Beyond Insight – getting to grips with patient safety intelligence in mental health services

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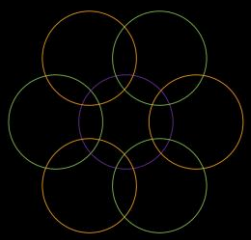

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HEALTH & SOCIAL CARE CONSULTING

About Niche & The Webinar

Tom McCarthy

About Niche & The Webinar

About Niche

- Three decades of health & social care consulting experience
- Team of two dozen employed and c100 expert associates
- Mental health as a core area of focus
- Clients range from individual providers, through systems to national work
- Three area of expertise:
  - Modelling
  - Evaluations
  - Investigations and reviews
- It is the intersection of our expertise areas that led us to today's topic
- Understanding patient safety runs through all we do

About today's topic

- "How do you know you are providing safe services?" is a central focus of all our work programmes
- Simple question, difficult to answer
- This morning's agenda to help steer you through some of its complexities
- From closed cultures, through the national imperatives, the importance of intelligence, through a PC lens & finally planning some next steps

Closed cultures

Nick Moor
Partner Emeritus (Mental Health Investigations)

Closed cultures

- One of the biggest ‘unknown unknowns” within services, one of the biggest fears for any board or leadership team, one of the most challenging things to understand.
- The CQC somewhat vaguely define a closed culture as “a poor culture that can lead to harm, including human rights breaches such as abuse.” This is of limited practical use, as it focusses on the consequences of a poor culture more than on its features.
- This section will provide you with a succinct outline of the features of a closed culture, how to spot one and importantly what to do the prevent them from occurring.
- Niche routinely undertakes investigations into mental health services related catastrophic outcomes, closed-cultures feature heavily in our work and can often (but not always) be a logical conclusion of stretched services, undervalued staff, poor recruitment practices and most of all, sustained poor leadership.
- We take an objective, systems-based view on why closed cultures develop and how something like a trigger tool can provide logic-based insights.

First of all… open cultures

- Looking at open cultures is just as important…
- Malik RF et al (2021) identify 37 features of an open culture which focus on open communication, open-mindedness and psychological safety.
- Importantly, leadership, employee attitudes, and organisational processes are all in place contributing to a positive culture. Crucially, this is borne from ‘tone at the top’; a board which is focussed upon quality and safety (patient first) within a complex set of competing priorities.
- Statements indicating an open culture include:
  - “We are open to views from a wide network, such as those of other departments, professions, and institutions.”
  - “We trust each other’s intentions”
  - “Respect for colleagues and patients is one of our most important values.
  - “I’m open to feedback”
  - “I don’t take sides and I won’t allow cliques to develop on my ward”…

The determinants of a ‘closed culture’

- **Poor ‘tone at the top’** - Closed cultures can either develop as a consequence of, and/or reaction to, poor leadership culture, particularly poor priority setting.
- **Trauma responses** - Environments of high expressed emotion, internalised and externalised trauma are often found in closed cultures. CAMHS /High Secure (examples repeated poorly handled restraint, dehumanising approaches), poor debrief and psychological support for staff can result in trauma.
- **Power imbalances:**
  - Between staff and patients – applying restrictions, unreasonably taking power and autonomy away from patients, forcing them into ‘the sick role’.
  - Between staff and families – blame upon families and parents, excluding families from decisions and information, lack of including families in the solution.
  - Between staff and patients – applying restrictions, unreasonably taking power and staff – partisan behaviours on wards, cliques, and favouritism.
- **Influencing behaviours** – strong personalities can influence others in terms of “its ok to speak to patients like rubbish”, role modelling very poor behaviours such as over-familiarity with patients, grooming, and abuse.

Identifying a closed culture

- Spotting a closed culture on a service visit or inspection is incredibly difficult. By their nature those units might have become adept at presenting a functional exterior.
- A mixture of hard and soft intelligence is required and the development of a weighted trigger-tool to spot such units is key. *No one will ever identify a closed culture through a questionnaire*. Closed-cultures can 'hide in plain sight' – looking at some obvious day to day metrics will surface the potential for a closed culture. These might include:
  - **Repeated long shift patterns / same staff on same shift –** Air traffic controllers work maximum 6 hour shifts with ten minute total interruption breaks every hour. Yet staff can routinely work 12–14-hour shifts on high-pressure wards; compassion fatigue.
  - **High number of complaints** – a lot of complaints may well be the best indicator that defects exist. Not upheld complaints may be a sign of institutional defensiveness.
  - **Or… a low number of complaints** – might indicate a culture which is 'clamped' where complaints are dissuaded or not escalated. People who are vulnerable might not want to speak out for fear of retribution.
  - **Incident reporting** - low numbers of incidents reported, or significant variances in incident reporting on different shift patterns or on different days.

(Continued)

- **High turnover of newer staff** - is an indication that all is not well in terms of culture. Equally, very low turnover of staff who have been on the same unit for years might indicate 'cliques'.
- **General noise** – where the culture of a unit is in question it is remarkable how easily this spills into social media. This is a particular feature where patients and families have felt powerless or feel their concerns have not been answered.
- **Inexperienced leadership** – with pressures on budgets, high-staff turnover and recruitment challenges, there is more likelihood of inexperienced / recently qualified people being put in as shift-leader etc. We see this more and more.

There are many ways to spot closed-cultures which we will explore more in this session. The above indicates just some of the factors which might indicate that a closed-culture has developed.

From our work we have concluded that there is **one key factor** which is more important than other factors in preventing closed-cultures…

The most important things to get right…

…. A good Ward-Manager

A good Ward (or service Manager) will:

- Know their staff but not unduly pander to induvial wants (i.e. shift patterns)
- Set firm boundaries on behaviour (zero tolerance on incivility)
- Uphold standards and controls
- Not entertain favouritism or partisan behaviours
- Projects role model behaviours
- Places extreme importance in care and compassion
- Pushes back on unreasonable operational / senior requests
- Holds the line on underperformance and corner cutting
- Is firm but fair and always consistent in their approaches.

The national perspective on mental health patient safety & local reflections

Helen Smith and Jonathan Warren

Facts and Figures

2021/22 12675 incidents resulting in severe harm or death were reported by NHS organisations in England

This is an increase in 2500 since 2019/20

In 2013 the budget for Mental Health homicide reviews was set at £2.1 million based on £23530 per investigation

There are on average 120 families bereaved as a result of MH homicides in the UK each year

In 2018-19, 168 independent investigations were being carried out into MH Homicides

Work-As-Prescribed

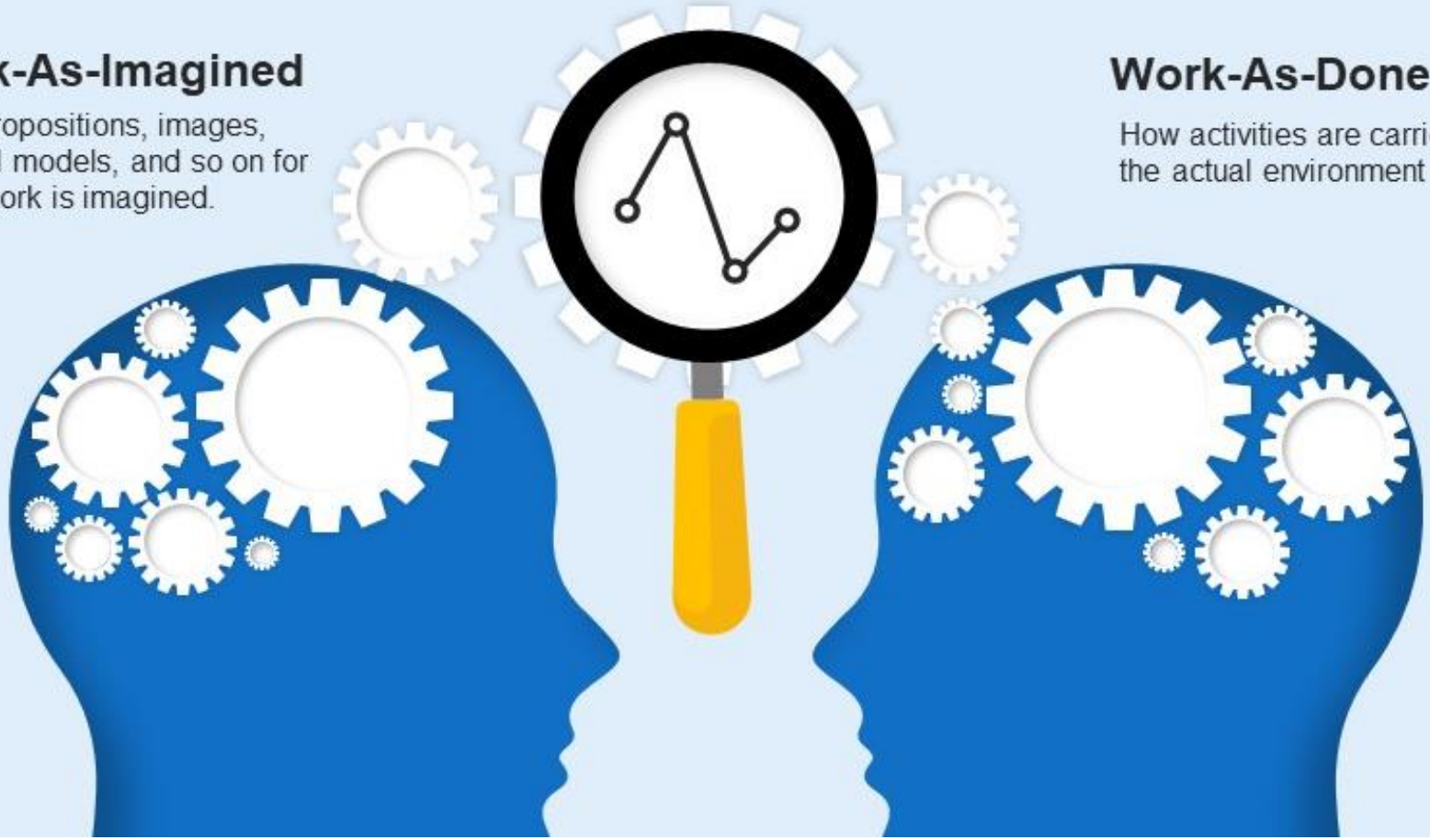
The formalization, specification and design of work

