NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETTING

Meeting Date: Wednesday 24th May 2017

Title and Author of Paper: Safety Report - January – March 2017
Author of Paper in response to this report – Tony Gray - Head of Safety & Security

Executive Lead: Gary O'Hare, Executive Director of Nursing and Operations

Paper for Debate, Decision or Information: Information

Key Points to Note:

- This report contains all the safety related incident and complaint activity for the period January – March 2017, and will be the final iteration of this report in this format.
- As part of the development of the "Learning from Deaths Action Plan", previously submitted to Board of Directors, the Trust is changing how it reports on its activity, and will now produce an integrated "Safer Care report", this will be produced on a monthly basis and presented to the Trust's Quality and Performance Committee on a bi-monthly basis.
- The full Safer Care Report will then be presented to Board of Directors on a quarterly basis in line with the following revised schedule.
- Due to the cancellation of the April Board the cycle is currently being adjusted to present the information in a timely manner.

NTW FT – Board Cycle – Safer Care Reporting Cycle

Report Title	**Board Date**	**Adjusted Board Date**
Safety Report Q4	April	May
Security Management Annual Report	May	June
Positive and Safe Annual Update	June	June
Safe Care Report Q1	July	July
Mortality Report	September	September
Safer Care Report Q2	October	October
Physical Assaults on Staff Annual Report	November	November
Safer Care Report Q3	January	January
Lone Working Annual Report	February	February
Safer Care – Forward Plan – Annual Review	March	March
Safer Care Report Q4	April	April

Risks Highlighted to Board: None

Does this affect any Board Assurance Framework/Corporate Risks? No Please state **Yes** or **No** If Yes please outline

Equal Opportunities and Legal and Other Implications: None

Outcome required: Noted for Information

Date for completion: N/A
Links to Policies and Strategies: • Incidents Policy • Complaints Policy • Claims Policy • Health & Safety Policy • Security Management Policy • Central Alert System Policy • Safeguarding Policy

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

Safety Report
May 2017
Reporting Period: January – March 2017

Shining a light on the future

Introduction

The following information is the activity that has been reported for the period January – March 2017, this is the final presentation of this report in this format, as the Trust moves in Q1 2017/ 18 to a more integrated Safer Care Report, in line with the new reporting cycle.

Incident Reporting and Management

Serious Incidents

The following information gives a detailed breakdown of the serious incidents that have occurred in the Trust in the last financial year, and gives the rationale for the increase throughout the year.

Table 1

Cause Group	2014-15	2015-16	2016-17
Aggression And Violence	2	9	9
AWOL And Abscond	1	2	3
Death	90	111	134
Fire	0	3	2
Inappropriate Treatment	2	2	3
Information Governance	1	1	1
Infrastructure	1	3	3
Medication	0	2	3
Patient Accident	9	12	14
Patient Ill Health	0	3	2
Safeguarding	1	0	4
Security	0	1	2
Self Harm	6	13	15
Totals	113	162	195

It can be seen above that the serious incident rate has increased from 162 in in 2015 – 16 to 196 in 2016 – 17, this was an expected increase, as the majority of the increase is around the review of deaths , this was in line with the plans put in place as a review of the serious incident framework of March 2015, and in preparation of the Learning from Deaths guidance that has now been issued and is currently supporting the Trust's approach to incident reporting and reflection, in advance of having a new Learning from Deaths Policy in September 2017.

There have also been minor increases over the period for self harm and violence incidents, but again this is down to more detailed discussions with Directors about incidents, and a more reflective review of them. The increase in patient accidents, is specific to fractures in Older Peoples services, but no significant themes of clinical concern have been identified.

The levels of investigation are as follows, all of these incidents are discussed in detail with Directors at the Group Business Meeting on a Friday morning and the level of investigation agreed in line with the following definitions:-

Level 1 – Concise internal investigation – Trust equivalent in Policy – After Action review.
Level 2 – Comprehensive internal investigation – Trust equivalent full serious incident investigation carried out by dedicated by central – serious incident investigation officers– STEIS reportable and to review by panel.
Level 3 – Independent Investigation – Trust equivalent – Independent Investigation by external serious incident investigator, likely also to be investigated externally by NHS England.

