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“ The focus on improving clinical correspondence – discharge letters and clinic letters – has for some years been on speed. We now have CQUINs for trusts, rewarding them with quality payments if they get a high percentage of letters to GPs within set time limits.

But is there a danger here in losing sight of the wood for focusing on the trees? The main goal of speeding up letter production and distribution is to ensure patient safety.

Let's remind ourselves of the safety issues involved. Between 2005 to 2008 the NHS Alliance carried out two surveys of 500 GP members. Its 2008 survey – conducted after three years of campaigning for better quality discharge summaries – showed that 70 per cent of GP practices experienced late discharge summaries “very often” or “fairly often”. Of these, 90 per cent said this compromised clinical care and 68 per cent said it compromised patient safety.

Things have moved on since then, driven first by contracts with financial penalties and now by CQUINs. The Royal College of Physicians has developed standards for compiling discharge summaries and many trusts have put in place electronic systems for collating and producing these summaries.

Clinic letters have received less attention but they are no less important. Unlike the

## ‘Automation can reduce the chances of transcription errors’

handwritten part of the medical notes, they are legible, dated and it is usually known who has written them. Consequently, they are regarded as an accurate record of what happened during the patient visit – and one that can be easy to read at one view. GPs see them as the vital link to what happened to their patient while in someone else's care and what the management plan is.

But GPs still report delays in receiving clinic letters and discharge summaries. More importantly, they still report quality issues. There is some way to go yet.

At Winscribe, we see how electronic systems can not only speed up clinical correspondence but also improve its quality. Integrating digital dictation and speech recognition with the PAS and other hospital systems means that elements of creating correspondence can be automated, reducing the chances of transcription errors or of simply missing out a letter on a clinic list.

From a management point of view, such integration also allows the automation of reporting – of demonstrating to commissioners where targets have been met.

Yes, speed matters – but only because fast, accurate communication improves safety.

Chris Rodwell is head of healthcare at Winscribe. [www.winscribe.com](http://www.winscribe.com)

## CLINICAL CORRESPONDENCE

# TIME TO DO BETTER WITH A LETTER

The risks and delays caused by an outdated clinical correspondence system can be tackled through technology – and a shift in attitudes, says Daloni Carlisle

When GPs talk about the importance of timely, accurate clinical correspondence for patient safety, it is worth spending a moment considering what this means.

“Let's take a classic example,” says Anna Bayes, a hospital doctor and management consultant and director of AB Consulting. “A GP has referred their patient to the cardiology clinic at the hospital for some checks for high blood pressure.

“The hospital consultant changes the patient's drug, perhaps changing it to a less potent one – and gives them a prescription. But the letter for the GP is delayed so the information never goes to the general practice. The patient takes the new drug – and the one prescribed by the GP because they have not fully understood the instructions given to them at the clinic.

“The next thing you know, the patient has continued on the original drug plus the new drug and the patient's blood pressure is very low. They have fainted – maybe falling and fracturing a hip – and they arrive at hospital in an ambulance along with a Tupperware box of all the drugs the paramedics could find in the house.”

Now that has to be the very definition of an unnecessary hospital admission and all because a clinic letter never arrived.

In 2010, Dr Peter Crouch at Taw Hill Medical Practice in Swindon detailed the safety risks from a primary care perspective in a report chronicling delays in receiving clinical correspondence from his local provider trusts. Broadly, he wanted to know who had seen his patient, where and when; the results of tests and investigations; management plans, diagnosis and changes in medication.

The consequences of not communicating this, he wrote, were: “Primary care working

largely in the dark unaware of what has been done to and for the patients who are registered with them for care and for whom they maintain their lifelong primary medical record.”

He detailed the risks. There was an increased risk of drug errors, including the GP prescribing duplicate or incompatible medication; of failure to recognise the impact of changes to medication/side effects; of repeated and unnecessary “over” investigation and a consequent risk of readmission. Nor was he in a position to understand the diagnosis or follow the medical plan.

So have things changed? Dr Michael Dixon, president of NHS Clinical Commissioners and chair of the NHS Alliance, thinks not: “I think timeliness has improved a little in recent years but quality? Not greatly.”

### Clinical engagement

Why is it, he asks, that a GP out of hours service can see a patient on a Saturday night, write a letter and deliver it by email to his surgery for Monday morning yet hospitals typically take two weeks to send on a clinic letter? “The answer is that hospitals are using a format that is 50 years out of date,” says Dr Dixon.

Dr Bayes could not agree more. Discharge summaries are usually written by the most junior members of the medical team and it is not a job they relish. “In the past when I have started a new job it was not uncommon to find a pile of discharge summaries waiting to be dictated,” she says. “This meant going back through the paper notes, trying to work out what happened to patients I never even saw.”

Clearly, this is far from ideal from a





patient safety point of view and now the CQUINs attached to discharge summaries have improved this significantly in many places. It is still possible though, that the quality is not improved by the requirement to produce the documentation faster, particularly with the new shift patterns for junior doctors meaning discharge summaries may end up being written by doctors unfamiliar with the patient.

No amount of technology will assist in this scenario – this is all about clinical engagement and doctors understanding clinical risks and putting correspondence higher up their priority list.

