falls
- pressure area care.

This is complemented by the “**ward profile**”, which allows SCNs to collect data on a number of significant factors such as staffing, sickness and absence levels and patient activity. Using these measures provides real support to SCNs in improving care quality.

The CQIs are currently being implemented throughout NHS Scotland, with individual boards deciding which clinical areas will be involved. SCNs are urged to review the CQIs regularly and use improvement methodology to improve practice.

### **eQIPS**

The Electronic Quality Improvement Programme for NHSScotland (eQIPS) initiative was developed in collaboration with the Information and Statistics Division (ISD). This web-based tool allows the easy collection, collation and reporting of CQI data at ward level and is currently being made available to SCNs and ward teams across NHSScotland. Access to the system by local teams is being supported by the national LBC facilitator network to ensure maximum benefit and a structured roll-out.

The eQIPS tool, the CQIs and learning from the development and roll-out process will be incorporated into the wider national quality data capture system being developed by ISD as a replacement for the “extranet tool”. This

supports early access to facilitative tools while ensuring wider consistency and integration as the new tool is developed and comes on-stream in 2011.

## **Releasing Time to Care**

The **Releasing Time to Care (RTC)** initiative, which is complementary to LBC, has also been launched in Scotland.

Developed by the NHS Institute for Innovation and Improvement and called “Productive Ward” in the NHS in England, RTC is essentially a quality improvement initiative that works hand in hand with LBC.

RTC builds on existing strengths by asking nurses to look anew at the way they work, identify how they can be more productive and effective, then make changes to their environments and working methods to improve quality and increase the amount of time they spend providing direct patient care. It uses a variety of tools, some of which have been adopted from industry, to help nurses analyse what goes on during the regular activities they carry out, such as administering medicines, supervising mealtimes and carrying out administrative and stock duties.

Following encouraging results from a six-month pilot in eight NHS board areas launched in July 2008, all boards across the country are now implementing RTC to their systems in acute general, mental health and community wards. An education package has been developed to support participating staff.

## **2. Measuring impacts**

### **Progress reporting template**

A **progress reporting template** against which implementation of LBC and RTC can be assessed has been developed and introduced following consultation with NHS board nurse directors and local facilitators. The template aims to ensure the delivery of consistent data on implementation from boards on a regular basis. These data can then be used to gauge progress nationally and to inform ongoing action at local and national levels.

The template consists of three parts:

- quality improvement
- learning and development
- changes in practice.

Information is sought on SCN activity in relation to key indicators of the impact of the role framework, such as workforce planning measures, education and development of SCNs and their teams, use of specialty-specific tools and learning from complaints, comments, concerns and compliments. The numbers of SCNs in NHS boards who have undertaken (or are undertaking) the LBC programme are recorded to give an indication of whether individual boards are on target to ensure all SCNs have completed the programme by the end of 2010.

Learning and development activity is a big part of the template, as it is seen as central in preparing SCNs for the new role, and changes in practice are covered in some detail. The template also covers CQI implementation, with specific questions on the percentage of services using the CQIs to guide their practice.

## **Progress reports**

**Data received through the progress reporting template indicate that all boards are on target to achieve their goals by the end of 2010.**

Where possible, the impacts on quality of care delivered are also being measured, and it is clear that the combination of the revised SCN role, the development of the CQIs and the introduction of RTC are producing tangible and measurable benefits for patients and staff.

