The NHS is currently facing unprecedented challenges in trying to improve the quality of services provided, while managing the most severe and protracted period of resource constraint in its history (NHS Confederation, 2014; Today’s NHS, 2015). The hour-a-day project was specifically designed by the author’s trust as an efficiency initiative, with the aim of saving an hour a day for each team member, releasing half that time as cashable savings, with the other half retained for the benefit of patient care. Saving time across 4,175 trust employees offered considerable scope for achieving efficiencies and reducing costs. In addition to achieving savings where possible, many services report that they now make better and smarter use of their time and resources (Berkshire Healthcare NHS Foundation Trust, 2015). The hour-a-day initiative was in place from autumn 2013 and drew to a close at the end of February 2015. A total of 92 services completed the process and delivered a combined saving of £1.9 million. Berkshire Healthcare NHS Foundation Trust (2015) demonstrated that the project was not overly complicated and simply offered an opportunity for busy staff members to take a reflective but introspective look at the way they work. For the majority, the hour-a-day initiative acted as a springboard for staff and managers alike to address and solve problems together.

The programme sought to empower staff at the same time as building support and enthusiasm for change across the trust’s services — it is this spirit of continuous improvement that provides the ‘golden thread’ that runs through many successful initiatives. One of the key factors in any project’s success is whether the participants take ‘ownership’ of the issues and harness the energy within the team so that they can respond jointly to any issues and find improvements in quality or make financial savings.

The aims of the project

The continence advisory service comprises a small team of 10 members, which includes five clinicians and four administrative staff who provide continence care to the whole of Berkshire.

The main aim of the project was to identify and achieve cash-releasing savings by 2016 as well as providing a platform for teams to examine their
CONTINENCE

THE SCIENCE — WHAT IS INCONTINENCE?

People can suffer from both urinary and faecal incontinence. Urinary incontinence is more common and up to six million people in the UK are thought to experience urinary incontinence, which is defined as the unintentional passing of urine. There are several types of urinary incontinence, but the most common are:
- Stress incontinence: urine leaks when the bladder is under pressure, such as during coughing or laughing
- Urge incontinence: a sudden, intense urge to pass urine
- Mixed: a mixture of both stress and urge urinary incontinence.

Faecal incontinence is an inability to control bowel movements, resulting in the involuntary passage of stools. The most common causes are:
- Rectal problems: severe constipation (resulting in overflow diarrhoea), or diarrhoea itself, mean that stools cannot be retained properly
- Sphincter muscles: events such as childbirth can damage the muscles at the base of the rectum
- Nerves: nerve damage through conditions such as diabetes or multiple sclerosis may mean that nerve signals sent from the rectum may not reach the brain in time.

Source: NHS Choices: www.nhs.uk

processes so that they could discover and eliminate problems. More detailed aims were:
- To focus on improving services without apportioning blame
- To provide an initiative led and owned by front-line staff and managers
- To mobilise the whole workforce to achieve maximum efficiencies
- To identify and remove activities which provide no value
- To improve the experience of staff, service users, families and carers
- To enable the ongoing sustainability of any changes that were made
- To re-invest time into activities that add quality to the care and services delivered.

THE CONTINENCE ADVISORY SERVICE

The continence advisory service’s hour-a-day project ran alongside the redevelopment of the service itself, and helped to ensure that all staff in the team were fully involved in the process and any subsequent changes. All of the continence advisory service team were required to attend the meetings to collaborate in the project and the leader was a trust representative who had experience in running similar projects.

Staff attending the five project sessions had the opportunity to voice their opinions, concerns and ideas for future ways of working. The sessions resulted in the following:
- A review and redevelopment of the service’s care pathways
- An acknowledgement that the continence advisory service team was a strong unit, able to demonstrate resilience during periods of uncertainty, for example during the rollout of a new IT system (this affected the continence advisory service greatly, as the team is ‘paperless’ and requires a user-friendly computer system)
- A review of existing management information to enable accurate measurement of current practice
- Planning for changes required to meet proposals set out for the future, in liaison with commissioners.