However, technology can help in other areas. Digital dictation and speech recognition can make a vast difference not just to speed but also to the quality of clinic letters, says Dr Bayes.

Beyond implementing digital dictation and speech recognition is integrating clinical correspondence systems with the hospital Patient Administration System so that patient demographics can be automatically added to letters and discharge summaries. Automation reduces the risk of data being

## ‘The DH was persuaded to put targets into the model contract but we still see a lot of lip service’

transcribed in error and can help make sure the letter is sent to the correct GP – a common source of delay, adds Dr Bayes.

“It also means you can dictate your clinic letters from a clinic list,” she adds. “This means that if you miss a patient off it is immediately apparent. You can also track the patients who did not attend because it is all there on the system.”

Systems can be configured to import data from lab systems, from prescribing systems – from just about any hospital system you care to mention, adds Chris Rodwell, head of healthcare at Winscribe.

They can even be configured to make letters available to patients via a portal, he says. “Ideally what you want is for the

patient to get home from the clinic and to be able to see their own letter. This is all part of making patients safe and empowering them.”

For a few trusts, all this is in place and patient care is safer as a result. But for many, it is a long way off partly because clinical correspondence is still not seen as a priority by many managers and doctors.

“Yes, the Department of Health was persuaded to put targets into the model national acute contract and yes we have CQUINs,” says Dr Dixon. “But we still see a lot of lip service paid to this.”

And if CQUINs and contracts have so far failed to shift the paradigm, what will it take to make clinical correspondence a must-do item for trusts?

Dr Dixon is hopeful that clinical commissioning will be an important lever. “I think when GPs from clinical commissioning groups start to get round the table with secondary care providers then we will start to see some change.

“That’s when we will start to see the safety aspect of all this come into much sharper focus because GPs will start to demand some change.” ●





“When the National Quality Forum in the United States deemed pressure ulcers to be “never events” it prompted a debate about the degree to which pressure ulcers can be classified as avoidable or non-avoidable. Whatever your view, such bold statements have changed the way pressure ulcers are perceived. Most in the NHS now view healthcare acquired pressure ulcers as a patient safety concern on a par with medication or surgical errors.

From a patient’s perspective, pressure damage to the skin is traumatic and painful. They develop as a result of an individual receiving inadequate preventive care when they are immobile or incapacitated, for example, following spinal or trauma injuries. For these patients, the development of a pressure ulcer adds insult to injury.

Pressure ulcers are also costly to treat and it’s true to say that prevention is far cheaper than the cure. Yet the economic impact described in this supplement is poorly recognised by many in the health service – as is the ability to make massive changes for a small investment.

Experience in the US following the National Quality Forum’s declaration have shown us what can work. Policies that align funding to performance, to ensure that hospitals no longer receive funding for the management of patients

### ‘Pressure ulcers should have the potential to impact on trust income’

who develop “never events”, can be a mechanism to change behaviours. Promoting pressure ulcer management as an indicator of care quality and sharing information on pressure ulcer incidence publicly can also have a powerful effect.

Here in the UK, it is vital that board level sponsorship is in place to raise awareness and drive behaviour change. Pressure ulcers should be regarded as an indicator of care quality that has the potential to impact on trust performance indicators and income, for example through CQUIN payments.

Policy initiatives such as the Safety Thermometer and the QIPP programme have helped to raise awareness at senior management levels. Reassuringly for boards, many of the initiatives that can reduce pressure ulcer incidence are relatively low cost.

Undoubtedly, initiatives to address pressure ulcers lack some of the “glamour” of other trust activities. However, their prevention is a fundamental part of ensuring high quality patient care, promoting patient safety and health service efficiency. On this basis they are deserving of more attention.

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[www.aderma.info](http://www.aderma.info)

Showing managers images of pressure ulcers is a potent way of driving home how serious they are for the patient



## PREVENTING PRESSURE ULCERS IN ACUTE CARE

# FACING UP TO PAINFUL TRUTHS

Pressure ulcers can be devastating for the patient but are finally being given a higher profile nationally, reports Jennifer Trueland





Ruth Ropper is passionate about preventing pressure ulcers and recognises the need to get managers on board. But rather than show them the figures, she says the surefire way to get managers to take pressure ulcers seriously is to show them the pictures.

"Images have a real impact," she says. "People can really see for themselves what we're talking about, and how horrible it is for patients. Patient stories help, too – hearing from the people the effect that pressure ulcers have on them, and on their families."

Ms Ropper, a member of the UK Tissue Viability Society and a tissue viability nurse specialist with NHS Lothian, explains what pressure ulcers mean to patients.

"If somebody develops a pressure ulcer it impacts their whole life," she says. "If you're unwell you take longer to heal, if you have an open wound you're at risk of infection, you might have to have repeated dressings, it can affect your body image – the impact on the individual and the family is huge, which is why preventing it is very, very important."

The figures are also eye watering. According to research published in the *Journal of Wound Care* last year, the costs of treating a pressure ulcer vary from £1,214 for category 1 (least serious) to £14,108 for the most serious category 4 ulcers.

The now defunct NHS Institute, which included pressure ulcers as one of its high impact actions, quoted research suggesting that pressure ulcers occur in between four and 10 per cent of patients admitted to hospital, and around 30 per cent of people in nursing homes. Citing 2004 research, it estimated the cost to the NHS of treating all hospital acquired pressure ulcers as between £1.4-£2.1bn per year – to put that in context, that was around 2 per cent of the entire NHS budget when the research was conducted a decade ago.

