Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Report subject:	Learning from Experience report – trimester 3 2017/18 (incorporating an update on the national Learning from Deaths framework)
Agenda ref. no:	
Report to (meeting):	Board of Directors meeting in public
Action required:	Discussion and approval
Date of meeting:	
Presented by:	Avril Devaney, Director of Nursing, Therapies & Patient Partnership

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	Yes
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	Yes
Be recognised as an open, progressive organisation that is about care, well-being and partnership	No
Which CQC quality of service domains this report reflects:	
Safe services	Yes
Effective services	Yes
Caring services	Yes
Well-led services	Yes
Services that are responsive to people's needs	Yes
Which Monitor quality governance framework/ well-led domains this report reflects:	
Strategy	Yes
Capability and culture	Yes
Process and structures	Yes
Measurement	Yes
Does this report provide any information to update any current strategic risks? If so, which?	
See current risk register in the agenda of the public meeting of the Board of Directors at http://www.cwp.nhs.uk/about-us/board-members/our-board-meetings	No
N/A	
Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No
N/A	

1. Situation

This Learning from Experience report aggregates qualitative and quantitative analysis from key sources of feedback from people who access and deliver the Trust's services, and other relevant sources of learning, covering the period from December 2017 to March 2018, trimester 3 of 2017/18. The report compares current performance across a four trimester time series to mitigate seasonal variations, whilst also facilitating the identification of potential triggers to detect and prevent incidents by comparing current performance with the previous trimester.

