West London NHS Trust
Imperial College Healthcare NHS Trust

Learning Lessons from Serious Incidents involving Co-existing Mental Illness and Substance Misuse

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AIMS

To assess how well the trust has been learning lessons about co-existing mental illness and substance misuse (CMISM) serious incidents.
To use a Quality Improvement framework to improve care and outcomes for people with CMISM

BACKGROUND

- Serious Incidents (SIs) in healthcare are events where the potential consequences to those involved are so significant, they warrant immediate investigation and action (1).
- SIs are events which should **never happen** and therefore we **must** learn lessons from them.
- The human factors theory identifies a hierarchy of strength of recommendations in investigations, with **policy and training** recommendations being the **weakest**, and **systems change** being the **strongest** (2, 3). See Figure 1.
- However, recommendations triggered by SIs come from a **managerial panel** and not from those **working at the heart of the system**.
- A trust audit of SIs between April 2012 and April 2014 found 50% of SIs in involved patients with CMISM. It concluded that the core assessment was generally poor or out of date for service users with CMISM. The majority of people with CMISM did not have substance misuse diagnosis recorded, or an appropriate substance use care plan.

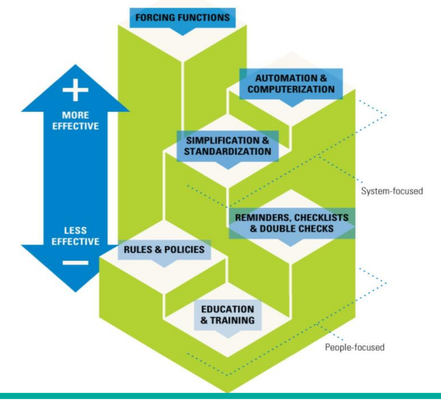

Figure 1 (6). Diagram visualising the hierarchy of intervention effectiveness in healthcare

METHODOLOGY

Phase 1: Re-audit: Thematic meta-analysis of 94 SIs in local services between 2016 and 2020, studying the proportion involving CMSM, and the management of these cases as well as how well the trust wide governance process facilitated learning lessons. The outcomes (see below) of Phase 1 informed Phase 2 methodology.

Phase 2: Conversation cafés: Using Model for Improvement methodology (4, 5).
Online facilitated conversations were conducted for frontline clinicians with successive Plan-Do-Study-Act (PDSA) cycles. These 'conversation cafés' were designed to explore a different approach to learning lessons, asking staff to engage with each other to explore barriers, to good care experienced at the frontline explore potential solutions.
Themes were drawn from the conversations, feedback sought from participants, and successive conversations modified to reflect changes implicated by the previous cycles.

PHASE 1 RESULTS AND CONCLUSIONS

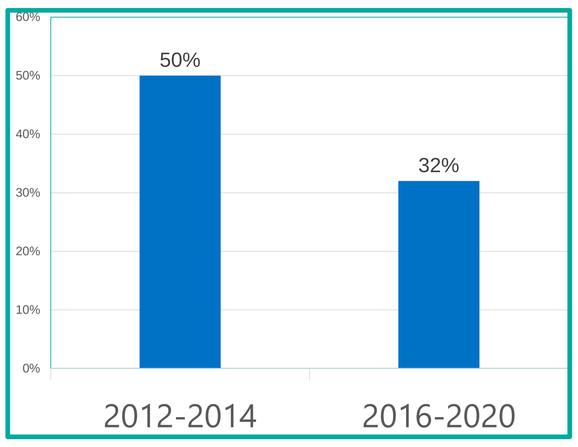

Figure 2. Proportion of Serious Incidents noted (by auditors) to have CMISM as a contributing factor in previous audit (2012-14) and our Phase 1 audit (2016-20)