In the last few years, pressure ulcers have begun to receive high-level attention. Just last month NHS England published its business plan for the next three years. Among the measures to improve the patient experience is a commitment to rolling out public reporting of pressure ulcers.

Also at a national level, the National Institute for Health and Clinical Excellence is working on new guidance on pressure ulcer prevention, updating its 2005 guideline and the organisation has also published a pathway on pressure ulcer management.

In England, initiatives such as the Patient Safety Thermometer (which includes measurement of pressure ulcer prevalence) have been introduced, and there are commissioning for quality and innovation (CQUIN) payments tied to pressure ulcer measurement, in a bid to improve quality.

Not everybody agrees with this method, however. Although delighted to see pressure ulcers taking a higher profile, Alison Hopkins, outgoing chair of the Tissue Viability Society, and chief executive of Accelerate CIC, which provides specialist wound and lymphoedema services to the NHS, argues that prevalence measurement is not the way to go.

"The poorest wards will have the lowest prevalence because they won't record them," she says, adding that prevalence does not take into account things like case mix.

Grading ulcers at any one point in time is also problematic, she says, because sometimes it is not immediately clear. For example, someone with a black mark on their heel might simply have a blister with hard skin that will fall off, or they could have deeper damage which, in a diabetic, might mean losing a leg. "We don't know what it is until we've watched and waited," she says.

Of course it is important to pick up where negligence has been a contributor, but classification of an ulcer as a 3, for example, does not necessarily imply negligence.

There are a number of toolkits and

## 'I don't think we'll ever get to zero pressure ulcers but we're looking at what's avoidable and what isn't'

initiatives designed to prevent pressure ulcers. The NHS Institute Skin Matters work (still available on its archive website) includes case studies of how trusts and others went about trying to tackle the issue and reduce the harm – and the bill.

In Scotland, health boards are encouraged to use the US-developed SSKIN tool, which asks nurses to consider: Surfaces, such as mattresses and cushioning; Skin inspection; Keep moving; Incontinence (including moisture); and Nutrition. Money has been allocated to boards to promote pressure ulcer prevention, although it is up to each board to decide how to use it.

At NHS Lothian, Ms Ropper has been funded to run a year-long programme supporting pressure ulcer prevention. The "One a Day to None a Day" initiative was so named because data suggested that Lothian hospitals had around 32 pressure ulcers per month – almost one a day – and the idea was to reach zero.

The project involves link nurses, who are educated and supported to raise awareness in their clinical areas, as well as the development and distribution of resource packs. Around six months into the project, numbers of pressure ulcers have almost halved – there were 17 in March – but it is anticipated that raising awareness will push the numbers up in the short term.

"I don't think we'll ever get to zero pressure ulcers, but we're looking at what's avoidable and what isn't," says Ms Ropper.

Ms Hopkins believes that the big change that is needed is cultural – pressure ulcers have to be seen to be the business of everyone in the multidisciplinary team.

"The doctors who clerk the patient in should be looking at the skin, the physio should be looking at the skin. At the moment we have people in silos – skin is 'nurse', ankle rotation is 'physio' and medication is 'doctor'," she says.

High-level board engagement and senior management engagement is also essential as this determines funding decisions. "Yes, you have to get support at board level," says Ms Hopkins. "But they have to really understand the statistics – otherwise it makes a mockery of what we're doing and becomes a way of bashing nursing staff."

And that won't help patients. "Pressure ulcers are a hugely important issue," she says. "And I'm glad they are being taken seriously, but we've got to get this right." ●



## PRESSURE ULCERS: CASE STUDIES

# PILING THE PRESSURE ON THE PROBLEM

Determination by key individuals can rally trust staff into dedicating themselves to pressure ulcer prevention. Jennifer Trueland details two successful local campaigns

## CASE STUDY 1: THE SHA

Ruth May admits that it wasn't easy at first to get senior management on board with an ambitious programme to cut the incidence of pressure ulcers. But the then nurse director for NHS Midlands and East persevered and soon won the support of the executive team at the strategic health authority, and also the chief executives of local primary care trusts.

The result was a campaign that saw a dramatic reduction in prevalence of new grade 2, 3, and 4 pressure ulcers in the Midlands and the East of England – down by 36 per cent between April and October last year.

"I came back from maternity leave in January 2011, and in February reports from the ombudsman hit my desk," she says, referring to the *Care and Compassion* report that detailed failings in the care of older people. "It was heartbreaking – it was really all about basic care, about hydration, about skin. Everything is connected. I decided if we focused on one thing, then it would help the other things, too."

Ms May, who is now regional chief nurse, says she did a great deal of talking to her fellow board members and to PCT chiefs to make her case. "I took a lot of stick at first, but they were actually great," she says, adding that the projected cost savings helped to persuade the finance directors.

Eventually it was agreed that the goal of eliminating all but grade 1 pressure ulcers would be one of the SHA's high level ambitions.

