NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: Wednesday 28th January 2015

Title and Author of Paper Safety Report – July – December 2014
Tony Gray – Head of Safety / Patient Experience

Paper for Debate, Decision or Information: Information

Key Points to Note:

Incident Activity & Analysis

The Trust continues to actively encourage reporting of incidents as part of its overall safety culture. The number of reported serious incidents has reduced in the period July - December 2014, from the high reported activity for the same time last year, this reduction is seen in all areas, that were previously highlighted as concerns. Regular updates are provided to both the Trust's Quality & Performance Committee as well as the Operational Group Business Meeting. Through Incidents report, as well as through the regular meetings with respective Clinical Commissioning Groups.

Identification of Themes

- There is a new section on the themes identified from the Serious Incident Review process. The panel members now review all the incidents from the previous quarter, serious incident reviews, and identify the appropriate actions to support the clinical services.

Action Planning & Impact of Action

- There is an update provided on the Sign up to Safety Initiative
- The report contains the action planning processes in place, and an update for any published independent investigations and a current update on all ongoing Parliamentary Health Service Ombudsman Complaints reports.

Safety of Transformation

- An update on the Safety of Transformation is included in the report.

Outcome required: Noted for Information

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
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Safety Report
January 2015
Reporting period – July - December 2014

Introduction
This is the Safety Report for the reporting period July – December 2014.

The Safety Programme
The Safety Programme (SP) is one of the two key programmes of the Trust, and encapsulates the Trust's approach to achieving its overall safety goal of reducing incidence of harm. It has four key dimensions, seen in the figure below:

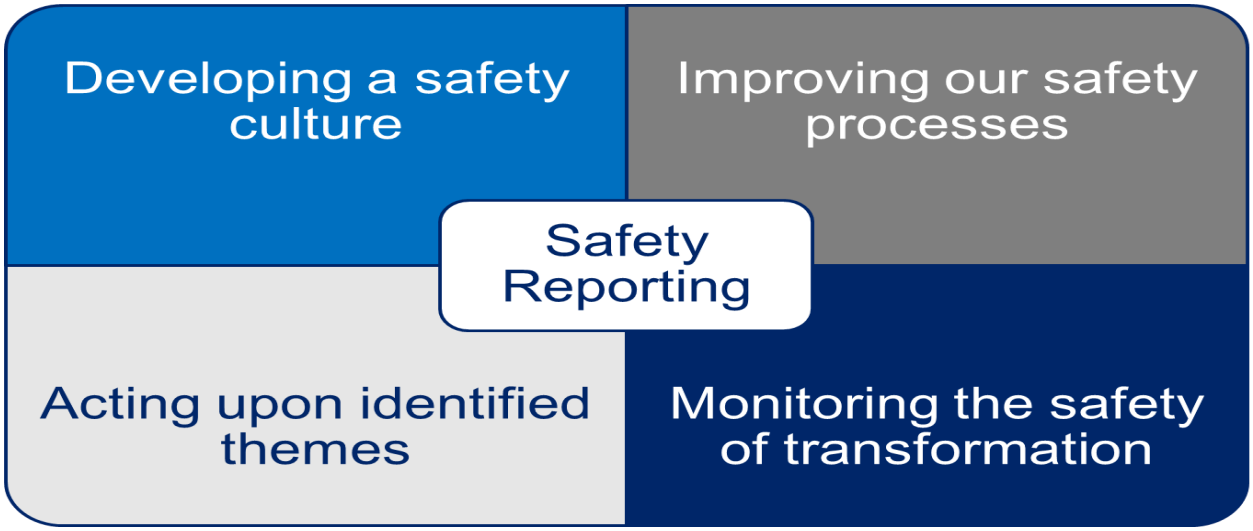


Fig1: Safety Programme Dimensions

The Safety Report is the mechanism for providing reporting, analysis and progress with actions, for the purpose of assurance to the Board and key committees. It is available to all staff via the Trust intranet. The "four quadrant" approach is now familiar. These four quadrants are: Incident Activity & Analysis, Identification of Themes, Action Planning & Impact of Actions and Safety of Transformation (formerly Assessment of Impact).

The Context of This Report: NTW's Approach to Reporting of Incidents & Commentary of Reporting Approaches across the *NHS*

NTW has always adopted an open and active reporting culture. We encourage the reporting of all incidents of harm. As the degree and extent of harm may be difficult to determine in the immediate aftermath of an incident, due to a number of reasons, such as the incident being considered in isolation of all other incidents, the incident affecting the reporter, which impacts the level of harm. NTW always reports the highest numbers of incidents for Mental Health Trusts. However, when rates per 1000 bed-days are considered, NTW is no longer the biggest reporter (NEQOS benchmarking report 2013).

'Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.'
(NRLS Organisation Patient Safety reports, March 2013)

This approach is especially important to understand in regard to the reporting of Serious Incidents (SI's) including unexpected deaths. As part of its open and active reporting culture, the Trust encourages the reporting of all deaths, including those which might be presumed to be from natural causes. In this our practice is notably different to many other MH organisations, which may be much more conservative in their reporting. Our approach is to report all unexpected deaths as SI's to start with, and to commence an investigation into the incident. As more information becomes available, e.g. from the incident investigation, post mortem and ultimately, the Coroner's Inquest, those deaths determined to be due to natural

causes are removed from the data set and de-escalated as serious incident with our Commissioners.

Therefore the set of “unexpected deaths” includes deaths subsequently determined to be due to natural causes. The removal of these deaths leaves a set of deaths which we term as “Unnatural deaths”. This set of deaths is subjected to further analysis in the regular Board updates presented by the Trust Public Health lead. The most up to date report is being presented at the September 2014 Board of Directors meeting.

It should be noted that this set of incidents includes deaths due to accidents, drug overdose or misadventure, as well as those subsequently determined by the Coroner to be due to suicide, or with narrative conclusions.

This process of clarification depends on a number of factors, including internal investigations, police or accident investigations, post mortem and toxicological investigations, and of course Coronial processes. Therefore, the eventual status of a particular death may remain in doubt for a period of months to, in some cases, years. It is expected that due to changes in the Coronial processes, this delay should start to reduce and indeed some Coroners have already intimated there wish to conclude all inquests to within 6 months from date of death.