Work-As-Imagined

The propositions, images, mental models, and so on for how work is imagined.

Work-As-Done

How activities are carried out in the actual environment



The problem with reviews

Focus on compliance with work as prescribed/imagined V work as done

Check behaviour against lists of polices/procedures and evaluate compliance

Reviewers often hold the view that more compliance = > safety

Recommendations can regularly take the form of more rules which can often have perverse effects

The case of the Central Line Associated Bloodstream Infection?

- Hospitals signed onto a central tool and given training, tools, new procedures and other technical help
- No correlation between high scores and infection rates
- Some hospitals infection rates decreased as compliance worsened
- No association between compliance measurement and outcome

Rule fatigue

- More than 600 rules apply to the work of a ward nurse
- A ward nurse can recite, on average, fewer than three of those rules. That's less than 0.5%
- Yet work gets done, and the majority of patients actually don't get hurt when receiving care

"its too simple to say the NHS doesn't learn. One of the reasons re seem not to learn is the messages from inquiries are already familiar. Just as important to ask why the NHS – often skilled senior staff – don't do things they know are beneficial"

Louis Appleby

We wanted to complete our review with a different focus

The Just culture community

- What is “Just Culture”?
  - The acknowledgement that all humans are destined to make mistakes, and destined to drift into at-risk behavioral choices, regardless of how well the system is designed
  - Shift of focus: from errors and outcomes to system design and behavioral choice

Just Culture

1. Don’t ask who is responsible , ask what is responsible
2. Understand the difference between work as imagined and work as takes place
3. People don’t come to work to do a bad job; understanding the importance of restorative vs retributive justice
4. People are not the problem to control but the solution to harness: considering forward vs backward accountability
5. Supporting second victims and reducing the negative consequences and creating personal and organizational resilience

A structure for understanding how people work in a complex health care system

System Engineering Initiative Patient Safety (SEIPS)

Tools & Technology
Characteristics such as:
- Usability
- Accessibility
- Familiarity
- Level of automation
- Portability and functionality
- Maintenance (outdated, malfunctioning)

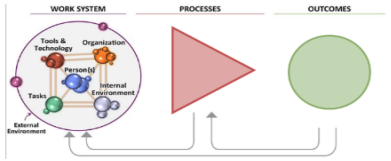
Tasks
- Specific actions within larger work processes
- Includes task attributes such as:
  - Difficulty
  - Complexity
  - Variety
  - Ambiguity
  - Sequence

Person
- Individual characteristics:
  - Psychological impacts (e.g., frustration, stress, burnout)
  - Cognitive factors (attention, memory, confusion)
  - Preferences, personal goals
  - Knowledge, competence, skills
  - Physiological factors (illness, dehydration)
  - Physical strength and needs
- Collective characteristics: team cohesiveness

Organisation
- Structures external to a person (but often put in place by people) that organise time, space, resources, and activity.
- Within institutions:
  - Work schedules/staffing
  - Workload assignment
  - Management and incentive systems
  - Organisational culture (values, commitment, transparency)
  - Training
  - Policies/procedures
  - Resource availability and recruitment
- In other settings:
  - Communication infrastructure
  - Living arrangements
  - Family roles and responsibilities
  - Work and life schedules
  - Financial and health-related resources

Internal environment
Physical environment such as characteristics of
- Ambient environment: lighting, noise, vibration, temperature
- Physical layout and available space
- Housekeeping: cluttered, organisation, cleanliness

External environment
Societal, economic, regulatory and policy factors outside an organisation



Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

Tools & Technology
- Describe the equipment/tools you use
- Describe the equipment design
- Share your insights into equipment availability and appropriateness
- Share your insights into equipment reliability
- Describe how information is presented (eg records/IT systems)
- Describe alarms and alerts
- Are any tasks automated?
- Describe where equipment is positioned. Is this optimal?
- Are tools/technology maintained and updated?
- Are manuals, procedures and supports accessible?

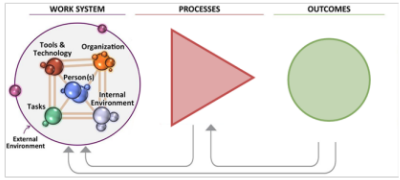
Organisation
- Tell me about how the patient pathways work
- Describe the information flow (how information is communicated)
- What is the communications workload like?
- Tell me how new information is flagged
- Where is new information held?
- Describe the leadership and supervision arrangements
- Describe how works is scheduled/allocated
- Describe staffing levels and resourcing
- Describe the safety/organisational culture
- Describe how change management works

Tasks
- Tell me about the task demands you face
- Describe the tasks which are complex or challenging to carry out
- Talk me through your experiences of the workload
- Are there time pressures? If yes please tell me more
- Does task repetition/monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

Person
- Tell me about the patient mix
- Describe the team who deliver patient care
- Who else is part of the team (eg admin, domestic)?
- How familiar are team members with care processes/pathways?
- Are roles/responsibilities clearly defined?
- Describe how training is organised to support safe care
- Describe the team dynamics
- Describe the impact of personal factors (eg stress, morale, tiredness)

Internal environment
- Does the workspace support safe patient care/task performance?
- Share your thoughts on the layout of the environment
- Is the workspace appropriate for the task?
- Where are tasks completed?
- Describe any distractions you experience regularly
- Do interruptions impact patient care/task performance? If yes, how?
- Describe the impact of the ambient environment (eg lighting, noise, air quality)

External environment
- Describe any relevant national targets
- Tell me how the following impacts (if at all):
  - Policy and regulatory demands
  - Accreditation standards
  - Political decision making
  - Global events



Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

The importance of going soft in safety

Improving patient safety culture – a Practical GUIDE

www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide

- Culture and Leadership
- Teamwork and Communication
- Just and Restorative Culture
- Psychological safety
- Promoting diversity and inclusive behaviours
- Civility

Civility Saves Lives

The importance of intelligence

Paul Smith

Overview

- Current challenges with measuring patient safety within mental healthcare settings
- Using data and information to monitor and improve patient safety
- Potential future directions: better data/adoption of new techniques such as machine learning

Current challenges with measuring patient safety in mental health settings

- Data collection fragmented and not specifically designed for purpose
- Lot of data available, but variation in how well it is used and often limited analytical resource
- Focus on limited range of problems (and for mental health, setting); siloed approach to safety
- Huge variation in reporting (not only inter-organisation but also *intra:* between wards, services and teams)

In addition:

- Patient safety in mental health settings is under-researched compared to other settings (weak body of evidence, relative lack of published academic papers)
- Unique safety challenges in mental health settings: capacity to make decisions, greater community focus, risky behaviour (e.g. self-harm), measures to address these (e.g. restraint) can result in further risk to patients, high levels of distress, high percentage not there by choice….
- Very few indicators on mental health patient safety, or what should be measured and monitored

Niche's approach to using data for improvement

- Development of an Integrated Trigger Tool to support mental health trusts, services, provider collaboratives and systems in understanding if services are operating safely
- The tool seeks to address many of the current key barriers facing services: failing to make the most of existing data, lack of analytical resource, data not adding value for management and frontline staff
- Designed to answer fundamental questions such as:
  - How have our services been performing in the past?
  - What do our services look today?
  - Where are our current problems likely to be?
  - Are we responding and improving?
  - Where are my areas of large variation/outliers?

