NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING

Meeting Date: 22 July 2015

Title and Author of Paper Safety Report – April - June 2015
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 increased in the period April - June 2015 from the previous year, but is still lower than the high reported in 2013 / 14.

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
July 2015
Reporting period – April - June 2015

Introduction
This is the Safety Report for the reporting period April – June 2015.

1. The Safety Programme (NTW Corporate Decision Team – Quality Sub Group)

The Safety Programme (SP) wass 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:

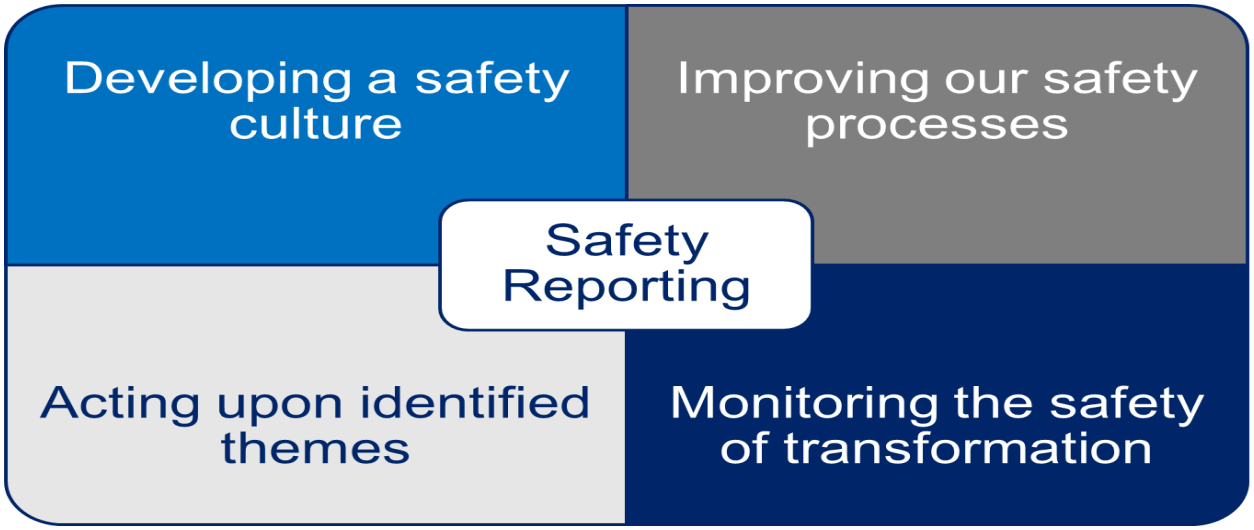


Fig1: Safety Report Dimensions

The safety programme is now closed and work streams taken over by the NTW Corporate Decision Team – Quality Sub Group. 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 2015). The latest NEQOS report based on the most up to date NRLS figures was discussed in detail at the Trust's Quality and Performance Committee in February 2015.

'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 Trust updates presented by the Trust Public Health lead.

With agreement of the Medical Director and the Executive Director of Nursing and Operations the Trust has considered the recently published NHS England Serious Incident Framework. Serious incidents are considered by the Directors each week at Group Business Meeting. For some serious incidents the investigation is decided to be at the After Action Review level with escalation as appropriate depending on the findings. This is currently being built into the review of the Trust's Incident Policy NTW(O)05.

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 April – June there were 43 serious incidents, this was 11 more 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 January – March 2015, that have been reviewed between April – June 2015, more information on this is on page 15. • Safeguarding Processes. • Communication • Risk Assessment • Falls Management • Record Keeping • Staffing Levels • All Aspects of Clinical Care • Medicines Management
3 – Action Planning & Impact Of Action	**4 – Safety Of Transformation**
The independent report and action plan relating to Mr E were published in May 2015 more information relating to the action plan process is on page 19. For Serious Incidents. • Less reported fractured neck of femurs due to improved compliance with the Trust Falls Policy. • Only 2 admissions of Children to Adult Wards for the whole of 2014 / 15 a significant reduction on previous years. • 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 development of the Personality Disorder Hub Team.	More information on page 20

Section 1: Incident Activity & Analysis

At the end of the financial year the Trust had reported over 31,193 incidents in 2014 /15, this is the highest reported in NTW. In comparison, 121 of these were classified as serious incidents in line with Clinical Commissioning Group Guidance. This is one of the lowest figures we have had for serious incidents for a number of years. 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	April - June	+/- on previous period	Number Of incidents Annual	+/- Year on Year
11/12	6,551	-	26,337	-
12/13	6,889	+338	29,111	+2,774
13/14	7,819	+930	30,486	+1,375
14/15	7,816	-3	31,193	+707
15/16	7,603	-213 YTD	7,931	YTD

The Trust continues to roll out the web based reporting system, with the following sites now live.
Ferndene
Hopewood Park
Monkwearmouth Hospital
Tranwell Unit
Centre for the Health of the Elderly
Elm House
Rose Lodge

1 in 5 incidents are now reported through the web reporting system.

Data for June 15 is still being inputted, it is expected this data will become more accurate and live as web based reporting is implemented across the Trust with the project being completed by October 2015.

