NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING

Meeting Date: 25 November 2015

Title and Author of Paper: Safety Report – July - September 2015
Tony Gray – Head of Safety / Patient Experience

Paper for Debate, Decision or Information: Information: Information

Key Points to Note:

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Incident Activity & Analysis

The Trust continues to actively encourage reporting of incidents as part of its overall safety culture. The number of reported serious incidents has increased in the period July - September 2015 from the previous year, and is comparable with the high number reported in 2013 / 14.

Regular updates are provided to both the Trust's Quality & Performance Committee as well as the Operational Group Business Meeting, through the Incidents report, as well as through the regular meetings with respective Clinical Commissioning Groups.

Identification of Themes

- There is a new section on 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 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, an update for any published independent investigations and a current update on all ongoing Parliamentary Health Service Ombudsman Complaints reports.

As part of the review of our safety requirements, and in line with changes to the Director portfolios at both Executive and Operational level, this report will be reviewed over the next 2 quarters in line with the new Corporate Decisions Team – Quality Sub Group – requirements, and in line with our Safety Improvement Plan for Sign up 2 Safety

Outcome required: Noted for Information

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

Safety Report
November 2015
Reporting period – July - September 2015

Shining a light on the future

Introduction

This is the Safety Report for the reporting period July - September 2015.

1. NTW Corporate Decision Team – Quality Sub Group

The Quality Sub Group, has now taken over its responsibility around reviewing the safety systems of the Trust, and with phase 1 of Transforming Corporate services nearing full implementation with the transfer of the safety function to the Nursing Directorate , the responsibility of this report and the presentation of such , will now sit with the Executive Director of Nursing and Operation's with the design and content, being produced in partnership with the new Triumvirate of the Group Medical Director / Group Nurse Director and the Safety Team working together to update the current position of the Trust's Safety agenda.

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 has historically repored the highest number of incidents for Mental Health Trusts. However, when rates per 1000 bed-days are considered, NTW is no longer the highest reporter (NEQOS benchmarking report 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 Mental Health organisations, which may be much more conservative in their reporting. Our approach is to report all unexpected deaths as SI's to start with, and to commence an investigation into the incident. As more information becomes available, e.g. from the incident investigation, post mortem and ultimately, the Coroner's Inquest, those deaths determined to be due to natural causes are removed from the data set and de-escalated as serious incident with our Commissioners.

Therefore the set of "unexpected deaths" includes deaths subsequently determined to be due to natural causes. The removal of these deaths leaves a set of deaths which we term as "Unnatural deaths". This set of deaths is subjected to further analysis in the regular Trust updates presented by the Trust Public Health lead.

With agreement of the Medical Director and the Executive Director of Nursing and Operations the Trust has considered the recently published NHS England Serious Incident Framework, and when serious incidents are considered by the Directors each week at Group Business Meeting, it is appropriate for the investigation to be at the After Action Review level with

escalation as appropriate depending on the findings. This is currently being built into the review of the Trust's Incident Policy NTW(O)05.

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

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

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 de-escalated and removed from further analysis.

Safety Report At A Glance

1 - Incident Activity & Analysis	2 – Identification Of Themes
The number of serious incidents has reduced. For the period July - September there were 58 serious incidents, this was 33 more than the same period last year however this is reflective of the decision to investigate more deaths of those patients that have been in contact with services by carrying out a local after action review . This is in line with the national serious incident framework, more information on serious incidents is on page 10.	There is a new section on identification of themes for the incidents in the period April – June 2015, that have been reviewed between July - September 2015, more information on this is on page 15. • Communication • Risk Assessment • Record Keeping • All Aspects of Clinical Care • Medicines Management

3 – Action Planning & Impact Of Action
The action plan relating to Mr E is currently being managed. For Serious Incidents. • The Trust has the lowest rate of open action plans since the organisation came into operation. • Work has progressed with both clinical services and Clinical Commissioning Groups to complete and close a number of historical action plans.

Section 1: Incident Activity & Analysis

At the end of the financial year the Trust had reported over 31,218 incidents in 2014 /15, this is the highest reported in NTW. In comparison, 115 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.

From April 2015 this year, the Trust has been implementing the web based incident reporting system, which allows a more responsive way of managing both serious incidents and all incidents reported. In this process it also means that reports such as this will include up to date accurate information of the Trust's reported activity. Also from April 2015, the Trust has implemented systems to comply with the new Serious Incident Framework, and has started to investigate more serious incidents that have been reported, the new framework gives that flexibility, whilst all the serious incidents are included in this report, they are not all reported through the external STEIS system. These are investigated as an after action review in, line with policy, the majority of these incidents are unexpected deaths within our addictions services, which would not be reported into a health based incident reporting system as they are commissioned by local authority services. These deaths are also not reported into the National Reporting and Learning System which is in line with current guidance.

Table 1 – All Incident Activity

Year	July - September	+/- on previous period	Number Of incidents Annual	+/- Year on Year
11/12	6,957	-	26,338	-
12/13	7,436	+479	29,111	+2,773
13/14	8,043	+607	30,506	+1,395
14/15	7,796	-247	31,218	+712
15/16	8,112	+316	19,768	YTD

The Trust has fully rolled out its web based reporting system, with the last community service going live in October 2015.

