South Staffordshire and Shropshire Healthcare
NHS Foundation Trust

Learning Lessons Quarterly Bulletin

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Newsletter Date October 2016

Focus on Findings of Serious Incident Investigations

Welcome to South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Learning Lessons bulletin.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. This new quarterly bulletin is an important component of a number of key approaches embraced by the Trust to drive forward the quality agenda.

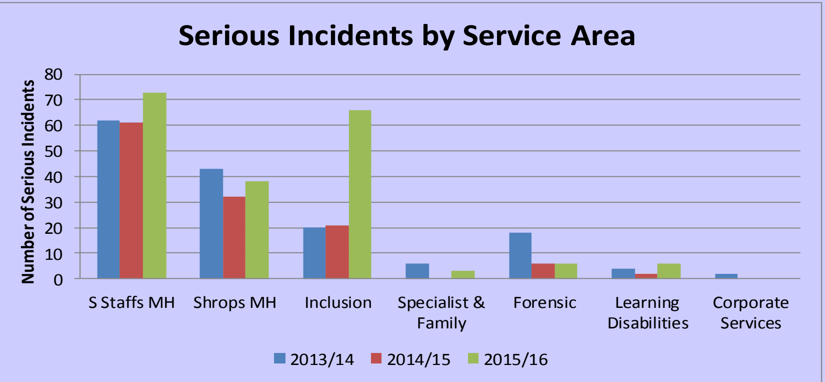
The ultimate aim of evaluating our services and learning lessons is to improve outcomes for service users. This bulletin is intended to support this aim by communicating and strengthening local and national lessons to be learnt from both positive practice and areas for improvement.

In this issue we have focused on our leaning from the recent review of serious incidents 2014- 2016

We hope that you find this bulletin informative and useful and welcome your ideas and input into future issues.

Statistics on Serious incidents in SSSFT

- In 2014 - 2016 South Staffordshire and Shropshire Healthcare NHS Foundation Trust reviewed 320 incidents in order to ensure we learn lessons.
- The highest number of serious incidents related to unexpected deaths of community patients accounting for 64% of all serious incidents
- There was a 72% reduction since 2013/14 in RIDDOR reporting of staff injuries
- Reported incidents of serious self harm fell by 63% since 2013/14



"The incident details are uploaded to outside agencies such as the NPSA and CQC. That's why there should be no person identifiable information".

Learning Lessons Features

What is a "Serious Incident"?

A Serious Incident is any incident that occurs within the services of South Staffordshire and Shropshire NHS Foundation Trust, or that involves any individual receiving care delivered by, or in partnership with, South Staffordshire and Shropshire NHS Foundation Trust, that resulted in any of the following:

◊ The **unexpected or avoidable death** of one or more patients, staff, visitors, members of the public or of any patient known to services who has been discharged within the last 12 months

◊ **Serious harm** to one or more patients, staff, visitors or members of the public. Or where the outcome requires a life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm.

◊ A suspected **homicide** or injury where foul play is suspected involving a patient in receipt of services or of any patient known to services who has been discharged within the last 12 months

◊ A scenario that prevents or threatens to prevent the ability of South Staffordshire and Shropshire NHS Foundation Trust to continue to deliver healthcare services for example, actual or potential **loss of personal / organisational information, damage to property, reputation or the environment, or IT failure.**

◊ Allegations of **abuse**

◊ Adverse **media coverage** or public concern about the organisation or the wider NHS.

◊ One of the core set of "**Never events**" such as, inpatient Suicide using non-collapsible rails and escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners.

◊ Any incident where a younger person (**under 18 years** of age) is admitted into an acute mental health ward

◊ Any **fall** which resulted in a **fracture or serious harm**

◊ All **RIDDOR** reportable incidents

We investigate incidents in order to learn lessons and to share good practice. In addition to investigating serious incidents we may also carry out clinical reviews in to any serious near misses, clusters or trends.

Learning Lessons Features

Learning from Serious Incident Investigations

This page outlines the findings of the review of serious incident investigations 2014-16.

Key Findings—Overview

Mental Health	Inclusion
* Lack of effective use of case management processes (e.g. CPA) * Lack of engagement of carers * Not following Dual Diagnosis Policy * Lack of robust discharge planning*	* Risks relating to sporadic use of Class A drugs not addressed* * Risk Assessment not uploaded* * No recovery plan*
Cross Divisional	
* Risk assessment not reflected in the risk management plan/ no summary of risks identified * Lack of regular communication with the GP * Lack of formulation of decision making * Lack of variation of strategies for engagement * Limitations in the assessment of suicidality * Lack of assertive/proactive follow-up/ Lack of follow up to DNA * No review of medication* * Ineffective inter-agency working* * Physical health needs not included in risk assessment* * Lack of follow up to DNA	

*New theme identified 2014-15
* New theme identified 2015-16

Key Findings—Detail of new themes

Lack of robust discharge planning:

It is important that the service user and their significant other are fully engaged in the planning for discharge from both inpatient and community services. This includes transfer to other services. The discharge plan needs to include key risks, symptoms of deterioration and actions to be taken in the vent of deterioration.

