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PUBLIC PROVIDER LEADER

How can your Board use the Measuring and Monitoring for Safety Framework?

Wednesday, June 21, 2017

10:00 am MST / 12:00 pm EST

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Speakers

Abigail Harrison
Associate Director, Digital and Innovation, Haelo

Francine Thorpe
Director of Quality & Innovation, NHS Salford Clinical Commissioning Group (CCG)

Dr. G. Ross Baker
Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

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Agenda

- Abigail Harrison and Francine Thorpe will reflect on their experience with the Measurement and Monitoring of Safety Framework
- Discussion led by Ross Baker
- Ross Baker on how Canadian boards can use the Measuring and Monitoring for Safety Framework

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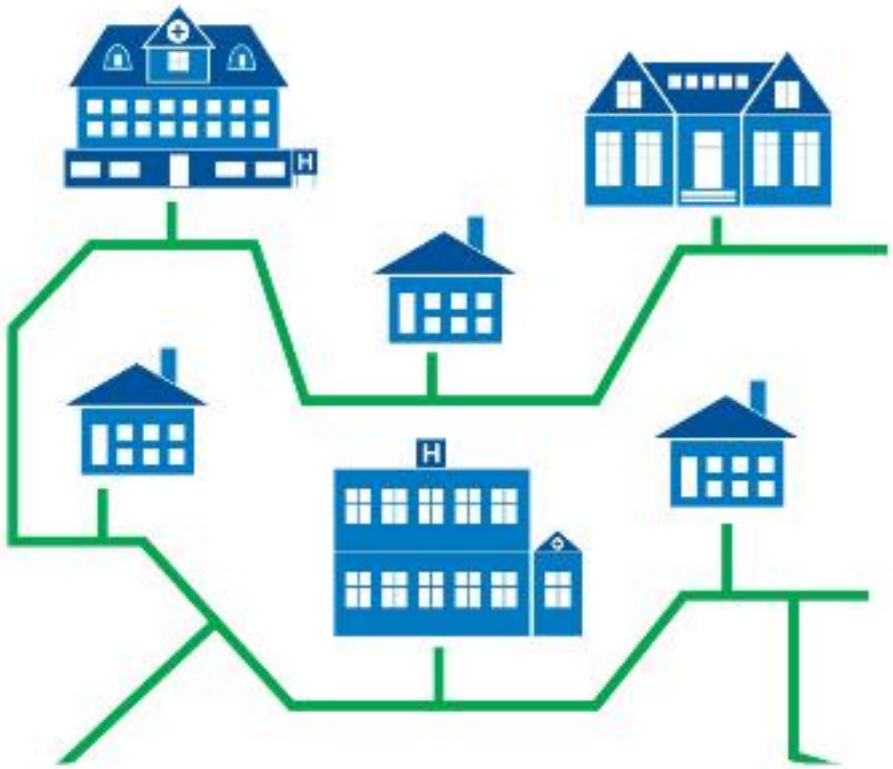
Making Safety Visible

Learning from the exploration of the 'Measurement and Monitoring of Safety' framework with boards in Greater Manchester, England

#Makingsafetyvisible

Safety is a whole system issue…



SAFETY MEASUREMENT AND MONITORING MATURITY MATRIX (SaMMM)

