

Box 2

Case study: Using the framework in practice

University College London NHS Hospitals Foundation Trust is using the framework to reflect on their approach to measuring and monitoring patient safety. The Trust initially completed a review of their approach using the case study template that we had developed in the course of our research to assess the five framework dimensions.

The review by the hospital showed a strong focus on measuring past harm and reliability, together with evidence of good practice in the sensitivity to operations dimension. For example, the Chairman and Chief Nurse hold coffee mornings with ward sisters to elicit information on safety. Posing the question to ward staff ‘what safety issues keep you awake at night?’ on executive walk-rounds led to problems being identified. These were then fed into the organisations formal safety monitoring processes and were considered alongside other data at the Quality and Safety Committee meeting. The dimensions anticipation and preparedness, and integration and learning were less mature. For example, human reliability analysis, regular safety culture surveys and safety cases were not embedded. Feeding back lessons learnt from safety measurement and monitoring data to frontline clinical teams was also an area for improvement.

The measurement and monitoring framework was then introduced to UCLH board members using a training session scheduled before a monthly board meeting. Board members were sent the Measurement and Monitoring of Safety summary report, together with case study material relating to the BP Deepwater Horizon incident. The case study data illustrated the pitfalls for boards of focusing on certain metrics, (i.e. lost time injury rates), and not seeking assurance that risks on a risk register were being mitigated. Providing a non-healthcare example enabled the board to reflect on their own approach to measuring and monitoring safety: They were able to extrapolate learning points from the case study into a healthcare context.

In the session board members were asked to identify gaps in the hospital's processes. The session was therefore used as a Board-level organisational check to identify the strengths and weaknesses in the current safety measurement and monitoring approach. Feedback from board members was very positive. The ten guiding principles resonated with board members who reflected on the dangers of perverse incentives, fragmentation of safety information and the importance of data integration.

The framework has since been used to underpin the Trust's Patient Safety Strategy to create a more balanced approach to safety measurement and monitoring. In particular the Trust has strengthened the integration and feedback of safety information to clinical teams and is developing more indices of anticipation and preparedness. For example, safety cases will be used to empower clinical teams to identify safety critical task steps and processes.

The Chief Nurse has used the framework as the basis for developing a ward-level care thermometer which combines input, process, outcome and patient experience data and examines the relationships between them:

- (i) Input –staffing; percentage time out (i.e. annual leave, maternity leave etc...), temporary staff usage (anticipation and preparedness of the staffing and skill mix on a ward)
- (ii) Input- process of care; including the percentage of patients getting enough help with their meals, vital sign observations completed and hand hygiene compliance (reliability measures)
- (iii) Outcome- incidence of harm; including percentage of patients who experience harm free care, falls with harm, pressure ulcers and preventable dose omissions (past harm).
- (iv) Outcome –patient experience; using complaints and friends and family test data (past harm {including psychological as well as physical harm} and sensitivity to operations, respectively).

The care thermometer is used to identify 'worry wards', the aim being to identify wards that are struggling and to intervene before a serious incident occurs (anticipation and preparedness). The care thermometer is fed back to ward sisters and is an example of how different measures can be combined to support integration and learning.

The Trust also used the framework as the foundation for the Risk Team's recent away-day. This led to the identification of perverse incentives that may have been created in some areas and to recognition that 'integration and learning' is the main area where the Risk Team needs to improve how it does things. An action plan for the coming year was developed which included improving aggregation of data from claims, complaints and incidents, and improving the approach to checking recommendations from serious incident reports have been sustained.