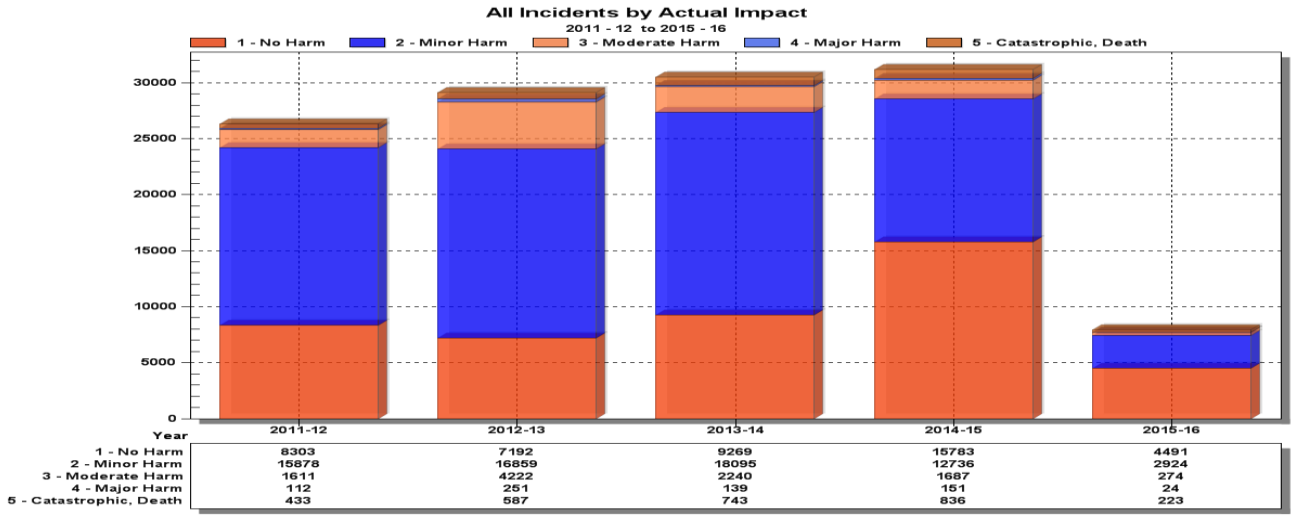
There has been an increase in serious incidents in the first quarter of 2015, and this is the highest figure for this quarter in the last 5 years, this has to be viewed with caution as a number of unexpected deaths of which there were 33, are still cause unknown so may return as a natural cause and will reduce this figure over time.

Table 1a –Serious Incident Activity

Year	April - June	+/- on previous period	Number Of Serious incidents Annual	+/- Year on Year
11/12	39	+16	120	+29
12/13	39	0	128	+8
13/14	30	-9	156	+28
14/15	31	+1	121	-35
15/16	43	+12	47 YTD	-

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

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



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. In the above graph catastrophic death incidents, also include those where the Trust has been notified by services / relatives that the patient has died naturally.

In reviewing the above information it can be seen that whilst overall incident reporting is increasing the moderate incidents have reduced year on year, with a minor increase in major incidents in 2014 / 15. If the current incident activity for Q1 2015 / 16 is maintained throughout the full year, we would continue to see an overall reduction in moderate and major incidents.

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

Table 2

April – June 2014		April – June 2015		+ / -
Cause Group	**2014-15**	**Cause Group**	**2015-16**	
Aggression And Violence	2838	Aggression And Violence	3055	+217
AWOL And Abscond	246	AWOL And Abscond	242	-4
Contractor/Public/Visitor Incident	7	Contractor/Public/Visitor Incident	12	+5
Death	165	Death	214	+49
Fire	38	Fire	28	-10
Human Resources Process	0	Human Resources Process	1	+1
Inappropriate Behaviour By Others	6	Inappropriate Behaviour By Others	10	+4
Inappropriate Patient Behaviour	329	Inappropriate Patient Behaviour	421	+92
Inappropriate Staff Behaviour	18	Inappropriate Staff Behaviour	13	-5
Inappropriate Treatment	0	Inappropriate Treatment	4	+4
Infection, Prevention And Control	28	Infection, Prevention And Control	23	-5
Information Governance	92	Information Governance	82	-10
Infrastructure	20	Infrastructure	18	-2
Medical Device, Equipment	13	Medical Device, Equipment	10	-3
Medication	216	Medication	214	-2
Mental Health Act	2	Mental Health Act	13	+11
Patient / Staff Safety	3	Patient / Staff Safety	16	+13
Patient Accident	724	Patient Accident	465	-259
Patient Clinical Issue	17	Patient Clinical Issue	19	+2
Patient Ill Health	727	Patient Ill Health	219	-508
Police Issue	2	Police Issue	0	-2
Safeguarding	694	Safeguarding	807	+113
Security	390	Security	460	+70
Self Harm	1051	Self Harm	1055	+4
Service Delivery	41	Service Delivery	13	-28
Staff Accident	145	Staff Accident	116	-29
Staff And Patient Accident	2	Staff And Patient Accident	9	+7
Staff Ill Health	2	Staff Ill Health	3	+1
Unknown Patient Injury	0	Unknown Patient Injury	64	+64
Total	**7816**	**Total**	**7606 YTD**	**+117**

Data for June 2015 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 Trust by the Director of Public Health.

Serious Incidents

Table 4

The following table indicates the number of serious incidents reported annually .