	PATHOLOGICAL	REACTIVE	BUREAUCRATIC	PROACTIVE	GENERATIVE
PAST HARM	Patient harm is viewed as an inevitable side effect of delivering healthcare treatment. No mechanisms exist to learn lessons from past harm.	Lessons are learnt from past patient harm only when media or regulatory pressure forces the organisation to investigate or review its past harm data.	Incident reporting, claims, complaints, HSMR, SHMI, routine databases, case note review etc. are used to measure past harm but the measurement culture focuses an ticking boxes to prove past harm measures are in place.	A range of past harm measures are used. Specialty-specific harm metrics exist. Incident investigation is used as a `window on the system' not just to identify root causes. Reporting and learning from near misses or close calls is embedded.	Innovation takes place to introduce and refine past harm measures. There is a cultural norm that safety measurement should constantly evolve. Past harm measures that cross healthcare boundaries are in place.
RELIABILITY	Unreliable clinical systems, processes and pathways are accepted as the norm. Process reliability is not measured because it is not recognised as important.	Measurement of clinical system, process and pathway reliability is externally driven: The only reliability measures in place are those set nationally or by commissioners.	System, process and pathway reliability data is collected but the data is not used as a platform for improvement work. Reliability measures are sometimes misapplied leading to false assurance that processes are safe.	System, process and pathway reliability data is used to inform the focus of improvement work. There is a mature understanding of the strengths and weaknesses of reliability measures. Reliability measures are applied appropriately.	Poor reliability of systems, processes and pathways is viewed as unacceptable: Improvement work focuses on improving levels of reliability across ALL clinical and non-clinical areas. Innovation takes place to develop and implement measures of reliability that cross healthcare boundaries.
SENSITIVITY TO OPERATIONS	No importance is attached to observing, listening or seeking safety intelligence from frontline staff, patients carers.	Information on what is happening at the healthcare 'coal face' is only sought out when a serious incident or high profile patient harm occurs.	Safety walk-rounds, staffing level data, conversations with staff, patients, carers etc. are used but the true value of informal safety intelligence is lost because the culture focuses on ticking a box (to satisfy external regulators these methods are being used.	There is real appreciation of the value of soft safety intelligence gathered from observations and conversations with staff, patients and carers. Such safety monitoring data is actively sought and triangulated alongside other information to identify safety risks.	Real-time information systems have been implemented which take the pulse of the organisation on a moment by moment basis: This involves utilising real time patient, carer, and staff feedback systems, and intelligent data forecasting systems that predict patient flow and emerging risks.
ANTICIPATION AND PREPAREDNESS	No measures or methods to anticipate future harm are utilised (e.g. safety culture surveys, system safety assessment, training and sickness absence data).	Few measures or methods to anticipate future harms are utilised. Staff training and sickness absence data is collected but the organisation does not use it to predict future erosions in safety	Methods to anticipate future harm are in place. The focus is on demonstrating to external regulators and commissioners they are being used. There is no or little appreciation of their diagnostic value.	Safety culture surveys are used to diagnose emerging safety problems. Process mapping is routinely used to identify gaps in pathways. Staff training and sickness absence data is used to anticipate safety erosions and staff burnout.	Emerging safety risks are thwarted because measures that support anticipation provide real time data that is quickly acted on. Anticipating emerging safety risks is a cultural norm. There is an ability to view all types of safety data through the lens of 'will care be safe in the future:
INTEGRATION AND LEARNING	There is no integration and learning from different sources of safety data because safety information is not collected or sought out by the organisation.	Safety data from past harm, reliability, sensitivity to operations and anticipation dimensions is only integrated after a serious patient harm occurs and/or at regulator insistence. Feedback to frontline staff on lessons learnt is patchy.	Safety dashboards are in place which meet regulatory and/or commissioner requirements. The attitude is 'job done' once the dashboards have been developed; there is no effort to improve them. Feedback and learning mechanisms look good on paper but do not work in practice.	Mature safety dashboards exist which integrate past harm, reliability and anticipation metrics. The importance of triangulating hard data from safety metrics with soft safety intelligence is understood. Lessons learnt reach frontline staff because good feedback mechanisms are in place.	Safety dashboards are based on real time data. Triangulation of safety metrics and soft safety intelligence is very mature: The culture is that safety is a never-ending journey. Lessons learnt are effectively shared with frontline healthcare teams and are shared with other organisations.

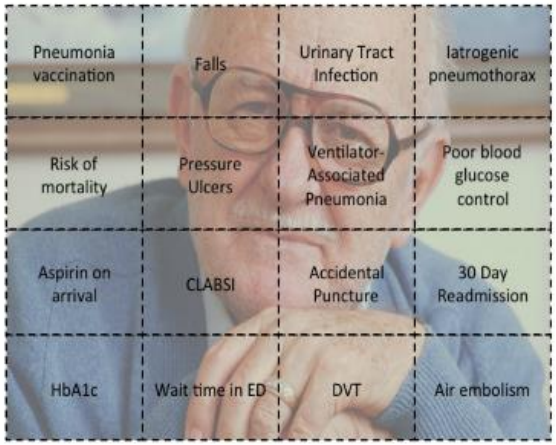
Vincent, Burnett and Carthey (2013)

