Northumberland Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 28 September 2016

Title and Author of Paper: Learning and Improving Report
Author of Paper in response to this report – Tony Gray - Head of Safety & Security

Executive Lead: Gary O'Hare, Executive Director of Nursing and Operations

Paper for Debate, Decision or Information: Information

Key Points to Note:

- This is the new 6 monthly report relating to learning and improvement in the Trust. As this report develops it will include all quality and safety systems that contribute to learning across the organisation.
- This first report focuses on the last 10 years of the organisation and the systems of safety that have developed over time and provided assurance, both internal and external, to the organisation and were put under close scrutiny during the recent Care Quality Commission inspection.
- It was acknowledged that the safety systems of the Trust were robust and evidence of learning could be seen from the floor to the board in an open and transparent way. The Safety Team will continue to develop and improve on the reporting and learning systems in order to maximise opportunities for learning both locally and nationally when things go wrong or issues of what could have gone better are identified.
- The Board reporting cycle for Safety issues is noted below.

NTW FT – Board Cycle – Safety Reporting	
Report Title	**Board Date**
Unexpected Deaths Report – 6 monthly report	April
Security Management Annual Report	May
Complaints Annual Report	June
Safety Report – Jan – June – 6 monthly report	July
Learning and Improving from activity - 6 monthly report (Serious incidents, Complaints, Claims, Disciplinary, Grievances, Tribunals)	September
Unexpected Deaths Report – 6 monthly report	October
Reported Physical Assaults on Staff – NHS Protect	November
Safety Report – July - December – 6 monthly report	January
Lone Working Annual Update	February
Learning and Improving from activity - 6 monthly report (Serious incidents, Complaints, Claims, Disciplinary, Grievances, Tribunals)	March

Risks Highlighted to Board :	None

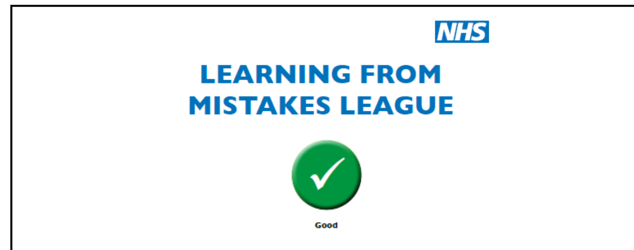
Does this affect any Board Assurance Framework/Corporate Risks? Please state Yes or No: If Yes please outline	No

Equal Opportunities, Legal and Other Implications:	None

Outcome Required:	Board of Directors to receive for information.

Link to Policies and Strategies:	Incident Policy Complaints Policy Claims Policy Health & Safety Policy Security Management Policy Central Alert System Policy

Northumberland, Tyne and Wear NHS
NHS Foundation Trust



Learning and Improving from Activity Report September 2016

Shining a light on the future

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Introduction

Learning is defined as “the acquisition of knowledge or skills through study, experience, or being taught”.

The purpose of this report is to evidence the improvements that have been made over time within the Trust. This initial report will act as a baseline against which to continually measure improvements in the future and will be presented to Board every 6 months, with each report acting as a reflection exercise to indicate where learning has resulted in improvements in the quality and safety of care provided.

The Care Quality Commission report records quality and safety improvements that were evidenced to inspectors by staff; were articulated in the pre-inspection review information shared prior to the inspection; but also importantly from the national triangulation exercises that are carried out to gain assurances from elsewhere.

This situation was not achieved overnight. It has been a long journey to build the systems, information and embedded processes which have evolved over the last 10 years since the Trust was created in 2006. This initial report provides the Board with the background and context of those developments, recognising that the Board has changed several times over that period.

In the context of the activity of the Trust from its inception, central teams have had to re-build knowledge in line with refreshed policies and procedures, and develop the central intelligence within the Trust’s risk management system. It is this system, and the individual stories of experience from serious incidents, complaints and claims that is shared in a multitude of ways across the Trust, that allows the knowledge to flow to create the experience of learning. Reports have been adjusted so many times based on feedback that they are unrecognisable from the initial information produced at the start of the Organisation.

The purpose of this initial report is not to inform the Board on numbers of incidents and whether they have increased or reduced and the possible reasons behind this. This report offers an insight into the physical improvements that have been made over time to the processes and practices within the Trust. It sets the scene of wide-ranging developments, including systems developed to identify the learning and knowledge creation, which builds the Organisational memory. Future reports will update the Board on further developments and improvements every 6 months as part of the safety reporting cycle.

Background and Context – Creating a system to learn

In 2006 when the Trust was first created national policies and standards had been adopted in different ways in each of the previous organisations. This meant that one of the first tasks was to create effective governance systems and to be able to report on the Trust’s activity to clinical and operational teams, governance committees and the Board. This was difficult for a number of reasons such as:-

- Separate information technology networks where information was feeding into and being stored.
- Different modes and standards of reporting which made comparison to similar services impossible.