Number of serious incidents reported annually	2013-14	2014-15	2015-16
AA09 Absented Themselves From Hospitals	2	0	0
AA10 Absented Themselves During Escorted Leave	1	1	0
DE01 Unexpected Death	99	80	17
DE03 Alleged Homicide To A Patient	1	1	0
DE04 Alleged Homicide By A Patient	2	1	0
DE06 Unexpected Death - More Than 6 Months	0	1	0
DE16 Alleged Homicide By A Patient To A Patient	1	2	1
DE18 Unexpected Death Local AAR	0	9	19
DE19 Alleged Homicide Not In Receipt Of Services	0	0	1
F01 Actual Fire - Patient Area	0	0	1
IG03 Breach Of Patient Confidentiality	3	1	0
IG07 Poor Information Sharing	1	0	0
IN02 Loss Of Electricity	1	1	0
IT04 16-17 Admitted To Adult Ward	2	2	1
PA01 Patient Fall On Same Level	1	1	0
PA04 Patient Fall From Height	1	0	0
PA06 Patient Fall From Chair/Wheelchair	1	0	0
PA07 Patient Fall From Toilet/Commode	1	0	0
PA08 Patient Found On Floor - Not Witnessed	1	1	1
PA16 Struck By Moving Vehicle	1	0	0
PA18 Injury Cause Unknown	2	0	0
PA26 Fracture Neck Of Femur	12	7	1
PI01 Unexpected Deterioration In Health	1	0	0
PI02 Patient Choking	0	0	1
SG03 Safeguarding Adults - Staff Allegation	0	1	0
SG23 MARAC	1	0	0
SH01 Actual Self Harm	14	3	0
SH02 Attempted Suicide	0	2	0
SH05 Attempted Self Harm	0	0	1
SH06 Suspected Self Harm	0	1	0
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	3	1	1
V03 Physical Assault Of Patient By Patient	1	1	2
V04 Threatening Behaviour By Patient To Staff	2	0	0
V33 Allegation Of Sexual Assault By Patient On Other	1	0	0
V34 Alleged Physical Assault By Patient To Other	1	0	0
Total	**157**	**117**	**47 YTD**

Number of Serious Incidents reported in the period April - June	2013-14	2014-15	2015-16
DE01 Unexpected Death	29	22	16
DE03 Alleged Homicide To A Patient	0	1	0
DE04 Alleged Homicide By A Patient	1	0	0
DE16 Alleged Homicide By A Patient To A Patient	0	0	1
DE18 Unexpected Death Local AAR	0	0	17
DE19 Alleged Homicide Not In Receipt Of Services	0	0	1
F01 Actual Fire - Patient Area	0	0	1
IG03 Breach Of Patient Confidentiality	2	1	0
IN02 Loss Of Electricity	0	1	0
IT04 16-17 Admitted To Adult Ward	1	0	1
PA07 Patient Fall From Toilet/Commode	1	0	0
PA08 Patient Found On Floor - Not Witnessed	0	1	0
PA18 Injury Cause Unknown	1	0	0
PA26 Fracture Neck Of Femur	5	2	1
PI02 Patient Choking	0	0	1
SH01 Actual Self Harm	3	2	0
SH05 Attempted Self Harm	0	0	1
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	1	1	1
V03 Physical Assault Of Patient By Patient	0	1	2
V04 Threatening Behaviour By Patient To Staff	2	0	0
V33 Allegation Of Sexual Assault By Patient On Other	1	0	0
Total	**47**	**32**	**43**

Following discussion by Executive Directors and further discussion with the Group Directors in February 2015 , it was agreed that certain unexpected deaths would not be reported to Clinical Commissioning Groups, but would still be locally investigated by clinical teams, these are recorded as a new category DE18 Unexpected Death – Local After Action Review, the Trust will still obtain 24 hour reports in order to ensure compliance with our Duty of Candour responsibilities and to ensure that families , carers and staff are supported after the incident. These deaths will no longer be reported as a patient safety incident.

Fractures and patient accidents are reducing both from an annual perspective and in the last reporting period. Fractures have reduced from a high of 17 in 2012/13 to a new low of 7 in 2014/ 15 ,and this continues in 2015 / 16 with only 1 fracture reported in the first quarter.

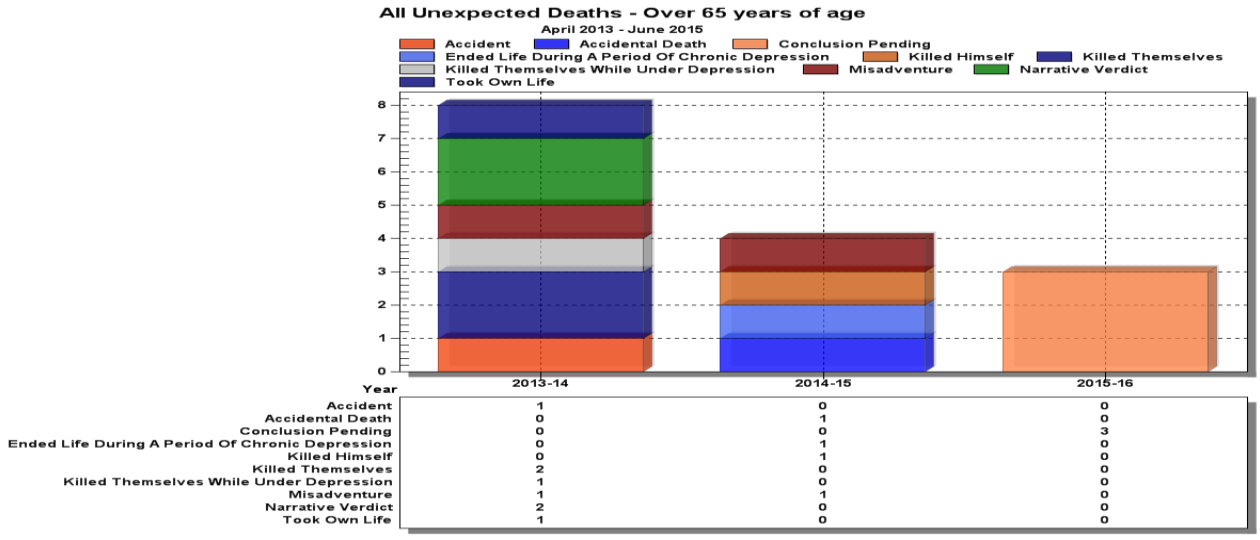
Unexpected Deaths by Coroner Conclusion

Table 5

Coroner Conclusion	April – June 2013-14	April – June 2014-15	April – June 2015-16
Accidental Death	0	2	0
Accidental Overdose Of Drugs	0	1	0
Accidental Overdose Of Non-Prescribed Medication	0	1	0
Conclusion Pending	1	1	17
Dependence On Drugs	0	1	0
Died As A Consequence Of The Depressive Phase Of Illnes	1	0	0
Died As A Result Of Dependence On Alcohol	0	1	0
Drug Related Death	1	1	0
Ended Life During A Period Of Chronic Depression	0	3	0
Excess Of Drugs	1	0	0
Killed Themselves	4	0	0
Killed Themselves While Under Depression	1	0	0
Misadventure	9	3	0
Narrative Verdict	3	3	0
Open Verdict	1	1	0
Suicide	4	0	0
Their Actions Resulted In Their Death	0	1	0
Took Own Life	4	3	0
Total	30	22	17

