Safer Intelligence

June 2017

What do we know about safety?

Findings of a scoping exercise of the collection and use of 'safety' data across health and social care in Salford

Safer Salford

Contents

Background

In the wake of the Francis[1] and Berwick[2] Reports, the Health Foundation commissioned Professor Charles Vincent to review what and how data is used in healthcare in relation to safety, capturing learning from other safety critical industries. The resulting report, the Measurement and Monitoring of Safety[3] (MMS) Framework proposes that assessing safety by what has happened in the past does not allow us to know how safer our care is today or will be in the future. Vincent suggests a framework which can be used to structure thinking about safety against five domains: past harm, reliability, sensitivity to operations, anticipation and preparedness, and learning and integration.

The core principles of the MMS Framework underpin the Safer Salford programme, which has four key priorities: leadership, culture, intelligence and improvement. This scoping exercise is the first output of the Safer Intelligence workstream. Our aim is to build a measurement system to answer the question "what can we learn about safety in health and social care in Salford?"

Methodology

During July and August 2016, Haelo undertook a scoping review to answer the question, "what safety data is currently collected across the Salford health and social care economy, and how is it used?". In addition to a review of public documents and data reports, representatives from health and social care organisations in Salford were

[1] Available at http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report
[2] Available at https://www.gov.uk/government/publications/berwick-review-into-patient-safety
[3] Vincent, *et al*, 2013, The Measurement and Monitoring of Safety, The Health Foundation. Available online at: http://www.health.org.uk/publication/measurement-and-monitoring-safety

consulted via a series of semi-structured, informal interviews (supplemented with follow up queries via email), framed by the five domains of the MMS Framework.

This work is not intended to be an exhaustive review, but is representative of the views of health and social care leaders about what information is routinely collected that is used as 'safety data'. The outputs of that scoping exercise are collected and summarised in this document.

Key findings

The information presented in this report provides an insight into the current work in Salford to understand and learn from data collected across Salford. The examples outlined here highlight a proactive commitment from partners to ensure safer practices and reduce harm. In addition, there is significant evidence that information collected both locally and regionally is being used to shape future priorities for improvement.

A number of key themes have emerged from this scoping report to gather and collate information used as 'safety data' in Salford.

- Using the MMS Framework to structure discussions about safety has **surfaced many examples of data sources that might not be traditionally considered safety related**, for example, delayed discharges and uptake of mandatory training. Rather than introducing new safety measures, value can be added to all aspects of the health and social care system by thinking differently about existing data

- All sectors were fairly **robust in use of 'past harm' data**, with mortality data, incidents and specific harm indicators such as the Safety Thermometers being key sources of information in this area

- Some examples of data being used for prediction and prevention were identified, however this is the exception, and **opportunities for learning and planning for the future based on past data are being missed**

- There is a **difference between how sectors use and understand data**, in social care there is a greater focus on risk assessments and information being transferred on a case by case basis, whereas secondary care has a greater focus on larger data sets – this should be exploited as an opportunity to learn from how different sectors operate and communicate information

- We found **limited examples of how data, information and knowledge is shared between organisations within Salford**. There is considerable room for improvement in how learning from safety data is shared and embedded, both within organisations, and across the whole Salford system.

Past harm

All sectors have well established systems for using past harm data, with mortality data, incidents and specific harm indicators such as the Safety Thermometers being key sources of information in this area.

The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR, also termed Dr Foster) are widely accepted measures by which hospital safety is monitored. Hence, these are consistently reported and reviewed at board level within both hospital trusts in Salford, with a view to initiate and action improvements. Salford City Council (SCC), within their public health function, utilises mortality data for prediction, such as determining population life expectancy and planning seasonal flu responses.

In addition to mortality, in healthcare a whole range of harms are monitored as indicators of the safety of care delivery. Examples include falls, pressure ulcers, medicines omissions, and self-harm (in mental health). In social care on the other hand, past harm would tend to be measured by incident reporting.

Incident reporting is well established in the culture of the hospitals whereas in primary care incidents are under-reported. Salford CCG are beginning to monitor reporting levels within GP practices as a performance measure to try to encourage more proactive reporting. In social care, incident reporting centres around safeguarding with well-established formal channels through which reports are escalated. However, while there are good examples of pro-active incident reporting, the MMS framework warns us against reliance on incident data. Although incident data from adverse events can be a rich source of learning, reporting systems have been shown to be a poor measure in terms of giving realistic numbers of adverse events and near misses[3].

