NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETTING

Meeting Date: 27 April 2016

Title and Author of Paper: Safety Report - January – March 2016
Author of Paper in response to this report – Tony Gray - Head of Safety & Security
Dr Damian Robinson – Group Medical Director

Paper for Debate, Decision or Information: Information

Key Points to Note:

- In line with the previously agreed schedule, this is the final quarterly safety report, and from now on the schedule for reporting on Safety and Unexpected Deaths will follow the timeframes below.

Unexpected Death report	April
Safety Report including all incident activity	July
Unexpected Death report	October (to include annual comparison against National Confidential Inquiry into Homicide and Suicide)
Safety Report including all incident activity	January

- In order to complete the current reporting cycle, and implement the start of the new cycle, it is necessary for the Board of Directors to receive both the Quarter 4 - Safety Report, and the Unexpected Death report at Board in April 2016
- Representative from the Safety Team will be attending an event on 21st April 2016 hosted by Tees, Esk and Wear Valleys NHS Foundation Trust, and facilitated by Mazars, in relation to the findings and learning from the report into Southern Health NHS Foundation Trust. The outcomes of which will feed into the Trust's Morbidity and Mortality Group.
- The Trust is also actively involved in the Learning Disability Mortality Review Programme (LeDeR), and this will also feed into the Trust's Morbidity and Mortality Group. More information is available here.
- The Trust has been informed of a formal review to be carried out by the Care Quality Commission into how all Mental Health and Learning Disability trusts investigate and learn from deaths. More information is available here. The Board of Directors will be kept up to date through the Safety Report and Unexpected Death report updates on a quarterly basis.
- The Trust's Incident Policy NTW(O) 05 has been reviewed and is now available to all staff, this will be subject to further review and changes, following completion of all of the above work.
- Information Included in the Learning section of the report includes the new "Learning from Mistakes League" in which the Trust is at position 44, and rated as good, out of a total of 230 Trusts.
- Information now included in this report relating to the Positive and Safe Strategy in respect of reporting of activity of Physical Interventions.

Outcome required: Information

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

Safety Report
April 2016
Reporting Period – January - March 2016

NHS
LEARNING FROM MISTAKES LEAGUE
Good

Shining a light on the future

Introduction

This is the Safety Report for the reporting period January – March 2016, but will all give the Board of Directors an end of year review of incident reporting for the full period April 2015 – March 2016.

Incident Reporting within Northumberland Tyne and Wear NHS Foundation Trust

The Corporate Decisions Team - Quality Sub Group, has now taken over its responsibility around reviewing the safety systems of the Trust, and the safety function is now fully embedded into the Nursing Directorate at the end of 2015. One of the immediate priorities was to re-draft the Trust's Incident Policy NTW(O)05, this has now been re-written, consulted on, approved and disseminated, and the changes are currently being implemented. The Executive Director of Nursing and Operations has overseen the changes in line with agreed changes identified by the Chief Executive. A lot of information has been removed from this policy, including a number of outdated appendices, which has reduced the policy and supporting practice guidance notes by 80 pages. This policy is now fully inclusive of the NHS England Serious Incident Framework – March 2015, and reflects the practice, the Trust that has had in place since this document was first published.

This report is written to give the Board of Directors an update on the current position of incident reporting for all incidents and the most serious incidents.

Incident Activity & Analysis

All Incidents

At the end of the last financial year the Trust had reported 31,904 incidents, this is an increase of 677 incidents on the previous year and the highest reported in any year for NTW. This should be seen as a positive generally, given the full and completed implementation of the web based incident reporting system was completed throughout this year. As part of the web based implementation it has been possible to provide direct access to incident guidance at the point of reporting around definitions of serious incidents, responsibilities in relation to Duty of Candour for managers and practitioners.

All incidents are immediately notified to managers and specialists at the point of reporting to allow for immediate action and support.

Table 1 – All Incident Activity

Year	January - March	+/- on previous period	Number Of incidents Annual	+/- Year on Year
11/12	6369	-	26338	-
12/13	7547	+1,178	29111	+2,773
13/14	7472	-75	30507	+1,396
14/15	8050	+578	31227	+720
15/16	7185	-865	31904	+677

The Safety Team continue to work with clinical and operational services to improve the quality of what has been reported and make some minor changes as part of the learning from the project.

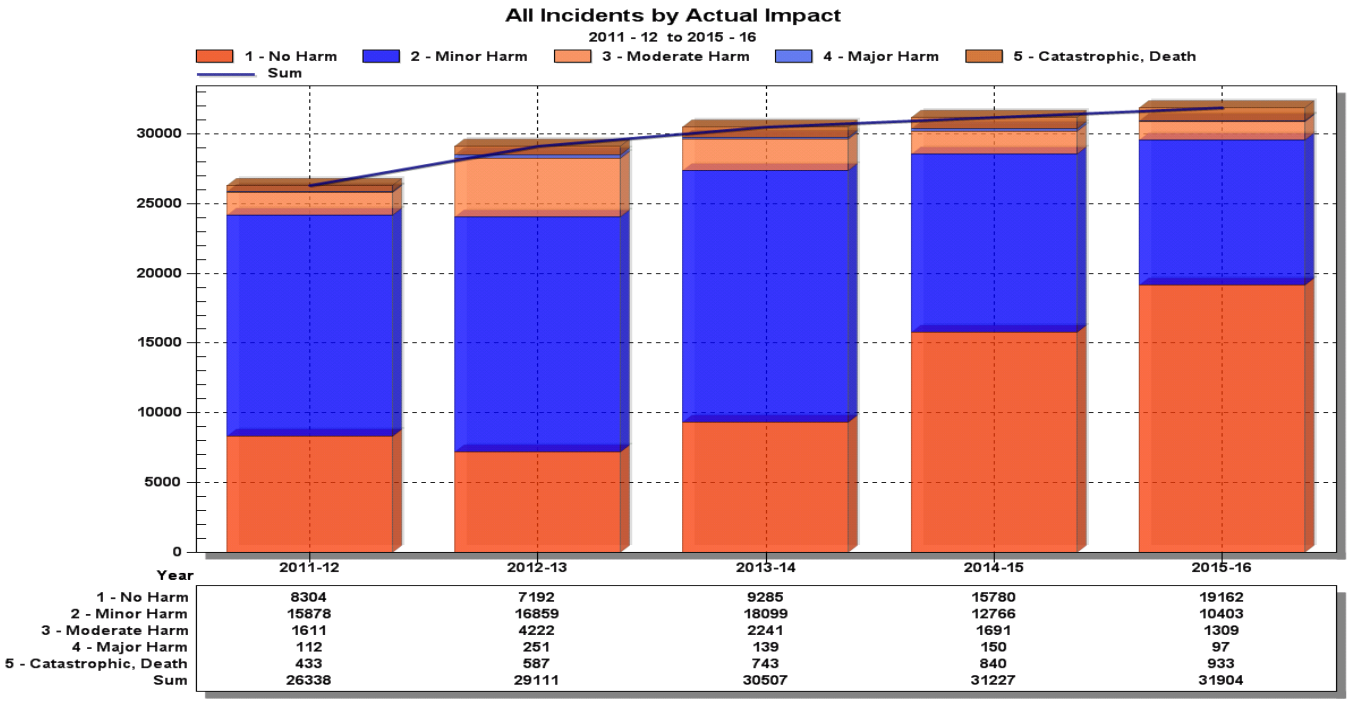
Serious Incidents

Table 2 –Serious Incident Activity

Year	January - March	+/- on previous period	Number Of Serious incidents Annual	+/- Year on Year
11/12	38	-	119	-
12/13	39	+1	127	+8
13/14	30	-9	159	+32
14/15	27	-3	118	-41
15/16	46	+19	186	+68

All Incident Activity

Graph 1: All Incidents by Actual Impact – Data Period - April 2010 – March 2016



While an overall high reporting picture is indicative of a good safety culture, the desired configuration is one of high reporting with declining levels of harm over time, especially in terms of moderate, severe and catastrophic impact. In the above graph catastrophic death incidents, also include those where the Trust has been notified by services / relatives that the patient has died naturally.

In reviewing the above information it can be seen that whilst overall incident reporting is increasing, the moderate and major incidents have reduced year on year, whilst catastrophic death incidents have increased, this is inclusive of all deaths reported, not just those that have been classified as serious.

More work on the approach to this level of reporting will be considered in line with the national review being carried out by the Care Quality Commission , and any outcomes from the analysis of the Mazars report and national Leder programme mentioned previously.

