RLDatix

eBook

Connecting health and care operations: Achieving NHS productivity targets without compromising patient safety

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One of the biggest challenges facing health system leaders is balancing the ambitious productivity targets for 2024/25 set by NHS England without compromising patient safety.

Patient safety remains the cornerstone of all operational strategies. As health and care providers strive to enhance productivity and efficiency, it is crucial to ensure that safety does not take a back seat.

Here, we present a comprehensive eBook on **achieving productivity and efficiency plans without compromising patient safety**. We believe this can be achieved by connecting healthcare operations.

This is safer health and care.

The foundation of safety

Through our national programme of implementation and support to NHS organisations making the challenging transition to Learning from Patient Safety Events (LFPSE), we have learned valuable lessons about the best ways to use and maximise engagement with risk and incident software.

In this eBook, here are some of those lessons.

Accurate and thorough recording of safety incidents is the bedrock of a robust safety management system. Detailed records provide the data necessary for meaningful analysis and improvement, while effective reporting mechanisms ensure that the right information reaches the right people at the right time, enabling timely interventions and corrective actions.

"As an organisation we are now very aware of what our highest risks are, what the actions plans are, and who is owning them. It gives us much better control over assurance as we have visibility over risks and how things are actually moving."

Lisa Richards,
Trust Risk Manager, Royal Devon University Healthcare NHS Foundation Trust

Learning, continuous improvement, and cultivating the right environment

The new Patient Safety Incident Response Framework (PSIRF) emphasises the long-term commitment to fostering a learning environment and urges organisations to respond proportionately, and learn continuously. With this in mind, health and care organisations can ensure that their productivity and efficiency plans are firmly anchored in safety.

There is no quick fix or simple switch to flick that instantly, or even quickly, will cultivate the right environment for learning. The growing of this environment is a long-term project that will require energy and buy in from every single staff member, no matter the job title.

Creating the right environment for learning not only unlocks higher visibility of incidents and risks, and learning opportunities that can make processes safer for both staff and patients, but also the opportunity to make process improvements for greater safety, efficiency and productivity.

While it's possible to achieve benefits to both patient safety and productivity, it's important to recognise that learning doesn't always lead to improvements in them simultaneously, and may produce opportunities to improve one or the other. However, productivity gains should never come at the cost of safety.

"DCIQ has been met with excitement and unanimous support, thanks to its ease of operation and instant access to reliable real-time data from across the organisation. The new centralised risk management process, which embraces an open culture focusing on patient safety, has encouraged reporting of incidents and received overwhelmingly positive feedback."

Richard Harrington,
Information Systems Manager,
Yorkshire Ambulance Service NHS Trust

Tackling blame culture and building a learning culture

Blame culture is an issue across the NHS, especially across incident reporting, with a long-standing stigma building from reporting incidents or events that involve another staff member, particularly where they may be involved with the cause. However, in order to grow a learning environment a shift must be made towards a blame-free culture. Risks and incidents will still exist even if they aren't reported, however, in shining a light on them, they are made visible and steps can be taken to understand, learn, and mitigate them. This visibility is only achievable when staff have the ability and confidence to report incidents and risks without any worry of repercussion. The conversation must shift from 'Who has done something wrong?', to 'What has gone wrong?'.

Achieving this in practice is a difficult program that requires first and foremost complete buy in from leaderships teams at all levels. It's important the same message, that incident reporting and risk is embraced, is cascaded to all staff to make them feel not only comfortable, but empowered to report and incident or risk.

> **"We are starting to see a safer NWAS due to the ability to triangulate data captured within the system to identify clear trends and themes."**
>
> **Jonathan Taylor,**
> Head of Risk and Assurance
> North West Ambulance Service

Case Study: Building a strong reporting culture - North West Ambulance Service NHS Trust

In 2022, North West Ambulance Service NHS Trust (NWAS) took the decision to implement a new incident reporting system, DCIQ, in order to align risk reporting across the organisation and build a stronger culture that embraced both risk and reporting.

