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Reflections 3 YEARS ON

A COLE • B VAUGHAN

KING'S FUND CENTRE

Nursing Development Units

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Nursing Development Units

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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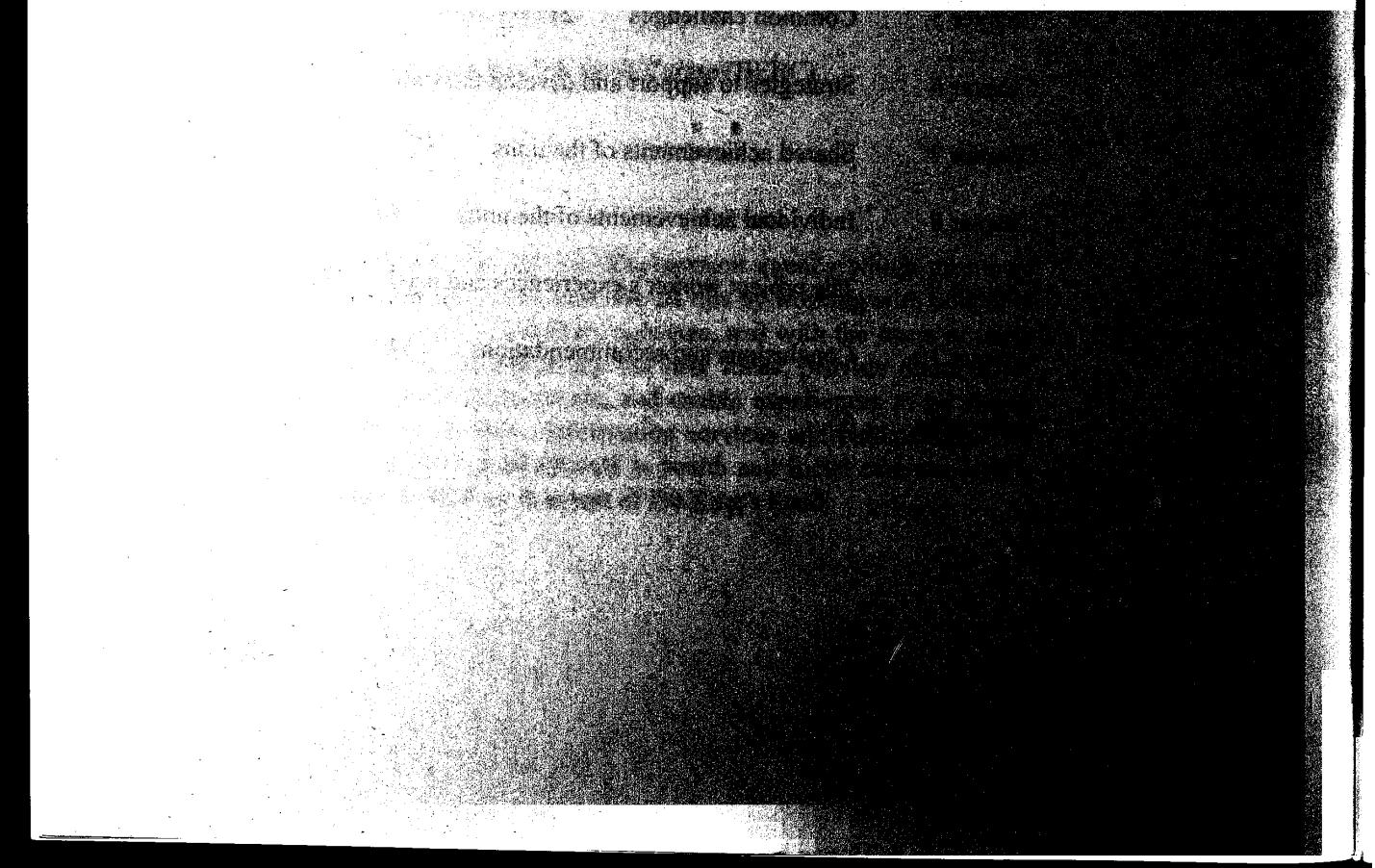

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Gillian Black	– formerly Project Worker, King's Fund Centre
Amanda Evans	– Clinical Leader, Byron Ward, King's Healthcare (formerly Camberwell)
Brenda Hawkey	– Clinical Leader, Homeward, Brighton
Jackie Horner	– Clinical Leader, Paton Ward, Southport
Sharon Waight	– Clinical Leader, Maud Alexander Ward, West Dorset
Barbara Sheppard	– Researcher, Homeward, Brighton
Lynn Batehup	– formerly Director of the King's Healthcare NDU
Martin Smits	– Director of Nursing, Brighton
Joy Warren	– Researcher, West Dorset

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Executive summary

1. There is no doubt that Nursing, Midwifery and Health Visiting Development Units (NDUs) are an effective way of improving the quality of patient care through the development of nurses and nursing.

2. This outcome is achieved in three specific ways, all of which can be linked to *A Vision for the Future – The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care**

> (i) Small-scale project work focusing on specific aspects of nursing to ensure that care is based on well-founded knowledge and research (e.g. wound care, pain management, and nutritional assessment). (Targets 1, 3, 5 and 9)
>
> (ii) Development of nurses through such actions as the use of Individual Performance Review, Personal Development Plans and the introduction of primary nursing. (Targets 1, 5, 6 and 10)
>
> (iii) Exploration of new approaches to nursing such as the nursing role in rehabilitation, nurse–patient relationships, user involvement and the use of nursing beds. (Targets 1, 2 and 9)

3. NDUs can act as exploratory pilot sites for the development of new approaches to care delivery. They can function as a local resource in developing models of good practice, acting as a role model, providing teaching and consultancy and contributing to policy making.

4. The focus of work is driven by the context in which it takes place and dependent on local needs and situations. Both professional and corporate aims must be taken into consideration in formation of strategies.

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* See note 16 on p.64

5. Work emerging from the NDU can be of value both locally and nationally. Strategies for dissemination are emerging but still require further attention.

6. NDUs enhance recruitment and retention. Staff satisfaction is high, despite work being undertaken at a time of great uncertainty within the health service.

7. No additional funding is required for provision of patient care in NDUs. Additional costs relate primarily to evaluation and research, time for staff development and consultancy and secretarial support to help with the additional administration.

8. Some costs can be offset by fund raising through such activities as open days, seminars and workshops and the value of the NDU as a resource centre for information and advice.

9. Strong clinical leadership is essential within NDUs as the focus for identifying areas for development, supporting the clinical team, and relating with others within the organisation.

10. The role of the clinical leaders can be very demanding and it is essential that mechanisms are sought to reduce the pressures, such as the provision of professional, managerial and secretarial support.

11. Effective evaluation of the work of NDUs is critical. The importance of collecting baseline data in order to be able to demonstrate development cannot be overemphasised, nor the time and skills required to do this work well.

12. The time which it takes for an NDU to develop should not be underestimated, particularly as the culture within which they are working is also subject to so much change.

13. For organisations to benefit from the work of NDUs local integration and dissemination are essential. Help and support from senior managers and educationalists should be considered to facilitate this aspect of the work and ensure that it is effective.

14. Local support mechanisms are essential for the ongoing work of NDUs and as the number of units grows it is recommended that the national network is backed up by local networks.

15. Consideration should be given to strategic membership of steering groups, including representation from purchasers, providers and users.

16. Factors which facilitate the growth of an NDU can be identified as: strong clinical leadership, managerial support, local networks, administrative support and effective communication within the local organisation with a sense of 'ownership'.

17. Factors which require particular attention include the development of critical evaluation, local integration, dissemination and a realistic review of workload.

In summary, NDUs are a valuable asset for any service provider. They can make a significant contribution to the quality of patient care through constantly exploring and developing new practice initiatives. Hence they will always have a place to fill in developing services. Consideration should be given to the way in which they can work collaboratively with practitioners, managers and educationalist in order to meet both professional and corporate needs and develop nursing practice.

Chapter 1
INTRODUCTION

In 1988, the King's Fund Centre (KFC) set up the Nursing Developments Programme under the leadership of Jane Salvage to foster the development of nursing practice. Early the following year, a unique scheme was announced, funded by the Sainsbury Family Charitable Trust, to provide pump priming funds and support for four nursing development units over a period of three years.

A total of 29 nursing units submitted applications for the grants. These were then reviewed to produce a shortlist of six, ranging in clinical specialty from rehabilitation of elderly people to intensive care. Finally, in July 1989 the four units who would receive grants were identified. In the meantime a project worker for the programme had also taken up post at the KFC, part of her remit being to support the four units during their initial period.

This report outlines some of the current views of those who have been involved in the project throughout, describing what they hoped to achieve; their perceptions of the experience and the outcomes of their work. In compiling the report, information has been gathered from a series of interviews with the clinical leaders and some of the staff involved with each of the four units. Reports from both the units and the KFC which have been produced over the three-year period have also been used. Some conclusions have been drawn and recommendations put forward which will be of value in the future for others who would like to work as Nursing, Midwifery or Health Visiting Units.

Reflections **3** *years on*

NURSING, MIDWIFERY AND HEALTH VISITING UNITS

Nursing, Midwifery and Health Visiting Development Units (NDUs) have been defined as a 'care setting which aims to achieve and promote excellence in nursing ... and where change is almost a way of life'.[1] They act as pilot sites for exploring ways in which nursing can be developed both through the use of research-based practice and exploration of new ideas. Because of the wide range of clinical settings in which NDUs can be found they encompass great variability and must be responsive to local needs. Thus, while there are core characteristics which can be identified, each unit will also have unique features which reflect the context in which it is sited.

In all NDUs, patients or clients are consciously placed at the centre rather than the periphery of the interests of the health care team; an open, questioning and supportive approach to care is encouraged; and there is a belief that nurses, midwives and health visitors can themselves introduce innovations which will benefit patients.

When the NDU project started, the KFC had three examples of successful NDUs on which to base its model:

- Burford in Oxfordshire;[2]
- Tameside in Stockport;[3]
- Beeson Ward at the Radcliffe Infirmary in Oxford.[4]

However, the Beeson experiment came to a premature end, partly as a result of medical resistance and lack of management support,[5] at much the same time the KFC project started. The KFC was determined to learn from Beeson's lessons when it laid down its criteria for the awards. In essence, these were:

1 *Development of nursing.* There should be a clear statement of the way in which nursing would be developed in the unit.

2 *Clinical leadership.* It was recognised that successful and lasting change depends largely on the presence of strong clinical leadership. The clinical leader with responsibility for day-to-day care and long-term strategic planning needed to be clearly identified.

3 *Commitment from the organisation.* The KFC required evidence of support for the project from senior nurses, medical and paramedical colleagues and from general management. It also proposed the setting-up of a steering group to formalise this process.

4 *Staff participation.* Staff needed to take ownership of the project from the start so that the whole team became committed to its success.