The information below breaks down all incident activity into the types of incidents reported, the picture of incident reporting is changing in trend due to the implementation of the web based reporting, this is due to a number of reasons as below:-

- Timeliness of reporting, reports such as these, if produced close to the data period, would now be accurate based on activity that has been reported as there is no lag in data input from paper to electronic incident system as it is now all electronic input, i.e. this report includes information that was submitted the day prior to the generation of the report, previously before web based reporting, it would have not included incidents up to 10 working days before with the exception of serious incidents.
- Types of incidents may change over time as reporters now have access to the system direct and can choose the incident category to accurately reflect what they are reporting, there are over 400+ types of incidents under the categories below.
- This may be evident in the data below for some of the significant changes such as safeguarding, unknown patient injury, inappropriate patient behaviour etc.

The number of deaths shown in the table above includes expected deaths, which are not under coronial investigation. A detailed breakdown on unexpected and natural deaths is reported separately to the Board of Directors by the Group / Deputy Medical Director (Safety).

The data below tells a number of things as follows:-

- There is a direct correlation between violence and aggression and self harm, for a number of patients receiving services, the approaches to manage this activity and reduce or mitigate the impact are built into the positive and safe strategy in place within the Trust. The positive aspect of this is the majority of these incidents are low harm, due to the care plans and interventions of staff supporting the most complex patients in the Trust. We can see from other reports such as the physical assault on staff report that a lot of the activity is generated by a small number of patients in a small number of services.
- Some types of incidents have naturally increased due to staff knowing fully what to report as the web system gives them further help and clarity, and staff may have identified the correct categorisation of incident.

Table 3 – Quarterly Comparison of all incidents by incident type

January – March 2015		January - March 2016		+ / -
Cause Group		**Cause Group**		
Aggression And Violence	2957	Aggression And Violence	2652	-305
AWOL And Abscond	193	AWOL And Abscond	184	+9
Contractor/Public/Visitor Incident	8	Contractor/Public/Visitor Incident	5	-3
Death	239	Death	245	+6
Fire	30	Fire	32	+2
Human Resources Process	1		0	-1
Inappropriate Behaviour By Others	5	Inappropriate Behaviour By Others	12	+7
Inappropriate Patient Behaviour	542	Inappropriate Patient Behaviour	467	-75
Inappropriate Staff Behaviour	13	Inappropriate Staff Behaviour	26	+13
Inappropriate Treatment	2	Inappropriate Treatment	3	+1
Infection, Prevention And Control	30	Infection, Prevention And Control	43	+13
Information Governance	95	Information Governance	140	+45
Infrastructure	24	Infrastructure	18	-6
Medical Device, Equipment	12	Medical Device, Equipment	5	-7
Medication	221	Medication	224	-3
Mental Health Act	13	Mental Health Act	7	-6
Patient / Staff Safety	7	Patient / Staff Safety	10	+3
Patient Accident	707	Patient Accident	403	-304
Patient Clinical Issue	7	Patient Clinical Issue	27	+20
Patient Ill Health	315	Patient Ill Health	190	-125
Police Issue	3	Police Issue	10	+7
Pressure Ulcer Inside NTW	0	Pressure Ulcer Inside NTW	11	+11
Pressure Ulcer Outside NTW	0	Pressure Ulcer Outside NTW	6	+6
Safeguarding	731	Safeguarding	748	+17
Security	601	Security	424	-177
Self Harm	1084	Self Harm	1072	-12
Service Delivery	32	Service Delivery	48	+377
Staff Accident	168	Staff Accident	115	-53
Staff And Patient Accident	2	Staff And Patient Accident	4	+2
Staff Ill Health	5	Staff Ill Health	5	0
Unknown Patient Injury	3	Unknown Patient Injury	46	+46
Unlawful Detention	0	Unlawful Detention	3	+3
	8050		**7185**	**-865**

Serious Incidents

The following table indicates the number of serious incidents reported annually.

Table 4 – Annual Comparison of all serious incidents by incident type

Number of serious incidents reported annually	2013-14	2014-15	2015-16
Aggression And Violence	8	2	9
AWOL And Abscond	3	1	2
Death	105	95	136
Fire	0	0	3
Inappropriate Treatment	2	2	2
Information Governance	4	1	1
Infrastructure	1	1	3
Medication	0	0	1
Patient Accident	20	9	12
Patient Ill Health	1	0	3
Safeguarding	1	1	0
Security	0	0	1
Self Harm	14	6	13
Totals	**159**	**118**	**186**

Table 5 – Quarterly Comparison of all serious incidents by incident type

Number of Serious Incidents reported in the period January - March	2014	2015	2016
AA09 Absented Themselves From Hospitals	1	0	0
AA10 Absented Themselves During Escorted Leave	0	1	1
DE01 Unexpected Death	18	14	12
DE08 Unexpected Death - Natural Causes	0	2	0
DE18 Unexpected Death Local AAR	0	7	19
F01 Actual Fire - Patient Area	0	0	2
IG03 Breach Of Patient Confidentiality	1	0	0
IT04 16-17 Admitted To Adult Ward	1	0	0
PA04 Patient Fall From Height	1	0	0
PA26 Fracture Neck Of Femur	4	1	3
PI01 Unexpected Deterioration In Health	0	0	1
S23 Weapon Discovered/Found	0	0	1
SH01 Actual Self Harm	2	1	5
SH02 Attempted Suicide	0	1	0
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	1	0	1
V03 Physical Assault Of Patient By Patient	1	0	0
V36 Aggressive Behaviour To Staff	0	0	1
AA09 Absented Themselves From Hospitals	1	0	0
Totals	**31**	**27**	**46**

In the above table the changes to the types of investigations carried out into unexpected deaths can clearly be seen, with 19 deaths reported subject to an After Action Review only for 2016

compared with 7 the previous period. This was following discussion with Directors, the Trust will still obtain 24 hour reports in order to ensure compliance with our Duty of Candour responsibilities and to ensure that families, carers and staff are supported after the incident. These deaths will no longer be reported as a patient safety incidents through the National Reporting and Learning System.

The following table indicates the Coroner Conclusion (Outcomes) for the unexpected deaths reported over the last quarter, in comparison to previous years. More information relating to this is provided in the Unexpected Death report presented to Board of Directors separately.

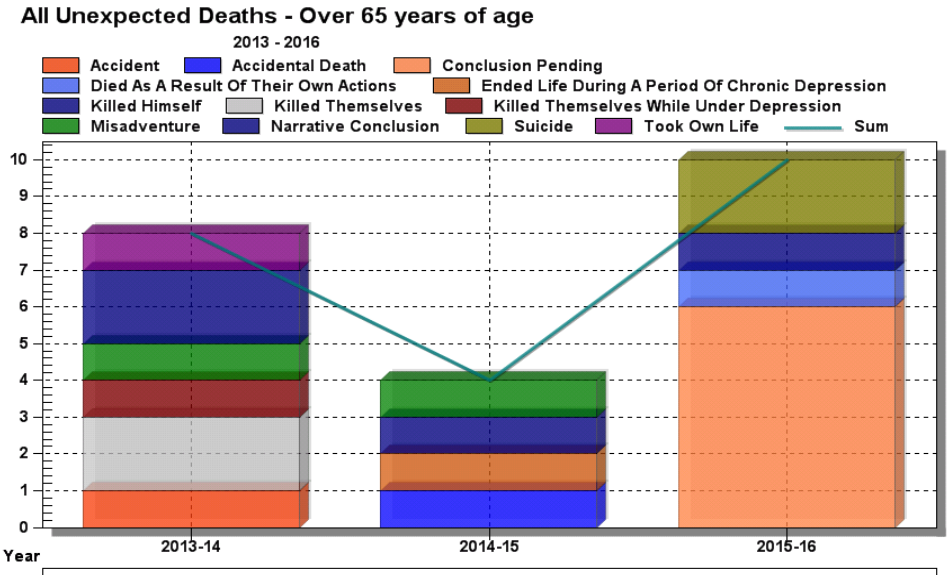
Table 6 – Quarterly Comparison of all Unexpected Death by Coroner Conclusion

Coroner Conclusion January - March	2014	2015	2016
Accident	1	0	0
Accidental Overdose Of Drugs	1	0	0
Combined Effects Of Alcohol And Prescribed Medication	1	0	0
Conclusion Pending	0	2	31
Drug Related Death	1	5	0
Drug/alcohol Related Death	1	0	0
Killed Herself	1	0	0
Misadventure	6	7	0
Narrative Conclusion	2	2	0
Open Conclusion	3	1	0
Suicide	1	4	0
Accident	1	0	0
Accidental Overdose Of Drugs	1	0	0
Combined Effects Of Alcohol And Prescribed Medication	1	0	0
Totals	**26**	**24**	**31**

Whilst the full unexpected death report, completes the full analysis to highlight any areas of concern over time. It has been previously agreed to report on the following areas relating to unexpected deaths:-

- Unexpected deaths relating to self harm / cause unknown in over 65's.
- Unexpected deaths relating to Crisis and Home Treatment Services.
- Unexpected deaths relating to Addictions Services.
- Unexpected deaths relating to recent discharge from In-Patient Services.

