Modernising Nursing Careers
Delivering the vision of High Quality Care for All

Chris Caldwell
Programme Director

Suzie loader
Project Director

Modernising Nursing Careers
Department of Health, England
From Unacceptable variations To Expecting Excellence
Overview of presentation

- Understand key policy drivers
- Gain insight into challenges and opportunities
- Learn from the experiences of others
- Appreciate the skills required of clinical leaders in delivering the quality agenda
National Policy Drivers

Quality & Efficiency

Challenge or Opportunity?
Quality at the heart of the NHS

- Raising standards
- Stronger involvement of clinicians in decision making at every level of the NHS
- Fostering a pioneering NHS

High quality care for all

- Empowering frontline staff to lead change that improves quality for patients
- Valuing the work of NHS staff

High quality care for patients and the public

- Help to stay healthy
- Empowering patients
- Most effective treatments for all
- Keeping patients as safe as possible

Freedom to focus on quality

- Help to stay healthy
- Empowering patients
- Most effective treatments for all
- Keeping patients as safe as possible
Keep Quality at the core – the driving principle behind everything we do.
Respect and dignity
We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care
We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion
We respond with humanity and kindness to each person’s pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find the time for those we serve and work alongside. We do not wait to be asked, because we care.

Improving lives
We strive to improve health and wellbeing and people’s experiences of the NHS. We value excellence and professionalism wherever we find it - in the everyday things that make people’s lives better as much as in clinical practice, service improvements and innovation.

Working together for patients
We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

Everyone counts
We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others’ opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.
Nursing Policy Drivers

Modernising Nursing Careers

Our greatest opportunity in decades ….. Or just fine words?
The vision

• NHS Next Stage Review (NSR) ‘High Quality Care for all’ (2008):
  – a vision for nursing – Leader, Partner, Practitioner
  – improve quality of nursing care
  – retain the best candidates to nursing

• Modernising Nursing Careers (2006, 2008):
  – UK-wide initiative
  – equip nurses with skills and capabilities
  – create a more flexible and competent workforce
Nursing

UK Modernising Nursing Careers Coalition

• Role, Image & Recruitment
• Degree level registration
• Preceptorship
• Career Framework
• Advanced Practice
• Clinical Academic & Educator Careers
• Skills Passport
• Metrics
• Leadership

Transforming Community Services

Action on Health Visiting

New Horizons
Nursing today...

Requires an intricate interplay between fundamental care and high-level technical competence, bio-medical knowledge and decision-making skills and the ability to develop therapeutic relationships based on compassion and holistic and intelligent care.
Pre-Registration

- Review of pre-registration education
- Widen access & encourage diversity from school leavers to mature entrants and existing health care assistants
- Health Care Support Workers
  - Training, competence, regulation
- Nursing as a career choice
  - Marketing & updating the image of nursing
- Student support
Marketing Nursing as a Career: Enhancing the Image of Nursing

- Develop a role profile of an ‘ideal’ Registered Nurse - values, skills, attributes, behaviours
- Understand what will attract the right people with the right values into the profession
- Identifying recruitment / retention best practice in co-production with stakeholders, e.g. Council of Deans, NHS Employers
- Develop a Marketing Strategy for Nursing to coincide with the publication of the Commission report

Aim:
- Enhanced recruitment of student nurses
  - Reduced attrition rates
  - Increased numbers of qualifying nurses moving into employment
- Enhanced recruitment of qualified nurse to difficult areas e.g. Learning Disabilities, Mental Health & Health Visiting
  - Improved retention rates
- Enhanced image of Nursing

- Marketing nursing from the inside out…
Post-registration Nursing Careers

• Leader Practitioner Partner
• Preceptorship
• Revalidation
• Skills passport
• Career framework
• Clinical Academic & Educator Careers
• Advanced Practice
Taking forward Preceptorship

NSR commitment: ‘A foundation period of preceptorship … at the start of their careers … begin the journey from novice to expert … , laying a solid foundation for life-long learning’

NMC principle of mandatory preceptorship

£30 million annual funding

National framework project:
- National stakeholder engagement (Scoping good practice and existing activity, developing rationale, communications and engagement, products)
- Nursing framework launched November 2009
- Final multi-professional framework due Spring 2010
Mapping Nursing Careers

• Taking forward recommendations of consultation on the post-registration framework

• Modelled the framework across a number of pathways:
  - Health Visiting (Children & Families)
  - Ill & Disabled Child
  - Learning Disabilities
  - Cancer Nursing

– Collaborative approach with SHAs, HEIs, providers, professional organisations/other key stakeholders

– Incorporated concepts of: Practitioner Partner & Leader

• Graphic map to support Career Framework model published in Nov 2009

• Integration into quality road map (to be published in March 2010)

• e-tool to be developed with good practice guide (Spring 2010)

• Aligned with rest of the UK & NHS Career framework
Advanced Practice

• CHRE review
• Advancing practice across the professions
• Standards & guidelines for employers & commissioners
• Refining the practice standard
• Future regulation
Delivering policy

Leaders for Quality Nursing

Do you have the skills?
Quality – as service users see it

Safety

How safe will I be?

Effectiveness

How effective will my support and treatment be?

Experience

What will the experience be like?
How should leadership be enacted?
• clear narrative
• starting with patients – voices, involvement
• local leadership and influence
• strategic and political leadership
• commissioning

• What DH is doing?
  • Front line to the Board

• National Leadership Council:
  - Clinical leadership fellowships
  - Multi-disciplinary leadership development framework
  - Accreditation
What do we need to do?

- Shift our mindsets - Talk it up
- Value each other & show our value
- Share and listen
- Demonstrate leadership
- Be courageous & confident
- Start and end with patients and users
- Build communities
“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change”

Charles Darwin
Improving the patient experience – a world-class service

Steve Barnard   Sandy Harding
Charge Nurse    Training & Development Co-ordinator
Cwm Taf Local Health Board, Wales
Improving The Patient Experience

A World Class Service

Sandy Harding
Stephen Barnard
Introduction

• A patients experience within the outpatients department can determine their whole view of care they will receive within the organisation.