5 *Staff development.* The KFC wanted to see evidence of plans to provide formal and informal learning opportunities as well as personal support for all staff.

6 *Evaluation.* This was seen as an essential component of the work and evidence was sought of how the unit was planning to evaluate its care and assess its effectiveness.

7 *Finance.* The KFC sought evidence that the health authority or trust was committed to providing adequate resources for the unit over a reasonable time-span.

8 *Equal opportunities.* In line with the KFC policy, the units were questioned about their equal opportunities policy for staff and for patients.

The four units which met these criteria most successfully in the assessors' view were Homeward in Brighton, Byron Ward in King's Healthcare (then Camberwell), Paton Ward in Southport and Maud Alexander Ward in West Dorset.

- Brighton NDU, a 23-bedded unit for the rehabilitation of elderly patients based in Brighton General Hospital, received a grant of £85,000 over a three-year period. This was to finance a researcher to work on evaluation of the unit's activities as well as for a consultancy fund and computer equipment.

- King's Healthcare NDU, based at Byron Ward in Dulwich Hospital (now King's College Hospital, Dulwich), was a 17-bedded acute medical ward. Its £84,000 grant was to part-fund the new post of Director of Nursing Development and Research as well as a research post, some secretarial support and a continuing-education fund.

- Southport NDU, a 28-bedded acute care of the elderly ward at the Promenade Hospital in Southport, received a £90,000 grant to part-fund a clinical practice co-ordinator and key workers, plus secretarial support and a continuing-education fund.

- West Dorset NDU, a 24-bedded acute medical ward at the Weymouth and District Hospital, was awarded a £90,000 grant to part-finance a clinical specialist post, a research nurse and a continuing-education fund.

Chapter 2
AIMS OF THE UNITS

When the four successful NDUs submitted their proposals to the King's Fund Centre (KFC), they listed their aims and objectives for the following three years. A number of these related specifically to their own vision of how an NDU should be developed, but, interestingly, several of these aims were common to all four units.

SHARED AIMS

Primary nursing

All four NDUs stressed in their applications the importance of developing nursing skills, and linked this closely to the introduction and development of primary nursing. Only one NDU, Southport, did not explicitly embrace this objective, preferring instead to talk of using 'individualised care' and 'moving toward the goal of primary nursing'.

Innovation

All NDUs laid great emphasis on innovation and developing an environment where 'new ideas flourish' and where 'a free exchange of knowledge is not threatening'. Similarly, all recognised the importance of putting ideas and research into practice, and assessing their usefulness.

Patient participation

Just as importantly, the successful applicants all felt strongly that patients should participate in, and not be the passive recipients of, their care. The Byron Ward statement of philosophy and values said:

'Patients have a right to high standards of nursing. They also have a right to be informed and involved in their care and treatment.'

The Brighton team said this should not only be confined to patients. The staff aimed to *'welcome and encourage the active participation of the carer in the individual's care and rehabilitation'.*

Dissemination

All four units recognised the importance of disseminating their work to a wider audience. Either explicitly or implicitly they saw themselves as the prototype for a model which might be spread to other wards in their specialty.

Support worker

Interestingly, three of the four wards wanted to use their new 'seedbed' status to explore the role of the support worker in nursing settings. This has particular relevance in the light of changes in nurse education, and the emphasis placed on effective use of resources.

Quality assurance

Two out of four – King's Healthcare and West Dorset – had already laid plans for formal quality-assurance programmes to measure the quality of care provided.

Status of nursing

What, perhaps above all, united the successful applicants was the vision of an NDU as one that was '*a nursing-led initiative to demonstrate what nursing can offer*'(Director of Nursing, Brighton). Success would enormously enhance nursing's credibility.

The Southport mission statement said: '*In fulfilling this aim* [of improving patient care], *it is hoped that the status of nursing will be raised, so that it can be identified as a legitimate and valued specialty.*'

INDIVIDUAL AIMS

Brighton

Brighton NDU wanted to focus on a number of areas, including:

- the nurse's role in rehabilitation;
- standard setting; and
- the therapeutic involvement of children with elderly patients.

In their application document, the team pointed out that there was widespread confusion over what rehabilitation should involve and who was responsible for which aspects. Over the following three years, the unit planned to examine in depth the nurse's role in rehabilitation of elderly people, and identify the essential skills needed.

The method of standard setting proposed would use a 'bottom up' approach in which a clinically oriented working group would produce the standards and criteria for some aspects of care which would then be fed back to other colleagues in the team.

They also aimed to set up a project which would put elderly patients in touch with children. Similarly, there were plans to extend the unit's diversional therapy to include activities such as horticulture, art, music and drama.
Another aim was to introduce a computerised ward-based system to provide the necessary information for resource management. It was noted that the

effective running of this system would depend upon nurses becoming computer-literate.

The unit's overriding aim was to *'develop our nurses as individuals on the basis that if you could improve the quality of the individual nurse, then you improve patient care ... It was also a case of getting them to look more reflectively at their care.'* ***(Clinical Leader, Brighton)***

King's Healthcare

King's Healthcare's specific aims included:

- providing a 'protected' environment where innovative nursing could take place,
- implementing and evaluating the effects of primary nursing,
- encouraging the participation of patients and relatives,
- developing a coherent quality-assurance programme, and
- devising a strategy for research to be put into practice.

The ward team aimed to set up an information resources area for patients and relatives as part of its attempt to create greater consumer involvement. They also planned to develop teaching and information material about particular tests and treatments that patients might be facing, and to evaluate their effectiveness.

As part of their educational programme, they proposed to produce an individual development plan for each nurse in the NDU, and to set up a system for recording and reviewing performance. They also aimed to evaluate systematically both patients' and relatives' satisfaction with the service.

The current clinical leader of Byron Ward said that they saw themselves as slightly different from the other three units in that they had actually been set up as an NDU the year before receiving additional funding, and were already starting to implement changes by February 1989. By the time they received the go-ahead from the KFC, Byron Ward had well-established research links with King's College Department of Nursing Studies through the joint appointment of a lecturer/ clinical nurse specialist who acted as Director for the NDU. They

had also begun primary nursing and had started operating a quality-assurance programme.

King's Healthcare had originally planned to use the additional researcher to work on another practice area as well as Byron Ward. The clinical leader recalled that they were very conscious that they were already being seen as a special case. They thought an effective way of building bridges would be to spread the resources. However, at that time there was a view at the KFC that it was too early for such action and that resources should be concentrated on one place at a time.

Southport

Southport produced a number of objectives which included:

- setting up a multidisciplinary education forum,
- developing a programme of health education for fit elderly people, and
- establishing closer links with the district's large independent nursing-homes sector.

There were other more specific plans to produce an education package for patients about discharge, encourage interest from those returning to practice, conduct a patient/carer satisfaction survey, and set up and develop a rehabilitation unit.

Their clinical leader felt that becoming established as an NDU would benefit every elderly care ward in the hospital. They did not see themselves as being that exceptional, but did feel they had a lot of things to offer the rest of the organisation.

It was also hoped that the recognition would help recruitment and retention in a traditionally difficult area for staffing.

West Dorset

The West Dorset team wanted to strengthen an already established move towards improved patient care, spreading the NDU concept through sharing their experience and knowledge, and in turn learning from others. Maud

Alexander Ward, where the NDU was sited, is one of three medical wards providing an acute service. They aimed to become known as a resource centre within the unit providing a service for colleagues in order that care could be developed in all areas.

The hub of their work centred around promoting nurse–patient relationships, with the patient being seen as the focal point of all care. Primary nursing had already been established, and this would be further developed alongside designing small-scale, ward-based research studies around communication, pain assessment, discharge planning and self-medication. With the implementation of this work in practice a 'resource centre' would be created for medical, nursing and professional issues which could be shared by all health professions.

Maud Alexander Ward had already pioneered the use of Excelcare, a computerised system of care planning and documentation. They now proposed to develop this work in order to evaluate the quality of care the unit was providing and to measure progress over the three-year period.

SUMMARY

The original objectives identified by all four units were ambitious and encompassed a wide range of different activities. Time has shown that it is not always possible to remain on target for all that it is hoped will be accomplished, and it is evident that effective changes cannot be introduced too quickly. External events, such as staff or organisational changes, have made a significant impact on both the pace and direction of development work and influenced its progress.

This has been the case for all four units and, as time passed, some of the original objectives were modified. However, the value of making a clear statement of intent at an early stage in development work cannot be underestimated since it acted as the focus for action planning and gave direction to the work undertaken.

Chapter 3

ROLE OF THE PROJECT WORKER

INITIAL ROLE

Gillian Black joined the King's Fund Centre (KFC) as a project worker on the NDU project in November 1989. She had nursed in both acute and community settings, and was working in community nursing education at the time of her appointment. She had a considerable track record of introducing change both in the health service and in education. She also had a degree in philosophy and politics.

The KFC recognised from the start that nurses introducing change needed support and this was to be the principal role of the project worker. With the backing of experience from the KFC she would be able to offer advice and guidance on how to introduce change, how to make that change stick and how to develop support for that project.

SPECIFIC ROLES

Planning the programme of work

At one time or another in the first year, all four NDUs tried to do too much. Additionally, some units found it harder to break down their work into manageable objectives than others. The project worker was able to help them to develop a realistic programme of work and assist staff to realise these objectives. She also encouraged unit leaders not to become too wedded to

particular plans. '*The overall aim, after all, was to improve patient care. If we found the objectives weren't helping, then we were happy to jettison them.*' Thus flexibility in the light of experience was the order of the day.

Acting as a sounding board

People could try out ideas on the project worker. She was an outsider who could bring a different perspective to bear. She could also help to refine ideas generated within the NDUs, and share ideas and information which had been gleaned from all four units.

Acting as a consultant on professional policy and the change process

This could involve advice or help on specific needs such as how to do a library search or putting NDU staff in touch with particular experts. Equally, it might be a matter of providing help on wider issues such as the NHS changes or how to foster greater consumer involvement.

Special learning opportunities about the change process were provided for the four NDU leaders. This was very much a two-way process with many of the issues and/or problems addressed – such as time management and presentation skills – being suggested by the NDUs themselves.

Creating a climate conducive to developments

The project worker helped NDU leaders to look at ways of influencing their managers to support the project. In order to do this, it was important to consider not merely the interest of nursing but also the interests of the organisation as a whole.

The meetings of the steering groups, which consisted of managers and clinicians as well as NDU representatives, helped foster this approach. There were also a number of seminars and group meetings for managers with direct responsibility for the NDUs.

Supporting the NDU staff

The relationship between the project worker and NDU staff was one of partnership. The project worker aimed to support them in their own training and development rather than imposing development on them. She felt that they were successful in pointing out the diversity and flexibility within which ideals of patient-centred practice and staff participation could operate. (See also Chapter 6 on staff support).