Although the SHA made it clear to local trusts that this was a priority area, there was no one-size-fits-all approach. And Ms May confesses she was impressed and moved by the ingenuity shown across the region (see

the Luton and Dunstable case study). The SHA board, including the chair, made a point of asking about pressure ulcer prevention when they visited hospitals, she says, and this helped to keep up momentum.

"It got to the point that people were talking to them about pressure ulcer prevention every time they visited," she laughs. "They would joke that nobody wanted to talk about anything else."

A deliberate decision was taken to use the NHS Safety Thermometer to measure prevalence, which meant that data was captured from across the whole NHS in the region, not just hospitals.

"It meant that 55,000 patients were being measured every month – that's a fantastic achievement," she says.

It was important to realise that by raising awareness, the number of reported pressure ulcers would increase, she adds.

### Hearts and minds

Staff buy-in and engagement is also essential, she adds. "Yes, you need executive support, but you also need to get to the hearts and minds of the people delivering the care."

The SHA also took the innovative step of running a public-facing campaign involving Michael McGrath, who has muscular dystrophy. "We wanted people at risk of getting pressure ulcers – and their families – to know how to prevent them happening, and what to do if they thought they were at risk."

Mr McGrath, a power-chair user, who has led expeditions to the north and south poles, says he is now "acutely aware" of the risks associated with pressure ulcers, and takes action including checking his skin regularly, moving position as often as he can and ensuring he is properly hydrated.

The campaign made use of patient stories,

Medical staff have long struggled to push pressure ulcers up the list of trusts' priorities



including a family explaining in their own words how a pressure ulcer had affected them, and also gives access to education tools.

In December 2012, the SHA reported that 574 patients in the Midlands and East had a grade 2, 3 or 4 pressure ulcer on prevalence day in October, 1.09 per cent of the 52,570 patients checked. This was down by more than 400 patients since the previous April. In addition, numbers of grade 4 pressure ulcers halved, suggesting that preventative action was helping to stop ulcers worsening.

National moves such as the CQUIN on



The CQUIN on pressure ulcers has gone some way to raising the injury's profile





pressure ulcers help to keep the issue high profile, she says – and she doesn't see the new commissioning regime post-April 2013 reducing the impetus around pressure ulcer prevention.

"Lots of people have been really brilliant in taking this on," she says. "It can take bravery to stand up and say what's right, and our clinical leaders have been fantastic."

For more detail about the campaign see [www.eoe.nhs.uk/page.php?page\\_id=2241](http://www.eoe.nhs.uk/page.php?page_id=2241)

## CASE STUDY 2: LUTON & DUNSTABLE

On the orthopaedics and trauma ward at Luton and Dunstable University Hospital, there is a system for spotting potential pressure ulcers – and stopping them develop.

If anyone notices a red area of skin on a patient, they call out "red alert" – actually call it out – and all the staff at that end of the ward hurry to the bedside.

"It's called 'see, swarm, solve,'" says tissue viability clinical nurse specialist Sylvia Woods. "Someone sees it, everyone swarms, and then they come up with a plan."

This is one of the ways in which Luton and Dunstable is endeavouring to eliminate all but the most unavoidable of pressure ulcers. Importantly, the "red alert" is sounded at the

## 'If anyone notices a red area of skin, they actually call out "red alert" and all the staff hurry to the bedside'

earliest possible sign that an ulcer might be about to develop that gives the team a chance to take action to prevent an ulcer forming.

It is clear that Luton and Dunstable responded enthusiastically to the old SHA's ambition to eliminate grade 2, 3 and 4 pressure ulcers (see first case study). Last year, two pilot wards – trauma and orthopaedics and stroke – were chosen to take forward ideas which might help reduce pressure ulcer incidence. These wards, where patients are frequently elderly and have mobility issues, were deliberately among the most challenging in the trust.

"Yes, these groups have the highest numbers of at-risk groups," says Ms Woods. "But if it could be done there, it could be done anywhere."

The preventive measures are all evidence

based. "It might involve repositioning the patient more frequently, checking nutrition and hydration, all sorts of things," she adds.

But the initiative has also tested inventiveness. The trauma and orthopaedics ward nurses started wearing flashing badges, adapted Blue Peter style from some flashing Christmas ear-rings bought cheaply at the local pound shop. When they are wearing the badges around the hospital, other staff ask what it's all about.

The stroke ward also put Blue Peter skills to the test, inventing their own form of "turn clocks" – little clocks which have timers set to alert staff to when the patient needs to be repositioned or otherwise checked by the team.

The ideas are intentionally simple and easily understood by patients and relatives as well as staff. "Sometimes I think we over think things," says Ms Woods. "But it's about coming up with the simple things – small steps, which really make a difference."

At the end of the pilot, the orthopaedics ward had managed more than 120 days without a pressure ulcer, while the stroke ward had achieved more than 70.

"They have particularly complex patients, so that was a real achievement," says Ms Woods. "The whole ward was utterly devastated when one did occur, and everyone was really keen to learn if anything could have been done differently to prevent it."

## Growing attention

Now the trust is rolling out pressure ulcer prevention to all wards, a process that is expected to take around 15 months.

"We're not being prescriptive about it, because we know that what works in one ward isn't necessarily the best thing for another. But we've got really strong support from the executive team, and real enthusiasm from the staff on the ground, who have been coming up with some great ideas."