Indications from progress reports on LBC and RTC implementation suggest that alongside an increase in direct patient care time, staff are seeing:

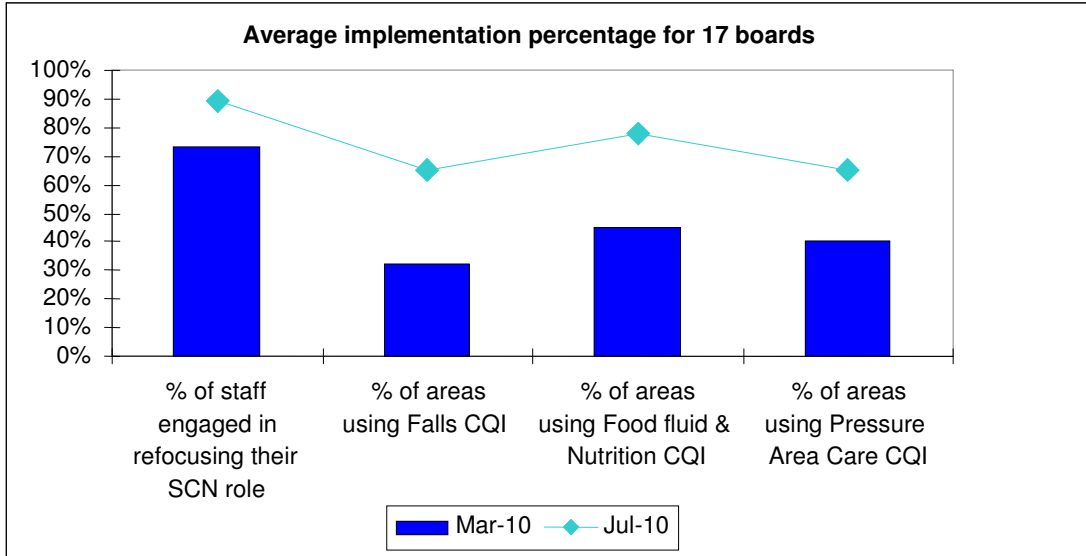
- improved leadership ability
- greater efficiency
- enhanced morale and team-working
- the development of a care environment that is safe and secure.

Implementation rates as of August 2010 across the projects in 17 NHS boards (14 territorial boards and three special boards) are shown in Fig.1,<sup>4</sup> which also shows comparative data on implementation rates in March 2010.

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<sup>4</sup> It should be noted that eight of the NHS boards have included band 6 nurses in their statistics, and two have included allied health professionals.

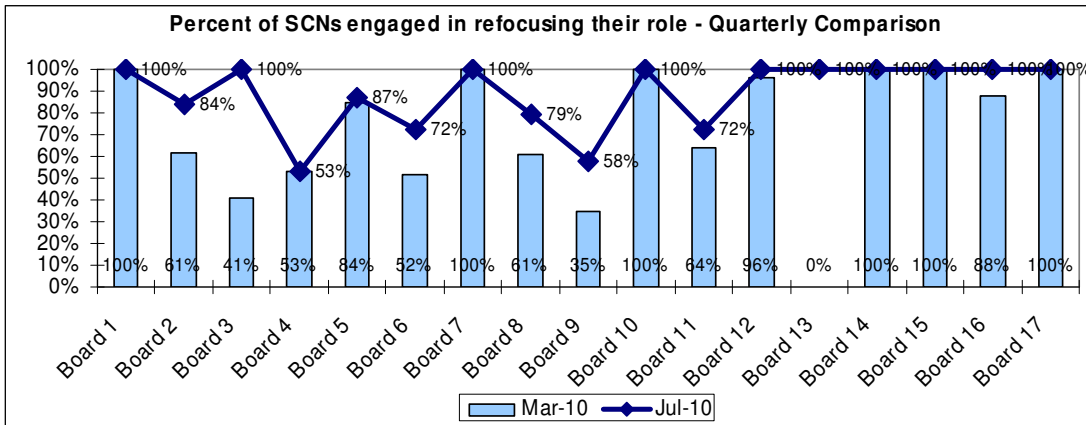
**Fig.1**



**LBC**

All boards are well on track to ensuring that the target of all SCNs having refocused their role to reflect the LBC role framework by the end of 2010 (see Fig. 2).

**Fig. 2**



This means that while 1750 staff had refocused their role as of March 2010 – a significant success – a further 383 need to have done so by the end of 2010.