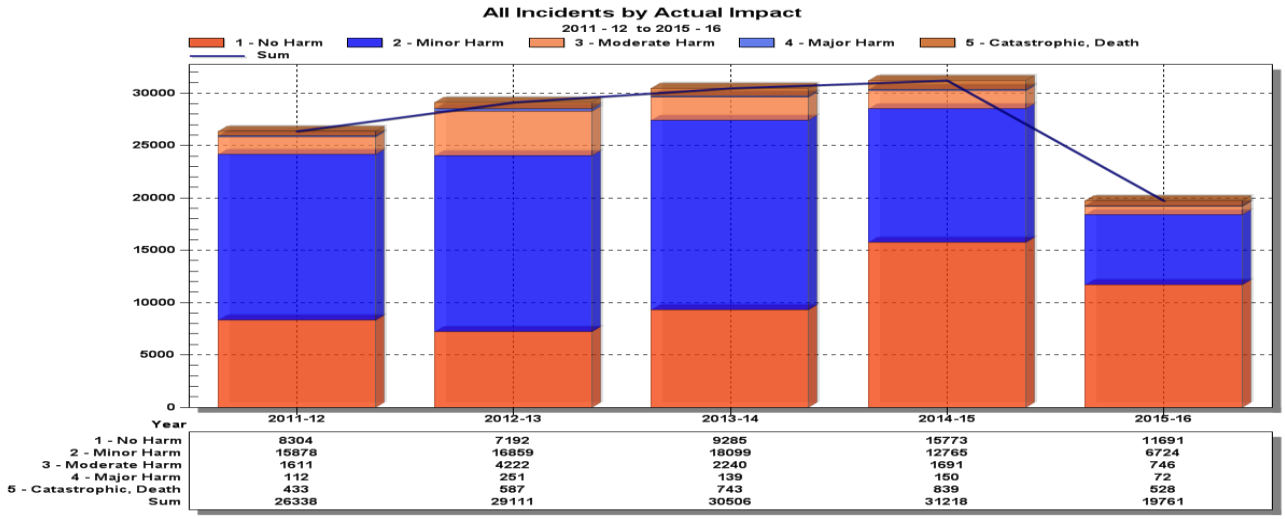
The Safety Team are now working with clinical and operational services to improve the quality of what has been reported and make some minor changes as part of the learning from the project.
There has been an increase in serious incidents in the second quarter of 2015, and this is the highest figure for this quarter in the last 5 years, this has to be viewed with caution as a number of unexpected deaths of which there were 40, are still cause unknown so may return as a natural cause and therfore may reduce this figure over time.

Table 1a –Serious Incident Activity

Year	July - September	+/- on previous period	Number Of Serious incidents Annual	+/- Year on Year
11/12	25	-	120	-
12/13	33	+8	127	+7
13/14	38	+5	157	+30
14/15	25	-13	114	-41
15/16	58	+33	108 YTD	-YTD

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

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



While an overall high reporting picture is indicative of a good safety culture, the desired configuration is one of high reporting with declining levels of harm over time, especially in terms of moderate, severe and catastrophic impact. In the above graph catastrophic death incidents, also include those where the Trust has been notified by services / relatives that the patient has died naturally.

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

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

Table 2

July - September 2014		July - September 2015		+ / -
Cause Group	**2014-15**	**Cause Group**	**2015-16**	
Aggression And Violence	2797	Aggression And Violence	3104	+307
AWOL And Abscond	251	AWOL And Abscond	235	-16
Contractor/Public/Visitor Incident	7	Contractor/Public/Visitor Incident	11	+4
Death	210	Death	214	+4
Fire	25	Fire	40	+15
Human Resources Process	0	Human Resources Process	1	+1
Inappropriate Behaviour By Others	6	Inappropriate Behaviour By Others	9	+3
Inappropriate Patient Behaviour	410	Inappropriate Patient Behaviour	536	+126
Inappropriate Staff Behaviour	13	Inappropriate Staff Behaviour	23	+10
Inappropriate Treatment	10	Inappropriate Treatment	6	-4
Infection, Prevention And Control	29	Infection, Prevention And Control	22	-7
Information Governance	114	Information Governance	146	+32
Infrastructure	30	Infrastructure	20	-10
Medical Device, Equipment	34	Medical Device, Equipment	11	-23
Medication	285	Medication	334	+49
Mental Health Act	16	Mental Health Act	5	-11
Patient / Staff Safety	6	Patient / Staff Safety	15	+9
Patient Accident	732	Patient Accident	463	-269
Patient Clinical Issue	8	Patient Clinical Issue	26	+18
Patient Ill Health	566	Patient Ill Health	201	-365
Police Issue	5	Police Issue	6	+1
Safeguarding	665	Safeguarding	905	+240
Security	423	Security	424	+1
Self Harm	953	Self Harm	1107	+154
Service Delivery	51	Service Delivery	36	-15
Staff Accident	137	Staff Accident	113	-24
Staff And Patient Accident	4	Staff And Patient Accident	5	+1
Staff Ill Health	6	Staff Ill Health	3	-3
Unknown Patient Injury	3	Unknown Patient Injury	89	+86
Unlawful Detention	0	Unlawful Detention	2	**+2**
	7796		8112	**+316**

In reviewing the information above, the Trust is starting to see a changing trend in incident information due to implementation of the web based reporting, this is due to a number of reasons as bellow:-

- Timeliness of reporting, reports such as these, if produced close to the data period, would now be accurate based on activity that has been reported as there is no lag in data input from paper to electronic incident system as it is now all electronic input.
- Types of incidents may change over time as reporters now have access to the system direct and can choose the incident category to accurately reflect what they are reporting, there are over 400+ types of incidents under the categories above.

- This may be evident in the data above for some of the significant changes such as safeguarding, unknown patient injury, inappropriate patient behaviour etc.

