**NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS MEETING**

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| **Meeting Date:** | 27 January 2016 |

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| **Title and Author of Paper:** | Safety Report: October - December 2015<br>Author of Paper in response to this report: Tony Gray, Head of Safety & Security, and Dr Damian Robinson. Group Medical Director |

**Paper for Debate, Decision or Information**: Information

**Key Points to Note:**

- This report has been updated to indicate the operational change in responsibility of Safety within the Trust from the Executive Medical Director to the Executive Director of Nursing and Operations.
- The report has been updated to indicate the changes to the Corporate Decision Team – Quality Sub Group.
- The Board are asked to note and agree to the change to the board schedule of reporting on safety and unexpected deaths as identified on page 5.
- The report describes the approach for Safety management following implementation of Phase 1 of Corporate Transformation, with the leads for Safety being the Group Nurse Director and Deputy Medical Director supporting the Safety Team within the Trust.
- This report includes the request from the previous board discussion around how we learn from incident activity. The learning section has been added at page 14.
- The Safety Messages section has now been adjusted to include all Internal CAS alerts, as this shows we are communicating learning and changes to practice to front line clinical teams.
- Further work is planned on our sign up to safety implementation plan, and the subsequent Safety report will include this.

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| **Outcome required:** | Noted for information and agreement to reporting schedule change. |

Northumberland, Tyne and Wear NHS
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# Safety Report
# January 2016
# Reporting Period–October–December 2015

Shining a light on the future

## Introduction

This is the Safety Report for the reporting period October – December 2015.

## Incident Reporting within Northumberland Tyne and Wear NHS Foundation Trust

The Corporate Decisions Team - 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 completed and plans being put in place for commencing phase 2 following 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.

This report is written to give the Board of Directors an update on the current position of incident reporting for all incidents and the most serious incidents. It is acknowledged that a more thorough report on the current approaches to incident reporting within the Trust, following the publication of the Southern Health NHS Foundation Trust report into their investigation of deaths produced by an independent company called Mazars was published in December 2015 will be coming to the Board of Directors in March 2016. It is also an opportunity to give the Board of Directors an update on the current approaches to the Trust Safety agenda.

Previous reports have explored the Trusts culture of reporting and this is now well embedded. At the end of October 2015 the Trust completed the project of web based incident reporting which saw the transition of paper based incident reporting systems which utilised 3 separate types of forms to an electronically submitted incident form, that automatically notifies managers and specialists that an incident has occurred in order to provide appropriate support to clinical and operational teams, and reduce any delay of notification.

Changes have been made to the classification of serious incidents, following the publication of the revised serious incident framework in March 2015. All serious incidents, complaints significant safeguarding cases and any complex clinical cases are discussed with the Group Directors and Executive Director of Nursing and Operations every Friday morning as part of the standard Group Business Meeting agenda. This is also an opportunity to agree the degree of investigation for some incidents that don't naturally fit the serious incident framework. An example of this type of serious incident would be an unexpected death within our addictions services, where it is reasonable known from coroner update that the death is likely directly related to the addiction. These incidents will still be classified as serious , however the level of investigation and need to be reviewed by the independent serious incident panel has been removed. Other incidents that are discussed and agreed relate to self harm, violence and unexpected deaths with crisis teams where there has been limited contact, or the individual after contact was not taken on to be provided with care and treatment. All this classification and assessment of what is and isn't being classified as a serious incident, is currently being written into the revise Incident Policy NTW(O)01.

This report is written to give the Board of Directors an overview of the Trust' Serious Incident activity, underpinned by all incidents that are reported within the Trust for the 3rd Quarter of 2015 / 16.

Following discussion with the Executive Director of Nursing and Operations and with the

approval of the board, there is a plan to move to 6 monthly reporting of this activity and to continue the 6 monthly report of Unexpected Deaths, so that the Board of Directors receives a quarterly update in future in January, April, July and October.

