A common criticism of NHS trusts that have run into difficulty is that they have focused too heavily on balancing their books, chasing foundation status and hitting government targets.

In some cases staff numbers have been cut and the skill mix diluted to save money, but patient care has suffered as a consequence. Research conducted over the past six years on behalf of the Burdett Trust for Nursing revealed that clinical issues barely featured at some NHS board meetings, some of which are held in private anyway.

Concern about some organisations’ skewed priorities were raised in October by nurse leaders and patients’ representatives at a meeting organised by Nursing Standard and the Patients Association.

Attendees agreed ten priorities for action (see box, opposite) that, taken together, would help to achieve our Care campaign’s objective of ensuring patients’ fundamental needs are always met. Top of their list was that boards and senior managers must ensure that patient care is always their core focus.

The most notorious case of a trust that lost its way is Mid Staffordshire, which is now the subject of a public inquiry over what went wrong. As part of its attempts to turn round the organisation, the new management team decided to hold board meetings in public and encourage patients to participate. Patient experience and quality of care issues take up much of the public agenda, and meetings begin with a patient or staff story.

Sir Stephen Moss, a nurse by background who recently stepped down as chair of the trust board after three years in post, began the January meeting by stressing the main focus of the board was patient care and quality.

Cancer nurse specialist Thelma Proffitt, retiring after 42 years, then told the board about the improvements she had made and what else the trust could achieve in the area of cancer care.

But it was also clear that, despite this patient focus, the trust was not achieving all it wanted to in terms of quality.

A list of 82 serious incidents in this financial year was received with dismay. Non-executives were keen to establish whether this indicated a deteriorating position or simply a change in reporting. Sir Stephen said this
was despite the creation a few years ago of a ‘zero harm group’, a network that aims to improve patient safety. ‘It is clearly not working. How are we going to change our approach?’ he asked.

There was disquiet about a decision to keep the A&E closed overnight, but the board was adamant that the unit should not reopen unless it could offer and sustain safe care.

Colin Ovington, director of nursing at Mid Staffs since June 2010, says the trust has moved from the ‘dysfunctional’ position it was in before, but acknowledges progress is required to achieve consistent standards. ‘The improvements are having an effect. We still have things going wrong, but not in a systematic way,’ he says.

Changes have included the presence of the director of nursing and other senior nurses on the wards: ‘It is a key element of how you work with staff,’ he says. Staff are more involved in how things are done in the organisation – senior nurses, for example, now meet each other regularly and are working on a nursing strategy together.

Clinical supervision and staff appraisals have been strengthened and the trust also has a board-level director of patient experience. One of the changes patients will have noticed is a ‘comfort round’ every two hours, where they are asked if they need a drink, a toilet visit or any other assistance.

In these ways the executive team at Mid Staffs is ensuring it sends out the important message to every level of the organisation that – even though it faces a £20 million deficit – patient care must come first.

**Leadership**

The message that care must be an organisation’s core focus needs to be led from the top, according to Jocelyn Cornwell, director of the Point of Care project at the King’s Fund, a healthcare think-tank.

Board members should spend time in clinical areas to see for themselves what is going on, and to question and discuss patient care, she says.

This helps to convey a message to staff. By saying ‘I will come to you’, the manager is recognising the importance of maximising staff input into patient care.

NHS boards have been increasing their focus on quality and patient safety. For example, Central Manchester University Hospitals NHS Foundation Trust’s board spends 60 per cent of its meetings discussing patient care. Chair Peter Mount told a recent Care campaign conference that every board member also carried out unannounced monthly visits to clinical areas. He said: ‘Of course, I am not au fait with everything that is going on in the trust – any board members who say they are would not be telling the truth. But if something is going wrong, I will find out about it pretty quickly and my first question will be “what are we doing about it?”’

Experts believe the culture of any care organisation is directed by the board. If it believes providing quality care is paramount then this should be communicated to staff in a number of ways – through the board papers and staff newsletters and in meetings.

It should also be evident in approaches taken by organisations to make patients central to care.

The director of nursing provides a crucial steer, both in terms of downward communication from the board and in representing nurses’ concerns at the top table, says Ms Cornwell. ‘How they conduct themselves, the kind of leadership they offer, how they articulate the complexity of the patient experience to the board, and a team approach on the wards are key.