Past ← Present → Future

Past ← Present → Future

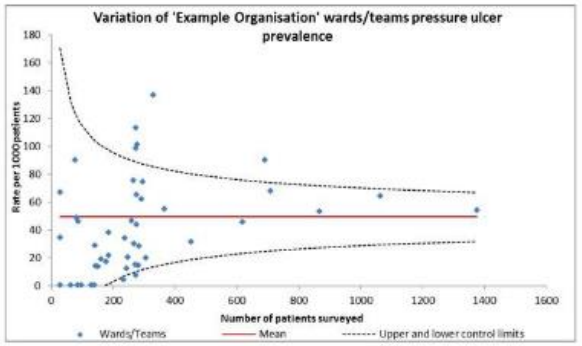
The Comparison Dashboard	The Strategic Dashboard
• How do we compare to… – Other hospitals? – Regulatory standards? – Targets? – Pay for performance thresholds? • Hundreds of measures – Processes • Measures are typically – Externally defined – risk-adjusted – apples to apples (rates per procedure e.g.) – Slow – Tinged with fear	• Are we on track to achieve our aims? – Reduce harm – Improve outcomes – Improve satisfaction – Reduce costs • A few key measures – Outcomes, Drivers • Measures are typically – Internally defined – Close to real time – "Good enough"

What do we mean by harm?



Assurance → Inquiry

Funnel – Org level



Past ← **Present** → Future

Focus Incessantly on Reliability

ADVANCING QUALITY
GOOD BETTER BEST

NHS
National Institute for Health and Clinical Excellence

Measure flow within and between systems

Right Care Right Person Right Place

Measure Behaviours

Safety Huddles

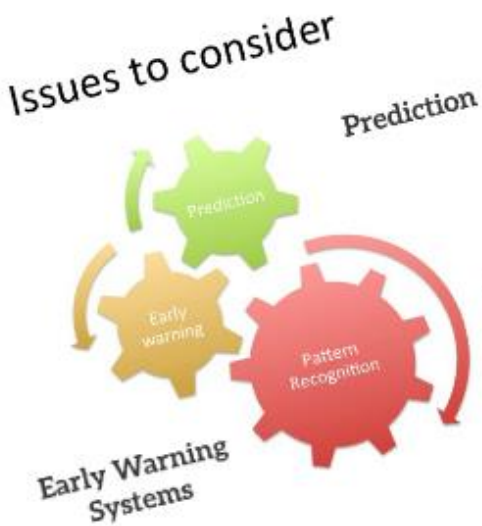
Progress Technologies Aggressively

Remote monitoring of frail elderly

Be Connected

Past ← Present → **Future**

From lagging to leading



The key is bringing it all together…

Our goal: Salford will be the safest health and social care system in the UK by 2022

Safer Salford

Aim: to collaboratively produce and test a roadmap by 2018 for Salford to become the safest health and social care system

- **L**eadership — Creating an environment which will facilitate development and spread of safety improvements
- **C**ulture — Develop a tested tool to enable units to understand and improve their safety culture
- **I**ntelligence — Build a measurement system to answer the question “is health and social care getting safer in Salford?”
- **I**mprovement — Share learning and build evidence-based change packages to improve patient safety in priority areas