It is noteworthy that following the publication of the Francis report and updated guidance from the CQC, the reporting practice of other Mental Health Trusts has shifted in the direction of our own.

These points should be taken into account when reading this report. Importantly, when considering the figures for unexpected deaths over the reporting period, it should be borne in mind that as virtually none of these have been considered by a Coroner, a proportion will in time be shown to be due to natural causes or accidents, at which point they will be removed from further analysis.

4 Quadrant Safety Report At A Glance

1 - Incident Activity & Analysis	2 – Identification Of Themes
The number of serious incidents has reduced. For the period July – December there were 65 serious incidents, this was 14 less than the same period last year, more information on serious incidents is on page 10.	There is a new section on identification of themes for the incidents in the period April 2014 – September 2014, that have been reviewed between July 2014 – December 2014, more information on this is on page 15. Themes identified Safeguarding Processes GP Communication Risk Assessment Consent to Share/ Record Keeping Falls Management
3 – Action Planning & Impact Of Action	**4 – Safety Of Transformation**
No further independent action plans have been published, more information relating to the action plan process is on page 19. • Less serious incidents of violence on in-patient wards, coupled with lower impact of harm reported for all physical assaults for both in-patient and community services, this is as a result of lone working systems, staff attack systems, improvement to in-patient environments, increased staffing levels, improved and increased management of violence and aggression training, and peer reviews of physical interventions. • Less reported fractured neck of femurs due to improved compliance with the Trust Falls Policy. • Less serious incidents relating to self harm, due to safer management of patient risk, improvements in the in-patient environment, increased staffing levels, better support of in-patient teams with the support of the ACE Team and the development of the Personality Disorder Hub Team.	More information on page 20

Section 1: Incident Activity & Analysis

The Trust reported over 30,000 incidents in 2013 /14. In 2013 / 14, 156 of these were classified as serious incidents in line with Clinical Commissioning Group Guidance. The following table indicates the numbers of incidents over the last 5 years for the reporting period and the annual figure.

Table 1 – All Incident Activity

Year	July - December	+/- on previous period	Number Of incidents Annual	+/- Year on Year
10/11	11771	+1133	24092	+2741
11/12	13417	+1646	26336	+2244
12/13	14674	+1257	29105	+2769
13/14	15196	+552	30449	+1334
14/15	13606*	-1590*	21418	YTD

Data for December is still being inputted, but it will still be expected that this figure will be lower than previous reported periods.

At the end of 2013/14 the total incidents reported was 30,449, and for the comparative periods, incident rates have begun to reduce, and this follows the trend for the last report.

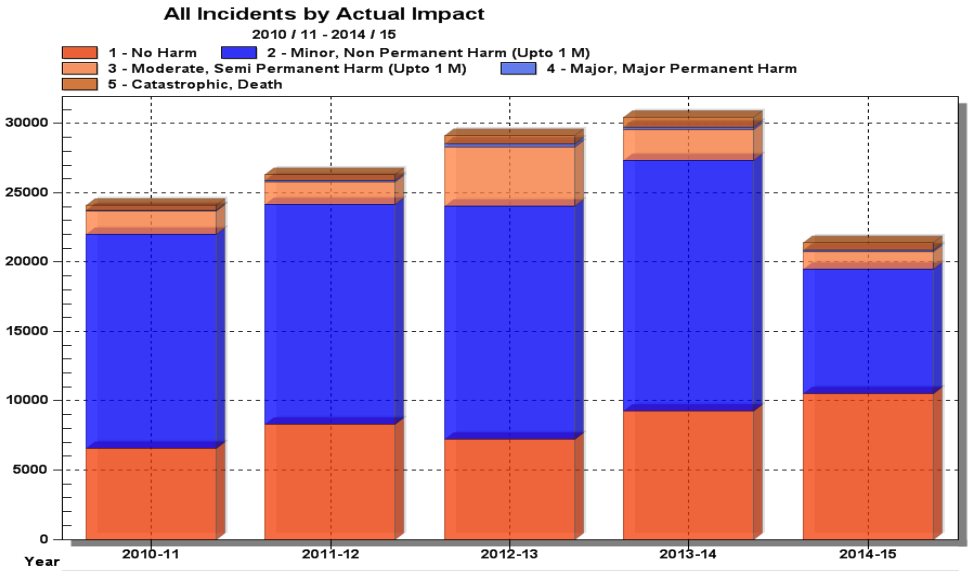
Table 1a –Serious Incident Activity

Year	July - December	+/- on previous period	Number Of Serious incidents Annual	+/- Year on Year
10/11	46	-10	91	-27
11/12	46	0	120	+29
12/13	59	+13	128	+8
13/14	79	+20	156	+28
14/15	65	-14	97	YTD

As with all incident reporting we have seen a reduction in serious incidents for the last reporting period, with a reduction of 14 serious incidents for the same period comparison in 2013/14.

Grading of harm: the following graph provides information about the grading of harm.

Graph 1: All Incidents by Actual Impact – Data Period 2010 - 2015



Year	2010-11	2011-12	2012-13	2013-14	2014-15
1 - No Harm	6530	8302	7190	9252	10524
2 - Minor, Non Permanent Harm (Upto 1 M)	15468	15878	16856	18075	8971
3 - Moderate, Semi Permanent Harm (Upto 1 M)	1652	1611	4221	2240	1261
4 - Major, Major Permanent Harm	105	112	251	145	124
5 - Catastrophic, Death	337	433	587	737	530

While an overall high reporting picture is indicative of a good safety culture, the desired configuration is one of high reporting with declining levels of harm over time, especially in terms of moderate, severe and catastrophic impact. Following the quality check carried out by the Safety Team, it is evident that a number of incidents were incorrectly graded as major / moderate, and the figure has reduced in 2013 / 14 and continues to reduce in 2014/15. It is also evident that quality check relating to no harm and minor harm is helping to improve the quality and accuracy of this information.

The breakdown of incidents is shown in Table 2, below.