All serious incidents are coded as the record is created in the incident system, which gives the opportunity to compare and contrast the activity over time, this allows the safety team to provide information to the clinical groups in the Trust, and indicate whether certain incidents are increasing or decreasing and explore the reasons for this.

Learning From Deaths

Since the publication of the Care Quality Commission report on Learning, Candour and Accountability and the National Quality Board's report on Learning From Deaths, set a number of standards that the Trust has reviewed in line with it's historic approach to reporting and learning from deaths, the actions resulting from this have previously been reported through to the Board of Directors. From now on the actions will be reported on a monthly basis through this report, with a quarterly update being provided through the Safe Care Report that goes to Board.
The changes to the way we report and reflect on deaths and will inform part of our policy that will be in place by September 2017 is:-

- *Patients who have died under their care are properly identified.*
- *Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.*
- *Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.*
- *Appropriately trained staff are employed to conduct investigations.*
- *Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.*
- *Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.*
- *Families and carers are involved in investigations to the extent that they wish.*
- *Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.*
- *Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.*
- *That particular attention is paid to patients with a learning disability or mental health condition.*

One of the First changes being made is to create a Mortality Dashboard that highlights in an automated format the comparison of deaths occurring in the organisation that are recorded in the Electronic Healthcare Record as well as what has been reported through the Trust's Risk Management System (Safeguard), whilst this is under testing at this time, this is now being populated with current activity and is available to the Safety Team of the Trust, to review the content, a screen shot of the dashboard is included below, data is currently being presented to cover the following areas:-

- Number of deaths
- Deaths by Services
- Coroner Conclusions / Outcomes

- Comparison between Electronic Health Record and Risk Management System
- Detained Status of Patient
- Age and Sex of Patient

As this system develops it will also include more qualitative data such as:-

- Diagnosis of Patient
- Cluster of Patient, at first cluster and at time of incident
- Avoidability / Preventability assessment
- Deaths reviewed as Independent Investigations , Full SI (STEIS reportable), Full SI, not STEIS Reportable (Addictions – self harm related deaths), Concise Investigations (AAR) – addictions deaths, other deaths of concern by Directors, Mortality Review.

The following table gives specific detail on the review of deaths across the Trust. The Trust for a significant period of time, has been well placed when national reports by the Care Quality Commission and the National Quality Board are considered. The updated action plan on the work involved is included at Appendix 1.

Table 2 – All deaths that are reviewed in line with the SI framework.