2. Background – Key performance indicators

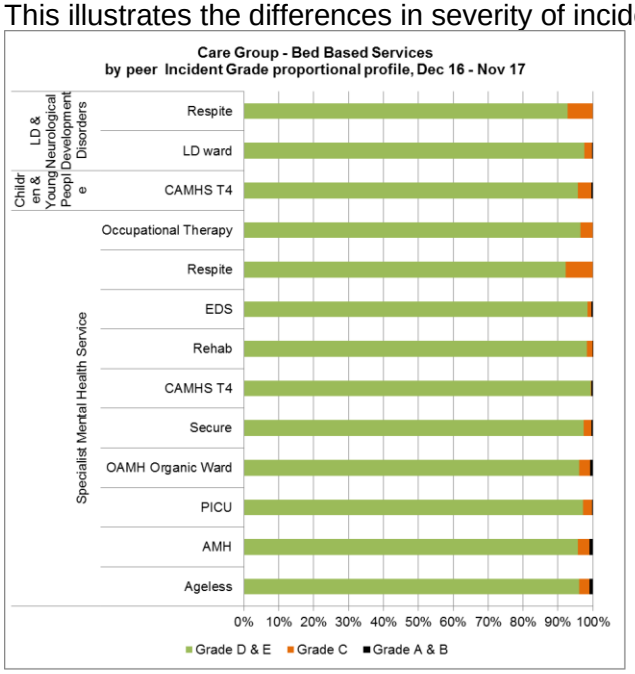
2.1 Performance indicators

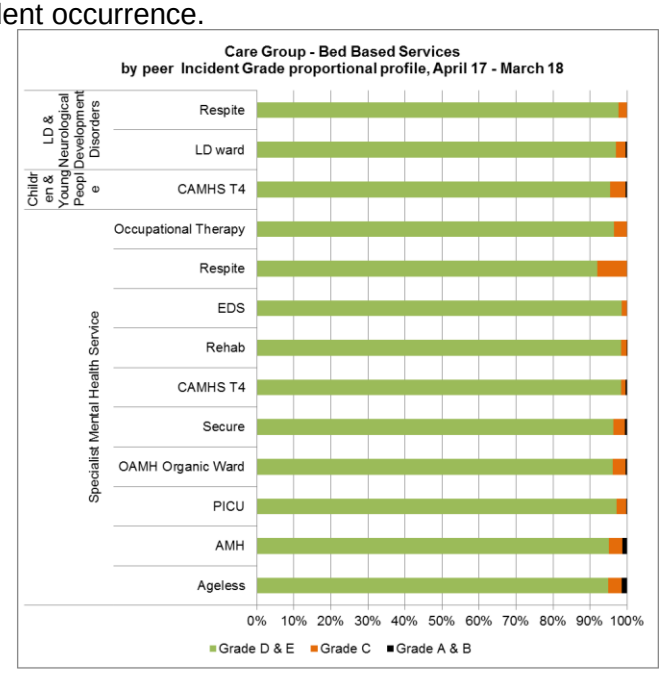
Performance indicator			2016/17	2017/18			RAG rating
			T3	T1	T2	T3	
Number of safety incidents reported			**3178**	**3186**	**3347**	**3004**	↓
Number of safety incidents by speciality	*Inpatient*		*2002*	*2154*	*2318*	*1954*	↓
	Community physical health		*742*	*602*	*575*	*557*	↓
	Community mental health		*364*	*370*	*365*	*384*	↑
	Other		*70*	*60*	*89*	*83*	↓
Mortality monitoring **subject to a case record review*	Inpatient deaths (including deaths 30 days after discharge)		9/ ***78%**	3/ ***100%**	3/ ***100%**	0/ ***100%**	=
	Deaths reported to the Trust		628/ ***14%**	477/ ***16%**	420/ ***18%**	**558/ *18%**	=
Reports to external agencies	**StEIS**		45	33	**59**	**53**	↓
	National Reporting & Learning System		1686	1576	**1985**	**1755**	↓
	NHS Resolution	Non clinical	2	0	**4**	**4**	=
		Clinical	1	1	**2**	**1**	↓
	NHS Protect						
	Staff assaults		258	288	**310**	**297**	↓
	Missing patient		36	44	**70**	**106**	↑
	Suspected theft		5	3	**9**	**4**	↓
	Damage to property		19	18	**15**	**30**	↑
	Lost or missing items		92	65	**39**	**33**	↓
Number of complaints			100	84	**97**	**125**	↑
Number of compliments			1040	822	**1203**	**957**	↓

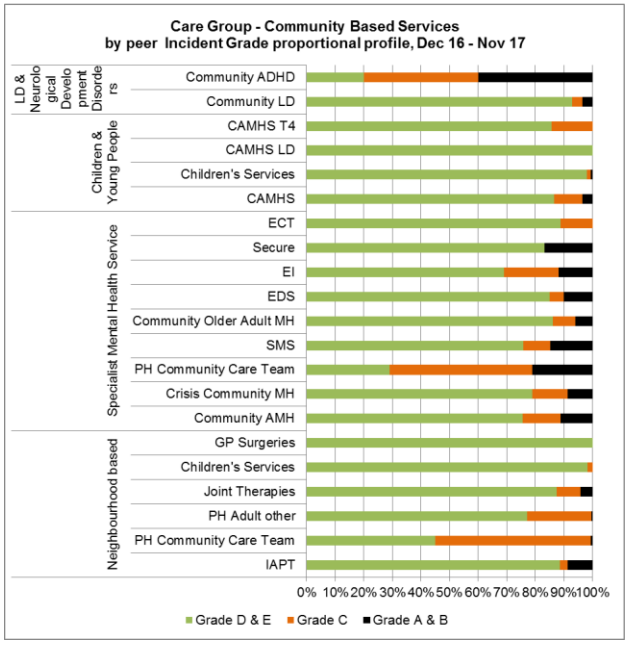
2.2 Proportional reporting performance indicators – Incident reporting