The number of deaths shown in the table above includes expected deaths, which are not under coronial investigation. A detailed breakdown on unexpected and natural deaths is reported separately to the Trust by the Director of Public Health.

Serious Incidents

Table 4

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

Number of serious incidents reported annually	2013-14	2014-15	2015-16
Aggression and Violence	8	2	5
AWOL And Abscond	3	1	1
Fire	0	0	1
Information Governance	4	1	1
Infrastructure	1	1	0
Medication	0	0	1
Patient Ill Health	1	0	2
Safeguarding	1	1	1
Self Harm	14	6	6
Unexpected Death	99	80	42
Alleged Homicide To A Patient	1	1	0
Alleged Homicide By A Patient	2	1	1
Alleged Homicide By A Patient To A Patient	1	2	1
Unexpected Death Local AAR	0	7	36
Alleged Homicide Not In Receipt Of Services	0	0	1
Patient Accident	6	4	4
Fracture Neck Of Femur	12	7	5
Total	**153**	**114**	**108**

Number of Serious Incidents reported in the period July - September	2013-14	2014-15	2015-16
AA09 Absented Themselves From Hospitals	1	0	1
DE01 Unexpected Death	26	20	23
DE03 Alleged Homicide To A Patient	1	0	0
DE04 Alleged Homicide By A Patient	1	0	1
DE08 Unexpected Death - Natural Causes	0	0	1
DE14 Unexpected Death NTW Not Main Care Provider	0	0	1
DE16 Alleged Homicide By A Patient To A Patient	1	0	0
DE18 Unexpected Death Local AAR	0	0	17
IG03 Breach Of Patient Confidentiality	0	0	1
IG07 Poor Information Sharing	1	0	0
ME07 Wrong Drug/medicine	0	0	1
PA01 Patient Fall On Same Level	1	0	0
PA04 Patient Fall From Height	0	0	1
PA06 Patient Fall From Chair/Wheelchair	1	0	0
PA08 Patient Found On Floor - Not Witnessed	1	0	1
PA26 Fracture Neck Of Femur	0	3	2
PI01 Unexpected Deterioration In Health	0	0	1
SG03 Safeguarding Adults - Staff Allegation	0	1	0
SG23 MARAC	0	0	1
SH01 Actual Self Harm	3	0	3
SH02 Attempted Suicide	0	0	1
SH06 Suspected Self Harm	0	1	0
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	1	0	0
V03 Physical Assault Of Patient By Patient	0	0	1
V38 Threatening Behaviour With Weapon To Staff	0	0	1
Totals	**38**	**25**	**58**

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.

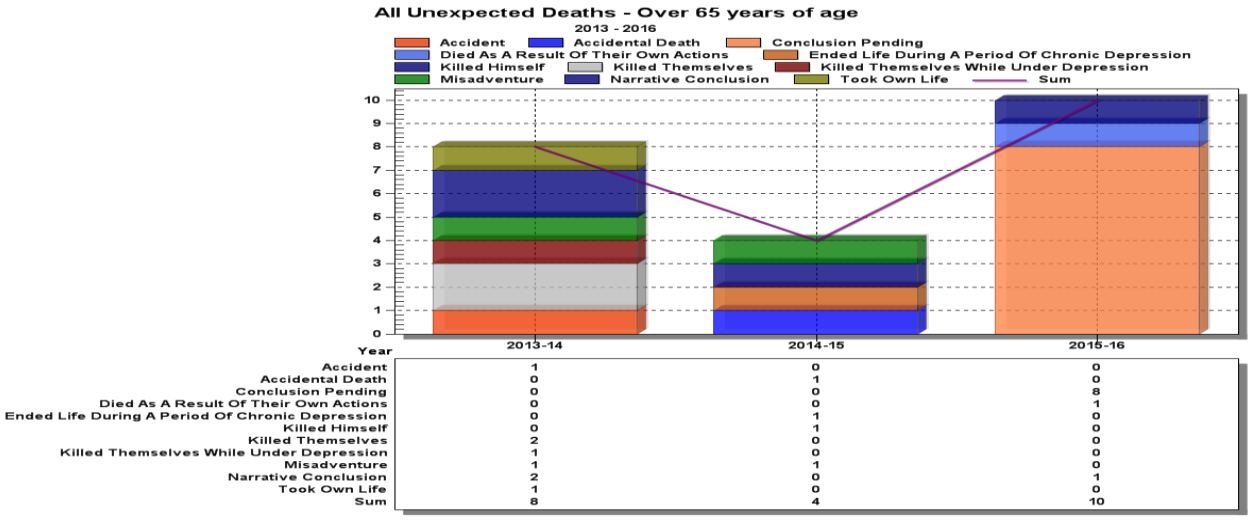
Unexpected Deaths by Coroner Conclusion

Table 5

Coroner Conclusion	July - Sept 2013-14	July - Sept 2014-15	July - Sept 2015-16
Accident	2	0	0
Accidental Death	3	1	0
Accidental Overdose Of Drugs	1	1	0
Conclusion Pending	0	0	37
Died As A Result Of Their Own Actions	0	0	1
Drug Related Death	1	3	0
Drug/alcohol Related Death	1	0	0
Killed Himself	1	1	0
Misadventure	8	8	2
Narrative Conclusion	7	3	0
Natural Causes	0	0	1
Open Conclusion	1	2	0
Suicide	1	1	0
Took Own Life	1	0	0
Total	**27**	**20**	**41**