Design principles for the tool

- Unlock knowledge about local problems in a form that aids understanding of causes and tracking the impact of potential solutions/improvement work
- Facilitate and encourage a culture of continuous learning and improvement
- There is no single source of data or measure of safety: a blend of metrics is required
- Measurement and monitoring should be examined in each clinical area
- Focus on a range of key metrics, no drowning in indicators
- Information should be targeted, digestible and easy to use
- Make the best use of data that is already available but be creative
- Data quality is an ongoing process

Current data sources

- Aim is to provide a comprehensive view of individual services in terms of activity, staffing and incidents taking place currently and historically.
- Around 20 separate source of data used currently
- Can accept data in most machine-readable formats taking a “code once” approach
- Modular design so new data and indicators can be added relatively quickly
  - Safeguarding referrals
  - Complaints data
  - HR formal processes
  - Grievances
  - Seclusion episodes
  - Staff rota data
  - Staff in post data
  - ESR data (sickness etc)
  - Medical staff investigations and referrals to GMC
  - NMC referrals
  - Incidents data
  - Ward stay data
  - Bed capacity data
  - Patient leave data
  - Community referrals and contacts
  - Friends and Family Test
  - Patient experience
  - Staff experience
  - Claims data

Domain 1: Staffing

Rationale: Appropriate staffing plays a key role in the delivery of safe and effective care.

This goes beyond overall numbers and incorporates the knowledge, skills, experience, and mix of staff required to look after patients who are often complex and challenging.

Examples of indicators in this domain:

- Staff turnover/throughput
- Vacancies
- Use of non-qualified staff
- Use of temporary staff (bank and agency)
- Staff working consistently long hours
- Selected staff survey questions (national and internal e.g. PULSE)

Domain 2: Service users

People should have a positive experience of care, which should be responsive to a patient's personal needs. The perspectives of patients and carers provide valuable insight into the quality and safety of care and are often indicators of risks within services.

Examples of indicators in this domain:

- Feedback from the Friends and Family Test
- Complaints
- Selected patient survey questions (national)

Domain 3: Care and treatment

Services should, as far as possible, be based on evidence-based and nationally agreed best practice which ensures care is delivered in a safe environment, and that patients are protected against abuse and improper treatment.

Examples of indicators in this domain:

- Use of patient leave
- Use of restraint
- Use of seclusion
- Observation levels
- Use of rapid tranquilisation

Domain 4: Incidents

Although completeness and accuracy often far from perfect, incident recording and analysis is potentially one of the richest data sets available and can be used as a starting point to reveal wider organisational issues. Increased scrutiny and use of data will encourage standardised reporting and improved data quality: poor incident reporting is, itself, a potential indicator of a closed culture.

Examples of indicators in this domain:

- Levels of harm
- Near miss recording
- Medication errors
- Incidents of violence and aggression
- Self-harm
- Mortality

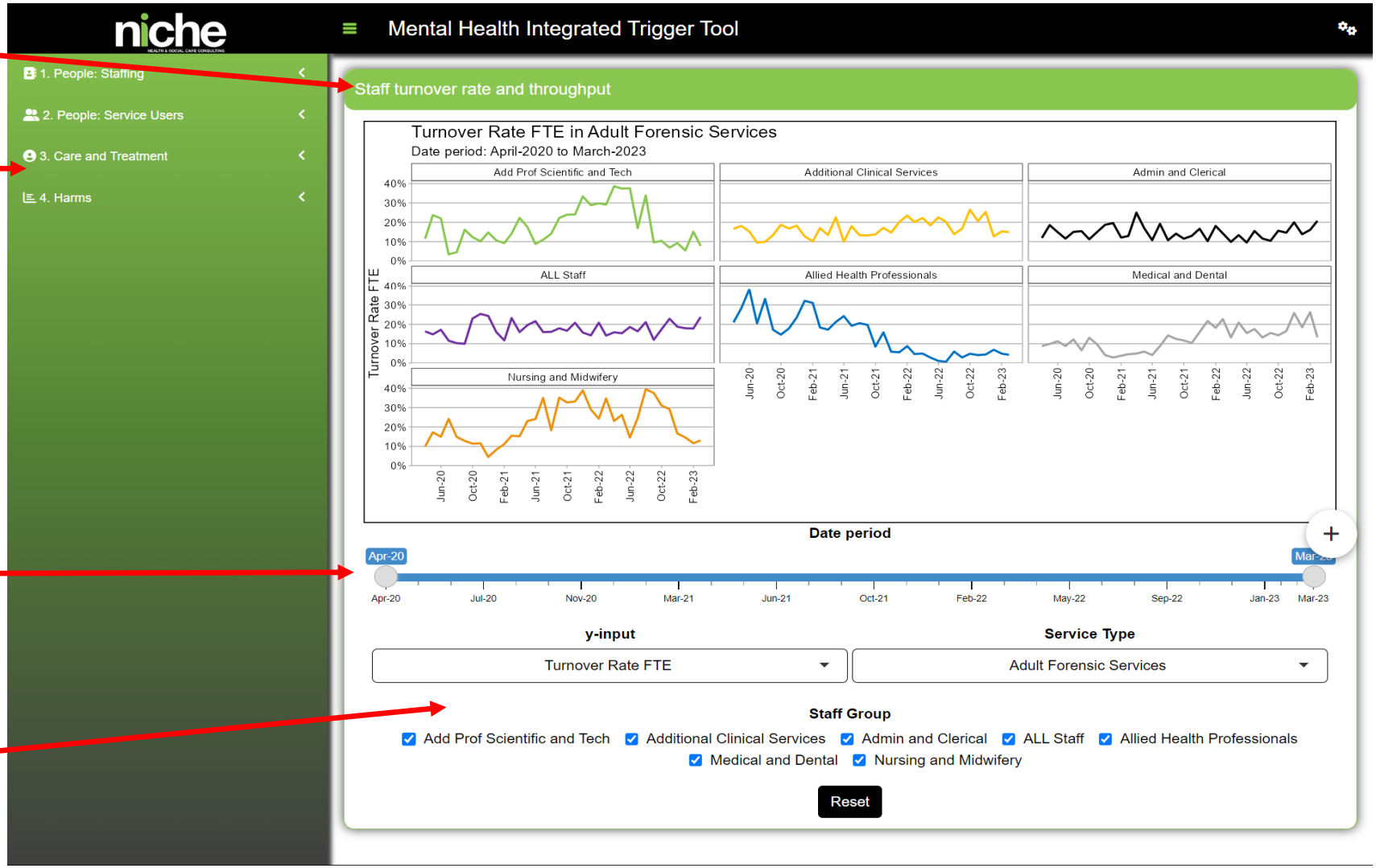
Mental Health Integrated Trigger Tool overview

