Patient safety is more than delivering clinical standards, ticking boxes and following NICE Guidelines

Nick Welch

We were led to believe that the "New NHS" in England would place the provision of healthcare into the hands of those who really know patients - our GPs. We lay representatives who have been recruited onto local and national bodies might challenge this: too many people commission services without fully understanding the needs of and risks to orthopaedic patients whose care is often seen as discretionary. The NHS in Scotland and Wales, whilst organised differently, would seem to be struggling with similar issues albeit by a different route.

Is the safety of orthopaedic patients too expensive for 21st century commissioners? Is patient safety compromised by a reluctance to build into the structure of healthcare delivery measures necessary to maximise good patient outcomes? Fully integrated and enhanced recovery patient pathways are not currently adequately understood,

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supported, protected, planned or discussed by the gatekeepers of our healthcare either with health and social care workers or with patients. For example, the ongoing debate about follow-up x-rays and the ability of various disciplines (e.g. Orthotists) to cross-refer patients without sending them back to their GP. Enhanced recovery programmes have been high-jacked for the purpose of cost containment at the expense of quality.

It does not have to be like this: better outcomes for patients in the long run achieves NHS goals and is likely to enable the services to run more effectively and efficiently.

As well as an adherence to best clinical practice patient safety requires:

- A commitment to manage me as a patient from the first appointment to the final discharge in an agreed care programme tailored to my particular needs
- Treatment by an appropriately trained multi-disciplinary team under the aegis of a named consultant who is responsible because he is authorised to effect change
- A joined up health and social care service, which can manage patients across CCG borders
- Wards adequately staffed by nurses qualified in orthopaedic or orthogeriatric care. Enhanced recovery is high turnover high intensity nursing, it requires adequate staffing levels.
- An understanding that short term planning is not necessarily the most cost effective strategy
- A willingness to undertake the necessary research where there is inadequate evidence.

Above all, steps taken to ensure patient safety should be a partnership between those commissioning the service, health and social care providers and, on equal terms, the recipients of the service: the patients and their next of kin.

Recently, the British Orthopaedic Association's Patient Liaison Group wrote a paper highlighting the information a patient should have before the day of their operation[1]. We strongly believe that a well-informed patient is better empowered to help those responsible for their healthcare to manage their recovery and minimise the risks that currently beset many Trusts.

There are no easy fixes. The NHS piggy bank contains limited funds; those who control our Health Services locally need to learn to plan the service more wisely. Cutting the numbers of healthcare professionals, fragmenting care pathways and discouraging or financially penalising best clinical practice will not solve the issues. However, simply doing the opposite has patently not worked either.

Unless clinicians and patient groups engage with commissioning leads in their respective Clinical Commissioning Groups those who are responsible will not know what is fundamentally necessary to ensure patients are treated in a safe and wholesome environment. It is the duty of commissioning General Practitioners to ensure we are getting the most cost effective treatment – in other words treatment that maximises our chance of the best possible recovery and reduces the long term impact on their limited resources. It is an orthopaedic surgeon's duty to evidence and supply cost effective quality. Commissioners must listen to the GPs, the Acute Trusts, the Specialists as well as patients. These are the people who can best advise on adequate staff levels, appropriate patient management and patient expectations – all of which, if properly addressed, will enhance the patient experience and reduce risk to the patient, both in hospital and in the community.

This may mean that the commissioners will need to fund pathways in a more empathetic way – encouraging and protecting more intense acute and rehabilitation phases in the knowledge that the better outcomes reduce long term costs, by giving patients the best chance of a complete recovery.

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Journal of Trauma and Orthopaedics: Volume 02, Issue 03, pages 54&55
Title: Patient safety is more than delivering clinical standards, ticking boxes and following NICE Guidelines
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None of this need be complicated: indeed keeping the process simple, taking it step by step, and ensuring each part of a given orthopaedic patient pathway is in line with best practice and directly connected with the following steps helps reduce putting the patient at risk. Building in agreed time lines identifying when the various hospital and community health and social care disciplines should become involved reduces delays to the treatment pathway and improves the patient experience.

There are guidelines about staffing levels and staff competencies which should be enshrined in service commissioning – shortfalls put patients at risk.

Best clinical practice should be backed up by appropriate studies, and where these do not exist it is incumbent on the clinicians to undertake the necessary work.

The supply of walking aids, prostheses, and orthoses should be managed with patient needs in mind, and patient safety should not be compromised by short term budget pruning.

Patient safety is the responsibility of all the participants in the process: the Commissioners, the Acute Trusts, primary and secondary health and social care providers and patients. Providing fully financed, appropriately tailored patient pathways with integrated health and social care, which have been agreed by those responsible for delivering the service, to well-informed patients will help improve patient safety and compliment the clinical efforts of the healthcare providers. ■

References

1. "Information you should know before your orthopaedic intervention" BOA PLG Web page.

Nick Welch spent 35 years in the Pharmaceutical Industry and since retiring has been a member of the BOA's PLG for the past eight years. At the end of 2014 he will have completed his three-year stretch as the PLG's Chair. He will then continue to represent patients on NICE, NHS-E and his local CCG committees as well as contributing to the PLG from the ranks of Corresponding Members.

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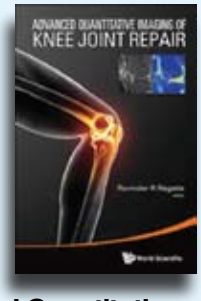

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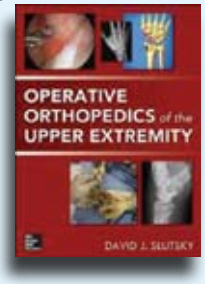

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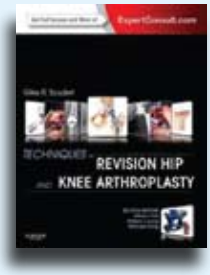

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