Standing in the river holding a torch: SWOT and lessons on medical quality from the English National Health Service

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Brief Introduction

- 114 Care Homes
- 10 Surgical Centres
- 30% of country's 111 services – 3 million calls per year
- 40% of country's healthcare in prisons
- Launching a new model of primary care

Doctors and healthcare institutions in England

care UK

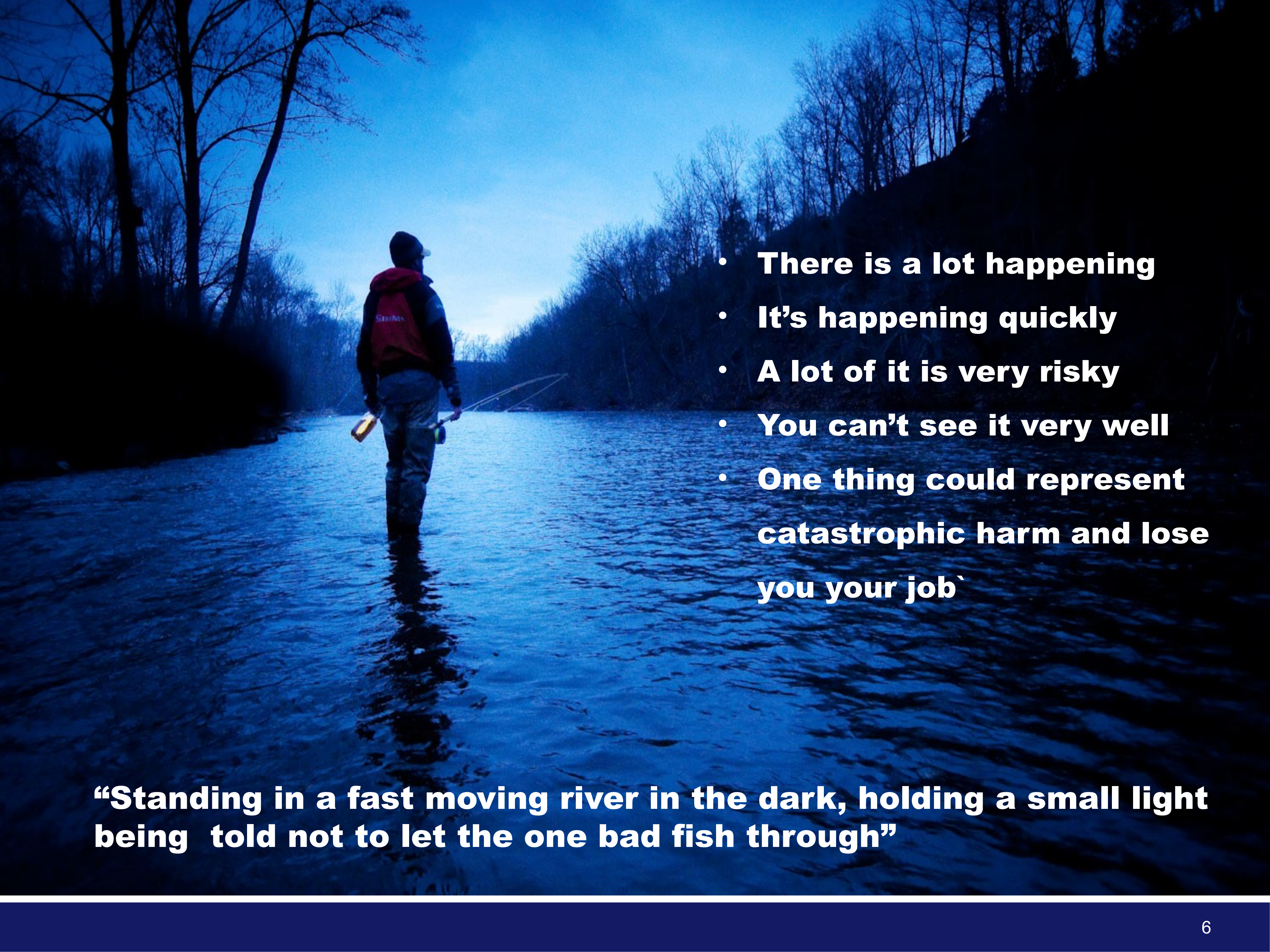
	NHS Primary Care 35,561	NHS Secondary Care 46,236	Other
Employed by	GPs working in small business groups (7,962)	The state through NHS hospitals	Range of other organisations
Status	Self employed (but more becoming employees)	Employees	Mixed
Pay governed by	Money earned through contracts with NHS	Nationally negotiated pay agreements	Range of arrangements
Accountable for quality	To professional body Through contracts for service	To professional body As part or employing organisation's accountability	To professional body Through host organisation's contracts
Measured for quality	CQC inspections, contract requirements	CQC inspections, contract requirements	CQC inspections, contract requirements