Sub-metric

Domain

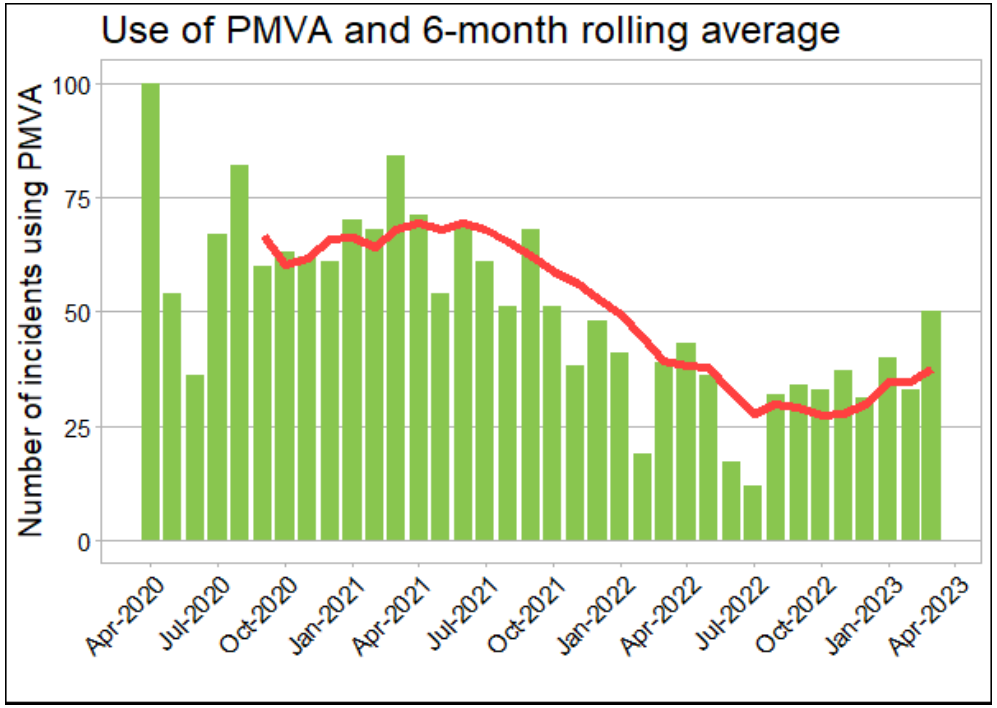
Time period

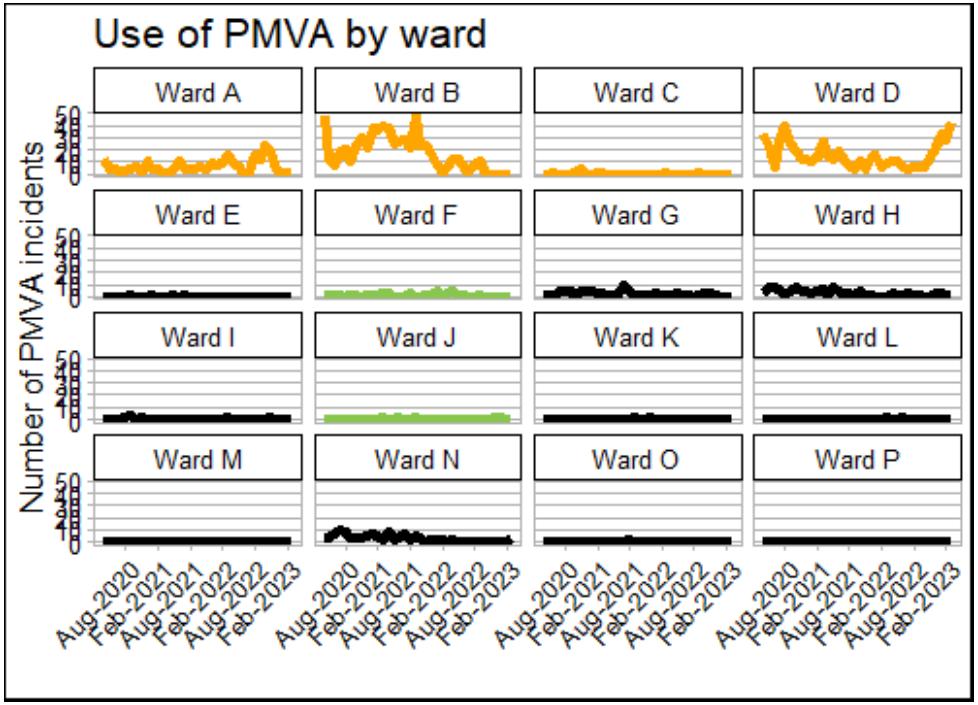
Analysis units



Sample output – PMVA by site and ward

Example shows use of PMVA for selected service and by ward within the service, colour coded by gender (male/female/mixed)