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

Graph 2: Unexpected Deaths (Older People – Over 65) – Data Period – 2013 - 2015



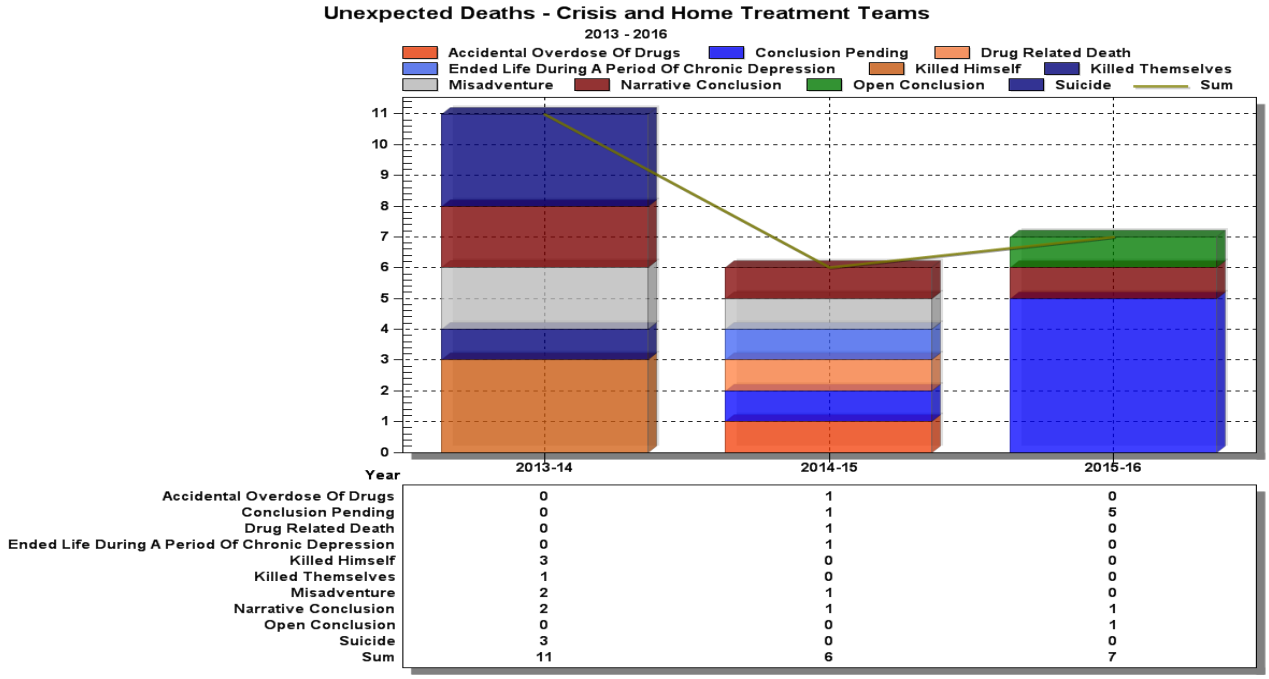
Following an increase in unexpected deaths for those over 65 years of age in 2013 / 14, this area has been monitored continuously. The increase in activity in 2015 /1 6 relates to local AAR of unexpected physical health related deaths, in line with the new serious incident framework, in which it has been agreed by Directors to review these incidents, it can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths.

Unexpected Deaths Involving Crisis And Home Treatment Teams

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

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

The following graph gives the breakdown for the period and the increase previously identified in 2013 / 14, which reduced in 2014 / 15, has increased again in 2015 / 16 , information for this area, has been provided to the crisis team to carry out their own review into these incidents, and the update is awaited.

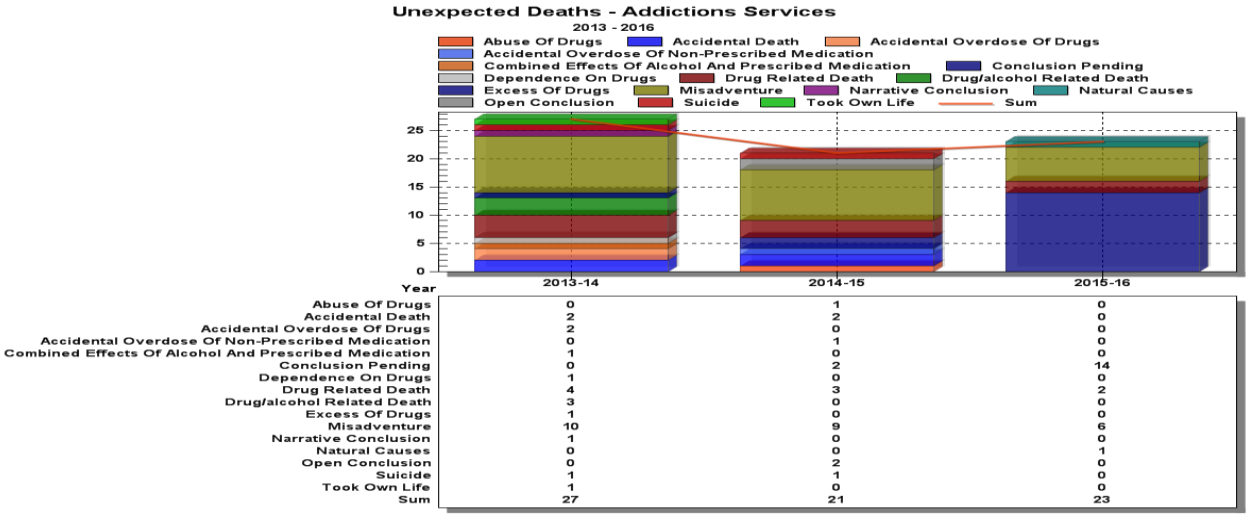


Year	2013-14	2014-15	2015-16
Accidental Overdose Of Drugs	0	1	0
Conclusion Pending	0	1	5
Drug Related Death	0	1	0
Ended Life During A Period Of Chronic Depression	0	1	0
Killed Himself	3	0	0
Killed Themselves	1	0	0
Misadventure	2	1	0
Narrative Conclusion	2	1	1
Open Conclusion	0	0	1
Suicide	3	0	0
Sum	11	6	7