• As nurse managers it is important to ensure that all staff understand that it is everyone's responsibility to deliver Customer Service Excellence.
Aim

To show as an organisation how we have worked to have a clear vision of our patients' expectations, and how these expectations may be met, anticipated and exceeded.
Objective

• By the end of this session you will recognise the nurses role in meeting this vision.

• Identify the tools available to obtain a clear vision of patient expectations.

• Apply the principles which support the process to an action plan.
Customer Service

• Its not rocket science, it is common sense.
• But it is a challenge to deliver customer service excellence, 100% to 100% of customers.
• How to :- Framework
  On-going journey
  Prioritise actions
Our Pet Hates

- Cancelled appointments
- Using the term ‘bear’ with me’
- Not keeping promises
- Poor communication e.g. short notice, waiting times, reasons for delays
- Attitude- Defensive / poor attitude to patients and staff
Pet Hates

• Internal complacency

• Not given priority attention

• Staff ‘huddles’

• Staff ignoring you

• Patient not being treated as if they were a family member
<table>
<thead>
<tr>
<th>What Makes A Customer Service Experience - Good Or Bad</th>
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<tr>
<th>Good</th>
<th>Bad</th>
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<tbody>
<tr>
<td>• Consistency</td>
<td>• Little or no communication</td>
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<tr>
<td>• “there for you” “diffusing situation before it occurs” (USA model)</td>
<td>• Rude attitude</td>
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<tr>
<td>• Smiling &amp; welcoming</td>
<td>• “feeling invisible”</td>
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<tr>
<td>• Acknowledgement</td>
<td>• “no can do attitude”</td>
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<td>• Positive communication</td>
<td>• “acceptance that poor service is the norm”</td>
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<td>• Recognition of poor service</td>
<td>• Lack of knowledge</td>
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<td>• Caring, understanding, helpful</td>
<td>• Unclear processes</td>
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<tr>
<td>• “nothing is too much trouble”</td>
<td>• Hierarchy attitude</td>
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<tr>
<td>• Being respected</td>
<td>• Breach of confidentiality</td>
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</table>
What will be the impact of implementing the Customer Service Excellence Indicator?

How easy will it be to IMPLEMENT the customer Service Excellence Indicator?
Moving Forward

- Baselines and Actions
- Small steps in right direction
- Big leaps
- Share success & failures
- Communicate
- Keep measuring
What we did to move forward.

1. PLAN OF ACTION
2. NEXT STEP
3. CUSTOMER SATISFACTION SURVEY
4. RESULT
5. WHAT CAN WE ACHIEVE
6. HOW
<table>
<thead>
<tr>
<th>Customer Service Culture Statements</th>
<th>How To (Including Measures)?</th>
<th>Owner(s)</th>
<th>When</th>
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</thead>
</table>
| There is clear ownership for customer service delivery across the whole organisation               | • Explore if there is a "lead" Senior Manager for customer service delivery within the Trust.  
• If no lead, lead to be identified.  
• Develop & communicate Customer service strategy for the directorate  
• Ensure staff are communicated routinely as part of directorate meetings on customer service issues | S. Harding  
A. Wilkins  
A. Wilkins & CS Project Group  
HoD's                                                                                   | 14/5/09  
14/5/09  
14/7/09  
Ongoing                                                                                   |
| Become obsessed with understanding & delivering what the customer wants                           | • Leading by example i.e. being proactive in approaching patients without them asking for help  
• Communicating excellence i.e. regular feedback on good patient experiences at directorate meetings  
• Involve Patient Experience Manager in C.S. project  
• Undertake a fact finding exercise to assess current internal & external customer service delivery to inform action plan | C.S Project Group  
HoD's  
S. Harding  
CS Project Group                                                                                         | Immediate  
Ongoing  
5/5/09  
14/7/09                                                                                       |
| Understand the diversity of your customer base & implement inclusive customer service delivery solutions | • Review the existing communication methods/content to check if we are or are not addressing diverse customer service needs i.e. app't letters asking if patient has specific needs in relation to equality/diversity  
• Involve E & D lead to assist in identifying customers E & D and all staff being able to easily access this information as required e.g. access to interpreters/Braille appt letters/religious beliefs practices | D. Chick  
Y. Owens  
M Williams                                                                                       | 12/6/09  
14/5/09                                                                                       |
| Specify the behaviours you expect from your staff                                               | • Agree a Customer Service "Promise"/"Mission statement" for Directorate using the 10 point plan  
• All HoD's to act as role model in delivering excellent Customer service  
• Routine Agenda item at all staff meetings                                           | CS Project  
HoD's  
HoD's/Supervisors/                                                                            | 14/5/09  
Immediate                                                                                       |
Quick Wins

• We chose Patient information as something we could develop.

• Sister Debra Evans and Myself took ownership of this, and developed an action plan to enable, Training preparation and analysis to improve customer service giving what the customer wants 2009/10.
Quick Wins

• This training development will improve our customer service from very good to excellent, in the next customer survey giving patient information.

• By training all staff members qualified and non qualified, how to access Eido Healthcare and British association of dermatology sites. Where we can obtain patient information leaflets, that we use regularly in the department.
### Action Plan

Find out needs and prepare training program for patient information within Aberdare Mountain Ash and Prince Charles hospitals.

<table>
<thead>
<tr>
<th>Need to prepare investigate and correlate.</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
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<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
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<tbody>
<tr>
<td>Assess needs and where to obtain information needed</td>
<td>wk 1</td>
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<td>Prepare and develop training plan and presentation</td>
<td>wk 2</td>
<td>wk 3</td>
<td>wk 4</td>
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<td>Develop competence’ and test to achieve competence level</td>
<td>wk 5</td>
<td>wk 6</td>
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<td>Implement training and assess make any adjustments</td>
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<td>Revise any updates</td>
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<tr>
<td>Maintain training and look into other site’s we may gain information</td>
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Development From Action Plan

• All Departments in the trust have access to patient information leaflets which can be accessed via the intranet or the internet.

