

## NHS COUNTY DURHAM AND DARLINGTON INTEGRATED BUSINESS BOARD

### Organisational Patient Safety Incident Reports

#### 1. Introduction

'Organisational patient safety incident reports', are published by the National Patient Safety Agency (NPSA)

This paper serves to provide the board with an overview of the organisational patient safety reports for

- NHS Co Durham,
- County Durham and Darlington NHS Foundation Trust,
- County Durham and Darlington Community Healthcare,
- Tees, Esk and Wear Valleys NHS Foundation Trust,
- Northumberland Mental Health Trust

#### 2. Implications and risks

All NHS organisations are required to meet the national reporting and learning services, 'data quality' standards.

This report highlights that NHS County Durham were underperforming against the data quality standards during October 2008 and March 2009. This was due to the connectivity problems with the reporting and learning system at that time.

NHS County Durham's performance against the standards will be monitored by the internal performance group. The standards and the associative reporting timeframes have now been integrated into the reviewed SUI policy.

The national reporting and learning system publish the '*Organisational Patient Safety Incident Reports*' in the public domain.

#### 3. Recommendations

The board are requested to accept this report for information.

Document management				
Version	Date	Summary	Owner's Name	Approved
1.0	13/01/2010	Management Executive	Kirstie Hesketh	
1.0	26/1/10	IBB	E Graham	

#### **4. Author and sponsor director**

Author: Kirstie Hesketh  
Title: Patient Safety and Governance Manager

Director: Elizabeth Graham  
Title: Director of Nursing and Clinical Quality  
Date: 1/12/09

<b>Purpose of paper</b>	Information sharing <b>Yes</b> Development/discussion <b>Yes</b> Decision/action <b>No</b>
<b>How does the paper support / have implications for:</b>	
<b>NHS County Durham's 4 Strategic Aims</b>	Aims 1 and 3
<b>Our Vision Our Future workstreams</b>	N/A
<b>World class commissioning competencies</b>	WCC 1, 4
<b>Standards for better health</b>	Standard C1
<b>Use of resources</b>	N/A
<b>Targets and Vital signs</b>	N/A
<b>NHS Constitution</b>	.NHS Values 2,5
<b>Darzi Principles</b>	Principle 1 - change will always be to the benefit of patients, whether in terms of clinical outcomes, experience or safety.
<b>Impact on / Involvement of partners</b>	Discussion topic at CQRG
<b>Equality &amp; Diversity</b>	There are no equality or diversity implications arising from this review
<b>Other policies / Issues</b>	Being Open SUI Policy

## NHS COUNTY DURHAM AND DARLINGTON INTEGRATED BUSINESS BOARD

### Organisational Patient Safety Reports

#### 1. Introduction

'Organisational Patient Safety Incident Reports', are published by the National Patient Safety Agency (NPSA). The reports provide evidence of organisational activity in respect of reporting patient safety data to the national Reporting and Learning System (RLS), over a six-month period.

In publishing the data, the NPSA aims to provide tools to support NHS organisations in analysing and learning from patient safety incidents, to prevent patient harm in the future.

The reports are profiled against similar organisations in terms of size and provision. This provides comparative data, enabling commissioning organisations the opportunity to review the reporting culture of its provider organisations.

This paper serves to provide the Board with evidence of the organisational patient safety reports, for the period 1<sup>st</sup> October 2008 to 31<sup>st</sup> March 2009, for the following organisations:

- NHS County Durham,
- County Durham and Darlington NHS Foundation Trust,
- County Durham and Darlington Community Health Services
- Tees, Esk and Wear Valleys NHS Foundation Trust,
- Northumberland Mental Health Trust

#### 2. National Context

The National Reporting and Learning Service is one of three divisions of the National Patient Safety Agency (NPSA), an arms length body of the Department of Health. Established in 2001, its mandate was to identify patient safety issues and find appropriate solutions. When a patient safety incident happens, NHS staff in England and Wales can make confidential online reports via their local reporting systems. These reports are then fed into a database, the Reporting and Learning System (RLS). Clinicians and safety experts analyse the reports to identify trends or common risks and opportunities to improve patient safety. Healthcare organisations are then provided with feedback and guidance to improve patient safety in the form of organisational incident summaries.

At a national level the NRLS receives in excess of 60,000 incident reports a month. Despite these volumes, the NPSA has experienced difficulties in establishing a timely and accurate picture of the major patient safety problems faced by the NHS, due to the poor data quality of incident reports.

Although many NHS organisations, already refer to various aspects of guidance with regard to submitting reports to the national Reporting and Learning System (RLS), the NRLS has not previously published a set of standards to address the quality of reporting.

A set of Data Quality Standards (Table One), together with guidance on their use, have now been developed to improve the quality, accuracy and timeliness of the patient safety incident data submitted to the RLS.

**Table One: NRLS Data Quality Standards - 2009**

No.	Criterion title	Minimum standard
1	<b>Reporting to the National Reporting and Learning Service (NRLS)</b>	NHS organisations should submit all their reported patient safety incidents (PSIs) to the NRLS's Reporting and Learning System (RLS).
2	<b>Regularity of reporting</b>	Every NHS organisation should submit reported PSIs regularly to the RLS – regularly is defined by the NRLS as at least monthly.
3	<b>Exclusion of person identifiable information</b>	Every NHS organisation should ensure that PSIs reported to the RLS do not contain person identifiable information in free text fields.
4	<b>Recording actual degree of harm as a result of the PSI</b>	Every NHS organisation should ensure that the degree of harm recorded for each PSI describes the <b>actual harm</b> to the patient <b>as a direct result of the PSI</b> .
5	<b>Speed of reporting of the most serious PSIs to the NRLS</b>	Every NHS organisation should report PSIs with an actual degree of harm of either "severe" or "death" (as described in 4) to the RLS within two working days of the incident occurring.