Compliance rates with the CQIs, measured against baseline observations taken before their introduction, show improvements across the board. Data from one NHS board, for instance, show that food, fluid and nutrition compliance is up from 50% to 95%, pressure area care from 60% to 80%, and falls compliance has risen marginally from 64% to 66%. Average compliance for all three CQIs across wards has risen from 70% to 90%.

Of the wards and departments planning to use the CQIs across NHSScotland:

- 914 are planning to use the Falls CQI
- 982 are planning to use the Food, Fluid & Nutrition CQI
- 959 are planning to use the Pressure Area Care CQI.

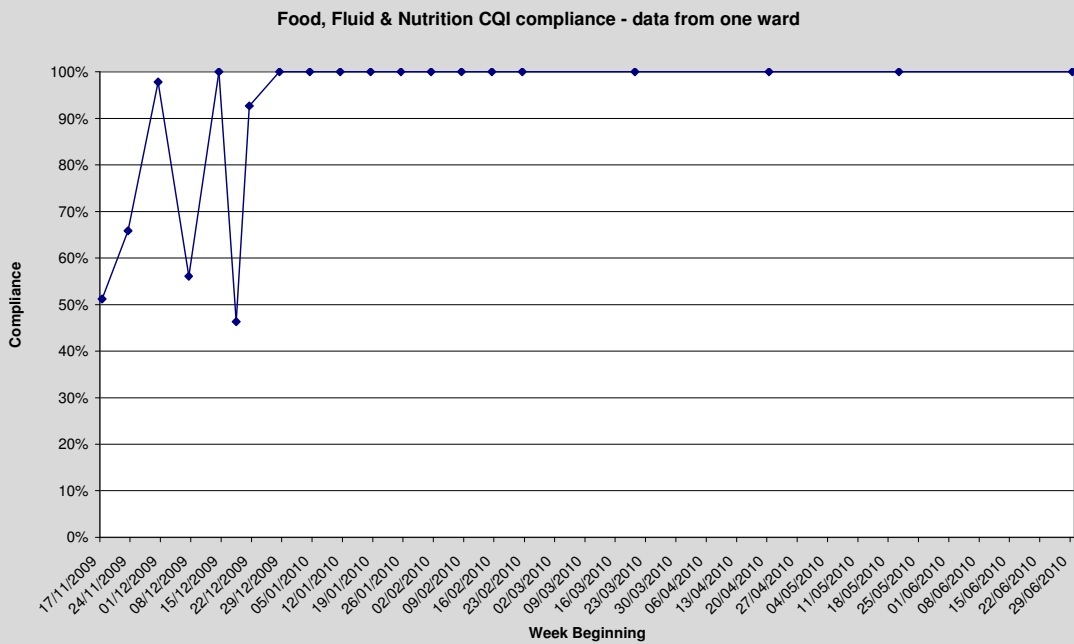
There is therefore impressive spread of the CQIs across Scotland. Indications are that wards and departments are making informed choices on which CQI(s) to implement to reflect local needs.

Data from individual NHS boards are available from executive nurse directors and local LBC facilitators.

Box 1 shows two examples of CQI data collected to date.