• Patients have difficulty absorbing all the verbal information they are given by the Dr’s. by giving up to date leaflets patients can take them away, read them and hopefully have a better understanding of the condition or procedure to be undertaken.
Aim

• To Provide Patients with information without disturbing other staff members to obtain Leaflets

• To training each staff member to access and print information Via EDIO Healthcare

• To streamline the storage of information leaflets held keeping information up to date at all times.
Application of action plan

Needs:-
We identified that there is a need for patient information.

Preparation And Development Of A Training Plan:-
This was developed and tested by Myself and Sister Debra Evans.

Develop Competent Level Of Achievement:-
A test was set and trialled to a level that could be achieved at all levels.
Application of action plan

Implementation Of Training:-

Training was undertaken any adjustments made, to improve delivery of the training.

Revised Any Updates:-

At the time there are none however this is ongoing.

Maintain Training And Look At Other Sites That Give Information That We Could Use:-

We looked at other site and are using The British Association of Dermatology, which is useful and relevant to our use.
EIDO HEALTHCARE INFORMATION

- EIDO Healthcare was established in June 2000 in response to the growing need in the UK healthcare sector for improvements to the informed consent process.

- The word “EIDO” itself emphasises the reasons behind the establishment. “EIDO” is an ancient Greek word meaning to see completely; to understand or become aware; to be conscious or informed of - in essence, this is our “Reason For Being” (raison d’être)
We believe that informed consent should be a process, based on discussion and dialogue - rather than just a signature on a piece of paper.

Patients need to be properly informed so that they can share in the decision-making process.

Clinicians need support in order to provide timely and comprehensive information to their patients.
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<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Anaesthetics</td>
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<td>Breast</td>
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<td>Cardiology</td>
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<td>Cardiothoracic</td>
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<td>Colorectal</td>
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<td>Cosmetic</td>
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<td>Day Case</td>
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<td>Ear Nose Throat</td>
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<td>Endoscopy</td>
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<td>General</td>
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<td>Laparoscopy</td>
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<td>Maxillofacial</td>
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<td>Metabolic Surgery</td>
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<td>Neurosurgery</td>
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<td>Obs and Gynae</td>
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<td>Ophthalmology</td>
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<td>Orthopaedic</td>
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<td>Upper GI</td>
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<td>Urology</td>
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<td>Vascular</td>
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Click here to view EIDO's full library of patient information documents.
Frequently Asked Questions

Are your documents 'standard' or can they be customised?

EIDO documents describe accepted clinical practice. They can be customised to make sure they fully meet local needs.

Who writes your documents?

EIDO authors are all practising specialist surgeons who have trained and qualified in the UK. They only write documents in the areas in which they specialise.

Who validates your documents?

EIDO documents are validated by clinicians, proof readers, and external organisations such as the Plain English Campaign and Patient Concern. Each document bears the Plain English Campaign Crystal Mark. EIDO is a Platinum status Corporate member (the only healthcare organisation to enjoy this status of the Plain English Campaign).
**Have your documents been developed with patient input?**

Yes. The library was piloted twice, within a NHS hospital and a private hospital. Audits have also been carried out at hospitals which have been using INFOrm4U for more than a year. The results were excellent. Copies are available on request.

**Are your documents updated?**

Yes. EIDO documents are updated at least once each year, and more regularly if required, based on changes in medico-legal law and clinical practice.

**How are the documents delivered?**

EIDO documents are delivered via the Web Download Centre (DC). The DC tracks usage of the documents by your hospital to help implementation and to provide a useful audit trail for your own reporting needs. The documents are in PDF format.

**Are different languages and formats available?**

Yes. EIDO’s Translation Service provides an ‘off the shelf’ library of the most commonly used documents in six languages. In addition, we can provide our documents in most foreign languages, as well as in Braille and on audiotape, via our ‘On demand’ service.
Outcome

So Far all of our Staff existing and new have been trained and use regularly Patient information Leaflets Via EIDO Healthcare. British Association of Dermatology and ARC Arthritis Research.

**Improving Customer service Excellence within the Outpatients Department’s and striving to achieve a world class service**

However this has Spiralled and Managers and Dr’s have expressed interest, having seen the information available that they didn’t know existed.

Physiotherapy, Secretarial, and Occupational Therapy Staff, to name some, expressed an interest as information from theses site’s help them explain to patients up to date information, which they can give knowing its up to date and that we are all using in the trust. Maintaining continuity an important aspect of care.

*We have now Dr’s and other staff that print of there own Patient information Leaflets a big step forward.*
Having A Clear Vision Of Patients Expectations And Exceeding Them Have Improved The Patient Experience Making It An Excellent Service.
If Anyone would like further information or have any questions. You can contact myself via email steve.barnard@wales.nhs.uk. And I will respond with an answer, if possible or Sandy.harding@wales.nhs.uk

We will be around this morning if you would like to speak to us or look at some of the tools we used in our action plans etc?

ARE THERE ANY QUESTIONS

Thank You For Listening I Hope You Gained Some Knowledge Which Would Help You Develop Customer Service Excellence At Your Hospital.
Refreshments & exhibition viewing
Productive Outpatient Departments’ Programme

Sue Mellor
Project Lead for Productive Ward
Royal Bournemouth & Christchurch
NHS Foundation Trust
The Productive Clinic

“Releasing Time to Care”

Sue Mellor PW Lead
Ruth Middlemass – PW Lead
Sue Rendell – SCL OPD
Carly Whitby – HCA OPD
Kate Bond – DCL GUM
Nicci Southey – HCA GUM
We Wanted to do it differently

The Royal Bournemouth and Christchurch Hospitals

“putting patients first”

NHS Foundation Trust
A Bit of background

• Approximate Budget - £220 M

• Ageing Population

• Emergency admissions – 27,447
The Productive Ward – What is it??

A structured programme comprising start-up kits, baseline modules and specific care modules.

Empowers nurses and others to review, rationalise and improve core ward processes.

Reduces inefficiencies and releases time to enable nurses and therapists to spend more time in direct patient care.