Table 2

July – December 2013		July – December 2014		+/-
AWOL And Abscond	462	AWOL And Abscond	391	-11
Contractor/Public/Visitor Incident	12	Contractor/Public/Visitor Incident	11	-1
Death	355	Death	368	+13
Fire	85	Fire	49	-36
Inappropriate Behaviour By Others	9	Inappropriate Behaviour By Others	10	+1
Inappropriate Patient Behaviour	588	Inappropriate Patient Behaviour	661	+73
Inappropriate Staff Behaviour	38	Inappropriate Staff Behaviour	23	-15
Inappropriate Treatment	6	Inappropriate Treatment	16	+10
Infection, Prevention And Control	30	Infection, Prevention And Control	50	+20
Information Governance	133	Information Governance	212	+79
Infrastructure	62	Infrastructure	52	-10
Medical Device, Equipment	12	Medical Device, Equipment	44	+32
Medication	741	Medication	476	-265
Mental Health Act	18	Mental Health Act	20	+2
Patient / Staff Safety	12	Patient / Staff Safety	8	-4
Patient Accident	1660	Patient Accident	1224	-436
Patient Clinical Issue	26	Patient Clinical Issue	17	-9
Patient Ill Health	1034	Patient Ill Health	858	-176
Police Issue	10	Police Issue	6	-4
Safeguarding	1163	Safeguarding	1289	+126
Security	734	Security	727	-7
Self Harm	2125	Self Harm	1845	-280
Service Delivery	129	Service Delivery	72	-57
Staff Accident	378	Staff Accident	252	-126
Staff And Patient Accident	6	Staff And Patient Accident	5	-1
Staff Ill Health	9	Staff Ill Health	8	-1
Unknown Patient Injury	0	Unknown Patient Injury	3	+3
Violence And Aggression	5359	Violence And Aggression	4909	-450
	15196		13606	-1590

Data for December 2014 is still being inputted into the system, so a number of the incident category figures will change.

The number of deaths shown in the table above includes expected deaths, which are not under coronial investigation. A detailed breakdown on unexpected and natural deaths is reported separately to the Board of Directors this month.

Serious Incidents

Table 4
The following table indicates the number of serious incidents reported annually and in the period July - December for the last 3 years.

Number of serious incidents reported	2012/ 13	2013/ 14	2014/ 15 YTD		Jul - Dec 2012	Jul - Dec 2013	Jul - Dec 2014
AWOL / abscond	5	3	0		**1**	**2**	**0**
Unexpected Deaths	73	98	74		**29**	**51**	**52**
Homicides	1	4	3		**1**	**3**	**3**
Physical Assaults	9	8	2		**5**	**2**	**0**
Self Harm	10	14	4		**7**	**9**	**2**
Under 18 Admissions	3	2	2		**3**	**0**	**2**
Fractured Neck of Femurs / Fractures	24	19	8		**9**	**7**	**4**
Information Governance	1	4	1		**0**	**1**	**0**
Other	1	4	3		**2**	**4**	**2**
Total serious incidents reported	**127**	**156**	**97**		**57**	**79**	**65**

The figures for unexpected deaths for years 2012 and 2014 were broadly similar same, with the increase noticeable in 2013. Most of the deaths for 2014 have yet to be examined by the Coroner and it is likely as indicated above that a number will be classed as natural causes or accidents.

Fractures and patient accidents are reducing both from an annual perspective and in the last reporting period.

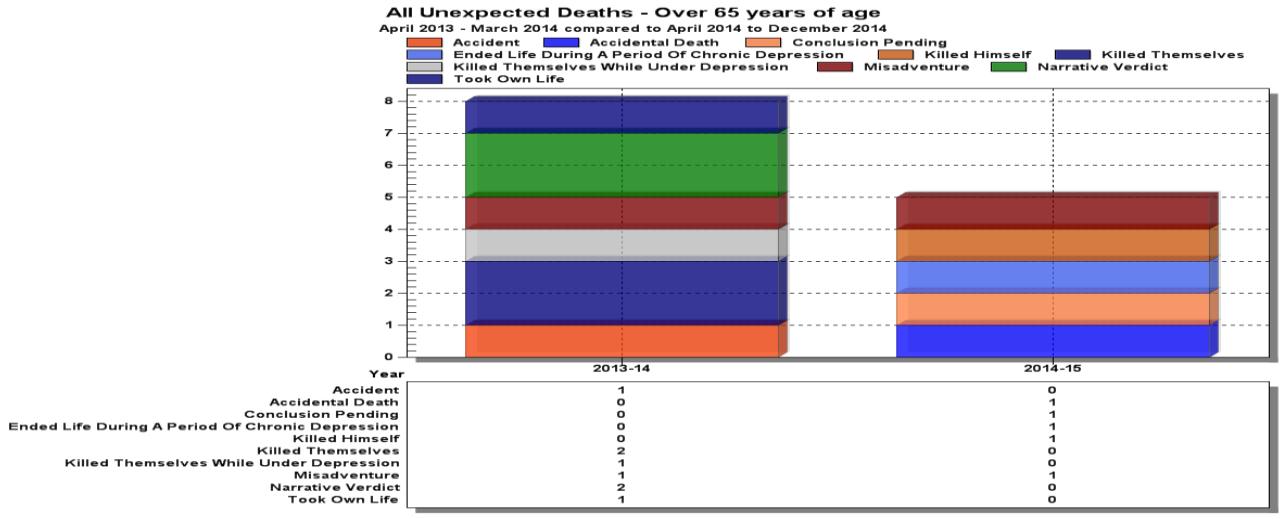
Unexpected Deaths by Coroner Conclusion

Table 5

Coroner Conclusion	Jul - Dec 2012	Jul - Dec 2013	Jul - Dec 2014
Abuse Of Alcohol	1	0	0
Accident	0	2	0
Accidental Death	5	4	0
Accidental Overdose Of Drugs	0	1	0
Accidental Toxic Effects Of Drugs And Alcohol	0	1	0
Dependence On Drugs	1	2	0
Dependent On Drugs And Alcohol Abuse	1	0	0
Drug Related Death	0	2	3
Drug/alcohol Related Death	0	2	0
Killed Herself	0	2	0
Killed Himself	0	3	1
Killed Themselves	2	0	0
Killed Themselves While Under Depression	1	0	0
Misadventure	8	13	4
Narrative Verdict	6	7	1
Open Verdict	3	1	2

We have undertaken some further analysis of unexpected deaths to see if there are any areas for further exploration.