The team at NWAS designed a campaign aimed to align staff on how risk should be perceived, encouraged the reporting of all incidents and risks, and DCIQ itself. This effective campaign consisted of simple programs such as:

- Datix champions to promote the software and incident reporting
- Reviewing the working around risk on incident forms to increase reporting rates
- A personal thank you to all staff who submitted an incident
- Staff incident reporting training

These programs combined helped reshape the culture at NWAS around reporting, that has in turn brought about greater visibility, learning, and patient safety.

Read the full case study here.

> **"When we decided to take this journey and implement DCIQ, we made the decision to ensure staff weren't apathetic, like, or dislike Datix. We wanted them to love Datix."**
>
> **Jonathan Taylor,**
> Head of Risk and Assurance
> North West Ambulance Service

Building processes to succeed and deliver patient safety

In order to achieve productivity while not compromising on patient safety, the processes in place across the entire healthcare organisation need to be robust, fit for purpose, and utilise the correct supporting systems and technologies where possible.

It's necessary to collaborate with all owners or stakeholders across all departments, both clinical and non-clinical, when shaping processes to ensure that they run efficiently for all involved, with patient safety put first and foremost.

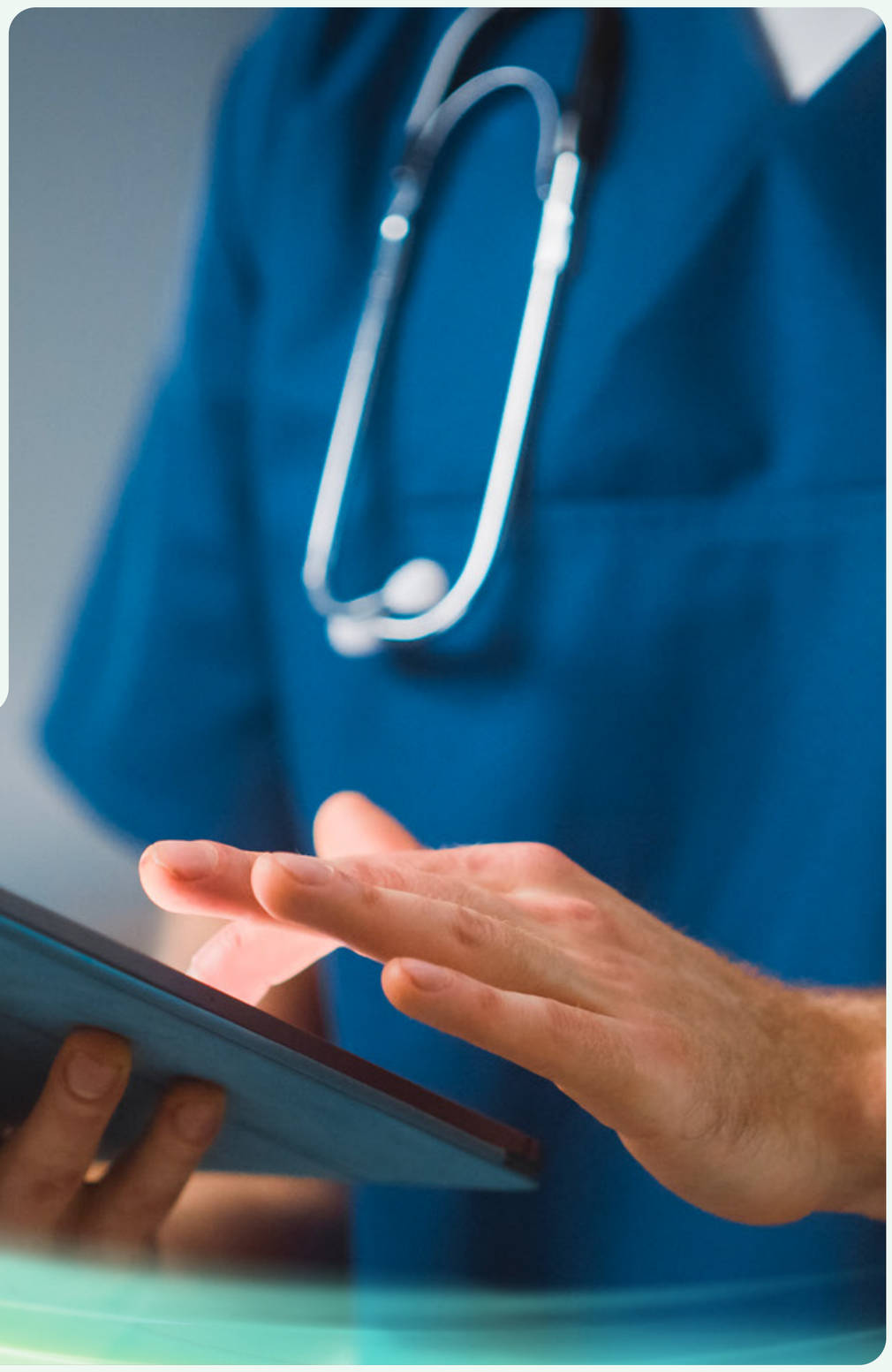
> **"Having the right people in the room was crucial to making sure the new process was as robust as possible. We needed to make sure we had the DCIQ administrators and clinical staff talking together to understand what the best way forward would be. Getting in the room and hearing the conversations is really important."**
>
> **Mark Rogers,**
> Safety and Quality Systems Lead,
> Royal Devon University Healthcare NHS Trust