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 - 2015



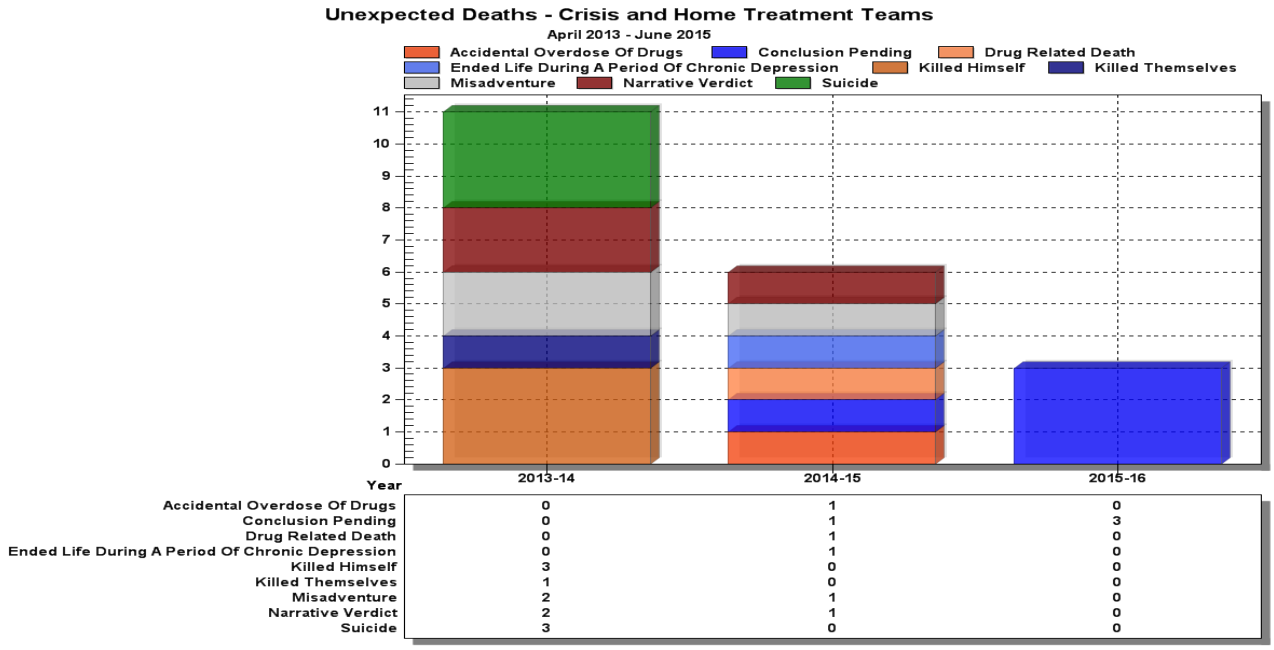
Following an increase in unexpected deaths for those over 65 years of age in 2013 / 14, this area has been monitored continuously. The increase in activity in 2015 /1 6 relates to local AAR of unexpected physical health related deaths, in line with the new serious incident framework.

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 - 2015

The following graph gives the breakdown for the period and the increase previously identified in 2013 / 14, which reduced in 2014 / 15, has increased again in 2015 / 16 for the first quarter, this needs to be kept under review.

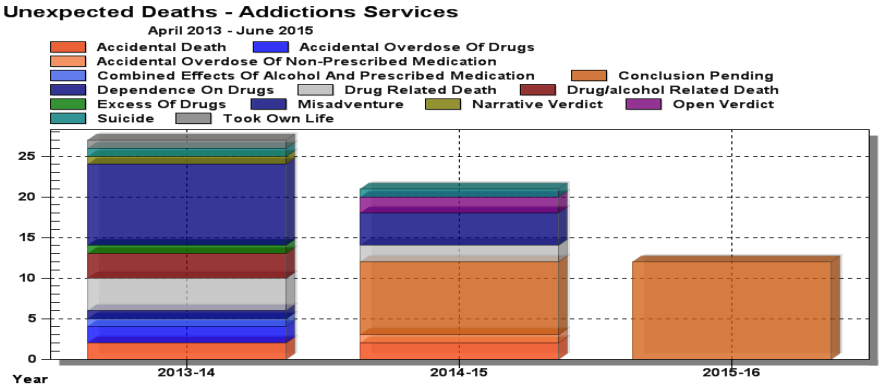


Year	2013-14	2014-15	2015-16
Accidental Overdose Of Drugs	0	1	0
Conclusion Pending	0	1	3
Drug Related Death	0	1	0
Ended Life During A Period Of Chronic Depression	0	1	0
Killed Himself	3	0	0
Killed Themselves	1	0	0
Misadventure	2	1	0
Narrative Verdict	2	1	0
Suicide	3	0	0

Graph 4: Unexpected Deaths – Addictions Services - Data Period – 2013 – 2015.