Graph 2: Unexpected Deaths (Older People – Over 65) – Data Period – 2013 – 14 compared to 2014 – Present.



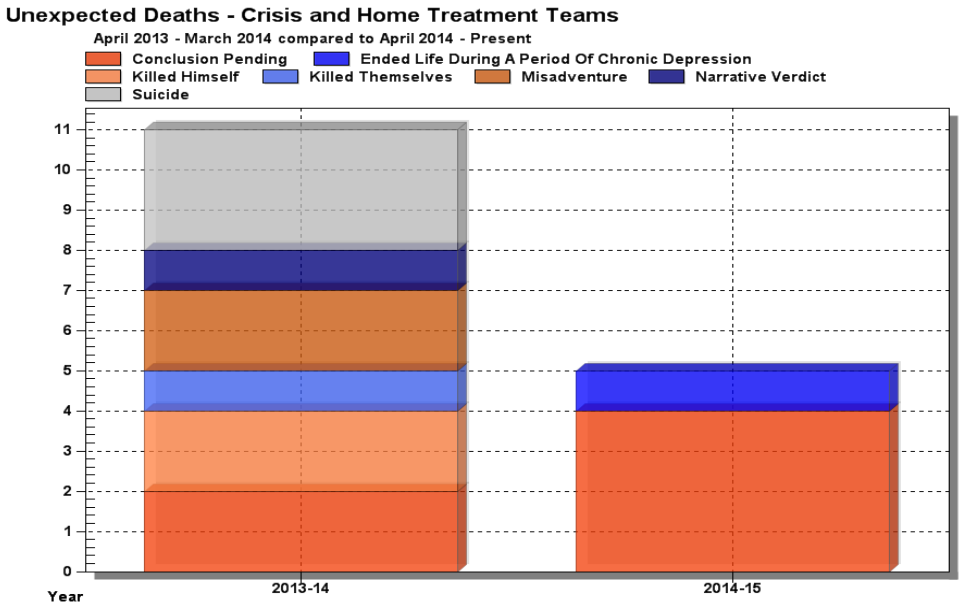
Following an increase in unexpected deaths over the last year, this area has been monitored continuously, for the same period, the activity in line with all serious incidents has reduced.

Unexpected Deaths Involving Crisis And Home Treatment Teams

There had been an increase in the numbers of unexpected deaths of patients in the care of Crisis Resolution and Home treatment teams, in 2013 / 14. It was agreed that this activity would be monitored closely.

Graph 3: Unexpected Deaths – Crisis Resolution & Home Treatment Team - Data Period – 2013 – 14 compared to 2014 – Present.

The following graph gives the breakdown for the period and the increase previously identified, has more than halved.

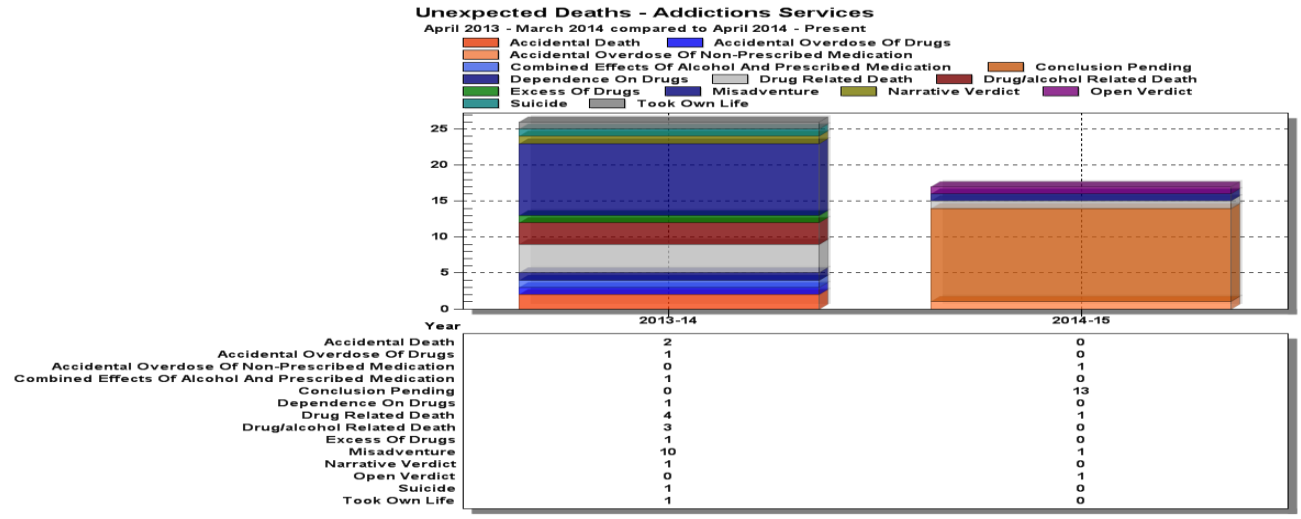


Year	2013-14	2014-15
Conclusion Pending	2	4
Ended Life During A Period Of Chronic Depression	0	1
Killed Himself	2	0
Killed Themselves	1	0
Misadventure	2	0
Narrative Verdict	1	0
Suicide	3	0