Good practice example: Proactive reporting of incidents

In 2016, GMMH staff reported 2769 patient safety incidents across inpatient and community services, for which 110 had a 3-day review and 25 met the threshold for investigating by root cause analysis, meaning they were classified as 'serious incidents.' Serious Incidents "are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified."[4]

Reviews into serious incidents are not held for the purpose of apportioning blame but for establishing the facts that led to an incident to support learning and help to mitigate future occurrences of similar incidents.

NHS and social care organisations are asked to submit a range of safety data to the Care Quality Commission. This data tends to be steered towards past harm and is used for the purpose of judgement (rating the safety of the organisation) and comparison against other organisations.

[4] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Different versions of the Safety Thermometer[5] have been adopted by both hospital trusts in Salford as a way of tracking the numbers of harms over time for the purpose of improvement. The Safety Thermometer provides a good example of how past harm data can potentially be used to guide improvement but it is important that teams take ownership of their data so that it is not simply seen as a reporting exercise.

Good practice example: Measuring harm for improvement

The NHS Safety Thermometer is a point of care survey that provides a 'temperature check' on levels of harm within teams, wards and organisations by measuring the proportion of patients who are 'harm free' on a given day each month. There are different versions of the Safety Thermometer available including Classic, Medication and Mental Health. The Classic Safety Thermometer measures the four most commonly occurring harms in healthcare: Pressure ulcers, falls, catheter urinary tract infections (UTI) and venous thromboembolism (VTE). The Safety Thermometer is designed to be used for improvement rather than assurance, providing 'just enough' data for teams to be able to monitor their own efforts to improve.

There are many existing examples of using data and information to monitor the occurrence and frequency of harm. However there are also opportunities to use existing data differently, such as making analyses of trends to form predictions and ensuring learning is shared across organisational boundaries.

Reliability

In clinical settings, high reliability is deemed important at both organisational and unit level. Clinicians are concerned with the delivery of effective, standardised care. This is typically ensured by working to clinical protocols, implementing standard assessments (such as falls risk assessment in hospital or a needs assessment in adult social care) and then audit of compliance with processes and protocols and the use of electronic systems to standardise procedures. Examples of these are demonstrated at various levels in the primary care and acute sectors.

At an organisational level, reliability of processes is assured by Key Performance Indicators (KPIs) and the Commissioning for Quality and Innovation (CQUINs) payments framework. These can relate to very specific clinical processes such as the prescribing of statins for patients with a diagnosis of cardiovascular disease, packages of processes, like the sepsis care bundle CQUIN, or broader initiatives such as establishing a recall process for cancer patients.

The Salford Standard[6], for example, is a comprehensive list of Key Performance Indicators (KPIs) for GP practices, primarily intended to quality assure the care delivered by each of Salford's 46 GP practices. It is not exclusively focussed on safety but domains include medicines optimisation, safeguarding, patient safety and experience and access. Such KPI suites demonstrate how organisations place considerable emphasis on the importance of process reliability.

Assuring reliability is not as black and white in adult social care, where the blanket implementation of protocols may not always be appropriate. In adult social care, clients

[5] www.safetythermometer.nhs.uk
[6] http://www.salfordccg.nhs.uk/salford-standard

are ‘managed and supervised’ meaning that risk of harm to a person receiving care is balanced against the individual’s needs and wishes. As the Salford CCG Head of Funded Care explained, “An extremely important factor that needs consideration is that care homes [are not] wards or units. They are literally communal living arrangements for a variety of people. Some service users may wish to participate in behaviours that may cause harm and whilst this is unwise, if they have the capacity to make this choice staff in care homes must allow/facilitate it. Examples being refusal of use of pressure relieving equipment, certain care interventions etc.”

While reliability is robustly monitored across the health and care economy, what is less evident is the ability for parts of the system to review the reliability of preventative processes further upstream, such as falls prevention in care homes or cardiovascular disease prevention in primary care. Where reliability data is already collected within an organisation for the purpose of assuring performance, there are also opportunities to maximise the value of the data by analysing it for learning and integrating it across the system in cross-organisational and multidisciplinary forums.