Handover **M**edicines **C**are Homes

Encouraging a bold change in how our leaders think about safety



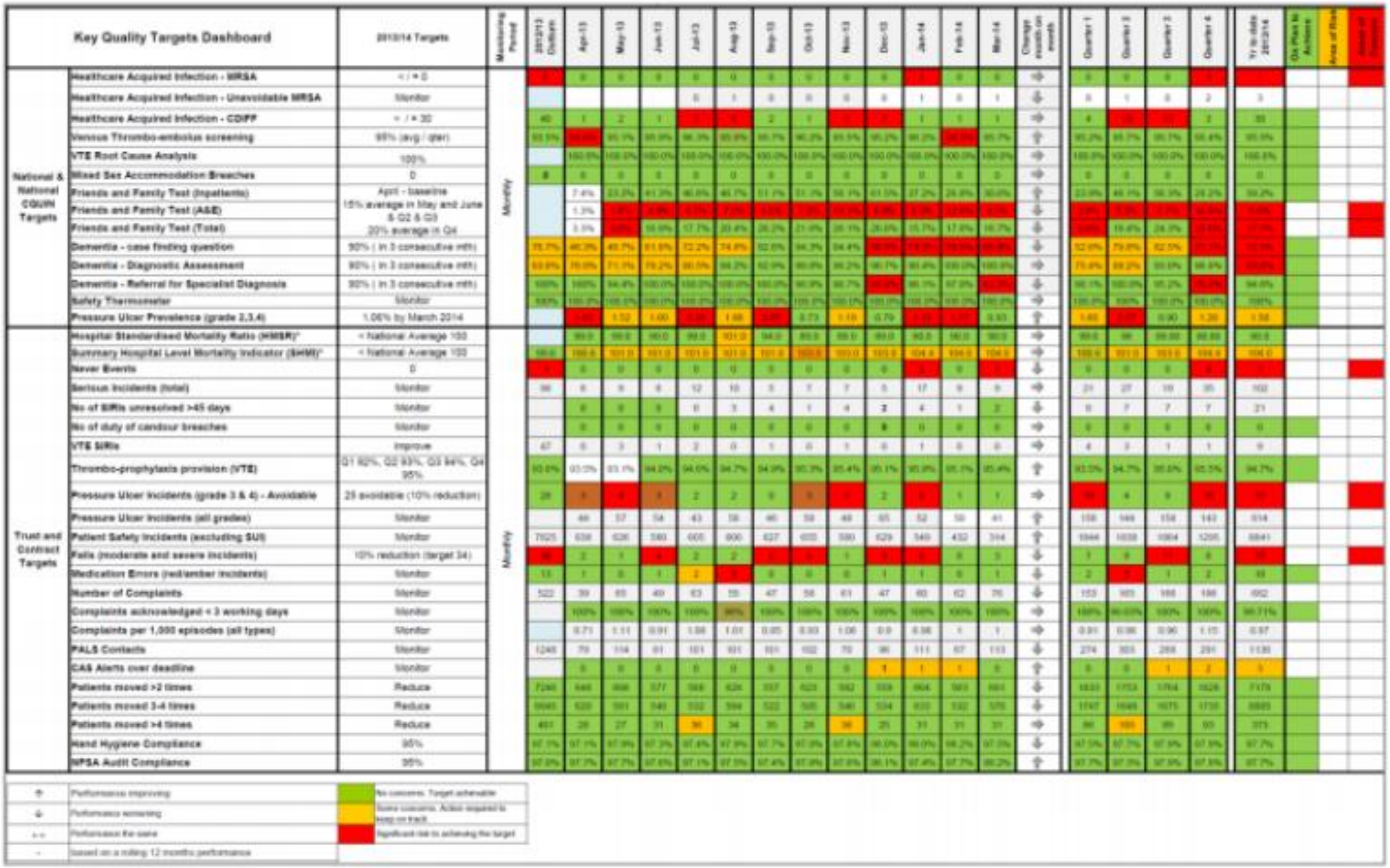






Recognising that we're living in the past…

Moving from performance…



Key Quality Targets Dashboard		2013/14 Targets	Monitoring Period
National & National CQUIN Targets	Healthcare Acquired Infection - MRSA	< / = 0	Monthly
	Healthcare Acquired Infection - Unavoidable MRSA	Monitor	
	Healthcare Acquired Infection - CDIFF	< / = 30	
	Venous Thrombo-embolus screening	95% (avg / qtr)	
	VTE Root Cause Analysis	100%	
	Mixed Sex Accommodation Breaches	0	
	Friends and Family Test (Inpatients)	April - baseline 15% average in May and June & Q2 & Q3 20% average in Q4	
	Friends and Family Test (A&E)		
	Friends and Family Test (Total)		
	Dementia - case finding question	90% (in 3 consecutive mth)	
	Dementia - Diagnostic Assessment	90% (in 3 consecutive mth)	
	Dementia - Referral for Specialist Diagnosis	90% (in 3 consecutive mth)	
	Safety Thermometer	Monitor	
	Pressure Ulcer Prevalence (grade 2,3,4)	1.06% by March 2014	
Trust and Contract Targets	Hospital Standardised Mortality Ratio (HMSR)*	< National Average 100	Monthly
	Summary Hospital Level Mortality Indicator (SHMI)*	< National Average 100	
	Never Events	0	
	Serious Incidents (total)	Monitor	
	No of SIRIs unresolved >45 days	Monitor	
	No of duty of candour breaches	Monitor	
	VTE SIRIs	Improve	
	Thrombo-prophylaxis provision (VTE)	Q1 92%, Q2 93%, Q3 94%, Q4 95%	
	Pressure Ulcer Incidents (grade 3 & 4) - Avoidable	25 avoidable (10% reduction)	
	Pressure Ulcer Incidents (all grades)	Monitor	
	Patient Safety Incidents (excluding SUI)	Monitor	
	Falls (moderate and severe incidents)	10% reduction (target 34)	
	Medication Errors (red/amber incidents)	Monitor	
	Number of Complaints	Monitor	
	Complaints acknowledged < 3 working days	Monitor	
	Complaints per 1,000 episodes (all types)	Monitor	
	PALS Contacts	Monitor	
	CAS Alerts over deadline	Monitor	
	Patients moved >2 times	Reduce	
	Patients moved 3-4 times	Reduce	
	Patients moved >4 times	Reduce	
	Hand Hygiene Compliance	95%	
	NPSA Audit Compliance	95%	