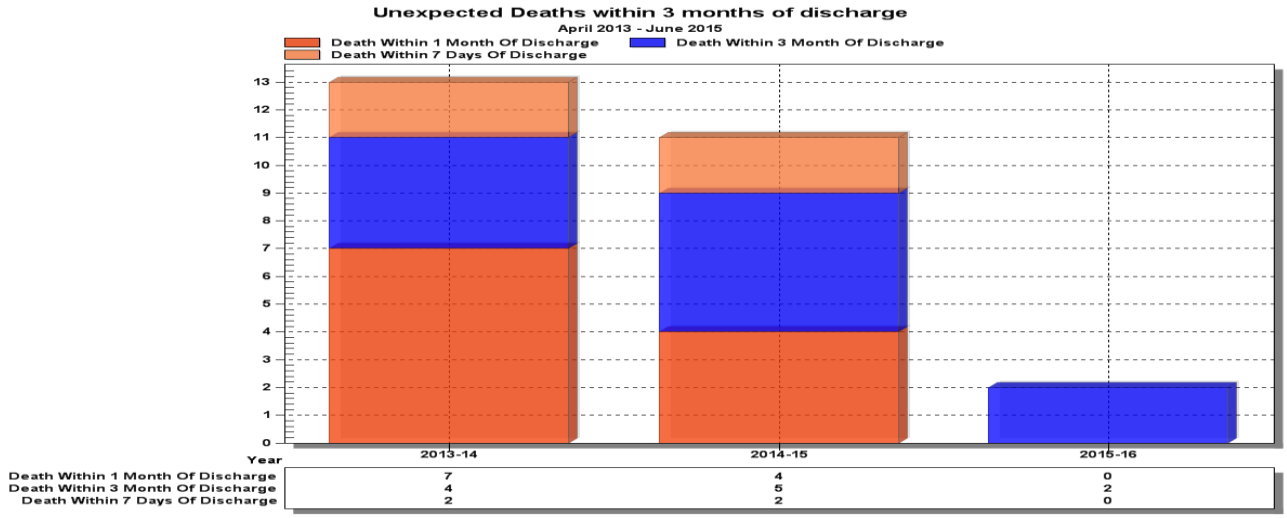
The following graph gives a breakdown of the unexpected deaths the period.

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.



Year	2013-14	2014-15	2015-16
Accidental Death	2	2	0
Accidental Overdose Of Drugs	2	0	0
Accidental Overdose Of Non-Prescribed Medication	0	1	0
Combined Effects Of Alcohol And Prescribed Medication	1	0	0
Conclusion Pending	0	9	12
Dependence On Drugs	1	0	0
Drug Related Death	4	2	0
Drug/alcohol Related Death	3	0	0
Excess Of Drugs	1	0	0
Misadventure	10	4	0
Narrative Verdict	1	0	0
Open Verdict	0	2	0
Suicide	1	1	0
Took Own Life	1	0	0

Graph 5: Unexpected Deaths with a recent discharge from In-Patient Services - Data Period – 2013 – 2015.



Year	2013-14	2014-15	2015-16
Death Within 1 Month Of Discharge	7	4	0
Death Within 3 Month Of Discharge	4	5	2
Death Within 7 Days Of Discharge	2	2	0

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 11 serious incidents reported in 2014 /15 in comparison to the 13 reported in 2013 / 14. 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. As of today there are only 2 incidents reported this year.

Serious Incident Reviews

Over the last three years the following number of reviews was 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

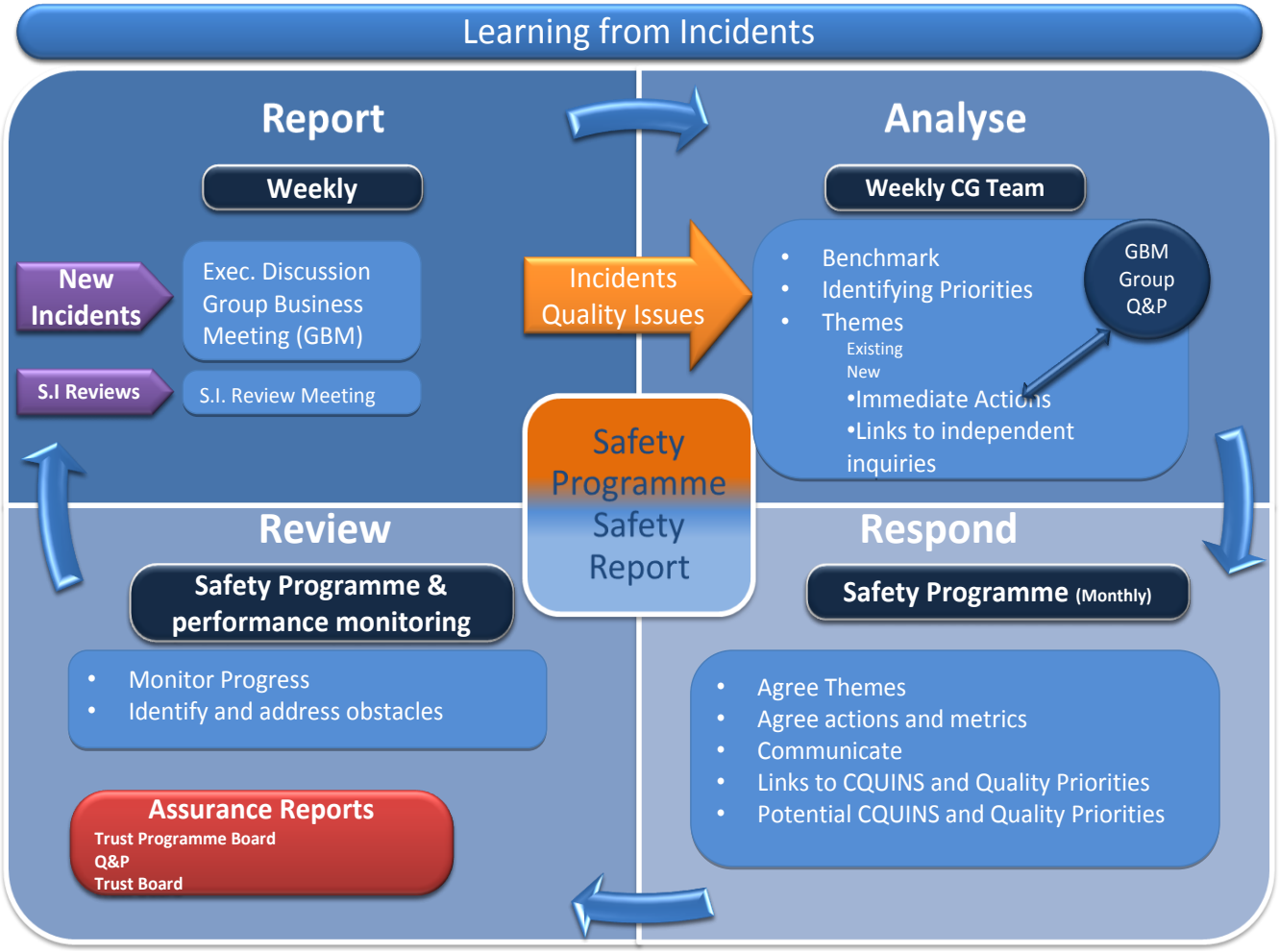
Number of serious incidents reviewed	April – June 13	April – June 14	April – June 15
	38	48	25