Graph 2: Unexpected Deaths (Older People – Over 65) – Data Period – 2013 - 2016

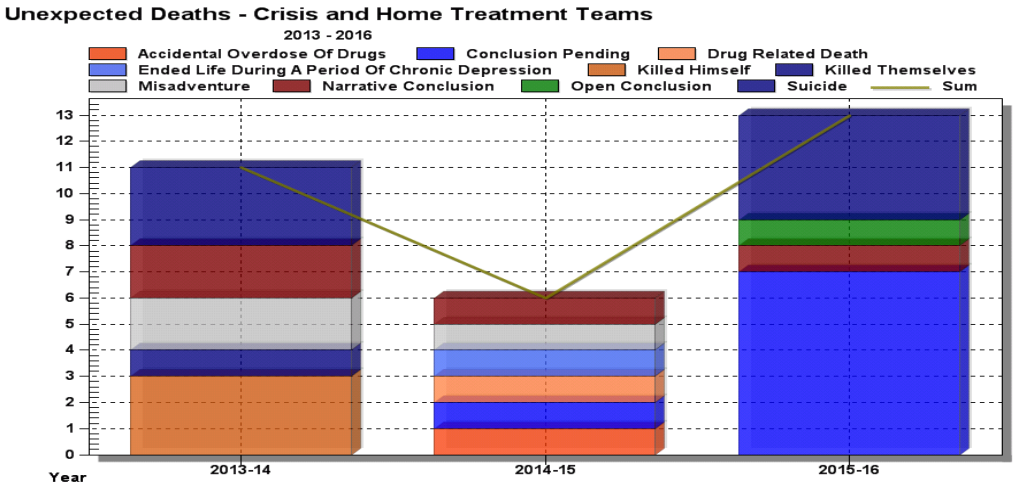


Year	2013-14	2014-15	2015-16
Accident	1	0	0
Accidental Death	0	1	0
Conclusion Pending	0	0	6
Died As A Result Of Their Own Actions	0	0	1
Ended Life During A Period Of Chronic Depression	0	1	0
Killed Himself	0	1	0
Killed Themselves	2	0	0
Killed Themselves While Under Depression	1	0	0
Misadventure	1	1	0
Narrative Conclusion	2	0	1
Suicide	0	0	2
Took Own Life	1	0	0
Sum	8	4	10

Following an increase in unexpected deaths for those over 65 years of age in 2013 / 14, this area has been monitored continuously. The increase in activity in 2015 /1 6 relates to local AAR of unexpected physical health related deaths, in line with the new serious incident framework, in which it has been agreed by Directors to review these incidents, it can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths, this activity will continue to be reported on.

Graph 3: Unexpected Deaths – Crisis Resolution & Home Treatment Team - Data Period – 2013 - 2016

The following graph gives the breakdown for the period and the increase previously identified in 2013 / 14, which reduced in 2014 / 15, has increased again in 2015 / 16 , information for this area, has been provided to the crisis team to carry out their own review into these incidents.
It can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths, this activity will continue to be reported on.

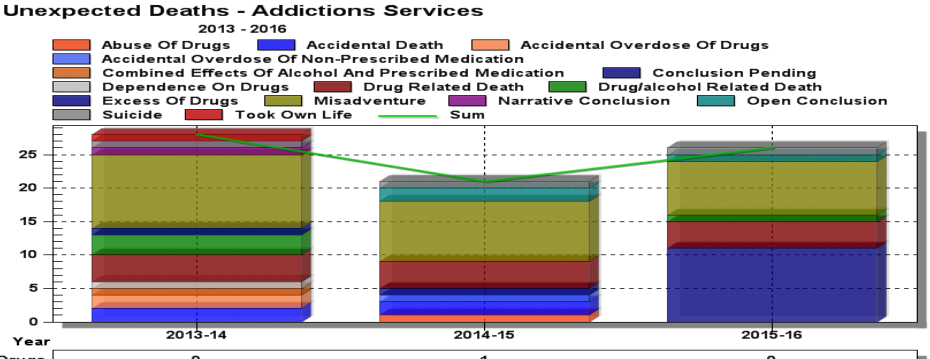


Year	2013-14	2014-15	2015-16
Accidental Overdose Of Drugs	0	1	0
Conclusion Pending	0	1	7
Drug Related Death	0	1	0
Ended Life During A Period Of Chronic Depression	0	1	0
Killed Himself	3	0	0
Killed Themselves	1	0	0
Misadventure	2	1	0
Narrative Conclusion	2	1	1
Open Conclusion	0	0	1
Suicide	3	0	4
Sum	11	6	13

Graph 4: Unexpected Deaths – Addictions Services - Data Period – 2013 – 2016.

The following graph gives a breakdown of the unexpected deaths in the period.

With revised governance systems now in place the activity of addictions services has been kept under constant review, in line with the Trust increase in 2015 /16, activity has increased in this area. It can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths, this activity will continue to be reported on.

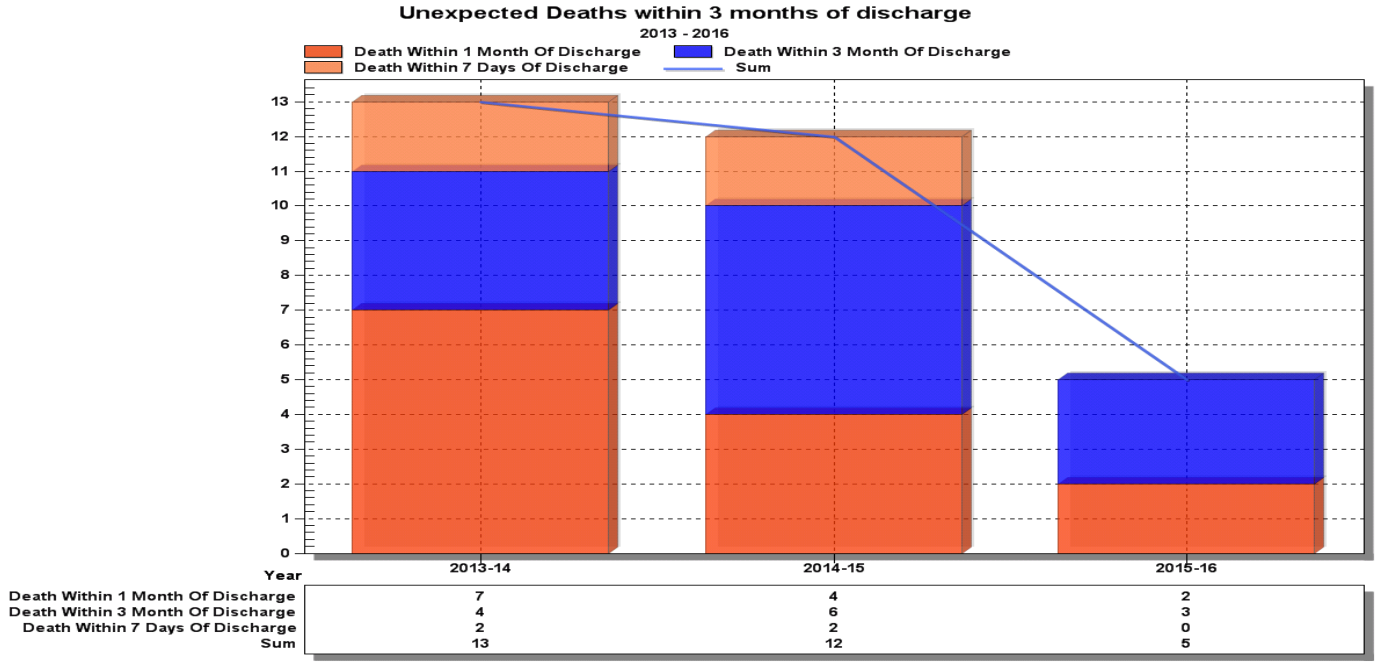


Year	2013-14	2014-15	2015-16
Abuse Of Drugs	0	1	0
Accidental Death	2	2	0
Accidental Overdose Of Drugs	2	0	0
Accidental Overdose Of Non-Prescribed Medication	0	1	0
Combined Effects Of Alcohol And Prescribed Medication	1	0	0
Conclusion Pending	0	1	11
Dependence On Drugs	1	0	0
Drug Related Death	4	4	4
Drug/alcohol Related Death	3	0	1
Excess Of Drugs	1	0	0
Misadventure	11	9	8
Narrative Conclusion	1	0	0
Open Conclusion	0	2	1
Suicide	1	1	1
Took Own Life	1	0	0
Sum	28	21	26

Graph 5: Unexpected Deaths with a recent discharge from In-Patient Services - Data Period – 2013 – 2016.