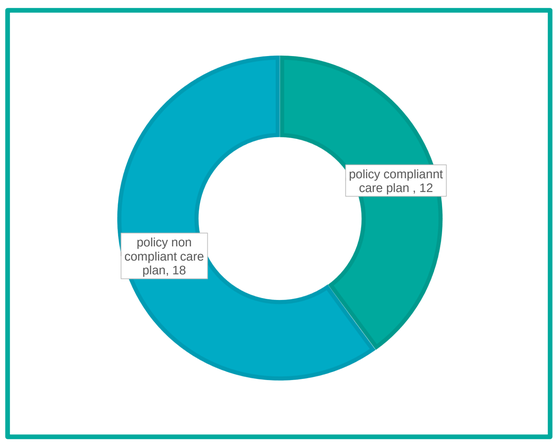

Figure 3. Proportion of CMISM related Serious Incidents that had policy compliant care plans.in 2016-2020 audit. (N=30)

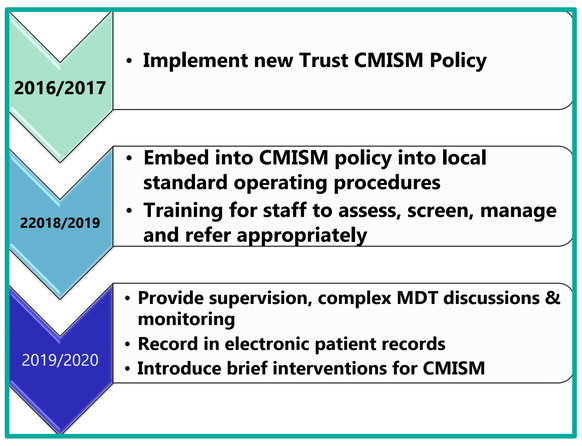

Figure 4. Evolution of quality and "strength" of serious incident recommendations between 2016 and 2020 about co-existing mental illness and substance misuse

We found the percentage of SIs with CMISM involved had decreased from 50% to 32% between the two audits.

But we found that of the 32% (30) where CMISM was involved, only 12 had policy-compliant care plans. In 18 cases (19% of all SIs), there were missed opportunities to have implemented better CMISM care plans.

In the SI reviews, we found that over the four years between 2016 and 2020, the investigating panels seemed to have evolved the quality and strength of their recommendations for further learning from very transactional to more relational approaches.

Challenges conducting the analysis

- SIs were not easily available and it took time to access them.
- We couldn't easily extract information about SIs from our electronic records or incident reporting system (IR1) on this cohort of people.
- SIs not clustered e.g. by year, service line, level of severity. This delayed analysis.
- SI report format (although much more uniform than previously) still made it challenging to extract some information easily. e.g service line, level, incident type

PHASE 1 RECOMMENDATIONS

Governance

- Add CMISM to template for all SIs as part of the terms of reference.
- We recommend the incident reporting systems has CMISM incorporated as a SI category to facilitate easier audit and learning lessons.

System

- Ensure easy access to services for people with CMISM by addressing interface barriers, and improving signposting of existing services
- Improved communication channels between services (see Phase 2)
- Ensure provisions of services for people with CMISM

Training

- Use QI approach to get frontline staff to develop formative educational approaches
- Training techniques that support changes in **attitude** not just knowledge
- See Phase 2

