Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Learning From Incidents

Tony Gray
Head of Safety and Security

Shining a light on the future

Background and Context

NTW FT reports a significant number of incidents and one of the highest in Mental Health and Learning Disability Services in the UK. Last year we reported more than 32,000 incidents within the Trust. This has increased by 2,000 incidents each year within the organisation. Most incidents are reported by in-patient services.

Previous national, historical information indicated that we have reported more medication incidents in a data period than all the GP practices in England.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.'

(NRLS Organisation Patient Safety reports, March 2013)

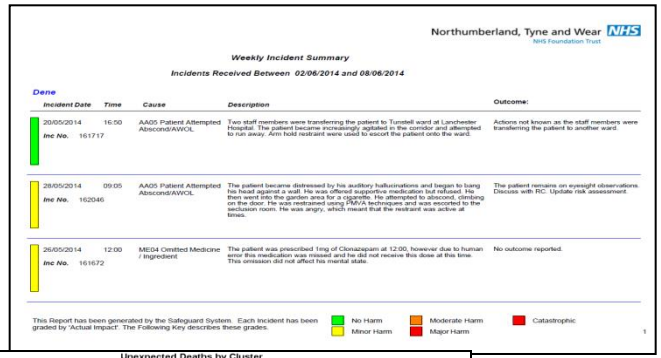
Northumberland, Tyne and Wear NHS
NHS Foundation Trust

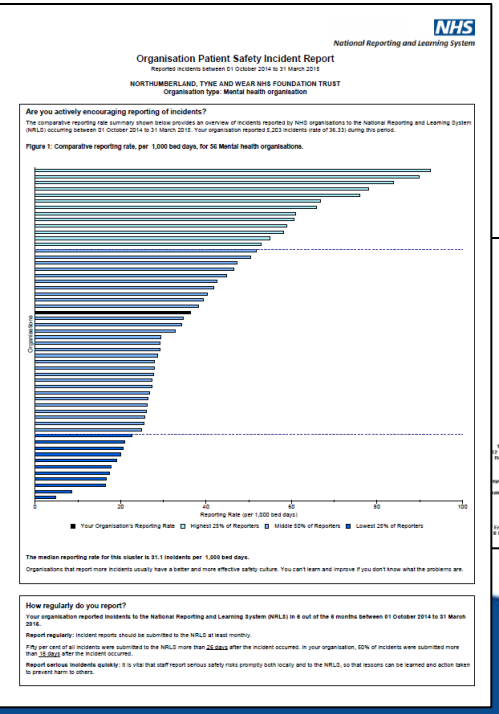
What do we do with the information (the presumed black hole!)

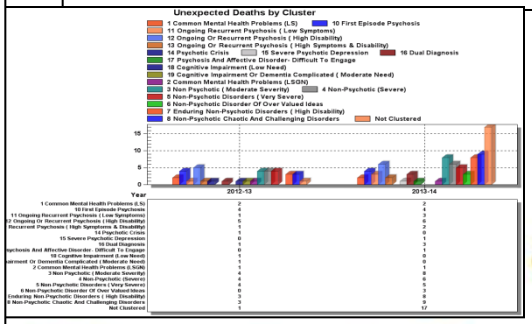
- 35,000 electronic scheduled reports every year
- Currently produces information for the clinical dashboards
- Identifies serious incidents and complaints in the

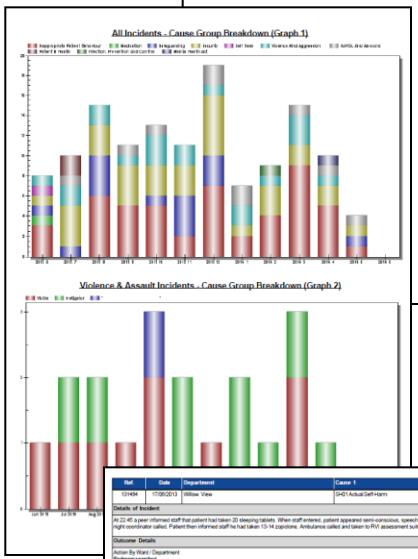
Individual dashboards, for revalidation purposes.