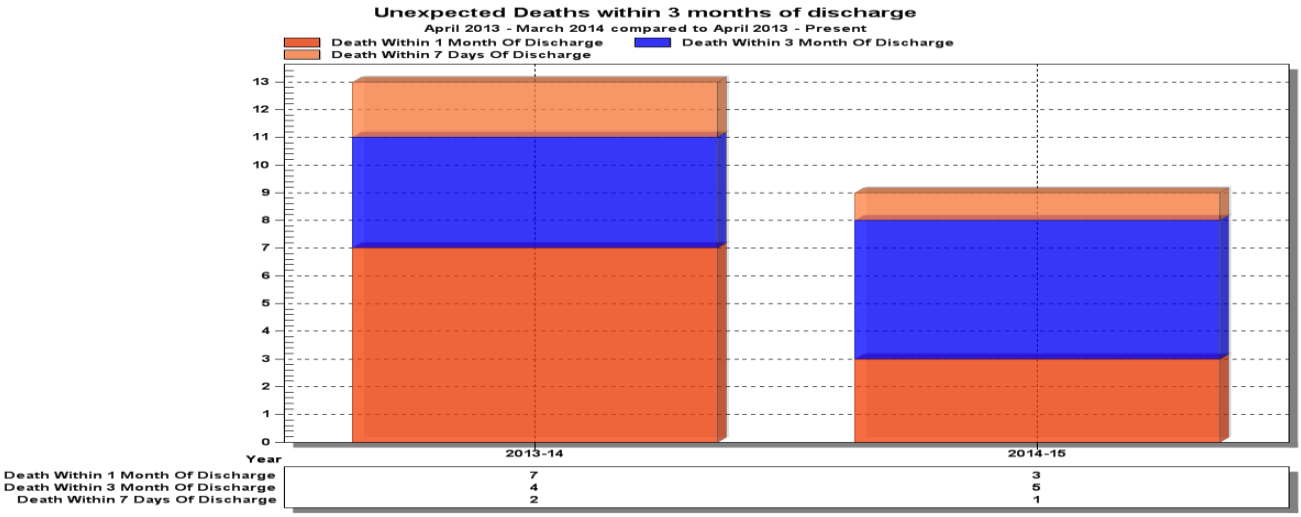
Graph 4: Unexpected Deaths – Addictions Services - Data Period – 2013 – 14 compared to 2014 – Present.

The following graph gives a breakdown of the unexpected deaths the period.

With the governance systems now in place the activity of addictions services has been kept under constant review, again there has been a significant reduction in serious incidents for this period in comparison to the activity last year.



Graph 5: Unexpected Deaths with a recent discharge from In-Patient Services - Data Period – 2013 – 14 compared to 2014 – Present.



The above graph indicates there has been a decrease in this activity for the current data period.

We know that the period after discharge from in-patient services is a time of high risk. This graph shows that there has been 9 serious incidents reported this year to date in comparison to the 13 reported last year. The Transition protocol has been implemented to improve the transfer of care from hospital into community and this area of care will receive continuing close scrutiny.

Serious Incident Reviews

Over the last three years the following number of reviews were carried out, on the basis that there has been an increase in serious incidents there is a natural need to increase the number of reviews to ensure timely reflection of each case.

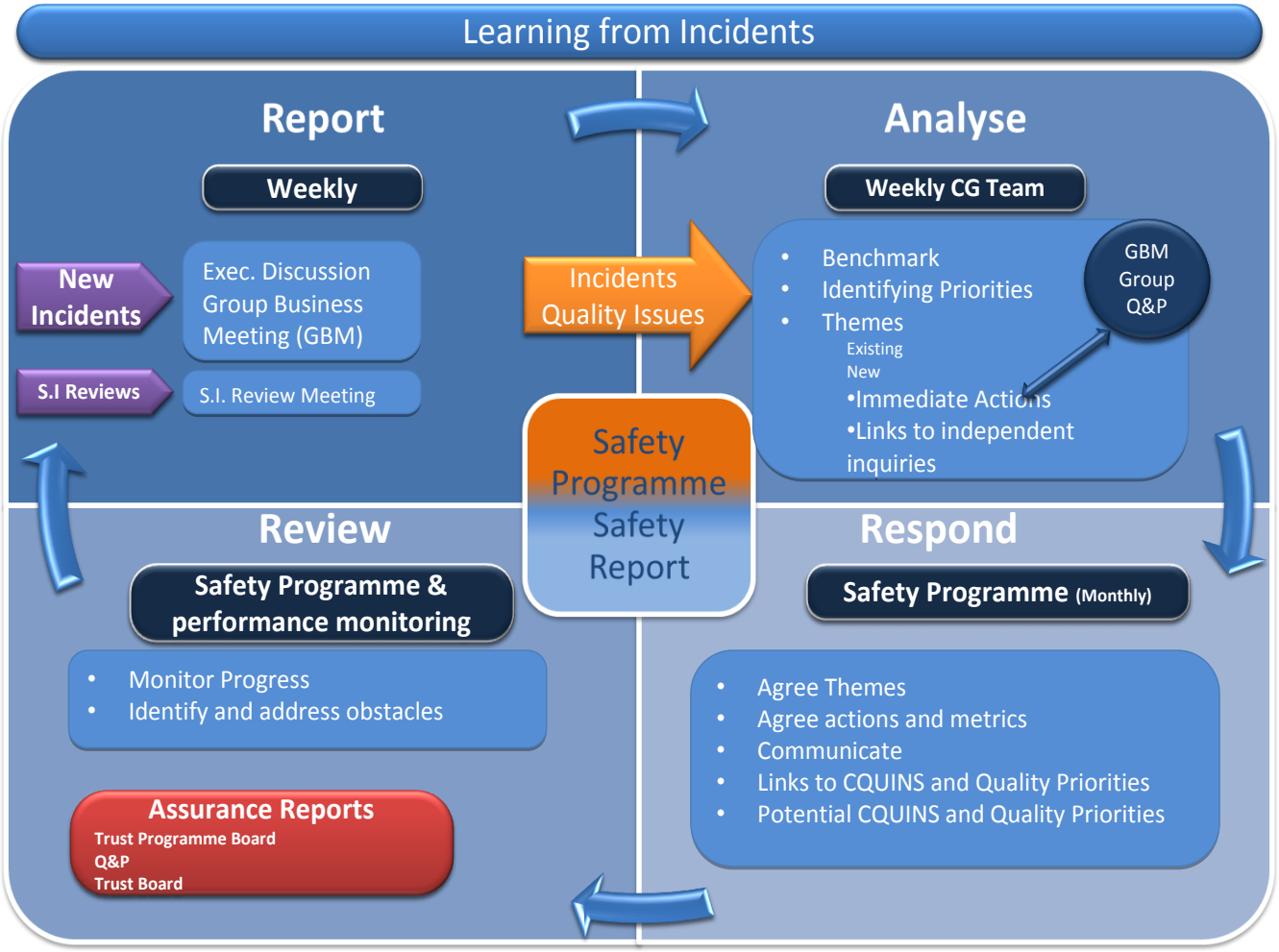
Table 6

Number of serious incidents reviewed	Jul - Dec 2012	Jul - Dec 2013	Jul - Dec 2014
	67	89	69

In order to maintain a robust serious incident investigation process, the serious incident investigation team has been recruited to, and there are now 7 dedicated serious incident investigators. Having this direct control allows for greater planning relating to the management review of serious incidents, and it can be seen from the above activity, that 2013/ 14 increase in serious incidents has been managed appropriately and reviewed in a timely manner through the serious incident panel, which now meets every Thursday, and has coped with the demands of more incidents. As reported through the Trust's Patient Safety Group, the Serious Incident Review Process is now regularly seeing incidents reviewed within the 60 day timescale, and this process has been supported by the dedicated team of investigators.