= improved patient and staff experience!
Productive Ward / Community – the Module Structure
“Getting the Basics Right”

- Well Organised Clinics
- 3 Second Rule
- 5S – Sort, Set, Shine, Standardise, Sustain
- Colour Coding - Standardisation
- Stock Levels
- Knowing How We are Doing
- Clinic Status at a Glance - Standardisation
So we took the concept

We took the concept to see how it could fit

• To see how it can fit for Us
  – Activity Follows
  – Identifying Waste, over stocking, duplication, looking.
  – 5 s Game
  – Hairdryer
  – Action Planning
  – Regular Cohort Meetings
  – Buddy System
  – Shared Drive – Symbols, Sops,
  – Library support
  – 3 Foundation modules
The Productive OPD – getting there.

**Creativity**

- Thinking outside the box.
- Try new ideas. Ok to make mistakes.
- The small things that make the big differences.
- Striving for excellence.
- Sharing good practice, with each other.
- Seizing opportunities.
- Taking risks.
Caring – the heart of nursing

“The patient is the most important person in our hospital. He is not an interruption to our work: he is the purpose of it. He is not an outsider in our hospital: he is part of it. We are not doing him a favour by serving him: he is doing us a favour by giving us the opportunity to do it.”

Mahatma Ghandi
General Outpatients

• 150,703 new patients, 215,259 follow ups last year.
• 3 hospital sites.
• 5 different clinic areas within 1 site.
• Approx 32 specialities.
• 2 Clinical Leaders, 8 staff nurses (7 F/T) and 36 HCA (12 F/T).
Problems.

- Resistance to change.
- Time spent with patients.
- Loss of time (looking for equipment, staff, patients).
- Disorganised/untidy department.
- Stock/material waste.
- Lack of development within the service.
How we started

• Staff awareness sessions
• Team meetings
• Brain storming
• Identify Leads – Carly (HCA) + Wendy (HCA)
• Linked to Practice Development Unit
• Vision
Our Vision.

- organised and tidy department
- undertake to continually audit and improve our department
- that we put patients first and they are valued
- privacy and confidentiality
- an accessible patient centred service responsive to patients needs
- treat patients and visitors with consideration, equality, dignity and respect
- improvement of our service to achieve clinical excellence
- ensure patients receive timely appropriate information relevant to their care
- nurture each individual
- take care to trust and respect our colleagues
- safely treat patients in a calm environment
Tools / modules.

Tools

• Activity follows, show % time spent with pts.
• Audits, show how we are doing, sustainability.
• 6 Phase process (Hairdryer) - general structure of each module.

Modules

• 3 Foundation modules – knowing how we are doing, well organised clinic, clinic status at a glance
• Observations, improvement of patients journey
• Nursing procedures, development and improvement.
  – Taking bloods
  – MRSA swabbing
  – Cleaning of ENT scopes
6 Phase Process – Hairdryer.
Hairdryer – ideas for ENT scopes.
Knowing how we are doing.
Well Organised Clinic - Treatment room.
Before.                          After.
Clinic Status at a Glance.

<table>
<thead>
<tr>
<th>DOCTOR</th>
<th>8.00 AM</th>
<th>9.00 AM</th>
<th>10.00 AM</th>
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<tbody>
<tr>
<td>Mr. Davies</td>
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<td>HCA Thomas</td>
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<td>HCA Stockley</td>
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<tr>
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<td>Dr. Armitage</td>
<td>HCA Barnett</td>
<td></td>
</tr>
<tr>
<td>BDEC</td>
<td>Dr. Cavan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDEC</td>
<td>Dr. Taylor</td>
<td>Foot Clinic</td>
<td>HCA Anker</td>
</tr>
<tr>
<td>Office</td>
<td>HCA Jameson</td>
<td>HCA Waldon</td>
<td></td>
</tr>
</tbody>
</table>

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust
Challenges.

• Getting staff “on board”.
• Adaptation from ward to department.
• Lateral thinking.
• Time.
• Reliance on/support of other departments/areas.
Some achievements.

Completed

- Foundation modules
- Organised/tidy department.
- Bloods taken in clinic
- ECG in clinic
- All patients MRSA swabbed.
- Cleaning of ENT scopes

In progress

- Weights – privacy/dignity.
- Malnutrition Universal Screening Tool.
- Patient/notes flow.
- One stop booking of all diagnostics.
Impact.

• Improved team spirit, empowerment of staff.
• Removal of waste activities
• More direct care time with patients.
• Clean tidy areas, less clutter, anyone able to find equipment immediately.
• Improved standards and quality of care.
Staff comments.

• Before
  – It will never work!
  – Been there, done it all before.
  – We’ve always done it like this.
  – More work and no time.

• After
  – It’s great to be able to find everything - see it, read it, pick it up.
  – We have much more contact time with our patients.
  – I love the way we bandy idea’s around, see them grow and take place.
  – Hard work but we and the patients all benefit in the end.
Was it worth it?
Genito Urinary Medicine

• On average the clinic sees 24,000 patients a year.

• These include new patients, rebooks and follow ups.
From the beginning

- We reviewed all modules from Productive Ward and Productive Community to establish which could be made relevant to the clinic setting.
- We had MDT meetings to involve all members of staff for them to air their ideas.
- ‘Before’ (& after) photos
- Put a lead team together to move PC activities forward
- Took full advantage of other departments in the hospital taking part in PC for extra support i.e. Main outpatients.
Releasing time to care
(areas for improvement)

- **GUM**
  - **DRUGS**
    - Re-evaluate how the drugs in the dept are stored
  - **STORAGE**
    - Re-organise the storage areas in the department, (5S'S)
  - **STOCK LEVELS**
    - Stock rotation.
    - Over ordering.
  - **COMMUNICATION**
    - Regular meetings.
    - P.W contact and prep talks.
    - Communication + clinic at a glance board.
  - **PUTTING PTS FIRST**
    - Knowing how we are doing board.
    - Releasing time to care.
Our store Cupboard
Outreach Drugs Box
Our Patients at a glance
Clinic at a glance
Our Chaperone trolley
Privacy and dignity: locking the door!