Whilst the number of reviewed incidents has reduced, this is in line with the reduction in number of serious incidents.

In order to maintain a robust serious incident investigation process, there are 7 dedicated serious incident investigators. Having this direct control allows for greater planning relating to the management review of serious incident. Serious incidents are investigated and reviewed by 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 2015/ 16 the Serious Incident Panel members have taken the Quarter 4 incidents that occurred between January - March and were reviewed between April – June 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 25 serious incidents reviewed for Quarter 4 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.

It is also important to note that any reduction in serious incidents may well magnify specific themes if they are only identified in a small number of reviewed incidents.

The themes identified below fall into 10 key headings:-

- Aspects of Clinical Care
- Communication
- Falls Management
- Good Practice Noted
- Individual Practice
- Medicines Management
- Record Keeping
- Risk Assessment and Management
- Safeguarding
- Staffing Levels

Aspects of Clinical Care

There were 11 out of 25 incidents identified where there were clinical care issues:-
Issues identified under this header including care planning, waiting times, cross cover arrangements in periods of absence, discharge planning, and missed appointment follow up. All these issues had appropriate actions created for the individual services.

Communication

A theme of communication was identified in 10 of 25 incidents, these were as follows:-

Of the 10 incidents, the communication issues varied between the following:-
Communication between NTW Teams
Communication to the GP
Communication within a Team

All Services received actions to reflect on the communication issues within the teams and when liaising with other services.

Falls Management

There were only 2 of 25 incidents relating to falls in the quarter, with 1 incident being a self harm attempt and a fall from height, and the other themes identified from the 2nd fall are highlighted in the practice issues below. As falls have continued to reduce, this theme will be removed from the list.

Good Practice Noted

Good Practice was identified in 1 out of 25 incidents, in one incident staff's prompt actions prevented a patient from absconding which could have led to a more significant incident from occurring.

Individual Practice

Individual practice issues were identified in 5 out of 25 incidents, this can range from failure to complete documentation correctly in line with Trust policy, which may result in a local improvement plans / supervision being carried out, to a full breach of Trust Policy which would require a full investigation being carried out where there were significant concerns about individual practice. Whilst these occurrences are rare, it is important to acknowledge that the serious incident process will identify such issues as part of the investigations even if they are unrelated to the incident, when they come to light.

Medicines Management

There were 4 out of 25 serious incidents that had a theme of medicines management, which all had appropriate actions in place, the significant one, being an action to alert all teams to the risk of increased suicidality relating to anti-epileptic medication.

Record Keeping

Record Keeping was identified as a theme 13 out of 25 serious incidents. The trust has in place comprehensive policies and guidance to support record keeping, and all professional bodies also produce complimentary guidance and expectations for professionals. These are checked against for each incident review, and there are high expectations for accuracy of clinical data, that professionals must adhere to, which is why this is always highlighted as a theme. There is not a repeat occurrence for individuals and these 13 serious incidents span 11 different services within the Trust.

Risk Assessment and Management

There were 8 out of 25 serious incidents identified with a theme of risk assessment and management and as previously reported on this can be, the correct risk management tool being utilised for the correct type of patient, i.e. adult, children, service specific. Risk

assessments not being updated when there was a change of risk that impacted on care provision. 1incident highlighted risk scores which should have been higher, and led to a more robust plan of care.

Safeguarding Processes

A theme of Safeguarding was identified in 2 of 25 incidents.

The first of the incidents related not using the correct process to escalate a safeguarding concern; this will be negated by the roll out of web based reporting by October 2015.
A second incident related to the fact that the clinical team had not considered fully seeking advice from the Safeguarding Team for support

Staffing Levels

Whilst there is current high profile attention to staffing levels within the NHS, only 3 incidents out of the 25 serious incidents reviewed found an issue relating to levels of staff. All 3 incidents were in community services, and related directly to waiting lists due to vacancies and staffing establishments or sickness absence and cross cover arrangements.

Action Planning and Impact of Actions

The above themes give a view of the 25 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.
- Less serious incidents relating to under 18 admissions due to more pro-active care and better bed management.

