The National Stop the Pressure Programme for England

Prof. Jacqui Fletcher,
RN and Senior Clinical Advisor

STPP – Stop The Pressure Program -- is a health improvement methodology for England (not the whole of the UK), originally started 2012 in east of England region, and then spread across the central area of England, encompassing 88 organizations.

Momentum was lost, and then picked up again in 2016 (led centrally) when the Chief Nurse decided she wanted reduction of PUs to be one of her strategic objectives.

What is STPP?

- STPP is a system-wide improvement program working across acute and community settings.
- STPP works in collaboration with key partners in social services and care home settings.
- STPP is integrated with NHS Improvement as part of a wider Patient Safety Campaign and an improvement priority within the NHSI business plan for 2016/2017-18

STPP has 3 main teams:

1. NHS England
2. Improvement (regulatory)
3. Carter team (trying to take forward massive changes in model hospitals and model communities)

STPP also works with Academic Health Science Networks.

This is part of patient safety business plans.

Aims of STPP:

- Develop and implement national definitions.
- Develop and implement local reporting mechanisms.
- Develop and implement and national measurement strategy.
- Review delivery of pressure ulcer prevention education and develop a national curriculum and competency framework to be used by both pre-and post- qualification staff.
- Deliver an improvement collaborative to tackle variation in practice in providers.
- Develop a strategy for public engagement in pressure ulcer prevention.

In order to do so, we need to develop the evidence base by:

- Doing a review of Trust Improvement plans
- Working with Improvement Collaboratives
- Liaising with other system-wide organizations
    - NHS England
    - AHSNs
    - Regional Clinical groups
- Developing consensus

What has already been done?

- A review of Trust Improvement plans (248 Trusts, 172 plans received)
- Working with NHS England (reactor red program) through a National Consensus meeting with 137 delegates with a consensus on 14 of 24 statements. A round 2 survey is being planned.

There are less than 2 full time people in this program, so we're not able to support randomized control trials. We're trying to develop consensus instead.

Improvement Plans were gathered from all the organizations (248 trusts submitted 172 plans).

- We put together statements to test.
- Got 137 specialist nurses to a meeting, and achieved consensus on 14 of 24 statements. Consensus defined as 70% agreement.

We've taken the rest and we're going to have a second round of voting with a bigger audience to see if we can achieve consensus.

Within the improvement plans, common themes we saw:

1. Leadership – support from above – must be embedded with executive staff (not just with clinical staff)
2. Program Management support
3. Appropriate governance
4. Quality Improvement (QI)methodology --PDSA, tests of small change cycles
5. Partnership working -- wasn't just a hospital working on their own – they were working with their communities, local nursing homes, local academics
6. Use of data/measurement -- they were just collecting numbers and reporting them, without understanding what they meant in terms of health improvement! (This is a big problem.)

> **An aside:** Patient Safety Thermometer has been a national priority since 2012. All organizations are submitting data. We have data set of 4,000,000 patient reports around harm in healthcare. It was originally put forward of measuring prevalence and incidence, with some really poor definition of what a new pressure ulcer was, compared to what an existing pressure ulcer was. We're using our new definitions group to clarify this.
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> It's SUCH a big data set, we don't want to lose it.

7. Documentation – it's generally so poor, sometimes we take the blame for something that didn't happen in our care, just because we can't PROVE that it didn't happen in our care.
8. Clinical Focus – working on delivering bundles of care as a way of driving down PU numbers.
9. Review of TVIN Resources (tissue viability) – the amount of specialist support in hospitals is really variable. Iniquitous.
10. Education – constant theme – everybody talked about the need for MORE education but nobody talked about evaluating the IMPACT of the education. How do we deliver it? What difference does it make?
11. Equipment – having timely access to equipment and what difference that makes.

What was MISSING from these reports is:

- Any mention of nutrition
- Incontinence management linked to PUs
- Patient experience
- Seated patients (It's a big challenge – we talk about mattresses but we need to talk about seating!)
- Bariatric care (larger people) – nobody talked about how to manage those patients to decrease PUs.

What we've achieve consensus on:

1. In England, we should use the term Pressure Ulcer. (76% agreed)
2. In England, a pressure ulcer should be defined as: "A pressure ulcer is localized damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful." (97% agreed)
3. In England, a pressure ulcer which has developed due to the presence of a medical device should be referred to as a medical device-related pressure ulcer. (95% agreement)
4. In England, the NPUAP 2015 definition of device-related pressure ulcers should be used: "Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes." 90% agreement)
5. In England, a pressure ulcer which has developed at end of life due to 'skin failure' should be referred to as a "Kennedy ulcer". (79% disagreed)
6. In England, organisations should follow the current system recommended in the International Guidelines incorporating categories 1, 2, 3, 4. (82% agreement)
7. In England, organization should follow the current system recommended in the International Guidelines incorporating DTI. (92% agreement)
8. In England, organisations should follow the current system recommended in the International Guidelines incorporating unstageable. (71% agreement)
9. In England, the DoH definition of avoidable/unavoidable should be used. (90% agreement)
10. In England, the 72-hour rule should be abandoned. (80% agreement)
11. In England, device-related pressure ulcers should be reported and identified by the notation of (d) after the report e.g. Superficial PU (d) to allow their accurate measurement. (94% agreement)
12. In England, Kennedy ulcers should not be measured. (84% agreement)
13. In England, all datix (or alternative) reports should identify the patient using the NHS number, not the Hospital number, to assist in reducing duplication of reporting. (98% agreement)
14. In England, there should be an agreed teaching resource to assist in understanding the difference between a PU and a DFU. (95% agreement)

The Carter team, in our recent meeting with them, were obsessed with counting the number of patients who have PUs but then no one looks at the numbers! Nobody is looking at how quickly we can heal them! We want to reduce prevalence AND incidence. We must heal them quickly as well as preventing PUs in the first place.

National audits – not just counting how many PUs but what assessment have they had? What equipment have they had? What went wrong? What's in place now? More data is needed on an

organizational level, ward/clinic/caseload level and the patient level, insofar as risk, interventions and occurrences of PUs are concerned.

The education working group has just started. The aim is to look at what education already exists, how to make future recommendations, and develop a national curriculum and a set of resources behind that – make all the curriculum available – games, activities (not just PPTs!) They will develop core modules in a matrix style.

Focuses of education are to include:

- Understanding the current educational profile across the health economy and identifying gaps to be addressed
- Developing a set of recommendations for the future provision of education in this area
- Setting a timetable for key pieces of educational development
- Developing a recommended National Curriculum that may be adopted by all relevant education providers
- Developing an implementation plan to support the roll-out of the curriculum
- Developing resources that may be used to facilitate standardised education provision and to encourage interactive and engaging education provision
- Improvement collaboratives – these are 90-day improvement programs. We plan to work with 20 organizations, looking at Patient Safety Thermometer data. What are the hotspots? Is it in ICU? We will be asking orgnanisations to VOLUNTEER to participate.

We want to get public engagement and raise awareness and will be planning a campaign with national radio stations. We have well-known DJs on board. There is a Stop the Pressure day coming up on November 16, 2017.

Conclusion:

We are aware that in order to affect change and improvement, this will have to be done as a large-scale program.

Our aim is reducing harm to patients. We know that we must do this collaboratively. If you are in England and want to participate, contact me!