The NPSA recommends that all NHS health care organisations comply with the Standards. This will help ensure consistently high quality reporting, which informs the development of patient safety guidance.

The standards will also aid the improvement of data analysis for local organisations and ensure they meet their obligations under the Data Protection Act.

This raises a challenge for commissioners, in respect of what monitoring arrangements need to be put in place to provide assurance that our providers meet these standards. This dialogue is due to take place at the Clinical Review Quality Group.

### 3. Incident Analysis

The analysis is presented in association with the 'Data Quality Standards'.

#### 3.1 Reporting Activity

Table two, provides information on the numbers of incidents reported to the RLS by the NHS organisations included in this report for the six-month period.

**Table Two: Number of Incidents reported to the RLS 1<sup>st</sup> Oct 2008 – 31<sup>st</sup> March 2009**

NHS Organisation	Number of incidents reported
NHS County Durham	14
County Durham and Darlington Community Health Services	121
County Durham and Darlington NHS Foundation Trust,	2,836
Northumberland Mental Health Trust	4,902
Tees, Esk and Wear Valleys NHS Foundation Trust,	3,422

Figures One to Five (Appendix One) illustrates the reporting activity further. Due to the diversity and size of the organisations, the data has been benchmarked against a number of organisations of equal size. This comparative data is referenced in each of the titles.

Analysis shows that:

- County Durham and Darlington Community Health Services, Tees, Esk and Wear Valleys NHS Foundation Trust and Northumberland Mental Health Trust are among the top 25% of reporters, and currently exceed the national reporting median.
- County Durham and Darlington Foundation Trust are among the middle 50% of reporters.
- NHS County Durham are in the lowest 25% of reporters and at a reporting rate of 0.3 per 10/000 population are significantly reporting below the median rate of 4.1 when compared to 104 PCT's.

The reporting profile for NHS County Durham initially appears disappointing. The low reporting rate can be explained and is attributed to connectivity problems between the PCT's incident reporting system at this time and the reporting and learning system. Despite regular incident uploads being successfully completed by the patient safety team, the incidents failed to be accountable to NHS County Durham on the Reporting and Learning System. A small number of PCT's nationally are still unable to report to the NRLS because of this very problem.

With the introduction of 'Safeguard', this problem has now been addressed.

### **3.2 Regularity of reporting**

Every NHS organisation should be reporting incidents to the RLS on a monthly basis.

Table Three provides information on the regularity of reporting and also discloses how promptly incidents are being reported. The significance of monitoring the occurrence is that serious incidents need to be reported quickly so that lessons can be learned and

action taken to prevent harm happening to others. The RLS has established that 50% of all incidents are submitted more than 57 days after the incident occurred, therefore 57 days is indicated as an acceptable standard at this time.

Overall the regularity of reporting and occurrence rate is poor, with the exception of Northumberland Mental Health Trust who reports consistently on a monthly basis and report 50% of their incidents within 22 days of occurrence.

**Table Three: Regularity of Reporting**

<b>NHS Organisation</b>	<b>Regularity (Standard - monthly reporting 6/6)</b>	<b>Occurrence (Standard - 50% of incidents are reported 57 days after occurrence)</b>
NHS County Durham	2/6	86 days after incident reported
County Durham and Darlington Community Health Services	1/6	109 days after incident reported
County Durham and Darlington NHS Foundation Trust,	3/6	121 days after incident reported
Northumberland Mental Health Trust	6/6	22 days after incident reported
Tees, Esk and Wear Valleys NHS Foundation Trust,	6/6	81 days after incident reported

### 3.3 Types of incidents reported

Figures six to ten (Appendix two) provides graphical information on the top ten incidents that each organisation has reported.

County Durham and Darlington NHS Foundation Trust and County Durham and Darlington Community Health Services are predominantly reporting incidents relating to medication and patient accidents, the latter type being most likely attributed to patient falls.

The Mental Health Trusts as expected report high incident rates in relation to patient accidents, disruptive/ aggressive and self-harming behaviour.

NHS County Durham has mainly reported medication incidents to the RLS. Figure seven illustrates that as a PCT the incident reporting rate for medication incidents is greater than for comparative PCT's. Which indicates that reporting of medication incidents in PCT's is poor, since the total number of incidents reported by NHS County Durham was only 14.

The information contained in the organisational patient safety reports, are scrutinised by the Patient Safety and Governance Team and are reviewed against alternative data that is available on the organisations such as incident data on Safeguard and STEIS. Any concerns are raised with the respective organisation directly or through the 'Quality Review' groups. For example dialogue needs to take place with County Durham and Darlington NHS Foundation Trust (figure six) to establish why their report evidences that they have had no incidents relating to medical devices / equipment. Zero incidents, in this category for an organisation of that size, is unusual and requires exploration.

### **3.4 Incident reported by degree of harm**

Every NHS organisation should record the degree of actual harm a patient incurs as a result of an incident. Not all organisations apply the national coding of degree of harm in a consistent way, which makes the comparison of harm profiles of organisations difficult.

Currently the NRLS state that nationally 66% of incidents are reported as no harm and just over 1% as no harm or death.

Therefore to address the inconsistency and quality of this data, a data quality standard has been developed and organisations are encouraged to report actual harm, not potential harm.

Figures eleven to fifteen (Appendix three) provides the board with an overview of the degree of harm reported by the organisations included in this report. Incidents reported as being severe or having resulted in death, will have been reviewed by the Strategic Health Authority as serious untoward incidents on STEIS.

It is intended that in early 2010, the Patient Safety and Governance Team will be accepting responsibility from the SHA for the management of STEIS, and will overview the serious untoward incidents for these organisations. This will enable for more robust analysis of the data, presented in organisational patient safety incident reports.