With 10 members of staff (nine were present at the sessions — one was unable to attend due to geographic location), the continence advisory service team worked collaboratively with the locality manager and each session was tailored to begin fostering an appetite for change using national key performance indicators as a framework for improvement activity (NHS Institution for improvement and Improvement, 2008).

SWOT analysis (see Table 1) looks at a team’s strengths, weaknesses, opportunities and threats, and staff were given the opportunity to discuss each SWOT key point and how these related to the current service. The work was summarised and some clear areas for improvement emerged, which cut across all four SWOT areas:
- Triaging referrals and starting to run group sessions, for example, a ‘well-woman clinic’ focusing on general bladder health. This was mainly aimed at women with straightforward bladder dysfunction who were identified during triaging and offered a choice of attending a group session or having a one-to-one appointment
- Staff diary management: staff were encouraged to keep accurate diaries so that the project leader was able to see if staff could make better use of their time
- Administrative support: for example, many staff members were not familiar with the computer system and needed more input from the IT team
- The use of technology in the future, such as the trust’s computer system, which provided access to a wide variety of administrative and clinical services, such as medicines and patient profile summaries (MaPPs); quality impact assessments; finance training, etc.

Over the initial three sessions staff process-mapped, problem-solved, shared best practice, and standardised their processes, for example trialling a computer-based monthly team planner to log the hours spent with patients, meetings, travel, etc.

Hour a day
The hour-a-day process enabled staff to develop a shared sense of purpose and a common understanding of...
Flexible dosing to suit a wide range of patients. Let's take a look.

**MOVICOL**, **MOVICOL** Plain, **MOVICOL** Chocolate, **MOVICOL**S Liquid Orange Flavour, **MOVICOL**-Half, **MOVICOL** Paediatric Plain and **MOVICOL** Paediatric Chocolate.

**Precautions for use:**
- MOVICOL Sachet of white powder which dissolves in 125ml of water to make a lemon/lime flavoured drink. Each sachet contains 13.125g macrogol 3350, 0.1785g sodium hydrogen carbonate, 0.0893g sodium chloride and 0.0505g potassium chloride. Does not contain flavourings or sweeteners. MOVICOL Chocolate Sachet of light to dark brown powder which dissolves in about 250ml of water to make a chocolate flavoured drink. Each sachet contains 13.125g macrogol 3350, 0.1785g sodium hydrogen carbonate, 0.3507g sodium chloride and 0.0233g potassium chloride. MOVICOL Plain Sachet of white powder which dissolves in about 62.5ml of water to make a lemon and lime flavoured drink. Each sachet contains 13.125g macrogol 3350, 0.0893g sodium hydrogen carbonate, 0.1785g sodium chloride and 0.0233g potassium chloride. MOVICOL Paediatric Plain Sachet of white powder, which dissolves in about 62.5ml of water to make a lemon and lime flavoured drink. Each sachet contains 6.563g macrogol 3350, 0.0893g sodium hydrogen carbonate, 0.1785g sodium chloride and 0.0235g potassium chloride. Do not contain flavourings or sweeteners. MOVICOL Paediatric Chocolate Sachet of white to light brown powder, which dissolves in about 125ml of water to make a chocolate flavoured drink. Each sachet contains 6.563g macrogol 3350, 0.0893g sodium hydrogen carbonate, 0.1785g sodium chloride and 0.0235g potassium chloride. Does not contain flavourings or sweeteners. MOVICOL Liquid contains benzyl alcohol. Do not exceed the maximum fluid content of the re-constituted solution does not replace regular fluid intake and adequate fluid intake must be maintained. Diagnosis of impaction should also be reported to Medical Information at Norgine Pharmaceuticals Ltd can be found at www.mhra.gov.uk/yellowcard. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 825606. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 825606. References:
3. Date of preparation: December 2015.
The concept of ‘energy for change’ outlines the capacity and drive of a team, organisation or system to make the difference necessary to achieve its goals (Land et al, 2014). The concept provides an insight into how five domains for change — social; spiritual; psychological; physical; and intellectual — are the key elements needed to drive change. The concept was shared with staff at the meetings with the aim of counterbalancing the sense of disharmony that can linger in response to previous organisational changes.