The following graph gives a breakdown of the unexpected deaths in the period.

We know that the period after discharge from in-patient services is a time of high risk. This graph shows that there has been 12 serious incidents reported in 2014 /15 in comparison to the 13 reported in 2013 / 14. The Transition protocol has been implemented to improve the transfer of care from hospital into community and this area of care will receive continuing close scrutiny. At the end of 2015 / 16, 5 incidents have been reported which is an improvement on the previous 2 years.



Serious Incident Reviews

Over the last three years the following number of reviews was carried out, on the basis that there has been an increase in serious incidents there is a natural need to increase the number of reviews to ensure timely reflection of each case.

Table 7

Number of serious incidents reviewed	Jan – March 14	Jan – March 15	Jan – March 16
	33	15	26

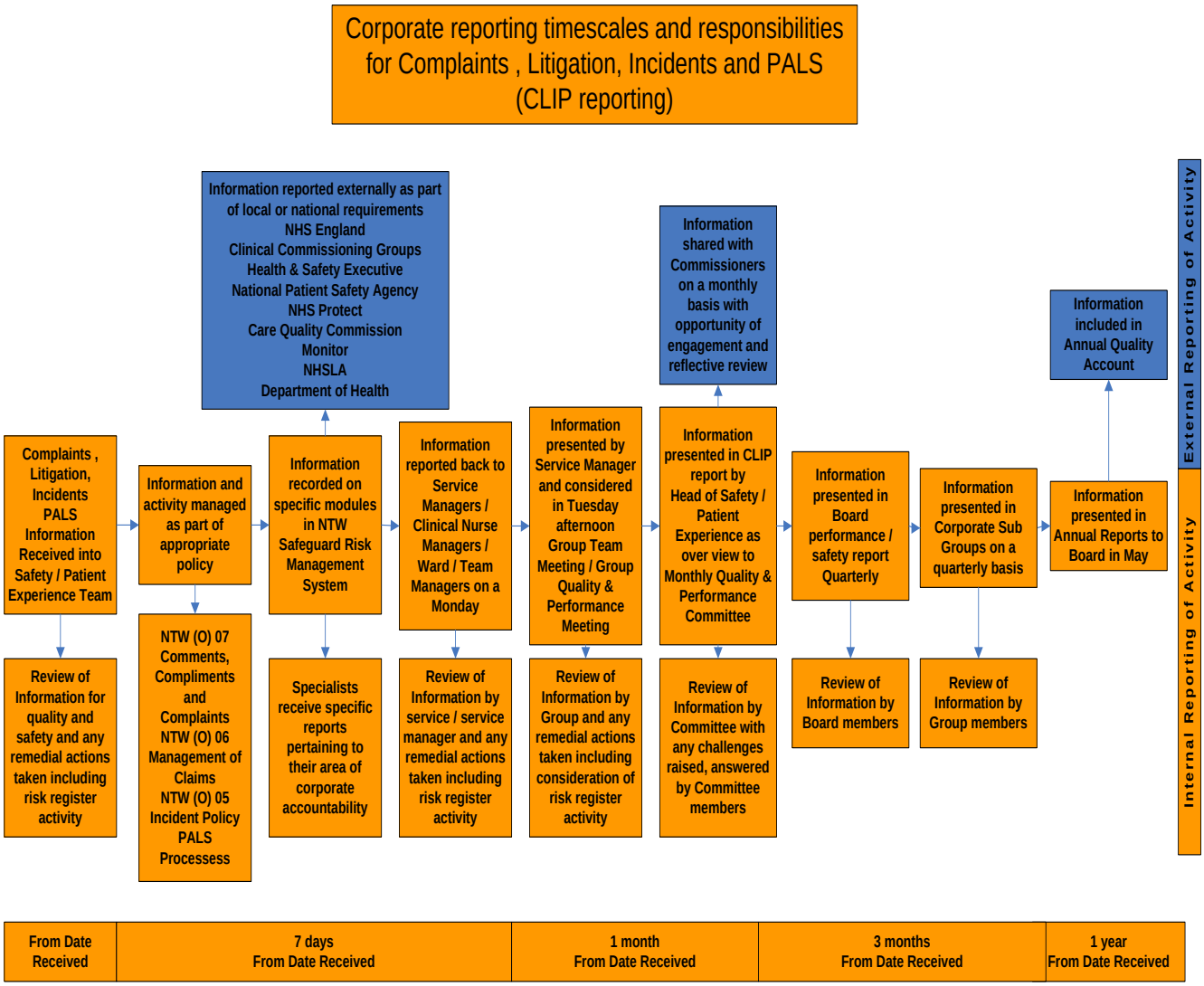
Whilst the number of reviewed incidents has reduced, this is in line with the reduction in the need for serious incidents to be reviewed by the full panel, many are completed with the local after action review only, and any supplementary actions picked up by individual services.

In order to maintain a robust serious incident investigation process, there are 7 dedicated serious incident investigators. Having this direct control allows for greater planning relating to the management review of serious incidents. Serious incidents are investigated and reviewed by the serious incident panel which meets weekly, and the Panel has coped with the demands of more incident reviews. As reported through the Trust's Patient Safety Group, the Serious

Incident Review Process is now regularly seeing incidents reviewed within the 60 day timescale, and this process has been supported by the dedicated team of investigators.
At the last update for the Patient Safety Group the average timescale for review was 78 working days, this is currently being looked at by the Patient Safety Team to improve this position to ensure that the incident investigations are completed in the 60 working day timescale in line with Clinical Commissioning Group and Serious Incident Framework requirements.

Identification of issues and Learning from Incidents

When activity is reported, in line with Trust policies, the learning from incidents occurs at different stages depending on the context and severity of incidents, the following chart gives an indication of the processes in place from the first 24 hours up to a full year review of incident activity, some based on review of 1 incident and annually more globally in comparison to year on year activity and in line with national reports and information.



Following this process, it can be seen how the Trust has implemented a number of activities to evaluate whether policies are working as intended to keep people safe and improve quality and safety of care. It is worthwhile mapping out the process when an incident occurs:-

Learning within 24 Hours

- The incident is reported through the web based interface in the majority of incidents within the Trust. The only incidents that occur are those that have been reported to the Trust directly from a Coroner's Officer prior to the team being informed, this only occurs for about 50 incidents out of 31,000 per year. This allows managers and any specialists who need to be notified that an incident has occurred.
- The nature of the incident will directly impact on the follow up action, for example a serious incident of unexpected death in Community Services, the immediate action is through our Duty of Candour processes, support families, carers and staff to come to terms with the loss, and support any agencies that are currently involved to understand the circumstances. However if there has been an in-patient unexpected death greater level of support may be required due to ongoing Police and possible Health & Safety Executive investigations.
- Within the first 24 hours, systems should have been stabilised, an assessment will have been carried out of whether there is a need to urgently communicate across the Trust through the Central Alert System, to inform other services of the risk of the incident re-occurring, there may be a consideration of creating a new risk through the risk management processes of the Trust. For any serious incident the service team are required to complete a 24 hour report, this indicates what they have done, who they have supported, how our responsibilities under Duty of Candour have been fulfilled. This report is sent to Group Directors so they are fully briefed about the incident.
- For any other incident managers will provide an update as they authorise the web based incident and submit it within the system, this provides assurances that all incidents within the Trust are being considered by managers, and appropriate action being taken, this is also an opportunity to see which patients may need more clinical support on in-patient wards, this is important as this is where 98% of the Trust's activity originates, and it is well recognised both locally and nationally that over 30% of this activity relates to aggression and violence.
- As part of immediate actions managers in partnership with the Safety Team of the Trust, can decide that it is important to cascade an outcome of the incident to other areas and teams. Examples of these alerts , are included in the Safety Messages section, but can also include CAS alerts to cover the following areas:-
    1. Any new type of illicit substance / Novel Psychoactive Substance (legal high) that is currently circulating and the risks they pose.
    2. Any new type of ligature risk following a self harm episode, with advice / guidance and support.
    3. Issues to do with clinical practice following the review of an incident or number of incidents.
    4. Clarification to clinical teams about standards and practice where it is found that clinical standards have not been complied with i.e. observation, seclusion etc.
    5. Standardisation of incident collection, in order to inform other agencies of risks such as ambulance delays etc.