## **4. Conclusions**

- The organisation patient safety incident reports provide NHS County Durham with an insight into the patient safety culture and risk management processes of provider organisations. The reports encourage openness and transparency in communications about patient safety incidents.
- This report enables members of the Board to address the key actions outlined in the NPSA's Briefing for Boards paper (October 2009) on Organisational Patient Safety Incident Reports
- The introduction of the data quality standards is a tool that will enable improvements to be made in the quality, accuracy and timeliness of the patient safety data being reported.
- Improvements in organisational reporting should be evident through future reports and will be monitored through quality contracts.

## **5. Recommendations**

The Board is requested to accept this report for information.

## **6. Author and sponsor director**

Author: Kirstie Hesketh  
Title: Patient safety and governance manager

Director: Elizabeth Graham  
Title: Director of nursing and clinical quality

Figure 1: County Durham and Darlington NHS Foundation Trust, comparative reporting rate, per 100 admissions, for 44 large organisations.

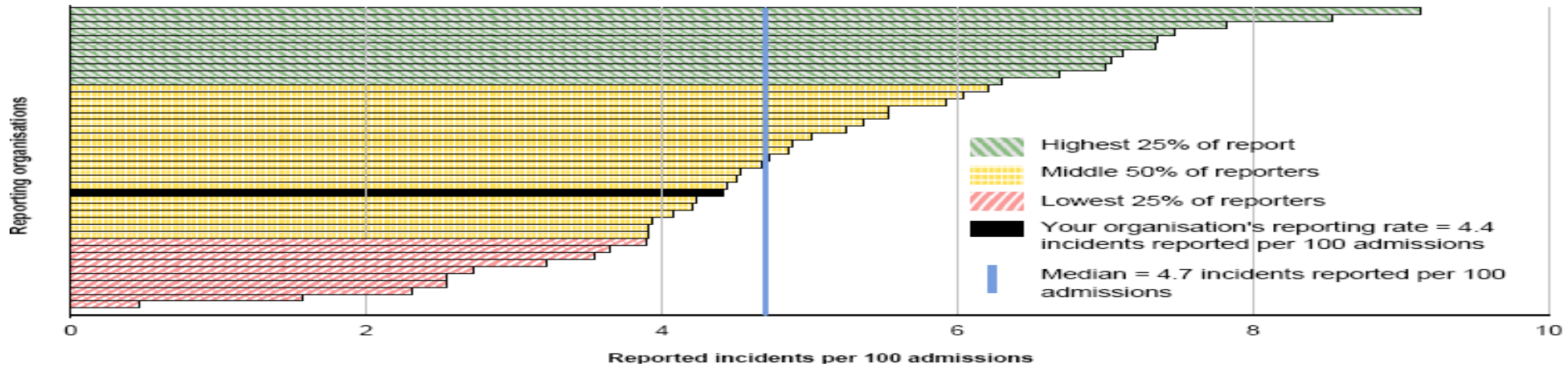
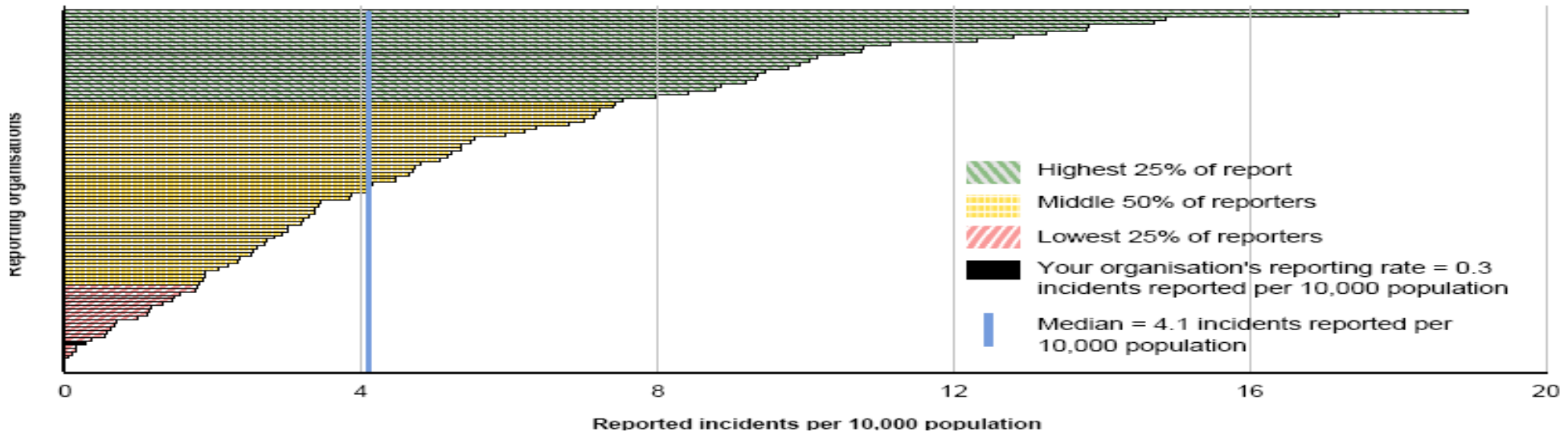
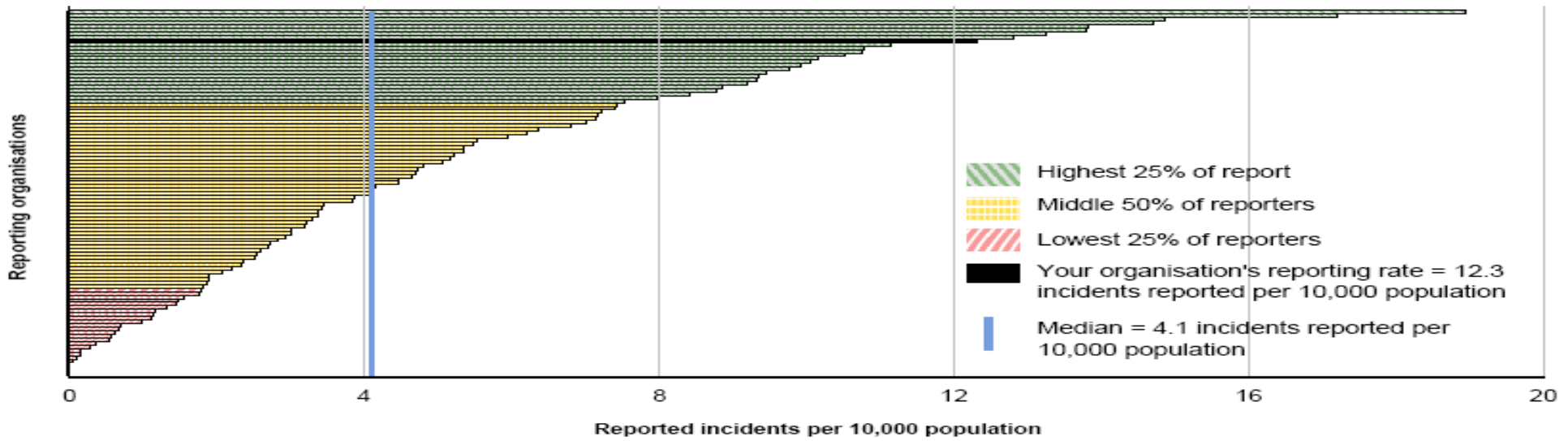