The energy for change concept was used to help staff understand some of the more humanistic aspects of change by emphasising the ‘good’ in human nature to enable them — and their managers — to make informed decisions. For example, in counselling, this approach allows a psychologist to focus on ways to help improve an individual’s self-image through focusing on areas that make them feel worthwhile.

This approach helped to improve the overall continence advisory service performance, for example, helping team members develop a shared sense of purpose and a common understanding of what change was required to take the continence advisory service into the future. The meetings acted as a springboard for staff to reflect on the challenges involved and hone in on the improvements required.

NEW WAYS OF WORKING

Before the project, patients would self-refer to the continence advisory service or be referred by other healthcare professionals. They would undergo telephone triage before being seen individually in clinic. However, the project highlighted that a lot of time was being spent repeating the same

Table 1: A strength, weakness, opportunity and threat analysis of the team (SWOT)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>→ Independent and autonomous practitioner</td>
<td>→ Do not always know what others are doing</td>
<td>→ Groups</td>
<td>→ Passwords and IT</td>
</tr>
<tr>
<td>→ Supporting colleagues</td>
<td>→ Emails</td>
<td>→ Telephone triage before first assessment by healthcare practitioner</td>
<td>→ Dealing with other organisations, e.g. Virgin Health</td>
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<td>→ Not just a job</td>
<td>→ Time</td>
<td>→ Teaching pelvic floor muscle exercise (PFME)</td>
<td>→ Parking permits in the community</td>
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<td>→ High knowledge and experience</td>
<td>→ Do not always limit to working hours due to enthusiasm</td>
<td>→ Group assessments</td>
<td>→ Badges</td>
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<td>→ Hard-working</td>
<td>→ Not offering</td>
<td>→ Learn</td>
<td>→ Time</td>
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<td>→ Excellent team working</td>
<td>→ Trust directives — smoking</td>
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<td>→ Administrative work</td>
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<td>→ Learning to say ‘no’</td>
<td>→ Different computer systems when it comes to home delivery service</td>
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<td>→ Highly skilled professionals</td>
<td>→ Referral information</td>
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<tr>
<td></td>
<td>→ Open to new ideas and treatments</td>
<td>→ Time management</td>
<td>→ Competing demands from commissioners</td>
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<td>→ Team players</td>
<td>→ Patients expectations</td>
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<td></td>
<td></td>
<td>→ Less stressful</td>
<td>→ Emails</td>
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<td></td>
<td></td>
<td>→ Mix of personnel (skills) personalities/knowledge</td>
<td>→ Sickness (cancellation of clinics; burden on other colleagues)</td>
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<td></td>
<td></td>
<td>→ Supportive caring and helpful</td>
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<td>→ Holistic assessments — time to do a full assessment</td>
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information to individual patients at each stage. Therefore, to help reduce the number of patients on the waiting list and to minimise the amount of time spent on telephone consultations, a new triaging guideline was created (Figure 1). Also, seeing patients in groups of 5–8 people meant that what would have represented a whole day’s clinic could now be reduced to one hour. This meant that staff had more time to deal with other more complex cases.

GROUP SESSIONS

Each session was an hour in length and covered the following:

- Anatomy and physiology of the lower urinary tract, pelvic floor muscles and prolapse
- Pelvic floor exercises
- Importance of healthy diet and fluid intake in promoting bladder health, including bladder irritants
- The importance of good bowel habits
- Realistic expectations of how long it can take for symptoms to improve.

Initially, the team member (a clinician or clinical nurse specialist) welcomed the patients and explained the aim of the session, which was to provide

Common bladder problems

The next stage of the session was used to go through some of the more common bladder problems.

Stress incontinence

This is where weakness in the pelvic floor muscle causes urine to leak on exertion, such as when coughing, sneezing, or even when moving from a sitting to standing position.