- Different language being used within the same processes, meaning that some activity was captured in one service but not another.
- Responsibilities of which function managed corporate activity was different in each of the 3 previous Trust's which meant some systems had been supported and developed more than others.
- Evidence was already available to indicate that some systems were operating with more governance than others, this was clear from both internal and external audits, and had there been a "well led" assessment, "requires improvement" would have been clear outcomes for some of these processes.
- As part of the creation of the Safety Team within the Trust, plans were put in place to review and standardise all governance systems to ensure that the information flow could move quickly through the systems from floor to board and vice versa.

Between 2006 and 2008, the Central teams standardised a number of systems which resulted in the following improvements.

- Single risk management system.
- Single Incident Policy and process for everything from the most serious incidents to those incidents that resulted in no harm.
- Single Complaints Policy.
- Single Claims Policy.
- Standardisation of reporting into clinical groups through their governance processes.
- Automated weekly service reports containing all incidents occurring the previous week.
- Weekly Director updates relating to all activity that would include learning, such as serious incidents, complaints, safeguarding and other complex clinical issues.
- Development of the national central alert system, to adopt the principles locally to create an internal safety reporting system, based on local learning, and a quick and wide ranging sharing system.

Embedding The Learning – Sharing the experiences wider than the team

Between 2009 – 2012 the learning systems that had been developed started to become embedded and improved upon; this resulted in the following improvements.

- Further re-writes of the Trust's policies to strengthen and improve local reflection by clinical and operational teams, and improve on the immediacy of learning and sharing.
- Further development of standard clinical working in line with the Trust's Service Development and Community Transformation agenda, drawing on the learning from serious incidents and complaints to improve the outcomes for patients and their families.
- An increase in automated reports from the risk management system to include the development and roll out of scheduled reports for on-going complaints sent daily to Directors; daily, weekly and monthly scheduled reports to specialist teams such as Security specialists, Safeguarding leads, Infection , Prevention and Control Teams, Fire Officers, Emergency Planning and Resilience.
- Transparency of reporting at Board with the first Safety reports being reported to the public board, as well as the first unexpected death reports being developed and shared with the organisation in direct comparison to data available from the office of national statistics and the National Confidential Inquiry into Homicides and Suicides.

- Creation of a dedicated team of serious investigators to create an independent and quality driven investigation process for patients, families and carers and to support the principles of being open, and achieve our compliance with the current Duty of Candour responsibilities a number of years before it was a legal requirement to do so.
- Development and re-writes of a number of clinical policies based on learning from experience, with changes to the Trust Falls Policy, following reviews of fractured neck of femurs, creation and development of transitions guidance for discharge for patients from in-patient wards moving into community services.
- Development of standard ways of working for Crisis Teams.
- Significant investment in in-patient services environments with an emphasis and standardisation of safety across the wards, with significant reduction of ligature access points and improvements around CCTV, staff alarms, walkie-talkies, anti-barricade doors and access systems. These developments were made in line with the clinical services transformation agenda, and the Estates strategy followed this transformation, the significant learning from incidents and evidence of a well led organisation was the fact that money was allocated to improve in-patient environments acknowledging that some had a limited lifespan due to development of new hospitals that would ultimately replace them.

Current Developments based on learning

Between 2012 and 2016 further operational developments have been made across the organisation, some of which relate to learning from incidents locally but a lot of which relate to national developments which have influenced locally set quality priorities.

Changes and improvements identified in this time frame are as follows:-

- Significant improvements to the physical health agenda within mental health services in line with the parity of esteem.
- Creation of Tissue Viability Nurses and Physical Health Champions.
- Creation of specialist roles following unexpected outcomes of serious incidents, such as the Trust Search Dog and Handler and the Clinical Police Liaison Lead to increase the partnership working with the Police.
- Development of a robust and assured safeguarding reporting system to inform local authorities of all the required activity.
- Further developments of the Trust's Incident reporting system to create a web-based on-line reporting system that gives managers immediate notification of incidents that have occurred within their service, allowing for timely support and improvement.
- This system also creates immediate notification to specialists across the organisation.
- Further enhancements to clinical services with the opening of new Hospitals to provide enhanced clinical environments that promote recovery and reduce risk.
- Compliance and support for the Care Quality Commissions – Deaths Review. The Trust has submitted its information to the formal review and also supported the sharing across the Northern Alliance Trusts. A further event is being organised by Mazars on the 7th October 2016, and further information will be shared.
- The Care Quality Commission are also consulting on changes to next year's Quality Reports for Trusts to include transparent reporting of mortality in both numbers and learning. This is not a significant issue for the Trust as we have been reporting on similar activity through the Board publicly since 2009 in both the 6 monthly report on

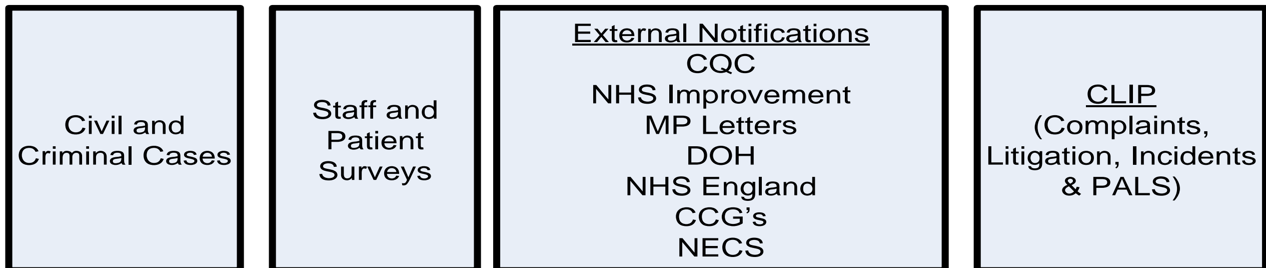
deaths and the safety report which has included the learning from reviews of serious incidents.