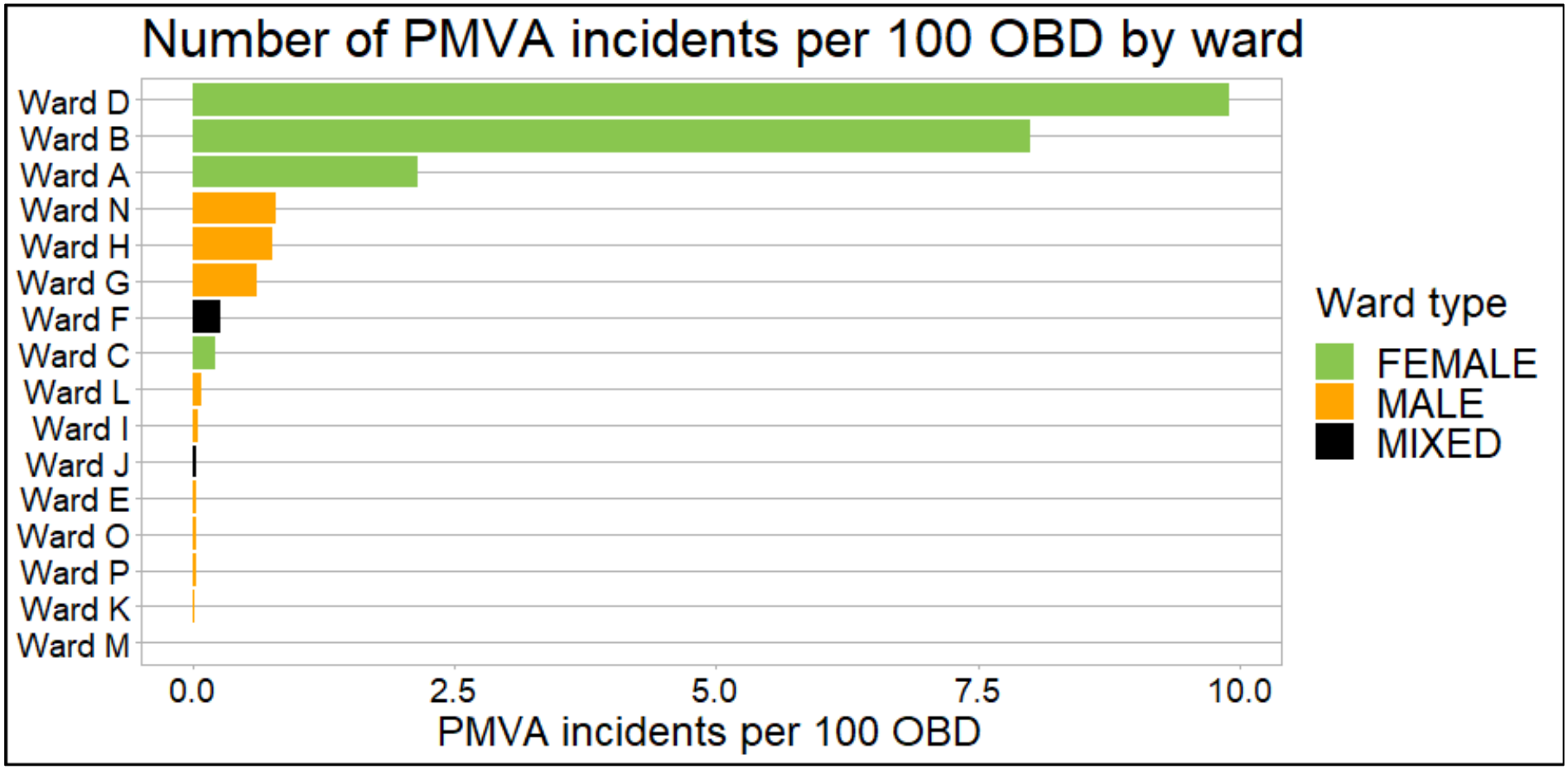




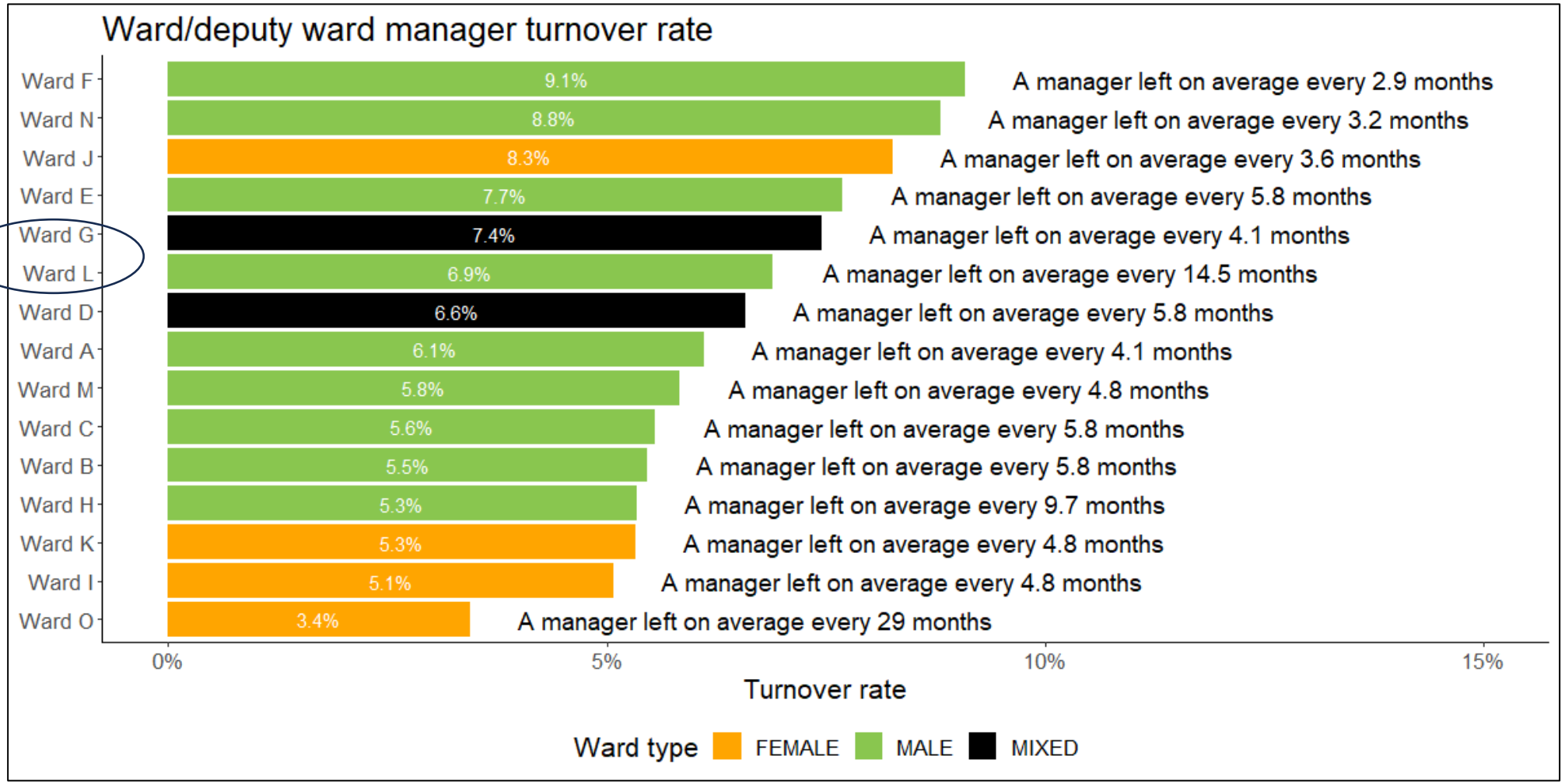
Data can be displayed at any sub-level required by the user: organisation, site, service, ward, individual patient, gender, time interval, location, staff group, severity…

Sample output – PMVA use adjusted by occupancy

Data can be combined an overlayed from different sources, in this case the PMVA incidents data was combined with bed occupancy (used to adjust for the number of patients on each ward)

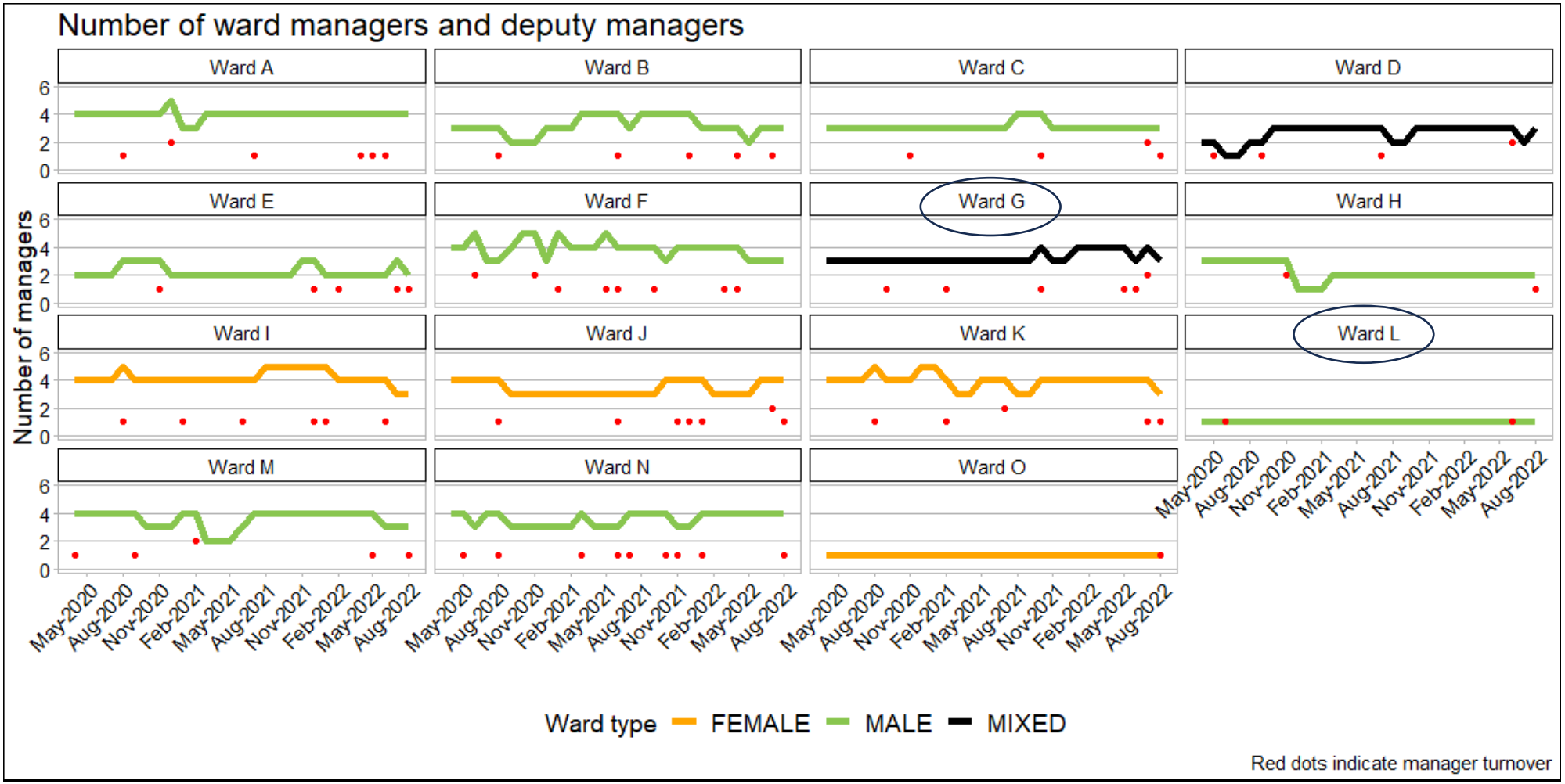


Sample output – ward manager stability/turnover



Interesting indictors can be developed from existing data to highlight potential issues, and bring out some of the finer detail beneath high level numbers (e.g. the turnover rates of Wards G and L…)