Sensitivity to operations

Common to all of the organisations is a basic reliance on day to day unstructured conversations and meetings to inform leaders ‘are we safe today?’ There are however examples of practices that are well established in some organisations yet culturally unheard of in others and it is in these examples that opportunities exist to share practices:

- Safety huddles are commonplace on the wards at SRFT and they are currently being rolled out in GMMH’s Woodlands unit. However, they are not standard day to day practice for GP practices and care homes.
- Senior nurse/manager walk-arounds take place regularly in both hospital trusts but are not commonplace in primary and social care.
- SRFT operates an accreditation system for wards (NAAS[7]) which ensures that care is delivered to the trust’s expected standards and that best practice is spread. Community and outpatient equivalent systems have also been developed.

Each organisation has its own mechanisms for monitoring capacity and flow, but information is not always shared readily between organisations. For example, internally, staff at SRFT can see, at the click of a button, where pressure points are within the hospital through the Clinical Utilisation Review (CUR) tool (see below). However, GP practices who refer patients in to the hospital are not able to see this information therefore an opportunity is missed to gain more value from this comprehensive dataset. More could be done to encourage organisations’ systems to speak to each other so that there is greater shared situational awareness between the acute and social settings or between primary care and mental health and so on. Salford’s integrated care and neighbourhood models provide potential means of achieving this.

[7] http://www.haelo.org.uk/films/naas-provide-outstanding-care/

Good practice example: Safety huddles

Safety huddles are regular quick meetings for sharing current information about the safety of people/patients or staff. They are one example of how good sensitivity to operations can be fostered within a team. The Woodlands ward at Meadowbrook (one of GMMH's Salford locations) is testing safety huddles with a view to roll-out across the unit.

A safety huddle should be focussed on at least one agreed patient harm and should be informed by the use of data for improvement. All workers concerned with providing safe care, including non-clinical staff should be involved in meeting in a non-judgemental environment where they are empowered to speak up. As well as providing a forum for honest, safety focussed conversations, safety huddles can provide a great opportunity to collectively share and celebrate successes.[8]

Anticipation and preparedness

Strategically, there are opportunities to use existing data for planning safe services and minimising threats to safety. The public health team in Salford City Council undertakes demographic data profiling looking at factors such as age, health issues and life expectancy across the Salford population. This data is used for the planning of public health initiatives but isn't yet shared in the context of planning and building safe services. Safety culture tools can be used by teams to build a proactive, safety-focussed team culture and surface unhealthy team behaviours. They are used in pockets within SRFT but we found no evidence of them being adopted elsewhere. Likewise, there was little evidence of human reliability analysis methods, such as Failure Modes and Effects Analysis (FMEA) being adopted in the planning of services, except for some ad-hoc work within SRFT.

At a point of care level, risk assessment tools – such as NEWS (National Early Warning Score), the Waterlow score and falls risk assessments – are used on all patients in the acute trusts as key anticipation and preparedness measures. In SRFT, at-risk patients can be identified on live status displays (e.g. sepsis red flag) on the wards to ensure that appropriate measures are implemented in a timely way. This example shows how technology can play a key role in care level anticipation and preparedness.

One area where more emphasis is placed on leading indicators is staffing. Both SRFT and GMMH have robust systems to monitor staffing levels and assuring that staff are adequately trained.

Individual providers, such as GP practices and care homes on the other hand are responsible for monitoring staffing and training internally. As such, monitoring of trends in staffing at a system level is very difficult due to a lack of pooled data. The example from Salford Royal demonstrates the opportunity to be taken by sharing data across the wider system to understand issues of flow for patients and residents in Salford.

8 http://www.improvementacademy.org/documents/Projects/hush/Huddles%20Manual%20Booklet_Oct2017.pdf

Good practice example: using data for planning care

SRFT has two sophisticated systems at its disposal which allow leaders to not just monitor safe staffing levels but to respond to daily demands in real time and predict and plan for pressure points. Trendcare allows leaders to immediately identify imbalances of staffing on wards and dynamically adjust skill mix and staff numbers as required. The Clinical Utilization Review tool helps managers monitor and respond to the needs of patients by identifying the levels of care required. This helps to identify blockages in the system, thus improving flow. Both systems are readily available for SRFT staff to view at any time.

Integration and learning

Integration and learning is difficult to evidence as it is much softer concept, although we found evidence of some formal feedback loops.

Feedback systems are service-dependant rather than organisation wide. There are some examples of how organisations try to reach a wide audience with learning from incidents, such as via intranet pages and newsletters but these methods could be developed much further to capture more learning and present it in a meaningful way to staff. In secondary care, learning from incidents is cascaded via committees and departmental structures. DATIX reports in primary care are shared with practices by the CCG and these can then be discussed at neighbourhood level meetings. In adult social care, interrogation of and learning from incidents happens at a local level, within teams.