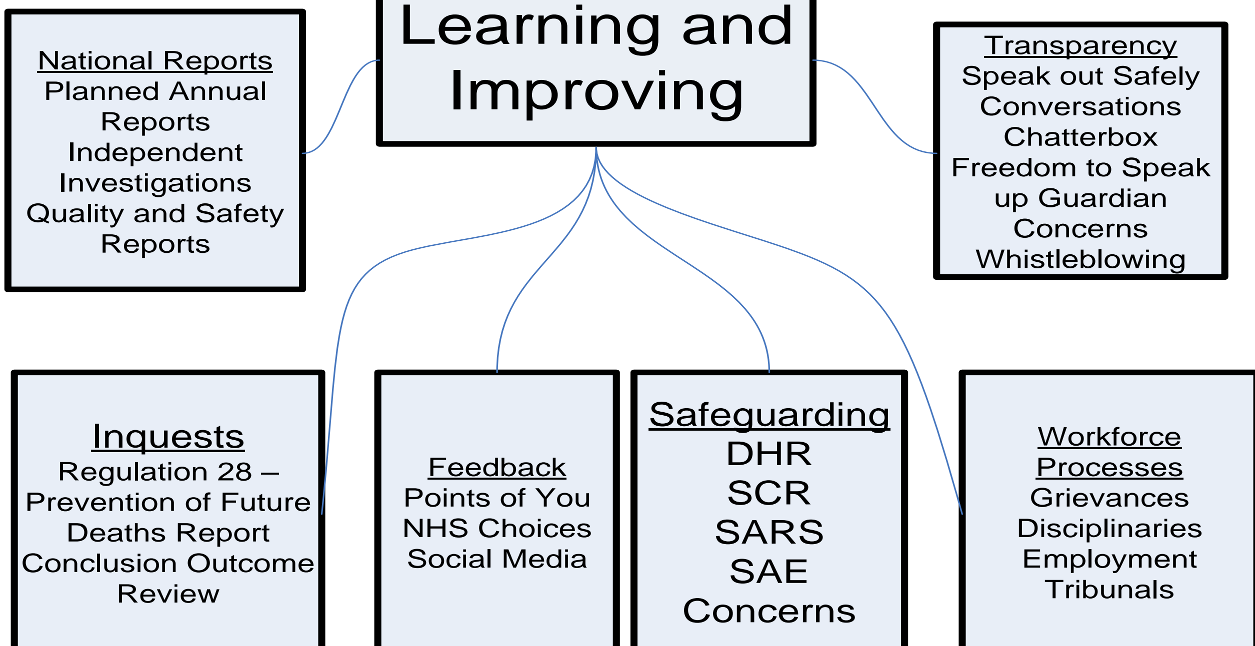
- Current developments also include refreshed and updated information available to all clinical teams relating to the “Positive and Safe Strategy”, which will mean clinicians have up to date physical intervention data down to individual patient level data that can be interrogated, and utilised in reflective exercises. This will form part of the roll out of “Talk First” and will be available electronically by November 2016.

Future Developments 2016 onwards

It is the intention of the Safety Team to build on the strengths of learning and expand this across the organisation to transparently report on all activity that we learn from to ensure all staff have a clear understanding of what has occurred in the organisation, and how we are embedding further systems to learn. It is important that for the learning to be maximised it has to be appropriate to the audience, i.e. the learning from an activity on an in-patient ward may not be appropriate to a community service, but it is still important to acknowledge that an incident affecting a patient has occurred.

The following gives a breakdown of all of the information that will be built into subsequent learning reports at every level and inclusion in the next 6 monthly report.


Learning and Improving Information
Civil and Criminal Cases
Staff and Patient Surveys
External Notifications
CQC
NHS Improvement
MP Letters
DOH
NHS England
CCG's
NECS
CLIP
(Complaints, Litigation, Incidents & PALS)


Learning and Improving
National Reports
Planned Annual Reports
Independent Investigations
Quality and Safety Reports
Transparency
Speak out Safely Conversations
Chatterbox
Freedom to Speak up Guardian
Concerns
Whistleblowing
Inquests
Regulation 28 – Prevention of Future Deaths Report
Conclusion Outcome Review
Feedback
Points of You
NHS Choices
Social Media
Safeguarding
DHR
SCR
SARS
SAE
Concerns
Workforce Processes
Grievances
Disciplinaries
Employment Tribunals