In addition, a series of seminars were organised for NDU staff to foster collaboration. These covered evaluation, time management, personal power and assertiveness. Further seminars were organised for the managers. A research interest group, made up of researchers from the four NDUs, also met.

The other element of support was protection, particularly at the start. As soon as the units received the grants they were exposed to publicity, and understandably managers hoped to promote their work and publicise the so-called 'centres of excellence' within their organisations. In the early stages, however, it was felt that the units needed space and time to decide for themselves when they went public. There was a view that it was important to have an initial period when they could just get on with their work without outside interference and at this stage too much external exposure of their work was discouraged.

Disseminating information

Once the time was ripe, the project worker helped to publicise the scheme as widely as possible. She spoke at local and national events. In 1990, she and the programme director made a presentation to the Nursing Division of the Department of Health, followed by a similar event at the Welsh Office. Presentations about the work were also made by the programme director to the then Secretary of State for Health and members of the NHSME.

Work was also undertaken in spreading both individual experiences and lessons which had been learned about how to bring about change. In 1992 the KFC held a major conference on the work undertaken by NDUs who had received grants; this was accompanied by the publication of *Work in Progress*,

a series of booklets outlining some of the developments.[6] In addition, the KFC Communications Department was helpful in advising NDU staff how to devise publicity material which could be used both locally and nationally.

Contributing experience of other NDUs

The NDU Network of the KFC, a loose association of around 50 units, provided a useful back-up source for the four projects. Information could be shared, problems aired and sometimes solutions found through the experience of others with similar aims and ideas.

Chapter 4

DEVELOPMENT STRATEGIES

The development strategies adopted by NDUs to ensure their success had to be targeted at four groups:

- NDU staff themselves,
- other nurses,
- other disciplines, and
- management.

NDU STAFF

In general, the NDU leaders were extremely successful in winning the support of their own team. There has been enormous commitment and enthusiasm from staff, evidenced in part by the increased stability of the workforce over the three years and the amount of unpaid time many staff have been prepared to devote to NDU activities. At the end of the second year, for instance, 82 per cent of the staff said they would work on an NDU again, and 44 per cent said they would like to be involved in setting up another NDU.[7]

That said, it is clear that the initial proposals to become NDUs had, through force of circumstances, been developed by senior nurses and managers with little direct involvement from the ward nurses. Although the leaders attempted to involve everyone, once the award was a reality, many nurses remained unsure of what it all meant, and felt uncertain about the changes anticipated and what part they would have to play. However, as time went on staff understanding of, and commitment to, the NDU project grew. They were much

more actively involved in drawing up the second year's objectives, which were in turn greatly influenced by the NDU's actual working experience.

The only exceptions to this general rule appeared to be night staff who, on all four NDUs, were less involved in staff development than day staff, a phenomenon which has been identified elsewhere (see p.24). Similarly, on one NDU in particular, nursing auxiliaries, many of whom were nearing retirement, did not appear to become so involved.

OTHER NURSES

Three of the four NDUs had plans to extend the NDU principle to other areas of the hospital. Despite this, the reaction of nurses from nearby wards tended to range from indifference to a degree of hostility in the early days. Several NDU leaders remarked on the irony of the fact that they appeared to be celebrated nationally, and yet cold-shouldered locally. *'When we got the grants we had a tremendous response from other areas, and loads of visits, but we were actually quite disappointed that in our own elderly care unit, the response was so poor. Whether it was jealousy or misunderstanding I don't know.'* ***(Clinical Leader, Brighton)***

At West Dorset, the main problem was that colleagues felt that NDUs were 'special' and therefore their experience could not be replicated in 'ordinary' wards. They seemed to feel, *'Oh, it's Alexander Maud again. They're different; they've got the resources; they've got these extra staff. They can do these things, so let them get on with it.'*

In all the units, the clinical leaders had tried hard to guard against the 'special case' tag, and yet they encountered suspicion from colleagues. Part of this was attributed to the traditionalism of many nurses. The attitude was still 'If it ain't broke, don't fix it'. There was a general feeling that: *"If you have not been trained to stand back and take a fresh look, then a degree of change can be really threatening. It appears to come down to the fact that many nurses are not secure in their own ability and roles."* ***(Clinical Leader, King's Healthcare)***

Things began to improve when nurses at staff level – rather than the unit leaders – started to spread the word. It also made a difference when they were able to offer expertise or experience which other wards needed – a particular example being related to the named-nurse initiative.

The clinical leader in Brighton believes there is a strategic lesson to be drawn from this. *'Each of us thought we would be exempt from this problem, and yet none of us were. I think it needs some kind of organisational involvement. Our managers have got the responsibility to try and help us.'* She also questioned the wisdom of what was then the KFC approach to this issue. *'In retrospect I would pay a lot more attention to reaching out to other wards and bringing them in from the start. The KFC felt there was enough for us to do in our list of objectives without having to worry about the PR side and that would come later. I think probably it should have come first.'*

OTHER DISCIPLINES

All of the NDUs had initial problems with other disciplines, largely because the new way of working, in which *patients were at the centre of care and the nurse their primary carer*. Inevitably this involved different working relationships with other professions. Most have now worked out some sort of *modus vivendi* for multidisciplinary care.

For some units the experience has been a very positive one. In Brighton relations with other professions have improved tremendously. Nurses now have respect as colleagues and equals. Initially some of the therapists were worried that nurses would take over their jobs, but once they grasped the philosophy, it led to much better teamwork. The biggest difficulty at Brighton, as with other NDUs, has been in relations with the junior doctors, who have sometimes rejected a system which appeared to marginalise their contribution. They have also been uncomfortable with nurses' growing assertiveness but effective communication has been the key to better working relations.

In West Dorset, staff were involved in careful negotiations with consultants when implementing primary nursing. Conversely, at Southport, the two

consultants were, if anything, seen to be over-compliant. As the clinical leader commented, *'They tend to say: "Whatever you want to change, that's fine with me". Whatever we discuss, they will say: "Yes, go ahead". But it doesn't sink in. There is still no real meeting of minds.'*

At King's Healthcare, the difficulties were even more daunting. Staff were dealing with a total of 12 consultants as well as large numbers of junior doctors, none of whom stayed for more than six months. The main problem, according to the clinical leader, was that medical staff had different values from nurses and were looking for different things. For instance, doctors became very frustrated when, immediately after primary nursing had been introduced, they were directed not to the ward sister but to the patient's primary nurse – because it appeared to take much longer to gather the information and they were getting much more than they needed. The initial solution here was for the clinical leader to go with the doctor to find the appropriate nurse and then to ask the relevant questions on the doctor's behalf.

It was felt that when changing practice in this way, nurses need to give more thought to how it will affect other professions. *'It was very easy for us to concentrate on being nurses and to some extent ignore the effects of what we were doing on other people. It was a sort of arrogance: like it or lump it. If you are changing the ground rules, I feel now you have got to be more proactive.'* ***(Clinical Leader, King's Healthcare)***

MANAGEMENT

All the NDUs recognised from the start – as did the KFC in its criteria for selection – that management support was one of the keys to ultimate success. Initially, this was forthcoming. Each of the grant applications came complete with numerous pledges of support from general managers, chairpeople and senior nurses. Yet, the real spanner in the works was the NHS reforms which began to bite with a vengeance during these years, and virtually destroyed any hope of management continuity.

At Brighton, for instance, the entire management structure changed three times in the first three years of the NDU. As the clinical leader commented, *'Initially the management we had was very supportive, but they left. A year ago we discovered we had a completely new management, so recognising the importance of winning them over, we did a presentation to key people in the organisation, and now they've all changed again.'*

Nevertheless the importance of keeping managers informed at all stages was emphasised. *'I wouldn't say we necessarily "keep in" with our management. I actually disagree with some of their ideas, and that doesn't make me very popular. But we are quite honest with our management, and we do keep them informed. And that's important. There are lots of areas that are doing tremendous work, but nobody knows about it.'* ***(Clinical Leader, Brighton)***

The precarious state of Byron Ward, which has been threatened with closure on several occasions because of its size, meant that management co-ordination and support were critical. One important factor in the ward's continuing survival was that the lecturer/clinical nurse specialist had overall management authority for the ward and was also privy to senior management discussions. This enabled Byron to anticipate events to some extent.

On one occasion, for instance, when another ward was closed almost overnight, the Byron Ward team, realising how vulnerable they were, sat down to devise a strategy to protect the unit. One of the results of this was a special seminar at which influential figures, including Jane Salvage, then Programme Director, Nursing Developments, King's Fund Centre, and Jenny Wilson-Barnett, Professor of Nursing, King's College, were speakers. As the clinical leader states: *'We deliberately went out of our way to invite people with influence to say "you have got something here in King's Healthcare that is worth keeping".'*

Although the NDU's steering group was used to plan this seminar there were some doubts about the overall effectiveness of this group. The clinical leader at King's Healthcare felt she would '... *question the value of a group that only meets every quarter. Things happen too quickly for it to be of much help on a day-to-day basis.'*

Reflections 3 years on

Perhaps the biggest tribute to King's Healthcare's managerial acumen is the fact that they survived at all, given their vulnerability at times. Most recently, Byron Ward was faced with the prospect of moving sites to become part of a larger ward or changing clinical specialty. Instead, the ward team proposed that they should remain on their present site and become a nursing-led service. This was agreed by the Trust management. A report of this can be found in Evans, A and Griffiths, P, *The Development of a Nursing-Led In-Patient Service*, King's Fund Centre, 1994.

The West Dorset team also emphasise the importance of maintaining links with a changing management structure. *'We have worked very hard to maintain support. There has been constant communication between new managers and nurse leaders. Involvement in steering-group meetings has helped, all of which has led to good working relationships.'* ***(Clinical Leader, West Dorset)*** The management attitude at West Dorset was very supportive throughout, although somewhat distanced from the day-to-day running of the project. As the clinical leader observed, *'They have always recognised that they have got something special in their midst, but their feeling has been: let them get on with it.'*

Some occurrences are, of course, impossible to legislate for. At Southport, difficulties arose with the appointment in 1990 of a clinical leader who had differing views from both clinical staff and managers, making working relationships very difficult. This situation resolved with his departure and relationships are now extremely good. The current clinical leader believes that the moral behind this whole episode is that teamwork and staff commitment are essential, and that management support can never be taken for granted. Isolation is to be avoided at all costs. *'You have got to remain flexible. You have got to keep abreast of things and be willing to change to accommodate outside influences. The major need is to get support from anyone and everybody.'* ***(Clinical Leader, Southport)***

Chapter 5
COMMON CHALLENGES

From the moment they started, the NDUs faced a range of challenges which had to be tackled. Many of these were common to all four units. As will be seen, most were resolved; a few were not.