Learning within 7 days

- Reports are produced for clinical teams relating to all their incidents and disseminated by the electronic risk management system on a Monday morning, this gives managers an insight to the incidents that have occurred in the previous week in their services, so they can look for trends or increases in their activity.
- Every Friday the Trust's serious incidents, safeguarding issues, complaints and complex clinical issues are discussed with the Group Directors and the Executive Director of Nursing at the Group Business Meeting. The same information has been shared electronically and anonymously with operational leads, so teams are aware of the types of serious incidents and complaints that have occurred within the Trust.
- The same reports are shared with the Operational Groups, so the focus is then on their own activity and any initial concerns can be discussed and shared with the Service / Directorate Managers.
- Investigations for serious incidents commence and plans for After Action Reviews start to take place, to inform of other team focussed issues.

Learning within 1 month

- Serious incident investigations and After Action Reviews will be well underway, with teams considering local learning after reflection, at any point to this learning CAS alerts or Safety Messages can be sent out.
- Every month reports are produced that highlights the Trust activity from individual teams and clinical groups that are considered through the Clinical Groups Quality and Performance processes, as well as corporately through the Trust's Board Sub Committees such as Quality and Performance, this allows a monthly reflection , and a discussion around trends acknowledging that the detail and outcomes of incidents , complaints and claims may not be known at this stage.
- The Trust's Corporate Decisions Team, sub group that looks at quality, will review any significant issues arising from the Trust's activity.

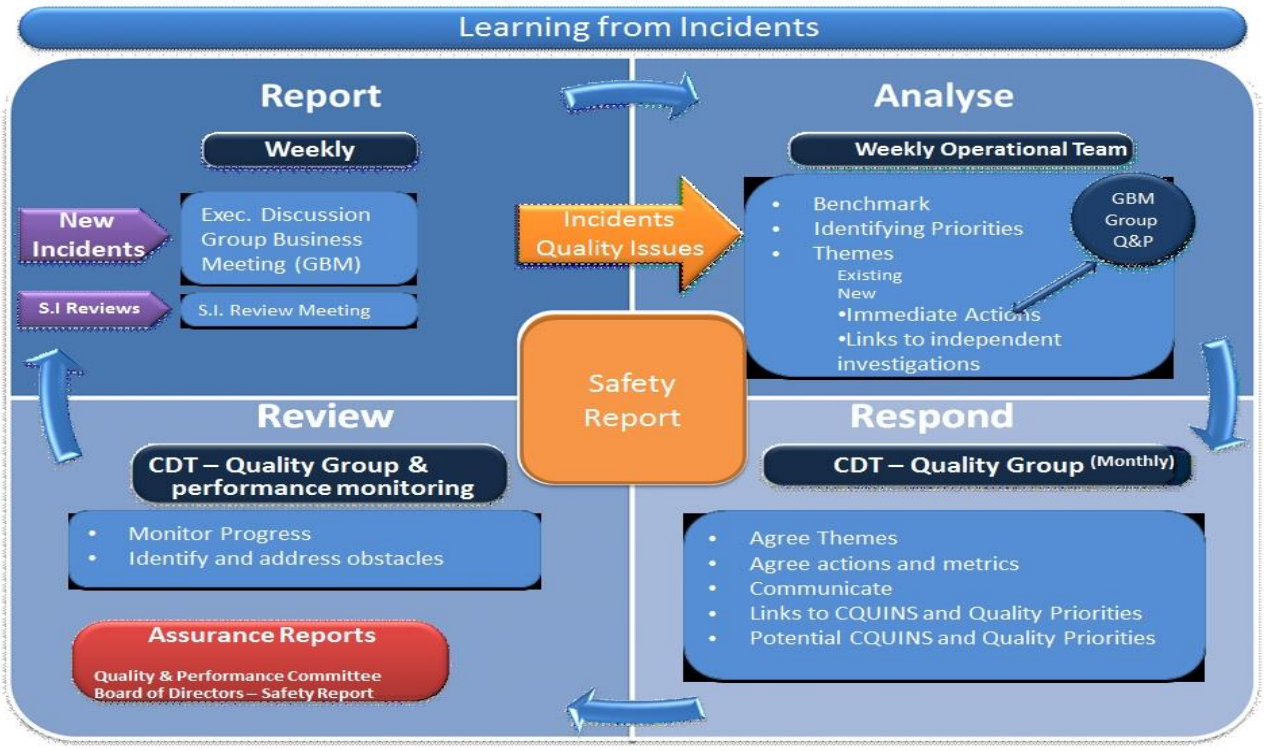
Learning within 1 – 3 months

- Many serious incidents and complaints investigations will be completed, with information fed back to families and carers, relating to the outcomes of the investigations. Action Plans will have been created and action will be actively managed within the services, along with discussions with Directors about the opportunities for improvements.
- Corporate meetings will have considered quarterly updates around incident activity in line with their terms of reference, such as Health , Safety and Security reviewing the physical assaults on staff, and other security related incidents. Medical Devices, Infection, Prevention and Control, Seclusion, Management of Violence and Aggression groups will also consider their specific incident information and consider any changes to policy and practice required.
- The Board of Directors receive this report, which outlines the activity for the last period, acknowledging the systems and processes in place within the Trust, and an update around increases or decreases to specific serious incident activity over the last quarter , but also with a longer look back of 5, 3 and 2 years specific to historical data.

Learning annually

- The Trust considers its activity in line with national data such as the National Reporting Learning System, with reports produced by the North East Quality Observatory every year and presented to the Quality and Performance Committee, this compares, loosely the activity of the Trust in comparison to other Trust's in the Mental Health Cluster.
- The Trust provides and update on the annual figures of Reported Physical Assaults in the month of January to the Board of Directors, so the Board can assess and understand the Trust's activity in respect of similar sized Trust's and understand why the Trust reports the high level of activity it has.
- The Board of Directors receives and annual report in respect of Security Management , to understand the types of security incidents the Trust gets exposed to and the role of the Local Security Management Specialists in aiming prevent and deter further incident activity, utilising such things as CCTV, Security Systems, Lone Working Devices etc.
- The Quality and Performance Committee receives annual information relating to Claims and benchmarking from the National Health Litigation Service, relating to the Trust's Claims profile.
- The Quality and Performance Committee receives annual information relating to the Parliamentary Health Service Ombudsman reported and investigated complaints, with detail around whether they have independently upheld complaints received.
- The Trust reflects on its incident activity in its annual quality account received by all members of the Trust, to review the culture of reporting. This allows for independent scrutiny from external stakeholders.

All of the above information and learning that takes place at every level, allows the external Commissioners to be assured that we have robust systems in place for reflection and learning, and the necessary improvements to quality and safety of care.
The following chart indicates visually the learning systems following the path of incidents and complaints.



Learning From Mistakes League

NHS trusts and foundation trusts will be publically ranked on their openness and transparency under a new 'Learning from mistakes league' launched by Monitor and the NHS TDA (now NHS Improvement) from March 2016.

Data for 2015/16 – which is drawn from the 2015 NHS staff survey and from the National Reporting and Learning System (NRLS) – shows that:

- 18 providers were outstanding
- 102 were good
- 78 gave cause for significant concern
- 32 had a poor reporting culture

The league table has been drawn together by giving providers scores based on the fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice and the percentage of staff who feel able to contribute towards improvements at their trust.

NHS Improvement (which will bring together Monitor, the NHS TDA, the NRLS and the Patient Safety Team) will work with providers at the bottom of the league to assist them with improving their openness and transparency.

Mike Durkin, National Patient Safety Director at NHS England said:

Learning from mistakes saves lives. In order to properly learn from mistakes we need to create a culture with openness and transparency at its heart.

By letting trusts know how well they are doing compared with their peers, we want to start a conversation involving clinicians, managers and supporters of the NHS about what we can all do to make all parts of the NHS as safe as they can be.

One of the most important duties of us all as clinicians, managers and supporters of the NHS is to cultivate an environment in which learning is at the heart of all we do. This goes far beyond education and training, important as they both are; and it can all too easily be forgotten as we wrestle with the day-to-day challenges of providing care.

We would like all providers to reflect on the data. We know that data cannot ever tell the whole story, and that is true even of data that is rooted in the insights of staff. But it can start a discussion, and, yes, a process of learning.