Section 2: Identification of Themes

The process for identification of themes from review of SI's has been previously described and is summarised in the slide shown. The diagram below shows how information reported from incidents is considered, analysed, responded to and ultimately the actions and improvements reviewed through the Trust's systems and processes for learning to take place.



Key Points

- A number of key themes have been identified through the Safety Programme.
- Certain themes are being monitored and managed through Operations/Groups.
- Each theme managed within the Safety Programme will have an "owner", who is responsible for the development of plans and reporting these developments back to the Safety Programme on a regular basis.

A "theme" can be defined as a quality or safety issue identified through review of incidents, complaints or from other sources of information, judged to be a suitable area for improvement actions, which can potentially lead to quality and safety improvements.

Throughout 2014 the Serious Incident Panel members have taken the first 2 quarters of serious incidents for period April – September that were reviewed at panel between July – December and have broken down the specific incident themes as follows:-

There are a number of recurring themes that have presented themselves in incident reviews, however it must be noted that these have not been seen in all incident reviews, and many serious incident reviews do not identify any concerns with the care and treatment, and sometimes the only findings are that the care and treatment was timely and appropriate and as expected in line with Trust policy and processes but still resulted in a negative outcome. All themes where improvements need to be made are included in the action plans of each serious incident which are owned by the service and quality checked for action and closure by the specific clinical groups governance groups and by the Trust's Patient Safety Group prior to being sent to the Clinical Commissioning Group for closure.

There were 69 serious incidents reviewed for the first 2 quarters of the year, it is important not to consider that this is a physical position of risk for the Trust, and that any of these issues directly impacted on the outcome, indeed many of these issues occurred in the patients care, a significant time prior to the incident, and it also needs to be put into context that the Trust's serious incident activity is a small component of the actual contacts with patients, to put this into context , the Trust is generally in contact with around 40,000 patients at any one time, sees, over 80,000 patients every year, and has over 250,000 contacts with those patients.

Safeguarding Processes.

A theme of Safeguarding was identified in 5 of 69 incidents, these were as follows:-

- Greater clarification required re practitioner responsibilities in Child Protection Meetings
- Embedding of an Integrated Think Family Approach (Safeguarding Team have already undertaken significant work in relation to the Think Family Approach)
- Recording who is attending appointments with Service Users
- A reliance on self -report with regard to safeguarding issues
- Accessing of Safeguarding Advice when information gained re previous assaultative behaviour and public interest disclosure

GP Communication

A theme of GP communication was identified in 11 of 69 incidents, these were as follows:-

- 1 incident where there was no communication with the GP, who was also providing care and prescribing.
- 3 incidents where the written communication with the GP was not recorded in the clinical record.
- 3 incidents relating to the GP not communicating with the Trust with respect to medication changes or changes in risk.
- 1 incident where the communication to the GP was delayed due to an admin. issue.
- 1 incident where the medication was changed, but the GP was not informed.
- 1 incident where the communication was sent to the wrong GP and returned.
- 1 incident whereby the GP was not informed in change of risk after the patient had been seen.

Risk Assessment

A theme of risk assessment was identified in 24 of 69 incidents (it must be noted that when incidents are mentioned below that where incidents are mentioned it may be the same incident that identifies a number of themes), this was the most prevalent theme, however it must be noted there were a number of different themes relating to risk assessment identified as follows:-

- 23 incidents involved FACE risk profile, which included, risk rating not reflecting level of risk, risk assessment not being updated when level of risk was changing, risk assessment was incomplete, risk information needed to be corroborated with other agencies and this had not been completed, poor risk formulation.
- 2 incidents had 2 different risk assessments in place when open to different services in NTW.
- 3 incidents had risk assessment not updated, when transferred to another service in NTW.

Consent to Share/Common Sense Confidentiality/ Record Keeping

The above theme was identified in 17 of 69 incidents and were broadly identified as follows:-

- 4 incidents included consent to share, relating to recording of information in the record, communicating with families, or discussions around consent with other healthcare providers.
- 10 incidents included issues of record keeping, including gaps in record keeping, recording family contacts, which is important in order to communicate effectively, specific templates not being completed with information in the record elsewhere, entries being made post mortem.
- 3 incidents included information sharing / disclosure, relating to explanations for the removal of third party information, use of jargon, processes operated relating to disclosure.

Falls Management

There were 10 incidents of 69 relating to fractures or patient falls, the themes were as follows:-

- 1 incident identified a delay in reporting the incident through the Trust systems.
- 2 incidents identified issues to do with following the Trust's Falls Policy.
- 2 incidents highlighted the responsibility of Doctors to work in partnership with multi-disciplinary team for decision making and escalation for assessment after a fall.
- 3 incidents highlighted issues relating to the medication regime of the patient and further assessment.
- 3 incidents highlighted the need for specialist equipment to be available to mitigate falls risk.
- 2 incidents identified a delay in either escalation of a blue light ambulance or attendance of the ambulance.

Action Planning and Impact of Actions

The above themes give a view of the 69 serious incidents that have been reviewed in the last period, and where necessary action plans have been created, these are managed by the individual services, with the appropriate corporate support as required. The changes identified in these actions have a direct result on future incident activity, as such we can see a difference in the types of incidents reported in this report. Examples of which are as follows:-

- Less serious incidents of violence on in-patient wards, coupled with lower impact of harm reported for all physical assaults for both in-patient and community services, this is as a result of lone working systems, staff attack systems, improvement to in-patient environments, increased staffing levels, improved and increased management of violence and aggression training, and peer reviews of physical interventions.
- Less reported fractured neck of femurs due to improved compliance with the Trust Falls Policy.
- Less serious incidents relating to self-harm, due to safer management of patient risk, improvements in the in-patient environment , increased staffing levels, better support of in-patient teams with the support of the ACE Team and the development of the Personality Disorder Hub Team.

