Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	22nd June 2016

Title and Author of Paper:	Lone Working System Update Tony Gray, Head of Safety and Security

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

Paper for Debate, Decision or Information:	Information

Key Points to Note:

The Trust has put a number of operational and managerial systems in place since the internal audit on Lone Working was carried out and this has resulted in an increase in the use of lone working devices. However there are still areas of concern which are currently being given close scrutiny by the Executive Director of Nursing and Operations, which include direct conversations around performance with Service Managers who receive the monthly report.

Within the body of the report, the current and future work for further improvements have been identified and are currently being managed in partnership between the Services and the Patient Safety Team, with operational updates being provided through Group Business Meeting. Each individual clinical group has its own action plan specific to its needs, and the size of its lone working system: Community Services is the largest, followed by Specialist Care Group, then Inpatients with a small number of devices, and currently Medical / Medical Education, which following discussion with the Medical Director will be absorbed into Service Line Management in Operational Services in June 2016.

Based on available information in the Trust's monthly performance report and available information provided by the Lone Working Contractor as part of the national framework agreement, Northumberland, Tyne and Wear NHS Foundation Trust has the highest usage of the system anywhere in the country for comparable size of contract, across all sectors not just the NHS. These figures have been supplied at request from the National Contract Manager, and are not currently available to other organisations, these figures are based on interaction with a device as a measure.

Percentage Devices Active (any signals generated – Ambers, Reds, Status Checks)
Across all NHS contracts – 31%*
Northumberland, Tyne and Wear NHS – 55%*
Across the top 6 NHS contracts by size – 42%*

***Based on activity up to April 2016**

This means that the lone workers in the Trust are 24% higher users of the system, than any other NHS organisation in the country.

This also means that the Trust has the highest use by 13% across the 6 largest contracts in the country across all sectors.

At any time within the system, non-usage will be for a number of reasons as follows:-

- Annual Leave
- Sickness / Absence
- Identified and acknowledged low user, due to risk assessment.
- Staff undertaking any type of training, so would not require device on those days.

Compliance by group as of June 2016:

- Community Services 75%
- Specialist Care 68%
- Inpatient Care 33.3%
- Medical/Education 3.7%

Risks Highlighted to Board :

Acknowledge that usage will not be 100% for any organisation using this system, and that there is no perfect number due to a range of factors identified above.

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

Equal Opportunities, Legal and Other Implications: None

Outcome Required: The Board of Directors are asked to receive this report for information and assurance.

Link to Policies and Strategies:	Security Management Strategy, Security Management Policy and Practice Guidance Notes

Action	Security Management Annual Report and Plan

Introduction

The purpose of this report is to provide assurance to the Board of Directors that the Trust has a lone working system in place that is keeping identified at risk staff safe, and that the Trust is taking all reasonable steps to improve the usage of the system, and that the use is continually improving and being monitored.

Group Business meeting has taken regular updates relating to lone working device roll out, the following gives a breakdown over time, with the devices in use at the end of each financial year.

Updates and Reports provided to Group Business Meeting or equivalent operational meeting.

Date	Meeting	Paper	Devices in use in period
October 2009	Operational Leaders Meeting	First update on pilot of 50 devices, and initial business case for national contract and 480 devices. (subsequently increased to 640 devices due to lower national take up of free contract).	2009 – 2011 roll out of 640 devices.
November 2012	Senior Management Team	Increase requirement as part of roll out of devices due to Community Transformation and inclusion of Junior Doctors.	2012 – 2013 849 devices in use.
October 2013	Senior Management Team	Increase in requirements of further 200 devices and increase in admin. Support for Lone Working System.	2013 – 2014 1,049 devices in use.
January 2014	Group Business Meeting	Escalation report around out of hours activity, and inability to find lone workers.	N/A
July 2015	Group Business Meeting	Increase in requirements of further 570 devices.	2015 planned roll out to increase devices to 1,600.
June 2016	Group Business Meeting	Agreement to extend contract with another 200 devices, whilst cleansing of unused devices is carried out.	2016 increase to between 1600 – 1700 devices.

Directors have at every stage supported the principles of lone working and the current implementation plan indicates that once all identified lone workers have a device in use, this will be the largest contract in the NHS in the country.

The Internal audits carried out into the use of the lone working system, indicated poor monitoring and improvements to use over time. The adjusted practice guidance note will build in the robust monitoring arrangements that have been put in place and this will be available to clinical teams by July 2016, the practice is already happening, which is evidenced by the increase in amber alerts.

This monitoring and improvement in use is currently under close scrutiny by the Directors at the Group Business Meeting and each of the clinical groups have robust action plans in place. This monitoring will continue and form part of the assurance process as standard in future which will be added to the monitoring section of the practice guidance note , so that there is a formalised quarterly report produced to ensure staff safety , in the same way that the group receives quarterly seclusion information in relation to patient safety.

The following information gives the breakdown on current use of devices, which has improved significantly over the last year, and is currently the best in the country, by organisation, but also by individual user. It is acknowledged that improvements can still be made and this will be subject to constant monitoring.

How do we know how we compare?

The following information has been supplied by Reliance Protect (the national contractor of the system), it is not commercially sensitive, and has been authorised to be used in this report upon request. It can be seen on page 5, that the Trust has a higher amber use than the national picture and this is increasing.

Explanation of Reliance Report Column Headings:
Descriptor of Columns in monthly report (not all this activity has been included in this report)

Low Battery
When the device is switched on it will automatically send a low battery signal to the Reliance Alarm Receiving Centre when the voltage drops below 3.6, devices that are switched off will not send a low battery signal. This column can be removed from the report if managers decide it adds no value.

False Alarm
If the user either presses the Red Alert Activation button on the back of the device or pulls the lanyard rip cord out of the device in error.

Genuine Red Alert User Closed Safely
User has activated a genuine Red Alert that does not require Police response e.g. for monitoring purposes or where a volatile situation is successfully deescalated by the user.

Genuine Red Alert Escalated to 999:
User has activated a genuine Red Alert which requires Police Response.

Total Status Checks
User performs a Status Check to check if there is sufficient battery and signal strength to record an Amber Alert.

Last Used: Date on which the device was last used.

Amber Alert:
The user records a 20 second voice message giving their own name and full address including post code of the property they are about to enter. This is the main measure of effective usage of lone working devices, the data below shows

the improvement in the last year, following both internal audits, there is no perfect number.

Live Devices

Connected devices in the last month, any disconnected devices that are removed from the contract any of their usage history are moved as well including amber alerts.

Northumberland , Tyne & Wear NHS Foundation Trust					
Month	Amber Alerts	Increase / Decrease	Live Devices	Increase / Decrease	Ave amber per device
May 16	16889	+417	1544	-8	10.9
April 16	16472	+2656	1552	-17	10.6
March 16	13816	+2969	1569	+91	8.8
February 16	10847	+1426	1478	+26	7.3
January 16	9421	+535	1452	+7	6.4
December 15	8886	-1241	1445	+97	6.1
November 15	10127	+2092	1348	+287	7.5
October 15	8035	+554	1061	+31	7.5
September 15	7481	+1351	1032	+7	7.2
August 15	6130	-1000	1025	+39	5.9
July 15	7130	-160	986	+6	7.2
June 15	7290	+585	980	+6	7.4

National View					
Month	Amber Alerts	Increase / Decrease	Live Devices	Increase / Decrease	Ave amber per device
May 16	188765	+13898	28618	+448	6.6
April 16	174867	+21166	28170	+2562	6.2
March 16	153701	-26939	25608	+507	6
February 16	180640	+51159	25101	-23	7.1
January 16	129481	+17653	25124	+876	5.1
December 15	111828	-8165	24248	+554	4.6
November 15	119993	+35246	23694	-1212	5
October 15	84747	-1089	24906	-178	3.4
September 15	85836	+6722	25084	-255	3.4
August 15	79114	-5827	25339	-1827	3.1
July 15	84941	+867	27166	+506	3.1
June 15	84074	-1859	26660	+790	3.1

Current Developments

A significant piece of work is underway to identify the reasons why some devices have had no use over a significant period of time, since staff have been trained, even if a low user the device should still be registered with activity such a battery status.

This detail has been included within the monthly performance reports since July 2015, but we still currently have 242 devices of this nature, it may well be that these staff have left the Trust, no longer need the device but have not returned it, or have lost the device and not reported it missing. Individual Service Managers are being contacted to establish the whereabouts of these devices, so that they can be formally disconnected or returned and re-used.

What have we done to improve usage within the Trust

Directors, Directorate Managers and Service Managers acknowledge that the management system historically in place to oversee and monitor the use of devices by lone workers has not been robust enough, and since the internal audit a range of measures have been put in place, to create the necessary improvements we can see in the annual activity improvements previously reported on.

Further developments are also currently being implemented to improve clinical care which will also assist to assess effective usage of devices within the Trust.

The monitoring document, that has been piloted in Community Services since October 2015, and will form part of Trust policy by July 2016, has included the following improvements in relation to monitoring effective use. Guidance attached at appendix 1.

- Team Managers effectively monitoring the lone workers device usage and comparing this usage to the Reliance Protect Service Managers Monthly Report.

- Standing agenda items of lone working usage on team managers meetings, to identify any concerns with the system that would impact on effective use, so these could be escalated quickly to the Patient Safety Team and onwards to the contractor.

- Developed the monthly report to become more meaningful to managers, with a simple to use guide in the supporting email, to assist with use.

- Sharing recordings of live incidents to aid with reflection and learning and using as evidence if required about why the Trust has invested so much time and resource in the system.

- The Patient Safety Team is working with the national contractor to improve the national reports that are produced to ensure that they are tailored to the needs of NTW as one of the biggest users of the system in the country.

- Building a network of similar users across the country to share experiences with, this is currently happening, but some organisations are still currently at the implementation stage.

Future Developments

- The main development that will assist managers to monitor the system live is the RIO to Outlook Calendar development which will allow managers to see all the visits clinical staff are making and compare this to their lone working activity, to understand any differences.
  More information on this is included in the following information leaflet at appendix 2, and this will really join the clinical activity to the lone working activity seamlessly

- Following every lone working device training session, a central monitoring system evaluation will be put in place to be monitored by the Lone Working Co-ordinator, to ensure new staff follow their training and implement all of the available guidance for safe use.

- A review of the lone working system and the monitoring guidance will be carried out 6 months after implementation with the outcomes reported through the Group Business Meeting.

- A further roll out of over 200 devices is planned from July 2016 onwards.

- New national reports are being developed that will be more intuitive than the current performance reports received; these will be supported by in-house reports an example has been included at appendix 3.

- Specific Group actions are set out in their respective actions plans appendix 5, 6 and 7

  Current Compliance

  Compliance by Group as of June 2016:

  - Community Services 75%
  - Specialist Care 68%
  - Inpatient Care 33.3%
  - Medical/Education 3.7%

The breakdown is shown in appendix 3.

Recommendation

The Board of Directors are asked to receive this report for information and assurance.

Gary O’Hare, Executive Director of Nursing and Operations

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Appendix 1

Guidance for monitoring use of Lone Working Devices

Date of issue:1st October 2015

Authors
Derek Henderson
Tony Quinn
Fiona Kilburn
Keith McHenry

Shining a light on the future

1. Introduction

1.1 The guidance for monitoring use of lone working devices has been developed following an audit carried out between November 2013 and January 2014 which found;

- Significant assurance that there is generally a sound system of control designed to meet the organisation's objectives in the area of lone working.

However;

- Based on work undertaken by the audit only limited assurance could be given that the controls described in Policy and PGNs are being consistently applied within the services.

1.2 The purpose of this guidance is to develop practice within Planned Care Community Services that allows Northumberland Tyne and Wear NHS Foundation Trust to have greater assurance that control measures in relation to lone working are being applied with more consistency across all services.

1.3 The instructions as to how lone working devices should be used can be found in the following Policy and PGNs

- Security Management Policy NTW(0)21
- SM-PGN 02 Lone Working
- SM-PGN 09 Protect Identicom Lone Worker Protection System.

1.4 All members of staff are reminded that if they have been provided with a lone working device they **MUST** use this on **ALL** occasions that constitute a lone working situation. Staff are reminded that regardless of how well we may know particular patients, it is **NOT** possible to predict with certainty the situation we are going into and for this reason it is **SAFEST** for all concerned to activate the lone working device for all lone working situations.

2.0 Procedure for monitoring use of Lone Working Devices

2.1 All staff who see patients in a non NTW setting will be issued with a lone working device. This would not apply for staff working in Psychiatric Liaison services who only see patients in an acute hospital setting. Where this is the case the acute hospital lone working systems will be followed by Liaison staff.

2.2 Team managers will determine expected monthly usage for each member of staff. This will be recorded on the LWD monitoring form.(appendix A)

2.3 The Team Manager will monitor on a monthly basis, actual usage against expected usage for each member of staff using the monthly LWD reports.(appendix A)

2.4 Where actual usage is lower than expected usage, the Team Manager will meet with the staff member to determine why this is, and agree action to be taken to address this. A record will be kept of this meeting.

2.5 If a member of staff has three occasions within a rolling twelve month period of actual usage being less than expected usage, stage 1 actions will be taken.

2.6 If there are any subsequent occasions of actual usage being less than expected usage within the twelve month period stage 2 actions will be taken.

2.7 Team Managers will provide CCMs with monthly LWD usage reports (Appendix A).

2.8 CCMs will provide Service Managers with quarterly LWD usage reports (Appendix B)

2.9 Service Managers will provide quarterly reports to Safety and Safeguarding Sub-group each March, June, September and December.

2.10 Any team showing 75% or less of staff who are compliant with LWD usage for the quarter will have this included on the CMT risk register to allow CMT to monitor effectiveness of actions being taken.

3.0 Stage 1 Actions

3.1 For any member of staff who has had 3 occasions of actual usage of LWD being less than expected usage over a rolling 12 month period.

3.2 CCM, Team Manage, Professional Lead and member of staff will meet to discuss the importance of compliance with the LWD Policy.

3.3 The Team Manager will bring examples of occasions where LWD should have been used but was not.

3.4 Reasons as to why member of staff has not used LWD will be discussed and actions agreed as to how this can be addressed.

3.5 A risk assessment will be carried out along with expected LWD usage.

3.6 A performance plan will be put in place and a target of full compliance for the next 6 month period will be set.

3.7 The Team Manager will monitor performance plan on a monthly basis. If there are no further occasions of non-compliance, the Team Manager will meet with the member of staff at the end of the 6 month period to agree the performance plan has been completed successfully and to make a record of this accordingly.

3.8 If there are any further occasions of non-compliance within the 6 month period, stage 2 actions will be initiated.

4.0 Stage 2 actions

4.1 CCM, Team Manager and Professional Lead will meet with member of staff to inform them that stage 2 actions are to be initiated.

4.2 CCM, Team Manager and Professional Lead will carry out a risk assessment of lone working situations the member of staff works in and will put in place any further risk management processes that are required whilst stage 2 actions are being carried out.

4.3 Team Manager will provide a fact finding report to the Service Manager.

4.4 The Service Manager will consider on the basis of information in the fact finding report if a disciplinary investigation is required.

4.5 The Service Manager will write to the member of staff to inform them of their decision along with rationale for this.

4.6 If a disciplinary investigation is to be carried out, normal disciplinary procedures will be followed in accordance with NTW Policy.

4.7 If a disciplinary investigation is not be carried out, a further performance plan will be put in place to say how compliance will be achieved and the timescale the performance plan will cover.

Appendix A

Monitoring of Lone Working Device Usage

Completed by _____ Month _____

Team _____

Staff Name	Job Title	Hours worked	Expected usage Amber Alerts/Signal status Check	Actual usage Amber alerts/Signal status Check	Compliant
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No

Names of staff assessed as requiring a LWD but has yet have not been given one

Total % of staff compliant with LWD usage

……..

Actions being taken:

Appendix B

Lone Working Device usage

CCM Quarterly Report to Service Manager

Name of CCM …….

Period covered from ……. to ……..

	% of staff compliance each month			Average % for the 1/4
Team				

Number of staff assess as requiring LWD but do not have one as yet …….

Comments and actions being taken:

Appendix 2

Frequently Asked Questions

Do I have to set the colour categories in my Outlook calendar every time a new appointment is booked?

No. This only has to be done initially. Once you have set the colour categories in your Outlook calendar the appointments will automatically appear with the pre-set colour.

Does my Outlook calendar populate my RiO dairy?

No. The transfer of appointments only work from RiO to Outlook.

How long does it take for the RiO appointment to appear in my Outlook Calendar?

Your RiO diary synchronises with your Outlook calendar every 45 minutes, on the hour, quarter past, half past and quarter to the hour. This only happens between 8 am and 8 pm. Any appointments entered outside of these hours would be picked up at the next synchronisation.

What happens if I delete an appointment from my RiO diary?

If you delete an appointment from your RiO diary, it will be deleted from your Outlook calendar within 45 minutes when Outlook synchronises with RiO.

If someone else manages my diary, will I get alerts each time an appointment is added?

Yes, you will be notified every time an appointment is added amended or cancelled.
Email alerts can be turned off if required by contacting the Informatics Service Desk.

Frequently Asked Questions

Why does an appointment I have removed from my Outlook calendar keep re-appearing?

The appointment must be cancelled in RiO or it will re-appear in your Outlook calendar when RiO next synchronises with Outlook.

How will I know if an appointment has been added to my diary by someone else?

If email alert preferences are set, an email will be sent to you and an appointment will appear in your Outlook calendar.

Find out more...

<u>Operational Assistance</u>

For operational queries or issues contact the PCP Team:

- **Tel:** **0191 5665411**
- **Hours:** **Monday to Friday 09.00 - 17.00**
- **Email:** **pcp@ntw.nhs.uk**

<u>Technical Assistance</u>

For technical queries contact the Informatics Service Desk:

- **Tel:** **0191 2466999**
- **Hours:** **Monday to Friday 08.00 - 17.00**
- **Email:** **servicedesk@ntw.nhs.uk**

<u>RiO Appointment Management User Guide on the Intranet</u>

Services> Corporate Services> Informatics> Informatics User Guides

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

RiO to Outlook Calendar (ROC)

Quick Reference Guide

About RiO to Outlook Calendar (ROC)

Microsoft Outlook is currently used as the primary tool throughout the Trust for managing non-clinical appointments, whereas all clinical appointments are recorded within the RiO HCP diaries. Clinical staff are therefore required to manage two electronic calendars stored within different systems.

Many HCP's manually copy appointments from the RiO diary into the Outlook calendar, others only record appointments in their Outlook calendar or in their paper diaries. This can cause issues with cancelled and rescheduled appointments becoming unsynchronised between the different calendars.

How ROC Will Help?

The implementation of the ROC system within the Trust will enable clinicians to record all appointments, both clinical and non-clinical, into their RiO diaries.

ROC will automatically:

- Copy all appointments from the RiO diary into the relevant Outlook calendar.
- Remove any appointments cancelled in RiO from the Outlook calendar.
- Update the Outlook calendar if changes are made to an appointment in RiO.
- Recreate any Outlook calendar appointments that have been deleted from the Outlook calendar but not cancelled within RiO.
- Notify, by email, of any appointments added or amended in RiO (if email alert is enabled).
- Synchronise the RiO diary with the Outlook calendar every 45 minutes, between 8 am and 8 pm.

RiO Appointments

The RiO appointments which will be copied into the Outlook calendar are:

Community, Clinic and Other Activity.

Please note:
Other Activity appointments will be called Diary in the email alert and in your Outlook calendar.

Setting Up Categories in the Outlook Calendar

The appointments can be set-up to be colour coded in your Outlook calendar to reflect the colours of the appointments in your RiO diary.

1. Open up Outlook and select 

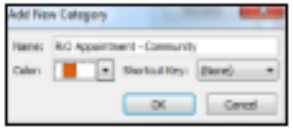
2. Select
3. Click 

4. From 

the picklist select 

5. Select 

6. In the Add New Category dialogue box enter the category of appointment and select the colour as in the RiO diary. As shown below:



7. Click OK

Please note:
The text in the name box should be entered as shown below and the corresponding colours from the RiO diary selected from the picklist.

- RiO Appointment - Community (select orange).
- RiO Appointment - Clinic (select yellow).
- RiO Appointment - Diary (select green).

ROC Management

Email alerts are automatically sent to inform the HCP that an appointment has been added, or amended in their Outlook calendar.

Email alerts will contain the following information:

- Date / Time.
- Client ID: RiO number and Service User's initials.
- Appointment Type: community / clinic / other activity.
- Location.
- Team.
- Duration: in minutes.
- Comments.

Administrative staff will no longer be required to email HCPs with the details of appointments booked, or amended in RiO.

Email alerts can be turned off, if required, by contacting the Informatics Service Desk.

Please note:
ROC will only copy appointments from RiO into the Outlook calendar. Any appointments recorded directly into the Outlook calendar will not be replicated in RiO.

Compliance with Information Governance

Information that transfers from the RiO diary to the Outlook calendar must comply with information governance standards.

Important:
The comments section in RiO appointments must not contain any person identifiable or sensitive information.

Appendix 3

Staff usage of Lone Worker devices, according to clinical groups: May 2016

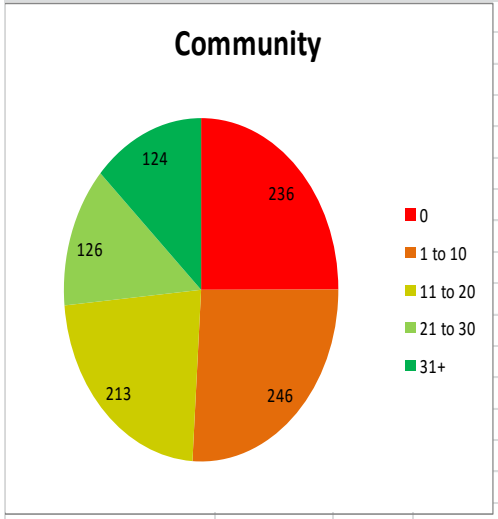
Community	
Number of Ambers per month	Number of staff
0	236
1 to 10	246
11 to 20	213
21 to 30	126
31+	124
	945

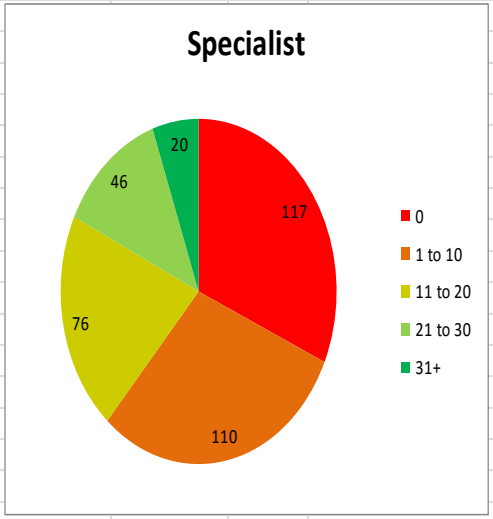
Specialist	
Number of Ambers per month	Number of staff
0	117
1 to 10	110
11 to 20	76
21 to 30	46
31+	20
	369

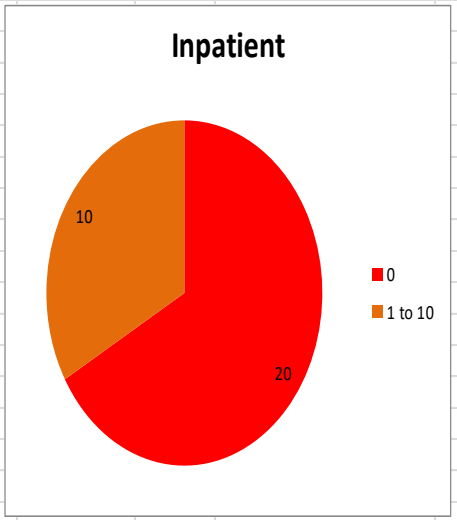
Inpatient	
Number of Ambers per month	Number of staff
0	20
1 to 10	10
11 to 20	0
21 to 30	0
31+	0
	30

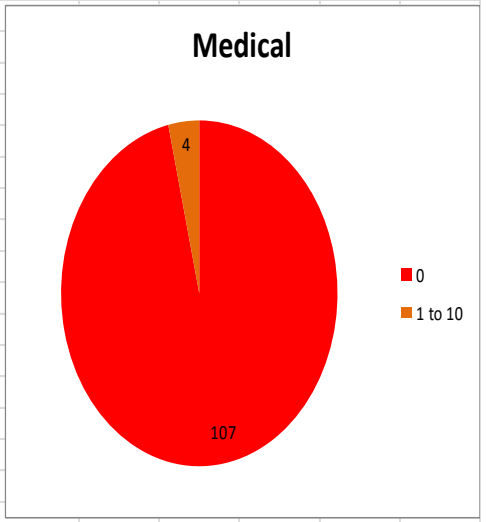
Medical	
Number of Ambers per month	Number of staff
0	107
1 to 10	4
11 to 20	0
21 to 30	0
31+	0
	111

1455









Percentage use:

Community: 75% **Specialist: 68%** **Inpatient: 33.3%** **Medical: 3.7%**

Appendix 4

Lone Working Device Audit Report: Community Services Group Action Plan

April 2016 update

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
No formal process for confirming escalation and user profile records are updated	PGN to be updated to include check of escalation/user profile at annual appraisal	Directorate Triumverates in conjunction with Patient Safety Team	As part of PGN review to be carried out in March 2016	April 2016 update Meeting held with patient Safety lead on 16/3/16 and agreement reached that updated PGN will incorporate guidance for monitoring of LWD usage as previously agreed in community services. Currently waiting for updated PGN to be circulated for comment May 2016 PGN still in process of being reviewed June 2016 No further update	
	Annual appraisal record to be amended to include an appendix to check if escalation/user profile details have changed	Directorate Triumverates in conjunction with Workforce Department	April 2016	April 2016 update Draft template to be tabled at Community Services Q and P meeting on 10/5/16 for comment May 2016	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
				Medical Staffing contacted to see if same proforma can be incorporated into SARD for medical staff <u>June 2016</u> Amended appraisal agreed and to be implemented from July 2016. Action complete.	
	Local induction forms to include record of escalation/user profile being updated when staff member joins the team.	Directorate Triumvirates through team OD Plans	All teams to have completed by 31/8/16	<u>April 2016 update</u> Discussed at Community Services Safe Group in March. Confirmation of action having been carried out to be ascertained at May Safe Group meeting <u>May 2016</u> Discussed at safe group. Acknowledged that not all induction forms have been amended to include section for updating escalation details. Work is ongoing <u>June 2016</u> Local Induction forms amended to include check of escalation details. To	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
				be implemented from July 2016. Action complete.	
	All staff to be reminded of need to update escalation/user profile as circumstances change.	Directorate Triumvirates	Through March meeting of Safe Sub group	<u>April 2016 update</u> Discussed at Community Service Safe Group in March. Confirmation of action having been carried out to be ascertained at May Safe Group Meeting <u>May 2016</u> Confirmation that staff have been reminded of need to update escalation details as circumstances change. Action to be closed	Agreed at safe meeting to close this action as it is complete AQ
Monitoring of usage of LWD by Team Managers is not consistent	Standardised guidance already introduced in October 2015.Guidance refresher sessions to be facilitated for Team Managers who will then cascade to all team members	Community Clinical Managers in team manager meetings. Team Managers in team meetings and individual supervision	All team managers to have attended a session by 30/4/16. Team Managers to have cascaded training by 31/5/16	<u>April 2016 update</u> Discussed at March Safe Group Meeting. Confirmation of action having been carried out to be ascertained at May Safe Group Meeting <u>May 2016</u> Confirmation received that CCMs have provided refresher training to team	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
				managers. To confirm at June meeting if team managers have cascaded to teams <u>June 2016</u> Confirmation refresher training has been provided in all teams with exception of one team due to new team manager just coming into post. This will be completed by end of June 2016. Staff to be reminded of need to carry out status checks as well as setting amber alerts	
	A gap analysis to determine staff working in community services who are still to be issued with a lone working device will be carried out	Directorate Triumvirate	To be reported at March meeting of Safe sub group	<u>April 2016</u> Initial gap analysis carried out in February. Information to be updated again in May in recognition of staff turnover/new staff joining Community Services Group. <u>May 2016</u> SMs reminded at safe meeting of need for	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
	Monthly Reliance reports to be checked for accuracy and to report errors to Lone working device coordinator	Service Managers	Service Managers to report to safe subgroup each month errors which have been reported to lone working device coordinator and if errors have been rectified	appendix A and appendix B of guidance to be completed as this includes staff who have still to receive a LWD. <u>June 2016</u> Appendix A and B to be collated for all areas at July safe meeting. TQ to liaise with patient safety re staff still requiring a LWD. <u>April 2016</u> Service Managers checked February Reliance report for staff who continue to be included in the report but no longer work in their team(s). This identified 82 staff who are wrongly entered on the Reliance report. Directorate Manager currently working with Patient Safety Team to make amendments to report. <u>May 2016</u>	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
	Guidance to be written into PGN as part of review.	Directorate Triumvirates in conjunction with Patient Safety Team	As part of PGN review to be carried out in March 2016	Work with patient safety team continues in order to ensure staff are recorded against the correct team <u>June 2016</u> Work with patient safety and workforce still in progress. See above in action 1	
No guidance as to how monitoring of compliance with lone working PGN should be reported and monitored by Q & P groups	This is covered in the guidance sections 2.7-2.10. Monitoring will be through the Safe subgroup and then included in report to Group Q and P meeting accordingly.	Directorate Triumvirates	Service Managers will bring reports to March Safe sub group and quarterly meetings thereafter	<u>April 2016 update</u> Update report given to April Community Services Q and P meeting <u>May 2016</u>	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
	Report to be presented to March Q and P.			Updated LWD action plan to be reported at June meeting of CSG Q and P <u>June 2016</u> Updated LWD report to be given at group Q and P	
Team meeting minutes do not show evidence of the outcome of monitoring or actions taken where it has been found that staff are not using their device.	Team managers will be advised in guidance refreshers sessions of what should be discussed and recorded in team meetings and what should be discussed and recorded in individual supervision	Community Clinical Managers	All team managers to have attended a session by 30/4/16	<u>April 2016 update</u> Discussed in March Safe Group Meeting. Service Managers to be asked to send evidence of team meeting minutes to show lone working device usage is being discussed. <u>May 2016</u> This is work in progress. Examples of good practice to be brought to June Safe meeting <u>June 2016</u> Examples of good practice shared at June safe meeting.	

Issue highlighted in report	Action to be taken	Person(s) responsible	Target date	Progress/Update reports	Statement of completion
Team meetings do not show evidence of themes or sharing of lessons learned.	Team Meeting Agendas will have a standing agenda item to allow for discussion of issues such as charging of batteries, clarification of requirements, clarification of status of alerts etc to be recorded in team meeting minutes. This will also include teams over all compliance with lone working device usage	Team Managers	From May 2016 Team meetings onwards	<u>April 2016 Update</u> See above <u>May 2016</u> See above <u>June 2016</u> Agreed at safe meeting for a sample spot check of team minutes to be carried out of July business meetings	
Group Q and Ps to include report on use of LWD in its three monthly report to Q and P Committee.	CSG Quarterly reports to Q and P Committee will include information to show detailed thematic work which is being undertaken to ensure standards of care and compliance with lone working PGNs	Group Triumvirate	Each Quarter	<u>May 2016</u> CSG Q and P to put programme in place to show when quarterly reports to Q and P committee will be provided <u>June 2016</u> Programme to be agreed at Q and P meeting on 14/6/16	

April 2016 Update

Monthly Reliance Report for March shows a 22% increase in Amber Alerts from the February report which equates to an additional 2969 in total.

Service Managers are monitoring people showing on the report who;

Have never used LWD
Not used since2013
Not used since 2014
Not used since 2015

In February the total number of people in community services that fell into one of the categories was 222. This has fallen to 187 in March report with the biggest drop being in the not used since 2015 category. This number also includes 82 staff who are recorded on the report as working in community services when this is no longer the case. Directorate Manager is working with Patient Safety Team to amend report. Actions continue to be taken in accordance with LWD monitoring guidance for those staff who have worked in a lone working situation and are showing on the report as not having used LWD.

May 2016

Monthly reliance report for April shows a 18% increase in amber alerts from March report. This equates to an additional 2738 visits. The report shows no increase in carrying out of status checks and staff will be reminded of the need to carry out this action. There were 3 genuine red alerts in April, all of which were resolved satisfactorily. This information will be shared at next safe meeting to be cascaded into teams.

April report shows 142 staff working in community services as falling into one of the above categories re when LWD was last used which is a further reduction of 45 people from March report. Work with Patient Safety team to improve accuracy of report in relation to which staff are no longer working in community services is ongoing. Patient Safety report shows the number of LWDs in the system has increased by 38% in period April 2015-March 2016, however in same period the number of amber alerts has increased by over 200%.

June 2016

Reliance report for May not available at time of June update being made.

Appendix 5

Lone Working Device Action Plans – Specialist Care Group

Forensic Services – Action Plan – June 2016

Initial Action	Response	Further actions and action owner	By who	Timescale	Update
1. Confirm that the member of staff issued with the lone worker device still works within the Department. **2. There are currently 19 devices issued to staff across the service.**	S/M has liaised with the managers / leads to determine if the named individuals still work within Specialist Forensic Services & have the allocated device. Responses received and engagement with individuals has commenced regarding the process for use and informed of sanction if process is not followed. 4 staff have left the service: the devices are being reported as lost as per policy awaiting lost number to be allocated to inform Safety Department. 3 staff have returned the devices due to change in role & no longer meeting the lone worker criteria. Service Leads liaising with Safety Dept. to ensure current list of staff is accurate regarding work place.	Monthly checks of the list of staff & allocated devices. Safety Department informed of any changes to ensure data is up to date. Staff informed of their duty to maintain system as per guidance note via monthly supervision. Staff have been requested to ensure the following are kept up to date: Returns Form Escalation Contacts User Profile S/M to monitor & issue sanction as required.	Service Manager CNM & Service Leads	Actions will be completed by 31st March 2016. Monitoring will be ongoing on a monthly basis via clinical supervision structure & S/M checks. Letters and confirmation regarding usage / allocation to be complete by 30th April 2016.	1. Data cleansing complete & staff list updated – 18 staff allocated devices. (4 staff left service & 1 transferred to In-patient). 2. Police contacted & lost number obtained x 4 & 1 device returned – Device Coordinator informed & names will be removed from list. 3. Emails sent to all staff to request compliance & ensure they use device allocated to them. No letters required as of 02/06/16. 4 02/06 2016 Monitoring is ongoing out of 18 staff 2 non-compliant re contact details these staff have left and will be removed from list in due time. All staff with devices are using them appropriately.

Initial Action	Response	Further actions and action owner	By who	Timescale	Update
	Sanction letters currently being sent to those staff deemed non-compliant.				No sanction letters required
3. Confirmation to be established that Service Manager receives regular updates about lone working device usage.	Monthly report sent by Safety Dept. to Service Manager regarding use. Compliance checked by S/M & service lead contacted regarding concerns or queries regarding non-compliance.	Service Manager sends the report to CNM & Service lead. As above staff compliance monitored and sanction issued as required. Monitor new staff joining the service and being allocated devices.	Jill Telford sends report to Dennis Davison.	Process confirmed with Jill & Complete. Reports will be sent to DD on a monthly basis these will be checked on a monthly basis to ensure continued compliance.	3. Reports received – reviewed & sent to relevant Managers. Ongoing: Review monthly. Staff are all Compliant
4. For Service Managers and CNM, Team Leads / Managers within Forensic Services to ensure there is a clear understanding of the expectations re. Lone worker usage.	Service Manager has discussed and circulated documents to ensure that individuals have the relevant documents and managers clearly disseminate & communicate with their staff: The expected use of devices Maintaining their data Checking & Testing the devices Leaving the service: what to do Action that will be taken if usage falls below expectation.	Discussed at Local Team meeting with staff. Email sent to all staff outlining expectation of staff. Letters to be sent to all staff explaining Trust expectations, policy and actions should an improvement of usage not happen.	Service Managers CNMs / Professional Leads / Team Managers	Complete – (this remains an ongoing action). First batch of letters to be sent by April.	4. 02/06/2016 2 staff – non-compliant with home contacts details being provided. Staff have left the service 5 devices indicated as not used, the devices have been reported as lost awaiting system to be updated

Specialist Adult – Action Plan – 17th May 2016

Initial Action	Response	Further actions and action owner	By who	Timescale

1. Confirm that the member of staff issued with the lone worker device still works within the Inpatient Care Group?	Feedback from Service Managers confirm the following:-
	Total Devices – 49
	
	• 42 on the Jan 16 list for addictions
	  ○ 31 in NRP
	  ○ 11 in Newcastle
	• 7 – Community Perinatal
	
	In NRP 14 devices are assigned to Turning Point staff. The monthly report is forwarded to the TP manager for review and action
	
	2 member of staffs has left the Trust
	4 staff members have moved to different groups, 6 are on LTS or maternity leave therefore **37** are active to the Specialist Adult Group.
		• Confirm new baseline position to Trust Lead.
		
		• Notify Group colleagues of internal staff changes that may impact on individual data bases.
			S/M
			
			S/M
				Complete
				
				Complete

2. Confirmation to be established that the respective Service Managers get regular updates about lone working device usage.	I confirm that I receive monthly reports. I review and usage is discussed at the appropriate meetings.	• Ensure the accuracy of the circulated data base.	Patient Safety Lead	March 2016 – (this remains an ongoing action)

Initial Action	Response	Further actions and action owner	By who	Timescale

3. For Service Managers and staff within the Specialist Adult group to meet to ensure there is a clear understanding of the expectations re lone worker usage.	I confirm that based upon that usage levels have been discussed with named individuals and appropriate action for low use has been taken.
	I wrote to 5 members of staff who were consistently not using their device in November 15. Another staff member in addictions with low usage is a NCC employee and he was verbally reminded to use appropriately.
	
	• Of the 5;
	  ○ 1 has returned their device.
	  ○ 1 is LTS
	  ○ 1 is on maternity leave
	  ○ 1 has slightly improved usage
	  ○ 1 is no longer on the monthly report
		• Service Managers will ensure that regular monitoring on lone worker usage occurs.
		
		• Service Manager to continue to review and act if appropriate.
		• Service Manager to contact Patient Safety Lead to understand the reasons for the staff member written to no longer being on the monthly report.
			S/M
			
			S/M
				Complete – (this remains an ongoing action)
				
				March 2016

Community CYPS – Action Plan – May 2016

Initial Action	Response	Further actions and action owner	By who	Timescale
1. Confirm that the member of staff issued with the lone worker device still works within the Department. Supply devices for those staff still outstanding.	CCM & Professional Leads liaising with Safety Dept. to ensure current list of staff is accurate regarding work place .Ensure systems in place for new starters and staff still awaiting devices.	• Regular checks of lists to keep Safety Dept. information is up to date. • All outstanding staff completing paperwork. • New starters complete Identicom paperwork as part of induction. • Staff will get Identicom paperwork completed at time of induction	CCMs /Professional Leads	On going Complete
2. Confirmation to be established that Service Manager receives regular updates about lone working device usage.	Monthly report sent by Safety Dept. to Service Manager regarding use.	• Service Manager sends the report to CCM and Professional Leads • Discussion with Device Coordinator has identified a benchmark of use for all staff. This should be 4/5 Status reports or Amber alerts per week.	Device Coordinator/ S/M	Complete
3. For Service Managers and staff within the Inpatient Care Group, to meet to ensure there is a clear understanding of	Service Manager has discussed in CMT expected use of devices and action to be followed if usage falls below expectation.	• Discussed at Local CMT & Team meeting with staff. • E Mail sent to all staff outlining expectation of staff.	Service Managers CCMs/Professional Leads	Complete – (this remains an ongoing action)

Initial Action	Response	Further actions and action owner	By who	Timescale
the expectations re lone worker usage.		• Letters to be sent to all staff explaining Trust expectations, policy and actions should an improvement of usage not happen. • Further letters/actions will be sent if staff do not comply		First batch of letters to be sent by April. Complete
4. SCG to adopt Community Services Identicom Protocol and revise to make it service specific.	All services to be familiarised with this and staff aware.	• Discussed at Local CMT & Team meeting with staff. • E Mail sent to all staff including the protocol	CCMs/Professional Leads	Ongoing will be completed end of May

CNDS, ABS, Kolvin Service –Action Plan - May 2016

Initial Action	Response	Further actions and action owner	By who	Timescale
1. Confirm that the member of staff issued with the lone worker device still works within service and monitoring of newly allocated devices is aligned with usage reliance reports. Lone worker device use and allocation will remain as a fixed agenda item within staff supervision sessions. The overall purpose of this discussion within supervision will relate to usage and also allow opportunity for staff to highlight any change of circumstances which may need to be reflected within escalation form.	Feedback from Service Managers confirm the following:- CNDS- 10 devices Kolvin – 3 devices ABS- 3 devices Devices have recently been introduced and a number of staff are awaiting training and allocation of devices. No staff have left either services following allocation. Supervisors have been made aware that lone worker device usage or related detail will be highlighted within supervision sessions.	- Patient safety have confirmed that reports reflecting usage following training completion will be included within April 2016 reliance report. - As devices are allocated we will ensure that staff are confident in use - Changes will be completed in the event of staff leaving services or joining either of the teams.	CCM/Team Managers	April 2016- continuous monthly process as usage figures are received.
2. Confirmation to be established that the respective Service Managers get regular updates about lone working device usage for CNDS, adolescent Bi	Service Manager on receipt of report will forward to CCM to allow for review of usage. Usage will be reported to the service manager identifying overall usage highlighting where there are deficits in use	• Ensure that the central team responsible for circulating this data is aware of the discrepancies. • Ensure the accuracy of the circulated data base.	Service Manager Patient Safety Lead	

Initial Action	Response	Further actions and action owner	By who	Timescale
polar service and the Kolvin service.				March 2016 – (this remains an ongoing action)
3. For Service Managers and staff within the Community, regional services to meet to ensure there is a clear understanding of the expectations re lone worker usage. Currently the teams using the devices currently are CNDS, Adolescent Bi polar service and the Kolvin service. Each team has recently commenced the process of attending the training and individual staff members are now being allocated with devices.	Service Managers have confirmed that based upon the information provided, usage levels have been discussed with named individuals and that usage levels are appropriate.	• Service Managers will ensure that regular monitoring on lone worker usage occurs. • Service Managers actions in this area will be monitored by Directorate Managers to ensure full compliance • Community clinical manager and team manager to ensure that usage is promoted within team meetings and any issues regarding usage are addressed ensuring that service manager is aware of any actions. • As a supportive measure staff have been provided with guidance relating to device usage which is an agenda item within team meetings and usage presentation is within team red safety folder in hard copy	Service Manager Directorate Managers Community clinical manager and team managers CCM and team managers	Complete – (this remains an ongoing action) Complete – (this remains an ongoing action) Ongoing to ensure regular review. Ongoing

Neurological Services – Action Plan – May 2016

Date identified	Issue	Actions	By when	By whom	Position
Feb 16	Historically neuro services staff have not met the scoring threshold to be issued with a lone worker devise. This was considered a risk and added to the team and neuro services risk registers for immediate action.	Following a risk assessment and careful consideration about staff safety it was agreed at Group and service level that all staff visiting patients in their homes or on community premises should use a lone worker devise	Feb 16	Service Manager	complete
	As above	All team leads to complete the lone work documentation and submit to the clinical management team	March 16	Team leads	complete
	As above	All staff to be trained in and commence the use of the equipment as per the policy	May 16	Team leads / Service Manager	Training and allocation of devised will commence 17/05/16
		Prior to the devises being issues the current local protocols and procures to enhance staff safety will continue to be operational	On going	Team leads / Service Manager/ Individual professional staff member	Ongoing until completion of training and devise allocation

Appendix 6

Inpatient Care Group – Action Plan – 20th May 2016

Initial Action	Response	Further actions and action owner	By who	Timescale
1. Confirm that the member of staff identified on the lone worker system has been issued with the device and it remains in use.	Feedback from Service Managers confirms that of the 28 on the original list the following amendments have been made:- • 4 have been returned (staff moves/staff leaving Trust) • Leaving a current open total of 24 •	• Service Managers review baseline monthly and notify key individual as per policy.	Service Managers	On a monthly basis.
2. Confirmation that monthly reports are sent to Service Managers and Group Support Officer on a monthly basis. **Regular receipts of this information will trigger appropriate actions/confirmation.**	Service Managers have confirmed that they receive timely monthly reports enabling ongoing monitoring and review.	• Ensure that the central team responsible for circulating this data is aware of the discrepancies.	Service Managers Lone Worker Device Co-ordinator	On a monthly basis On a monthly basis
3. Service Managers regularly meet with staff to ensure that there is a clear understanding and expectation re lone worker usage.	Service Managers have confirmed that based upon the information provided, usage levels have been discussed with named individuals and that usage levels are appropriate.	• Service Managers will ensure that regular monitoring occurs. • Service Managers actions in this area will be monitored by Directorate Managers to ensure full compliance.	Service Managers Directorate Managers	Complete – (this remains an ongoing action) Complete – (this remains an ongoing action)

Initial Action	Response	Further actions and action owner	By who	Timescale
4. A risk assessment of on call senior medical staff has indicated that this cohort of staff should have access to lone worker devices. This approach would bring them in line with colleagues from other clinical groups. .	Post risk assessment this staff cohort have been placed on the waiting list for lone worker devices. .	• Colleagues within the safety department to facilitate access to these devices in a timely fashion. • Once the lone worker devices are obtained then regular usage/compliance will be monitored as per action 2.	Head of Safety and Security Lead Consultants Service Managers	Awaiting confirmation