- Patient shared their experience of an examination in other department.
- Door was always locked but now patient made aware of this.
Lunchtime audit

• Needed to open over lunchtime
• Problem with queuing outside department.
• Adapted patient flow module.
• Carried out audit to assess number of turnaways.
• Looked at results from patient satisfaction audit.
• Audit results showed numbers of little significance and that patients would like later appointments.
Challenges

• Resistance to change of practice
• Timeout from regular duties
• Staffing levels
• Community project delayed us for 1 month
• Getting all denominations of staff on board
• Adapting PW to work in OPD
Ongoing Modules

- 5S the Health Advisor office
- Branch out into Reception and main office areas
- Drugs – storage and distribution
- Extending opening hours
- Increasing nurse led services
What PC has done for us

Happily Ever After . . .

• Established links with main outpatients
• Brought the team closer
• Allowed us to Re-Focus on the patient
• Helped us to achieve a well organised, tidy and efficient department.
• Making P.W work in our specialised area of GU.
• Creating a more cohesive service for patients as well as staff.
Contact us @

- Ruth Middlemass
- Susan.Mellor
- Sue. Rendell
- Kate. Bond
- @rbch.nhs.uk
- www.institute.nhs.uk/ Productive ward
Role redesign – where do we start?

Charlette Middlemiss
Associate Director, Workforce Development
National Leadership and Innovation Agency for Healthcare (NLIAH)
Role Redesign
Where Do You Start?

Charlette Middlemiss
Associate Director Workforce Development
NLIAH
Redesigned Roles

• Advanced Practitioner
• Clinical Nurse Specialist
• Assistant Practitioner
• Extended Scope Physiotherapist
Although now no longer popular with the public, toilet paper with a shiny surface was considered by the NHS to be extremely hygienic and efficient. Even the Prime Minister extolled the virtues of its qualities.
Drivers Influencing Role Redesign
“The NHS cannot afford, either in service of financial terms, to continue to provide or staff the service in the way it does currently”

“Delivering more of the same through traditional roles and methods of delivering care will not be sustainable in the future”

A strategy for a flexible and sustainable workforce 2007
• 10 years of workforce growth
• 54,000 WTE (1999) to 71,000+ WTE (2008)
• An increase of over 17,000 staff
• 32% growth
More Challenges - Productivity

• Challenging financial environment, but demand and innovation will not stand still

• Strong focus on increased levels of efficiency and productivity

• The NHS will have to learn to do more with less - “working smarter not harder”

Annual Operating Framework 2009
Workforce Challenges Ahead

- Unlock the potential of the substantial level of investment in the system over the past years
- Not about further resources
- A clear focus on:
  - what the barriers are;
  - how they can be removed;
  - how optimum value can be secured from previous investment

*Annual Operating Framework 2009*
What is Role Redesign?

Role redesign is an essential building block of service redesign and can be achieved through:

- Creating new roles
- Expanding the depth and breadth of roles
- Moving tasks up, down or across traditional boundaries
Aims of Role Redesign

- Improve patient experience
- Tackle areas of pressure or staff shortage
- Extend opportunities for staff development
- Deepening and broadening existing roles
- Optimalising efficient working
- Making the most of human resources including staff time, knowledge, skills and understanding.
- Assist in moving barriers to service change
- Bridging gaps between services and sectors
- Provide career opportunities
When to do Role Redesign?

- Staff skills are not being optimised
- Improvements need to be made
- The service is not fully relevant to the emerging needs of patients
- The service has not changed significantly despite advances in technology
- Service demand is exceeding the capacity to deliver care
- Service demand has dropped
Standards for Role Redesign

- Business Case approval
- Sustainability of role change
- Good Practice in Human Resource Management
- Full Stakeholder Engagement
- Improvements in Patient Safety or Service Quality
- Focus on the Patient
- Knowledge, Skills & Competence of New Role is identified
- Emerging and accepted good practice is utilised
- New Roles designed on Competences (NOS)
- Service & Workforce Analysis, Patient Pathways & Risk Assessment

“Standard and Guidance for Role Redesign in the NHS Wales” WD NLIAH
Role Redesign Process

- Creating a Vision
- Building a Business Case
- Communicating the need for change
- Securing the support and agreement of stakeholders
- Action Planning
- Monitoring Progress
- Evaluation
New Roles, Extended Roles, Changed Roles and New Ways of Working

- **New roles** - refers to an entirely new role which creates a new type of worker. In some instances this will correspond with the development of a new service. These roles may require regulation.
New Roles, Extended Roles, Changed Roles and New Ways of Working

• **Extended Roles** - continue to work within the parameters of an existing role. Extended roles have additional or new duties, tasks or competences requirements. These roles may require broader or deeper knowledge, skills and understanding.
New Roles, Extended Roles, Changed Roles and New Ways of Working

- Changed Role - refers to a role for which the volume of existing activity has changed. This may involve some tasks being moved to a different worker or provided through use of technology, so that a role can focus on a higher volume of specific, or specialist work.
Specific Considerations

- What effect will the new role have on the existing structure?
- Consider Workforce Supply
- Who will manage/supervise the role? Clinical supervision?
- Are there funding implications? Where will the funding be sourced and when will it be available?
- Is the post full time? Part time? Available as job share?
- How will the duties be covered in the event of absence?
- What is the level of autonomy of the role?
- What are the limits and demarcations?
- Will the role cross traditional/professional boundaries?
- Are there any clinical governance considerations?
- Are there regulatory considerations?
- What are the likely education, training and CPD needs?
- For how long is the post likely to be sustainable?
- Will the role set a precedent?
Role Redesign - Key Outcomes

Right Service in the
Right Place at the
Right Time with the
Right Staff with the
Right Skills using the
Right Technology* at
the Right Cost

* “Standard and Guidance for Role Redesign in the NHS Wales” WDU NLIAH
The Old System
Was Comfortable
Find the solutions from below

The project team
The Maybe Person

At the moment of decision they procrastinate - hoping and waiting for an easier option. Inevitably the decision ends up making itself.
The Grenade

After a Period of Calm, an Explosion of Unfocussed Ranting and Raving About Things Not Even Related to the Present Circumstances
The Whiner

They Feel Helpless and Overwhelmed by an Unfair World.

Their Standard Is Perfection but No One Ever Measures Up to It.
The No Person!!