The plan moving forward is to report to the Board of Directors in the following way.

| | |
|---|---|
| Safety Report including all incident activity | January |
| Unexpected Death report | April |
| Safety Report including all incident activity | July |
| Unexpected Death report | October (to include annual comparison against National Confidential Inquiry into Homicide and Suicide) |

**Incident Activity & Analysis**

At the end of the last financial year the Trust had reported over 31,225 incidents, this is the highest reported in NTW. Given the current year to date figure for 2015 /16 it is likely that this annual total will be surpassed. In comparison, 115 of these were classified as serious incidents in line with Clinical Commissioning Group and serious incident framework 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.

The Trust has now fully implemented 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 | October - December | +/- on previous period | Number Of incidents Annual | +/- Year on Year |
|---|---|---|---|---|
| 11/12 | 6,461 | - | 26,338 | - |
| 12/13 | 7,239 | +778 | 29,111 | +2,773 |
| 13/14 | 7,154 | -85 | 30,507 | +1,396 |
| 14/15 | 7,562 | +408 | 31,225 | +718 |
| 15/16 | 8,180 | +618 | 25,913 | YTD |

The Safety Team continue to work 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 3rd quarter of 2015, and this is the 2nd highest figure for this quarter in the last 5 years, this has to be viewed with caution as a number of unexpected deaths are still cause unknown so may return as a natural cause and therefore

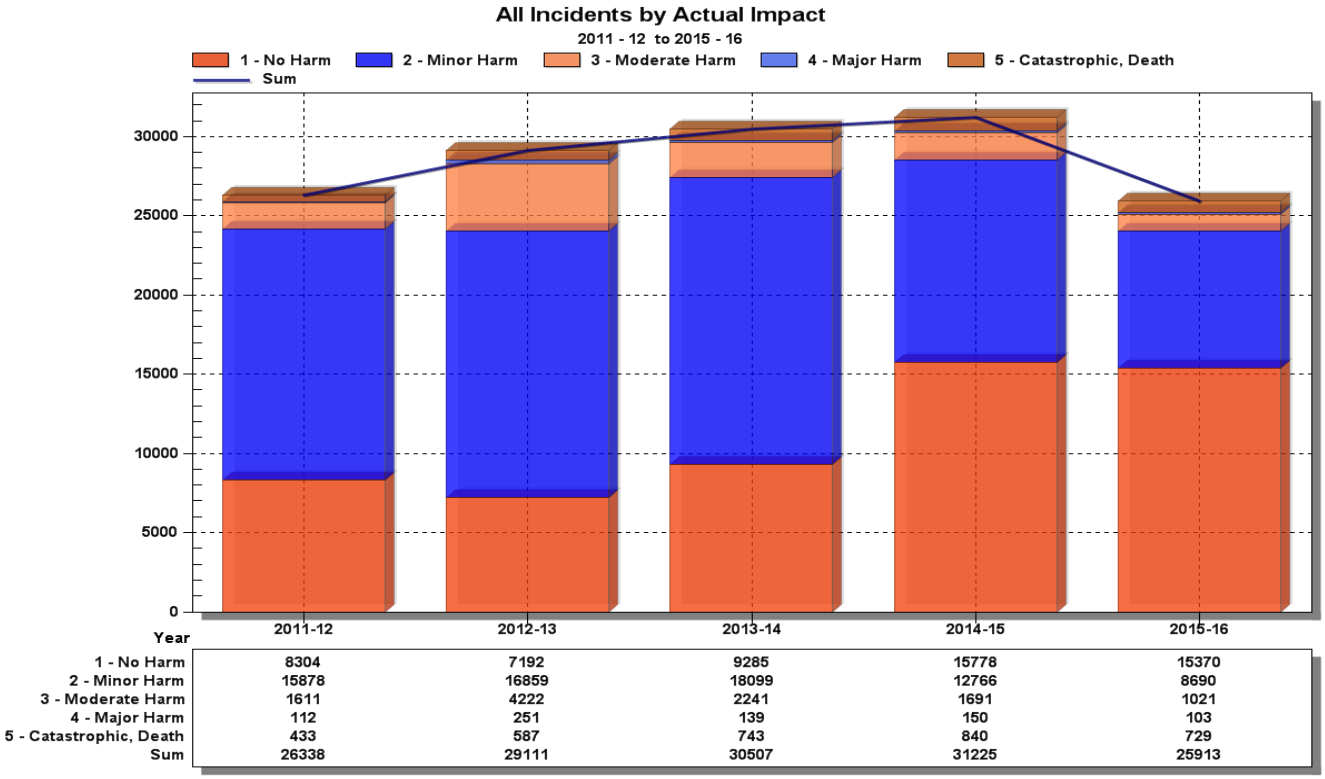
may reduce this figure over time. It can also be seen that the serious incident rate for 2015 / 16 is the 2nd highest overall and it is likely that this will exceed the highest figure reported in 2013 / 14, again this needs to be viewed with caution depending on the outcome of a number of unexpected deaths.