No review of medication:

There must be evidence in the service user record that medication is regularly reviewed including side effects, storage and monitoring of associated physical health needs. Medication prescribed should be reflected in the records including formulation and alignment to diagnosis.

Ineffective inter-agency working:

There must be evidence in the service user record of communication with other agencies. Regular case reviews should be on a multi-agency basis. Evaluation of risk must always be shared between agencies and reflected in the risk assessment.

Risks relating to sporadic use of Class A drugs not addressed:

There should be evidence in the service user record that the service user is reminded on a regular basis of their reduced tolerance to opiates particularly when on a reducing dose or when the service user changes the frequency of being given their medication.

Risk Assessment not uploaded:

Where any documentation is completed by hand this must be scanned in to the system and uploaded at the earliest opportunity with a note in the progress notes when this has been completed.

No recovery plan:

All service users must have an up to date care/recovery plan based on their assessment of risk/need.

Agreed Recommendations from Annual Report on Serious Incident investigations

The Trust has agreed with the findings of the review and is supporting the implementation of the following recommendations as a result:

All staff to ensure carers contact details are recorded.

Ensure staff document refusal by the service user to have physical observations.

Harm from falls to continue to be monitored by wards on a monthly basis

Staff to continue to receive guidance on the effective identification of suicidality

Staff RIDDOR's will continue to be monitored through the risk management quarterly report

The Trust will continue to engage with commissioners to support the Suicide Strategy Group with Public Health, in order to meet the recommendations in "Preventing suicide in England - A cross-government outcomes strategy to save lives".

Useful Resources:

Root Cause Analysis Investigation - https://www.england.nhs.uk/patientsafety/root-

Investigating accidents and incidents: http://www.hse.gov.uk/pubns/hsg245.pdf

Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation
https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and20Checklist%20Guidance.pdf

Trust Incident Policy http://www.sssft.nhs.uk/images/Policies/Incident_Policy/

Serious Incident SOP -
http://intranet.sssft.nhs.uk/sites/DocumentCentre/_layouts/15/WopiFrame.aspx?

National Resources

Patient Safety First is a national campaign and is sponsored by the National Patient Safety Agency and the NHS Institute for Innovation & Improvement. The campaign aims to make safety of patients everyone's highest priority with no unavoidable deaths and no unavoidable harm . The Campaign website contains a range of simple, yet effective ideas for improving patient safety within organisations. The link to the Patient Safety First Campaign website is: http://www.patientsafetyfirst.nhs.uk

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Central Alerting System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Risk management distribute relevant alerts to directorate risk co-ordinators for cascading. Further information about alerts can be found at: https://www.cas.dh.gov.uk/Home.aspx

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Serious Incident Framework

Supporting learning to prevent recurrence

The revised Serious Incident Framework published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. It replaces, the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013).

The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again.
Further information can be found at the following link: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

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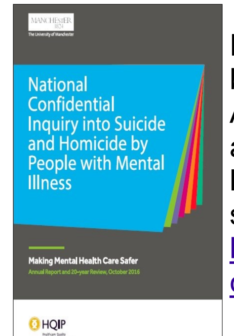
This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments (these can be found in NICE clinical guideline 16).
Further details about this guidance can be seen at the following link: https://www.nice.org.uk/guidance/cg133



In October 2016 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness released its 2014 report. The report covers the Annual Report and 20-year Review 2016 presents findings from 2004 to 2014, and reviews 20 years of data collection. It provides the latest figures on suicide, homicide and sudden unexplained deaths and highlights the priorities for safer services. The link to the report on the University of Manchester website is: http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

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This Bulletin is available on the Trust website at :

http://www.southstaffsandshropshealthcareft.nhs.uk/Default.aspx

Or alternatively

A hard copy can be obtained by contacting the Trust Risk Management Department on 0300 790 7000 ext 8695

- We welcome your feedback on this Learning Lessons Bulletin to help us to ensure that future editions are helpful and informative

- We would also welcome your ideas for future features or areas of learning you feel are relevant to be cascaded across the Trust

For all enquiries and comments please Contact:

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