In some examples, multidisciplinary and cross-organisational forums exist where learning from incidents can be shared, such as Medicines Safety Group and the Safeguarding Forum. The Safeguarding Team within Salford CCG, for example, provides oversight of significant incidents and feed information from these into the Safeguarding Forum that brings together care providers, including care home managers.

Safety data is integrated at board level typically through dashboards within board reports, for example the SRFT Board of Directors report. In this example, each indicator receives a RAG (red, amber, green) rating for assurance but also much of the data is now presented over time in SPC (statistical process control) format, presenting the opportunity to analyse and question the data. This report provides the SRFT board with the o*pportunity* to learn about safety from past harm and reliability data but the there is less emphasis on using data for prediction. Furthermore, although there will be informal transfer of information via existing governance structures, it is unclear how data is used to support learning at a systematic organisation-wide level.

	Salford Royal NHS Foundation Trust	*Salford CCG and Primary care*	*Salford City Council (including public health and social care)*	*Care Homes sector*	*Greater Manchester Mental Health*
Past Harm	Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR, also termed Dr Foster) are the two leading mortality indicators for hospital safety in the UK. SRFT reviews both with a view to introducing initiatives to improve safety, e.g. improved handover arrangements. Governance team reports weekly figures around inquests to 3 committees including SIARC meeting (Governance managers and CCG) and SUI assurance committee.	Mortality statistics are monitored via public health. Database sits in public health. Suicides, request for coroner's statements and death on practice premises all mandatory for reporting.	Mortality and birth stats available from NHS Digital. e.g. winter trends (Public Health), CDOP (Social Services). Suicides- Primary Care mortality data combined with information pulled from coroner. Aim in future to triangulate with GP data.	Monitoring of mortality within specific care homes would be down to individual market providers but mortality data monitored by CCG and SCC.	Mortality incidents are reviewed in a monthly Trust Mortality Group, which reports to the Quality Governance Committee through to the Trust Board. Mortality data is presented, with trends in Monthly Board Performance Report.
	Incident reports via DATIX. SIARC incidents (200-300 per year) investigated by staff trained in Root Cause Analysis (RCA), quality assured by risk team. SUI (Serious Untoward Incidents, approx. 30 per year).Subject to RCA approach. Other incidents RAG rated. Level reported depends on rating. Incidents not typically analysed for trends except high frequency incidents such as falls. Quality and People Experience Committee reviews and monitors adverse events twice yearly to ensure learning shared across the organisation.	All DATIX reports from GPs come through to CCG. Salford Standard KPIs around incident reporting, sharing and learning. Practices expected to: Abide by 'Duty of Candour', use Insight software, carry out full investigation (Root Cause Analysis where applicable), share within practice, identify learning and implement change. Numbers of incident reports monitored by CCG to encourage increased reporting. Learning shared via neighbourhood forums.	Incident reporting inconsistent. No systematic process across Salford, service dependant. SCC have accident and RIDDOR reporting process. Commissioned services contractually required to have their own incident reporting systems. 'Market' providers, again, tend to take reactive approach.	DATIX not used. All care homes should have an internal process for incident reporting. Quality of this varies, e.g. BUPA would be quite robust compared to a small independent provider. As a backup, this is partly covered by audit. E.g. by infection control team, safeguarding team or environmental health. CCG safeguarding team are notified of all SG1s (safeguarding incidents) via contact centre and monitored via safeguarding dashboard. Safeguarding Provider Forum (multi agency) reviews data and instigate improvement work as a result.	Incident reporting via DATIX (2769 patient safety incidents reported across inpatient and community services during 2016 – (High percentage of incidents low harm, no harm) with 110- 3 Day reviews and 25 reaching the threshold for investigating by root cause analysis as per NHS SUI Framework (2015). Investigations undertaken to support learning and mitigate future occurrences. Patient safety incidents are reported weekly to the NRLS
	Classic Safety Thermometer. Medicines Safety Thermometer.	No Safety Thermometer or equivalent exists for use in GP practice.	Harm indicators are not used in social care. Using data to monitor harm is not in the culture.	There have been efforts to adopt the Classic Safety Thermometer in care homes but data has shown events to be rare and so this approach has not gained traction in this setting.	Classic and Mental Health (Including medicines) Safety Thermometers both used.
	Dashboard to Board of Directors from Quality Improvement team subdivided into acute and community and includes mortality data, safety thermometer data, patient satisfaction and staff satisfaction using SPC, where appropriate.	QOF indicators monitored via GP dashboard. SMASH (Salford MedicAtion Safety DasHboard). Pulls data from SIR (Salford Integrated Record) automatically by search. Individual incidents are flagged directly to practices.	-	CCG safeguarding dashboard monitors safeguarding incidents.	Reporting by monthly Board Performance Report includes: monthly SUIs, mortality, violence and aggression, safeguarding, pressure ulcers, length of stay and readmissions, complaints and compliments
	CQC data requirements. The data reported includes % of staff reporting of errors and near misses, number of serious incidents and never events and rate of harm-free care.	CQC data requirements	CQC data requirements.	CQC data requirements.	CQC data requirements.
	Ad hoc case note review, e.g. children's safeguarding.	Ad hoc case note reviews take place 'infrequent' in typical GP practices.	SIR can be interrogated by public health e.g. diagnosis of malnutrition. NB. Use of this slightly limited- cannot access certain areas such as mental health and sexual health as not included in consent process. Selective case note review for suicides, RCA in infection control outbreaks, social services incidents, serious case reviews.	Case note review would take place for all safeguarding incidents, jointly by CCG and SCC.	Ad hoc case note review.