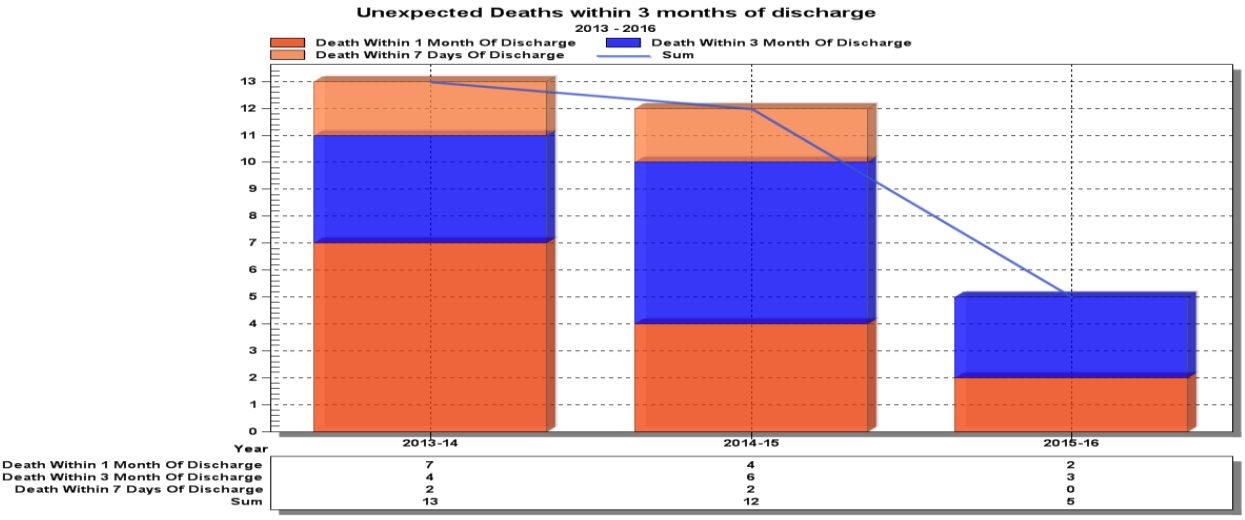
Graph 4: Unexpected Deaths – Addictions Services - Data Period – 2013 – 2015.

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

With revised governance systems now in place the activity of addictions services has been kept under constant review, in line with the Trust increase in 2015 /16, activity has increased in this area.



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



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

We know that the period after discharge from in-patient services is a time of high risk. This graph shows that there has been 12 serious incidents reported in 2014 /15 in comparison to the 13 reported in 2013 / 14. The Transition protocol has been implemented to improve the transfer of care from hospital into community and this area of care will receive continuing close scrutiny. At the time of this report only 5 incidents have been reported thus far in 2015 / 16.

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

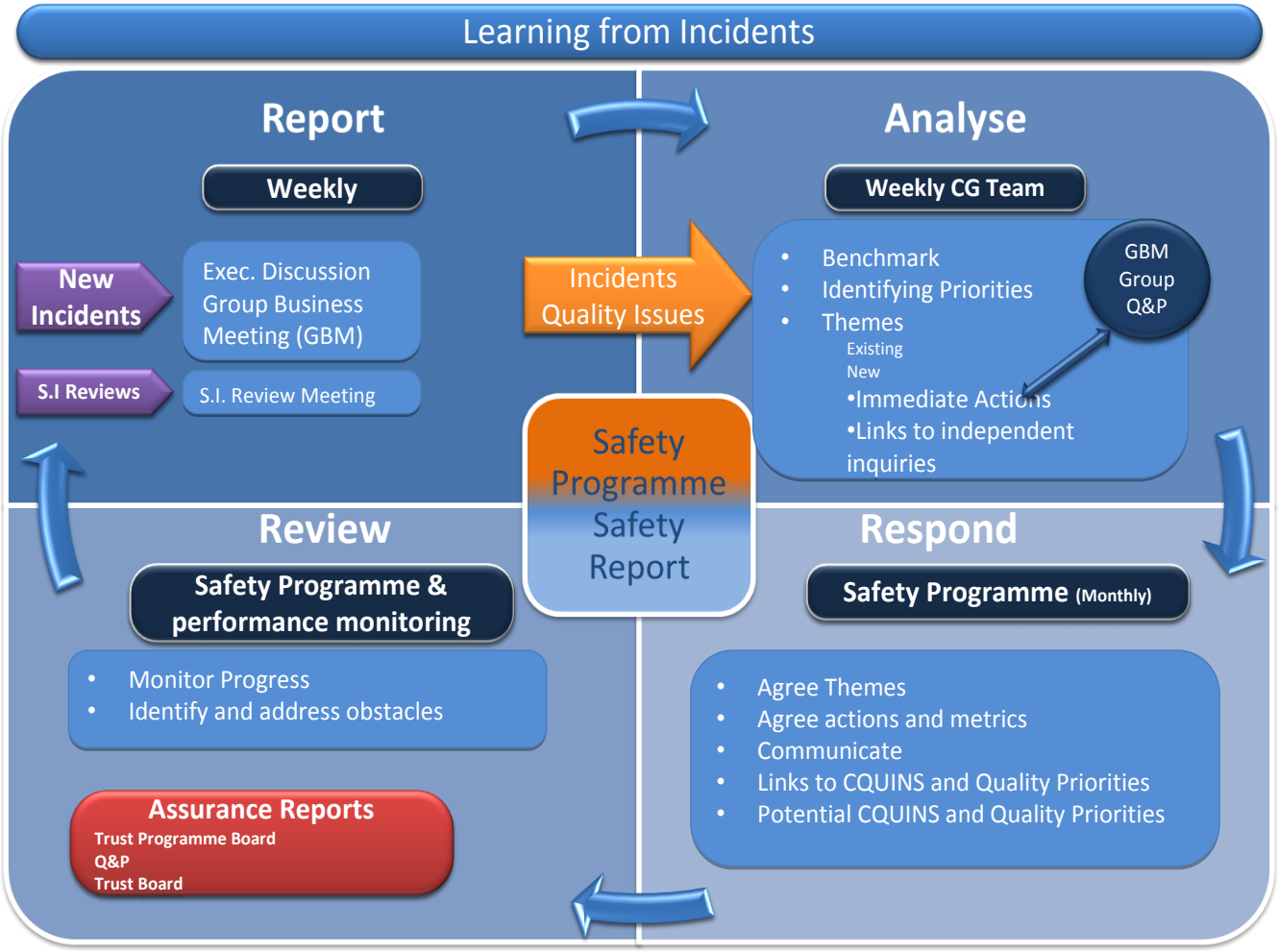
Number of serious incidents reviewed	July - Sept 13	July - Sept 14	July - Sept 15
	54	30	25