Urgency and urge incontinence

This is where patients get the urge to urinate suddenly and often do not make it to the toilet. They often need to go the toilet very frequently and/or only pass small amounts of urine (less than 500mls) when they do get there. Urge incontinence can be exacerbated by the patient regularly going to the toilet ‘just in case’, as this means that the bladder muscle (detrusor) is not being stretched by being filled, which reduces its capacity. In urge incontinence the bladder is what is termed ‘overactive’, so the bladder repeatedly ‘squeezes’ to give patients the feeling that they need to go to the toilet rather building more slowly to a severe urgent feeling that makes the

Figures 2–4.
Educational diagrams provided for patients in the group sessions.
These easy-to-follow explanations were provided in the group sessions to help patients better understand their symptoms and bodily functions:

- The bladder is like a balloon; it fills gradually until approximately half-full, after which there is an urge to pass urine. At this point, you can ignore the urge and the feeling will go away temporarily; or you can decide to go to the toilet. The pelvic floor muscles will ‘squeeze’ to support the bladder and help prevent leakage until you decide to go to the toilet. The bladder holds approximately 500ml of urine and you will normally go to the toilet between four and seven times in any 24-hour period.

- The pelvic floor comprises a number of muscle layers that run from your coccyx (the bone at the base of your spine) to your pubic bone. They work alongside the deep stomach muscles and close the openings to the rectum and vagina by creating tension (imagine you are stopping yourself passing wind or urine). These muscles are structured like a hammock that acts as a suspension for all your pelvic organs. Pelvic floor muscle exercises involve repeatedly contracting these muscles to strengthen them. You can tell if you are performing the exercises correctly by using a mirror to view the contraction externally (you will see anus contract); women can place a clean thumb inside the vagina (pressing ‘downwards’ and to the left or right) to feel the muscles squeeze against their thumb.

Factors that can increase urgency include:

- Anxiety
- Constipation
- Alcohol
- Urine infections
- Some medications
- Caffeine
- Poor fluid intake
- Bladder irritants such as citrus juice, black currents, etc.

The team then discussed with the group how much they should be drinking; about decreasing caffeine; preventing constipation etc, as well as other lifestyle problems that can exacerbate urgency, including:

- Being overweight: this puts more strain on the pelvic floor muscles
- Smoking: excessive coughing can weaken the pelvic floor muscles.

General tips

Patients should avoid going to the toilet ‘just in case’. This becomes a vicious circle, leading to a small bladder capacity, more frequent urination, and subsequent urgency. In fact, the detrusor muscle can be trained to hold more urine, e.g. sitting on a hard chair helps to defer the urge and turning to another activity or task will often take the mind off going to the toilet (Berkshire Healthcare NHS Foundation Trust, 2011).

A strong urge to urinate is likely to pass, particularly if patients perform some of the endurance pelvic floor muscle exercises. Bladder overactivity and urge incontinence are not psychosomatic, but using ‘mind over matter’ can help with bladder control (Berkshire Healthcare NHS Foundation Trust, 2011):

- Method one: when the patient has the urge to pass urine, they can go to the toilet and prepare to urinate but try counting to 60 before relaxing and actually passing urine. As they are already sitting over the toilet it will not matter if they cannot hold on, as any ‘leakage’ will simply fall into the toilet. They need to continue to practice counting to 60 every time they go to the toilet until they can hold on and do not leak. When they can do this, they should try counting to 60 before sitting on the toilet and then
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Once they can achieve this, they can then start to extend the time from 60 seconds until eventually they can extend the interval between urges to pass urine by 15 minutes.

Method two: this involves so-called ‘latch key incontinence’ where lots of women report that the moment they are struggling to find their keys and open the front door, they lose control of their bladder. Therefore, on arriving home they should practice counting to 60 once they have put the key in the door, but before opening it. While they are standing and counting, they should practise pelvic floor squeezes as these will help the sphincter hold-on, as well as helping to ‘calm’ the irritable detrusor muscle. Once they can master this, the urge will decrease and once they have counted to 60 they can open the door and go inside and continue with method one.

Rising to use the toilet at night
While in younger people it is normal to sleep through an entire night without getting up to urinate, as people age they may find themselves increasingly rising in the night to use the toilet. However, where patients have a problem with getting up more than twice in the night, this should begin to resolve once they can hold-on longer during the day. The following advice is provided for patients experiencing a frequent urge to urinate at night:
- Try to avoid caffeinated drinks for five hours before bedtime
- Cut down the number of drinks in the evening
- Just take sips if you are thirsty during the night
- Do not try to hang on when you get the urge at night as this will just disrupt your sleep.