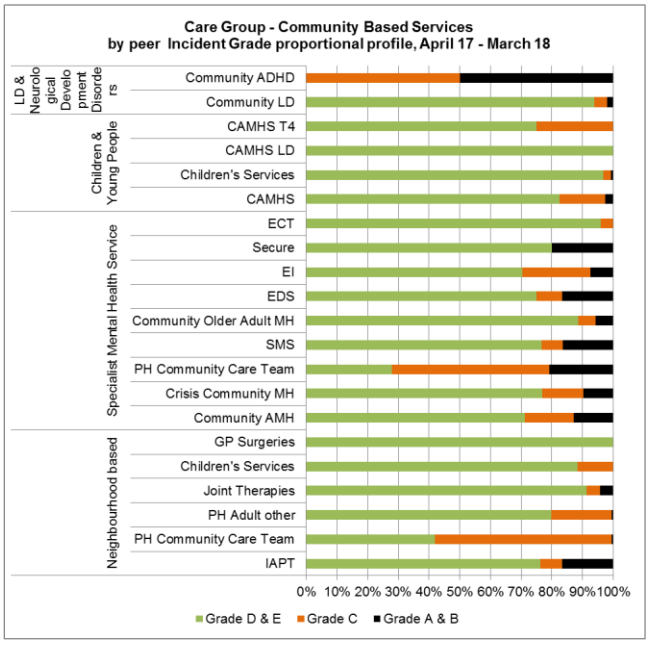
"Proportional reporting" of incidents measures incidents against the specific history and service specifications of a service type. This approach was taken following a Quality Account aspiration to develop how CWP measures incident reporting profiles – for example physical health community teams' reporting profiles are influenced by pressure ulcer incident reporting because of the way they are reported as required nationally.

The charts below show a proportional split of incident grade per care group and service peer group This illustrates the differences in severity of incident occurrence.









Service Peer Groups are a tier mechanism to group together teams that provide similar services. The development has been shared with the Learning from Experience Group meetings that they support and have been published in each of the most recent ward and community LDPs and they are aligned to the organisational redesign to Care Group structures.

By presenting the incident reporting profiles in this way, the charts reveal fundamental differences between the service types that can be used to identify where focus is needed to reinforce the Zero Harm message that reporting no or lower harm incidents promotes learning to be able to potential mitigate future actual or significant harm incidents. The charts can further inform potential

opportunities for both Service Improvement and Quality Improvement activity. Continuous improvement is demonstrated by community learning disabilities, ECT, early intervention (EI), community older adults mental health, physical health adult other, respite, eating disorder services (EDS) and joint therapies of which all of these peer groups have seen a reduction in moderate and serious harm incidents in April 2017 to March 2018 compared with November 2017 to December 2017.

3. Analysis

3.1 Incident reporting

Analysis of the last four trimesters of incident reports shows a decrease in the number of incidents reported, however this does not represent a significant decrease and trimester 3 has previously been the lowest reporting period of the year. All service areas have contributed to the decrease, excepting community physical health services. Reporting incidents shows that patient safety is a high priority and that we have the capability to learn from experience.

Six fewer serious incidents were reported to StEIS this trimester. The top five ranked incident categories are self-harm (1); violence (2); estates and facilities (3); pressure ulcers (4); falls (5). Each rank has remained the same position as trimester 2 2017/18.

Organisation Patient Safety Incident Reports for the providers of the NHS in England was published by *NHS Improvement* in March 2018. CWP have reported 2365 patient safety incidents to the *National Reporting & Learning System* that occurred between April 2017 and September 2017. The report showed that CWP continues to rank 24th for reporting of incidents when benchmarked against 54 other mental health trusts across the NHS in England. CWP are in the upper middle range of reporters, demonstrating a good reporting culture in providing safe services and improving care and quality. The report indicated that CWP reports 20% more self-harm related incidents compared to other mental health trusts, which is a priority area for Quality Improvement that has been identified as part of the developing Quality Account for this year. Since the period of the NRLS report however, the number of self-harm incidents this trimester has reduced by 30%. This represents a good starting point for the said planned quality improvement work in this area.

To identify all deaths, CWP has devised a mortality comparison report from the national list of deceased persons held by NHS Digital. The report compares the list to the information held on the CWP clinical care record to identify people who have died while accessing our care including people discharged from our care within 6 months of their death. The report is updated in retrospect of a person's death, thus increasing the scope and number of deaths to review further.