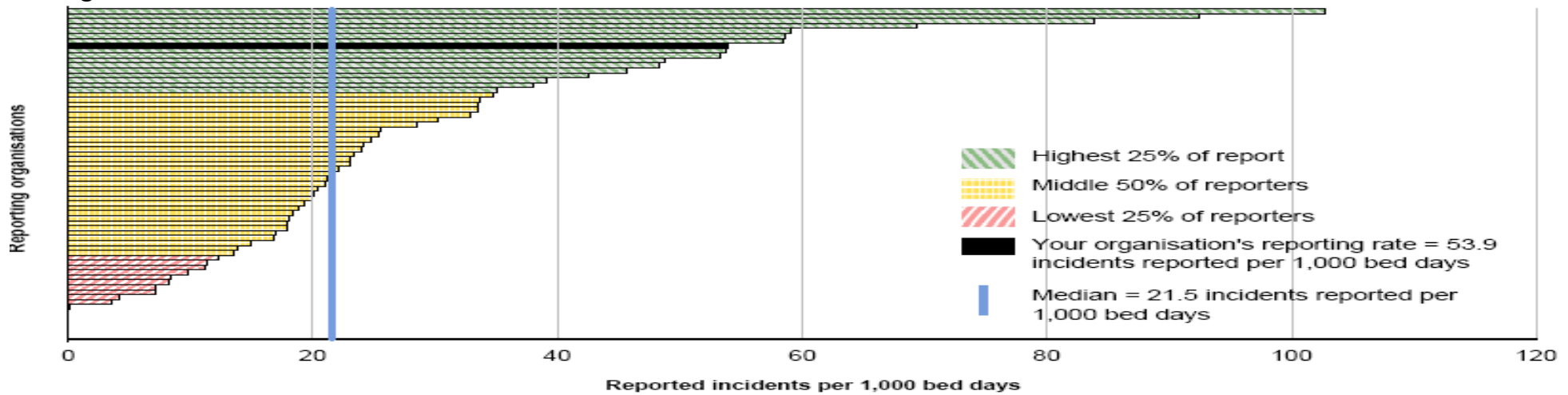
Figure 2: NHS County Durham, Comparative Reporting Rate per 10,000 population, for 104 primary care organisations with no inpatient provision.



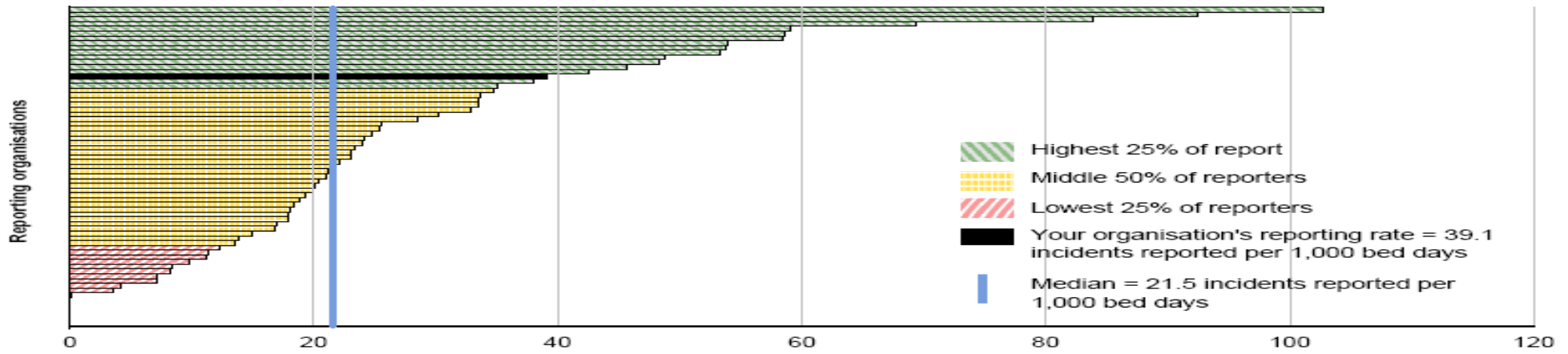
**Figure 3: County Durham and Darlington Community Health Services, comparative reporting per 10,000 population, for 104 primary care organisations with no inpatient provision**