Bowel problems
According to the Bladder and Bowel Foundation (2014c), there is a close relationship between the muscles and nerves that control bladder function and those that control bowel movements. Similarly, the bladder and colon are closely located and if there are large amounts of stool in the colon this can put pressure on the bladder and prevent it filling as much as it should, causing the bladder to contract unnecessarily, or impede bladder emptying. All of these problems can lead to daytime or nighttime urinary incontinence, urinary tract infections, and, in some cases, vesicoureteral reflux (the backward flow of urine from the bladder into the kidneys).

The group sessions stressed the importance of preventing constipation, causes of which include (Bladder and Bowel Foundation, 2014c):
- Not drinking enough water
- Not eating enough fibre and/or fresh fruit and vegetables
- Some slimming diets
- Medication
- Pregnancy.

Easy methods of preventing constipation include (Bladder and Bowel Foundation, 2014c):
- Increased fibre
- Increased water intake
- Exercise
- Not ignoring the urge to go to the toilet.

During the session, staff provided hand-outs concerning constipation and its treatment.

Future plan of action
At the end of the session, patients were asked if they had any further questions. They were also encouraged to consider their future plans for dealing with any bladder problem. Going forward, if patients had implemented the recommended lifestyle changes but there was still no improvement, they were offered a clinic appointment. In these cases, they were informed that they should complete a patient questionnaire and send it through to the team.

Also, at the end of the session, evaluation forms were handed out so that patients could provide feedback on how useful they found the session. A takeaway questionnaire was also provided for patients to fill-in and return if they felt they needed a further clinic appointment.

AUDIT
The continence advisory service team fully embraced the initiative and welcomed the opportunity to reflect on their processes and achieve improvements.

Despite the project being at an early stage and with only a few group sessions having been carried out at the time of writing, the team had already managed to achieve significant savings. Seeing 6–8 patients in an hour-long group session, instead of individually for an
hour each, means that a whole day of clinic time is saved and the waiting list greatly reduced.

The project has also freed-up time for clinicians to perform other tasks in the day, including telephone consultations, clinic triage and home visits. The whole process is simpler and improvements have been seen through reduced numbers of patients waiting to be seen for their initial continence assessment.

CONCLUSION

The continence advisory service had always operated an open referral system to make it more accessible for patients who might find the subject embarrassing and have to find the courage to admit their problem, even to an appropriate clinician. In recent years, referral rates have risen as general awareness of continence promotion increased. This placed increasing pressure on the team to meet patient needs as referral rates began to climb.

With no extra resources available to recruit more staff as well as increasing clinic waiting times, the hour-a-day programme was developed, which made use of group sessions for patients (mainly female) to try and achieve savings in time and resources. It was felt that a group session would provide the initial care and support that some patients required, as well as avoiding individual clinic appointments, and this had a positive effect on waiting times. Individual clinic appointments were still available for those who needed more specialist support.

The group session focused on providing general information that would ordinarily have been discussed in an individual clinic appointment, as patients often come to the service without having seen any other member of the primary care team for support.

Referrals to the continence advisory service were triaged according to the patient’s suitability for the group and all those deemed to have complex health needs were referred directly to individual clinic appointments. Patients were referred to the group if they had what appeared to be non-complex continence issues without any other medical pathology.

REFERENCES


KEY POINTS

- The NHS is facing unprecedented challenges in trying to improve the quality of services, while managing severe resource constraints.

- The ‘hour-a-day’ project was specifically designed as an efficiency initiative, with the aim of saving an hour a day for each team member.

- Saving time across 4,175 trust employees offered considerable scope for achieving efficiencies and reducing costs.

- With regard to continence services, the continence advisory service team decided to start running a group session for people with bladder problems.

- The project was not overly complicated and simply offered an opportunity for busy staff members to take a reflective but introspective look at the way they work.

- For the majority of staff in the local area, the hour-a-day initiative acted as a springboard to address and solve problems identified with the service together.

- This meant that, rather than clinicians seeing patients individually, six to eight patients were seen together in one hour, thereby actually saving more than an hour a day.

- In addition to achieving savings where possible, many services report that they now make better and smarter use of their time and resources.