Although not one of the pilot wards, the trust's short-stay medical admissions unit has also shown great success in tackling pressure ulcer prevention – and managed to go more than 180 days without one. It used a "flip chart" process which clearly showed the number of pressure ulcer-free days, and which could be seen by staff, patients and visitors.

Other wards are looking at using the SSKIN bundle (see main article), and the trust is making use of "safety crosses" to give live, real-time information which is posted on the walls of the ward.

Again it has a hand-crafted element, with days without pressure ulcers shown by a green dot, with red dots to show days where there has been one.

Ms Woods agrees that pressure ulcers have too long been regarded as the bottom of the heap, and is glad that the issue is gaining more high-level attention. ●





“As the single largest public health system in the world, employing 1.3 million people, of whom almost half are clinically qualified, the NHS's workforce accounts for the largest proportion of the healthcare budget and is under continual scrutiny.

This workforce is also extremely mobile, moving in, around and out of the NHS infrastructure during what is usually a very long contract term. The Francis Inquiry has brought the spotlight yet again on to the workforce, focusing on excellence in recruitment, training and competency of staff.

Looking to the future, the ability to mobilise healthcare professionals is going to be critical. Ensuring these workers are compliant, and therefore of minimal risk to the service, is a time consuming and expensive process. Staffing agencies have a key role in supporting the NHS in this.

We believe that three key factors can underpin patient safety through workforce compliance: adherence to framework agreements, use of technology and nationwide adoption of the NHS Skills Passport.

Those frameworks designed for the provision of temporary staffing should be promoted across the primary care landscape by NHS England and the CCGs. By way of illustration it was estimated that in 2010 approximately

## **'The Skills Passport empowers staff to take control of compliance'**

£360m was spent on temporary staffing in the primary care sector, with very little of this coming through framework agreements, opening the system to risk through variations in compliance and wild fluctuations in cost.

By using technology, and a model similar to the electronic patient record, a common compliance platform could be established. It would reduce duplication of effort, drive standards and support mobilisation of the workforce. By centralising this essential recruitment requirement, costs could be drastically reduced while speed of response and supply would be greatly enhanced. HCL has invested in its own such technology platform, HCL Clarity, based upon workforce transparency and real-time management information, features often not readily available at trusts.

The Skills Passport for health and social care professionals has been piloted and has been nationally adopted in Scotland. Its roll-out across England would reduce the millions of essential but duplicated compliance procedures an individual is subjected to. It also empowers healthcare professionals to take ownership of their own compliance, which can only drive standards – and patient safety – up.

Stephen Burke is CEO of HCL Workforce Solutions. [www.hclplc.com](http://www.hclplc.com)

## **WORKFORCE COMPLIANCE**

# **ENSURING TEMPORARY IS TRUSTED**

With the pressure on to meet minimum levels of staffing, how can managers guarantee that their many temporary workers are trained and safe, asks Daloni Carlisle

The Francis Inquiry rightly highlighted the danger of low staffing levels, particularly of doctors and nurses, and called for minimum staffing levels to ensure patient safety.

The government has resisted calls for national mandatory levels, saying they risk driving standards down to the lowest common denominator, and would rather see trusts refine existing tools for local use.

What is now becoming apparent as trusts look into minimum staffing levels is that achieving them will sometimes mean using temporary workers. The question then is this: how can nursing managers be sure of the safety of these temporary workers?

For Jackie Knowles, head of clinical governance and compliance at HCL PLC, which supplies over 2,000 staff a week to clients that NHS trusts, this comes down to compliance.

"Compliant agency supply is integral to trusts wanting to meet a set minimum staffing level as agency supply can fill gaps for short term staffing fluctuations due to absence, leave cover or increases in patient acuity," she says. "Compliant, competent, well vetted agency workers can fill this staffing need without compromising patient safety."

The RCN is in principle against casualising the workforce, although policy director Howard Catton does recognise that temporary workers have a role to play in achieving minimum staffing levels – and that this must be done with safety in mind.

"It is absolutely essential that trusts are sure people are who they say they are," he says. "You have to be sure that nurses have the skills, background and experience that the agency claims for them."

At its most basic, says Ms Knowles, compliance is all about initial recruitment and ongoing checks that employment

agencies must carry out on healthcare professionals, set out in the NHS Employers Standards and good industry practice.

"The Care Quality Commission inspects the NHS against these safe recruitment standards and therefore it is imperative that agencies supplying the NHS get their vetting and selection process right for patient safety," she says.

The NHS Employers Standards apply to all staff, not just agency workers and are currently under revision to ensure these meet service needs and continue to be fit for purpose in the new NHS. NHS Employers expects to launch new standards early this summer. Their use is policed through procurement frameworks and individual trusts' quality assurance teams.

### **Held to account**

Nyla Cooper, programme lead on safe employment at NHS Employers, explains: "NHS trusts are strongly recommended to use agencies that have a framework agreement, such as with the Government Procurement Services (GPS), due to regulatory processes being in place to monitor their recruitment practices and compliance of the code of practice for international recruitment of healthcare professionals."

So on one level, NHS trusts that use employment agencies that are approved under the various procurement frameworks that operate throughout the NHS ought to be assured they are getting compliant healthcare professionals. HCL is on all the major frameworks.