Whilst the number of reviewed incidents has reduced, this is in line with the reduction in the need for serious incidents to be reviewed by the full panel, many are completed with the local after action review only, and any supplementary actions picked up by individual services.

In order to maintain a robust serious incident investigation process, there are 7 dedicated serious incident investigators. Having this direct control allows for greater planning relating to the management review of serious incidents. Serious incidents are investigated and reviewed by the serious incident panel which meets weekly, and the Panel has coped with the demands of more incident reviews. 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.
At the last update for the Patient Safety Group the average timescale for review was 64 working days, this is a significant improvement and work progresses throughout the full process of incident investigation to get this under the 60 working day timescale in line with Clinical Commissioning Group and Serious Incident Framework requirements.

Section 2: Identification of Themes

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



Key Points

- A number of key themes have been identified through the serious incident review process.
- Certain themes are being monitored and managed through Operations/Groups.

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

Throughout 2015/ 16 the Serious Incident Panel members have taken the Quarter 2 incidents that occurred between April – June and were reviewed between July - September and have broken down the specific incident themes.

There are a number of recurring themes that have emerged 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. Sometimes the only findings are that the care and treatment was timely and appropriate and in line with Trust policy and processes but sadly still resulted in a negative outcome. All themes where improvements need to be made are included in the action plans of each serious incident which are owned by the service and quality checked for action and closure by the specific clinical groups' governance groups and by the Trust's Patient Safety Group prior to being sent to the Clinical Commissioning Group for closure.

There were 25 serious incidents reviewed for Quarter 2 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. , The Trust has 40,000 patient contactss at any one time and sees, over 80,000 patients every year, resulting in 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 5 key headings:-

- Communication
- Risk Assessment
- Record Keeping
- All Aspects of Clinical Care
- Medicines Management

<u>Communication</u>

There were eight reviewed incidents which had a total of ten issues relating to communication. Five incidents were for community services and three for specialist services; there were no communication issues for inpatient services in the 2nd quarter. All issues identified have the appropriate actions created to improve outcomes.
Five issues relate to poor communication with the GP. Within this there are two issues which relate to referrers not being given the clinical rationale as to why the patient has not been taken on for treatment, in different community teams.
Two issues relate to poor communication surrounding the search for an under 18 admission bed with a protocol not followed correctly and subsequent issues relating to transfer and discharge
Three issues relate to poor communication with other health professionals / services involved in a patient's care.

Risk Assessment and Management

2 incidents had 2 issues relating to risk assessment / risk management, All issues identified have the appropriate actions progressed to improve outcomes.

1 issue related to the full range of information in relation to risk assessment not being uitlised and the other that the clinician's record did not fully reflect their considerations when assessing risk.

Record Keeping

There were 8 incidents where record keeping was identified as a theme. This was 3 less than last recording period and 7 less than the highest number reported. As can be seen from the break down across the groups that on 4 occasions the quality of the record did not reflect information known either from a third party or about an intervention delivered. Communication with G.P's was noted twice but within different teams.
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, guidance, audit and clinical supervision requirements to support the quality of record keeping, and all professional bodies also produce guidance setting out expectations for professionals.
The analysis of data to date does not identify any specific teams or processes as an area of concern but just the need to continually support clinicians to be able to deliver the expected standard.