**Figure 4: Northumberland Tyne and Wear NHS Trust Comparative reporting rate, per 1,000 bed days, for 67 mental health organisations.**

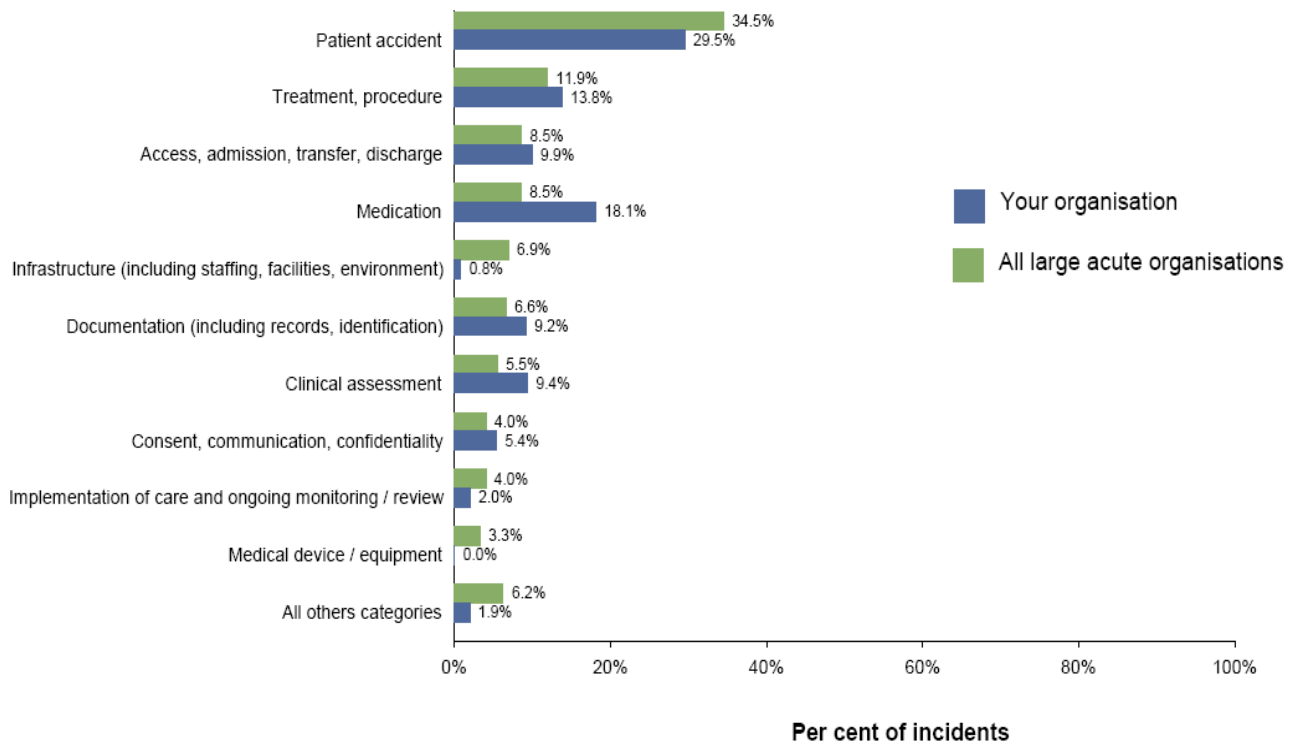


**Figure 5: Tees, Esk and Wear Valleys NHS Foundation Trust, comparative reporting rate, per 1,000 bed days, for 67 mental health organisations.**