**Table 2 –Serious Incident Activity**

| Year | October - December | +/- on previous period | Number Of Serious incidents Annual | +/- Year on Year |
|---|---|---|---|---|
| 11/12 | 21 | - | 119 | - |
| 12/13 | 25 | +4 | 127 | +8 |
| 13/14 | 42 | +17 | 157 | +30 |
| 14/15 | 31 | -9 | 113 | -44 |
| 15/16 | 41 | +10 | 143 | +30 YTD |

## All Incident Activity

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




| Year | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|---|---|
| 1 - No Harm | 8304 | 7192 | 9285 | 15778 | 15370 |
| 2 - Minor Harm | 15878 | 16859 | 18099 | 12766 | 8690 |
| 3 - Moderate Harm | 1611 | 4222 | 2241 | 1691 | 1021 |
| 4 - Major Harm | 112 | 251 | 139 | 150 | 103 |
| 5 - Catastrophic, Death | 433 | 587 | 743 | 840 | 729 |
| Sum | 26338 | 29111 | 30507 | 31225 | 25913 |

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, 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 information below breaks down all incident activity into the types of incidents reported, the picture of incident reporting is changing in trend due to the implementation of the web based reporting, this is due to a number of reasons as below:-

- 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, i.e. this report includes information that was submitted the day prior to the generation of the report, previously before web based reporting, it would have not included incidents up to 10 working days before with the exception of serious incidents.
- 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 below.
- This may be evident in the data below 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 Board of Directors by the Group / Deputy Medical Director (Safety).

The data below tells a number of things as follows:-

- There is a direct correlation between violence and aggression and self harm, for a number of patients receiving services, the approaches to manage this activity and reduce or mitigate the impact are built into the positive and safe strategy in place within the Trust. The positive aspect of this is the majority of these incidents are low harm, due to the care plans and interventions of staff supporting the most complex patients in the Trust. We can see from other reports such as the physical assault on staff report that a lot of the activity is generated by a small number of patients in a small number of services.
- Some types of incidents have naturally increased due to staff knowing fully what to report as the web system gives them further help and clarity, and staff may have identified the correct categorisation of incident.