DISSEMINATION

All the NDU leaders recognised from the start that disseminating information about their work would be critical to their success. This was achieved through open days, workshops, publication, conferences, student teaching, responding to enquiries, and inviting visits. The longest-running NDU, King's Healthcare, seems to have managed to make the greatest impact within its organisation, contributing to strategic planning and helping to develop team nursing, individualised care and individual performance review.

TIME

It took time for the NDU message to be assimilated and for initial suspicions and misunderstandings to be resolved. Many would now agree that it can take a minimum of two years for a unit to establish itself within an organisation.[8]

At King's Healthcare it is believed that it could take even longer: *'I think change on this scale is time-consuming and lengthy, and I'm not sure we are really going to see the effects of NDUs for another 3–5 years, and then it becomes more difficult to make the links between cause and effect.'* ***(Clinical Leader, King's Healthcare)*** Such views are also reflected in the study of the long-established Tameside NDU.[9]

ORGANISATIONAL SUPPORT

NDUs will flourish best in a climate which supports their philosophy and aims. Although there have been shining examples of management commitment to the NDU philosophy over the past three years, this has, in general, been patchy and uncoordinated.

Several NDU leaders indicated they could not fight the battle by themselves and would have appreciated help from senior managers in championing the NDU cause. The Turner Shaw and Bosanquet report on the NDU project calls for:

- development of a contract and clear strategy for action between the organisation and the NDU nurses;
- regular reviews of progress based on the NDU's stated objectives;
- setting up steering groups *before* the NDU is established;
- drawing up clear plans as to how the performance and achievement of the NDU can be measured;
- regular meetings between NDU leaders and their managers.[10]

COSTS

One of the critical questions raised about NDUs is: are they more expensive than 'ordinary' wards? Unfortunately, that is a much more complex question than it might seem.

The DoH-funded evaluation says there is no evidence that NDUs cost more than other wards in terms of direct patient care,[11] and there is general agreement that this perspective is justified. However, this does not take into account the costs of the new posts established as part of the development initiatives. Moreover, extra funding obviously helps. All NDUs acknowledged that the KFC funding made a big difference, and was perhaps essential to give the project a 'kick start'.

In addition, education and staff development need to be seen as integral parts of quality patient care. It is therefore crucial that they are properly costed in the initial budget.

EVALUATION

All those involved in setting up the NDUs had recognised the importance of evaluation in order to provide objective measures of their progress. Yet, in practice, this turned out to be more difficult than most had imagined.

Brighton appointed a researcher to conduct this evaluation and an action research was adopted which followed a cycle of evaluation–action–re-evaluation across the three years. King's Healthcare and West Dorset relied to some extent on their existing quality-assurance indicators, QUALPACS and Excelcare. However, even when the measures of performance had been agreed, there was difficulty in some NDUs in identifying how the data would be collected or who would be responsible.

One of the problems was that in two wards at least, the situation changed so radically during the period under study that comparisons were next to impossible. Southport, for instance, was at one stage primarily a rehabilitation ward and at another stage largely a continuing-care ward. Equally, Byron Ward has had a totally different group of patients since it became a nursing-led unit, and this has inevitably had a knock-on effect on the planned longitudinal study of patient outcomes.

The West Dorset team relied on an internal evaluation of their work. In the light of experience, they believe this was a mistake. *'I think we should have had some outside evaluation of what was going on and had more evidence. It's meant our reports tend to rely on anecdotal material.'* ***(Clinical Leader, Dorset)***

ROLE OF THE CLINICAL LEADER

The original KFC selection criteria recognised the crucial importance of the clinical leader to an NDU's success. The fact that all four units are still thriving is clearly in part a tribute to the ability, enthusiasm and tenacity of the clinical leaders.

However, all the leaders talked at one stage or another of the 'loneliness' of their job, and it could be that this was partly responsible for the fact that two of the leaders left before the end of their three-year contracts. It would seem that the personal development plans, offered to most NDU staff, did not extend to the leaders themselves. Only one had the opportunity to discuss and review personal objectives with a manager on a regular basis emphasising the critical need to ensure effective working relationships with managers at a local level.

Formal meetings between the NDUs were limited for the first couple of years, although a series of seminars were organised over this period of time to foster collaboration. Over the last year, the leaders met every quarter, and these meetings have been 'phenomenally useful', both as a means of problem-solving and as therapy.

THE 24-HOUR TEAM

All NDU leaders acknowledged that to begin with night staff were not as involved in staff development and innovation as day staff. This was partly a logistical problem because it was difficult to get both groups together at the same time. It was also an organisational one since there tended to be a management division between nights and days. Although this improved gradually as some ward sisters began to take on 24-hour responsibility and greater flexibility was introduced into working arrangements, it remains an issue for most units.

THE NURSING ROLE

NDU leaders agree that some of the biggest changes in the last three years have occurred in nurses themselves. By putting nursing care at the hub of the process, and encouraging development and new ideas, the NDU experiment has made nurses more confident and assertive as well as more skilled practitioners.

It has also helped to articulate what nurses actually do. The researcher at Brighton states: *'Part of my mission was to try and make rehabilitation nursing visible; to allow nurses to put into words what they were doing. My observations, for instance, suggested that as patients get better, nurses in rehabilitation withdraw the physical care and increase their emotional care. Yet for most people – including nurses themselves – nursing is all about doing physical things. They are what they do.'* ***(Researcher, Brighton)***

This has been difficult for some nurses to come to terms with. On Byron Ward, for instance, many administrative tasks have been delegated so that registered nurses spend more of their time doing what they were trained to do – care at the bedside. *'It has become legitimate to be with your patient for a length of time, taking, say, 30 minutes at the bed and not feeling guilty about it. I think there is a culture within nursing that believes that being busy means doing. It's quite a culture change for people to feel comfortable not to be seen to be doing. But it's put them in a position to be able to care more effectively.'* ***(Clinical Leader, King's Healthcare)***

However, the new emphasis on bedside care has – almost inevitably – thrown up problems as well. One, identified at Brighton, is that turnover of patients, far from increasing as had originally been predicted, has actually slowed down. However, as the clinical leader says, *'I don't apologise for this because I feel we're discharging patients more safely, and we are getting a lot of good feedback from colleagues and patients.'* The team now want to examine readmission rates which, they suspect, will be lower among the patients from their ward than from other medical wards.

A similar syndrome was apparent at King's Healthcare. As the clinical leader says: *'If you have got ongoing continuity you're obviously in a better position to identify deeper and more significant things. The problem is that the more you uncover, the more needs you have to meet. And the more you can't meet these, the more there is the potential for a phenomenal guilt trip.'*

The onus on disseminating their work may also have helped staff to clarify in their own minds what it is they are doing and why, which is helpful in clarifying the nursing role.

OVERTIME

The corollary to staff commitment is, almost inevitably, extended working hours. While this is a reality of any professional role, all NDU leaders identified it as a problem at times. Staff would frequently skip meal times, come in their own time for meetings, stay late and do much of their research in their own time.

The solution to this situation is not obvious. As the Brighton clinical leader suggests, *'Clearly most people have to give some extra time, but it has been over and above what you would reasonably expect.'* Nevertheless, staff evidently felt the benefits outweighed the drawbacks.

Nurses on Maud Alexander Ward would seem to expect to do some things in their own time. *'What was important to them was to have an environment where, if they did extra work, this was recognised by colleagues. If no one supports or listens to you, then it's not worth it.'* ***(Clinical Leader, West Dorset)***

It is also worth noting that these nurses have taken on board a way of working which is reflected in many other professional groups, i.e. of seeing a job which needs doing, rather than a series of tasks to be completed within a given time-frame.

Chapter 6

STRATEGIES TO SUPPORT AND DEVELOP THE STAFF

Development of nursing staff is at the heart of the NDU philosophy, and all units took this very seriously. There were a number of different approaches both to staff development and the often interrelated issue of staff support.

STAFF DEVELOPMENT

Personal development plans

Most NDUs introduced personal development plans (PDPs) for their staff. Over half the staff surveyed for the DoH evaluation reported they had had PDPs by the second year.[12] Perhaps predictably, enrolled nurses were less likely than registered nurses to have a plan, and nursing auxiliaries were the least likely to have one. Most felt the PDPs had been very helpful in their own development.

At King's Healthcare, the PDP was seen as the linchpin of staff development in an NDU. *'Our development plan means everyone has an orientation programme when they are first appointed, culminating with a performance review after three months. We establish their objectives and then make time for them to get out and do things such as learning to search the literature or small-scale research. We try to get people to become experts in different areas so we can draw on each other.'* ***(Clinical Leader, King's Healthcare)***

Setting objectives

Some staff were involved in the setting of the unit's second- and third-year objectives. This provided a gauge by which staff could measure their achievements so far. *'It actually provided a strategy for saying, you haven't solved this problem, but look at the problems you have solved.'* ***(Clinical Leader, King's Healthcare)*** Such involvement acted as a powerful motivator for the clinical team giving them a sense of ownership and personal involvement.

Professional development

Perhaps the biggest contrast in life before and after the NDU has been in the amount of education and professional development staff have had access to. Before the NDUs were set up, the amount of formal education had ranged from 0.6 days to 2.4 days per person over five years. In the NDUs' first three years, this rose to between 2.5 and over 5 days per year. It could, however, still be suggested that this is a relatively small amount of time compared with what other professionals would expect and usually get. In addition, many nurses had the opportunity to get involved in small-scale research projects, meetings, supervised practice, quality-assurance initiatives and even exchange visits to the USA.

Alongside this increased confidence in their own abilities came a growing preparedness to question anything they had doubts about. As one clinical leader put it, *'I think nursing is the worst profession for jumping on a bandwagon and going along with the crowd. That wouldn't happen on our unit. If we have doubts, then we will have the courage to say no, we're not doing that.'* ***(Clinical leader, Southport)***

Primary nursing

Primary nursing is an inherently democratic way of organising nursing care, and there can be little doubt this has increased staff's sense of involvement and participation. Their roles became more clearly defined and there was a greater sense of responsibility for the patients they were working with, in line with

observations made elsewhere.[13] This method of work organisation was also in accord with the overriding NDU philosophy that all staff, as well as all patients, should be valued equally.

The confidence to disagree

The nurses' questioning attitude did not necessarily extend to the internal decision-making process, which was not always seen by team members as being as democratic as the leaders had hoped.

The researcher at Brighton encouraged not only patients but also nurses themselves to voice criticisms or reservations about the project. These revealed a number of areas of concern, including some resentment at the amount of extra time which some people *felt* they were expected to spend on the ward. The criticisms came as something of a surprise to senior nurses, but discussion sessions helped to clear the air and led to corrective action being taken.