The incidents team have taken suggestions from staff who report and approve incidents to improve the efficiency and effectiveness of incident reporting. Datix have made the suggested changes and these will be tested in April 2018.

3.2 Falls incidents

There has been a Trustwide increase in the reported number of falls this trimester from 146 to 223, of which 96% of incidents resulted in either low or no harm, which is better that the 'ideal' proportional incident reporting profile. Quality Improvement work is continuing (in both inpatient and community settings) in line with the Trust's Zero Harm continuous improvement plans.

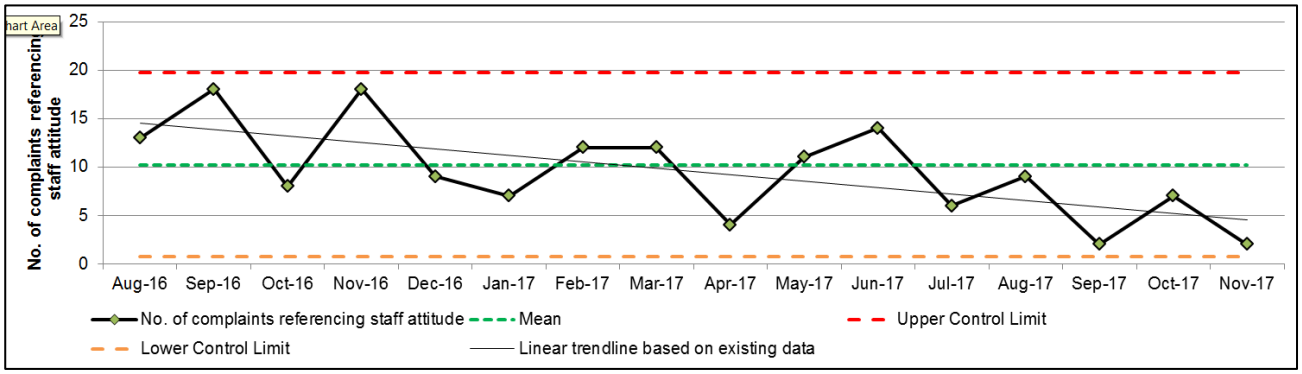
3.3 Incidents associated with managing behaviour that challenges

In November 2017, the number of prone position restraint incidents increased and exceeded the statistical upper control limit. Whilst this increase is individual rather than thematic, associated with two people with behaviour that challenges accessing intensive psychiatric care, the Trust is about to embark on in-depth clinical reviews of all incidents of physical restraint to build on the significant and sustained improvements to-date, as a response to the 90-day quality improvement cycle which has been completed, and in alignment with one of the CQC's current strategic mental health priority areas. This will be supported by the Trust's Clinical Expert Champion for Zero Harm &

Quality Improvement, whose clinical review aims to see what can be learnt about why prone position restraint incidents are persisting and from that make recommendations.

3.4 Feedback from people who access the Trust's services

During this trimester, the Trust received 97 complaints under the NHS complaints procedure. Of these, they were received per locality as follows: CWP Central & East *n. 32* complaints, CWP West *n. 34* complaints, CWP Wirral *n. 28* complaints and *n. 3* for *Corporate Support Services*. Staff attitude associated as a theme has decreased by 43% this trimester and has become the second highest ranked theme after being the longstanding highest reported theme, demonstrating the effectiveness of improvement work following identification of this as an issue through this report.



This trimester, there has been an increase in the number of compliments recorded, from 822 to 1233. This follows work by the complaints team in promoting the new system for recording compliments at induction and when delivering training and drop-in sessions to teams.