**Table 3 – Quarterly Comparison of all incidents by incident type**

| October - December 2014 | | October - December 2015 | | + / - |
|---|---|---|---|---|
| **Cause Group** | **2014-15** | **Cause Group** | **2015-16** | |
| Aggression And Violence | 2983 | Aggression And Violence | 3375 | +392 |
| AWOL And Abscond | 189 | AWOL And Abscond | 193 | +4 |
| Contractor/Public/Visitor Incident | 5 | Contractor/Public/Visitor Incident | 12 | +7 |
| Death | 227 | Death | 238 | +11 |
| Fire | 33 | Fire | 31 | -2 |
| Human Resources Process | 0 | Human Resources Process | 1 | +1 |
| Inappropriate Behaviour By Others | 6 | Inappropriate Behaviour By Others | 15 | +9 |
| Inappropriate Patient Behaviour | 379 | Inappropriate Patient Behaviour | 460 | +81 |
| Inappropriate Staff Behaviour | 12 | Inappropriate Staff Behaviour | 29 | +17 |
| Inappropriate Treatment | 8 | Inappropriate Treatment | 5 | -3 |
| Infection, Prevention And Control | 26 | Infection, Prevention And Control | 31 | +5 |
| Information Governance | 105 | Information Governance | 143 | +38 |
| Infrastructure | 28 | Infrastructure | 21 | -7 |
| Medical Device, Equipment | 10 | Medical Device, Equipment | 14 | +4 |
| Medication | 212 | Medication | 282 | +70 |
| Mental Health Act | 6 | Mental Health Act | 6 | 0 |
| Patient / Staff Safety | 2 | Patient / Staff Safety | 18 | +16 |
| Patient Accident | 724 | Patient Accident | 406 | -318 |
| Patient Clinical Issue | 12 | Patient Clinical Issue | 19 | +7 |
| Patient Ill Health | 395 | Patient Ill Health | 224 | -171 |
| Police Issue | 3 | Police Issue | 5 | +2 |
| Pressure Ulcer Inside NTW | 0 | Pressure Ulcer Inside NTW | 2 | +2 |
| Pressure Ulcer Outside NTW | 0 | Pressure Ulcer Outside NTW | 1 | +1 |
| Safeguarding | 679 | Safeguarding | 736 | +57 |
| Security | 395 | Security | 376 | -20 |
| Self Harm | 925 | Self Harm | 1302 | +377 |
| Service Delivery | 34 | Service Delivery | 31 | -3 |
| Staff Accident | 160 | Staff Accident | 120 | -40 |
| Staff And Patient Accident | 2 | Staff And Patient Accident | 2 | 0 |
| Staff Ill Health | 2 | Staff Ill Health | 3 | +3 |
| Unknown Patient Injury | 0 | Unknown Patient Injury | 79 | +79 |
| | **7562** | | **8180** | **+618** |

## Serious Incidents

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

### Table 4 – Annual Comparison of all serious incidents by incident type

| Number of serious incidents reported annually | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| Aggression And Violence | 8 | 2 | 6 |
| AWOL And Abscond | 3 | 1 | 1 |
| Death | 103 | 90 | 108 |
| Fire | 0 | 0 | 1 |
| Inappropriate Behaviour By Others | 0 | 0 | 1 |
| Inappropriate Treatment | 2 | 2 | 2 |
| Information Governance | 4 | 1 | 1 |
| Infrastructure | 1 | 1 | 0 |
| Medication | 0 | 0 | 1 |
| Mental Health Act | 0 | 0 | 1 |
| Patient Accident | 20 | 9 | 9 |
| Patient Ill Health | 1 | 0 | 2 |
| Safeguarding | 1 | 1 | 2 |
| Self Harm | 14 | 6 | 8 |
| **Totals** | **157** | **113** | **143** |

### Table 5 – Quarterly Comparison of all serious incidents by incident type

| Number of Serious Incidents reported in the period October - December | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| AA10 Absented Themselves During Escorted Leave | 1 | 0 | 0 |
| DE01 Unexpected Death | 26 | 23 | 14 |
| DE04 Alleged Homicide By A Patient | 0 | 1 | 1 |
| DE16 Alleged Homicide By A Patient To A Patient | 0 | 2 | 0 |
| DE18 Unexpected Death Local AAR | 0 | 0 | 16 |
| IN02 Loss Of Electricity | 1 | 0 | 0 |
| IT04 16-17 Admitted To Adult Ward | 0 | 2 | 1 |
| MH01 Amendable MHA Error | 0 | 0 | 1 |
| PA01 Patient Fall On Same Level | 0 | 1 | 1 |
| PA16 Struck By Moving Vehicle | 1 | 0 | 0 |
| PA18 Injury Cause Unknown | 1 | 0 | 0 |
| PA26 Fracture Neck Of Femur | 3 | 1 | 3 |
| PI01 Unexpected Deterioration In Health | 1 | 0 | 0 |
| SG23 MARAC | 1 | 0 | 0 |
| SH01 Actual Self Harm | 6 | 0 | 3 |
| SH02 Attempted Suicide | 0 | 1 | 0 |
| V01 Physical Assault Of Staff By Patient | 0 | 0 | 1 |
| V34 Alleged Physical Assault By Patient To Other | 1 | 0 | 0 |
| **Totals** | **42** | **31** | **41** |

In the above table the changes to the types of investigations carried out into unexpected deaths can clearly be seen, with 16 deaths reported subject to an After Action Review only. This was following discussion with Directors, 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 incidents through the National Reporting and Learning System.