But Ms Knowles says: "If NHS hospitals are relying on agencies to be doing that compliance work for them, they need to be confident that the agencies are doing what is asked of them. The agency and trust must





Agencies' supply of nurses is coming under increasing scrutiny following the Francis report

**'The worker could get back into the system and no one is any the wiser. Agencies have a very big part to play here'**

work in partnership to ensure the appropriate compliance levels are upheld."

She would, for example, consider it good practice for trusts to request an agency placement checklist – a one-page summary about an individual's compliance checks.

"Some of the trusts we work with are routinely requesting these checklists but some are not," she says. "I think it should be mandatory. NHS trusts need to hold agencies to account."

NHS Employers agrees, saying employers have a duty to seek written assurances that checks have been done. "Any additional checks applied by the employing

organisation must be proportionate to risk and form part of their contractual agreements with that agency and as part of any scheduled auditing and monitoring processes carried out by the trust," says Ms Cooper.

Mr Catton adds: "It is important that trusts are clear with agencies about the skills and experience they need and it is equally important they work closely with agencies and build relationships to ensure the people they want are the people who are delivered."

The risks of not having the structures to hold agencies to account can be high, adds Ms Knowles. For a start, trusts sometimes find they have to go "off framework" when they need specialist staff at short notice – a situation that can often be avoided by using software that gives transparency around the workforce.

Trusts that do not have the right structures and agreements in place when working with off-framework agencies may face even greater risks, suggests Ms Knowles.

In January, NHS Employers and the Independent Healthcare Advisory Service published joint guidance on information sharing on healthcare workers. It was prompted by concerns that practitioners whose fitness to practice had been called into question in one workplace could go on to work elsewhere without their track record following them.

While this guidance was written to ensure information sharing about healthcare workers between the NHS and the independent sector, Ms Knowles believes it has important implications for agencies, too.

"A worker whose fitness to practice is under question may register with an agency," she says. "If a rigorous vetting and selection process is not followed, there is a risk that this information never reaches the trust. The worker could get put back into the system and no one is any the wiser; patient safety may be put at risk. Agencies have a very big part to play here."

NHS Employers acknowledges this is a tricky issue. "There is a fine line between duties to share information about healthcare workers with the aim of protecting patients and the legalities which surround patient confidentiality, and individuals' rights under the European Convention on Human Rights and the Equalities Act," says Ms Cooper.

Everyone needs to understand their respective role here and NHS Employers is currently developing good practice guidelines with health unions that it expects to publish this month.

When all is said and done, though, Ms Knowles argues that temporary workers can contribute to maintaining patient safety – but only if trusts and their partner agencies are proactive in ensuring the right people get to the right place at the right time. ●



## WORKFORCE COMPLIANCE: CASE STUDIES

# PUTTING THE CHECKS IN THE POST

Pat McLaren looks at the experiences of a locum doctor who underwent compliance checks – and at the vetting procedure from a trust's point of view

## A LOCUM DOCTOR'S PERSPECTIVE

Dr Lucy Haurisa finished her training in Germany in 2010 and has since worked as a locum doctor in several NHS hospitals. From that experience, she believes that current UK structures support patient safety.

In particular, she says the checks for compliance – including language testing – are a real plus. Add in the chance for locums to have dedicated learning time and national guidelines help locum doctors work effectively and she says she felt safe to work across multiple sites.

Dr Haurisa came to the UK to follow up an interest in public health. Colleagues suggested working here in the NHS to broaden her experience.

"They had all said good things about the NHS and so I became curious about the healthcare system and researched how to do an attachment in the UK," she says.

In summer 2012, she secured a clinical placement at an NHS ENT department in Portsmouth, which gave her the confidence to work as a locum doctor in the NHS.

"I had very helpful colleagues in Portsmouth who recognised the specialist knowledge I had and were happy to help me learn and then apply for locum work," she says.

"Colleagues have been proactive in explaining how the UK system works and sharing important information with me, including patient safety guidelines."

To minimise risk to patient safety, Dr Haurisa completed the following key compliance checks before working as a locum doctor in the NHS supported by HCL:

- Pre-screen and full registration checks including her CV, UK and non-UK police checks, Right to Work verification, references, GMC registration check and Fitness to Practice checks.

- A face-to-face interview, including a language competency review.
- An occupational health summary review, and a review of references to support the doctor working in the UK.
- Mandatory training, including safeguarding of vulnerable adults and children as well as health and safety training required in the NHS.

In addition to compliance checks, as a locum doctor placed by HCL Doctors, Dr Haurisa was also supported to work at each NHS hospital through an induction programme and a named contact at HCL.

Making sure she was safe to work here in the UK as a locum doctor was as important for Dr Haurisa as it was for potential employers. She says: "Patient safety is very important, and so I liked the idea of having all of these checks. It was time consuming, yes, but pretty straightforward and my German qualifications helped."

## Inadequate vetting

In comparison to the German healthcare system, Dr Haurisa says the way in which NHS doctors train together and are structured to work in departments promotes patient safety standards.

"In Germany, the structure is not as transparent, and training happens in blocks. I really enjoyed working in the UK because I knew my responsibilities, and who to direct questions to." She continues: "When working with patients I was encouraged to discuss and learn from experience and not only guidelines."