Some leaders equated a lack of disagreement with consensus. However, an independent survey of staff attitudes indicated this was not necessarily the case.[14] This study suggests four other reasons why staff might refrain from criticism:

1 Some felt reluctant to disagree because dissension might be seen as disloyalty.

2 Some were not used to democracy or felt it was not really present.

3 Some felt they lacked the knowledge to present another view.

4 Some lacked the confidence to speak within a group.

To some extent, these findings are not unexpected as it is inevitable that some members of a team will be more involved with development work than others. They do, however, stress the critical importance of establishing effective communication strategies within the team as well as with others.

STAFF SUPPORT

Project worker

One of the project worker's key roles was to provide support not only to the NDU leaders but also to the practitioners (see Chapter 3). This was achieved in a number of different ways such as working alongside them, finding time to talk with them, and being accessible in response to felt need.

Informal support network

Most units developed a strong network of support within the staff group, fostered no doubt by the sense of 'all being in the same boat'. Such a network is vital if nurses are to feel free to question and – occasionally – to make mistakes. As the clinical leader in Brighton said, *'Because we were doing things that were different from the norm, we had a lot of blocking at management level and at colleague level. Really we felt we had to support each other, for instance, when we disagreed with a consultant over the best way to manage a wound. If you are questioning then you have got to have a very sound knowledge, but you have also got to have someone there to support you and say, "Yes, you're right".'*

It was also this support that encouraged staff to stay on the ward after their shift or to fill in for a sick colleague when off duty. *'I'm not saying that it's right. But if you know that a colleague is ill and they are a friend who you care about, then you'll step in. It's part of the way in which our personal and professional lives overlap on this ward.'*

Development posts

Each NDU developed new posts as part of the project, and in different ways these helped to provide back-up to the practising nurses. The two researchers, at West Dorset and Brighton, were particularly helpful in this respect since part of their brief was to assist nurses to develop their own research skills. In both instances, their work was seen as invaluable not only in providing insights into what needed to change, but also in providing encouragement and a 'sounding board' for new ideas.

Another important factor raised was that in one instance the researcher was not a nurse (Brighton). In her words: *'I came in without any preconceptions. I wasn't seen as being there to test nurses or to pick them up on anything. I was there as a learner. I could say: "Why are you doing that?" They actually had to tell me everything. If I didn't understand, I would just ask. I was able to say, "You have got an amazing amount of knowledge".'*

External support

All units found support from outside the NDU. King's Healthcare, for instance, looked to its links with Normanby College of Nursing (now part of the Nightingale Institute, King's College, London) and King's College nursing department. Southport has had morale-boosting backing from the chair of the trust and the former local MP, Ronnie Fearn, who is also chair of the Carers' Association. Brighton has had the services of a clinical psychologist every fortnight as well as forging useful links with the newly appointed patient advocate. Although its initial patron, Assistant Chief Nursing Officer Martin Smits, has now moved to become Director of Nursing, he continues to be extremely supportive and chair the Steering Group. In West Dorset, links have recently been made with other NDUs providing a valuable forum for support, discussion and debate.

Administrative staff

All four NDUs had a ward clerk in post. In King's Healthcare this was elevated to a ward co-ordinator who took on board some of the clerical work which had previously been undertaken by the nurses, thus freeing nurses to concentrate on patient care. Similarly, in Brighton, an administrative worker was appointed to free nursing time. There was also some secretarial support in all the units, which they found invaluable.

Chapter 7

SHARED ACHIEVEMENTS OF THE UNITS

In some ways a worse time could hardly have been chosen to launch the NDU project. Wholesale organisational changes brought about by the NHS reforms have led to a high degree of instability over the last three years, with the introduction of Trusts and the accompanying changes in both managerial and service structures. This situation has been compounded by major upheavals within nursing itself, such as clinical grading and the introduction of Project 2000, and the inevitable teething problems that any new initiative will face. In the light of this, perhaps one of the NDUs' most impressive achievements is that all four have survived, and are actually stronger than when they began, having made, in the intervening three years, many breakthroughs, some of which are outlined below.

PROGRESS TO DATE

At the outset of this project, all of the units identified specific aims which they hoped to achieve over the forthcoming years. Some of these were common to all four, while others were individual. Their efforts can now be seen to be bearing fruit and there is no doubt that their work has had a direct impact on the quality of care offered to the patients with whom they work. It must also be said, however, that the original aims were ambitious in terms of both the number and extent of changes planned, and in some instances have had to be modified in the light of time and experience. Baseline measurements were not always collected at the outset of work so the achievements are not always supported by formal data. Nevertheless, it is possible to catalogue the progress which has been made and, of equal importance, to identify lessons which have been learned from the experience of these units for future work.

Reflections **3** *years on*

SHARED AIMS

Primary nursing

As was stated in their original aims, three of the four units have a well-established system of primary nursing. The fourth unit, Southport, operates within an advanced team-nursing structure, each team taking responsibility for a group of six patients throughout their stay, with decentralised responsibility and accountability for patient care.

This advance has become particularly relevant since the requirement for all patients to have a named nurse proposed in the *Patient's Charter,*[15] and the units have been used as a source of expertise in relation to this initiative. In particular, King's Healthcare and West Dorset have run workshops and provided consultation for other units within the hospital as well as holding open days and sharing their experience and expertise regarding primary nursing on a wider front.

Innovation

Within *A Vision for the Future*[16] is a requirement that practitioners will develop at least three areas of practice in relation to research, and it is pleasing to note that all the units can already give clear examples of such initiatives. In many instances, these changes have been brought about in response to a local need identified by the staff. This demonstrates the proactive way in which the staff themselves respond to problems which they have identified as influencing the care they offer patients.

For example, in Southport there was some concern about whether the nutritional needs of the elderly patients were being met. As a direct response to this situation, one of the team undertook a literature search, surveyed the patients to elicit their views and negotiated with the catering staff for a change in provision of services. Since that time, a user-friendly assessment guide has been introduced which is now used regularly with patients to determine their current nutritional status; from the information gained in this way, nurses can offer informed advice and care on dietary needs.[17]

Similarly, in West Dorset, there was concern about pain management in the ward. A local study was established which has led to the introduction of a pain-assessment chart based on previous research. Not only is this chart used regularly on the NDU but it has also been adopted on other wards. While figures are not directly available to reflect alterations, in practice it can be said that there is an increase in awareness of pain as a significant patient-problem, as well as an increase in knowledge about pain management. These two changes are likely to have improved the care offered to patients. Furthermore, the nurse who undertook this work is also seen as a source of expertise beyond the NDU and consulted by other practitioners on pain management.

Similar initiatives have been carried out on all the units leading to changes in practice related to, among others, wound management, discharge planning, and opportunity for reminiscence.

The critical development here is the commitment of the NDU staff to challenge their own practice, identify areas where they feel things could be improved and take the initiative to explore ways in which this could be achieved. Environments have been created which are open to change and, as was stated at the outset, *'new ideas flourish* [and] *a free exchange of knowledge is not threatening.'*

Patient participation

Patient participation was another shared aim of all the units and there is ample evidence that considerable progress has been made on this front. In Brighton, for example, a Patients' Forum has been established to elicit views on the service, and it has been possible to introduce many changes within the ward in response to the information gleaned through it. Some of the changes are very small but nevertheless significant to the quality of life for the patients. For example, adjustments were made to a door which banged when closed and was particularly disturbing at night, notice boards were resited with information resource boards for each of the rooms, and choice of menu was expanded.

On a larger scale, one nurse's study of the potential value of music during rehabilitation revealed that personal choice of music was all important to

patients. This study was instrumental in winning management approval for the provision of personal stereos on the ward so that patients can now bring their own tapes into hospital and can choose when and which music they wish to listen to.[18]

Interviews with patients during the evaluation phase of the Action Research project had shown that very few of them had understood rehabilitation, primary nursing or the reasons why the ward was organised as it was. In response to this, an introductory video has been made in which nurses and patients outline rehabilitation and primary nursing, and discuss issues such as why the nurses on this ward do not wear uniforms. This video has proved invaluable in conveying key messages about the ward to patients, carers, new staff and visitors alike.

Some issues were beyond the control of the NDU team to change but gave them the information they needed to make a case to managers. An example here would be a call-bell system for the sitting-room and garden.[19]

A Carers' Panel has been established in Southport involving carers, lay-people and health care workers. The exchange of information through this forum has led to the establishment of a drop-in centre for carers to offer them support and advice. As a result of information gained through this group, revisions have been made in the respite service offered so that it can be planned on the basis of individual needs rather than being a fixed provision. Subjectively the staff feel that there has also been a reduction in admission rates as the carers feel more supported and therefore able to manage more effectively at home but more evidence is needed to substantiate this view.

The introduction of bedside handover, in both West Dorset and King's Healthcare, is another example of patient participation which both patients and staff have found helpful. There is less opportunity for messages to get mixed and an increased opportunity for patients to contribute their views. However, a useful lesson emerged from King's Healthcare in relation to this initiative. When this aspect of care was evaluated as part of the action research study, significant numbers of patients and relatives commented that, while they would listen to nurses exchanging information, they still did not fell able to

contribute themselves. This clearly illustrates the need to ensure that both nurses' and patients' perceptions are explored in response to changes in practice. Thanks to this information, further changes were made to reduce the number of people involved in the handover, to actively seek patients' contribution, and to help nurses develop skills to facilitate patient involvement.

Dissemination

When this project was established there was a view that the units needed a period of 'protected time' in order to undertake development work prior to concentrating on dissemination. With hindsight it may have been more appropriate to address this issue from the onset as a means of combating some of the perceived difficulties of being seen as elitist. Sharing experiences of both the processes of development as well as the outcomes of the work may have helped to make the NDUs more welcome locally. All the units have contributed to dissemination both locally and nationally through a variety of different methods. Over the past three years, many publications have appeared in the nursing press from the four NDUs. Annual reports have been produced by each of the units and circulated to Steering Group members, local managers and the KFC. Information booklets and assessment formats, which have been produced as a result of project work (e.g. the nutritional study, the pain project and the use of Individual Performance Review (IPR)), are in use beyond the NDUs, and the staff are seen as a local source of expertise in these areas.

A series of four seminars has been held at the KFC to share the experience of the NDUs, and *Work in Progress*,[20] a report outlining project work within the units to date, has been published. In addition, local seminars covering a wide range of topics have been organised to share the NDU experience with both nurses and other colleagues. For example, in West Dorset local conferences have been arranged relating to primary nursing and pain management, as well as presentations to other units on subjects such as bedside handover, self-administration of medication and the changing role of the ward sister. Staff have also contributed on many occasions to local and national conferences to present their work.

One area which still needs to be addressed is the interface of the NDU with the parent organisation and the manner in which the work can be disseminated locally. King's Healthcare have been most active in this area to date, offering local workshops and seminars in relation to primary nursing, the use of QUALPACS and IPR as a development process, but it must be pointed out that this unit was established a year prior to the other three. In West Dorset, a conference was held for key personnel, to celebrate the work of the NDU at the end of the funding period and to highlight continuing activity for which it is gaining local support.