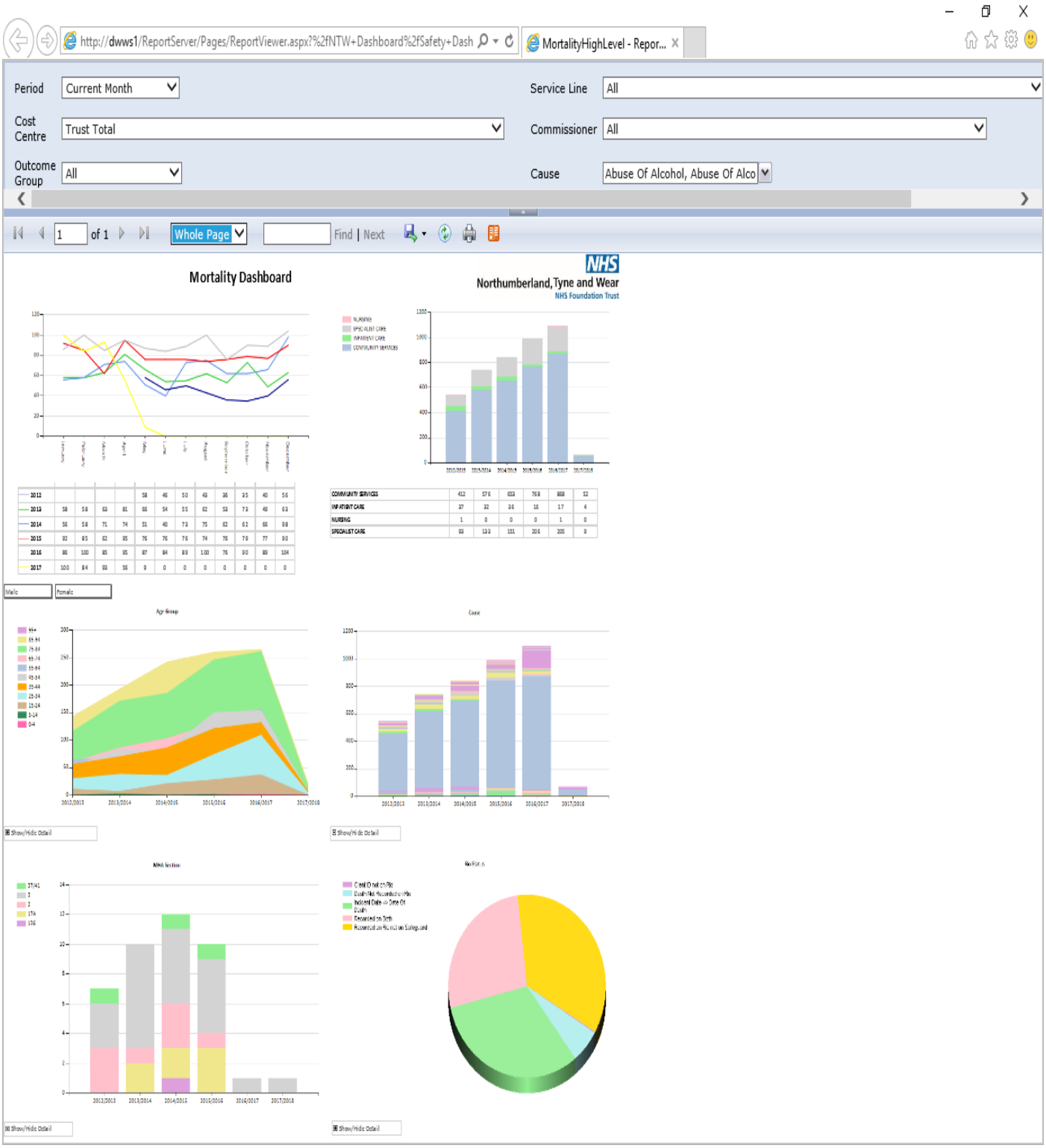
Those deaths that are not STEIS reported such as Addictions Service related deaths are subject to an after action review, this table also acknowledges an increase in the last year due to taking on the Sunderland Addictions Service. It has been well established that for mental health services, the greater the contacts with the population the greater numbers of deaths are likely to be reported.

It is also acknowledged that there is still no national way to compare death rates in mental health services, due to the diversity of services that are operated. Where comparisons can be made is in reference to the National Confidential Inquiry into Suicides and Homicides , and the detail from that report will be shared with the Board of Directors in September 2017 following publication of the national report.

Cause 1	2014-15	2015-16	2016-17
DE01 Unexpected Death	79	53	64
DE03 Alleged Homicide To A Patient	1	0	1
DE04 Alleged Homicide By A Patient	1	2	2
DE08 Unexpected Death - Natural Causes	0	0	3
DE14 Unexpected Death NTW Not Main Care Provider	0	1	0
DE16 Alleged Homicide By A Patient To A Patient	2	1	1
DE18 Unexpected Death Local AAR	7	53	63
DE19 Alleged Homicide Not In Receipt Of Services	0	1	0
Totals	90	111	134

The Trust's Mortality Dashboard is in it's early stages of development, and it is expected that once fully embedded , it will start to identify areas of learning about the Trust's activity, this will be the first time that the Trust's Electronic Health Record and Risk Management Systems have been compared to give rates of death and understand why they are different.

A screenshot has been provided below. This currently contains similar information to that provided in the Trust's Unexpected Death's Analysis Report.



Incident Reporting

The following information gives a detailed breakdown of the incidents that have occurred in the Trust in the last year, in comparison to the previous years, it is evident that incidents are on the increase, some of which is to do with the ease of reporting the activity through the web based system, this also acknowledges that 2016 -17 was the first full year of embedded reporting through this system.