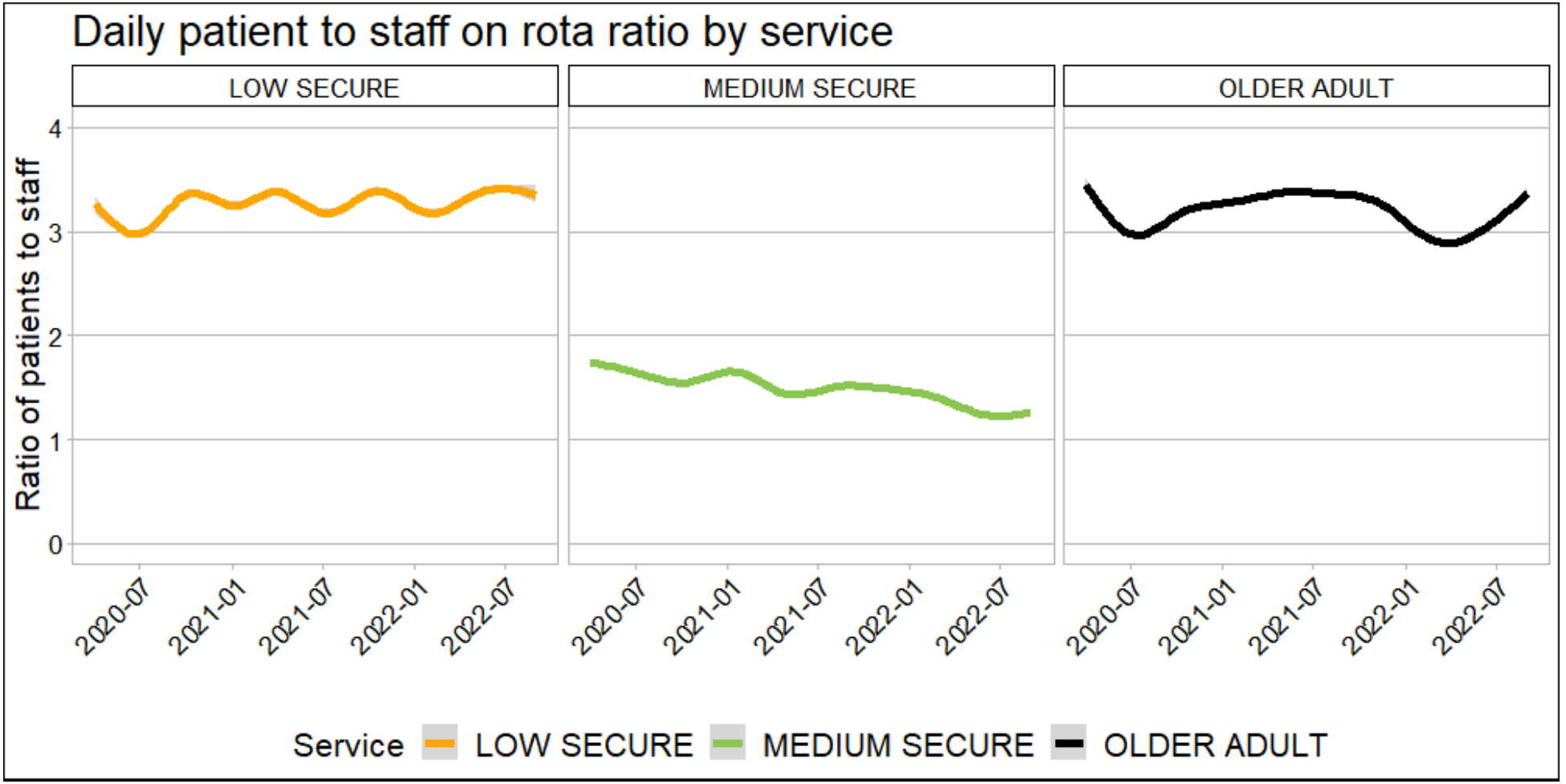
Sample output – number of managers on ward



The importance of metrics working together - an additional measure generated from the tool can provide insight into the previous apparent anomaly.

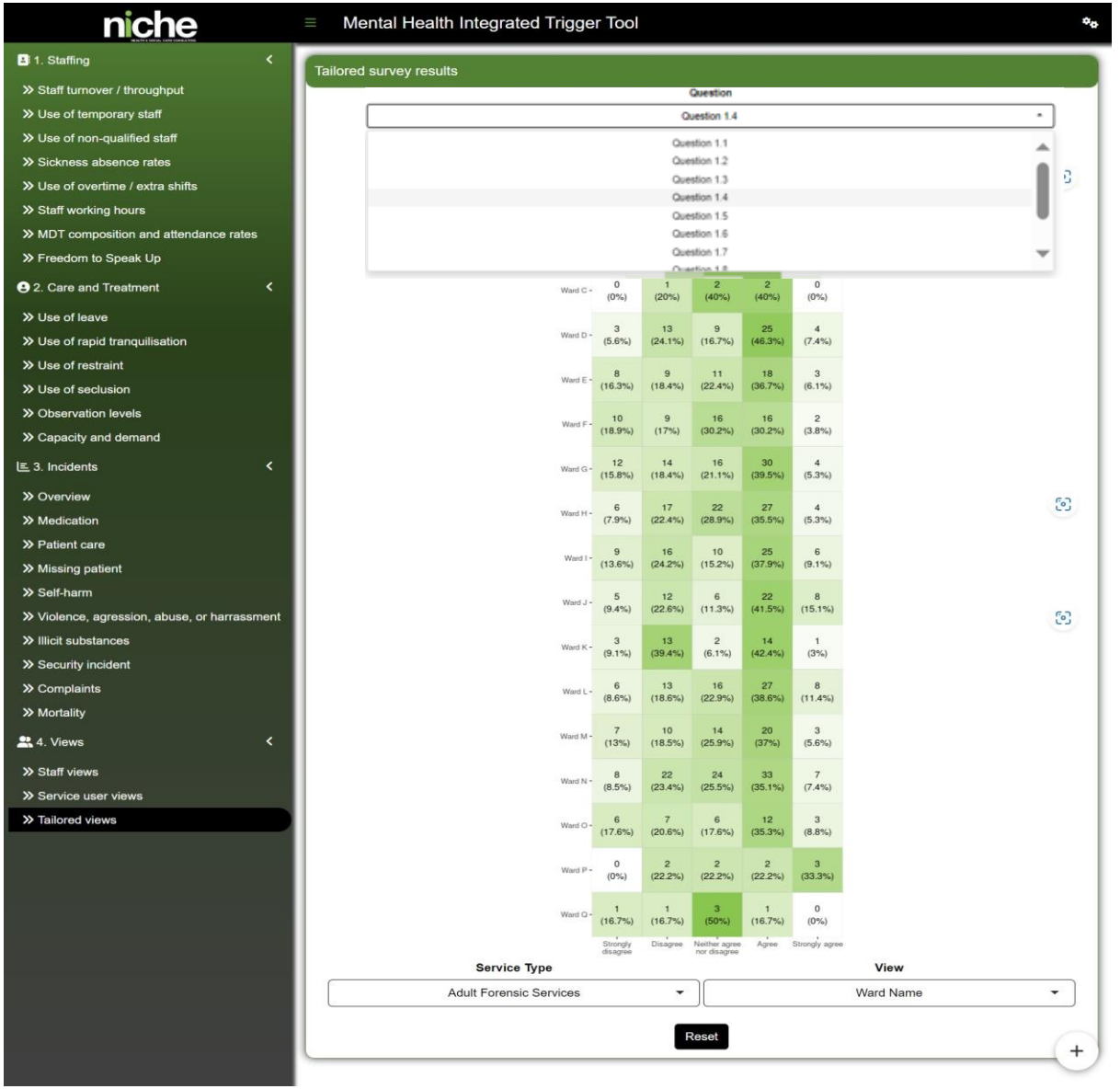
Sample output – staff to patient ratios by service

Data can be combined an overlayed from different sources allowing users to make judgements about staffing levels and trends. Can be sliced various ways e.g. by ward, whether staff qualified, bank/agency.



Tailored local intelligence

- In addition to metrics derived from standard data captures, there is also the ability to add very tailored “soft” intelligence through automated surveys
- Recognise that hard metrics alone cannot always yield full insight into what is happening on the ground
- Customised surveys fully integrated into the tool and allow capture of issues individual organisations feel are worthy of ongoing interrogation and monitoring
- More flexibly captures the opinions of staff and how they are feeling



How the trigger tool can be used currently

- Ability to identify trends, outliers, “hot-spots”, areas of concern, and areas of best practice
- Understand if performance is static, improving, or declining in a statistically robust manner (Statistical Process Control built into indicators)
- Array of metrics allows “joining of the dots” to drill-down to root causes, and insights that can be triangulated with other intelligence
  - Are there any issues related to understaffing or not having the correct mix of skills and experience?
  - Are there any areas of high/low restrictive interventions?
  - Is there anything anomalous or unusually high in staff and turnover and sickness/absence rates?
  - Is there appropriate use of bank/agency staff or any signs of overdependence?
  - Are incidents occurring on particular shifts, ward areas, or times of day?
- Standardised view of data across organisation and standardised ways of making comparisons (e.g. benchmark similar services/wards, adjust for size etc) – “a single version of the truth”
- Facilitates production of reports and responses to data requests: can be used by corporate, clinical, and governance/patient safety teams for reporting, reviewing, monitoring and compliance, and for rapidly producing third party information requests (e.g. CQC, ICB, NHSE)
- Trigger actions such restrictive intervention reduction plans based on any areas of potential risk identified and monitor the impact of any interventions.