Deadly to Staff Morale

Often Disguised As a Mild Mannered Normal Person

They Fight a Never Ending Battle for Futility, Hopelessness and Despair
“Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming down stairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it”

A A Milne 1926
Illustration E H Shepard 1926
Build on what you have

Value relationships
“Given enough time, small and gradual causes can produce large and radical effects”

Charles Darwin
1880
The Way Forward...

From
“More of the Same”

To
“Doing Things Differently Together”
Our experiences: New Forum Committee Members

Kate Dawson
Elizabeth Sawyer
Sandy Harding
Our Experiences

Sandy Harding
Cwm Taf Local Health Board
Job History

• Theatre Nurse – General – Ophthalmology
• Theatre / OPD
• Ophthalmic Nurse Practitioner
• KSF Co-ordinator for Trust (Secondment)
• Ophthalmic Nurse Manager
• Training & Development Co-ordinator for Directorate
Evolving of Cwm Taf Local Health Board

• 2008 Pontypridd & Rhondda merged with North Glam to form Cwm Taf Trust

• 2009 Cwm Taf Trust reconfigured to encompass the Local Health Board as part of the Welsh Assembly Plans

• Born is that of Cwm Taf LHB
Outpatients

- 6 Departments
- Covering the minimum 37 specialities weekly
- 100 Nursing Staff  –  44 Registered
  54 Un-registered
  01 Services Manager
  01 Training Co-ordinator
- 4 Plaster Techs
- 13 Reception staff
Developments

• Joshua

• HCSW Study Day / Forum

• Standardised Competencies

• Statutory Training Matrix

• Medical Records Apprentices

• Role Redesign

• Coaching for Performance
Lunch
& exhibition viewing
Chair’s welcome back

Sandy Harding
Outpatient Nurses Forum
Developing a nurse-led clinic

Dawn Homer
Rheumatology Nurse Consultant
Vitality Partnership
Laurie Pike Health Centre
RCN Outpatient Nurses Forum Annual Conference

Outpatients – our service – our future

Developing Nurse Led Clinics

Dawn Homer Rheumatology Nurse Consultant
Vitality Partnership
Community Rheumatology Service
www.bhamcrs.co.uk  rheum.lphc@nhs.net
07595552782
Learning Outcomes

• Understand how health policy reforms will impact on future provision of outpatient services

• Describe how nurse led services can be developed and the benefits that these have for patients

• Consider own role in relation to provision of nurse led services and seek required knowledge and skills in order to work in new ways
Overview

- Brief introduction to rheumatic disease and fit with nurse led clinics
- Policy context – with regard to health reforms
- Development of nurse led clinics in the community – “shifting the model of care”
- Questions/Discussion
Brief introduction to rheumatic disease and fit with nurse led clinics

- IA of which there are 200 forms affect approx 1% of the population more for OA
- Causes unknown environmental vs infective vs genetics
- 20% Follow ups in primary care musculoskeletal
- NICE guidance RA, High cost drugs & OA – poorly managed
- Obvious need for specialist nurses – little expertise in primary care
What RA looks like?

Joints that may be affected by rheumatoid arthritis
Punched out Erosions
Ankylosing Spondylitis – bamboo spine
Psoriatic Arthritis

Psoriatic Arthritis: Arthritis Mutilans—Telescoping
Systemic Lupus Erythematosus
Features of Scleroderma
None joint features

- Anaemia
- High acute phase response
- Nodules, vasculitis
- Autoantibody formation
- Fever, weight loss, fatigue
- Dry eyes, dry mouth
- Inflammatory lung disease
- CHD
- Nerve root entrapment and enthesopathy
- Depression

Determinants of poor prognosis & how it progresses
• Presence of antibodies, ↑ ESR/CRP, early erosions, poverty, low educational status
• Few experience remission and about 30% partial remission
• Majority lead to chronicity and permanent disability

Treatment

- Early diagnosis & rx before damage, tight control & assessment
- MDT approach
- Ed, support & self management
- Exercise
- Rapid access - helpline
- Access to biologic drugs (savings re delivery)
Policy Context – with regard to health reforms

- Politics – Health Policy
- Lord Darzi – care closer to home, LTCs & prevention
- No new investment after 2010, no cut in front line
- World Class & Practice Based Commissioning
- New drugs, NICE, MSF, new tech eg. Emis and uss and other less invasive diagnostics
- Variety of service models, Local enhanced services, ICAT, Independent, e.g. Oldham Pennine MSK and ours
- Payment by results PBR - Tariff (treatment & procedures based) undercut
- Patient pathways
- Patient choice – choose and book
- Outpatients referrals increasing 5% year on year
- Estimated 80% work can be taken out of secondary care
The Department for Health has set out 10 competencies for PCTs, aiming to:

- tackle health inequalities
- improve the health of their local population
- ensure fair competition and access to services
- engage with the public as customers to improve the patient experience
- determine objective outcome measures of effective service provision
- PCTs commissioning strategies outlining a 5-10 year plan redesign of heart disease, diabetes and rheumatology
- your department is likely to be scrutinised now or in the future (this varies for devolved countries)
So how could Dawn influence this?

- Rheum nurse consultants 13 in the UK (100’s of cns’s)
- Working in an acute Trust sphere of influence limited
- Strategic skills master class, service redesign, 3 action points
- Action point 3 specifically
- Oct 08 – April 09 business case
- July 09 launch of community rheumatology service
- Now 15 practices, 4 clinic bases, case load of 150 patients life long
- 20% cheaper, no overheads, no middle management
Development of nurse led clinics in the community – shifting the model of care

- Aston, Deprived population, more ill health, low educational attainment and equality issues 8:10 patients ethnic minority groups
- LPHC, HWMC, St James, Enki – Vitality 100,000K
- Phased approach Perry Barr and One Stop locality – reach out PCT wide “The worlds the limit”
- GPwSI Dr Empson - Triage
- Dawn Homer - Nurse Led Clinics for existing patients
- Links with SWBH
- Outcomes measurement
- Funding – contract
- Integrated model of care – skill set migration
- Potential for primary care research
- PBC savings reinvested in primary care
Development of nurse led clinics in the community – shifting the model of care