Doctors and healthcare institutions in England – the SWOT analysis

And our mission as leaders…

The NHS belongs to the people

It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.



• There is a lot happening
• It's happening quickly
• A lot of it is very risky
• You can't see it very well
• One thing could represent catastrophic harm and lose you your job`
"Standing in a fast moving river in the dark, holding a small light being told not to let the one bad fish through"

THIS IS SCARY. PROPERLY SCARY. AND DIFFICULT.

And leads to a number of potential responses:

1. **Getting out of the river**
2. **Intensive fishing**
3. **Hand dipping**
4. **Ecology**

“Standing in a fast moving river in the dark, holding a small light being told not to let the one bad fish through”

1. Getting out of the river

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- Don’t try and do the impossible in the river
- Do what you can do outside (manage finances, people, buildings, strategy, external relationships – all of which are important)
- Largely rely on the professional motivation and expertise of medical colleagues
- Support that by setting some clear rules on behaviour and process (e.g. surgical checklists)

BUT WHAT IF THE RIVER IS UNDER STRESS?

THE MID STAFFORDSHIRE
NHS FOUNDATI
TRUST
PUBLIC INQUIRY
Robert Francis QC

- **290 recommendations**
- **Massive expansion of inspection (through the Care Quality Commission – CQC) of health and social care organisations**
  - **£250m to run and 2,100 staff**
  - **Will have inspected and rated every hospital, GP, nursing home and care provider in the country**
  - **Big hospital inspections have 50 inspectors**
- **This is the biggest but not the only example of increased regulation of quality – most of the organisations involved have increased their requests for information**

2. Intensive fishing of the river

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- Positively
  - More nets catch more fish
  - Sends message that quality matters
- Negatively
  - Resource intensive and not sustainable
  - Changes the river in negative and unpredictable ways
  - Fish learn to avoid the nets
  - Focusses on finding and punishing the worst, not identifying, rewarding and spreading the best

3. Hand Dipping

- Selective information – measured in the right way (usually Statistical Process Control)
- Informal sources ("Leadership by walking about")
- Occasional random check
- Go deeper if something seems not to be right
- But done in an organised way

4. Ecology – improve the health of the river

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- Encourage local measurement for improvement not judgement
- Work on a culture of excellence
- Work on leadership development
- Engage patients as partners
- Respond to failures (wherever possible) with learning not punishment

Care

- **Salford Royal Hospital**
  - **CQC "Outstanding" rating**
  - **Lowest overall and weekend mortality in the region**
  - **Best staff and patient satisfaction results in the country**
  - **Series of impressive quality and safety improvements including:**
    - **100% reduction in MRSA blood stream infections**
    - **83% reduction in Clostridium difficile infections**
    - **48% reduction in cardiac arrests**
    - **79% reduction in Grade 2 pressure ulcers**

So you have a choice of responses:

1. Getting out of the river
2. Intensive fishing
3. Hand dipping
4. Ecology

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WHO Surgical Safety Checklist
(adapted for England and Wales)

NHS
National Patient Safety Agency
National Reporting and Learning Service

SIGN IN (To be read out loud)

Before induction of anaesthesia

Has the patient confirmed his/her identity, site, procedure and consent?
- ☐ Yes

Is the surgical site marked?
- ☐ Yes/not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway/aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and adequate IV access/fluids planned

Name:

Signature of Registered Practitioner:

PATIENT DETAILS

Last name:

First name:

Date of birth:

NHS Number:*

Procedure:

*If the NHS Number is not immediately available, a temporary number should be used until it is.