↑	Performance improving
↓	Performance worsening
↔	Performance the same
*	based on a rolling 12 months performance

to improvement…

Changing the question…

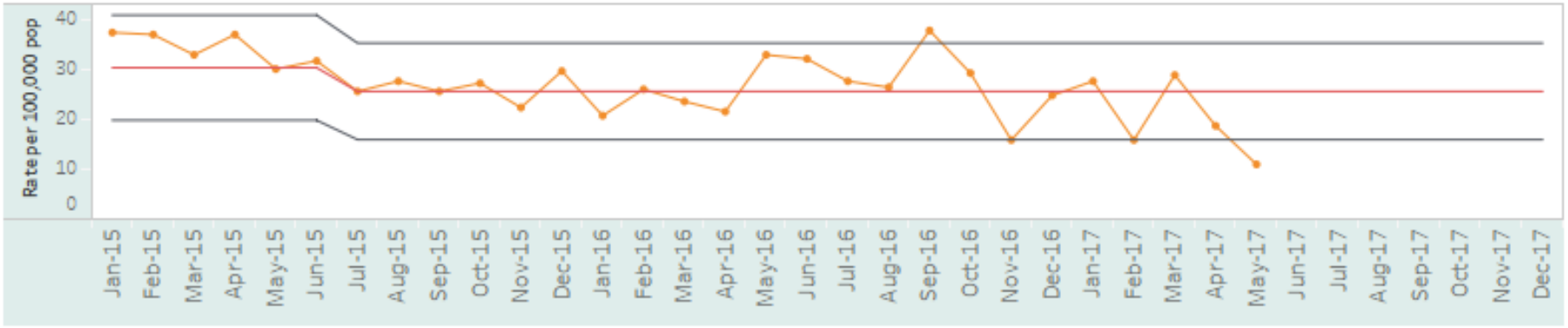
'Are we safe?'

'What can we learn about safety'

'Are we improving?'

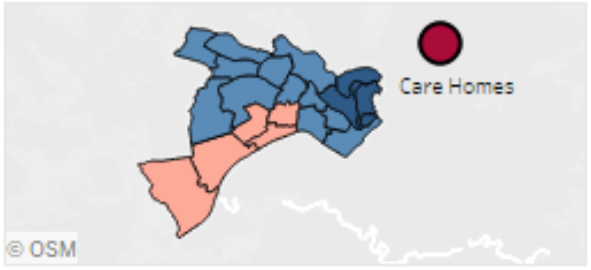
Medications

1) On average there are 26 admissions per 100,000 population from adverse medication events to SRFT a month



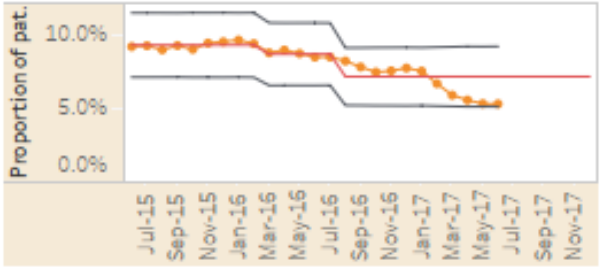
This chart shows the rate per 100,000 population of admissions to Salford Royal related to an adverse drug effect for Salford residents over time. The source of these data are SRFT IMT. This has not seen change over time since a slight reduction in 2015. ICD 10 codes Y40-Y59 used.