Active work is now under way in all the units to develop the dissemination aspect of the work and it is anticipated that clearer strategies will be developed over the forthcoming year which will ensure the continuity of the project.

Support workers

Work has also been undertaken in relation to support workers. King's Healthcare NDU created a ward-coordinator post following an activity analysis to identify what it was that kept qualified nurses away from the bedside – a post which has since been adopted by several other wards across the directorate.

In West Dorset, a new house-keeping role has been introduced following a QUALPACS assessment which highlighted the amount of time nurses were spending on non-nursing duties. This has resulted in nurses being able to spend more time with patients.

Brighton NDU have employed an administrative assistant who has supported the nurses in arranging visits to the ward and study days, and in the presentation of their research work, thereby improving dissemination and releasing nurses from clerical duties. They also have a number of voluntary workers who help with patient outings, organising games and musical evenings, and talking with patients, all of which are seen as activities which are invaluable in the rehabilitation of elderly people.

Quality assurance

Quality assurance has been an important aspect of work in all the NDUs though more formalised in some than others. For example, King's Healthcare have made extensive use of QUALPACS as a formal audit tool. They have also extended its use as a part of staff development through peer review, training primary nurses to use the tool to audit each other and the structured observation as an aid to reflective practice.[21]

In West Dorset, there has been an increase in scores using the Excelcare quality gauge. Audit tools developed to assess pressure sores and pain have shown improvements and, more recently, QUALPACS has been used to assess the overall quality of care and to act as a diagnostic tool in identifying areas for development. In Southport, readmission rates have dropped although it is difficult to demonstrate a cause-and-effect relationship here, and the unit is planning to use QUALPACS in the future.

In Brighton, the NDU has been monitoring quality through their standard-setting process (see below, p. 41). The Clinical Leader is also involved in teaching on the Quality and Standards in Nursing workshops held locally.

A point to be noted here arises out of an additional outcome in Brighton. Patient throughput has decreased over the past three years rather than increased as had been expected. There is a subjective feeling that patients are returning home with a greater degree of independence and are less likely to call on community services or require readmission – but more evidence is needed to substantiate this view.

Seeking measures of quality assurance remains difficult but one general manager has no doubts: *'You only have to walk on the ward to see the different emphasis. If you go on to another ward, while the standards are OK, you can see the differences.'*[22] Quantification will certainly give part of the picture but does not always reflect the essence of quality care.

Status of nursing

There is no doubt that NDUs are gaining momentum, spurred by the work of these four units. There has been formal commitment through the Government, demonstrated by additional pump prime funding for a further 30 units in 1991. An increase in the number of NDUs is also included in the 1993/4 NHSME objectives, all of which give some indication of the increasing interest in developing the nursing service.

It is also an indication of the NDUs' ultimate success that despite initial suspicions from other wards, there are now well-laid plans in all four units to expand NDUs into other parts of the specialty. In West Dorset, this brings to fruition the 1989 objective of making the entire medical unit an NDU. In King's Healthcare and Southport, plans are well advanced to introduce further NDUs and Brighton now has a second NDU, also supported by the KFC.

Perhaps one of the most tangible ways in which this aim has been achieved is demonstrated in the manner in which the Byron Ward team have successfully secured the 'go ahead' to open nursing beds. That the directorate management had sufficient confidence in the value of the concepts as well as the ability of the staff shows a growing respect for what nurses can offer to patients.

This is good news not only for the NDU movement, but also for the original four units for whom this expansion constitutes a significant vote of confidence from management. The four leaders have few doubts that they will continue as NDUs, despite the ending of their funding. As all the clinical leaders feel, *'The NDU has got to continue now. It's become part and parcel of the way we work. There's no way we'll let it slip now – it's just too important.'*

Chapter 8

INDIVIDUAL ACHIEVEMENTS OF THE UNITS

Many of the individual targets identified by each of the units relate closely to the shared aims of them all. One major aim in Brighton was to *'develop our nurses as individuals on the basis that if you could improve the quality of the individual nurse you would improve patient care'*. From the number of achievements already outlined, it is clear that this has been the case. More specifically, each unit had a series of individual aims and those which have not already been addressed collectively are outlined below.

BRIGHTON

The nurse's role in rehabilitation

The major project in Brighton related to an exploration of the role of the nurse in rehabilitation. Different aspects of this role were identified through both the action research project and the research projects carried out by individual nurses.

The action research project was based on a model of pluralistic evaluation.[23] It explored the perceptions of rehabilitation held by three major groups involved in the ward – the patients and carers, the nurses, and colleagues in other disciplines. In essence, the findings suggest that while nurses hold and practise a holistic model of rehabilitation, patients, carers and those working in other

disciplines see it predominantly as a process of physical recovery. If this is how rehabilitation is seen by others then the nurse's role is virtually invisible since it is focused more around the psychological, emotional, social and spiritual needs of patients. The major task facing the nurses has therefore been to articulate and communicate this holistic view to others in order that they can become more fully involved and benefit from the process. Additionally, the nurse's role has become more 'visible' as others have come to understand their function more clearly.

The individual nurses' projects have also contributed to this work, revealing other crucial aspects of rehabilitation and the key role nurses play in it. One project confirmed that all patients on the ward went through a process of grieving, underpinning the need for rehabilitation of everyone who has experienced the tragedy of the sudden onset of disability. The great importance of one-to-one discussion of what this experience means with each patient in privacy has been highlighted, offering the opportunity for patients to express their feelings of anger, sadness and despair away from the constraints of the ward. Other projects have revealed the comfort of reminiscence and music in patient's recovery, and of informing and involving the patients in the management of their wounds at every stage.

Standard setting

So far nurses have identified eight categories of standards, based around rights for patients such as freedom of choice and access to information. A combination of observation, questionnaires and auditing of records is used on a six-monthly basis. The audit tool is not intended as a disciplinary measure, nor for scoring or grading, but to help identify where standards have been achieved, to highlight those which are impractical and to identify areas for improvement.

Diversional activities

Considerable progress has been made in this aspect of the work with the introduction of reminiscence groupwork, choice of music, and pets as regular features.

Women in the NHS

Brighton NDU have also won an award from South-East Thames Regional Health Authority (SETHRA) for their work in the creation of development opportunities for women, flexible working conditions for staff and retention of women in the workplace.

KING'S HEALTHCARE

Primary nursing

This is firmly established as the unit's method of work organisation. The model developed is a sophisticated one giving primary nurses clear line management for a small team as well as case management responsibility for a group of patients.[24] The unit has also been called on locally and nationally for advice in this area.

Patient participation

Patient participation remains a fundamental linchpin of the ward's philosophy and has become even more pertinent in the light of the nurse-led service. Promotion of this approach has not always been easy (see p. 34) as there can be a degree of threat to staff but much has been achieved through such activities as bedside handover, follow-up telephone advice after discharge and closer nurse patient relationships with the introduction of primary nursing.[25] In addition, there is a patient representative on the NDU Steering Group.

Information resource for patients

The formal structure for this aspect of the work has probably been the one which has been least attended to. It had been hoped that the NDU would produce its own literature and teaching packages but this has only been achieved on a limited scale. However, the climate on the ward does mean that the nurses use a wide variety of other literature sources to support them in attending to their patients' educational needs and that the relationships built have resulted in the ward being used by some patients as a resource for information about health matters long after discharge.

Individual performance review

This was developed largely with the help of a joint appointee who worked with the unit as a project worker in the first year following the grant.[26] The structure of performance review and associated development plan has since been incorporated into the unit's orientation programme and become central to the way in which the unit operates. The system offers an opportunity to bring together the development needs of the individual with the need for clinical development for the unit as a whole, and is an extremely effective process for achieving these two ends.[27]

Action Research project

The implementation of primary nursing and its effects on all staff and patients have been extensively studied over a period of four years. The study design enabled the active collaboration of all ward staff in determining and implementing changes as a result of data collection. Undoubtedly, it has facilitated the development of role clarity within the unit, and established QUALPACS and audit as integral components of the effective total management of patient care.

Studying the effects of nursing on patients and relatives has produced some surprising findings, which will no doubt influence future ideas on nursing organisation and philosophy. Finally, studying the effects of nursing organisation on other colleagues very clearly showed that such changes cannot be brought about without careful collaboration and sharing, since effects on others can be enormous.

Academic links and research

King's Healthcare NDU aimed at making strong academic links with higher education in order that it would have effective research expertise and supervision and a sound academic, as well as practice, base. The first clinical leader had a joint appointment with the academic department of nursing at King's College, London, as a senior lecturer, and the researcher in the unit also has a link through an honourary lectureship with the same department. This collaboration has continued and will be maintained, helping to ensure that ongoing research and educational activities are of a high standard.

This model is very much in line with that recommended in the recent *Report of the Task Force on the Strategy for Research in Nursing, Midwifery and Health Visiting*[28] in relation to 'practice development centres'. Such centres will take the lead on promoting research-based care and carrying out sound trials on potential effective interventions for patient care.

Quality package

The unit has developed expertise in the use of a number of quality packages, including QUALPAC, documentation audit and standard setting. Their work in this area has resulted in involvement across the Trust in taking the work forward. For example, they have been involved in developing a new documentation audit tool and facilitating the directorate standard-setting group.

SOUTHPORT

For Southport, the major achievement which they see has been the way in which they have been able to individualise the care offered to patients, moving from routinised procedures to team nursing, care planning and much more flexible patterns of admission. Although they did not use a formal quality-assessment tool during the early phase of their work, there is considerable subjective evidence to support this and they plan to gather structured data in the future.

Carers' panel

This has been a resounding success and had considerable impact on the other changes which have been brought about over the past three years, which in turn has meant that some of the original aims have been modified. If a service is to be truly client-driven then it is essential to take note of the information gained through listening to users – and this is one of the major achievements of their work. Examples of action taken as an outcome of the carers' panel include:

- the establishment of the drop-in centre (see p. 35) which is gathering momentum and has attracted additional funding to be developed further;
- the introduction of individualised times for administering medications to fit with the patterns which have been established at home, particularly for patients admitted for respite care.

Multidisciplinary education forum

While some movement has been made in this direction, it has taken more time to establish effective multidisciplinary work than was originally hoped. While the medical staff at Southport have been very supportive throughout, some resistance was experienced among colleagues from other disciplines. This situation was exacerbated by concern about, for example, responsibility for advising carers about lifting and handling, and the potential for litigation. Despite these setbacks, the guidelines for carers have been redesigned to incorporate advances in knowledge in this area.

Discharge follow-up

To some extent, this work has also been hampered by the need to initially forge effective working relationships with community-based colleagues. This situation has been exacerbated by the fact that elderly care and community services have recently been established within separate Trusts, which has brought with it an added dimension of costing to be considered. Despite this setback, the team see this as a critical area for development and are continuing to explore ways in which the interface between the two services can be developed.