In that spirit, we are keen to emphasise that this is a first attempt at a 'Learning from mistakes league'. We also want to learn and improve, and would be open to suggestions from colleagues about how we might make this better in future.

Professor Sir Mike Richards, Care Quality Commission's (CQC) Chief Inspector of Hospitals said:

We welcome this new commitment to embedding an open and learning culture in NHS hospitals. There can be no improvement without real transparency on performance combined with the desire to understand and learn from the resulting information.

CQC will support this commitment by assessing Trusts' learning culture as part of our 'well-led' domain, using information from the NHS Staff Survey on openness and learning, combined with information from NRLS.

Northumberland , Tyne & Wear NHS Foundation Trust is currently rated at position 44 out of a possible 230 Trusts and rated as good.

NHS

LEARNING FROM MISTAKES LEAGUE

The rankings are as follows:

1 – **outstanding levels** of openness and transparency

2 – **good** levels of openness and transparency

3 – **significant concerns** about openness and transparency

4 – **poor reporting culture**

Issues Identified from Serious Incident Panels following review throughout Quarter 4.

Issues can be defined through review of incidents, complaints or from other sources of information, judged to be a suitable areas for improvement actions, which can potentially lead to quality and safety improvements.

Throughout 2015/ 16 the Serious Incident Panel members have taken the Quarter 4 incidents that occurred between October – December and were reviewed between January - March and have broken down the specific incident issues.

There are a number of recurring issues that have emerged in incident reviews, however it must be noted that these have not been seen in all incident reviews, and many serious incident reviews do not identify any concerns with the care and treatment. Sometimes the only findings are that the care and treatment was timely and appropriate and in line with Trust policy and processes but sadly still resulted in a negative outcome. All issues where improvements need to be made are included in the action plans of each serious incident which are owned by the service and quality checked for action and closure by the specific clinical groups' governance groups and by the Trust's Patient Safety Group prior to being sent to the Clinical Commissioning Group for closure.

There were 26 serious incidents reviewed for Quarter 4 of the year. It is important not to consider that this is a physical position of risk for the Trust, and that any of these issues directly impacted on the outcome, indeed many of these issues occurred in the patients care, a significant time prior to the incident so wouldn't be considered as root causes, and it also needs to be put into context that the Trust's serious incident activity is a small component of the actual contacts with patients. , The Trust has 40,000 patient contacts at any one time and sees, over 80,000 patients every year, resulting in over 250,000 contacts with those patients.

It is also important to note that any reduction in serious incidents may well magnify specific issues if they are only identified in a small number of reviewed incidents.

For quarter 4 reviews out of the 26 serious incidents there were 10 key areas where issues were identified as below:-

- All Aspects of Clinical Care
- Communication
- Falls
- Good Practice Noted
- Incidents with External Issues
- Medicines Management
- Record Keeping
- Risk Assessment and Management
- Safeguarding
- Staffing Levels

All Aspects of Clinical Treatment

All aspects of clinical treatment was an issue in 13 of the 26 serious incidents, the issues identified are as follows 3 relating to care planning, 5 relating to access to clinical information, 5 relating to clinical decision making, 2 relating to family involvement, 1 issue relating to transitions and 1 issue relating to training. All actions relating to improvements are picked up through individual action plans for the services.

Communication

There were 11 of the 26 serious incidents in the quarter with issues that relate to communication. 7 issues relate to poor communication within the Trust, 4 issues relate to communications with GP's, 2 issues identified issues in relation to family contact, 1 issue relates to a patient having difficulty contacting Trust services. 2 issues relate to poor communications from other organisations. All actions relating to improvements are picked up through individual action plans for the services.

Falls

The Trust continues to monitor the management of falls in line with the Falls Policy, fractured neck of femurs as serious incidents increased for the first time in 2015 / 16, increasing by 2 from the previous year for a total of 9 incidents. There were 3 incidents out of 26 relating to falls / fractures and the issues all relate to clinical compliance with the Trust Falls Policy, some of the issues relate to post incident actions so would not have prevented the fall. All actions relating to improvements are picked up through individual action plans for the services.

Good / Appropriate Practice

Good / appropriate practice was noted in 1 of the 26 serious incidents reviewed which resulted in no further actions for the services that provided the care.

Incidents with External Issues

There were 4 of the 26 serious incidents with external issues, these related to working in partnership with the Police and GPs. All actions relating to improvements are picked up through individual action plans for the services.

Individual Practice Issues

There were no individual practice issues identified in the 26 serious incidents.

Medicines Management

There were 6 out of 26 incidents where medicines management issues were identified and appropriately addressed, the pharmacist who is a member of the serious incident panel supports the clinical team with improvements and carries out actions in building learning into the Medicines Management Newsletter. All actions relating to improvements are picked up through individual action plans for the services.

Record Keeping

There were 18 out of 26 incidents where record keeping was identified as an issue. This is 3 more than the highest number reported in 2015 to 2016. The issues covered a number of points

in record keeping including completing and updating the core document including “Getting to know you”, core assessment, risk assessment and consent.
The area of historical risk information being removed from the record occurred on 2 occasions and this issue will be incorporated into the roll out of the trust wide clinical risk training. This has also been raised by team mangers via clinical supervision to assure the panel that robust mechanisms are in place to ensure that appropriate action is taken to raise standards.
The groups have in place lessons learned or reflective practice forums to continue to raise the concern that staff record keeping standards need to be maintained in line with Trust policies and professional bodies’ guidance. The lack of updating of records and recording of clinical decision making is not specific to any team but adherence to standards is expected and should be supported by Group leads. All actions relating to improvements are picked up through individual action plans for the services.

Risk Assessment and Management

Risk assessment and management issues is always likely to feature in incident reviews and improvements, given the difficulty of predicting risk, and the dynamic nature in each patients care, this issue featured in 14 out of 26 incidents, of these 3 issues related to risk management plans, 1 issue related to pressure ulcer risk assessment, 2 issues related to historical risk, the other issues related to the quality of the risk assessment. It is widely acknowledged the difficulty both in local and national investigation reports of fully mitigating this issue when providing care to complex patients who are high violence or suicide risk. All actions relating to improvements are picked up through individual action plans for the services.

Safeguarding

Safeguarding was identified in 2 out of the 26 incidents where safeguarding was an issue relating to non-reporting of safeguarding incidents, whilst across all reporting safeguarding is relatively stable as a reporting activity. All actions relating to improvements are picked up through individual action plans for the services.

Staffing levels

Staffing levels was identified in 3 out of 26 incidents, due to the level of vacancies within the Trust and nationally, this is always likely to figure as an issue, but the Trust continues to centrally recruit to all required vacancies. All actions relating to improvements are picked up through individual action plans for the services.

Independent Investigations Summary

Reported on separately to the Board of Directors

Sign up to Safety

The Sign up to Safety Campaign provides a platform for Northumberland, Tyne and Wear NHS Foundation Trust’s (NTW) patient safety improvement initiatives. The vulnerable groups that NTW serves include: people with mental health needs and learning disabilities, and sometimes acutely ill older people who have both physical and mental health problems. The initiatives outlined in this plan were selected from an examination of themes identified within the previous NTW Safety Programme. The following are the key stakeholders within the Safety Improvement Plan:

- Executive Lead: Chair of Corporate Decision Team – Quality Sub Group
- Members of Corporate Decision Team – Quality Sub Group
- Sign up to Safety Leads within NTW's Safety Team.
- Members of Group Business meeting

Sign Up to Safety Improvement Plan

The Sign Up to Safety Improvement Plan offers the opportunity to be proactive and identify 'gaps' in safety before they occur. NHS Trusts collect data which highlights what works well and what has not gone to plan, but this is after an incident has happened and is therefore a reactive approach to patient safety. NTW will be reviewing its current Serious Incident process, in line with the NHS England Serious Incident Framework (2015).
The trust already has a track record of adapting the principles of continuous improvement to implement transformational change; the plan, do, study, act (PDSA) cycle is another simple, yet proactive methodology which can equip frontline staff to try out small improved ways of filling the safety gaps before they occur and then measuring what difference has been made in reducing avoidable harm. Improvement skills required by all staff are shown in Appendix 1.
The NTW Sign Up to Safety Improvement Plan attempts to bring both approaches – the collection of data, including the review of the serious incident process, and improvement methodologies – together, hopefully creating a culture that measures safety improvement.