PHASE 2 RESULTS AND RECOMMENDATIONS

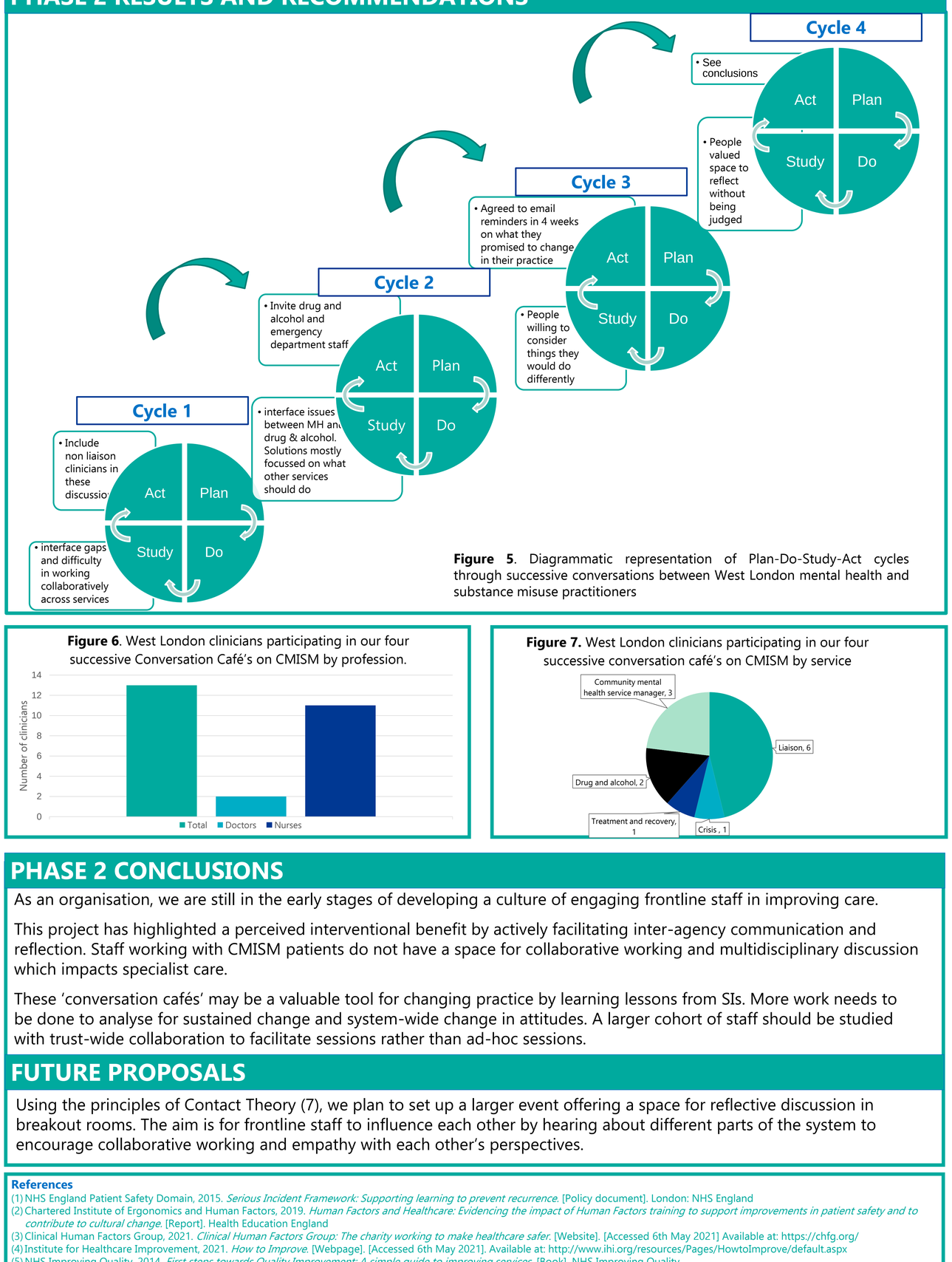

Figure 5. Diagrammatic representation of Plan-Do-Study-Act cycles through successive conversations between West London mental health and substance misuse practitioners

Figure 6. West London clinicians participating in our four successive Conversation Café's on CMISM by profession.

Figure 7. West London clinicians participating in our four successive conversation café's on CMISM by service

PHASE 2 CONCLUSIONS

As an organisation, we are still in the early stages of developing a culture of engaging frontline staff in improving care.

This project has highlighted a perceived interventional benefit by actively facilitating inter-agency communication and reflection. Staff working with CMISM patients do not have a space for collaborative working and multidisciplinary discussion which impacts specialist care.

These 'conversation cafés' may be a valuable tool for changing practice by learning lessons from SIs. More work needs to be done to analyse for sustained change and system-wide change in attitudes. A larger cohort of staff should be studied with trust-wide collaboration to facilitate sessions rather than ad-hoc sessions.

FUTURE PROPOSALS

Using the principles of Contact Theory (7), we plan to set up a larger event offering a space for reflective discussion in breakout rooms. The aim is for frontline staff to influence each other by hearing about different parts of the system to encourage collaborative working and empathy with each other's perspectives.

References
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