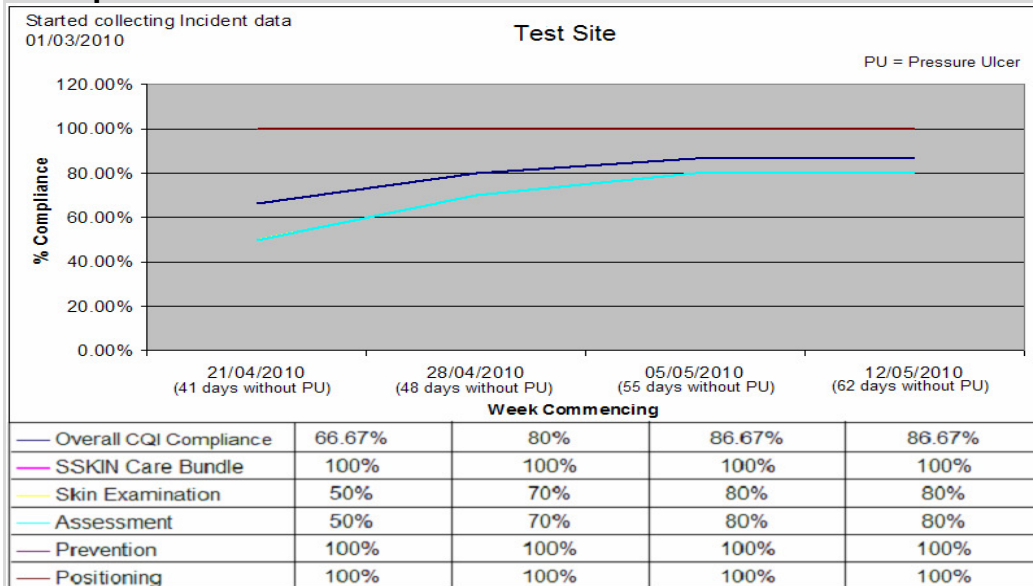
## Box 1. CQI data examples

### Example 1



Example 1 shows data on the Food, Fluid and Nutrition CQI from one ward. Initially starting from a low baseline, the ward used the Quality Improvement Model (Plan, Do, Study, Act – PDSA Cycle) to review their documentation over a period of weeks. By making changes to the documentation, they were able to demonstrate improvements in the way they assess and manage patients’ food, fluid and nutrition needs. The figure shows a variable pattern of performance and compliance over the first seven weeks as the ward team worked through a number of changes to find out what worked. Full compliance was attained by Week 8, and this has been maintained. Monthly audits were instituted following seven weeks of consecutive achievement of 100% compliance with the CQI.

### Example 2



Example 2 shows integration of CQIs with another national programme. The Pressure Area CQI has been linked with the National Tissue Viability Programme in a pilot programme. The CQI has been adapted to reflect the national programme’s SSKIN Care Bundle and piloted in three sites. The figure shows data from one site which demonstrate a positive association between improvement in CQI compliance and the number of days since a pressure ulcer was recorded.

## RTC

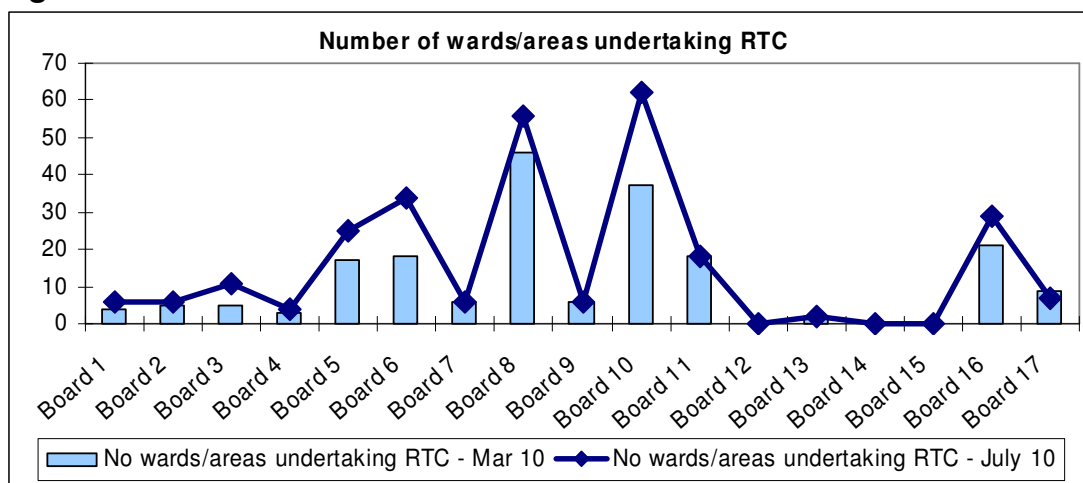
RTC is about changing working practices within wards over the long term. There is consequently no specific deadline for its implementation, and NHS boards have developed their own roll-out plans to reflect local needs.