Driver diagrams

A set of driver diagrams has been reviewed and provided to meet the programme aims. Driver diagrams are a type of structured logic chart with three or more levels which can assist and provide a "theory of change" as well as fulfil a range of other functions:

- help a team to explore the factors that they believe need to be addressed in order to achieve a specific overall goal,
- show how the factors are connected,
- act as a communication tool for explaining a change strategy, and
- provide the basis for a measurement framework.

Driver diagrams are therefore best used when an improvement team needs to come together to determine the range of actions they have to undertake to achieve a goal. They are well suited to complex goals where it is important for a team to explore many factors and undertake multiple reinforcing actions

Implementation

An implementation team led by Dr Damian Robinson – In-patient Group Medical Director and Vida Morris – In Patient Group Nurse Director and including the Sign up to Safety Leads will feedback on a quarterly basis to the Corporate Decision Team – Quality Sub Group. More information on Sign up to Safety is available below.

The initial draft of the plan has been discussed through the Corporate Decision Team – Quality Sub Group and following discussion it has been agreed to move the focus of the plan to a review of morbidity and mortality within the Trust, and more information will be included when the national picture has been clarified.

http://www.england.nhs.uk/signuptosafety/

Parliamentary Health Services Ombudsman Complaints Update

The following information gives a view of the ongoing Parliamentary Health Service Ombudsman (PHSO), activity for the Trust. The Trust is fully compliant with all response timescales. The Trust has being working with the PHSO, to updated all open complaints. Below is the position at the end of March 2016.

No requests were made for information in March 2016

Case number	PHSO reference	Opened	Current Status	Trust Outcome	Current Update

4 cases are currently under review and the Trust awaits the outcome.

Case number	PHSO reference	Opened	Current Status	Trust Outcome	Current Update
S 2664	210865	26.03.15	Request for files	Dealt with locally, not through Complaints Department	Sent further info 22.07.15
S 1904	219647	09.06.15	Request for files	Partially Upheld	Final Report Received – Partly Upheld – Actions to Complete
S 2620	235697	26.10.15	Request for files	Not Upheld	Draft Report Received 12.02.16 – Not Upheld – Awaiting Final Report
IP 2084	199797	17.10.14	PHSO Open	Upheld	Final report received – actions completed - awaiting further instructions

Positive and Safety Strategy Update

Physical Intervention Reporting

Following the Board Development Session, the Executive Director of Nursing and Operations has agreed to produce timely information for the Board of Directors, relating to the activity of Physical Intervention Reporting, and where it is available the latest national NHS Benchmarking data will be included.

Background and Context

The Trust has been actively involved in the Department of Health's national reporting of physical intervention and violence activity through the NHS Benchmarking network since 2011, and the latest information published was released in March 2016 covering the data period November 15 – January 2016, the Trust is identified in the following charts as RES052 (highlighted in red), the full report has been shared across the organisation, and is being assessed by the Positive and Safe Steering Group and all clinical services who are included.

A number of detailed reports have been produced by individual services / patients, so that all clinical services can review the activity in detail, and make contact with other similar services in other organisations to evaluate any learning.

This section of the report will develop over time, as the information both locally and nationally improves and becomes more meaningful. It can be seen from the high level information below that the Trust's activity can increase / decrease over a monthly period in direct comparison to the clinical activity of each patient, which was evident from the [previous information provided in the Board development session in March 2016.

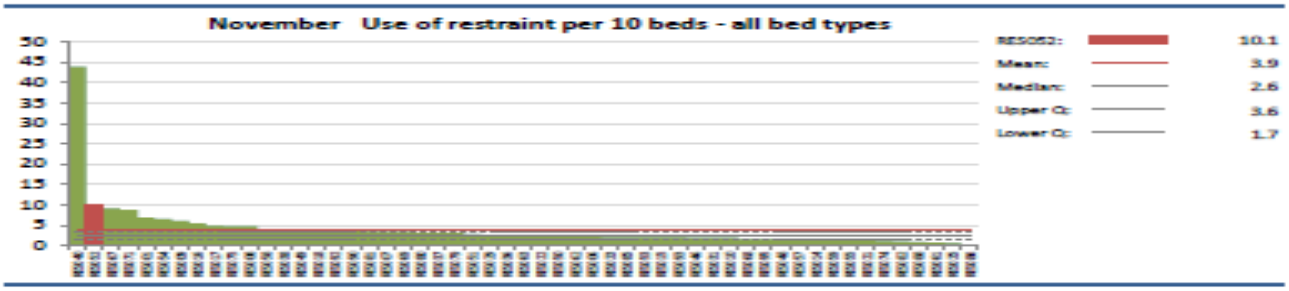


Figure 1

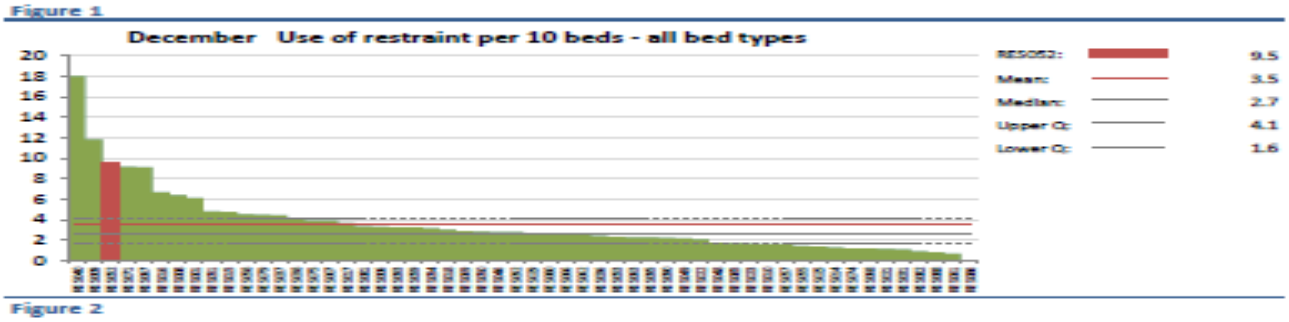


Figure 2

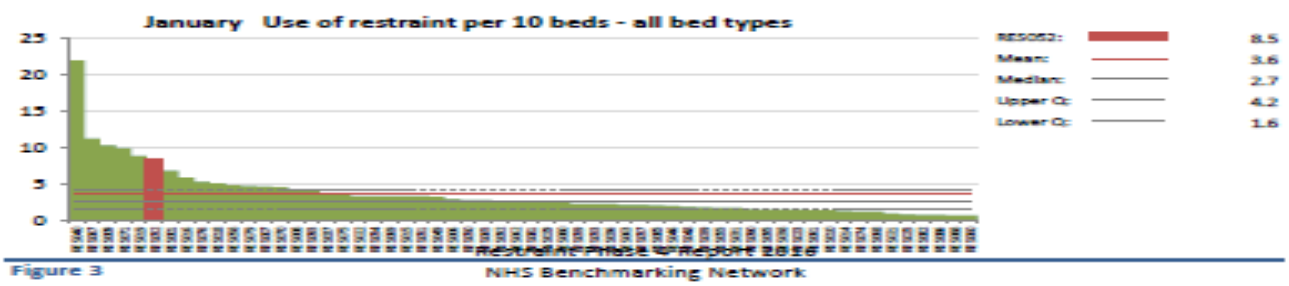


Figure 3

NHS Benchmarking Network

Appendix 1

Glossary of Terms used

Serious Incident - An incident occurring on health service premises or on other non NHS premises in relation to the provision of healthcare on such premises, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern. This shall include “near misses” or low impact incidents which have the potential to contribute to serious harm.

Unexpected Death – Any death either within in-patient or community services within six months of contact with mental health services, where by the nature of death is not certificated as a natural cause by a doctor, or whereby due to the undetermined circumstances it is referred to a Coroner and an inquest is convened.

Independent Investigation – An investigation carried out by an appointed panel of specialists to review to most serious incidents in a mental health organisation, namely homicides committed by those in receipt of mental health services. The process is the responsibility of NHS England, and the reports are published after being considered by all stakeholders.

Incident – Any activity which may or may not have resulted in harm including near miss activity, involving anyone who comes into contact with NTW services, including patients, carers, staff, visitors, members of the public.

Issue – A recurring or emergent issue of notable concern identified from a reflection of a single serious incident or a number of less serious incidents.

Safety Messages and CAS Alerts Disseminated between January 16 – March 16.