Aspects of Clinical Care

Four teams with ten separate issues (one team had two incidents).
One team had three issues identified:two isssues relating to assessment, general and the assessment of the substance misuse profile and the use of an interpreter.
One team had an issue in relation to communication of prescribing with the GP and lack of clinical recording in relation to adult concern notifications.
Not specifically a team, however a decision was made to admit a patient to a ward as opposed to being kept in custody after a serious violent offence.
Same team, two incidents, two issues per incident. Disregard of an alert that identifies a patient cannot read or write, an issue relating to clustering with the potential to change treatment.
Disregard of alerts on the clinical record and then assessment of capacity and the potential impact on care and treatment.

Medicines Management

Three incidents – with five issues relating to medicines management
One issue related to the awareness of clinical staff of the abuse potential of pregabalin.
One issue related to lack of communication between prescriber, staff and care coordinators when decisions were made to stop antipsychotic depot medications.
One issue raised the risk of medication reconciliation errors, particularly where GP Care Summaries are neither requested, nor cross-checked with current medication therapy

One issue related to the crossover of antidepressant therapies and the importance of ensuring therapeutic levels are maintained throughout.
One issue highlighted the risk of not appropriately flagging patient-reported incidence of medication non-concordance.

Action Planning and Impact of Actions

The above themes give a view of the 25 serious incidents that have been reviewed in the last period, and where necessary action plans have been created, these are managed by the individual services, with the appropriate corporate support as required. The changes identified in these actions have a direct result on future incident activity, as such we can see a difference in the types of incidents reported in this report. Examples of which are as follows:-

- Less serious incidents of violence on in-patient wards, coupled with lower impact of harm reported for all physical assaults for both in-patient and community services, this is as a result of lone working systems, staff attack systems, improvement to in-patient environments, increased staffing levels, improved and increased management of violence and aggression training, and peer reviews of physical interventions.
- Less delays related to the diagnosis of 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 in-patient environments , increased staffing levels, better support of in-patient teams with the support of the Personality Disorder Hub Team.
- Less serious incidents relating to under 18 admissions due to more pro-active care and better bed management.

Independent Investigations Summary

The Trust is currently working through the final drafts in readiness for the publication of 2 more independent investigations, and more information will be provided in the next report, when we have a publication date from NHS England.

All other actions plans are being appropriately managed.

Sign up to Safety

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

- Executive Lead: Chair of Corporate Decision Team – Quality Sub Group
- Members of Corporate Decision Team – Quality Sub Group
- Sign up to Safety Leads within NTW's Safety Team.
- Members of Group Business meeting

2. NTW Corporate Decision Team – Quality Sub Group

It is proposed that Sign Up to Safety supports the newly formed Corporate Decision Team – Quality Sub Group, and that the Sign Up to Safety Methodology - including this Safety Improvement Plan (SIP) and accompanying Driver Diagrams - are used to take the patient safety improvement initiatives forward. Delivering person and family centred care, along with communication and team work, are integral to the themes below. The SIP includes the detailed plans, in the form of driver diagrams, for each of the chosen themes.
As part of the phase 1 of transforming corporate services an opportunity has been taken to review the SIP and baseline activity relating to this. A further update will be provided in the next report.

3. Themes within NTW Safety Programme

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

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

4. Sign Up to Safety Improvement Plan

The Sign Up to Safety Improvement Plan offers the opportunity to be proactive and identify 'gaps' in safety before they occur. NHS Trusts collect data which highlights what works well and what has not gone to plan, but this is after an incident has happened and is therefore a reactive approach to patient safety. NTW will be reviewing its current Serious Incident process, in line with the NHS England Serious Incident Framework (2015).
The trust already has a track record of adapting the principles of continuous improvement to implement transformational change; the plan, do, study, act (PDSA) cycle is another simple, yet proactive methodology which can equip frontline staff to try out small improved ways of filling the safety gaps before they occur and then measuring what difference has been made in reducing avoidable harm. Improvement skills required by all staff are shown in Appendix 1.
The NTW Sign Up to Safety Improvement Plan attempts to bring both approaches – the collection of data, including the review of the serious incident process, and improvement methodologies – together, hopefully creating a culture that measures safety improvement.

5. Driver diagrams

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

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

Driver diagrams are therefore best used when an improvement team needs to come together to determine the range of actions they have to undertake to achieve a goal. They are well suited to complex goals where it is important for a team to explore many factors and undertake multiple reinforcing actions**6.Implementation**

An implementation team led by Dr Damian Robinson – In-patient Group Medical Director and Vida Morris – In Patient Group Nurse Director and including the Sign up to Safety Leads will feedback on a quarterly basis to the Corporate Decision Team – Quality Sub Group. More information on Sign up to Safety is available below.

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

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 currently has 14 open cases.

Case number	PHSO reference	Opened	Current Status	Trust Outcome	Current Update
C 2098	199724	13.11.14	PHSO Open	Decision not to Investigate	Final Report Received – Partly Upheld – actions to complete
C 2074	222359	21.05.15	PHSO Open	Partially Upheld	Update 21.08.15 – extended scope
C 1942	209870	25.02.15	Request for further info	Partially upheld then re-opened and partially upheld	Draft Report received 28.09.15 – Upheld – Awaiting final report
S 2169	210254	25.02.15	Request for files	Upheld	Draft Report Received – NOT UPHELD – awaiting final report
S 2664	210865	26.03.15	Request for files	Dealt with locally, not through Complaints Department	Sent further info 22.07.15
S 1904	219647	09.06.15	Request for files	Partially Upheld	Sent 17.06.15
S 2535	221171	30.06.15	Request for files	Partially Upheld	Sent 08.07.15
IP 2084	199797	17.10.14	PHSO Open	Upheld	Letter received – intention to investigate 17.02.15
IP 2115	209772	13.03.15	Request for files	Partially upheld then re-opened and not upheld	Draft Report received 28.09.15 – Partially Upheld – Awaiting final report
IP 2346	216342	19.05.15	Request for files	Partially upheld then re-opened and not upheld	Sent 28.05.15

Appendices:

Appendix 1 Glossary of Terms
Appendix 2 Safety Messages – July – September 2015
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.