Notable increases / decreases are as follows:-

- Aggression and Violence has decreased by 228 incidents in a year.
- AWOL and abscond has increased by 256 incidents, with the highest increases of detained patients failing to return from authorised leave and patients absconding whilst on escorted leave.
- Increase in deaths is as a direct result of web based reporting, where clinicians can now see the types of death to report (including expected).
- Fire and False alarms have increased at the same time that the site wide no smoking policy was implemented.
- Inappropriate Patient Behaviour includes smoking incidents and is one of the highest increases.
- Self Harm activity has increased significantly, this is considered fully within the Positive and Safe Strategy, and will be included in detail in the Annual Report at the Board of Directors in June.
- Safeguarding has increased as expected with the changes made to the Trust's Safeguarding Triage system.

All the activity is suitably considered at the Corporate Decision Team's – Quality Meeting and through the Trust's Quality and Performance Committee, where the themes and trends are analysed and understood. The clinical groups also provide an update through the Quality and Performance Committee on a 6 monthly rotational basis, exploring their own activity and the reasons for it.

Table 3 – All Incidents Reported by Year

Cause Group	2014-15	2015-16	2016-17
Aggression And Violence	11578	12563	12335
AWOL And Abscond	879	883	1139
Contractor/Public/Visitor Incident	27	44	35
Death	850	990	1092
Fire	126	135	159
Human Resources Process	1	4	6
Inappropriate Behaviour By Others	23	46	58
Inappropriate Patient Behaviour	1660	1910	2857
Inappropriate Staff Behaviour	56	95	99
Inappropriate Treatment	20	19	25
Infection, Prevention And Control	113	123	294
Information Governance	408	513	654
Infrastructure	102	78	96
Long Term Segregation	0	1	15
Medical Device, Equipment	69	42	47
Medication	934	1093	1165
Mental Health Act	37	34	24
Patient / Staff Safety	18	54	47
Patient Accident	2887	1795	1975
Patient Clinical Issue	44	90	92
Patient Ill Health	2003	875	974
Police Issue	13	19	18
Pressure Ulcer Inside NTW	0	13	27
Pressure Ulcer Outside NTW	0	7	34
Safeguarding	2770	3372	3848
Security	1810	1734	1996
Self Harm	4013	4555	6389
Service Delivery	158	137	265
Staff Accident	611	484	508
Staff And Patient Accident	10	20	12
Staff Ill Health	15	15	11
Unknown Patient Injury	6	277	65
Unlawful Detention	0	8	6
Waste Management	0	0	3
Totals	**31241**	**32028**	**36370**

Complaints Reporting and Management

Complaints Received

The following graph shows the number of complaints received in each of the 6 month periods, for comparative purposes and due to the change in language of the new policy all categories of complaints have been included as follows:-

Old Policy – Descriptors

- Category 1
- Category 2
- Category 3
- Joint Complaint – NTW Not Lead
- Joint Complaint – NTW Lead

New Policy – Descriptors

- Standard
- Complex
- Joint Complaint – NTW Not Lead
- Joint Complaint – NTW Lead

There have been a number of changes in the complaints process over the last year. The following table gives a breakdown of the Trust activity for all complaints received over the last 3 years, with reasons and rationale for the increase.

Complaints have increased during 2016/17 with a total of 436 received during the year (during which time we provided care and treatment for more than 81,000 people). This is an increase of 74 complaints (or 20%) from 2015/16, and the increase can be seen across many categories. Note there has been a reduction in complaints relating to restraint, which may be linked to the implementation of the Positive and Safe Strategy.
When considering the themes arising from complaints, it is clear to see that waiting times for Children and Young Peoples' Services features within this. Also there are several complaints in relation to the new ways of working. There has also been an increase in complaints relating to facilities which often relate to the no smoking policy and parking issues around major hospital sites.

Table 4

Complaint Type	2014-15	2015-16	2016-17
Category 2	64	25	0
Complex	192	210	153
Joint Not Lead	7	9	4
Joint NTW Lead	3	9	4
Non-Clinical Co	0	0	5
Standard	65	113	270
Totals	331	366	436

Complaints by Category

The following table gives a breakdown of complaints received by category, these categories are nationally approved, and information is sent to NHS Digital on a quarterly basis.