The following table indicates the Coroner Conclusion (Outcomes) for the unexpected deaths reported over the last quarter, in comparison to previous years. More information relating to this is provided in the Unexpected Death report presented to Board of Directors separately.

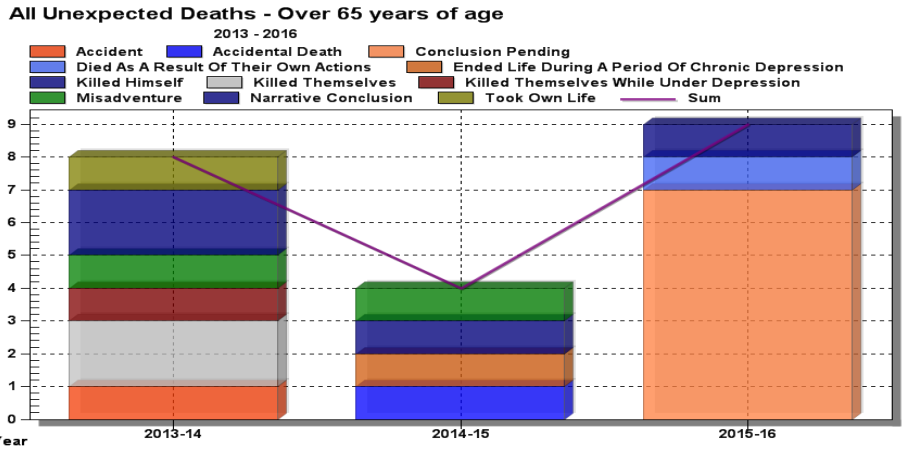
**Table 6 – Quarterly Comparison of all Unexpected Death by Coroner Conclusion**

| **Coroner Conclusion October - December** | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| Accidental Death | 1 | 2 | 0 |
| Accidental Toxic Effects Of Drugs And Alcohol | 1 | 0 | 0 |
| Action By Ward / Department | 0 | 0 | 1 |
| Conclusion Pending | 0 | 1 | 29 |
| Dependence On Drugs | 2 | 0 | 0 |
| Died As A Result Of Excess Alcohol | 0 | 1 | 0 |
| Drug Related Death | 1 | 1 | 0 |
| Drug/alcohol Related Death | 1 | 0 | 0 |
| Ended Life During A Period Of Chronic Depression | 0 | 1 | 0 |
| Killed Herself | 2 | 0 | 0 |
| Killed Himself | 4 | 1 | 0 |
| Killed Themselves While Under Depression | 0 | 1 | 0 |
| Misadventure | 7 | 6 | 0 |
| Narrative Conclusion | 1 | 2 | 0 |
| Natural Causes | 0 | 0 | 1 |
| Open Conclusion | 1 | 5 | 0 |
| Suicide | 4 | 3 | 0 |
| Took Own Life Due To Depression | 1 | 0 | 0 |
| **Totals** | **26** | **24** | **31** |

Whilst the full unexpected death report, completes the full analysis to highlight any areas of concern over time. It has been previously agreed to report on the following areas relating to unexpected deaths:-

- Unexpected deaths relating to self harm / cause unknown in over 65's.
- Unexpected deaths relating to Crisis and Home Treatment Services.
- Unexpected deaths relating to Addictions Services.
- Unexpected deaths relating to recent discharge from In-Patient Services.