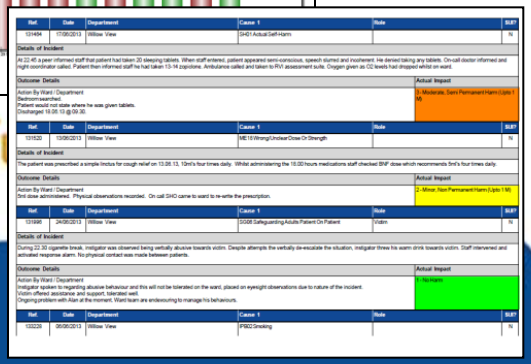
- Reports produced on request for individual patients.
- Produce information for the Board and members of the Public
- Click here and here











a light on the f

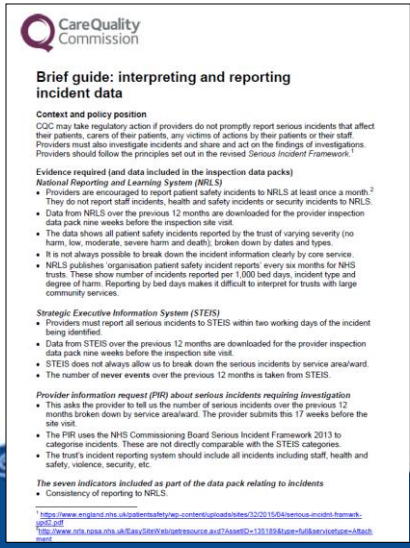
Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Serious Incident Activity

Of the 32,000+ incidents reported, approximately 150 per year are classified as serious incidents, with the majority being unexpected community deaths.

As part of recent Care Quality Commission (CQC) inspection there was robust scrutiny of the processes of reporting, investigation , learning and improvement in relation to incidents, with a significant number of data requests relating to serious incident activity , including activity reported through to STEIS (Strategic Executive Information Systems) and the National Reporting and Learning System.

The Trust had already reviewed the CQC guidance – relating to interpreting and reporting incident data issued in February 2016 available here


CareQuality Commission

Brief guide: interpreting and reporting incident data

Context and policy position

CQC may take regulatory action if providers do not promptly report serious incidents that affect their patients, carers of their patients, any victims of actions by their patients or their staff. Providers must also investigate incidents and share and act on the findings of investigations. Providers should follow the principles set out in the revised *Serious Incident Framework*.[1]

Evidence required (and data included in the inspection data packs)

National Reporting and Learning System (NRLS)

- Providers are encouraged to report patient safety incidents to NRLS at least once a month.[2] They do not report staff incidents, health and safety incidents or security incidents to NRLS.
- Data from NRLS over the previous 12 months are downloaded for the provider inspection data pack nine weeks before the inspection site visit.
- The data shows all patient safety incidents reported by the trust of varying severity (no harm, low, moderate, severe harm and death); broken down by dates and types.
- It is not always possible to break down the incident information clearly by core service.
- NRLS publishes 'organisation patient safety incident reports' every six months for NHS trusts. These show number of incidents reported per 1,000 bed days, incident type and degree of harm. Reporting by bed days makes it difficult to interpret for trusts with large community services.

Strategic Executive Information System (STEIS)

- Providers must report all serious incidents to STEIS within two working days of the incident being identified.
- Data from STEIS over the previous 12 months are downloaded for the provider inspection data pack nine weeks before the inspection site visit.
- STEIS does not always allow us to break down the serious incidents by service area/ward.
- The number of **never events** over the previous 12 months is taken from STEIS.

Provider information request (PIR) about serious incidents requiring investigation

- This asks the provider to tell us the number of serious incidents over the previous 12 months broken down by service area/ward. The provider submits this 17 weeks before the site visit.
- The PIR uses the NHS Commissioning Board Serious Incident Framework 2013 to categorise incidents. These are not directly comparable with the STEIS categories.
- The trust's incident reporting system should include all incidents including staff, health and safety, violence, security, etc.

The seven indicators included as part of the data pack relating to incidents

- Consistency of reporting to NRLS.