Dr Haurisa also highlights the promotion of ongoing training in the NHS, and has enjoyed the opportunities she has had to develop while working as a locum, joining training courses and attending seminars on a regular basis.

Jackie Knowles, head of clinical governance and compliance at HCL, says the risks of



**'There is a risk of communicable diseases if occupational health is overlooked, putting public health at risk'**



Locum doctors must be proved to be safe to work in the NHS



failing to carry out compliance checks are high. "Patient safety is put at risk by inadequate vetting," she says. "This could mean unverified identity, so you don't know whether the doctor is who they say they are, or whether they hold the qualifications they claim or are qualified for the role they applied for."

"There is a risk of communicable diseases if occupational health is overlooked – putting public health at risk – as well as of illegal workers in the healthcare system when right to work is not confirmed. Unchecked criminal records pose a potential risk to vulnerable adults and children. All of this can be minimised with rigorous vetting of each healthcare worker."

As for Dr Hautisa, she is now working in Cambodia to establish ENT services at a non-

governmental hospital to European standards, but may in future return to locum work in the UK. She adds: "I really enjoyed learning about the differences to my training and work experience in Germany, and retrospectively I can see what I did there could have improved if I'd had the experience I have received since being in the UK."

### SANDWELL AND WEST BIRMINGHAM HOSPITALS TRUST

A desire to create a more flexible nursing workforce has led Sandwell and West Birmingham Hospitals Trust, which serves a population of 500,000, to begin recruiting nurses from across the European Union in partnership with workforce solutions specialist HCL.

In addition to existing nursing staff, the trust runs its own nurse bank which it uses to create a flexible approach to staffing parts of the trust when it needs to vary bed capacity, ensuring patient safety is maintained.

The trust is actively recruiting to vacant and bank posts and the remaining staffing gaps had, until the partnership with HCL, tended to be filled through agencies. But now a group of experienced and compliant nurses from Spain and Italy have joined the trust to undertake flexible work placements across its three hospitals: Birmingham City Hospital, Sandwell General Hospital and Rowley Regis Hospital.

To create this more flexible workforce, the trust joined its local NHS trust cluster (Birmingham) to procure a staffing service in line with the HTE (Health Trust Europe)

framework agreement, and engaged HCL Nursing to source trained, experienced nurses to overcome the lack of local qualified resources who could provide the flexible service required.

"It was a challenge," says Helen Rudanec, managing director of HCL Nursing. "But not one unique to the Sandwell and Birmingham area. A growing number of our NHS clients are having difficulty recruiting qualified, compliant and flexible nurses and so we've developed relationships with several healthcare organisations across the EU to help meet that demand."

She continues: "By hand picking candidates, providing any necessary training, compliance checks and a tailored induction programme, we have created a bank of framework-approved nurses ready for rostering."

Glynis Fenner, nurse bank manager at Sandwell General Hospital, says the partnership has been a practical and pleasant experience to date. "With the bank in place, it has been much easier to meet the changing service demands across our sites. We have peace of mind because we know the staff are skilled and compliant."

She adds: "As the nurses are with us for a block placement, they offer our patients a continuity of care not provided by agency staff, and the few teething problems we've had, due to it being a pilot programme, are vastly outweighed by the enthusiasm each nurse has for providing quality patient care."

"We offer block placements for all staff working through our bank and other agencies." ●



A growing number of NHS clients are having difficulty recruiting qualified, compliant and flexible nurses, says HCL Nursing





“ Making businesses fly beyond their wildest dreams has been the day job for Achieve Breakthrough for the last 10 years. We are devoted to bringing about powerful, lasting change in the organisations with which we work, be they private sector firms like AstraZeneca and Novartis or public sector organisations like Royal Berkshire Foundation Trust or Hull and East Yorkshire Hospitals.

It is interesting that while many people perceive there to be a giant rift between the private and public sectors, many of the challenges they face are not so far apart. Doing more with less, being more creative and innovative, driving down cost while raising productivity... In the current climate, they all sound familiar regardless of the side on which you stand.

While many organisations spend vast amounts of time focusing on tweaking processes and systems, it is the development of people and their way of thinking that brings about the biggest shifts in performance and output.

NHS trusts are perfect examples of organisations where breakthrough thinking is having a profound effect on people's ability to transform their attitudes in the face of certain change. In so doing, new perspectives are created and, with them, a fresh approach to surmounting day to day challenges.

**‘Our work is changing the water in a fish tank, not the ornaments’**

In today's NHS, those daily challenges are of course considerable ones: an ageing population, funding cuts, the scrutiny resulting from the Francis Report, the fundamental reorganisation of the health service. All will require staff to challenge the habitual ways of doing things. Doing that will require a change in the mindsets and attitudes that created those habits in the first place.

At Achieve Breakthrough, we work with organisations to bring about just that kind of transformation in thinking. By supporting and consulting with senior and middle level managers, we help change the context in which they are operating. We look not at processes but at people's realities – we see our work as the equivalent of changing the water that is in a fish tank rather than the ornaments around which the fish are swimming. Our experience shows that it is the only way in which true, lasting transformation can be created.