2) The highest rate of admissions comes from 'Care Homes'



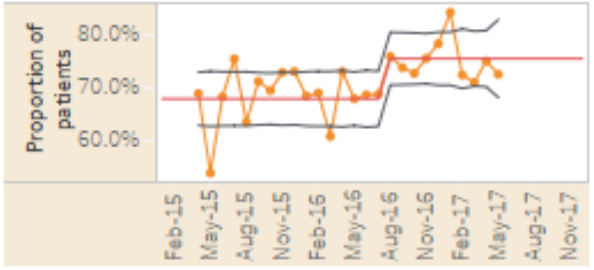
This chart shows the rate per 100,000 population of admissions to SRFT related to adverse durug efects split by neighbourhood. The more red an area, the higher the rate of admissions.

3) The presciption of antiplatelets without gastro protection medicines is reducing in Salford GPs



This chart shows the proportion of patients with a history of peptic ulcers prescribed antiplatelets without a co-prescription of gastro protective medicine. This is the most prevelant measure sourced from the SMASH dashboard

4) The proportion of patients with a meds rec completed within the appropriate time of admission at SRFT and GMMH is increasing

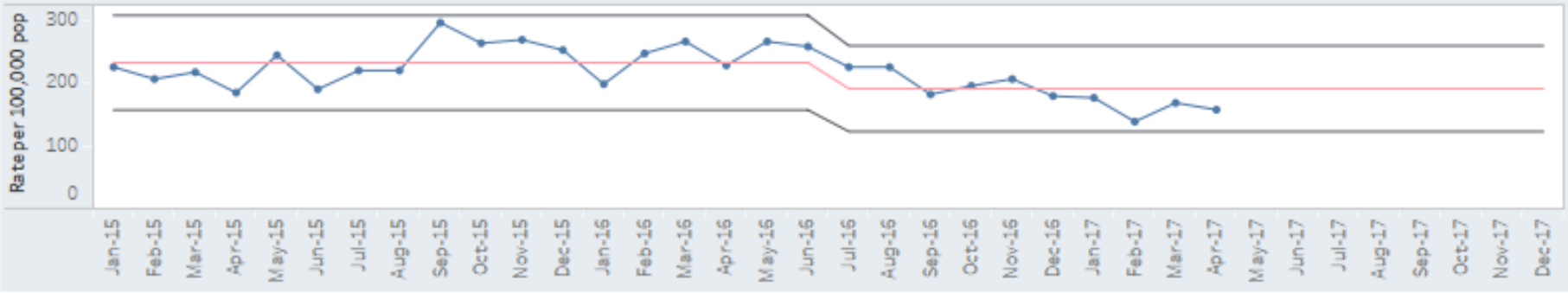


This chart shows the proportion of patients that receive medicines reconciliation within the apporpriate time frame of admission (24 hours/ 3 days) at Salford Royal and GMMH.

5) What other medication data sets exist in your setting? How can you use them with conjunction with the data displayed here?

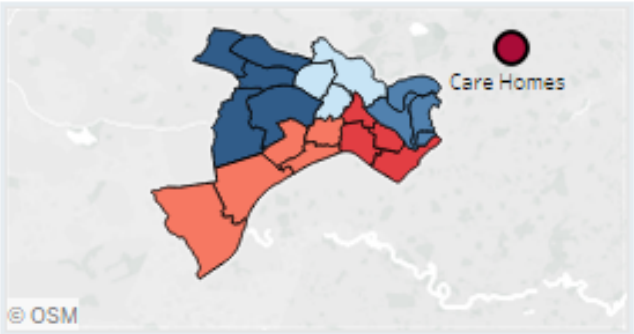
Falls

1) On average there are 191 admissions per 100,000 population from older people with a fall to SRFT a month



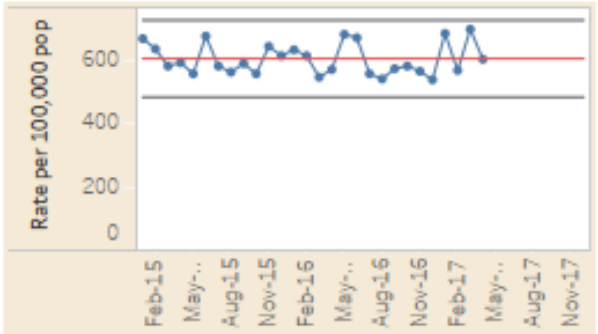
This data are taken from the SRFT data warehouse and show admissions coded as an injury due to fall from over 65s living in Salford. It is visualised as a U chart to show change over time. There is a statistically significant shift from Jul-16. What could have caused this? Does a lag in diagnosis coding have an effect?