Date Alert Issued	Alert Type	Title	Date Received	Reference No.
06/01/2016	NTW Internal Alerts	Introduction of Electronic Braden Scale	05/01/2016	NTW/INT/2016/01
06/01/2016	NTW Internal Alerts	Defibrillation Electrodes	06/01/2016	NTW/INT/2016/02
08/01/2016	NTW Internal Alerts	Severe Winter Weather - Level 2 - Alert and Readiness	08/01/2016	NTW/INT/2016/03
08/01/2016	NTW Internal Alerts	For the attention of all prescribers - Local CQUIN; Initiating antipsychotic treatment and associated monitoring	08/01/2016	NTW/INT/2016/04
08/01/2016	NTW Internal Alerts	Junior Doctor Industrial Action - 12th January 2016	08/01/2016	NTW/INT/2016/05
08/01/2016	NTW Internal Alerts	G.E. MAC 800 ECG Unit (follow up from CAS alert; NTW/INT/2015/036)	08/01/2016	NTW/INT/2016/06
11/01/2016	NTW Internal Alerts	For the attention of all prescribers - Local CQUIN; Initiating antipsychotic treatment and associated monitoring	11/01/2016	NTW/INT/2016/07
12/01/2016	NTW Internal Alerts	Warning; Novel Psychoactive Substance (NPS - so called 'legal high')	11/01/2016	NTW/INT/2016/08
13/01/2016	DH - Estates & Facilites	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Merlin Gerin - GENIE - Circuit Breaker	13/01/2016	EFN/2016/01
13/01/2016	DH - Estates & Facilites	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - GEC - RT - Ring Main Unit	13/01/2016	EFN/2016/02
07/01/2016	CMO Messages	Influenza season 2015/16 - use of antiviral medicines	07/01/2016	CEM/CMO/2016/001
14/01/2016	NTW Internal Alerts	Severe Winter Weather - Level 3 - Cold Weather Action Alert	14/01/2016	NTW/INT/2016/09
14/01/2016	DH - Estates & Facilites	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Reyrolle - C6T/C7T - Circuit Breaker	14/01/2016	EFN/2016/03
18/01/2016	DH - Estates & Facilites	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - Merlin Gerin - GENIE - Circuit Breaker	18/01/2016	EFN/2016/04
21/01/2016	NTW Internal Alerts	Lucozade Energy Recall	14/01/2016	NTW/INT/2016/10
18/01/2016	DH - Estates & Facilites	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Long & Crawford - T4GF3 - Ring Main Unit	18/01/2016	EFN/2016/05
25/01/2016	NTW Internal Alerts	Severe Winter Weather - Cold weather Alert Level 1 - Winter Preparedness and action	22/01/2016	NTW/INT/2016/11

26/01/2016	MHRA Medical Device Alerts	Various nebulizers and nebulization kits - risk of nebulizer not delivering therapy to the patient.	26/01/2016	MDA/2016/001
19/01/2016	Safety Message	There is nothing more rewarding than receiving a 'thank you' letter or card from a service user or their relatives/carers. It is a true sign of appreciation for the care and service we provide.	19/01/2016	SMIG68/190116
27/01/2016	NTW Internal Alerts	Changes to web-based incident reporting - SI classification and the removal of Acute Trust Services	27/01/2016	NTW/INT/2016/12
28/01/2016	NTW Internal Alerts	Met Office issues Amber warning of wind	28/01/2016	NTW/INT/2016/13
04/02/2016	NTW Internal Alerts	Drug alert warning; Strong Heroin	03/02/2016	NTW/INT/2016/14
04/02/2016	NTW Internal Alerts	Pharmacy, St Nicholas Hospital - change of telephone numbers	04/02/2016	NTW/INT/2016/15
05/02/2016	NTW Internal Alerts	BigHand System Downtime	05/02/2016	NTW/INT/2016/16
05/02/2016	CMO Messages	ZIKA VIRUS - AN UPDATE FOR CLINICIANS	05/02/2016	CEM/CMO/2016/002
08/02/2016	NTW Internal Alerts	Pharmacy & Infection, Prevention & Control (IPC) Controlled Drugs (Schedule, 2, 3 and 4 part 1)	05/02/2016	NTW/INT/2016/17
08/02/2016	DH - Estates & Facilites	High/Low Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Bonar Long - LV Cabinet - Unknown Model/Type	08/02/2016	EFN/2016/06
08/02/2016	MHRA Dear Doctor Letter - DDL	Valproate and risk of abnormal pregnancy outcomes: new communication materials	08/02/2016	DDL_VALPROATE_MATERIALS
08/02/2016	MHRA - CLDA - Drug Alert	DRUG ALERT CLASS 2, THE HERBAL RESEARCH COMPANY LTD, ST JOHN'S WORT TABLETS, THR 02231/0002, ASDA, SUPERDRUG AND HRI GOOD MOOD LIVERIES	08/02/2016	EL(16)A/01
08/02/2016	NPSAS	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	08/02/2016	NHS/PSA/W/2016/001
09/02/2016	NTW Internal Alerts	Industrial Action; Wednesday 10th February 2016	09/02/2016	NTW/INT/2016/18
09/02/2016	DH Supply Distribution Alert	Baxter IV Administration Sets (Colleague pump compatible and gravity) - Supply Disruption	09/02/2016	SDA/2016/001
09/02/2016	DH Supply Distribution Alert	Baxter Urology Irrigation sets ('Easyflow' and 'Uromatic' brands) - Supply Disruption	09/02/2016	SDA/2016/002

10/02/2016	DH - Estates & Facilites	Reporting of Defects and Failures and disseminating Estates and Facilities Alerts	10/02/2016	DH/2016/001
12/02/2016	Key Cards	Risk Assessment EIP and CYPS - Learning points from 1st December 2015	11/02/2016	KC/2016/01
12/02/2016	Key Cards	Learning from incidents; Key Message December 2015; EIP CTT Flowchart	11/02/2016	KC/2016/02
16/02/2016	Myth Busters	Myth - you have to click in and out of lots of folders on RiO to see Risk Assessments	16/02/2016	MB22/160216
12/02/2016	NTW Internal Alerts	Renaming of the 24 hour report (Serious Incident)	12/02/2016	NTW/INT/2016/19
12/02/2016	NTW Internal Alerts	Severe Winter Weather - Level 2 - Alert and Readiness alert - Regions affected: NEE NWE YH WM	12/02/2016	NTW/INT/2016/20
17/02/2016	NTW Internal Alerts	SOAD Communication (Second Opinion Appointed Doctor)	16/02/2016	NTW/INT/2016/21
19/02/2016	Key Cards	Transfer of Care Across Teams	18/02/2016	KC/2016/03
24/02/2016	NTW Internal Alerts	Reporting In-Patients as Missing People - concerns with 'Absent' criteria	23/02/2016	NTW/INT/2016/22
26/02/2016	NTW Internal Alerts	Severe Winter Weather - Level 3 - Cold Weather Action alert - Regions affected: NEE NWE YH WM EM	26/02/2016	NTW/INT/2016/23
29/02/2016	NTW Internal Alerts	Care Quality Commission (Findings of Mental Health Act Monitoring Visits - Section 17 Leave Forms)	29/02/2016	NTW/INT/2016/24
02/03/2016	MHRA Medical Device Alerts	Ambulatory syringe pumps (T34 and T60) and syringe extension sets used with the T34 pump, manufactured by Caesarea Medical Electronics (CME).	02/03/2016	MDA/2016/002
03/03/2016	NTW Internal Alerts	Cold Weather Alert - Level 2 - Alert and Readiness	03/03/2016	NTW/INT/2016/25
08/03/2016	Myth Busters	Myth: Everyone understands the phrase "Able to guarantee own safety" when they see it in a service users record.	08/03/2016	MB23/080316
08/03/2016	NTW Internal Alerts	Junior Doctors Industrial Action	08/03/2016	NTW/INT/2016/26
10/03/2016	MHRA Medical Device Alerts	All ZeniPower mercury-free hearing aid batteries - low risk of batteries exploding during use or if depleted.	10/03/2016	MDA/2016/003
04/02/2016	Field Safety Notice Weekly Upd	Accu-Chek Inform II Base Unit Handheld Base Unit (International)	04/02/2016	FSN/2016/01
18/01/2016	Field Safety Notice Weekly Upd	Arjohuntleigh Akron Tilt Table Couches	18/01/2016	FSN/2016/02
24/03/2016	NTW Internal Alerts	Changes to the Rapid Tranquilisation (RT) Policy	24/03/2016	NTW/INT/2016/27

24/03/2016	MHRA Medical Device Alerts	Estradiol immunoassays - interference from the drug fulvestrant (Faslodex®) may cause falsely elevated estradiol results.	24/03/2016	MDA/2016/004
30/03/2016	NPSAS	Risk of death from failure to prioritise home visits in general practice	30/03/2016	NHS/PSA/W/2016/002