Case Study: Creating systems to succeed by getting the right people in the room – Royal Devon University Healthcare NHS Trust

In 2018, Royal Devon University Healthcare NHS Trust were looking for a way to replace their inbuilt incident reporting system that supported their mortality review process. While implementing the new system and processes, they developed an ethos of ensuring that the right people were in the room to align on the desired outcome, and work out the best way to achieve that, whether it was the processes or workflow inside the software itself.

> **"We now have a much more mature risk management process in place that puts everyone on the same page, and ensures that the risks that need action are being managed in the appropriate way. We can now focus our resources and attention in the places necessary as we have a shared holistic view of our risk."**
>
> **Lisa Richards,**
> Trust Risk Manager,
> Royal Devon University Healthcare NHS Foundation Trust

This became crucial to ensuring that clinical staff and risk administrators broke down silos and avoided processes from being created in isolation. As well as managing their Risk Register through DCIQ, Royal Devon has now built a robust process inside the system for all Mortality Reviews and Structured Judgement Reviews that supports robust qualitative and quantitative thematic analysis, allowing for both red flags and areas of potential learning to be identified, and acted upon as necessary.



Top tips for success to make the most out of risk reporting and risk management:

1

Engage with the right people - Avoid scattergun alerting approaches that distract staff from their core focus. Review incident email notifications to ensure they are directed at specific staff personas responsible for patient care. By targeting the right individuals, you can reduce alerting distractions, manage access to sensitive data and improve efficiency.

2

Evaluate the impact - Ensure that productivity initiatives do not compromise safety. Evaluate how primary healthcare productivity metrics (e.g., number of patient episodes completed, procedures performed, or mean bed days reduction per procedure) impact safety metrics such as never events and harm-to-no-harm ratios. This holistic evaluation ensures that increased productivity does not come at the expense of patient safety.

3

Focus on the problem areas - Stop the tick-box incident investigation approaches and use a data-driven approach to identify problem areas. By directing investigations at genuine problems and learning opportunities, you can significantly improve efficiency and outcomes.

4

Ensure staff have easy access to safety data - Regularly review, refresh, and strengthen incident dashboard designs to ensure they are tailored for specific staff groups. These dashboards allow for the quick identification of actionable insights, allowing staff to spend more time on providing and improving the quality of care.

5

Measure safety standards - Track metrics such as the number of safety actions completed, incident reviews conducted, and investigations finished. Also, monitor overdue or outstanding actions and reviews. These metrics provide an overview of current level of activity, and enable the tracking of progress to ensure you are meeting regulatory timelines and act as proxies for safety productivity.

6

Continuous improvement - Encourage a culture of continuous improvement where staff regularly review learnings from events and implements ways to enhance both productivity and safety.

7

Reduce time spent on data entry - Leverage integrations such as patient lookups with Electronic Patient Records (EPR), staff lookups with Electronic Staff Records (ESR), and Single Sign-On (SSO) for users. This not only saves time but also reduces the risk of errors, ensuring data accuracy and completeness. Lengthy incident forms can be a significant barrier to productivity. By reducing data entry requirements through integrations, you can streamline the reporting process, making it less time-consuming and more efficient for staff. In addition, maximise use of document merging which reduces the time taken to export investigation reports and share them with external organisations and patients/families.