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

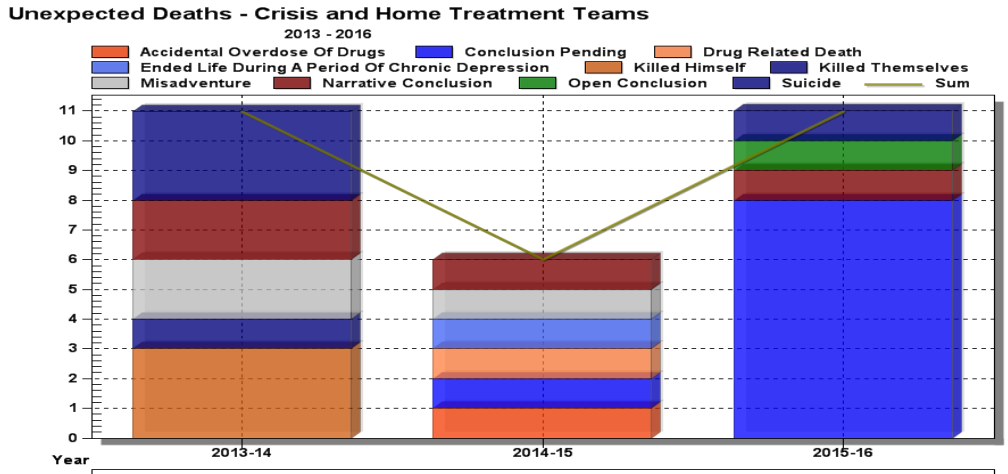



| Year | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| Accident | 1 | 0 | 0 |
| Accidental Death | 0 | 1 | 0 |
| Conclusion Pending | 0 | 0 | 7 |
| Died As A Result Of Their Own Actions | 0 | 0 | 1 |
| Ended Life During A Period Of Chronic Depression | 0 | 1 | 0 |
| Killed Himself | 0 | 1 | 0 |
| Killed Themselves | 2 | 0 | 0 |
| Killed Themselves While Under Depression | 1 | 0 | 0 |
| Misadventure | 1 | 1 | 0 |
| Narrative Conclusion | 2 | 0 | 1 |
| Took Own Life | 1 | 0 | 0 |
| Sum | 8 | 4 | 9 |

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, this activity will continue to be reported on.

**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.
It can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths, this activity will continue to be reported on.

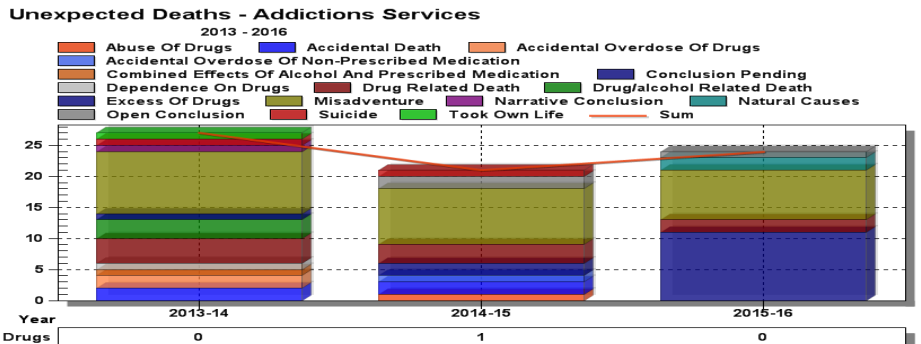



| | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| Accidental Overdose Of Drugs | 0 | 1 | 0 |
| Conclusion Pending | 0 | 1 | 8 |
| Drug Related Death | 0 | 1 | 0 |
| Ended Life During A Period Of Chronic Depression | 0 | 1 | 0 |
| Killed Himself | 3 | 0 | 0 |
| Killed Themselves | 1 | 0 | 0 |
| Misadventure | 2 | 1 | 0 |
| Narrative Conclusion | 2 | 1 | 1 |
| Open Conclusion | 0 | 0 | 1 |
| Suicide | 3 | 0 | 1 |
| Sum | 11 | 6 | 11 |

**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. It can be seen within 2015 / 16 data that the coroners outcome is not currently known for a number of deaths, this activity will continue to be reported on.