Rehabilitation unit

Southport NDU have been through a series of changes over the last three years in response to changes within the Trust, and at varying times have admitted patients needing both acute assessment and continuing care. Recently, their aim of offering a specific rehabilitation service has been achieved with the opening of a twelve-bedded stroke unit, a service which is new to Southport.

Return to practice

In achieving this aim, the NDU has worked in conjunction with the local College of Education which has now established a 'back to nursing' course. The NDU regularly offers clinical placements for those attending this course and has developed a programme to help them to regain both confidence and competence in practice.

West Dorset

In West Dorset, considerable progress has been made towards achievement of their original objectives although, as with the other units, there have been some changes along the way. With the appointment of the research nurse to support the ward team in project work as well as to carry out a project focusing on patients' experience of hospitalisation, a great deal of advancement has been made.

Health information projects

This has been one of the major areas of progress which started with concern about the way in which discharge was managed. The results from a questionnaire to patients about their needs on discharge brought to light an awareness among the team that they did not always have the knowledge or skills necessary to provide the support which patients wanted. In turn this has led to individual members of the team developing expertise in subjects which are of specific interest and concern to the client group they work with, and then acting as a resource for their colleagues. Thus all the team have access to detailed information about such areas as management of patients with Alzheimer's disease and asthma. Interestingly, as their knowledge of asthma grew, it became apparent that there was also a need to make links with practice nurses to share the support which could be provided, particularly as patients are now discharged so quickly from the acute care setting. This has been another area for action.

Through these activities, the nurses themselves have become a local resource, providing support not only for other members of the NDU team but also for colleagues working in other areas. To assist them in this work they have made links with the local Health Promotion Unit to help them gain teaching skills.

Small-scale research-based projects

Tissue viability has been one area for action which has led to the increased use of a risk-factor assessment as well as audit of both the frequency and the severity of pressure sores. Considerable improvement has been achieved in both these areas on the NDU and work is now under way with the local quality-assurance nurse to spread the use of the audit tool to other units in the Trust.

Similarly, work has been undertaken on areas such as self-administration of drugs, bedside handover and discharge planning, all of which have led to changes in practice.

Excelcare

The NDU has been the focus for exploring the use of this system which combines information related to quality assurance, skill mix and care planning based on predefined standards. Patients are then randomly selected just prior to discharge to complete a questionnaire related to the standards identified in their care plans.

While the recordings do indicate that there has been an improvement in the quality of care over the past three years, the team have expressed some reservations of the tool as it stands and been able to offer a valuable critique of its use. For example, the standards on which care is based are so broadly based that it is difficult to individualise care. Similarly, they have some doubts about the value of questionnaires on discharge, partly because patients find it difficult to recall, for example, their experiences of admission but also because, at that point in time, their major concern is to go home and they appear to be unwilling to criticise the service.

Spread to other wards

An original aim had been to spread the NDU work to three other medical wards and to some extent this has been achieved with extension in the use of QUALPACS as well as sharing of information through the resource centre. However, this has been the area where least work has been undertaken to date. One contributory factor here was that there was a feeling from the KFC at the time that it would be better to concentrate efforts in one area rather than risk diluting the work by spreading it too widely in the initial stages of development. Having said this there are now active plans to disseminate the work of the NDU locally and plans are going ahead to develop this way of working on other wards.

Patient's experience of hospitalisation

The focus of work for the research nurse has been to explore what it feels like to be a patient in hospital through a series of in-depth interviews. Early findings clearly bring to light the importance that patients place on the emotional support they get from hospital staff, friends and relatives, and other patients.[29] In telling their personal stories, patients can identify ways in which support is given. This in turn will provide useful knowledge to enable nurses to develop their practice and provide a supportive environment.

OTHER JOINT ACHIEVEMENTS

Staff confidence

All the NDU leaders, and many from outside the units, have noted that one of the most valuable gains has been in nurses' self-confidence and assertiveness. Nurse managers identified the development of staff as being the biggest difference between NDU staff and staff on other wards. '*It was amazing to me to see how staff can change given that push and that extra resource ... staff who have been around in the system for a long, long time, who'd never updated themselves, how they could change.*'

This increased self-confidence would appear to come principally from the staff development programmes which, through individual appraisal, have given staff a sense of direction and worth and, through education, the knowledge base to express their views. It may also be that simply being part of an NDU has heightened their motivation and sense of credibility.

Recruitment and retention

Three of the four NDUs have reported significantly improved recruitment and retention rates – possibly as a result of increased self-confidence and job satisfaction. In Brighton, for example, only seven nurses have left over a three-year period whereas previously staff rarely stayed longer than six months. Southport had a similar experience. As the clinical leader says, '*When it was announced we were to become an NDU, we got phone calls from nurses wanting to work on the unit. Nobody had ever, ever rung up before asking for a job. And it hasn't stopped.*' Retention rates have also improved at West Dorset. What has affected them most over the past few years has been nurses becoming pregnant – a feature which has not gone unnoticed in other NDUs!

The exception to this pattern has been King's Healthcare which has seen more rapid turnover, partly because of its position in central London, an area of traditionally high job mobility. Even so, the unit held on to its 'inherited' staff for much longer than expected. Recruitment was difficult to begin with, possibly because an NDU was an unknown commodity, and then improved dramatically in 1991 and 1992. Recently, it has proved trickier again – maybe because nursing beds are a novel concept. Another possibility is that some people might refrain from applying because they feel 'they're not good enough' for an NDU although this opinion does not seem to be widely held.

Despite all the external changes which have occurred within the NHS over the past four years, the progress which these units have made is considerable. Maybe one of the greatest achievements which they all share is that, even though their external funding has come to an end, they will all continue to work as NDUs supported at a local level. Furthermore, the contribution which they have made as 'pioneers' in this work has provided valuable information for the units who are now developing, making their paths that little bit easier.

Chapter 9

THE PROJECT WORKER'S EXPERIENCES AND NEEDS

The project worker's support for the NDUs in their first three years was clearly vital, but what support did she receive and what lessons are to be learnt from her experience? As will be seen, there are a number of pointers to the future here.

SUPPORT

A project worker needs a strong network of support. In Gillian Black's case, this was provided by a supportive manager, Jane Salvage, with whom she worked very closely. She also made use of an external supervisor who gave advice on some of the emotional components of change, and was able to call on the expertise of other project staff at the KFC as well as staff involved in other aspects of development work.

TRAINING

Previous experience of implementing change was invaluable, as were both a strong nursing background and an ability to remain detached from the units and ask the obvious but necessary questions. Courses in consultation and negotiating skills were also very useful, and since the work involved some responsibility for dissemination it was helpful to have good presentational skills.

COMMUNICATIONS

It became clear over the three years that spreading the NDU message effectively was one of the keys to survival. All units were encouraged to make use of the communications expertise of Lynn Woodward, the KFC head of press and publicity who worked closely with both the project worker and the units in developing strategies for this aspect of the work.

KFC–NDU LINKS

There was some uncertainty at the start about the relationship between the KFC and the units. Some units felt it had just been an exercise in grant-giving, and they could now go away and get on with it. Others felt they could not take any decision without the KFC's express permission. Gradually the relationship has been clarified. However, it has become apparent that there is no 'blue print' for effective development work and a high degree of flexibility is needed to respond to the individual needs of the units which change with time.

ENCOURAGING INDEPENDENCE

One of the aims of the project worker was to provide all necessary support to units while discouraging dependence. At the end of the three years, the units would be on their own. In general, this balance was found. However, unexpected problems arose when two of the leaders left before the end of the project. This inevitably meant greater input from the project worker and delayed the transition to independence. It does, however, emphasise how important it is to establish local support systems as changes in personnel will be an ongoing issue.

ORGANISATIONAL CHANGE

One thing no one could have predicted at the start of the project was the amount of organisational turmoil there would be in the NHS over the three-year period. This meant that the project worker spent much more time

'troubleshooting' than she could have expected. Again, however, the strategy wherever possible was one of assisting the staff to develop skills to respond to such situations themselves in the long run, rather than always acting on their behalf.

MANAGEMENT NEEDS

It became clear to the project worker that the managers needed as much support as the practitioners if the NDUs were to survive. Managers were undergoing so much change themselves that they were often unable to pay much attention to practitioners in a similar position. In addition, the upheavals meant that the original managers who had supported the project had been replaced by others.

As the project worker recalls, *'Both Jane* [Salvage] *and I spent quite a lot of time talking to managers, reselling and helping them to readjust to the idea. I also did quite a lot of work with the staff on how they could sell* [their work] *and could influence their managers to support them. Nurses have to learn that they need to look at things from the organisation's perspective, not merely a nursing perspective. They also have to acknowledge that managers are people as well – and you aren't selling out nursing by saying that.'*

CHANGE TAKES TIME

The final lesson from the project worker's experience is that change takes time. The units were ambitious in their plans and in some instances adjustments had to be made to a more realistic time-scale, bearing in mind that change is demanding both practically and emotionally. As the project worker has suggested, *'... the emotional component of change is very important and often underestimated'* – maybe an important lesson for all to learn.

SUMMARY

Project work can, in itself, be demanding and care needs to be taken to ensure that support is available and personal networks are developed. Having said this, there is no doubt that the eye of an independent outsider can provide invaluable help for those who are directly involved in taking change forward, not only as a sounding board but at times as an advocate.

Use of consultants to support the development of nursing and in particular of NDUs may be worthy of consideration on a wider scale in the future, especially as the NHS is shifting within the market economy.

Chapter 10

CONCLUSIONS AND RECOMMENDATIONS

There is no doubt that the efforts which have been put into the establishment of the NDU project have been worthwhile, and there is considerable evidence that the quality of patient care in the units has increased. In general terms, for example, there is a much wider use of research-based practice, alongside the development of individual team members who can act as local experts in specific aspects of patient care. With the introduction of primary nursing and readjustment of roles, the amount of time which qualified staff are spending with patients has increased. There is greater job satisfaction and a marked improvement in retention and recruitment of staff to the units, and most importantly greater participation and choice for patients.

This story of success is reflected not only by the major government grant awarded in 1991 to provide pump priming money for a further 30 units, but also by the inclusion in the 1993/4 NHSME objectives of the spread of the initiative. The value of developing the nursing service is now recognised much more widely and evidence is gradually building up of the effectiveness and efficiency of this work.[30,31]

However, it is also vital to learn lessons from the pioneers of this work in order that those who follow can benefit from their experience. Important factors have arisen from both this work and the more formal studies commissioned by the Department of Health,[32,33] which can act as signposts in planning future developments. While by their very nature of meeting local need there can be no 'blue print' for establishing Nursing, Midwifery and Health Visiting Development Units, principles have emerged which are common to all the units and these are outlined below.