	SRFT	*Salford CCG/Primary care*	*Salford City Council (including public health and social care)*	*Care Homes sector*	*Greater Manchester Mental Health*
Reliability	CQC data. National clinical audits (approx. 30-40) Local audits (approx. 80) Peer review in some specialities.	CQC data. Audit used as one of the methods for monitoring performance against the Salford Standard. Includes local and national audits as well as Data Quality Team audits.	- Audits form the main backbone of quality assurance in children's services. All internal services will do this. External commissioned services are required by contract to do audits but these are not reported centrally. Public Health have access to anonymised GP data via FARSITE.	CQC data. All CHs required to carry out audits and are asked for evidence of them. However, quality and consistency varies.	CQC data Audit. National and clinical audits monitored through the audit calendar e.g. Ligature audits
	KPIs- captured by SRFT and fed to CCG, CQUINs Measures range from handwashing audits and completion of falls risk assessments to the use of care bundles and tools such as the medicines safety thermometer. Performance measures via PRODACAPO, e.g. cancer waits, appointment targets. QI data for prioritised QI projects. QI dashboard presented to board monthly.	Integrated Care System (ICS) dashboard, developed by CCG and SCC business intelligence, pools performance data from whole health and care system for strategic use by ICS leadership. Salford Standard- a comprehensive list of KPIs monitored by the CCG team via dedicated dashboard. Includes monitoring method and set timescales. Alerts triggered if thresholds not met. Domains include medicines optimisation, safeguarding, patient safety and experience and access. Spot checks and audits feed into this. Standards reports- e.g. Key Therapeutic Topic Comparator Practice table. Data updated monthly via ePACT, reported to practices quarterly. Based on NICE guidance. Shared care monitoring- example of process measure. CQUINs e.g. medicines reconciliation, admissions and coding. NHS England performance metrics around GP practices. High level indicators measuring safety in primary care, e.g. prescribing.	Public Health work to numerous KPIs, monitored monthly. Performance measures in ICS dashboard (see across). Locality Plan dashboard developed jointly by CCG and SCC business intelligence provides e.g. public health performance data to Transformation Steering Group which is system-wide. Performance measures within: • Quarterly and annual Salford Safeguarding Children's Board performance reports (an independent statutory board) • Quarterly and annual Salford Safeguarding Adults Board (now an independent statutory board) • Quarterly Salford Children and Young people's Trust performance report Salford Community Safety Partnership New commissioning framework will capture KPIs, activity, quality outcomes, standards and audit schedule This will now be written into all contracts held by SCC, provided by SRFT.	Suite of standards being developed for care homes as part of new commissioning arrangements. Example of process reliability measure would be Intentional Rounding adopted by Salford CCG. Care homes Quality Assessment Framework- self assessment tool sits in Covalent- SCC's performance management software	Monitoring of standard risk assessments, e.g. STAR risk assessment tool, FRAMP, MUST, Waterlow (where required), early warning scores. KPIs and CQUINs monitored by the Performance Group which supports reporting to the CCG and NHS England. KPIs and CQUINs are reported in the Monthly Board Performance Report
	Waterlow score Early Warning Score (EWS) Falls Risk Assessment Tool (FRAT) Medicines Reconciliation	Medicines reviews	Falls risk assessment Care needs assessment	Falls risk assessment	Falls risk assessment Medicines reconciliation
	Evidence of care bundles by way of Advancing Quality initiatives. Never events	-	-	-	Completion of the quality safety metrics, which covers: PMVA, Physical Health, care planning, mental health act and risk assessments.