Table 5

Category Type	2014-15	2015-16	2016-17
Access To Treatment Or Drugs	0	9	7
Admission, Discharge & Transfer Arrangements	24	0	0
Admissions And Discharges	1	25	21
All Aspects Of Clinical Treatment	115	0	0
Appointments	1	22	20
Appointments, Delay, Cancellations - In-Patients	3	0	0
Attitude Of Staff	73	0	0
Clinical Treatment	0	15	18
Commissioning	0	0	1
Communication / Information To Patients	24	0	0
Communications	2	74	76
Consent	0	1	0
Facilities	0	6	29
Hotel Services	5	0	0
Integrated Care	0	1	0
Other	0	4	13
Patient Care	6	87	125
Patient Privacy & Dignity	6	0	0
Patient Status / Discrimination	16	0	0
Personal Records	16	0	0
Prescribing	0	24	26
Privacy , Dignity And Wellbeing	0	10	12
Restraint	0	9	4
Transport	37	0	0
Trust Admin/ Policies/Procedures Including Rec Man	1	11	17
Values And Behaviours	1	58	64
Waiting Times	0	10	3
Totals	331	366	436

Complaints Relating to Death

The table below shows those complaints that have been received with the theme of the complaint is relating to the death of a patient. It also needs to be acknowledged that not all complaints relating to death are received straight after death, some are received following the outcome of a serious incident investigation, or the outcome of a coronial investigation, this can be six months after the death.

The table indicates that the most common service to receive these types of complaints is the Trust's Crisis and Home Treatment Team Services, having 9 over the last 3 years, but this has to be acknowledged against the total number of contacts these services have.

Table 6

Department	2014-15	2015-16	2016-17
Alnmouth	0	0	1
Bothal (V8)	1	0	0
Castleside Ward	0	1	0
Central & S Northumberland CMHT Greenacres	0	1	0
Central & S Northumberland OP CMHT Greenacres	0	1	0
Crisis Response & Home Treatment GHD Tranwell	1	0	1
Crisis Response & Home Treatment Ravenswood	0	1	0
Crisis Response & Home Treatment S Tyne Palmers	0	1	0
Crisis Response & Home Treatment SLD HWP	1	1	1
CYPS Community NLD ADHD NGH	0	0	1
EIP North Tyneside Benton View	0	0	1
GHD Community Non Psychosis Team Dryden Rd	0	0	1
Hadrian Clinic Gainsborough	1	0	0
Hadrian Clinic Lowry	1	0	0
Hauxley	1	0	0
Hexham Adult CMHT Farnington Ctr	1	0	0
Information Department SNH	0	0	1
Lamesley	0	0	1
NCL North & East Adult CMHT Molineux	0	1	0
North Tyneside Recovery Partnership Wallsend	0	1	0
Older Adults Community Team MWM	0	0	1
SLD North Psychosis / Non Psychosis MWM	0	0	1
SLD Psychiatry & Liaison Team SLD Royal	1	1	0
SLD South Psychosis/Non Psychosis Doxford	0	0	1
Sunderland Adult Community Treatment Team	1	0	0
Treatment Centre SGP	1	0	0
Warkworth	0	1	0
Woodhorn	1	1	0
Totals	11	11	11

Parliamentary Health Service Ombudsman

The following information is the current activity that has been reported / requested via the PHSO.
The Trust as part of every response letter includes the PHSO contact details, in the last year the Trust responded to over 300 complaints. Complainants have the right to take their complaint to the PHSO even if the findings of the complaint are partially or fully upheld. The following are the on-going complaint activity with the PHSO.