Looking forward…..

- Getting the basics right – improving data quality of certain key fields, a safety "minimum data set"
- Greater focus on data from patients, carers and staff
- Qualitative data is also key
- Better measures for community data: some metrics are available but primarily inpatient focused
- Adoption of new techniques e.g. machine learning, moving safety to the individual patient level

The provider collaborative challenge

Katina Anagnostakis

EAST MIDLANDS ADULT SECURE CARE SERVICES
IMPACT
Having a positive impact on our futures

Cygnet Health Care | NHS Derbyshire Healthcare NHS Foundation Trust | Elysium Healthcare | NHS Leicestershire Partnership NHS Trust | NHS Lincolnshire Partnership NHS Foundation Trust | NHS Northamptonshire Healthcare NHS Foundation Trust | NHS Nottinghamshire Healthcare NHS Foundation Trust | PRIORY HEALTHCARE | St Andrew's HEALTHCARE

Patient Safety: A Provider Collaborative Perspective

Dr Katina Anagnostakis – IMPACT Clinical Director

IMPACT Provider Collaborative – Adult Secure Care

- Nottinghamshire Healthcare NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- St. Andrews Healthcare
- Cygnet Healthcare
- Elysium Healthcare
- Priory Healthcare

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Transforming outcomes by working collaboratively at scale.

Cygnet Health Care · NHS Derbyshire Healthcare NHS Foundation Trust · Elysium Healthcare · NHS Leicestershire Partnership NHS Trust · NHS Lincolnshire Partnership NHS Foundation Trust · NHS Northamptonshire Healthcare NHS Foundation Trust · NHS Nottinghamshire Healthcare NHS Foundation Trust · PRIORY HEALTHCARE · St Andrew's HEALTHCARE

Working together we have achieved…

EAST MIDLANDS ADULT SECURE CARE SERVICES
IMPACT
Having a positive impact on our futures

More patients placed closer to home

No LDA specialist placements out of area

More efficient use of our inpatient services

Quality improvement, safer services; better patient experience

More co-production and peer support workers

Cygnet Health Care · NHS Derbyshire Healthcare NHS Foundation Trust · Elysium Healthcare · NHS Leicestershire Partnership NHS Trust · NHS Lincolnshire Partnership NHS Foundation Trust · NHS Northamptonshire Healthcare NHS Foundation Trust · NHS Nottinghamshire Healthcare NHS Foundation Trust · PRIORY Part of MEDIAN · St Andrew's HEALTHCARE

Working together we have achieved…

EAST MIDLANDS ADULT SECURE CARE SERVICES
IMPACT
Having a positive impact on our futures

Clearer care pathways

Better support for transition and discharge

New service developments

Reduction in inequalities

Reduction in restrictive practice

Cygnet Health Care · NHS Derbyshire Healthcare NHS Foundation Trust · Elysium Healthcare · NHS Leicestershire Partnership NHS Trust · NHS Lincolnshire Partnership NHS Foundation Trust · NHS Northamptonshire Healthcare NHS Foundation Trust · NHS Nottinghamshire Healthcare NHS Foundation Trust · PRIORY Part of MEDIAN · St Andrew's HEALTHCARE

Challenges and Solutions

- Connecting with the right people
- Helping ICBs and system partners understand provider collaboratives
- Emergent change within the health & social care system
- Addressing safety, health inequalities & outcomes at a regional and ICB level

The IMPACT PC Approach

Shared Values
Collaboration
Building relationships
Open communication
Identifying shared purpose
Co-production
Innovative
Solution focussed

Safety Imperatives & Priorities

Self-harm and suicide
Violence and aggression
Other offending
Sexual safety
Physical health incidents; COVID
Medication errors
Absconsion/ AWOL
Safeguarding incidents
Closed Cultures
Restrictive Practice -
Long Term Segregation; Seclusion & Restraint

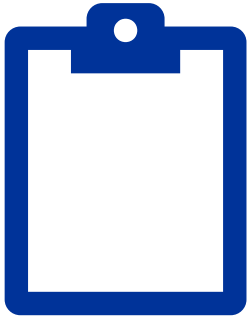
Interface between & with Providers

- Aligning joint objectives, intelligence and strategy
- Importance of clinical leadership and engagement
- Clinicians, Organisational Patient safety leads and teams working together; learning from each other; supporting each other
- E.g. Patient Safety Incident Response Framework (PSIRF) community of practice example

Oversight & Assurance

- **Quality Maturity Framework –** NHSE

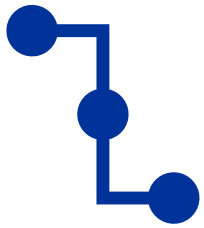
- **Data** – co-producing new data systems and approaches for the PC


Oversight & Assurance

Engagement and Intelligence

- Visits- ad hoc; responsive; Quality Service Reviews,
- Patient engagement - Service User Reference Group
- Feedback,
- Culture of how we do this - encourage challenges to be shared, encourage learning, offer support across the collaborative between providers etc.
- Weekly escalation call
- Are we seeing what we expect to see; how does this tally with the data?
- Buddying arrangements between organisations to improve safety


Oversight & Assurance

- **Governance systems** – CRGG to Board – sharing and pooling data; PSQG- lead provider oversight; new projects and initiatives generated and evaluated; iterative processes of QI

- **Collaborations with external partners:** Healthwatch; ICBs; CQC, Local Authority Safeguarding Boards; Criminal Justice System

- **Triangulating information**

Leading the Safety Agenda

- Some tension with culture shift to PSIRF - being a collaborative means we can ensure a focus on specialist areas, whereas providers and ICBs have a broader focus
- Importance of broader collaboration with ICBs and provider organisations – understanding how we work together
- Feeding learning into the system
- Implications of future delegation of specialised commissioned services to ICBs

Strategic deliver – tasks and planning for success

James Fitton

And

Learning from today

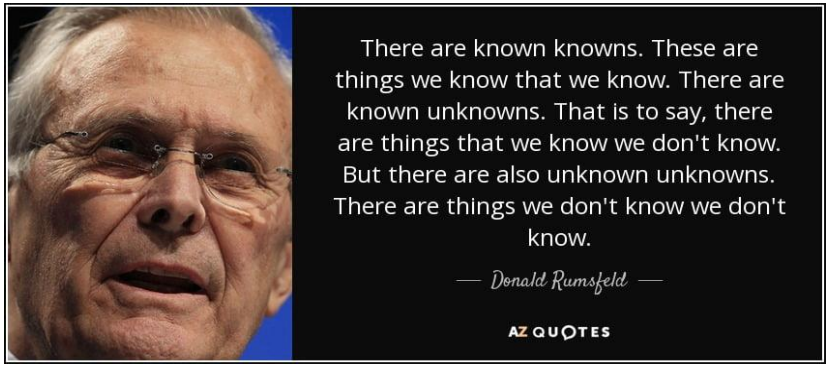
Tom McCarthy

Two key questions – and why they matter

It all boils down to these two questions:

1. **Do you know what your main safety problems are?**
   - Which services/locations/teams?
   - Which types of service user – perhaps across multiple teams?
   - When? When are the risky times?
   - Since when? Are they getting better or worse?
   - What are the risks? Just how poor an outcome are you risking?

2. **Do you know what to do about them?**
   - Is there local good practice which can be shared?
   - Is there clear national guidance/research evidence?
   - To what extent is innovative thinking required (always remembering that "innovative" also means "untested")?