	SRFT	*Salford CCG/Primary care*	*Salford City Council (including public health and social care)*	*Care Homes sector*	*Greater Manchester Mental Health*
Sensitivity to operations	Bi-weekly senior nurse walk-arounds happen in acute. Less robust in community. Safety huddles used routinely in acute and adult community. Handovers - crucial to safety but "an area where mistakes can often be made. A robust handover system, observed by all, is crucial." Day-to-day conversations. Operational and clinical meetings at a range of levels. NAAS, CAAS, OPAAS. Provides sensitivity to operations but also aims to spread best practice. CQC assessment/self-assessments. Complaints. Patient satisfaction survey, patient stories, 'talking mats', friends and family test. Staff survey- sensitive and highlights issues, e.g. 'Do you feel the Trust's top priority is safety?'	CCG carry out routine practice visits but also some of the above KPIs are monitored by spot checks. Not commonplace in GP practices. Locally, handovers from GP to GP e.g. holidays. Standard procedure would depend on practice. Day-to day unstructured conversations. Quality strategy includes various groups/forums which support intelligence, e.g. Monthly quality & contracts meetings, commissioner walk rounds, quality and safety, programme management group. Incident review meetings. Monthly GP neighbourhood meetings provide a forum for sharing learning and discussing issues.. Practice meetings are dependent on practice as to frequency, format, clinical/operational. Pharmacy technicians, working out in practices to a fixed work programme provide "soft" intelligence to CCG where problems exist. Complaints. Quality Strategy includes several engagement systems, e.g. Patient Panel Events, focus groups, surveys. Friends and family test- practices can add own questions.	Director of social care will meet with Assistant Directors and visit certain services as and when required. In adults and children's social care 1:1 meetings and/or supervision sessions. Day-to day unstructured conversations on case work etc. Team meetings and management meetings. Data gathered for CQC inspection and CQC Care In a Place review. Complaints. Adult social care and User survey and Carers' survey contain some safety questions, e.g. "Do you feel safe?" and "As a result of the service, do you feel safe?" Users and carers are involved in their assessment and support planning production (where appropriate). Various service user and carers groups. User Development workers.	Senior walk arounds not commonplace and not part of care home culture. Quality of handovers varies from home to home. Staff may be seen as complacent where actually processes just don't exist. Any adult safeguarding concerns involving care homes come to CCG safeguarding team, either directly or from CQC. The safeguarding team relies on "soft" intelligence around issues with care homes, workers, managers, etc., to support other data Operational meetings, handovers, debriefings and service user meetings are all things that should happen but is very variable and can be changeable. Complaints. See CCG and SCC entries.	Senior managers walk the wards at Meadowbrook and Woodlands (Salford units) weekly . 15 Steps walk around challenge as part of the Quality Matters agenda, this covers 4 ward areas each month. Safety huddles take place on one of the Woodlands wards with plans to roll this out across the unit. Unstructured conversations form part of clinical discussions on the wards and intelligence from incident reporting Operational and clinical meetings at a range of levels which report to the senior leadership team. Weekly Senior Leadership Team meeting and each service has a weekly senior management team meeting to cascade the information from Senior Leadership Team. Operationally there are daily board rounds. Complaints Inpatient complete survey on discharge and agenda item on SLT. "You said we did" posters. Friends and Family Tests in community services. Salford MATS survey. Within inpatient settings SafeWards is being embedded, this supports service user and staff meetings. Service users are asked for their feedback in a variety of ways: post episode of care, friends and family test, service user experience questionnaires. Picker staff survey.