[1] https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incdnt-framwrk-upd2.pdf
[2] http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=135189&type=full&servicetype=Attachment

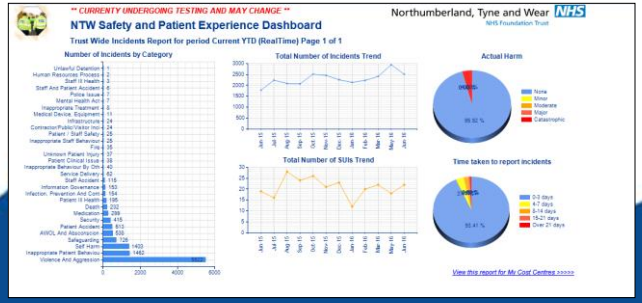
Shining a light on the future

Serious Incident Review Process

- **Incident Occurs.**
- **Incident reported.**
- **Consideration of Safety Alerts through CAS system for wide dissemination, within minutes or hours of incident occurring.**
- **Weekly update to Nursing, Medical and Group Directors of Incidents, Complaints, Safeguarding activity and any other concerns.**
- **Safety Messages in Chief Executive Bulletin.**
- **Serious Incident investigated by dedicated serious incident investigators.**
- **After Action Review, clinical reflection by the team – not debrief.**
- **Serious Incident – Multi-disciplinary panel every week, with Commissioner involvement, chaired by senior Medic or Nurse**
- **Smart actions with clinical service in attendance, including further alerts if required.**
- **Over-sight by Trust-wide Patient Safety Group**

Development work currently underway with Clinical Leadership

- Development of more meaningful Clinical Dashboards, with live data.
- Interactive for clinicians around specific patient risk.
- Exploration of incident data live upload to clinical record.
- Development of tailored reports for clinical teams in line with Talk First – Positive and Safe Strategy.
- Constant communications with other Mental Health and Learning Disability organisations to share learning and spread practice.
- Can we standardise and have one standard incident system?
- Can we standardise and have one standard policy and process?
- CQC Death review, are we the same , are we different, why are we different, can we benchmark? , what is the standard?
- Learning from national work relating to Physical Interventions.



Shining a light on the future

Case Vignette

- Patient A had been admitted to an acute admission ward informally, but continued to deteriorate and was detained under a section 3 of the Mental Health Act.
- Patient A had a diagnosis of Bi-polar affective disorder.
- Patient A had a history of use of alcohol and illicit substances, and was consuming these whilst on leave from the ward.
- Patient A became unwell and vomited the previous evening, but self reported due to consuming soft drinks too quickly. (another patient vomited also).
- Patient A was observed throughout the night, with no concern.
- Patient A found dead in bed the following morning.
- Incident subject to formal Police investigation for potential crime, and associated safeguarding issues.
- Incident subject to media attention and also at Coroner Inquest.

Initial Learning

- Significant use of alcohol and drugs by patients.
- Police investigation relating to death on the ward and also safeguarding concerns around vulnerability.
- Other patients either supplying or consuming drugs as well.
- Acknowledgment of limited means of prevention / detection of true picture of drug use / risk on wards.
- Drugs brought onto ward by patients, visitors, family members.
- Limited support by Police Search Dog teams due to capacity.
- Limitations in effectiveness of Observation and Engagement at night in line with policy in place at the time.
- Recognition for clinical teams to understand physical health issues relating to substance misuse.

Actions from Learning

- Business Case and implementation of Trust Search Dog and Handler
- Robust Search training carried out with in-patient services to standards of Forensic services.
- Awareness of drugs / legal highs training carried out by Trust Search Dog Handler.
- First conversations around need for Liaison role with Police.
- Complete culture change from Police around support. Development of Officers based on Hospital sites to deal with crimes and support.
- Review and changes to Observation Policy, including training for all clinicians on observation at night.
- Detailed summary in the form of witness testimony to Coroner of actions and improvements made, negated the need for a Rule 43 (Regulation 28 – Prevention of Future Death Report).
- Coroner outcome recorded as misadventure, however this doesn't mean that improvements weren't necessary, learning not focused on coroner outcome.

Current Risk (Organisation with a Memory)

- No further deaths on in-patient wards since incident, however deaths relating to drugs in Community still high.
- Substance misuse on the increase locally and nationally.
- Psychoactive Substances Act 2016 came into force on 26th May 2016.
- Safety Message to communicate standards last week of May 2016.
- NPS / Legal Highs captured as a separate incident, so we can respond immediately to low level activity to prevent more serious incidents.
- Trust Search Dog Handler, receives daily reports from clinical teams and responds to support teams , and liaise with Police for actions and improvements including where necessary prosecutions for supply.
- Awareness sessions still carried out with new clinicians, as national picture continually changes, as drugs become illegal.
- Alerts around drug risk communicated through CAS system when alerted by Drug Agencies / Police etc.

Lesson Learnt – Risk still present, being managed.

Thank You

Questions