- Wrote protocols, patient information and website www.bhamcrs.co.uk
- Access MDT - referral pathways
- Equipment & Drugs budget/prescribing pads
- Diagnostics and results gp home page
- IT training
- Networked with GP’s - buy in & premises
- Identified patients with informatics/gp registers
- Mail shot patients, follow on call
- PA books appts - choice of times, locations and maintains database
- Write management plan to patients, gp’s and specialist this also educates and up skills community clinicians
- Can deal with poly pharmacy and co-morbidity primary care resource
- Blackberry – helpline patients can call, text or email/nhs.net
- Rapid access slots
- KPI/ PROMS - Outcomes and template e.g. patient satisfaction
- Monthly return and six monthly reviews
- Exploiting community services eg matron, social services, return to work
- Exploring op’s for new nurses and a rheumatologist
1 Question before I say thank you and take your Questions?
References


- Oxford Handbook – Musculoskeletal Nursing (July 2009) Oliver S (Chapters 12 & 21 Homer D)
Adherence to medication and the patient with ‘difficult asthma’

Dr Jacqui Gamble
Sister Regional Respiratory Centre
Belfast Health & Social Care Trust
Adherence to Medication & Difficult Asthma

Jacqui Gamble
Regional Respiratory Centre
Belfast City Hospital
The Difficult asthma patient’s experience of taking steroid therapy

- Steroid Phobia - current side effects
  potential side effects

- Cost benefit analysis

- Knowledge

- Routine

Gamble et al 2007, J Clin Nur
Difficult or refractory asthma?

- **Difficult asthma** (BTS 2008) – difficult asthma—‘Persistent symptoms and/or frequent exacerbations despite treatment at step 4 or step 5’.

- **Refractory asthma** (ATS 2000)—Applicable only to patients in whom other conditions have been excluded, exacerbating factors treated, and patient believed to be generally compliant.
Adherence & Difficult Asthma

- Prevalence of non-adherence in difficult asthma
- Nurse-led intervention to improve adherence
- Feedback discussion to improve adherence
Non-adherence - Background

- 20% - 75% - chronic medical conditions
  - differing definitions, measuring methods, calculation methods

- 10 - 50% inhaled asthma medication taken as prescribed

- Probable issue in difficult to control asthma

- Measure the extent of problem

- Unclear about effective management strategies
Method

- Cross-sectional study - n= 182

- Prescription refill data for combination inhaler (LABA + inhaled steroid) preceding 6 months

- Expressed as a % of prescribed medication

- Non-adherence defined as - prescription filling of ≤ 50% of prescribed

Gamble et al AJRCCM (2009)
Adherence to inhaled combination therapy
# Group Variables

<table>
<thead>
<tr>
<th></th>
<th>Non adherent</th>
<th>Adherent</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>41.90 ± 13.80</td>
<td>42.2 ± 14.70</td>
<td>ns</td>
</tr>
<tr>
<td><strong>Sex (M/F)</strong></td>
<td>16/47</td>
<td>53/66</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td><strong>FEV$_1$</strong></td>
<td>1.95 ± 0.78</td>
<td>2.2 ± 0.80</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td><strong>Admissions in previous 12 months</strong></td>
<td>25% ≥ 3</td>
<td>10% ≥ 3</td>
<td>p&lt;0.05</td>
</tr>
</tbody>
</table>
## Medication

<table>
<thead>
<tr>
<th></th>
<th>Non Adherent</th>
<th>Adherent</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total beta-agonist doses</td>
<td>2012.6 ± 2237.6</td>
<td>1661.7 ± 2141.3</td>
<td>ns</td>
</tr>
<tr>
<td>(reliever)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own a nebuliser</td>
<td>30/61 (49%)</td>
<td>30/90 (33%)</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Nebs used in 6 months</td>
<td>99.1 ± 183</td>
<td>41.7 ± 86.5</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Prescribed daily Inhaled</td>
<td>1493.6 ± 539</td>
<td>1332.2 ± 550</td>
<td>p&lt;0.06</td>
</tr>
<tr>
<td>steroid dose (BDP equiv mgs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Prednisolone</td>
<td>25 (49%)</td>
<td>26 (51%)</td>
<td></td>
</tr>
</tbody>
</table>
## Quality of Life

<table>
<thead>
<tr>
<th>Metric</th>
<th>Non adherent</th>
<th>Adherent</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euro QoL Thermometer</td>
<td>0.54 ± 0.2</td>
<td>0.62 ± 0.20</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>AQLQ Symptom Score</td>
<td>2.80 ± 1.04</td>
<td>3.50 ± 1.57</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>AQLQ Activity Score</td>
<td>3.20 ± 1.13</td>
<td>3.70 ± 1.40</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>AQoL Total Score</td>
<td>3.06 ± 1.03</td>
<td>4.16 ± 6.20</td>
<td>p&lt;0.05</td>
</tr>
</tbody>
</table>
Conclusion

- Significant proportion are non-adherent (35%)
- Poorer Quality of life
- Increased admissions to hospital
- Increased inhaled and nebulised reliever use
- Strategies to improve adherence
Nurse-led intervention to improve adherence to medication in difficult asthma

- To develop and deliver an individualised nurse-led programme to improve adherence in difficult asthma.

- To evaluate and analyse the relationship between groups, the intervention and selected outcomes.
STUDY DESIGN

- Single blind, randomised, controlled, pilot study.
- 20 non-adherent difficult asthma patients.
- Randomised to control or intervention group.
Outcome measures

PRIMARY OUTCOME MEASURES
- Adherence to inhaled steroid therapy
- Adherence to oral steroid therapy

SECONDARY OUTCOME MEASURES
- Improvement in asthma symptom scores
- Improvement in Asthma quality of life scores
- Improvement in Hospital Anxiety and Depression Scores
- Improvement in lung function
- Reduction in courses of rescue steroids
- Reduction in hospital admissions
Experience of patients prescribed corticosteroid therapy

- Steroid phobia
- Self management
- Education
- Environmental factors
- Personal attributes

Intervention

- Control group - standard asthma management

- Intervention group – 12 week programme
  - interview
  - education
  - motivational interviewing
  - psychotherapy - CBT/relaxation/panic cycle