	SRFT	*Salford CCG and Primary care*	*Salford City Council (including public health and social care)*	*Care Homes sector*	*Greater Manchester Mental Health*
Anticipation and preparedness	Risk assurance framework embedded across organisation.	Covalent risk management software used by BI team to monitor risks against CCG work streams but this is not the same as monitoring the risk registers of all GP practices. Access standard within Salford Standard, CCG monitors practice capacity via 'mystery shopper' audit. Also feeds into GP dashboard. Risk registers not typically used in GP practices.	SCC use a system called CareFirst to manage/log all risk assessments and incident reports in social services. Annual Governance Statement. Corporate Strategic Risk register, RAG rated, quarterly updates. Individual service group Risk Registers; Specific projects will have risk logs/registers etc. Risk assessment used in all social work assessment and supporting planning processes (operational delivery).	Risk registers- again, variable. Some of the larger CHs might use risk registers.	Risk assurance framework embedded in the organisation
	NEWS scores Waterlow scores Falls risk assessment carried out within 6 hours of admission Risks pull through to status monitors on wards to ensure appropriate measures always taken, e.g. sepsis red flag.	-	Level of care determined by initial risk assessment. Paper-based falls risk assessment completed as part of section 2 assessment only.	Care Homes practice carries out falls risk assessment	STAR (mental health specific screening tool) completed on all admissions within 12 hours. Falls risk assessment (FRAMP) completed within 3 days of admission. Monitoring of malnutrition.
	Monitoring of mandatory training and appraisal. Some FMEA work done by QI team but ad-hoc. Performance team collect data around access, beds and capacity. Trendcare - Patient Acuity and Workload Management Clinical Utilization Review tool -to help make sure that patients are in the most appropriate place for the level of care that they need. 4 hour A&E wait time can essentially be used as a measure of flow across the whole system as any blockages can ultimately impact on this. Monitoring of mandatory training via Snowdrop.	Access to GP monitored via access KPI in Salford Standard but does not provide a reliable measure of flow. Bed availability is reported by hospitals to GPs at times of increased pressure, e.g. winter. Flow measures will be reported system wide via ICS dashboard.	Monitor corporately and within service groups: Staff absence information, and where necessary staff vacancies and/or turnover rates etc.	Staffing levels can be monitored by CCG if there is a suggestion that there are not enough staff or high incidence of unwitnessed falls. CQC places requirements around staffing levels and appropriateness of staffing on providers. CCG can request copies of duty rotas and do unannounced visits if concerns raised. Most providers train via e-learning due to cost implications. Quality of training could be improved greatly.	Learning from RCA/fishbone tool. Monitoring of mandatory training via the Learning Hub. Reports generated regarding safe staffing by business intelligence, this is collated from information received by nursing teams and discussed in the Directorate Management Board and Workforce Committee. Daily reports sent to district bed managers/on call managers to show availability of beds across the district services.
	Uses Pascale Metrics safety culture tool with teams across the organisation but not mandatory.	Safety culture surveys not standard practice.	Safety culture surveys not standard practice.	Safety culture surveys not standard practice.	Safety culture surveys not standard practice. .