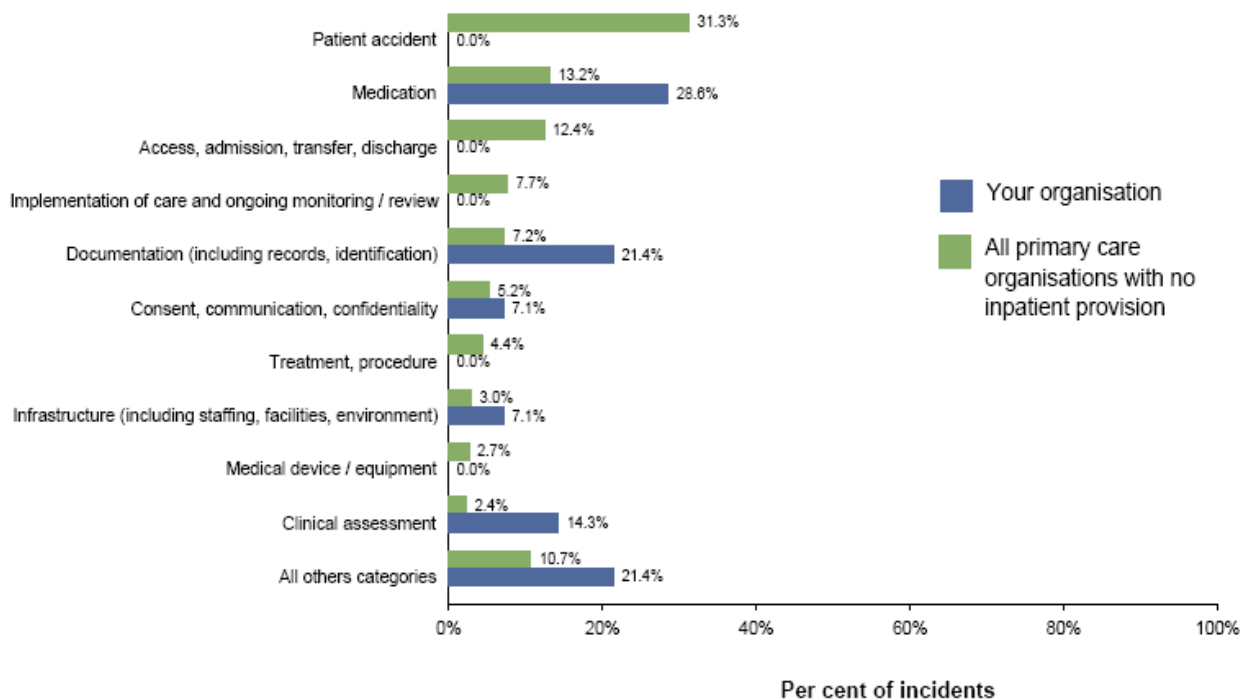


## APPENDIX 2

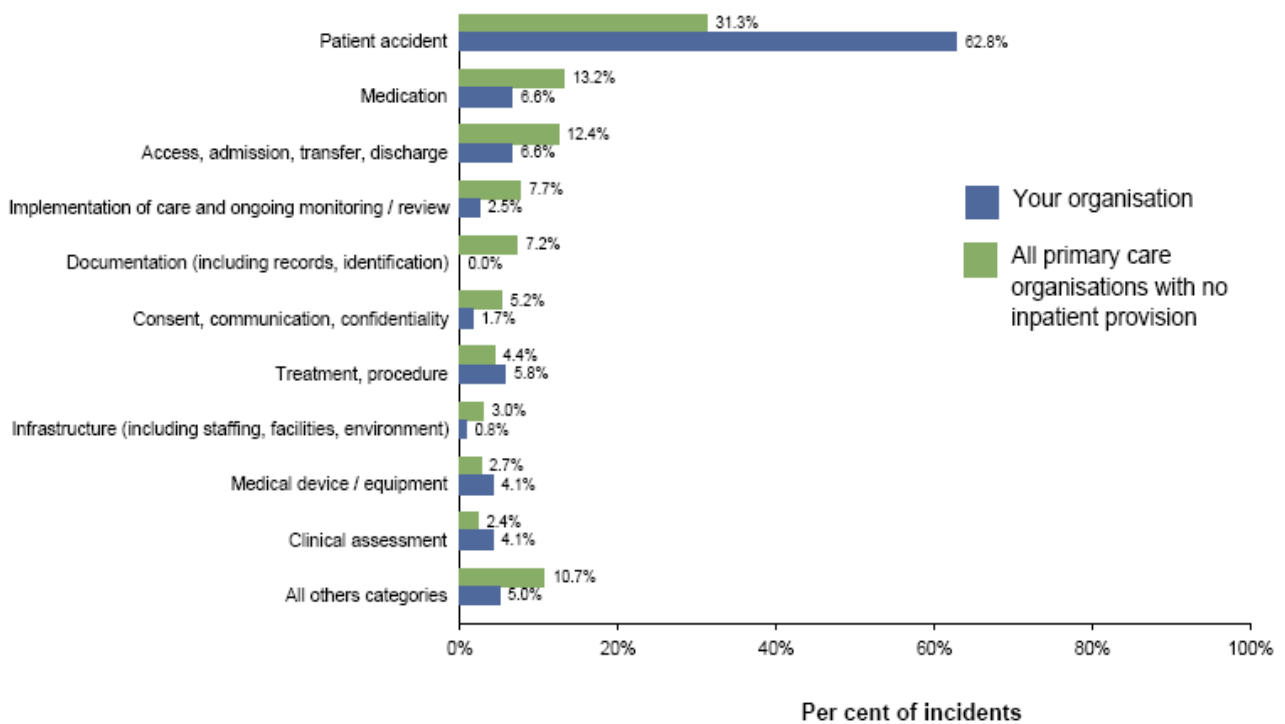
**Figure 6: County Durham and Darlington Foundation Trust - Top 10 incident types**



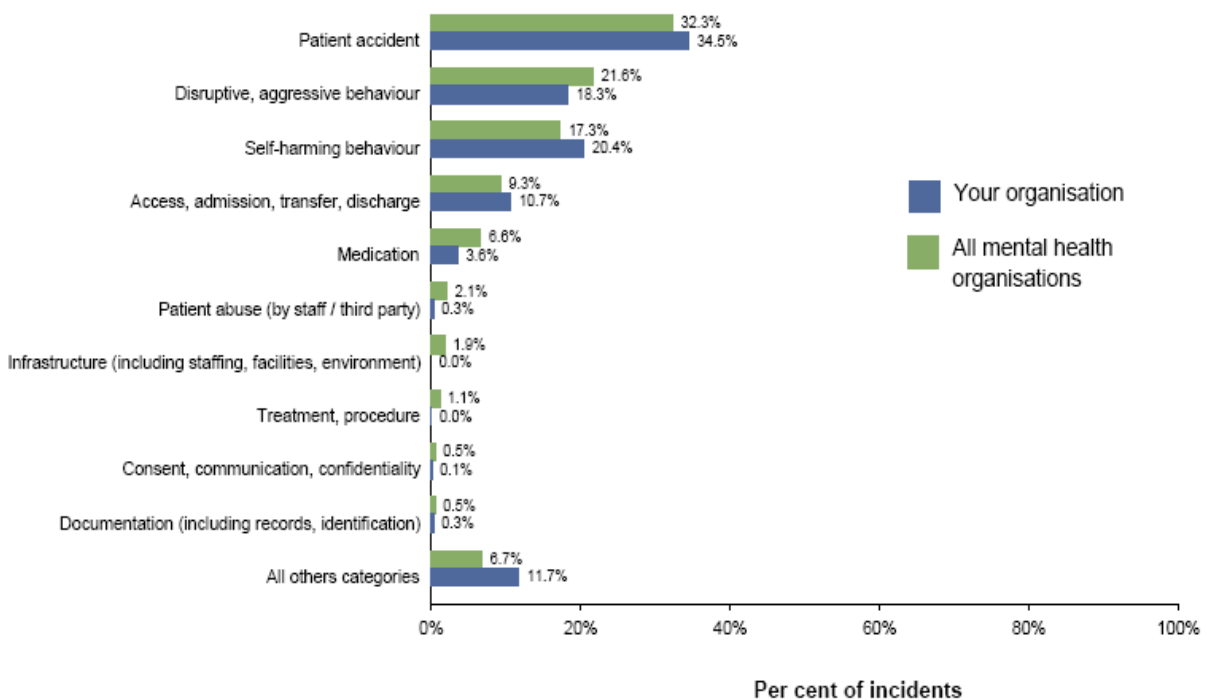
**Figure 7: NHS County Durham – Top 10 incident types**