As of August 2010, 14 NHS boards and a total of 272 wards/departments were undertaking RTC:

- 174 general wards
- 60 mental health wards
- 29 community hospital wards
- 9 outpatient departments.

Fig. 3 demonstrates the increase in wards implementing RTC between March and August 2010

**Fig. 3**



The six-month pilot of RTC in eight NHS board areas launched in July 2008 revealed benefits over four key areas:

- an improvement in the time SCNs had to undertake their new role
- increases in the time nurses spent on direct patient care
- better productivity and efficiency, with consequent savings
- heightened staff morale.

These benefits have been sustained since the pilot. Some examples of RTC in practice are shown in Box 2.

## Box 2. RTC in practice

Long-term impacts from RTC can be shown from the original RTC pilot wards:

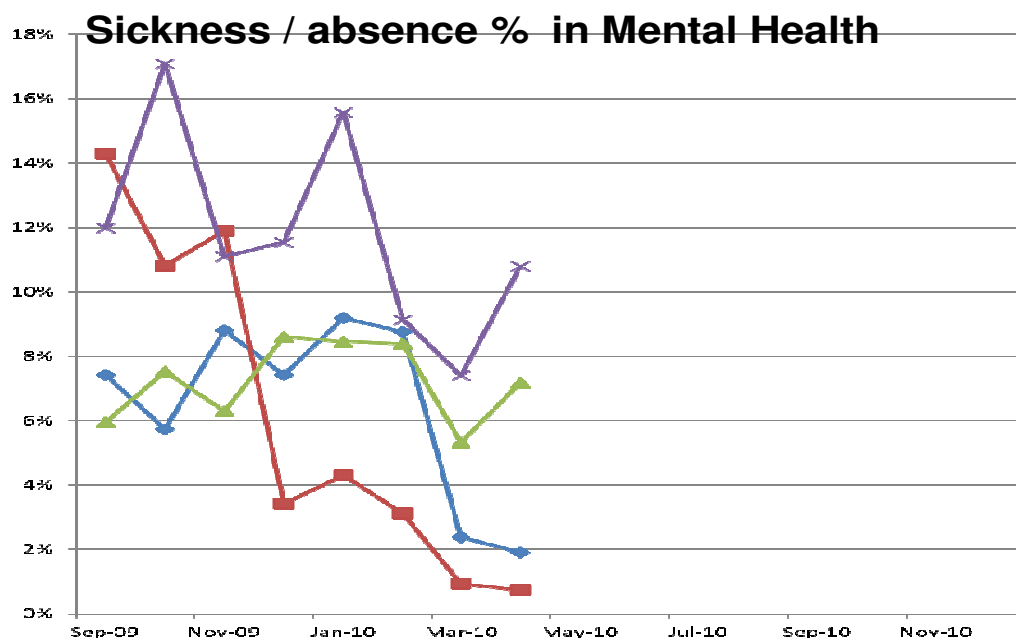
- three of the four RTC pilot wards have demonstrated that by undertaking RTC activity over a 12 to 14 month period, they have increased the amount of direct care time delivered to patients
- one site has shown a 25% increase from baseline over the period
- two have shown an overall improvement from baseline, but the level of improvement seen in the first 4–5 months reduced over months nine and ten (see table below).