Independent Investigations Summary

There have been no further publications of independent action plans since the last report.

Sign up to Safety

Sign up to Safety is a national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

Our Trust signed the Sign up to Safety pledge on October 29th, 2014 -

Put safety first – We commit to reducing avoidable harm in our organisation.

Continually learn – we will make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

Honesty – we will be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

Collaborate – we will take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

Support – we will help people understand why things go wrong and how to put them right. We will give staff the time and support needed to improve and celebrate progress.

The Trust has submitted its pledge, to Sign up to Safety on 29th October 2014, and we are now making plans to submit our improvement plans by 17th January 2015.

More information is available here.

http://www.england.nhs.uk/signuptosafety/

Ombudsman Complaints Update

Opened	Directorate	Complaints Number	PHSO Reference	Current Status	Current Update
21.01.2014	Urgent Care	1851	180628	PHSO – Enquiry	Final report received – Partly Upheld actions to be completed
11.06.2014	Urgent Care	2212	189517	Request for files	Files sent 12.06.14
24.07.2014	Urgent Care	1970	195207	PHSO – Final Report Received	Apology letter, action plan and cheque for £200 sent to NUTH Complaints Manager as Complaint Lead.
17.10.2014	Urgent Care	2084	199797	Request for files	Files sent 27.10.14
18.11.2014	Urgent Care	2164	201335	Request for files	Files sent 24.11.14
21.11.2014	Urgent Care	2335	200627	Request for files	Files sent 24.11.14
14.03.2013	Planned Care	1304	157483/0011	PHSO Open	Final report received – Apology letter sent to PHSO 28.11.14
13.08.2014	Planned Care	2029	195923	PHSO – Request for files	Files sent to PHSO on 22.8.14
06.11.2014	Planned care	2098	199724/0064	PHSO – Request for files	Files sent 24.11.14
24.07.2014	Specialist Care	1814	192159	PHSO – Request for files	Files sent 1.8.14
16.09.2014	Specialist Care	1794	199616	PHSO – Request for files	Files sent 25.09.14
08.07.2014	Specialist Care	2119	193884	PHSO – Request for files	Draft Report Received 26.09.14
05.11.14	Specialist Care	1846	201536	PHSO – Request for files	Files sent 11.11.14

Section 4: Safety of Transformation

Safety of transformation can be monitored in the following ways:

- Monitoring for signs of increased pressure on inpatient services.
- Monitoring for indications of increased pressure in community services.
- Monitoring the progress of development of agreed enablers for bed closures.

Over the past six months we have developed a suite of quality and safety metrics to monitor the safety of transformation. These cover a range of areas including inpatient services, community services, efficiency of services, safety and service user experience. These metrics have been signed off by commissioners and reports have been created to regularly report progress.

In addition work is on-going to review the clinical risks associated with transformation and ensure that sufficient mitigating actions have been implemented.

A Data Review Group was established to agree a suite of metrics to monitor the safety of transformation and a relatively large number of metrics were agreed by the group. (Appendix 4) Following discussion at the most recent Safety Programme Board it was agreed that the current suite of metrics needed to be reduced to a smaller more manageable number. It was also agreed that clarity regarding the governance of the safety of transformation is required. It was agreed that 2 executive directors, the executive director of Nursing and Operations and the Director of Finance would take forward the issue of streamlining the suite of metrics and their reporting arrangements prior to the next Safety Programme Board.

Appendices:

Appendix 1 Glossary of Terms
Appendix 2 Safety Messages – July - December 2014
Appendix 3 Diagram Showing how the Patient Safety System interacts with other systems
Appendix 4 Quality and Safety Metrics

Appendix 1

Glossary of Terms used

Serious Incident - An incident occurring on health service premises or on other non NHS premises in relation to the provision of healthcare on such premises, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be of significant public concern. This shall include "near misses" or low impact incidents which have the potential to contribute to serious harm.

Unexpected Death – Any death either within in-patient or community services within six months of contact with mental health services, where by the nature of death is not certificated as a natural cause by a doctor, or whereby due to the undetermined circumstances it is referred to a Coroner and an inquest is convened.

Independent Investigation – An investigation carried out by an appointed panel of specialists to review to most serious incidents in a mental health organisation, namely homicides committed by those in receipt of mental health services. The process is the responsibility of NHS England, and the reports are published after being considered by all stakeholders.

Incident – Any activity which may or may not have resulted in harm including near miss activity, involving anyone who comes into contact with NTW services, including patients, carers, staff, visitors, members of the public.

Theme – A recurring or emergent issue of notable concern identified from a reflection of a single serious incident or a number of less serious incidents.

Earlier involvement of Forensic Services in Serious Incidents (S.I.)

Reference No. SM62/141014 ***Date Issued*** 14/10/2014

A number of serious incidents reviewed have indicated that earlier involvement of forensic services may improve out-come. Where there is a history of violent or sexual offending, or where there is a concern about risk of harm to others in the future, consideration should be given to referral to the forensic service, or alternatively advice, support and guidance should be sought from that service.

The Trust actively promotes the role of the forensic services in improving and sharing the management of a patient with a forensic history and ensures their expertise in forensic matters is disseminated by means of shared training and through professional development.

To facilitate access to forensic advice regular community team consultation clinics are available for Trust staff to discuss cases with the Forensic Community Team. In such meetings, joint formulations and risk management strategies can be identified and developed. For a case to be discussed at the Forensic Liaison Clinic a referral would need to be logged on Rio. The referral would then be taken to the team meeting, which is held every Monday afternoon. The referral would be discussed within the team, then, if felt necessary, the referring team would be invited to the Forensic Liaison Clinic.

The Forensic Liaison Clinic is held on a monthly basis. The point of contact is Helen Dunlavy or Jennifer Addis, through whom cases can be booked for discussion. Please email them or call on contact 01912232503. If you have any questions or suggestions about patient safety please contact the safety team.