Achieving NHS productivity targets while ensuring patient safety is crucial to delivering high quality patient care and experiences to front line staff. By leveraging existing technologies, NHS organisations can boost efficiency without compromising care.

Right people, right place, right time

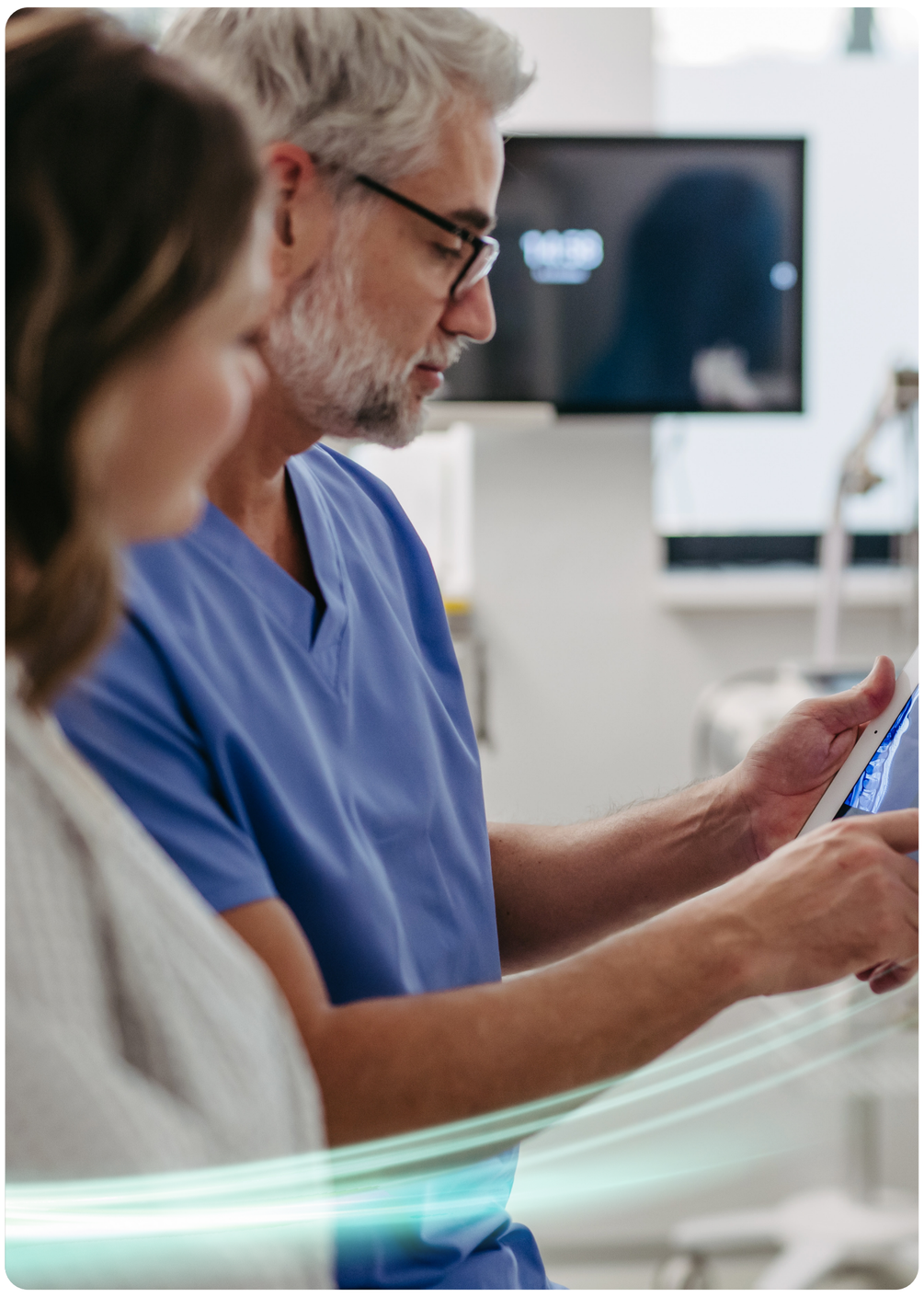
While risk management and incident reporting is a cornerstone of both patient safety and productivity, a second, equally important aspect that it is vital to get right is workforce rostering. To achieve patient safety you need to have confidence that all of your staff, whether it's Nurses, AHPs, Doctors or Junior Doctors, or anyone else, are in the right place at the right time to deliver safe care to their patients. In order to have this, you need to make sure that have efficient and effective rosters and job plans in place.