Board	Baseline (commencement of RTC)	December 2008	Sept/Oct 2009
W	Sept 08 = 22%	63%	31%
X	Aug 08 = 21%	63%	41%
Y	June 08 = 29%	43%	54%
Z	Aug 08 = 37%	59%	Not available

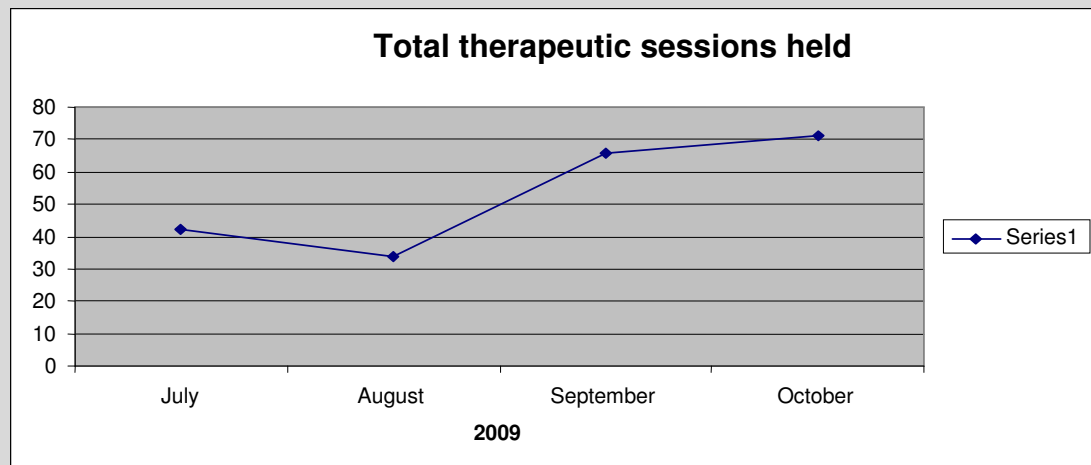
The combination of the increase in direct care time and efficiency savings has resulted in improvements in quality in the four wards (see table below).

Board	Improvement
W	Decrease in new MRSA and C-diff rates (from 6 to 0 for C-diff and 2 to 0 for MRSA).
X	A 10% increase in hand hygiene compliance.
Y	One formal complaint in the whole time that RTC had been in place, with the same site also reporting no new pressure ulcers reported over the same time period.
Z	The amount of staff with an up-to-date personal development portfolio increased from 15 pre-RTC to 39 (all staff) at the time of data collection.

A reduction of sickness absence since commencing RTC has been seen in three out of four wards in one NHS board. The sickness absence rate (%) for four mental health wards in this board are shown in the figure below.



One board has seen an improvement in the number of therapeutic sessions held since the commencement of RTC, from 42 in July 2009 to over 70 in October 2009 (see figure below).



A more formal evaluation and measurement mechanism that will demonstrate the impact of RTC across a range of areas is now being developed,.

For more examples in case study format, see:  
[www.leadingbettercare.scot.nhs.uk](http://www.leadingbettercare.scot.nhs.uk)

### Education and development

The impact of education and development initiatives in NHS boards, specifically the NES *Education and Development Framework for Senior Charge Nurses*, are also being assessed. Some indications of the education and development support within NHS boards for SCNs are shown in Box 3.

#### Box 3. Education and development support within NHS boards – summary

Taught training programmes to support SCNs (which are not supplied in all boards) vary from one to nine days in duration: 901 staff have attended such training to date.

Five NHS boards have included band 6s in their training and two have included allied health professionals.

Twelve boards are also using action learning sets.

Fifteen boards have completed a learning and development needs analysis.

Fifteen boards have mapped or linked their LBC learning to the SCN Knowledge and Skills Framework/personal development portfolio profiles and processes.

Twelve boards include the workforce and workload toolkit training of the Nursing and Midwifery Workload and Workforce Planning programme within their LBC training.

Eight boards have linked their programmes with their local higher education institutions.

### 3. Integration/synergy with other key initiatives

The real success of LBC and RTC may well be seen in demonstrating how they can help to deliver the broader strategic aims of NHSScotland.

LBC and RTC both have close links with the *Healthcare Quality Strategy for NHSScotland*<sup>5</sup> and are widely seen as vehicles through which the contribution of the nursing and midwifery professions to delivering on the quality strategy can be demonstrated.