Independent Investigations Summary

The report and action plan relating to the care and treatment of Mr E was published in May 2015, is available on the Trust's website. The Trust is currently managing the actions relating to this case. The detail of the report was considered by the Trust prior to publication and all actions are in hand and on time.

Sign up to Safety

The Sign up to Safety Campaign provides a platform for Northumberland, Tyne and Wear NHS Foundation Trust's (NTW) patient safety improvement initiatives. The vulnerable groups that NTW serves include: people with mental health needs and learning disabilities, and sometimes acutely ill older people who have both physical and mental health problems. The initiatives outlined in this plan were selected from an examination of themes identified within the previous NTW Safety Programme. The following are the key stakeholders within the Safety Improvement Plan:

- Executive Lead: Chair of Corporate Decision Team – Quality Sub Group
- Members of Corporate Decision Team – Quality Sub Group
- Sign up to Safety Leads within NTW's senior Clinical Governance and Safeguarding team
- Members of Group Business meeting

2. NTW Corporate Decision Team – Quality Sub Group

It is proposed that Sign Up to Safety supports the newly formed Corporate Decision Team – Quality Sub Group, and that the Sign Up to Safety Methodology - including this Safety Improvement Plan and accompanying Driver Diagrams - are used to take the patient safety improvement initiatives forward. Delivering person and family centred care, along with communication and team work, are integral to the themes below. The SIP includes the detailed plans, in the form of driver diagrams, for each of the chosen themes.

3. **Themes within NTW Safety Programme**

The following themes were identified within the NTW Safety Programme and have been selected for initial focus of the Sign Up to Safety approach.

1. **Violence to Staff and Physical interventions - Owner Gary O'Hare**
2. **Physical Health - Owner Anne Moore**
3. **Falls - Owner Anne Moore**

4. **Sign Up to Safety Improvement Plan**

The Sign Up to Safety Improvement Plan offers the opportunity to be proactive and identify 'gaps' in safety before they occur. NHS Trusts collect data which highlights what works well and what has not gone to plan, but this is after an incident has happened and is therefore a reactive approach to patient safety. NTW will be reviewing its current Serious Incident process, in line with the NHS England Serious Incident Framework (2015).
The trust already has a track record of adapting the principles of continuous improvement to implement transformational change; the plan, do, study, act (PDSA) cycle is another simple, yet proactive methodology which can equip frontline staff to try out small improved ways of filling the safety gaps before they occur and then measuring what difference has

been made in reducing avoidable harm. Improvement skills required by all staff are shown in Appendix 1.
The NTW Sign Up to Safety Improvement Plan attempts to bring both approaches – the collection of data, including the review of the serious incident process, and improvement methodologies – together, hopefully creating a culture that measures safety improvement.

5. Driver diagrams

Furthermore, a set of driver diagrams has been reviewed and provided to meet the programme aims. Driver diagrams are a type of structured logic chart with three or more levels which can assist and provide a "theory of change" as well as fulfil a range of other functions:

- help a team to explore the factors that they believe need to be addressed in order to achieve a specific overall goal,
- show how the factors are connected,
- act as a communication tool for explaining a change strategy, and
- provide the basis for a measurement framework.

Driver diagrams are therefore best used when an improvement team needs to come together to determine the range of actions they have to undertake to achieve a goal. They are well suited to complex goals where it is important for a team to explore many factors and undertake multiple reinforcing actions. Appendix 2 shows how the NTW Driver Diagrams are being used to achieve our aims.

6. Implementation

An implementation team led by Dr Jonathan Richardson and Anne Moore - which will include the Sign up to Safety Leads within NTW's Senior Clinical Governance and Safeguarding team e.g. the Clinical Lead for Quality and Safety - will feedback on a quarterly basis to the Corporate Decision Team – Quality Sub Group. The implementation team has already asked for additional medical representation - at the community services development day held on the 24th June.

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

Update on Medical Staff

In recognition of the importance of medical involvement in the safety process a Clinical Lead - Quality and Safety was advertised; we are pleased to announce that Dr Uri Torres has been appointed into this role following interviews. We are currently working with Dr Torres to agree a start date.

Parliamentary Health Services Ombudsman Complaints Update

The following information gives a view of the ongoing Parliamentary Health Service Ombudsman (PHSO), activity for the Trust. The Trust is fully compliant with all response timescales. The Trust saw an increase in complaints investigated by the PHSO, with a rise from 14 in 2013 / 14 to 20 in 2014 /15, this is in line with the national rise and as expected as communicated by the PHSO in a number of national documents released following the Francis Review. The Trust currently has 14 open cases.

Case number	PHSO reference	Opened	Current Status	Trust Outcome	Current Update
2212	189517	11.06.14	Request for files	Not Upheld	Sent 12.06.14
2084	199797	17.10.14	PHSO Open	Upheld	Letter received – intention to investigate 17.02.15
1814	192159	24.07.14	Request for files	Upheld	Sent 01.08.14
1794	199616	18.09.14	Final report received	Partially upheld	Partly upheld – actions completed and apology sent 30.04.15
2098	199724	13.11.14	Intention to Investigate	Decision not to investigate at this time – feels all points been previously answered	Telephone call received – intention to investigate 19.02.15
1628	205693	26.01.15	Request for files	18 complaints in the specified timeframe Jan 12 – Oct 12 – various outcomes	Sent 17.02.15
1894	206709	11.02.15	Request for files	Partially Upheld	Sent 17.02.15
2074	222359	21.05.15	Request for files	Partially Upheld	Sent 28.05.15
2169	210254	25.02.15	Request for files	Upheld	Sent 04.03.15
2664	210865	26.03.15	Request for files	Dealt with locally, not through Complaints Department	Sent 08.04.15
1942	209870	25.02.15	Request for files	Partially upheld then re-opened and partially upheld	Sent 06.03.15
2374	213836	25.02.15	Draft report received	Upheld	Comments by 29.06.15
2115	209772	13.03.15	Request for files	Partially upheld then re-opened and not upheld	Sent 24.03.15
2346	216342	19.05.15	Request for files	Partially upheld then re-opened and not upheld	Sent 28.05.15

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, and 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; this resulted in the Principal Community Pathways Benefits Realisation Report (BRR) for Sunderland & South Tyneside.