Appendix 2

Safety Message Reports

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

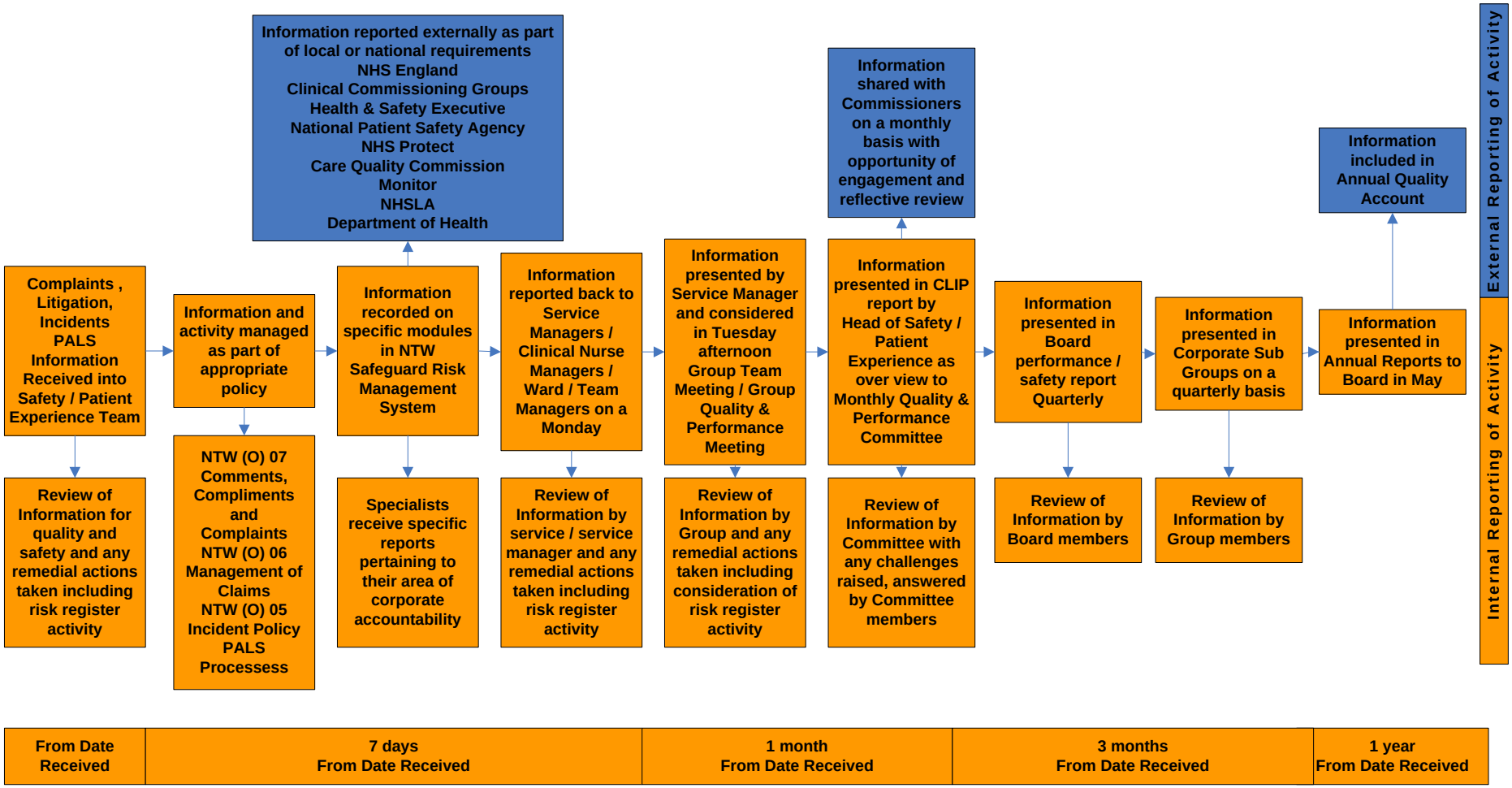
Learning from incidents

Reference No. SM64/180815 **Date Issued** 18/08/2015

It is extremely important, on an ongoing basis, that following review of Serious Incidents and near misses, learning points are fully disseminated across the organisation.
Two important issues have been highlighted from recent incident reviews, please discuss these within your team and incorporate into current practice accordingly.
Feedback to Referrer
When an urgent referral has been received and, following assessment, the client is not subsequently taken on for care and treatment, this must be fed back to the referrer and the clinical rationale provided. A record of this feedback being given should be documented in the Care Record.
Collateral History From Partners / Carers
Where a client is assessed and a partner/carer is present during the assessment, this may be in the client's home or an out-patient setting, it is important that the partner/carer is offered time to speak separately to staff. The partner/carer may have essential collateral information which can be utilised to inform risk assessment.
If this is offered and the partner/carer declines this opportunity then this should be documented in the Care Record.
If any additional information or clarification is required, please contact Vida Morris Group Nurse Director in Inpatient Care.

Appendix 3

Corporate reporting timescales and responsibilities for Complaints , Litigation, Incidents and PALS (CLIP reporting)



Appendix 4

Quality and Safety Metric Suite

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

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