The Chief Nursing Officer and NHS board nurse directors have emphasised that nurses, midwives and allied health professionals make up 70% of the workforce and lead or contribute to nearly every frontline service. They consequently have a huge impact to make in delivering on the quality strategy, with LBC and RTC key pillars of the efforts to maximise that contribution.

Harnessing this contribution through LBC/RTC provides real support to efforts to achieve NHS board strategic objectives, and wide integration with other national programmes has seen LBC and RTC supporting and complementing the implementation of several other national streams of work, including reducing healthcare associated infection, the National Patient Safety programme, the 18-weeks Referral to Treatment Standard, the Nursing and Midwifery Workload and Workforce Planning programme, and the Strategic Lean Programme.

### 4. Other related activities

Of note is the national conference “Leading Better care – One Year On”,<sup>6</sup> which was held in Glasgow on March 2010. Five hundred delegates attended, with presentations from the Cabinet Secretary for Health and Wellbeing and the Chief Nursing Officer. The aims were to mark progress to date and identify what has to be done in future. A series of presentations focused on progress since the project’s launch at national level, while concurrent workshops gave SCNs the chance to present findings from their own units. This facilitated a great deal of networking and sharing of experience and expertise between boards. The conference also saw the launch of the *Leading Better Care – One Year On* publication, jointly published by NES and the Scottish Government. The document showcases achievements to date and outlines the need for positive actions in the future.

The Leading Better Care website<sup>7</sup> has a similar function to the national conference in that it records progress to date, highlights work still to be completed and encourages and facilitates networking and sharing of experiences.

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<sup>5</sup> <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>

<sup>6</sup> <http://www.knowledge.scot.nhs.uk/lbc/lbc---one-year-on-conference.aspx>

<sup>7</sup> <http://www.leadingbettercare.scot.nhs.uk>

## 5. Challenges

Clearly, the achievement of the target of all NHS boards having achieved implementation of the SCN role framework by the end of 2010 requires a continued focus on support and development for SCNs across Scotland. While educational resources and funding for facilitation have been made available to support this, the current economic context means that such support will need to be provided within a challenging operational climate.

Beyond achievement of the core targets, the challenge will be to consolidate and maintain national consistency on the structure and function of the SCN role and to support ongoing succession planning. This will need to be embedded within NHS boards' planning, ensuring that clear expectations of the SCN role, performance and underpinning development are in place and are maintained.

## 6. Implications

Recognition of the great importance patients and clients place on nursing and midwifery services, and particularly on the clinicians who lead and support nursing and midwifery teams, has inspired the Scottish Government to take decisive steps to strengthen and enhance the SCN role. The result is that the SCN role is now being valued appropriately and has once again become something to which nurses and midwives aspire.

Empowered SCNs, supported and developed through LBC and RTC, are acting as clinical leaders and guardians of safety and quality and are engaging explicitly with efforts to meet strategic objectives at organisational and national level. This contribution is supporting the achievement of key outcomes in areas such as healthcare associated infection, nutrition, tissue viability, falls and improving the patient experience and is delivering considerable benefits at organisational level.

The transferability of *Leading Better Care* to other clinical leaders and those in supervisory roles in health care is also being increasingly recognised.

Finally, the links between LBC and RTC and other elements of national policy and strategy are vitally important. LBC and RTC comprise part of wider, cross-professional approaches to quality, which are encapsulated in the *Healthcare Quality Strategy for NHSScotland*. SCNs have a huge contribution to make in leading and delivering on the quality strategy, and LBC and RTC provide vehicles through which the contribution of the nursing and midwifery professions can truly be demonstrated.

*For more information on Leading Better Care or Releasing Time to Care, please contact Vicky Thompson, National Programme Leader, at: [v.thompson@nhs.net](mailto:v.thompson@nhs.net)*