The BRR focuses on triangulating available information to assess current performance of community teams in Sunderland and South Tyneside. These teams are still in the early stages of transition to the new ways of working, with some key elements not yet implemented and many elements only partially implemented. This means that for the majority of overall programme benefits, it is still too early to assess how well the model is working. Analysis of team performance will help understand pressures as well as good practice to inform the implementation process. Caution needs to be used when attempting to draw conclusions from the data in the BRR, caseload migration is on-going and legacy issues will still have an impact on team level data..

A Blueprint checklist has been developed, for the BRR which outlines the key building blocks of the model that need to be implemented for the overall programme benefits to be realised. The checklist is still being finalised, but already gives an indication that the model is still in the early stages of implementation. Key areas that are yet to be fully implemented include:

- All referrals for community services being triaged through IRS
- Scheduling of all assessment appointments
- Preparation of assessment documentation through IRS
- Accommodation for all teams
- Consistent use of 5 P formulation
- Treatment packages

Following the development of the new programme and locality plans, it will be possible to develop a more accurate timeline for expected benefit delivery, aligned to the implementation of these key building blocks.

The compiling of the BRR has raised some issues with the data quality, and has highlighted the need for a reporting mechanism; this will ensure that the data reported through the BRR is accurate and has been through stringent quality checks by both the Performance team and Transformation implementation Groups (TIGs). Future reports will be presented to Executive Directors with a month delay to ensure that all quality checks have been carried out and operational management have provided contextualisation to the information.

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.

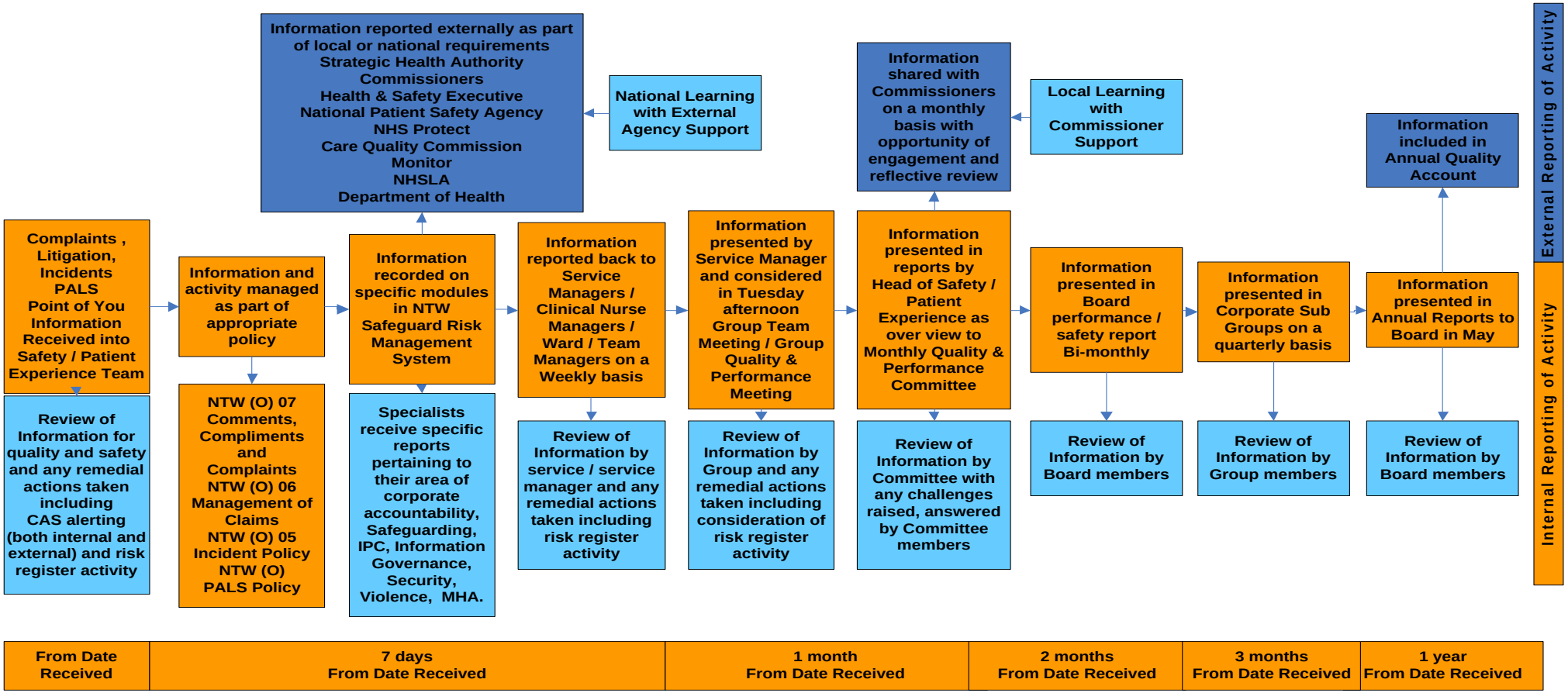
Incident – Any activity which may or may not have resulted in harm including near miss activity, involving anyone who comes into contact with NTW services, including patients, carers, staff, visitors, members of the public.

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.

There were no Safety Messages sent out between January 2015 and March 2015.

Appendix 2

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 3

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