Rostering and job planning are foundations of patient safety, and while it may be a basic of healthcare, it's integral to deliver successful health and care. Building a successful roster and job plan can bring not only patient safety, but do so in a way that achieves productivity.

To help you manage productivity and patient safety within the context of your workforce, below we've given our top tips to achieving various focuses through a workforce lens.

"Good quality job planning is the gateway to delivering high quality and efficient patient care."

The Carter Report (2016)



Tips to achieve both Productivity & Patient Safety

- Empower your staff to self-schedule, shift swap, directly book shifts and enable flexible working to support their work life balance and encourage a more motivated clinical workforce which can directly impact patient quality of care.

- Set up for the rapid allocation of resources to respond to major incidents.

- Integrated Rostering - One rostering platform for the full Organisation can support better coordinated care across departments to ensure all teams work together to move through the backlog/patient discharge.

- Continuous improvements: by analysing the data, and creating feedback loops for clinical end users the organisations can continually improve the way they approach rostering to protect the workforce and deliver effective and safe patient care.

Tips to achieve both Patient Safety & Workforce Safety

- Optimise workforce deployments: Use patient acuity, skill mix, bed occupancy, professional judgements to ensure you move workforce to where it is required - reduce errors that can be caused by understaffing, over-utilised staff, and stressful work environments.

- Improve continuity of care for patients: Align rosters with patient need, minimise shift changes, cancellations and impact to patient pathways.

- Awareness of multi-disciplinary teams: Roster all staff groups, grades and requirements on one end to end platform to ensure the full multi-disciplinary team is accounted for.

- Staff wellness/retention/sickness: Plan in advance for staff shortages as well as daily changes to staffing that could impact pressure and impact on staff wellbeing. Flag safety concerns, workforce risks and ensure your workforce are supported.

Tips to achieve Clinical Productivity

- Efficient use of resources: maximise the use of available resources whether that is redeploying staff, collaborating with other organisations, offering direct book opportunities for workforce, match workforce levels to peaks and troughs of patient demand.

- Ensure Rosters take into consideration wider context of needs: student nurses paired with senior staff for onboarding and support, ensure they feel fully supported throughout shift and are not called on for extra activities outside of their experience.

- Data driven decisions: Real time data, insights and triangulation of workforce and safety metrics give clinicians easy quick to access information to make decisions that do not impact or burden time that could be spent delivering clinical care.

Case Study: Salisbury NHS Foundation Trust

In the aftermath of COVID-19, Salisbury NHS Foundation Trust, like many trusts across England, experienced challenges in the way its nursing teams were making staffing decisions, and were looking for a way to ensure staffing was being managed safely, efficiently, and effectively.

Salisbury NHS FT placed SafeCare at the heart of this drive to improve staffing deployments and rostering, and drew up a series of programs to understand areas they could utilise the solution better and re-educate all staff on best practice and the importance of the system.

- More efficient redeployment of staff, while ensuring care outcomes have remained the same, or improved.
- Better equipped nursing workforce to determine staffing requirements in relation to patient acuity and dependency levels.
- Ongoing work to ensure that the improved knowledge in managing the daily deployment of staff is maintained and effectively embedded.
- Over 50% reduction of total bank and agency spend from £1,765,000 a month in January 2023, to £844,100 in April 2024

Read the full case study here.

“The increased accuracy in reporting acuity and staffing via SafeCare meant that the use of the visual software ‘Sunburst’ wheel (visual software) to present the latest and most accurate data during daily staffing meetings optimised effective decision-making at pace.”

Clare Holbrook-Jones,
Safe Staffing Matron Salisbury,
NHS Foundation Trust

RLDatix

Want to learn more?

Meet us at the HSJ Patient Safety Congress on 16-17 September in Manchester to learn more about how we are connecting health and care operations to enable you to meet your productivity targets without compromising patient safety.

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