Opened	Complaint Number	PHSO Reference	Current Status	Current Position	Trust Investigation Outcome
26.05.2016	2919	16000490	PHSO – draft report received	Complaint **not upheld**. Awaiting copy of final report.	Partially upheld
22.08.2016	2972	262641	PHSO – final report received	Complaint **upheld**. Revised action plan as requested by PHSO circulated	Upheld
15.09.2016	3024	266719	PHSO – final report received	Complaint **partially upheld**. Revised action plan as requested by PHSO circulated	Partially upheld
23.09.2016	2878	267570	PHSO – intention to investigate	Files sent 07.10.16 Email received 25.01.17 requesting Trust comments on scope of their investigation. Email reply sent 01.02.17.	Not upheld
20.10.2016	3269	272208	PHSO - enquiry	PHSO still considering this case for investigation.	Not upheld
20.02.2017	3144	C2003388	PHSO – intention to investigate	Files sent 01.03.17, Investigator identified	Partially upheld
06.03.2017	2982	C2008097	PHSO – intention to investigate	Files and records sent 15.03.17	Not upheld
02.08.2016	3033	262023	PHSO – Intention to investigate	Files sent 17.08.16. Investigator identified.	Partially upheld
28.09.2016	2926	268846	PHSO – final report received	Final report received – complaint **partially upheld**. Letter of apology and action from recommendation due out by 06.06.17	Partially upheld
26.03.2015	2664	210865	PHSO – revised draft report received	Revised draft report received – complaint is now **upheld**. PHSO advised Trust has no comments 13.04.17	Not upheld
30.09.2016	3062	161003-122905	PHSO – request for files	Files sent 04.11.16	Partially upheld
07.11.2016	1722	270818	PHSO – Intention to investigate	PHSO investigator appointed 01.03.17. Draft report anticipated July 2017	Unable to investigate

Appendix 1

Learning from Deaths / Mortality – Safety Team – Action Plan

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
Patients who have died under their care are properly identified.	• All deaths are reported through the Trust's Incident reporting system. • An analysis of this information from the national data submission shows a high concordance between incidents reported on the Trust Risk Management System (SafeGuard) and the Full Clinical Patient Record (RiO), which records all deaths reported through the national spine and available through Office for National Statistics around mortality.	• A mortality dashboard will be created which brings together both information systems to assess and analyse to give a zero attrition rate, based on patients that are current to services at death or have been recently discharged from services in the last 6 months. • Presentation of data will be compared to 2 other Trusts across the Northern Alliance to feedback to Mazars meeting in June 2017 (Sheffield Health and Social Care Trust, and South West Yorkshire Partnership Trust)	• Dashboard is live and undergoing testing • Still being planned	May 2017 June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Kelly Collier – IT Project Team Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.	• Case records are screened as part of the established investigation processes in line with the NHS England Serious Incident Framework. This covers predominantly unnatural cause deaths	• The Trust Incident Policy will be reviewed to establish a mortality review process, supported by the Alliance Health Service Network and North East Quality Observatory. This will extend coverage to natural cause deaths • A new deaths policy / PGN will now be created to sit within the Trust's incident policy	• Trust Incident web form has been adjusted with questionnaire relating to deaths, testing to commence in June.	June 2017 September 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor Head of Clinical Risk and Investigations
Staff and families/carers are proactively supported to express concerns	• This already occurs through established Duty of Candour principles, which has a 3 stage check, and is subject to quarterly monitoring and	• These principles will be extended to all deaths following an assessment of any concerns identified for any non-SI related death, which may include natural and expected deaths following	• Trust incident system being used now for all Serious Incidents to	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety

about the care given to patients who have died.	reporting to the Clinical Commissioning Groups as part of contractual obligations.	discussions with Directors after implementation of the new mortality review process.	report on Duty of Candour		Claire Taylor – Head of Clinical Risk and Investigations
Appropriately trained staff are employed to conduct investigations.	• The Trust has a central dedicated team of serious incident investigators, supported by lead clinicians from services to review all unexpected deaths in line with the NHS England Serious Incident Framework. • This team has undergone routine investigation training as part of their appraisals and CPD requirements.	• A review of the levels of investigation for non-SI deaths will be agreed and capacity and demand including any increased costs will be reported through to the Trust's Business Delivery Group. • Investigators will be trained in the use of Human Factors Frameworks	• Mortality Review to be carried out on agreed deaths commencing April 2017 with position reported on in Q1 Safer Care report	June 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.	• Within existing serious incident processes wherever information comes to light, or there is concern relating to the true independence of investigation, this is escalated to the Executive Director of Nursing and Operations, to seek authorisation to allocate to an external investigator, supported by a lead clinician in the Trust. • The Trust has a panel of external investigators	• Capacity and demand fluctuates for this and likely this will be impacted by a small group of external professionals being available, and facing more request from a number of Trusts in future. • Demand and compliance will be reported through the Trust's Safety Report. • New reporting cycle - Month1 for report to CDT-Q In May 17 and Safer Care Report – Q1 to Board in July.	• Month 1 report produced.	July 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Investigations are conducted in a timely fashion, recognising that complex cases may require	• The Trust reports on its compliance against current 60 working day timescales through the monthly All Incident report which is shared with Clinical	• Monitoring of these timescales will continue to be shared with CCG's , but information will start to be included in the Safety Report for Board in the next reporting cycle.	• Mortality Review to be carried out on agreed deaths commencing	July 2017 July 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety

longer than 60 days.	Commissioning Groups. Extensions are agreed in advance and by exception. • For cases reviewed in December 2016, 86% complied with the 60 day timescale. In one case an extension had been agreed with the CCG.	• Only deaths classified as serious incidents will be measured by the 2 / 60 working day timescales • New timescales will need to be agreed for other death reviews	April 2017 with position reported on in Q1 Safer Care report		Claire Taylor – Head of Clinical Risk and Investigations
Families and carers are involved in investigations to the extent that they wish.	• Families and carers are involved at the outset in all investigations, where they are contactable following a death. • Extensions are agreed to delay the investigation at their request due to impact of bereavement. • Reports are shared that answer the specific questions they have, and agreements in place with all coroners where deaths are subject to inquest to direct concerns or questions to the Trust to be included.	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. • This approach will need to be adopted from April 1st and included in new policy / PGN by September 2017	• Mortality Review to be carried out on agreed deaths commencing April 2017 with position reported on in Q1 Safer Care report	June 2017 September 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.	• The Trust has in place an effective dissemination process for learning, starting with the learning from activity update that is shared with all senior staff on a Thursday, which reflects on all the Serious Incidents, Complaints, Complex issues, Coroner outcomes, serious incident reviews of the previous week. This is shared through operational groups by	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. • The current Patient Safety Group will be reviewed to create a Trust wide Learning Lessons Group. • A regular Learning Lessons newsletter will be established. • The Trust is working with other MH Trusts in the North/Mazars to develop cross organisational learning.	• Group to be reviewed in line with Clinical Group Changes	July 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations Vida Morris – Group Nurse Director

	Tuesday at the latest for information. • Other organisations involved in an incident are included once identified as part of the serious incident process, and invited to attend after action reviews and the SI panel discussions. Non-engagement is escalated to Clinical Commissioning Groups and included in SI reports as actions for improvements.				
Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.	• The Trust has a transparent and open approach to reporting and learning from deaths. • A six monthly analysis of deaths has been presented in the open part of the Board of Directors meeting since 2009. The last 4 years reports are publicly available for scrutiny	• A review of the unexpected death report will ensure that there is a learning and improving section within this, similar to the established safety report. • All Trust reporting is being adjusted from April 1st with the monthly report having a deaths section in it. • 16/17 quality account template will be populated with 16/17 deaths activity to give the Executive Director and Non-Executive Director a first view of a future quality account • The Q1 – Safer Care report will include an introduction of the death data and any learning. • The Annual report on mortality to Board will be presented in September 2017 • Data will be reported in the Quality Account from June 2018, in line with DoH guidance	• Plans in place	October 2017 April 2017 April 2017 July 2017 September 2017 June 2018	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations Vida Morris – Group Nurse Director

That particular attention is paid to patients with a learning disability or mental health condition.	• This recommendation is applied across all service providers, and by default would naturally apply to a Mental Health / Learning Disability Trust	• Work needs to be completed to improve the quality of diagnosis of all patients who die, to understand their diagnosis. • In particular, to clarify the recording of a diagnosis of LD where the person is in a non-LD service. • Current practice will remain of capturing all LD deaths in LD services.	• Mortality Dashboard to include Diagnosis of Patient to clearly identify Learning Disabilities.	October 2017	Executive Director of Nursing and Operations / Operational Director of Service Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety