NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: 29 April 2015

Title and Author of Paper:
Safety Report : January – March 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 reduced in the period January – March 2015, from the high reported activity for the same time last year, this reduction is seen in all areas, that were previously highlighted as concerns. Regular updates are provided to both the Trust's Quality & Performance Committee as well as the Operational Group Business Meeting. Through Incidents report, as well as through the regular meetings with respective Clinical Commissioning Groups.

Identification of Themes

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

Action Planning & Impact of Action

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

Safety of Transformation

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

Outcome required: Noted for Information

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
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Safety Report
April 2015
Reporting period: January - March 2015

Shining a light on the future

Introduction
This is the Safety Report for the reporting period January – March 2015.

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

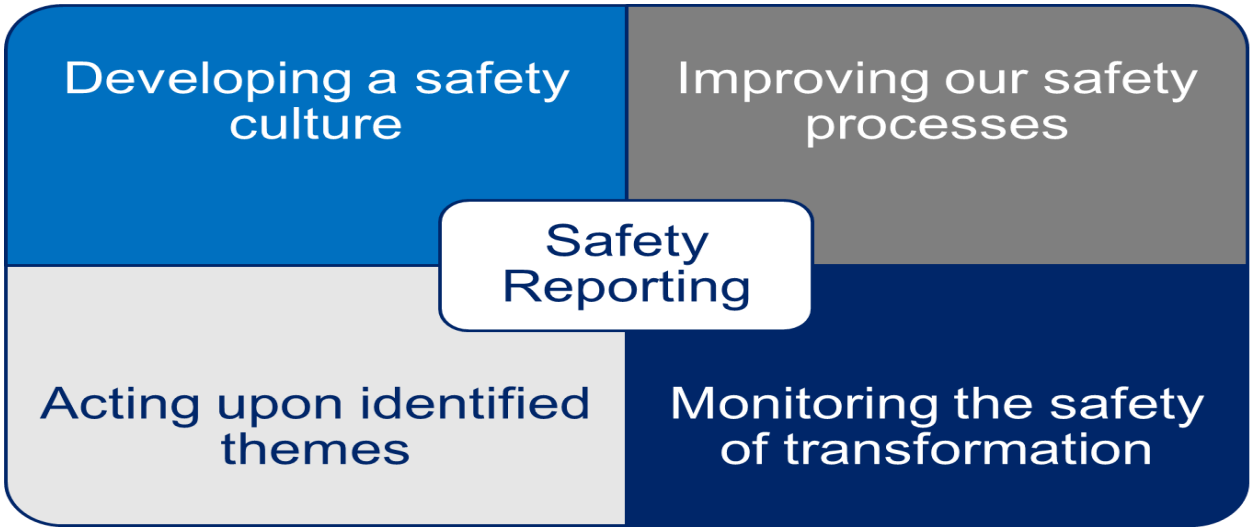


Fig1: Safety Programme Dimensions

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

Future of Safety Programme Board

It is recognised that one of the strengths of the Safety Programme Board was as a group where various work streams having a bearing on quality improvement were reported to.

The trust is in the process of strengthening the work done by the Safety Programme Board mindful that a "programme" is defined as a time limited (albeit medium to long term) piece of work whereas quality improvement should never be seen to have an end point.

The proposal is therefore to transfer the work of the Safety Programme Board to the "Quality Improvement Committee" that will:

1. Takes over themes currently being monitored by the Safety Programme Board.
2. Undertake this work under the umbrella of the national, "Sign up to Safety" initiative.
3. Oversee the delivery of the Trusts Quality Priorities alongside the long term Quality Goals.
4. Consider strategic developmental matters.

It is intended that the Quality Improvement Committee will report to the Corporate Decisions Team (CDT) to ensure organisational delivery of quality improvement and also for assurance purposes also report to Trust Wide Quality and Performance sub-committee of the Board. The membership is likely to remain similar to the Safety Programme Board with a monthly meeting.

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 Board updates presented by the Trust Public Health lead. The next report will be presented at the May 2015 Board of Directors Meeting.

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

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

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

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

4 Quadrant Safety Report At A Glance

1 - Incident Activity & Analysis	2 – Identification Of Themes
The number of serious incidents has reduced. For the period January - March there were 31 serious incidents, this was 1 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 July 2014 – September 2014, that have been reviewed between October 2014 – December 2014, 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**
No further independent action plans have been published, more information relating to the action plan process is on page 19. • 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

Incident Activity & Analysis

At the time of reporting the Trust had reported over 30,732 incidents in 2014 /15, some data is still being recorded in the system for March, so likely this figure will climb to over 31,000 incidents, 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	January - March	+/- on previous period	Number Of incidents Annual	+/- Year on Year
10/11	6,114	+250	24,092	+2,741
11/12	6,369	+255	26,336	+2,244
12/13	7,547	+1,178	29,111	+2,775
13/14	7,470	-77	30,486	+1,375
14/15	7,587	+117	30,732	+246 YTD

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

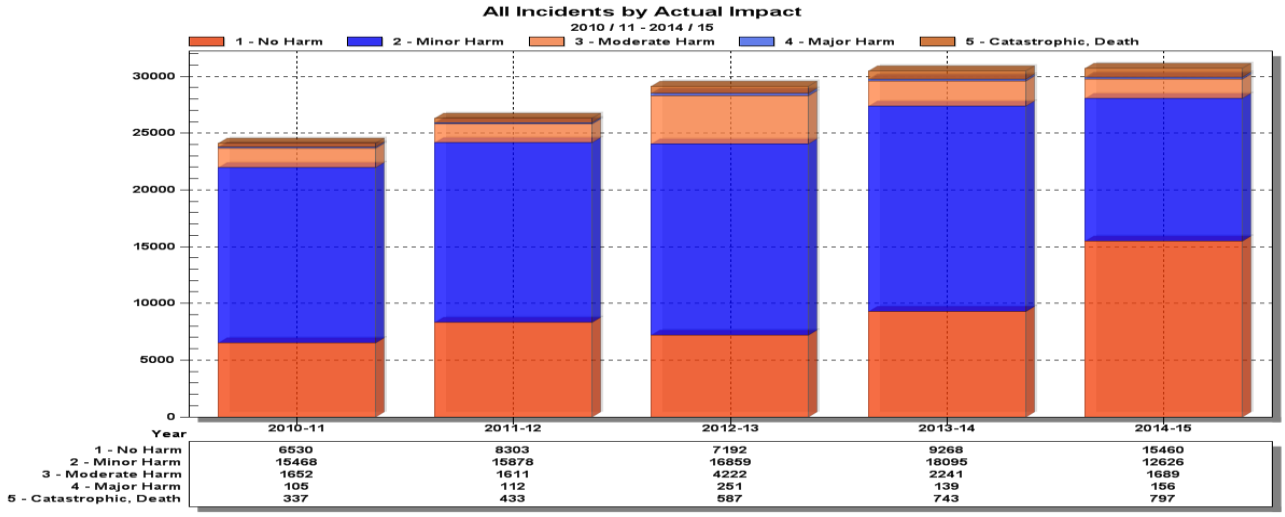
At the current year end of 2014/15 the total incidents reported was 30,732, and this figure will rise as the last of March's incidents are inputted by the end of April 15, whilst all incident rates have steadily increased including no and low harm incidents, serious incidents have fallen to their lowest figure for a number of years, with 35 less than the previous year, and the back to a low of 4 years ago.

Table 1a –Serious Incident Activity

Year	January - March	+/- on previous period	Number Of Serious incidents Annual	+/- Year on Year
10/11	23	0	91	-27
11/12	39	+16	120	+29
12/13	39	0	128	+8
13/14	30	-9	156	+28
14/15	31	+1	121	-35

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.

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

Table 2

January – March 2014		**January – March 2015**		+ / -
Cause Group	2013-14	Cause Group	2014-15	
AWOL And Abscond	216	AWOL And Abscond	178	-38
Contractor/Public/Visitor Incident	4	Contractor/Public/Visitor Incident	6	+2
Death	186	Death	201	+15
Fire	33	Fire	28	-5
Human Resources Process	1	Human Resources Process	1	0
Inappropriate Behaviour By Others	6	Inappropriate Behaviour By Others	5	-1
Inappropriate Patient Behaviour	319	Inappropriate Patient Behaviour	521	+202
Inappropriate Staff Behaviour	25	Inappropriate Staff Behaviour	12	-13
Inappropriate Treatment	5	Inappropriate Treatment	2	-3
Infection, Prevention And Control	19	Infection, Prevention And Control	29	+10
Information Governance	85	Information Governance	88	+3
Infrastructure	19	Infrastructure	24	+5
Medical Device, Equipment	13	Medical Device, Equipment	12	-1
Medication	208	Medication	215	+7
Mental Health Act	11	Mental Health Act	10	-1
Patient / Staff Safety	5	Patient / Staff Safety	7	+2
Patient Accident	806	Patient Accident	682	-120
Patient Clinical Issue	13	Patient Clinical Issue	5	-8
Patient Ill Health	526	Patient Ill Health	306	-220
Police Issue	2	Police Issue	3	+1
Safeguarding	582	Safeguarding	599	+17
Security	384	Security	557	+173
Self-Harm	1060	Self-Harm	1064	+4
Service Delivery	98	Service Delivery	32	-66
Staff Accident	173	Staff Accident	162	-11
Staff And Patient Accident	8	Staff And Patient Accident	2	-6
Staff Ill Health	2	Staff Ill Health	5	+3
Unknown Patient Injury	0	Unknown Patient Injury	3	+3
Violence And Aggression	2661	Violence And Aggression	2828	+167
Total	7470	Total	7587	+117

Data for March 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 Board of Directors this month.

Serious Incidents

Table 4
The following table indicates the number of serious incidents reported annually

Number of serious incidents reported annually	2012-13	2013-14	2014-15
AA05 Patient Attempted Abscond/AWOL	1	0	0
AA09 Absented Themselves From Hospitals	2	2	0
AA10 Absented Themselves During Escorted Leave	2	1	1
DE01 Unexpected Death	73	99	82
DE03 Alleged Homicide To A Patient	1	1	1
DE04 Alleged Homicide By A Patient	0	2	1
DE06 Unexpected Death - More Than 6 Months	0	0	1
DE08 Unexpected Death - Natural Causes	0	0	1
DE16 Alleged Homicide By A Patient To A Patient	0	1	2
DE18 Unexpected Death Local AAR	0	0	9
IG03 Breach Of Patient Confidentiality	1	3	1
IG07 Poor Information Sharing	0	1	0
IN01 Loss Of Telecommunications	1	0	0
IN02 Loss Of Electricity	0	0	1
IS09 Staff Suspension	0	0	1
IT04 16-17 Admitted To Adult Ward	3	2	2
PA01 Patient Fall On Same Level	0	1	1
PA04 Patient Fall From Height	1	1	0
PA06 Patient Fall From Chair/Wheelchair	1	1	0
PA07 Patient Fall From Toilet/Commode	1	1	0
PA08 Patient Found On Floor - Not Witnessed	4	1	1
PA16 Struck By Moving Vehicle	0	1	0
PA18 Injury Cause Unknown	0	2	0
PA26 Fracture Neck Of Femur	17	12	7
PI01 Unexpected Deterioration In Health	0	1	0
SG03 Safeguarding Adults - Staff Allegation	0	0	1
SG06 Safeguarding Adults Patient On Patient	1	0	0
SG23 MARAC	0	1	0
SH01 Actual Self Harm	6	14	3
SH02 Attempted Suicide	1	0	2
SH05 Attempted Self Harm	2	0	0
SH06 Suspected Self Harm	1	0	1
V01 Physical Assault Of Staff By Patient	4	0	0
V02 Physical Assault Of Visitor/Gen.Pub. By Patien	3	3	1
V03 Physical Assault Of Patient By Patient	0	1	1
V04 Threatening Behaviour By Patient To Staff	0	2	0
V22 Sexual Assault By Patient To Patient	1	0	0
V33 Allegation Of Sexual Assault By Patient On Oth	0	1	0
V34 Alleged Physical Assault By Patient To Other	0	1	0
V39 Aggressive Behaviour To Others	1	0	0
Total	128	156	121

Number of Serious Incidents reported in the period January - March	2012-13	2013-14	2014-15
AA09 Absented Themselves From Hospitals	2	1	0
AA10 Absented Themselves During Escorted Leave	1	0	1
DE01 Unexpected Death	23	18	15
DE04 Alleged Homicide By A Patient	0	0	0
DE06 Unexpected Death - More Than 6 Months	0	0	1
DE08 Unexpected Death - Natural Causes	0	0	1
DE16 Alleged Homicide By A Patient To A Patient	0	0	0
DE18 Unexpected Death Local AAR	0	0	9
IG03 Breach Of Patient Confidentiality	0	1	0
IG20 Damage To Patient Records	0	0	0
IS09 Staff Suspension	0	0	1
IT04 16-17 Admitted To Adult Ward	0	1	0
PA04 Patient Fall From Height	0	1	0
PA06 Patient Fall From Chair/Wheelchair	1	0	0
PA08 Patient Found On Floor - Not Witnessed	2	0	0
PA26 Fracture Neck Of Femur	5	4	1
PI11 Pressure Sore / TV Acquired In NTW	0	0	0
SG07 Safeguarding Children Patient On Patient	0	0	0
SH01 Actual Self Harm	2	2	1
SH02 Attempted Suicide	0	0	1
V01 Physical Assault Of Staff By Patient	1	0	0
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	2	1	0
V03 Physical Assault Of Patient By Patient	0	1	0
	39	30	31

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.

NHS England – Serious Incident Framework was released om March 27th 2015, and the Trust is currently considering the content in advance of changes to the Incident Policy NTW(O)05 in May / June 2015.

Further information:

http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

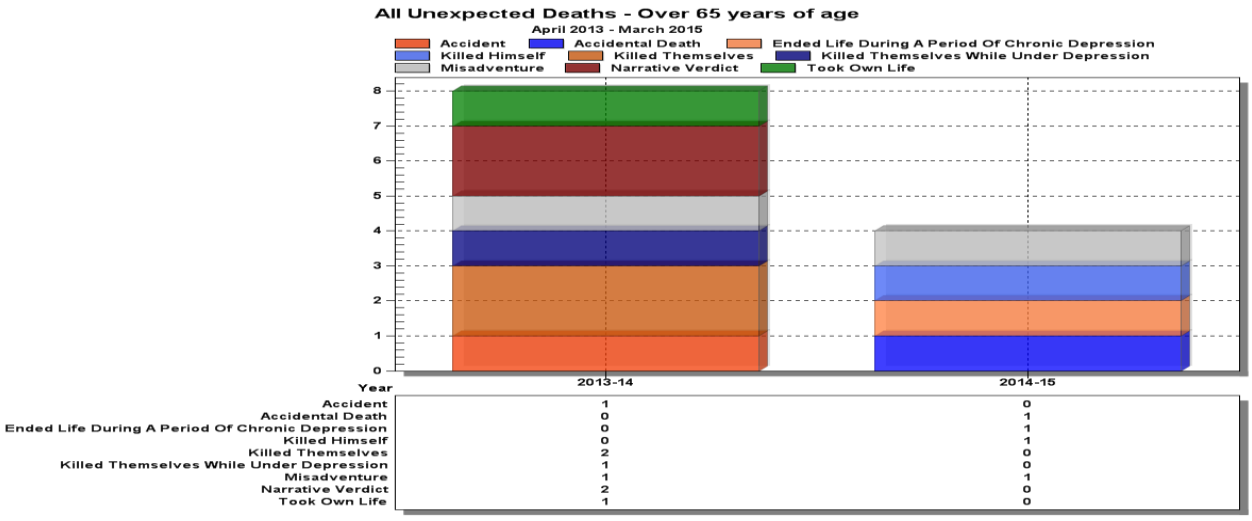
Unexpected Deaths by Coroner Conclusion

Table 5

Coroner Conclusion	January – March 13	January – March 13	January – March 13
Accident	0	1	0
Accidental Death	4	0	0
Accidental Overdose Of Drugs	0	1	0
Combined Effects Of Alcohol And Prescribed Medication	0	1	0
Conclusion Pending	2	0	15
Drug Related Death	2	1	0
Drug/alcohol Related Death	0	1	0
Killed Herself	0	1	0
Misadventure	4	6	0
Narrative Verdict	5	2	0
Open Verdict	3	3	0
Suicide	1	1	0
Took Own Life	2	0	0
Total	23	18	15

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



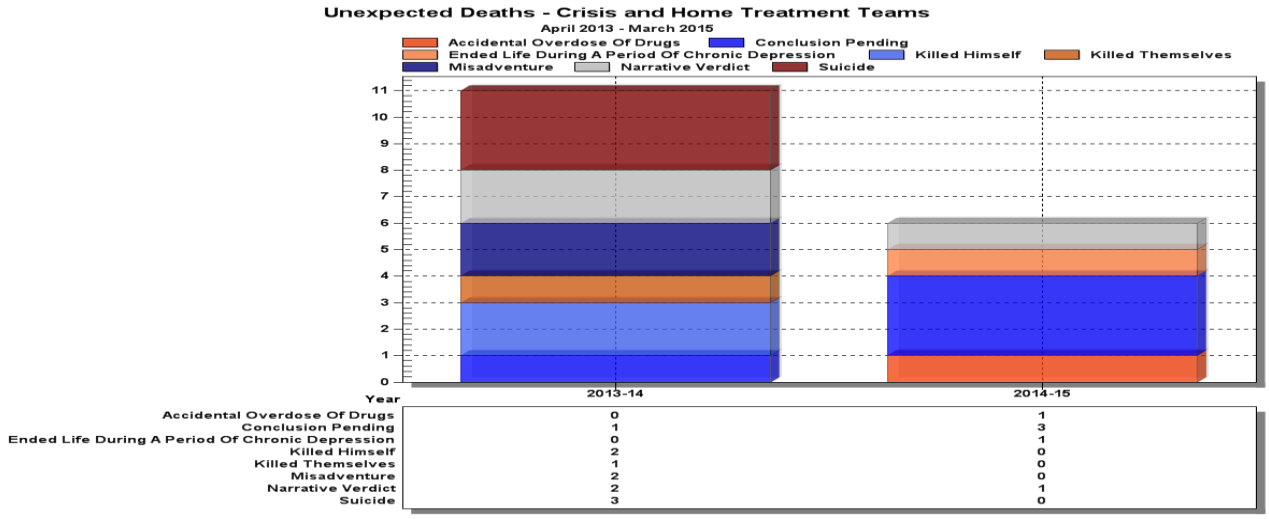
Following an increase in unexpected deaths over the last year, this area has been monitored continuously, for the same period; the activity in line with all serious incidents has reduced.

Unexpected Deaths Involving Crisis and Home Treatment Teams

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

Graph 3: Unexpected Deaths – Crisis Resolution & Home Treatment Team - Data Period: 2013 - 2015

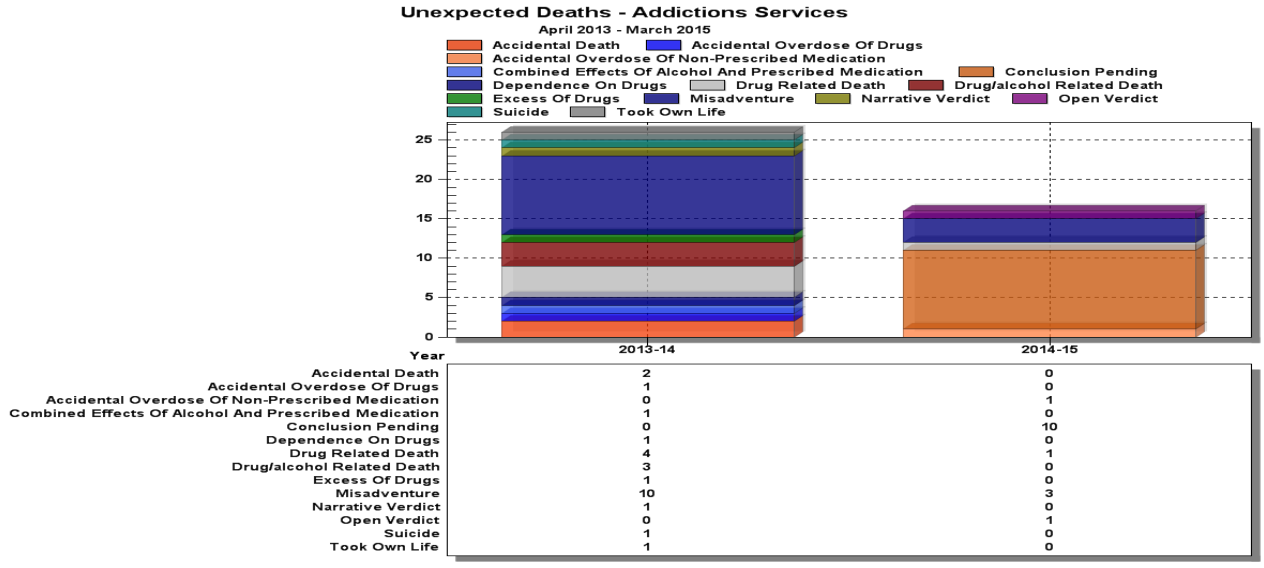
The following graph gives the breakdown for the period and the increase previously identified, has more than halved.



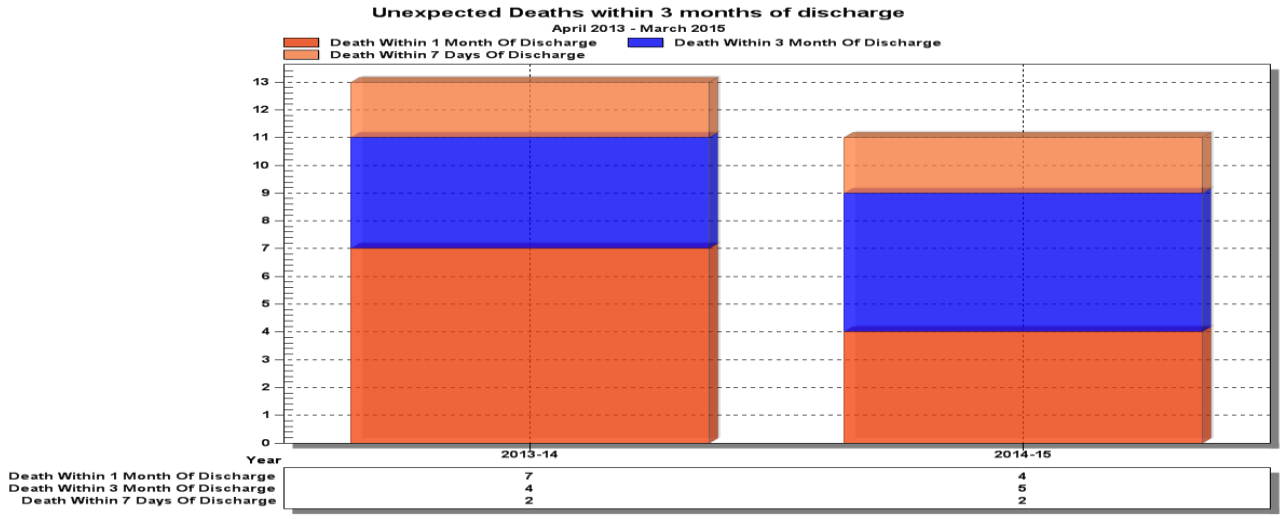
Graph 4: Unexpected Deaths – Addictions Services - Data Period: 2013 – 14 compared to 2014 – Present.

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

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



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



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

We know that the period after discharge from in-patient services is a time of high risk. This graph shows that there have been 11 serious incidents reported this year in comparison to the 13 reported last year. The Transition protocol has been implemented to improve the transfer of care from hospital into community and this area of care will receive continuing close scrutiny.

Serious Incident Reviews

Over the last three years the following number of reviews 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.

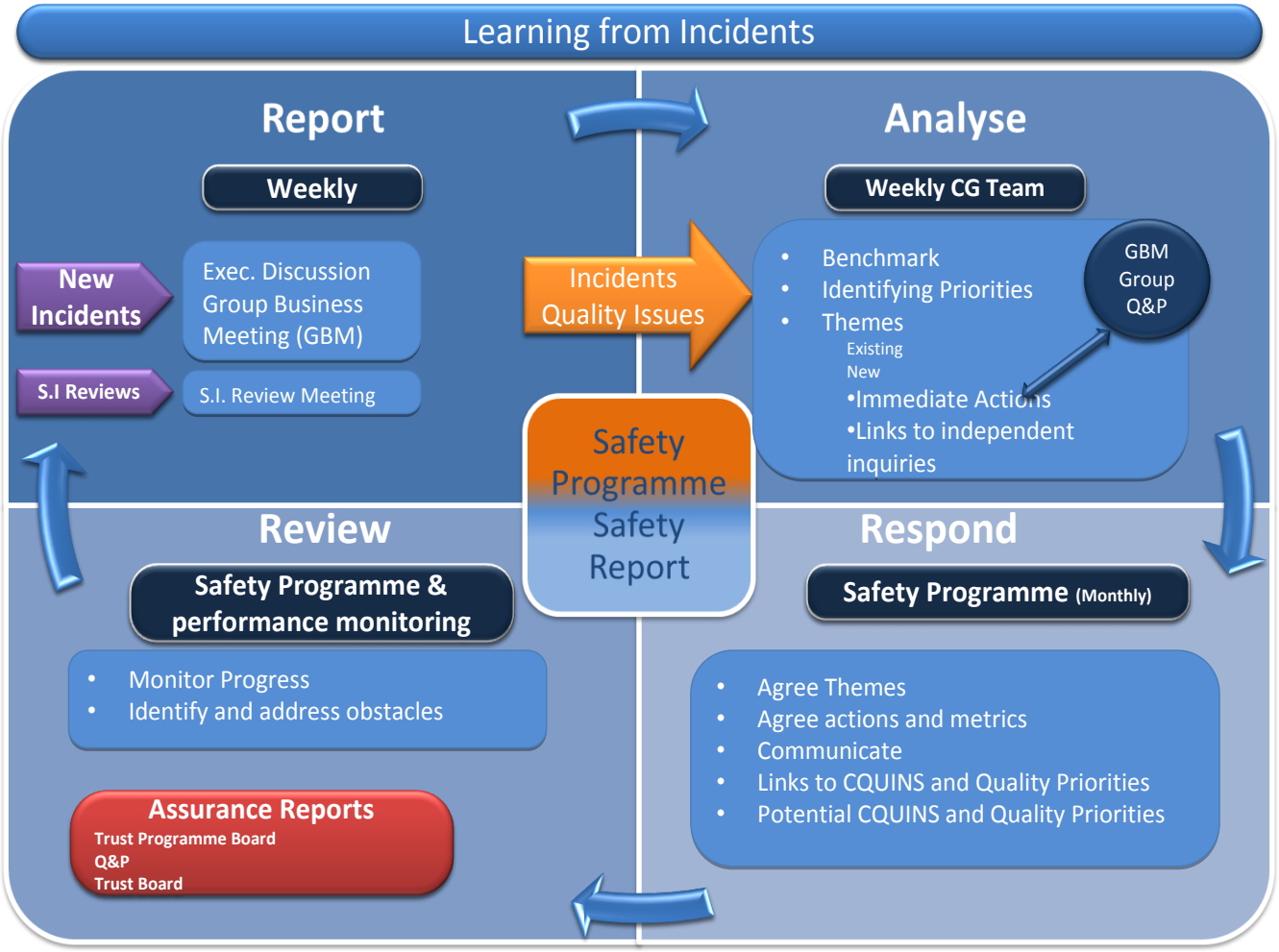
Table 6

Number of serious incidents reviewed	Jan – March 13	Jan – March 14	Jan – March 15
	49	33	32

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

Identification of Themes

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



Key Points

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

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

Throughout 2014/15 the Serious Incident Panel members have taken the Quarter 3 incidents that occurred between July – September and were reviewed between October – December and have broken down the specific incident themes as follows:-

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

There were 39 serious incidents reviewed for the first Quarter 3 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 8 key headings:-

- Safeguarding Processes.
- Communication
- Risk Assessment
- Falls Management
- Record Keeping
- Staffing Levels
- All Aspects of Clinical Care
- Medicines Management

Safeguarding Processes

A theme of Safeguarding was identified in 4 of 39 incidents, these were as follows:-

Two incidents – both relating to safeguarding issues although no direct theme can be identified as one issue related to limited incident reporting or consideration of referring the patient to MARAC and the other related to staff not updating a patient's records to include information regarding the reason why he was on probation which could have flagged up a safeguarding issues had it been explored further.

One issue relates to a patient who over a number of years had safeguarding issues. Although NTW Safeguarding Team had been contacted and safeguarding meetings had taken place it was identified during the incident investigation that there was limited incident reporting or consideration of MARAC involvement.

One issue was a patient who had confirmed that he was on a probation order but this was not explored by staff to inform/update the risk assessment. There was also no detail of the offence included in the electronic health care records. Exploration may have flagged up

safeguarding issues. During the investigation it was noted that there were no safeguarding alerts raised during the whole of this patients contact with NTW services.

Two incidents – both relating to safeguarding issues although no direct theme can be identified as one was related to staff being aware of issues and not informing the NTW Safeguarding Team and the other related to records not reflecting the information provided by the NTW Safeguarding Team.

One issue relating to known safeguarding issues being recorded in the patient's electronic health care record but NTW Safeguarding Team were not informed. At the SI panel the team were reminded to ensure that any safeguarding issue needs to be highlighted to the NTW Safeguarding team.

One issue relates to known safeguarding issues being received on three occasions from the Safeguarding Lead Practitioner regarding the outcome of MARAC meetings. However the patient's electronic health care records showed no further enquiry being made or an updating of risk assessments or management plans by the Care Coordinator or Forensic Workers to reflect this patient high risk to domestic abuse. Safeguarding concerns should always be addressed and a record made of how this will be done.

Communication

A theme of communication was identified in 10 of 39 incidents, these were as follows:-

Ten incidents - fourteen issues relating to communication and information sharing
Ten issues related to communication with GPs, ranging from a lack of communication, inaccurate or poor quality information provided to delays in communication. Two of the issues related to poor communication from Primary Care back to NTW.

One issue related to an issue with a pharmacist who highlighted to the team concerns about the patient being a risk to himself, but was expected to lead on this rather than the duty worker taking the lead.

One issue was a lack of communication between NTW and Children's Services. NTW staff were not always prioritising attendance at Child Protection meetings.

One issue was a lack of communication between NTW and the Gateshead Substance Misuse Service.

One issue was a lack of communication and shared pathway of care between two NTW teams and NCED.

Risk Assessment

A theme of risk assessment was identified in 9 of 39 incidents however it must be noted there were a number of different themes relating to risk assessment identified as follows:-

- 9 incidents in total 11 issues relating to risk assessment / management
- 2 incidents where risk assessment not updated a significant change in presentation or information
- 2 incidents where level of risk was underrated and 1 where imminence of risk not recognised

- 3 Incidents where risk assessment was either incomplete or not undertaken when required

Falls Management

There were 3 incidents of 39 relating to fractures or patient falls, the themes were as follows:-
Out of the 3 incidents reviewed, the common themes were as follows:-

- Recording of information relating to falls including
- Falls assessment tool,
- Physical health monitoring.

Immediate support for patients after a fall, including assessment of whether to move the patient or not in advance of attendance of a blue light ambulance.
Compliance by all staff to the training delivered and the Trust's Falls Policy, to prevent falls, and to manage them effectively when they occur.

Record Keeping

There were 16 incidents of 39 where record keeping was identified as a theme. Some actions grouped together multiple elements of non-adherence to a variety expected standards. On 5 occasions there was a generally poor clinical record maintained, then more isolated and unconnected actions related to record keeping. However, the area of record keeping and the lack of attention to detail and expected standards when recording clinical interventions and updating the record is concerning. Whenever record keeping is identified as an area of concern the team managers are asked to assure the panel that robust mechanisms are in place to ensure that it is either a one off occurrence or a system or individual practice issue and then identify appropriate actions to ensure a raised standard. 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.

Staffing Levels

Whilst there is current high profile attention to staffing levels within the NHS, only 2 incidents out of the 39 incidents reviewed found an issue relating to levels of staff and both these incidents occurred in the community services.

- 1 issue was associated with sickness and staffing levels in a Community Treatment Team, which would involve escalation through management as appropriate.
- 1 issue was associated with absence of band 7 to support clinical decision making, again which would involve escalation to management to ensure appropriate cover, neither impacted on the incident, but was supplementary to it as an associated factor.

All Aspects of Clinical Care

2 issues were identified from the 39 incidents:

- 1 relating to lack of urgency for a re-admission to hospital following a patient's deterioration.

- Another issue related to a clinical team's rationale for their risk assessment, when considering the patients protective factors.

Medicines Management

3 incidents out of 39 had themes related Medicines Management, 1 recurring theme relates to the value that access to the Summary Care Record would bring if Pharmacy Teams, and Clinical Services had access to the joined up record. Work is progressing in this area.
2 other incidents related to clinical teams recording all medications and any other substances that the patient had self-reported they were taking, to give a robust risk assessment.

Action Planning and Impact of Actions

The above themes give a view of the 39 serious incidents that have been reviewed in the last period, and where necessary action plans have been created, these are managed by the individual services, with the appropriate corporate support as required. The changes identified in these actions have a direct result on future incident activity; as such we can see a difference in the types of incidents reported in this report. Examples of which are as follows:-

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

Independent Investigations Summary

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

Sign up to Safety

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

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

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

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

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

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

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

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

The Trust has submitted its pledge, to Sign up to Safety on 29th October 2014, The following themes have been identified within the current safety programme and 4 have been selected for initial focus of the Sign Up to Safety approach, it is envisaged that all themes will be given the sign up to safety approach over the next 12 months.

a) Transitions/Transfers of care
b) Accurate Formulation
c) Risk Assessment
d) Observation
e) Family and Carer Involvement
f) Physical Health
g) Management of EUPD
h) Falls
i) Violence against Staff

The intension is to submit our improvement plans by the end of May 2015. More information is available here: http://www.england.nhs.uk/signuptosafety/

Update on Medical Staff

Dr Jonathan Richardson was appointed into the Deputy Medical Director – Quality and safety role in February 2015. In recognition of the importance of medical involvement in the safety process, the intention is to advertise for a clinical lead (Medical) in Quality and Safety in April 2015.

NHS England /Health foundation 'Q initiative'

Dr Richardson has also been nominated by the Royal College of Psychiatrists (RCPsych) to be the RCPsych representative on the NHS England /Health foundation 'Q initiative'.

Commissioned following the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis inquiry), the 2013 Berwick review, A promise to learn: a commitment to act, highlighted that 'the most important single change in the NHS… would be for it to become,

more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end'.

The Berwick review recognised that, as with every other health care system in the world, patient safety problems exist throughout the NHS, with the vast majority of issues a result of systems, procedures, conditions, environment and constraints. The report also identified that improvement requires a system of support; 'the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement'.

The review recommended that NHS England 'organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability'. This recommendation was subsequently accepted in Hard truths: the journey to putting patients first (the government's response to the Francis inquiry).

In spring 2014, NHS England approached the Health Foundation to partner with them to design and host the Q initiative. The Foundation agreed to proceed as there was strong synergy with its own aim to support the significant increase in the dosage of improvement capability across the NHS.

Together, the Health Foundation and NHS England have committed an initial £2m funding for 2015 to support the design phase of this long-term initiative.

The Health Foundation's UK-wide remit and funding mean that the initiative will extend to all four countries in the UK. The scope of the initiative will ultimately incorporate all domains of quality improvement, although it will start with a particular focus on those working to improve patient safety.

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 13 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	Updated 17.02.15
2335	200627	21.11.14	Request for files	Decision not to investigate at this time – feels all been previously answered	Sent 24.11.14
2164	201335	18.11.14	Request for further information	Partially upheld then decision not to investigate as complainant felt Trust could not satisfy concerns due to conflict of interest.	Sent 25.02.15
1814	192159	24.07.14	Request for files	Upheld	Sent 01.08.14
1794	199616	18.09.14	Final report received	Partially upheld	Actions to be completed by 24.04.15
1846	201536	05.11.14	Request for files	Upheld then re-opened and upheld again	Sent 11.11.14
2098	199724	13.11.14	Intention to Investigate	Decision not to investigate at this time – feels all points been previously answered	Updated 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
2169	210254	25.02.15	Request for files	Upheld	Sent 04.03.15
1942	209870	11.02.15	Request for files	Partially Upheld	Sent 06.03.15
2374	213836	25.02.15	Request for files	Not Upheld	Sent 04.03.15

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.

The Benefits Realisation metrics has been presented and discussed at various governance groups in the Community Service Group. Service Managers and Medical managers have been asked to discuss this at team level for information. As the transformation of services is at various stages across each pathway, the data will need to be developed further to give a full accurate picture; it has been recognised that the display of the Benefits Realisation metrics will need to be a user friendly team resource which gives a visible representation of the team's performance in PCP.

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.

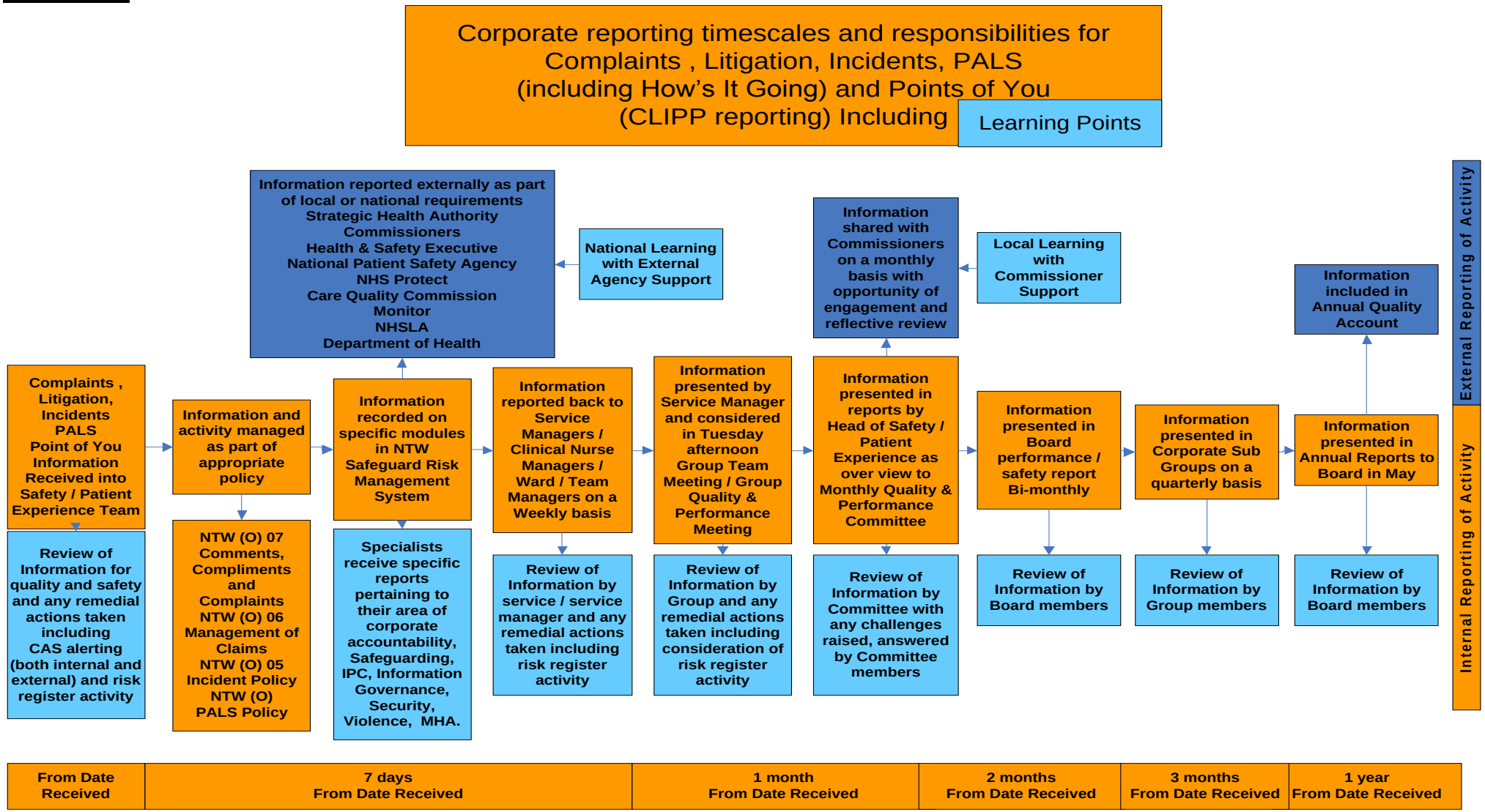
Independent Investigation
An investigation carried out by an appointed panel of specialists to review to most serious incidents in a mental health organisation, namely homicides committed by those in receipt of mental health services. The process is the responsibility of NHS England, and the reports 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
Information reported externally as part of local or national requirements
Strategic Health Authority
Commissioners
Health & Safety Executive
National Patient Safety Agency
NHS Protect
Care Quality Commission
Monitor
NHSLA
Department of Health
National Learning with External Agency Support
Information shared with Commissioners on a monthly basis with opportunity of engagement and reflective review
Local Learning with Commissioner Support
Information included in Annual Quality Account
External Reporting of Activity
Internal Reporting of Activity
Complaints , Litigation, Incidents PALS Point of You Information Received into Safety / Patient Experience Team
Information and activity managed as part of appropriate policy
Information recorded on specific modules in NTW Safeguard Risk Management System
Information reported back to Service Managers / Clinical Nurse Managers / Ward / Team Managers on a Weekly basis
Information presented by Service Manager and considered in Tuesday afternoon Group Team Meeting / Group Quality & Performance Meeting
Information presented in reports by Head of Safety / Patient Experience as over view to Monthly Quality & Performance Committee
Information presented in Board performance / safety report Bi-monthly
Information presented in Corporate Sub Groups on a quarterly basis
Information presented in Annual Reports to Board in May
Review of Information for quality and safety and any remedial actions taken including CAS alerting (both internal and external) and risk register activity
NTW (O) 07 Comments, Compliments and Complaints
NTW (O) 06 Management of Claims
NTW (O) 05 Incident Policy
NTW (O) PALS Policy
Specialists receive specific reports pertaining to their area of corporate accountability, Safeguarding, IPC, Information Governance, Security, Violence, MHA.
Review of Information by service / service manager and any remedial actions taken including risk register activity
Review of Information by Group and any remedial actions taken including consideration of risk register activity
Review of Information by Committee with any challenges raised, answered by Committee members
Review of Information by Board members
Review of Information by Group members
Review of Information by Board members
From Date Received
7 days From Date Received
1 month From Date Received
2 months From Date Received
3 months From Date Received
1 year From Date Received

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