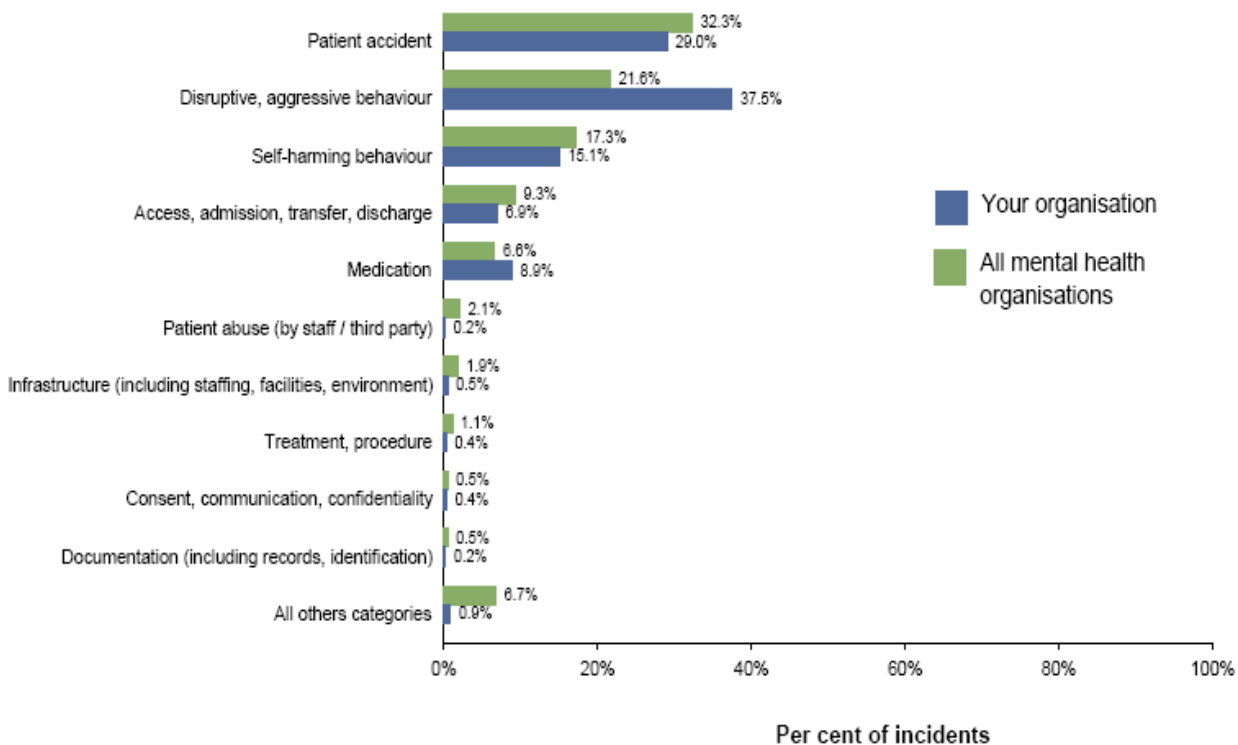
**Figure 8: County Durham and Darlington Community Health Services -Top 10 Incident types**



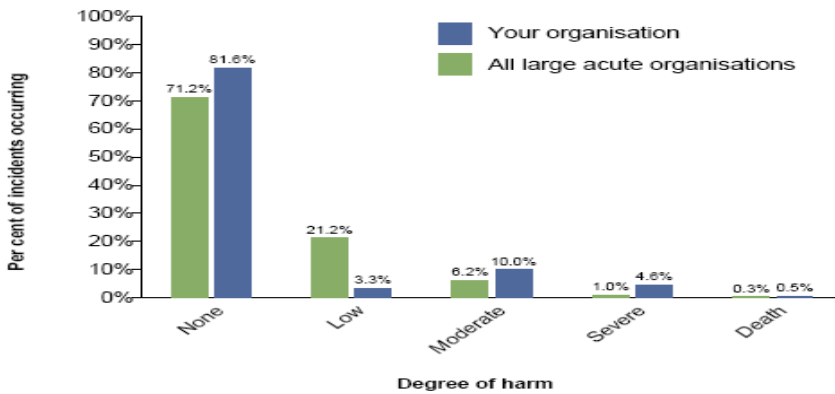
**Figure 9: Northumberland Tyne and Wear Mental Health Trust - Top 10 Incident Type**