3.5 Mortality monitoring

Last year, we welcomed the opportunity to learn from national guidance about how we can better identify, report, investigate and learn from deaths in care. In March 2017, the *National Quality Board* published the first edition of the 'National Guidance on Learning from Deaths'. *NHS Improvement* has published further guidance, 'Implementing the Learning from Deaths framework: key requirements for Trust Boards' in July 2017. *NHS Improvement* is encouraging Trusts to learn from each other and challenge each other to continuously improve the quality of their Learning from Deaths processes and the implementation of effective and sustainable improvements as a result. CWP continues to work with Mersey Care NHS Foundation Trust and other trusts as well as commissioners within the Cheshire and Merseyside footprint to ensure a consistent approach to overseeing implementation and sharing processes as this agenda evolves.

CWP has already begun to increase reporting of deaths that do not meet the criteria as a serious incident. When comparing the last 4 trimesters the number of deaths as a minimum, those subject to a case review has increased for both deaths of people who accessed inpatient services *[T3 2016/17 78%* to *T3 2017/18 100%]* and deaths of people who accessed community services *[T3 2016/17 14%* to *T3 2017/18 18%].* The information team have developed a mortality comparison report devised from the national list of deceased persons held by *NHS Digital*. The report identifies inactive and active patients who have died and compares this to the information held on the clinical care record that may be eligible for review. The report is updated in retrospectively of a patient's death, thus increasing the scope of deaths to review further.

The data relating to learning from deaths from April 2017 is available on the Board dashboard as a quality objective, it is published every 2 months with the agenda for the meeting of the Board in public. Further work will be undertaken during trimester 1 2018/19 to design and implement a bespoke learning from deaths webpage.

Mortality monitoring	2017/18	2018/19		
	T3	T1	T2	T3
Inpatient deaths (including deaths 30 days after discharge)/ subject to a case record	9/ 78%	3/ 100%	3/ 100%	**0/ 100%**
Deaths reported to the Trust/ subject to a case review record	628/ 14%	477/ 16%	420/ 18%	**558/ 18%**

CWP launched the first GR47 - Learning from Deaths Policy in September 2017 to ensure that all deaths in care (including "expected" deaths) are opportunities to learn and also to strengthen our engagement with bereaved families and carers. The policy was accompanied by a pilot of a "case record review" to help us identify this learning.

The policy describes how CWP intends to respond to and learn from deaths of people who die when receiving care or had received care from the Trust in the last 6 months leading up to their death. The timeframe was agreed with the CQC as being reasonable. The policy also outlines how the Trust engages with bereaved families and carers, including how they are supported by the Trust and involved in investigations where relevant.

The Mortality task and finish group undertook the final test series of PDSA (Plan, Do, Study, Act) tests in March 2017, further recommendations were made in relation to refining the case record review template in preparation to be made available onto electronic care notes and EMIS from April 2018. Further work is being undertaken to make the template available on PCMIS.

During this trimester n.15 case record reviews have been discussed at the weekly meeting of harm, none of which has led to further investigation. A clinical audit tool was developed and tested by sub members of the task and finish group. A total n.17 case record reviews reported as no problems in care were clinically audited of which one required further investigation. Learning outcomes from case record reviews identified:

- Need to review adequacy of systems to reliably contact the District Nursing Service out of hours.
- Improvements required to communication with families in relation to medication regimens in place for people receiving palliative care.

There is a 5% quality control process in place for reviewing case record reviews judged as their having been no problems in care, this will be monitored by the Mortality task and finish group who are next due to meet in May 2018.

Multi-disciplinary teams (MDT) should complete a case record review form, a national requirement from April 2018. The case record review form is available on CAREnotes and EMIS. Teams using PCMIS are using a paper form until it is available. This approach will help:

- Apply the 6Cs principles in reflecting on the care provided by the whole team and, just as importantly, in reflecting on the experience of care from the person's perspective.
- Make recommendations on further action, e.g. share learning, undertake reviews, investigations.

4. Recommendation

Recommendations from trimester 3 analysis
The recommendations below have been identified from the detailed analysis of learning from experience that is received by the Quality Committee. Updates and assurances received against these recommendations will be presented in the next report to the Board of Directors.