‘Back-to-ward Fridays’, where senior nurses work alongside other nurses –

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**New series**

The priorities for action drawn up in October by nurse leaders and patients’ representatives will each be explored in the next ten issues of Nursing Standard. They are to:

- Make patient care the core focus.
- Improve staffing levels.
- Enhance support for sisters and charge nurses.
- Reduce bureaucracy.
- Make the economic case for nursing – and for care assistants to be regulated.
- Prevent burnout.
- Make speaking out about poor care a professional expectation.
- Improve nurse training and close the theory/practice gap.
- Set explicit standards for nurses’ behaviour.
- Promote support for all nurse leaders.
usually in uniform – is a good way of ensuring all members of the nursing team understand better the pressure and constraints on ward staff.

The scheme, pioneered by Guy’s and St Thomas’ chief nurse Eileen Sills, also keeps senior nurses in touch with the patient experience and provides ward staff with leadership and practical support.

Ms Sills says 100 senior nurses are now involved in the programme and it means she can talk to her board about front line care with ‘authority and absolute clarity’. She says: ‘I am not reliant on feedback. We have developed our understanding of care by seeing it directly.’

At ward level, the messages a manager gives out about patient care, and the relative importance he or she places on hands-on care and monitoring through data collection, have an influence on what happens to patients.

Here the ‘productive ward’ management tool to streamline processes and environments can be used to release time for nurses to spend with patients.

Audits have shown that it can free up more than 40 per cent of nurses’ time. The programme has been associated with other benefits, such as reduced length of hospital stay and improved staff satisfaction.

Another patient-focused approach is the use of intentional rounding. Ms Cornwell says that, if patients have confidence that nurses will soon be with them to deal with their requests, there is the additional advantage of calmer clinical areas through a reduction in the use of call bells.

However, she warns there is a danger it can become a tick-box exercise used to build evidence that nurses have attended to patients every one or two hours, rather than identifying patients’ needs and responding to them.

She says an over-zealous focus on indicators can have unintended consequences. For example, a target to reduce the number of falls could lead to over-stretched staff telling patients to wet the bed rather than risk going to the toilet.

In addition, other positive aspects of the care experience, such as showing kindness, are not measured.

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### Campaign aims

Our joint campaign with the Patients Association aims to ensure that nursing staff always:

- **C – Communicate with compassion**
- **A – Assist with toileting, ensuring dignity**
- **R – Relieve pain effectively**
- **E – Encourage adequate nutrition**

The campaign will:

- Highlight obstacles staff face in delivering the campaign’s aims.
- Ask organisations to sign up.
- Support staff who expose care failings.
- Encourage patients to challenge poor care.

Go to www.thecarecampaign.co.uk
Twitter: http://tinyurl.com/twitter-care
Facebook: http://tinyurl.com/facebook-care

In January, prime minister David Cameron announced a range of measures to boost nursing care. They included a nursing and care quality forum to be chaired by Sally Brearley, a former nurse and fellow of the National Nursing Research Unit at King’s College London.

She believes patients should be asked by nurses and nursing students about the care they experience. ‘That should be absolutely integral. Part of the caring relationship is getting real-time feedback,’ she says.

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### Staff and board use patient films to improve care

Videos of patients’ and carers’ stories are being used to change the culture at East Kent Hospitals.

Deputy director of nursing Steve Hams says the films were introduced at board meetings to profound effect.

The first featured the case of 93-year-old Jean Dudley, who died at home after being discharged.

Her daughter spoke about her mother’s care, and that of other patients, which she had observed.

She noted that individuals were not helped with feeding, that little understanding of patients’ physical disabilities was shown, that one patient was given a tablet that had fallen on the floor, and that there was a disregard for dignity and privacy. ‘It was shocking,’ says Mr Hams.

‘My initial response was that it was an indictment of nursing care and I was very saddened.’

The videos have prompted intense discussion among board members and given them an insight into patient care.

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The trust now uses patients’ stories – good and bad – regularly.

The videos are shown to staff on the wards involved. The films are being used, with identifying details removed, in training programmes on how to deal with complaints. One patient’s story has led to improvements in the ambulatory care pathway.

Mr Hams stresses the experience of most patients is very good and says that he does not believe staff come to work with the intention of doing a bad job.

Nurses who see the videos about poor care are disappointed and sad, he says. ‘They want to make a difference and take the opportunity to adapt the way they work.’