**Figure 10: Tees, Esk and Wear Valleys NHS Foundation Trust – Top 10 incident type**



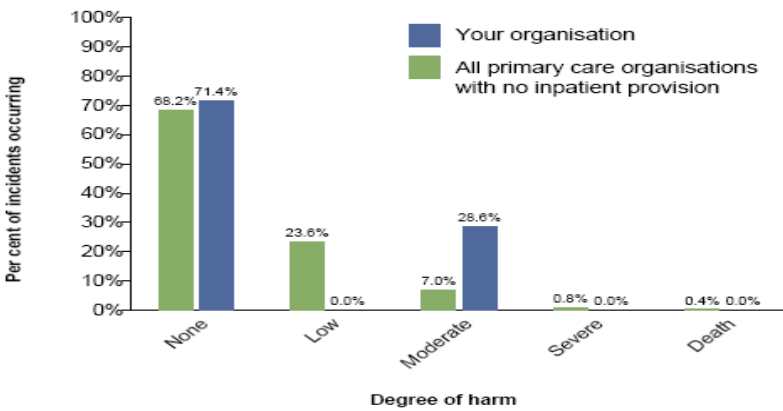
**Figure 11: County Durham and Darlington NHS Foundation Trust - Incidents reported by degree of harm**



Your figures:

Degree of harm	None	Low	Moderate	Severe	Death
Your figures:	2,314	94	284	130	14

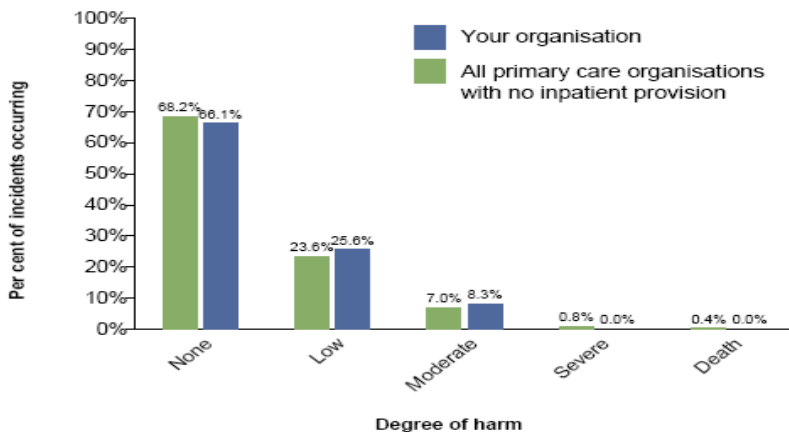
**Figure 12: NHS County Durham – Incidents reported by degree of harm**



Your figures:

Degree of harm	None	Low	Moderate	Severe	Death
Your figures:	10	0	4	0	0

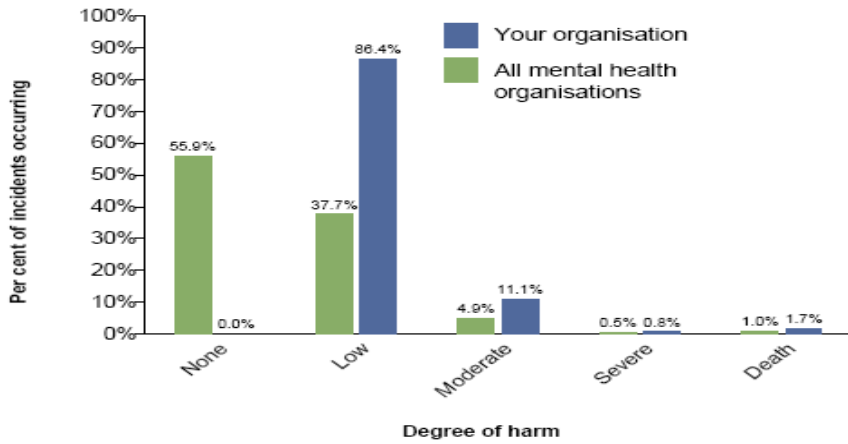
**Figure 13: County Durham and Darlington Community Health Services - Incidents reported by degree of harm**



Your figures:

Degree of harm	None	Low	Moderate	Severe	Death
Your figures:	80	31	10	0	0

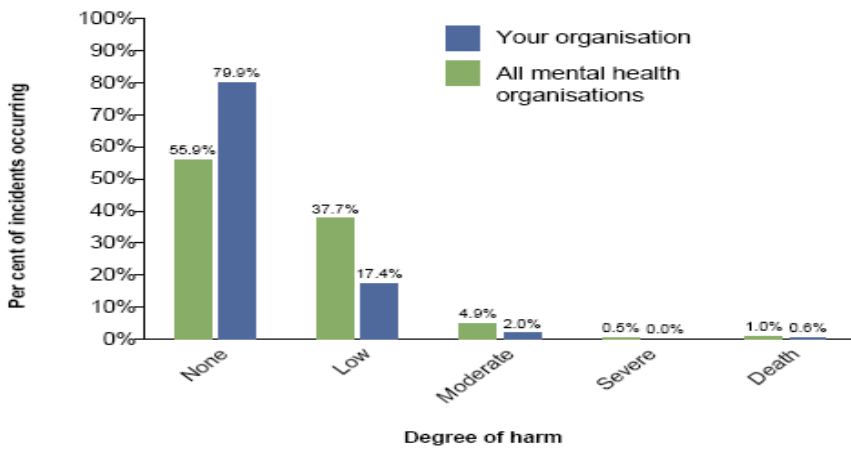
**Figure 14: Northumberland Tyne and Wear Mental Health Trust - Incidents reported by degree of harm**



Your figures:

Degree of harm	None	Low	Moderate	Severe	Death
Count	1	4,235	546	39	81

**Figure 15: Tees, Esk and Wear Valleys NHS Foundation Trust – Incidents reported by degree of harm**



Your figures:

Degree of harm	None	Low	Moderate	Severe	Death
Count	2,735	596	69	1	21