INTEGRATION

If NDUs are the pilot sites for innovation and exploration of new practices then there will always be a case for their existence, and it is important that they find a way of becoming a stable and valued resource within their parent organisations. It must, however, be recognised that not everyone would wish to work in this way and accept additional responsibility for critical evaluation, dissemination and public scrutiny. Ways need to be explored which help to develop effective relationships between NDUs and other wards which will facilitate the spread of their work.

Despite all the efforts of the NDU teams, there have still been perceptions of elitism, with the NDUs being seen as a 'special case' and different from their neighbouring colleagues. It may be that while the benefits of working as an NDU are readily acknowledged, less public attention has been paid to the responsibilities which are inherent in the work. Another factor which may have contributed to this perception is that they are often described as sites of 'clinical excellence'. It must be acknowledged that it is not just NDUs who strive for 'clinical excellence' and it could be suggested that a more appropriate approach would be to follow the Equal Opportunities' example and use terms such as 'working towards clinical excellence'.

It may also be helpful in the future for more attention to be paid to the way in which the NDU interrelates with other units at a local level. Support from senior managers in both nursing and other areas in promoting the NDU as a valuable resource for others to make use of could be of help. Formal mechanisms for establishing effective communications, such as regular seminars based in the NDU, senior-nurse support groups where the work is shared, exchange visits, workshops and a proactive consultancy service, may all prove useful in addressing this issue.

However, it must also be said that it is unlikely that this problem will ever disappear entirely as it would appear to be a part of human nature to view change with a degree of caution, and defensive responses are well documented.

STAFF SUPPORT AND INVOLVEMENT

One of the criteria which were used in the original selection process was that there would be involvement of the whole team in the NDU and indeed efforts were made to ensure that this was so. From the result of the staff-satisfaction survey undertaken as part of the DoH-funded evaluation, it would seem that there is an above-average degree of motivation among NDU staff, a finding which is also reflected in the Tameside study.[34] However, there were times when some team members felt less involved with the project especially in the early days.

One strategy which was particularly helpful in overcoming this difficulty was involving the staff in planning the ongoing objectives for the unit, and this is an approach which could be employed more widely. Similarly, the use of Individual Performance Review linked with Personal Development Plans was another way of involving all the team members and ensuring that their personal development linked with the overall aims of the unit. Clinical supervision, identified as a nursing target within *A Vision for the Future,*[35] would also be of help in supporting the team through development, and this is an area which is actively being explc.ed in many new NDUs.

Clinical leaders have also expressed feelings of isolation at times, which is not uncommon among those in such specialist roles. Provision of formal links with local managers may have lessened this difficulty as may have done liaison with the local educational institutions. The clinical leaders also all mentioned the value of regular meetings with one another to share ideas and experiences, and offer support. As the number of NDUs increases, it may be helpful to consider setting up regional networks to minimise travel, cost and time but maximise opportunities.

It would also appear that a steering group which only meets quarterly is not available often enough to be responsive to the day-to-day problems which the clinical leaders face. Consideration could be given to differentiating between a steering group, which could provide support on a wider front in strategic planning and in some of the political issues which arise in such an unstable

environment as the current NHS, and a local working group which would meet more regularly and be concerned with the detailed day-to-day events.

It has become apparent that establishing these local networks which can provide regular and ongoing support is a critical factor as the time approaches when external contacts with agencies such as the KFC is lessened. Establishment of local NDU networks, links with on-site managers and institutes of higher education, and identification of personal and professional support mechanisms for clinical leaders is strongly recommended for all NDUs in the future.

Time

The time which it takes to change both structures and attitudes should never be underestimated. It has certainly been the case for these four NDUs that it has taken longer than they anticipated to introduce and establish changes in practice. They have, however, felt a degree of external pressure to 'achieve' and show outcomes of their work at very early stages in the process.

In all cases help has been needed not only to chart what has been accomplished but also to be realistic in terms of what could be achieved and to learn to set priorities. Again this is an area where local managers could offer help with their experience and knowledge of the management of change. At the end of the day, it is better to ensure that careful planning and preparation are put into development work to ensure success rather than rushing too quickly and making mistakes along the way.

Having said this, important lessons can be learned from the experience of these NDUs. As nurses become more accustomed to living in a climate of change, recognising the value of their own work and gaining more public acknowledgement of the skills in expert practice, then it may be possible to shorten the time-span for future developments.

EVALUATION

Evaluation has been one of the most thorny problems for all the units and despite considerable effort there is still a paucity of evidence in terms of either quality of care or effectiveness of outcomes.

In both Brighton and King's Healthcare the action research approach has been used which is acknowledged as particularly appropriate for nursing contexts in that, by involving practitioners, it can overcome the problem of nurses' resistance to research findings.[36,37,38] Since results are fed back into the immediate setting and nurses 'own' the data, proposals for change are more likely to be realistic and therefore acted on.

Another critical lesson has been the importance of gaining baseline information before change is initiated in order that the outcomes can be more clearly demonstrated. Hopefully, as more information becomes available about ways of assessing the quality of nursing as well as the interrelationship of nursing actions to patient outcomes this will become less difficult. Nevertheless it will still present a demanding challenge.

This is another area where there is a need to share ideas and information rather than for each unit to work in isolation. There is a tendency for 're-inventing the wheel' as many units, for example, strive to develop their own patient satisfaction questionnaires rather than using well-validated tools. A case could be made for a wider national co-ordination of this type of activity.

DEVELOPMENT OF NURSES

The degree of commitment and energy shown by the staff in these units may, to some extent, be related to the emphasis which has been placed on continuing education within the units. It is interesting to note that high value has been placed on time to study, read, work alongside experts and develop in response to local needs rather than attendance at formal courses. The additional funding provided by the Department of Health to facilitate 'time out' for staff members was highly valued by all the NDUs and allowed team members the opportunity for individual project work to be undertaken.

This funding was not a large sum in terms of the total ward budgets (one-fifth of a 'D' grade staff nurse), but proved hugely successful in, for example, ensuring that practice was based on sound current knowledge as the team members became a local resource for specific aspects of care. It was also an effective motivator for the people involved and helped them to gain analytical skills through undertaking literature searches and small-scale studies as well as increasing their clinical knowledge.

RELATIONS WITH OTHER DISCIPLINES

Relationships with other disciplines were not always easy and some felt threatened by the development activities. In some instances, role boundaries were threatened and a degree of insecurity was felt as the nurses became more confident.

While these units concentrate on the development of nursing, it is essential that this work is carried out within a multidisciplinary context, and concern and respect are paid to the contributions of all the team members. The need for involvement of both managers and practitioners at a clinical level, at an early stage of the development process, is critical if conflict is to be avoided. It must be remembered that it is not just nurses who are subject to the current changes within the NHS, and many other occupational groups are having to reconsider the way they work.

Support of, and involvement in, collaborative work with colleagues in other disciplines focused around the identification of patient needs and an assurance that expertise is shared effectively can all be helpful.

It is maybe worth noting that the changes in nursing can be particularly difficult for some medical colleagues who have become accustomed over many years to being seen as having ultimate authority for all aspects of care. It has been found to be more effective to concentrate negotiation around patient need rather than nursing development as this is less threatening and indeed the fundamental reason behind the work.

EXTERNAL SUPPORT

Ensuring that there is a good network of external support for the unit is helpful in providing both advice and personal support for the team (see Staff Support, p. 56). There are times when people external to the unit can act effectively as advocates or help in negotiation on behalf of the unit, taking on a mentor-type function. The role of the external project worker is one way in which this support can be offered.

Support from those in other disciplines, such as medical colleagues, members of CHCs, purchasers and managers can also be invaluable in helping to disseminate the work of the NDUs in places were it may be more difficult for team members to gain access. This is one function which the formal Steering Group can undertake effectively and it is strongly recommended that careful consideration is given to the membership, bearing in mind the way in which members can support the unit through their links with other influential groups.

WORKLOAD

The workload for these units has been extremely high, particularly for the clinical leaders who have had to cope with supporting the team, as well as being the driving force behind the project. The critical role which they have to play in taking the work of an NDU forward should never be underestimated. However, if this type of work is to continue, it is important that ways are found of relieving some of the pressure.

The provision of secretarial support has been found to be one way in which pressure can be lessened, and in the long run it can also be seen as a cost-effective resource since the relatively more expensive nursing time can be used more appropriately. Excessive workload is also exacerbated by external expectations and there is a need to ensure that realistic goals are set. Similarly, the time which is spent in work external to the unit such as teaching, consultation and dissemination, all of which are of value to other patients and nurses, should be realistically assessed and costed.

COSTING

The major ways in which the additional funds have been used have related to research and evaluation, time out for staff development and secretarial support, all of which have contributed to the success of the units. To some extent the cost incurred is dependent on the individual needs and resources which are available locally. For example, if there are research skills within the NDU team it may be more appropriate to use additional funds for replacement staff to free time, but if this is not the case then funds may be used for consultancy or to pay a researcher to join the NDU staff.

Assessing the cost in relation to the delivery of service is inherently difficult, not least because the context in which the service is delivered has changed so rapidly. It has also been difficult to gain access to adequate information to make comparative estimations of costing,[39] although with the advent of the market economy in the NHS this scene is changing. In none of the NDUs has any additional funding been allocated to direct care delivery as this would create an unreal situation and in all cases the units have been subject to the same demands made by changes within the organisations.

It is important that costs are set against benefits in terms of improved quality of patient care and a source of expertise to others. Thus the additional funding which these units have received has been used to benefit an audience which is much wider than the single unit.

DISSEMINATION

There is an inherent difficulty in the dissemination of good practice which is by no means limited to nursing and this is still an area where more work needs to be undertaken at a local and national level to explore effective mechanisms.

At a local level, the units receive many requests for visitors to attend, which can be demanding of time. Ensuring that the visitors have clear objectives has been an important feature and designating visiting times has also helped to cut down the workload. Another method which has been found to be effective is

hosting other nurses to work alongside team members, whether they are from within the Trust or external to the organisation, which is less onerous for the staff and more time-effective. Similarly, running workshops and seminars, contributing to conferences and publications have all been used successfully.

The need for dissemination to a wide range of target audiences, including nurses, purchasers, managers of provider units, users and others with a vested interest such as Community Health Councils and user groups, remains a high priority. Development of the Nursing Developments Network is one central means of assisting the NDU teams in this work, and other strategies are being actively pursued.

SUMMARY

Overall, many lessons have been learned from the work of these four NDUs, all of which has added to our understanding, not only of the value of nursing in improving the quality of patient care but also in the strategies which enhance or inhibit this development. The time has now come to spread this work further and ensure that the contribution which nurses make to health care continues to grow.

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This report describes the aims and achievements of those who have been involved in the Nursing Development Unit Project over three years and outlines some recommendations for the future which have been drawn from their experiences.

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