We are always very happy to speak to anyone interested in learning more about our approach and our methodology, and how it can support fundamental change in an organisation. In the first instance, call Alex Small on 01225 852 863 or email alex@achievebreakthrough.com  
*Alex Small is business development director at Achieve Breakthrough.* ”



## WORKFORCE

# WHY A NEW ACT NEEDS A NEW SCRIPT

Getting from ‘discussion’ to ‘dialogue’ is crucial if major change is to be achieved but the pressurised climate of the NHS makes this a challenge, writes Claire Read





Mike Straw has spent the past 20 years working with private sector organisations to bring about change and transformation. Ask him how he does it and he talks of focusing on the mindsets and attitudes of those leading and working within an organisation. It is these, he suggests, which determine behaviour.

Yet at a time when the NHS is being asked to deliver more than ever before – safe, top-quality patient care on limited resources – he fears its leaders and managers are ill equipped to change those mindsets.

“People are in survival mode,” argues the managing director of Achieve Breakthrough, a business change consultancy which is working with increasing numbers of NHS clients. “And when we’re in survival, we feel compromised. At the middle management level, everyone is feeling under pressure, having to do more with less.

“They’re told to work harder, faster, quicker, smarter, more creatively but don’t make any mistakes. And that’s a really, really tough ask because when people feel threatened, as they do at the moment, they’re not at their most creative.”

None of which is to say that the NHS is not trying to change.

“Everyone is working desperately hard to change structures, to change processes, to do all of these things,” says Mr Straw. “But what

they run up against is the existing attitudes and behaviours. Inherently, this type of problem cannot be solved with the same level of thinking.

“It needs a breakthrough in people’s thinking and acting to bring about change. For that to happen, people’s potential needs to be unlocked, and leaders and managers who have the ability to do this are rare.”

As the holder of a master’s degree in organisational development, the chief executive of Hull and East Yorkshire Hospitals Trust is perhaps more sensitive than most to this line of argument. When Phil Morley joined the organisation two years ago, it had one of the worst mortality rates in the country and was failing on a series of other measures. His work to address those problems soon involved a concerted effort to change the way in which his staff talked about and approached challenges.

How necessary this was became clear when, during his first fortnight at the trust, he sat in what he describes as the most dysfunctional meeting he has ever attended, listening to people shouting over one another to share opinions.

“What makes human beings think the way they think is all about the language you use, the quality and quantity of conversations that people have,” he argues. “So if you want to start changing people’s behaviours you have to start changing the way they talk, the language they use, the quality of the conversations they have, the opportunity to have dialogue rather than discussion.”

#### Dramatic turnaround

He says sessions with staff from Achieve Breakthrough brought about that change in dialogue. “A really good example is that when I came to the trust, when mortality was so poor, we had a mortality monitoring committee. We changed it into a mortality reduction committee.

“Even by changing that conversation, people then feel this is our role here. It sounds really silly but just moving from mortality monitoring to mortality reduction made people think yes, we’ve been great at monitoring it, but we haven’t reduced it.”

That is no longer the case. In 18 months, the trust’s standardised mortality rate has fallen from a significantly above average 117 to within the normal range. Mr Morley says the improved dialogue between staff and renewed focus on the organisation’s aims played an important role in that improvement performance. The trust’s chief of workforce and organisational development agrees.

“It’s really pulling a team of people together to focus on what they all agree are the common goals,” says Jayne Adamson. “There’s nothing particularly magical in this other than you’re dealing with what’s stopping people doing that normally.”

## ‘When people feel threatened, they’re not at their most creative’

### HULL AND EAST YORKSHIRE HOSPITALS TRUST

Two years ago, Hull and East Yorkshire Hospitals was 168th out of 168 on yearly mortality rates. It was far from the only area in which performance was poor. “Most of our measures would have been red if you were going to RAG-rate them,” reports chief of workforce and organisational development Jayne Adamson.

Yet at the beginning of April 2013, the organisation was shortlisted for a Patient Safety Award. It is recognition of a dramatic turnaround – moving to 79th on mortality, reducing *C Difficile* infections by 50 per cent, reducing the number of cardiac arrest calls by more than 50 per cent, cutting the pressure ulcer rate by 40 per cent and falls by 25.

The award category in which the trust has been shortlisted is revealing: changing culture. For while the turnaround started with a restructuring – four health groups headed by what the trust refers to as a triumvirate of a medical director, a nursing director and an operational director – it was made possible by work to open up dialogue between those working in the organisation, confront frustrations, and work towards real change. That process was aided by Achieve Breakthrough, which has developed the organisation’s leaders and managers as part of a culture change programme.


“After their first Breakthrough session, the triumvirates came out with this concept of Health Groups United,” reports Mr Morley. “Acting for one is acting on behalf of all; speaking for one is speaking on behalf of all; a decision in one is a decision for all of us.”

“Up to that point, medicine worked in medicine and surgery worked in surgery and our clinical support services were supporting them but very separately; the same with family and women’s,” explains Ms Adamson.

“Now Health Groups United run their own transformation board. They looked at our *C Difficile* rates and we put a cohort ward in place and other measures and managed the rate down on the back of that. It’s also impacted the work that we are doing on mortality because we were working together. The Health Groups United part was a real catalyst, I think.”

“This is the kind of work we’ve been doing,” continues Phil Morley. “It’s not just been sitting in a room and saying nice words to each other. It’s all been with the purpose of improving outcomes for patients.” ●





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