2) The highest rate of falls come from 'Care Homes', 'Ordsall and Claremont' and 'Eccles and Irlam'



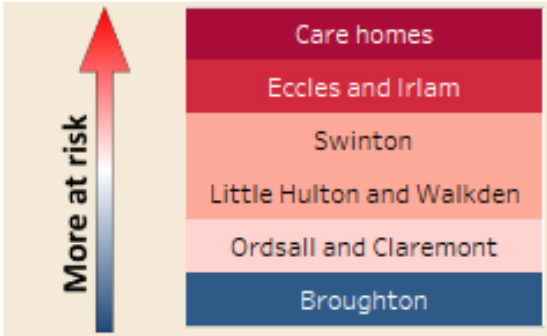
This data shows the split between different neighbourhoods of the admissions data above. The time period is Jan-15 to Apr-17. The more red a neighbourhood, the higher the rate of admissions. Care homes admissions are excluded and displayed separately

3) On average there are 607 referrals per 100,000 population to the falls team a month



This data is taken from SRFT IMT and show the rate per 100,000 population of referrals into the falls team. There are no signs of change over time.

4) Ranking by proportion of over 80s and dementia dignoses, 'Care Homes' is the most at risk area



This uses data from NHS England and the ONS. Looking at the proportion of population over 80 years old and the number of people on the dementia register, we can see which areas have a high risk of falls

Is there a relationship between the outcome measure (1,2) and the predictive measures (3,4)? Are there other data sets we can use to predict and reduce falls?

Assurance  Inquiry

Thank You

#Makingsafetyvisible

Ross, Abigail and Francine

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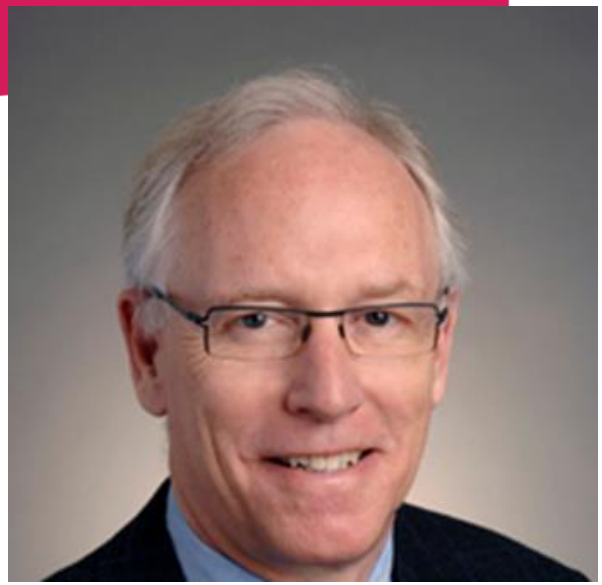
Dr. Ross Baker



How the Framework can form board understanding and help align strategic and operational approach to patient safety

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Questions and Answers

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Poll

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Call Recordings

Introduction of the Measuring and Monitoring of Safety (Vincent) Framework to Canada

- January 30, 2017
- http://www.patientsafetyinstitute.ca/en/toolsResources/Pages/Measuring-and-Monitoring-of-Safety-Vincent-Framework.aspx

Implementing the Vincent Framework at the Frontline

- February 23, 2017
- http://www.patientsafetyinstitute.ca/en/toolsResources/Pages/Implementing-the-Vincent-Framework-at-the-Frontline-2017-02.aspx

How can your Board use the Measuring and Monitoring for Safety Framework?

- June 21, 2017
- Recording and slides available in 5-7 days
- http://www.patientsafetyinstitute.ca/en/toolsResources/Measure-Patient-Safety/Pages/default.aspx

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http://www.patientsafetyinstitute.ca/en/About/Programs/shift-to-safety/Pages/leader.aspx

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