- Maximum 8 visits
Results

Adherence - baseline to 12 months

[Graph showing adherence to ICT over baseline to 12 months for control and intervention groups.]
Number of participants’ adherent to Inhaled combination therapy, baseline to 12 months

<table>
<thead>
<tr>
<th>Number of participants adherent to ICT</th>
<th>Study Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention Group (n=9)</td>
</tr>
<tr>
<td>Adherent</td>
<td>Non-adherent</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Baseline</td>
<td>0</td>
</tr>
<tr>
<td>6 months</td>
<td>3</td>
</tr>
<tr>
<td>12 months</td>
<td>4</td>
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### Secondary outcomes

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Groups</th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
<th>F</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS daily dose (μg)*</td>
<td>IG</td>
<td>1467 ± 176</td>
<td>1314 ± 242</td>
<td>1314 ± 242</td>
<td>2.42</td>
<td>0.14</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>1346 ± 197</td>
<td>1418 ± 243</td>
<td>1491 ± 236</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total reliever doses filled in 6 months</td>
<td>IG</td>
<td>4022 ± 2398</td>
<td>4400 ± 2427</td>
<td>4714 ± 2635</td>
<td>0.01</td>
<td>0.91</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>2200 ± 548</td>
<td>2300 ± 384</td>
<td>1900 ± 396</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total β2-agonist nebules filled in 6 months</td>
<td>IG</td>
<td>75 ± 43.5</td>
<td>105 ± 37.8</td>
<td>90 ± 44.3</td>
<td>&lt;0.01</td>
<td>0.99</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>136 ± 41.6</td>
<td>128 ± 45.8</td>
<td>152 ± 54.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily maintenance prednisolone dose (mgs)</td>
<td>IG</td>
<td>15.0 ± 8.4</td>
<td>9.38 ± 3.6</td>
<td>9.38 ± 3.6</td>
<td>99.5</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>16.7 ± 4.4</td>
<td>20.0 ± 2.9</td>
<td>20.0 ± 2.9</td>
<td></td>
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</table>
## Asthma Quality of Life

<table>
<thead>
<tr>
<th>AQLQ Domains</th>
<th>GROUPS</th>
<th>Minimal Clinically Important Differences</th>
<th>CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>IG</td>
<td>0.61*</td>
<td>-0.22 to 1.43</td>
<td>0.04**</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>0.39</td>
<td>-0.22 to 1.01</td>
<td>0.19</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>IG</td>
<td>0.54*</td>
<td>-0.30 to 1.38</td>
<td>0.09</td>
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<tr>
<td></td>
<td>CG</td>
<td>0.55*</td>
<td>-0.84 to 1.12</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>IG</td>
<td>0.78*</td>
<td>-0.18 to 1.75</td>
<td>0.05**</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>0.16</td>
<td>-0.37 to 0.68</td>
<td>0.55</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td>IG</td>
<td>0.40</td>
<td>-0.95 to 1.64</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>0.67*</td>
<td>0.04 to 1.30</td>
<td>0.05**</td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td>IG</td>
<td>0.62*</td>
<td>-0.95 to 2.21</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>CG</td>
<td>-0.18</td>
<td>-0.82 to 0.79</td>
<td>0.97</td>
</tr>
</tbody>
</table>
Limitations/Conclusions

- Small numbers, under powered
- Difficulty recruiting
- Positive primary outcome
- Provides data for a definitive larger study
Feedback discussion

- 40% altered adherence status
- Hypothesis- feedback discussion change behaviour
- Retrospective follow up
- Asthma outcomes
- Long term adherence
Feedback discussion content

- Semi-structured using prescription refill information to initiate discussion
- Normal behaviour
- Potential detrimental effects
- Eliciting reasons for non-adherence
- Discuss worries or concerns regarding medication
Results

- 6 months pre-discussion 100% non-adherent
- 9 months (median) post discussion 100% adherent
- 18 months (median) post discussion 90% adherent
## Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Pre-discussion</th>
<th>Time 2 9 months (median) post discussion</th>
<th>Time 3 12 months (median) post discussion</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% adherence to ICT</td>
<td>37.3 ± 2.5</td>
<td>88.5 ± 2.8</td>
<td>82.3 ± 4.4</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>ICS daily dose (μg)**</td>
<td>1616 ± 88</td>
<td>1294 ± 101</td>
<td>1281 ± 100</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>No. courses rescue prednisolone</td>
<td>2.2 ± 0.3</td>
<td>0.55 ± 0.20</td>
<td>0.71 ± 0.2</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Maintenance prednisolone dose (mgs)</td>
<td>14.1 ± 1.9</td>
<td>13.1 ± 2.1</td>
<td>11.5 ± 1.5</td>
<td>0.22</td>
</tr>
<tr>
<td>Total β2-agonist doses</td>
<td>1705 ± 453</td>
<td>1482 ± 372</td>
<td>1500 ± 485</td>
<td>0.29</td>
</tr>
<tr>
<td>Total β2-agonist nebulites</td>
<td>221.5 ± 90.9</td>
<td>93.3 ± 36.2</td>
<td>169.3 ± 59.4</td>
<td>0.32</td>
</tr>
</tbody>
</table>
Hospital Admissions

No. of hospital admissions

p = 0.006

TIME

pre-intervention  9 months post  18 months post
Conclusions

- 34% non-adherent to ICT, 49% non-adherent to oral prednisolone
- Poor adherence associated with ↑ medication use and admissions and ↓ quality of life
- An individualised nurse-led intervention improves adherence to ICT
- A feedback intervention improves adherence to ICT
Jacqui Gamble
Regional Respiratory Centre
Belfast City Hospital

Jacqui.gamble@belfasttrust.hscni.net
Tele: 028 9026 3740
Reproductive decision-making and experience of pregnancy and childbirth following HIV diagnosis – a longitudinal qualitative study of experience and care in Northern Ireland

Carmel Kelly
PhD Student
School of Nursing & Midwifery Research Unit, Queen’s University Belfast
Chair’s closing remarks

Sandy Harding
Outpatient Nurses Forum
Thank you for attending
Outpatients: Our Service, our future

We hope you have enjoyed the conference and look forward to welcoming you next year.

Have a safe journey home