TIME OUT (To be read out loud)

Before start of surgical intervention
for example, skin incision

Have all team members introduced themselves by name and role?
- ☐ Yes

Surgeon, Anaesthetist and Registered Practitioner verbally confirm:
- ☐ What is the patient's name?
- ☐ What procedure, site and position are planned?

Anticipated critical events

Surgeon:
- ☐ How much blood loss is anticipated?
- ☐ Are there any specific equipment requirements or special investigations?
- ☐ Are there any critical or unexpected steps you want the team to know about?

Anaesthetist:
- ☐ Are there any patient specific concerns?
- ☐ What is the patient's ASA grade?
- ☐ What monitoring equipment and other specific levels of support are required, for example blood?

Nurse/ODP:
- ☐ Has the sterility of the instrumentation been confirmed (including indicator results)?
- ☐ Are there any equipment issues or concerns?

Has the surgical site infection (SSI) bundle been undertaken?
- ☐ Yes/not applicable
  - Antibiotic prophylaxis within the last 60 minutes
  - Patient warming
  - Hair removal
  - Glycaemic control

Has VTE prophylaxis been undertaken?
- ☐ Yes/not applicable

Is essential imaging displayed?
- ☐ Yes/not applicable

Name:

Signature of Registered Practitioner:

SIGN OUT (To be read out loud)

Before any member of the team leaves the operating room

Registered Practitioner verbally confirms with the team:
- ☐ Has the name of the procedure been recorded?
- ☐ Has it been confirmed that instruments, swabs and sharps counts are complete (or not applicable)?
- ☐ Have the specimens been labelled (including patient name)?
- ☐ Have any equipment problems been identified that need to be addressed?

Surgeon, Anaesthetist and Registered Practitioner:
- ☐ What are the key concerns for recovery and management of this patient?

Name:

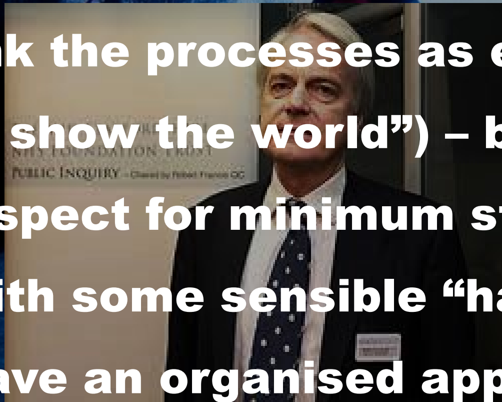
Signature of Registered Practitioner:

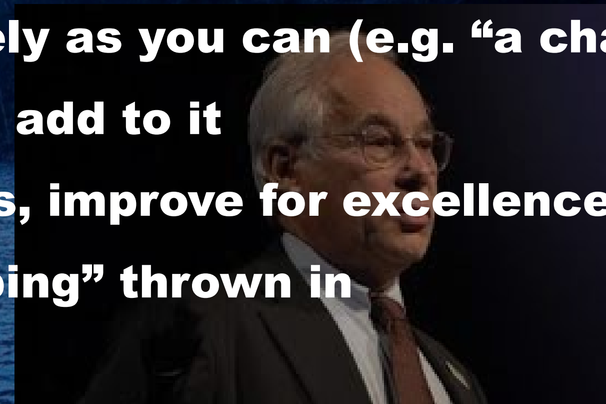
This checklist contains the core content for England and Wales

www.npsa.nhs.uk/nrls

Intensive fishing versus ecology (river health)

- **Work mostly on culture, learning and improvement**
- **You've probably got to participate in inspection anyway, so link the processes as effectively as you can (e.g. "a chance to show the world") – but don't add to it**
- **Inspect for minimum standards, improve for excellence**
- **With some sensible "hand dipping" thrown in**
- **Have an organised approach**





A word on your developing contractual relationship with doctors

- **Contractual relationships tend to emphasise transactional measure of performance…they may lead us in an unhelpful direction**
- **Contracting for culture is not easy, but needs to be done.**
- **Most of the time, work as though the contractual relationship does not exist…that we are partners in a shared endeavour.**
- **Contract for minimum standards and a commitment to work together on excellence**
- **Use quality improvement to bridge resource discussions (money, time, equipment) and quality**