Analysis and delivery quadrant

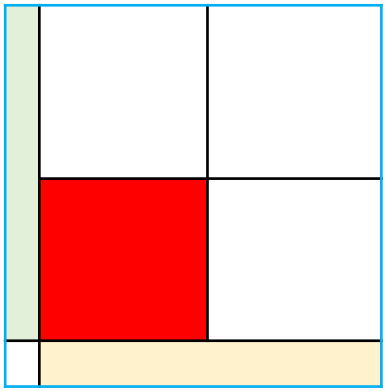
Extent of understanding of causes and solutions ↑

QUESTIONS - ***Low knowledge of this being a local problem*** - ***High understanding (in theory) of causes and potential solutions*** e.g. the impact of standardised approaches to risk stratification (instead of person-centred collaborative assessments) e.g. management of pressure ulcers in older patients	***FACTS*** - ***High knowledge that this is a local problem*** - ***High understanding of causes and potential solutions*** e.g. reduction of medication errors e.g. reduction of incidence of physical and verbal violence between patients, and from patients to staff
DISCOVERY - ***Low knowledge that this is a local problem*** - ***Low understanding of causes and potential solutions*** e.g. any of the examples here not known locally	***INTUITION*** - ***High knowledge that this is a local problem*** - ***Low understanding of causes and potential solutions*** e.g. reducing inequalities in safety events and outcomes e.g. safe retrieval of patients who have fallen e.g. modifiable behavioural factors in medication compliance*

Extent of awareness of the local problem →

*see National Patient Safety strategic research needs 2022/23

Quadrant 1 – Discovery
Low knowledge/low understanding



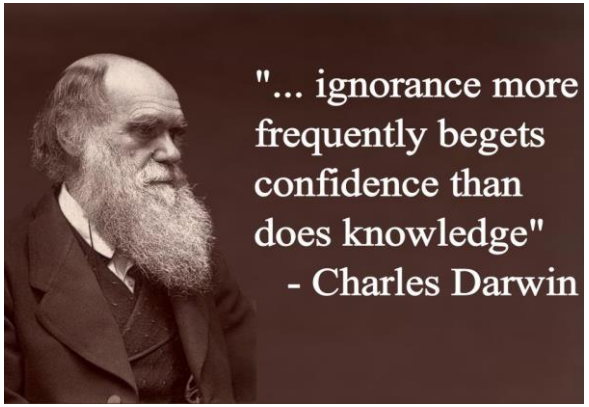
Tasks:

- Agree in-scope services
- Agree preliminary list of metrics
- Gather preliminary data – analyses, trends, benchmarks
- Discuss what this means – identify further metrics
- Develop ongoing datasets
- Discuss, review, refine

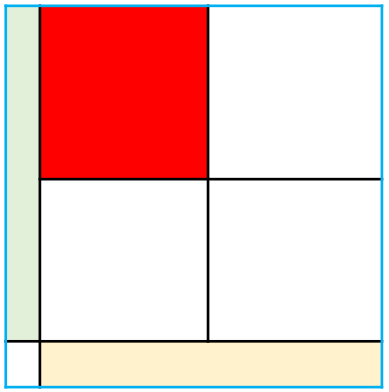
For example:

Medication errors

- Which specialities? Over what period?
- Any particular medication types?
- Analyse both incidents and near misses – by medication, ward, diagnosis, harm
- Qualitative discussion – what are the underlying system factors here? What is the pattern of antecedents and context in each case? What actions are possible, and why/how might they work?
- Develop ongoing dataset and dashboard on this basis
- Regular review



Quadrant 2 – Questions
Low knowledge/high understanding



Tasks

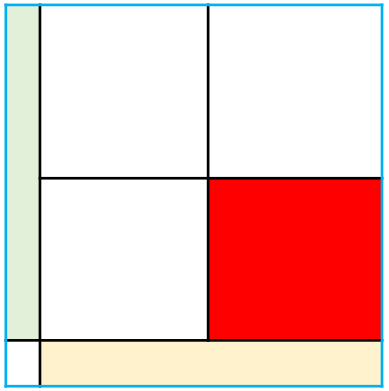
- Fully describe the problem – what, where, when, with what effect
- Research effective responses – local good practice, NICE, national guidance
- Develop an implementation plan

For example:

Risk stratification

- What are the current approaches to assessment and risk, ward-by-ward?
- What role does each profession play?
- Which tools and instruments are in use? Why? Who is supporting which approach?
- Who has what understanding of more modern NICE-approved approaches?
- Who supports change to NICE-approved approaches? How can this support be built into an implementation plan?
- How can local service user and carer organisations support work to develop person-centred and collaborative approaches to risk management?
- Who needs to do what by when?
- How will you know the approach is working? What will "working" look like? Plan for evaluation and review from the outset.

Quadrant 3 – Intuition
High knowledge/low understanding



Tasks

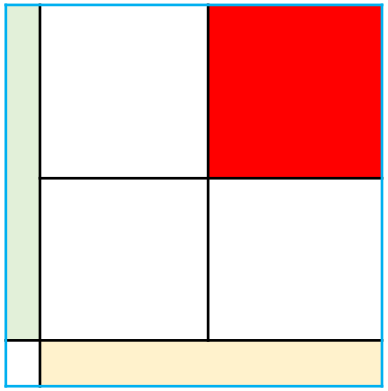
- Fully describe the problem – what, where, when, with what effect
- Research what we do know, and how it might help – locally and beyond
- Consider new local responses, taking care to develop:
  - A logic model – why and how will the intervention address the problem?
  - Things which could help or hinder – and how to promote or mitigate them
  - How you will know it is working – and how those metrics will be measured and reported
  - How you might need to check for unexpected effects
  - What is required for this response to be sustainable, if it works

For example:

Inequalities

- Analyse who is using which service, including trends over time. Remember all of the protected characteristics, and (where numbers permit) consider inter-sectionality too.
- Be clear what good looks like. Is over-use or under-use the main concern?
- Cross-analyse safety data with activity data. Where is there significant variance? Is that variance consistent over time? Is it consistent across teams/wards with otherwise similar functions?
- Discuss, research and debate potential responses to variances – including substantial engagement with the communities involved. This may take you beyond existing engagement networks
- Continue to monitor and review as ideas are tested, with an evaluation plan from the outset

Quadrant 4 – Facts
High knowledge/high understanding



Tasks

- Design an approach to assurance. How will you know this is working?
- In designing metrics, ensure you consider: effectiveness, equity, efficiency, acceptability to service users and staff, and relevance to the topic
- For quantifiable metrics, consider use of statistical process control to ensure routine surfacing of unusual events and trends
- Are there correlations between effects? Improvements or impacts which seem to be closely associated with other impacts?
- Don't ignore qualitative perspectives. Talk to relevant stakeholders regularly about the impact of what you're doing on safety: how they are perceiving changes, and why they think changes are (or aren't) having an effect

For example:

Violence reduction

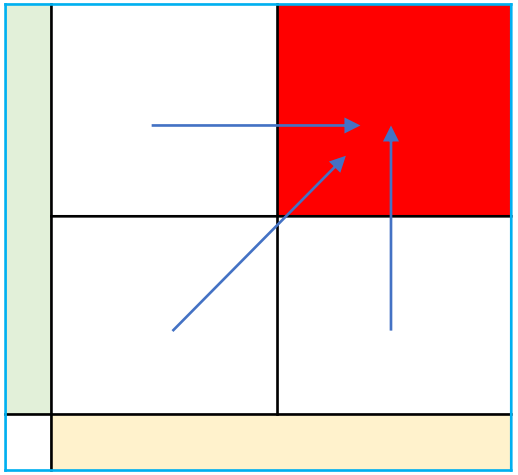
- Include within metrics: number, type, location and time of incidents; patient/staff characteristics, including protected characteristics; cost/time required for any new interventions
- Analyse carefully patterns and trends: do incidents happen at particular times of day? In particular rooms or types of room? Following other ward events? With certain levels of staffing available?
- Where are improvements being seen? Against all of these factors? Why are there differences?

From analysis to action

The process of turning all of the above into action plans, and then implementing those plans, must be **detailed**, **iterative**, and based on wide **engagement**.

For some high-performing services, this approach will also provide a framework for **excellence**. Here, organisations with services which are known to be of high quality – and where it is properly understood why they are of high quality – will have a basis for spreading good practice within that organisation, in ways most likely to be locally relevant and accepted.

The aim is to move all services and issues gradually towards the upper right quadrant. In doing so, knowledge of both the nature and scale of problems, a clear plan for improvement, and a system to provide assurance that improvement will be available for all services.



Learning from Today : Key points

This is a hugely complex topic

- Spotting a closed culture
- Understanding the national context & your approach
- Having reliable information to start ‘engaged conversations’ at all levels

There are approaches

- National frameworks & guidance
- Local systems
- Trigger tool
- Quadrant analysis

Learning from Today : Key points

Most importantly

- Go in softly
- Intelligence led
- Understanding, action planning, implementation

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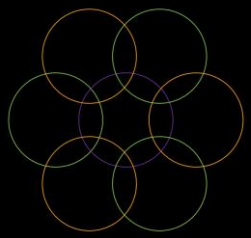

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