	SRFT	*Salford CCG/Primary care*	*Salford City Council (including public health and social care)*	*Care Homes sector*	*Greater Manchester Mental Health*
Integration and learning	Dashboard to Board of Directors from QI subdivided into acute and community and includes mortality data, safety thermometer data, patient satisfaction and staff satisfaction using SCP, where appropriate. QI dashboard model = primary generic high level dashboard provides health check over organization. Secondary dashboard provides specific information around live projects. Separate Board of Directors performance dashboard covers a wide range of metrics including: Mortality, safe staffing, cancer waits and even financial performance. Patient Experience, Patient Responsiveness and Adverse Events & Risk Management Report gives overview of numbers of incidents reported and complaints.	Access to GP dashboard, standards reports and SMASH. How GP dashboard used locally depends on practice. Practices RAG rated against Salford Standard. Action plans required when thresholds not met.	SCC corporate performance report - quarterly, focusing on key performance measures for each service group area, RAG rated, with action plans on an exception only basis. Some service groups also have a range of internal performance reporting processes, e.g. Children's safeguarding. Specific performance reporting for the Integrated Care Programme – Older People (with SRFT and Salford CCG); Input to Salford's Better Care Fund quarterly reporting (jointly with Salford CCG). 2 dashboards in particular are due to come online: Locality Plan dashboard, Integrated care system dashboard. Both currently in development and both intended for use at strategic level.	CCG safeguarding dashboard used by safeguarding team. Provide quarterly report to CQC. The dashboard might trigger actions and safeguarding team will look for trends and combine with intelligence from CQC. E.g. of action would be concerns meeting comprising CCG, SCC, CQC and the provider.	Dashboards are to be launched as part of the Quality matters workstream. Data provided to the Trust Board through the Monthly Performance Board Report to provide a health balance of the organisation.
	Feedback systems for DATIX are service dependant but a copy of final DATIX outcome goes to reporter. Worth bearing in mind that DATIX sometimes seen as a chore or submitted with intention of personal assurance rather than to create learning opportunities.	All DATIX goes through to CCG who produce a report to go out to all GP practices. These might then be discussed at 'neighbourhood' meetings.	Data in incident reports is very qualitative and individual reports can be interrogated as and when necessary but not really able to look at data trends, have overview. All integration and learning specific to individual services.	Feedback on incidents depends on provider's own system.	Incident reporting via DATIX investigated by root cause analysis. Trends and theme reports are presented at the Quality Governance Committee for cascade through management lines and shared with the CCG through the Performance & Quality Groups.
	6 monthly newsletter on SUIs. NAAS, CAAS, OPAAS used to spread best practice. CQC assessments are RAG rated and include action plans, as do NAAS/CAAS assessments. Joint health and safety committees with trade unions.	GP monthly newsletter is main communication stream from CCG to practices. Central alerting system- drug alerts direct to GPs. Safeguarding Boards. The Case Review functions of both the Children's and Adult's Safeguarding Boards ensure that relevant cases are reviewed, practice changes required are identified and that the resultant recommendations are fully implemented. Neighbourhood meetings are a potential forum for safety discussions between practices.	Annual report on adult social care. Risk awareness tool used in adult social care. Complaints/Compliments to Scrutiny Committee. Joint health and safety committees with the trade unions.	Information and best practice sharing can occur via the Safeguarding Provider Forum. CCG might then provide training but this is limited due to resources. Adult safeguarding board publishes an annual report, available online.	Incident feedback through MDT. Positive Lessons Learned events, Positive learning events feedback templates to PIR panel team meeting, splash screens, quarterly lessons learnt newsletter. High level summary of incidents reported through Quality Governance Committee. NRLS 6 monthly reports. Mental health benchmarking data set Host North West Mental Health Benchmarking group to share learning, new ways of working

Glossary

CAAS Community Assessment and Accreditation System

KPIs Key Performance Indicators

CQUIN Commissioning for Quality and Innovation

CQC Care Quality Commission

CDOP Child Death Overview Panel

FRAMP, Falls Risk Assessment and Management Plan

MATS Memory Assessment and Treatment Service

MUST Malnutrition Universal Screening Tool

MDT Multidisciplinary Team

NAAS Nursing Assessment and Accreditation System

NEWS National Early Warning Score

NRLS National Reporting and Learning System

PMVA Prevention Management of Violence and Aggression

PIR Post Infection Review

OPAAS Out Patient Assessment and Accreditation System

QI Quality improvement

QOF Quality and Outcomes Framework

RAG Red Amber Green rating

RCA Root Cause Analysis

RIDDOR Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

SCC Salford City Council

SIR Salford Integrated Record

SPC Statistical process control

SRFT Salford Royal Foundation Trust

Acknowledgements

The following people kindly gave their time and contributed to this document:

- SRFT: Siobhan Moran, Assistant Director Quality Improvement; Paul Dodd, Head of Risk Management; Liam Doyle, Quality Improvement Lead; Helen Carter, Corporate Matron; Steven Boyd, Children's Services Matron; Sarah Morrissey, End of Life Care Facilitator; Palliative Care Team
- Salford CCG: Chris Tyson, Business Intelligence Manager; Claire Vaughan, Head of Medicines Management; Jacquie Purser, Head of Continuing Care and Funded Nursing Care; Liz Walton, Designated Nurse for Safeguarding Adults; Dr Jeremy Tankel, GP/Safer Salford Board, Mhairi Yates, GP
- Salford City Council: Jennifer McGovern, Assistant Director, Integrated Commissioning; Debbie Blackburn, Head of Public Health; Alan Bunting, Head of Business Intelligence, Performance and Change; Sarah Cannon, Public Health Manager.
- Greater Manchester Mental Health: Miranda Washington, Deputy Director of Performance & Service Development, Karen Clancy, Deputy Director of Clinical Governance, Alison Chapman, Interim Business Intelligence and Performance Manager.

Safer Intelligence

Safer Salford