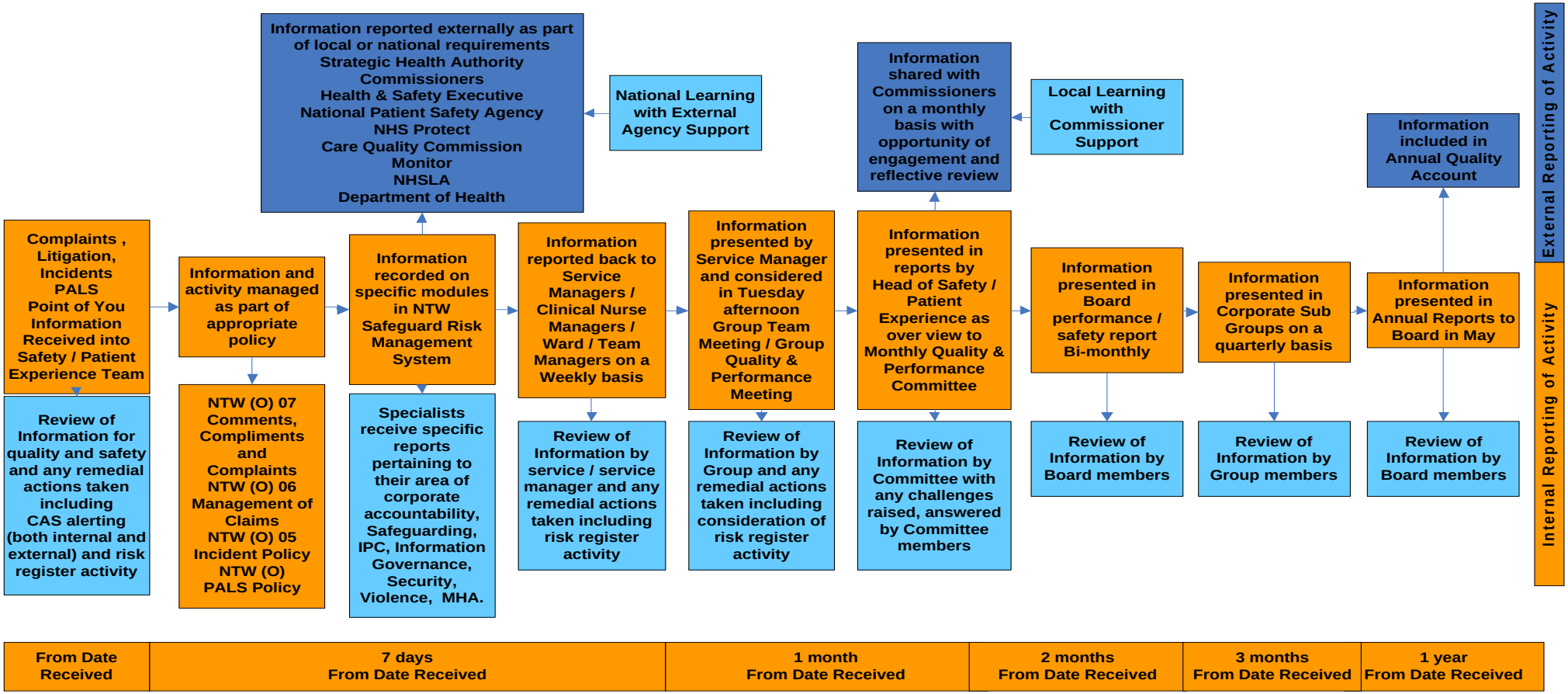
The importance of children's needs being a primary issue for all mental health staff

Reference No. SM63/041114 ***Date Issued*** 04/11/2014

The importance of children's needs being a primary issue for all mental health staff was highlighted in a recent Serious Incident.
When assessing and providing services to an adult with mental health problems, professionals must be alert to the needs of children for whom the adult has parental or caring responsibilities, or with whom the adult has substantial contact to ensure that the children have adequate support and protection. A child is defined as someone under 18. All assessments must inquire about the children in the adult's family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact, even if there appears to be no immediate concern of significant harm.
Health professionals must consider the needs of both the adult and the child, but the welfare of the child is always paramount. Members of staff have a responsibility to contribute to the assessment of all children and families in need, not just those in need of protection.

Appendix 3

Corporate reporting timescales and responsibilities for Complaints , Litigation, Incidents, PALS (including How's It Going) and Points of You (CLIPP reporting) Including Learning Points



Appendix 4

Quality and Safety Metric Suite

Reliance on beds	Number of out of locality admissions (admissions in NTW but to a different locality than service users CCG) Number of readmissions occurring within 28 days of discharge (90 Days for LD) Percentage of delayed discharges Average LOS (Discharges) Days Number of admissions to inpatient wards Bed Intensity (bed days v total spell days)
Community Demand	Number of people on community team caseload by cluster Number of people on community team caseload by cluster weighted
Mental Health Act Activity	Number of compulsory detentions
Safety	Number Violent Incidents Number of Incidents of Self Harm Number of Restraint Related Incidents Number of Suicide / Homicide Number of Sudden Unexpected Deaths Number of Patient Safety Incidents Number of Medication Incidents Service Users with 12 Month HCP
Service User and Carer Experience	Number of Complaints Number of Complaints Upheld
Efficiency	Percentage of DNA as a proportion of all booked appointments Face To Face Contact as a % of all time available Non Face To Face Contact as a % of all time available Flow Rate (referrals vs rate of discharge) Average Length of Stay in community services (referral to discharge) Average Wait for 1st Appointment (weeks) Average Wait from referral to treatment (weeks) Average Wait from assessment to treatment (weeks)
IRS	Total Referrals where scaffolding used Total referrals on to Crisis Services / Planned Care for assessment Average Time (Mins) from receipt of call to appointment being booked - Planned Care

	Numbers of patients signposted, by area signposted to, to post Triage Number of referrals by Referral Source Total Referrals open Total Referrals triaged but awaiting booked appointment (or further intervention)
Workforce	Sickness Use of Bank Use of Agency Use of Overtime Use of Locums Staffing Levels
Organisational Capacity	Vacancy Rate Staff Turnover