- The Safe Services Department should develop, by May 2018, an accessible learning from deaths web page to (a) publish the nationally required mortality monitoring data, and (b) provide information to describe the support that bereaved families can access.

- Head of Clinical Governance to allocate investigation managers to the 16 outstanding investigations to ensure that CWP contributes to the national LeDeR programme.

- Further analysis to be undertaken by the Safe Services Department and the Care Groups to streamline complaints categories to ensure they capture the best description of the actual theme to enable the identification of better learning from experience.

- The Complaints Team should review the complaints received by the Trust over the 2017/18 year to assess whether the themes that highlighted in the *PHSO* report are similar to those in the report and where they are, the national learning should be shared. A report should be presented to each of the local governance/ learning from experience meetings in July 2018 to help to identify quality improvement plans.

5. Action for clinical support services and clinical services

Clinical support service teams are asked to:
- Review the findings and key analysis within the report and identify any changes for improvement required to their enabling work programmes.

Clinical services are asked to:
- Review the findings and key analysis within the report at local Learning from Experience groups and identify:
    - Any areas of practice that warrant quality improvement work.
    - Any areas of practice that require enabling support from clinical support services.

An update in respect of the above will be sought for the next report to the Quality Committee.

Recommendation to the Board of Directors
The Board of Directors is asked to **approve** the report and **endorse** the recommendations contained within.

Who/ which group has approved this report for receipt at the above meeting?	David Wood Associate Director of Safe Services
Contributing authors:	Audrey Jones, Head of Clinical Governance Lisa Parker, Incidents Manager David Wood, Associate Director of Safe Services

Distribution to other people/ groups/ meetings:		
Version	Name/ group/ meeting	Date issued
1	Board of Directors	23/05/2018

Appendices provided for reference and to give supporting/ contextual information:	
Appendix number	Appendix title
1	Updates and assurances received against trimester 2 2017/18 recommendations

Appendix 1 – Updates and assurances received against trimester 2's recommendations

Consider self-harm as the Trust's identified "patient safety" quality improvement priority for 2018/19 as described in the Trust's Quality Account 2017/18.
The Trust's "patient safety" quality improvement priority 2018/19 has been agreed as a reduction in the severity of the harm sustained by those people accessing CWP services that cause harm to themselves.
The Mortality task and finish group to refine the GR47 - Learning from Deaths Policy to respond to the findings of PDSA (Plan, Do, Study, Act) cycles prior to full implementation of the policy, particularly in relation to case record reviews, across the Trust.
See appendix B, section 4.1.1.
CWP Consultant Nurse lead for LeDeR to be asked to present at the next Quality Committee meeting to update on how CWP is supporting this programme and to update on the governance framework from an NHS England perspective and the role of adult safeguarding boards.
The Consultant Nurse, Learning Disability Services, will be presenting on the learning disability services mortality audit and presenting the feedback from a learning event at the May 2018 Quality Committee.
The Medication Safety Officer (MSO) should work closely with the Safe Services Department to review those medicines incidents classified as 'other'. Analysis of any trends will be undertaken by the MSO as more data becomes available and as learning is discussed at the Medicines Management Group to identify improvements
See appendix B, section 12.
The business cycle of the Health and Well-being Group should include routine review of staff accident incidents resulting in harm to identify safer systems and mitigate harm.
The Health and Well-being Group reviews staff accident incidents resulting in harm to identify safer systems to mitigate harm.
Further analysis to be undertaken by the Safe Services Department to understand system weaknesses where control measures were in place but still resulted in an incident.
This work will be revisited once the developing guidance, nationally, on defining avoidability is published to ensure alignment, starting with judgements around those as per the current mortality work.
The business cycle of each sub committee should include at least one publication a year to assist with practice development through sharing a subject/ case scenario. These will be edited by the Director of Nursing and Medical Director (Quality).
This will be ensured as part of the corporate meetings review and the review of sub committee business cycles scheduled to be undertaken by the Medical Director (Quality) and the Associate Director of Safe Services.