Best Practice – Top Hospitals 2018

Special report: Insights from the winners
of the Top Hospitals awards

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Patient safety

Trusts continue to face the challenge of managing growing demand with a limited budget – essentially treating more people with less money – and, under these conditions, improving patient safety may seem like a difficult task. By autumn 2017, NHS plans were based on 7.3 per cent fewer acute beds than in 2010, while facing a 14.5 per cent higher rate of emergency admissions.[i]

The pressures came to a tipping point last winter when the NHS came under intense strain – the result of prolonged bad weather combined with a surge of flu and other illnesses. Poor patient flow, particularly due to delayed discharges, was a major contributor to the problems last year and, as bed numbers will not be increasing, resources will need to be better utilised if a repeat of this situation is to be avoided.

Tracking technology has the potential to relieve winter pressures and give staff greater control over patient flow by showing the real-time location of patients and equipment. The Scan4Safety programme, a "world first in healthcare" is being trialled at six hospitals in England and uses barcoding technology to provide traceability of products and data that "underpins better decision-making".[ii] It is hoped that it will reduce avoidable harm in hospitals, particularly human errors in surgical procedures and the administering of drugs. Tim Wells, a consultant cardiologist at Salisbury NHS Foundation Trust – one of the sites trialling the technology – says it provides them with "a level of data and insight that can be used to better challenge clinical practice and variation, helping us to reduce inefficiencies and improve patient experience and outcomes".[iii]

Data analytics is increasingly being recognised as a powerful tool in improving patient safety, providing trusts with critical decision-making support. Predictive intelligence is helping to detect patterns in admissions, arming managers with knowledge that facilitates better planning of available resources and workforce to coincide with spikes in demand, and many trusts are implementing e-Rostering software that works to improve patient safety through real-time visibility of staffing levels and patient acuity.

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Hospital culture is also a defining factor in patient safety. There has been a drive to change the pervading blame culture of the NHS, with a 'just culture' guide for managers published earlier this year. The hope is that supporting staff to be open about mistakes will make them more confident to raise the alarm when things go wrong and allow "valuable lessons to be learnt so the same errors can be prevented from being repeated".[iv]

In the National Reporting and Learning System report published in March this year, the number of incidents reported in October to December 2017 was 508,409, representing a five-fold increase on the number reported in October to December 2005 (135,356).[v] The NRLS states that as the reporting of safety incidents is largely voluntary, "increases in the number of incidents reported reflects improved reporting culture and should not be interpreted as a decrease in the safety of the NHS".[vi] This increase in reporting is positive as, the more comprehensive the data on breaches of patient safety, the more opportunities there are for learning from these incidents and avoiding patient harm in the future.

Case study: A culture of continuous improvement

Since 2011, South Eastern Health and Social Care Trust has put safety, quality and experience at the heart of everything they do. This has included the introduction of a Safety Quality and Experience (SQE) programme, which supports hospital staff to play a key role in improving care.

Emma Hannaway, head of performance and improvement, says the award win was recognition of the trust culture they have worked hard to build and embed. "We've had a real focus on safety, quality and experience since 2011 and it is our highest priority."

Management and clinical staff have worked in partnership to develop a culture of continuous improvement over time and Hannaway says it is embedded at all tiers of the organisation. "As a senior management team, we listen to the staff, we have a detailed programme of engagement and a lot of leadership walkarounds. Knowing that they are actively involved in the decision-making process gives the staff confidence and security.

"The culture is there from the top – it's not just words, it feeds down through the entire organisation and translates into what everybody does."

Hannaway says that it's about challenging the clinical staff to continuously improve, but the 'no blame' culture also means that staff don't take this as a criticism, instead recognising it as part of an ongoing journey. The trust has regular performance meetings where it can look at any declining areas, work out the reason behind it, and what it can collectively do about it as an organisation.

"Building this capability of quality improvement is something we've worked really carefully and extensively on. We attract really good clinical staff because of our culture and we empower them by giving them the space to be the best that they possibly can be. We show that we have faith in them to be able to do their jobs."

The organisation uses data to measure and monitor its safety performance. The SQE programme reports on different 'bundles', such as maternity or emergency, and the trust works to outline what 'good' looks like for each bundle using clinical indicators. The trust can then measure against its own previous performance, as well as benchmarking against other organisations.

Patient safety at the trust has also been enhanced by the introduction of Vocera technology, which enables instant communication between staff through the use of handsets that can be worn around the neck.

Hannaway says: "As a health and social care organisation we're under pressure to break even and meet performance targets – it's very difficult, which is why it's important to develop a culture of continuous improvement and find more efficient and effective ways of doing things. Safety, quality and experience is what drives us – it's almost like a mantra. We live and breathe it as an organisation."

References

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