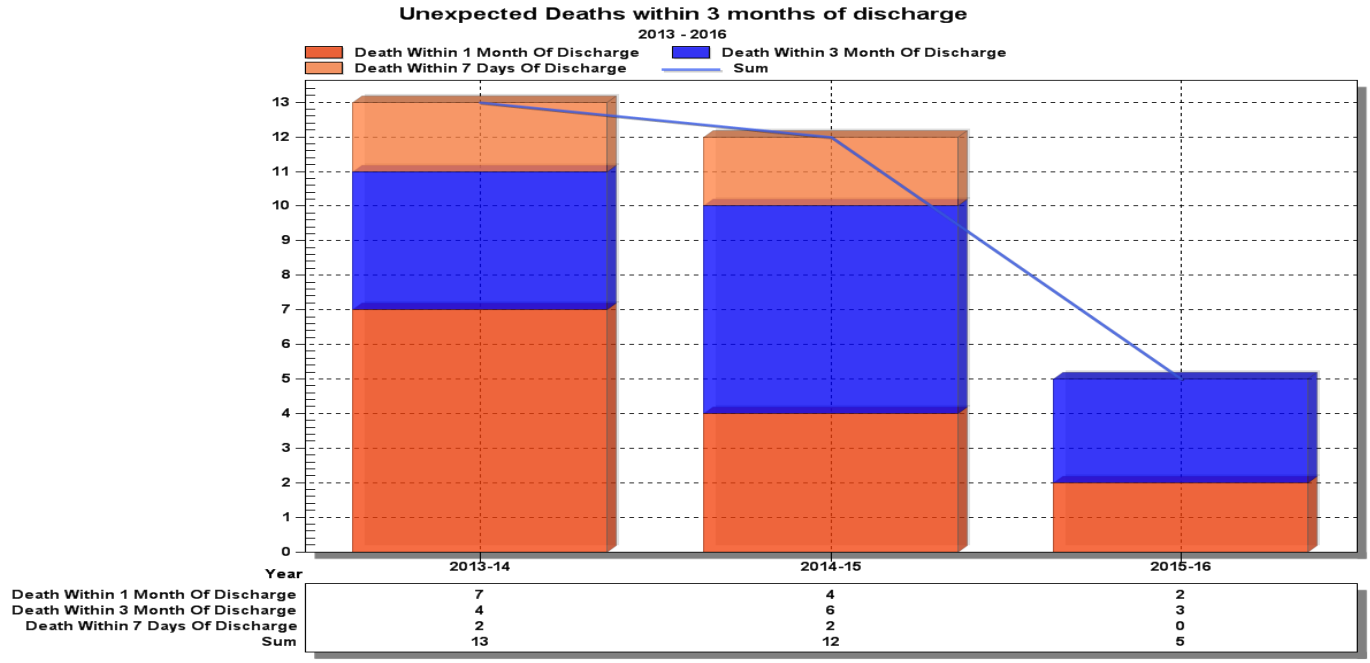



| | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| Abuse Of Drugs | 0 | 1 | 0 |
| Accidental Death | 2 | 2 | 0 |
| Accidental Overdose Of Drugs | 2 | 0 | 0 |
| Accidental Overdose Of Non-Prescribed Medication | 0 | 1 | 0 |
| Combined Effects Of Alcohol And Prescribed Medication | 1 | 0 | 0 |
| Conclusion Pending | 0 | 2 | 11 |
| Dependence On Drugs | 1 | 0 | 0 |
| Drug Related Death | 4 | 3 | 2 |
| Drug/alcohol Related Death | 3 | 0 | 0 |
| Excess Of Drugs | 1 | 0 | 0 |
| Misadventure | 10 | 9 | 8 |
| Narrative Conclusion | 1 | 0 | 0 |
| Natural Causes | 0 | 0 | 2 |
| Open Conclusion | 0 | 2 | 1 |
| Suicide | 1 | 1 | 0 |
| Took Own Life | 1 | 0 | 0 |
| Sum | 27 | 21 | 24 |

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

The following graph gives a breakdown of the unexpected deaths in the 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 7**

| Number of serious incidents reviewed | Oct - Dec 13 | Oct - Dec 14 | Oct - Dec 15 |
|---|---|---|---|
| | 35 | 39 | 27 |

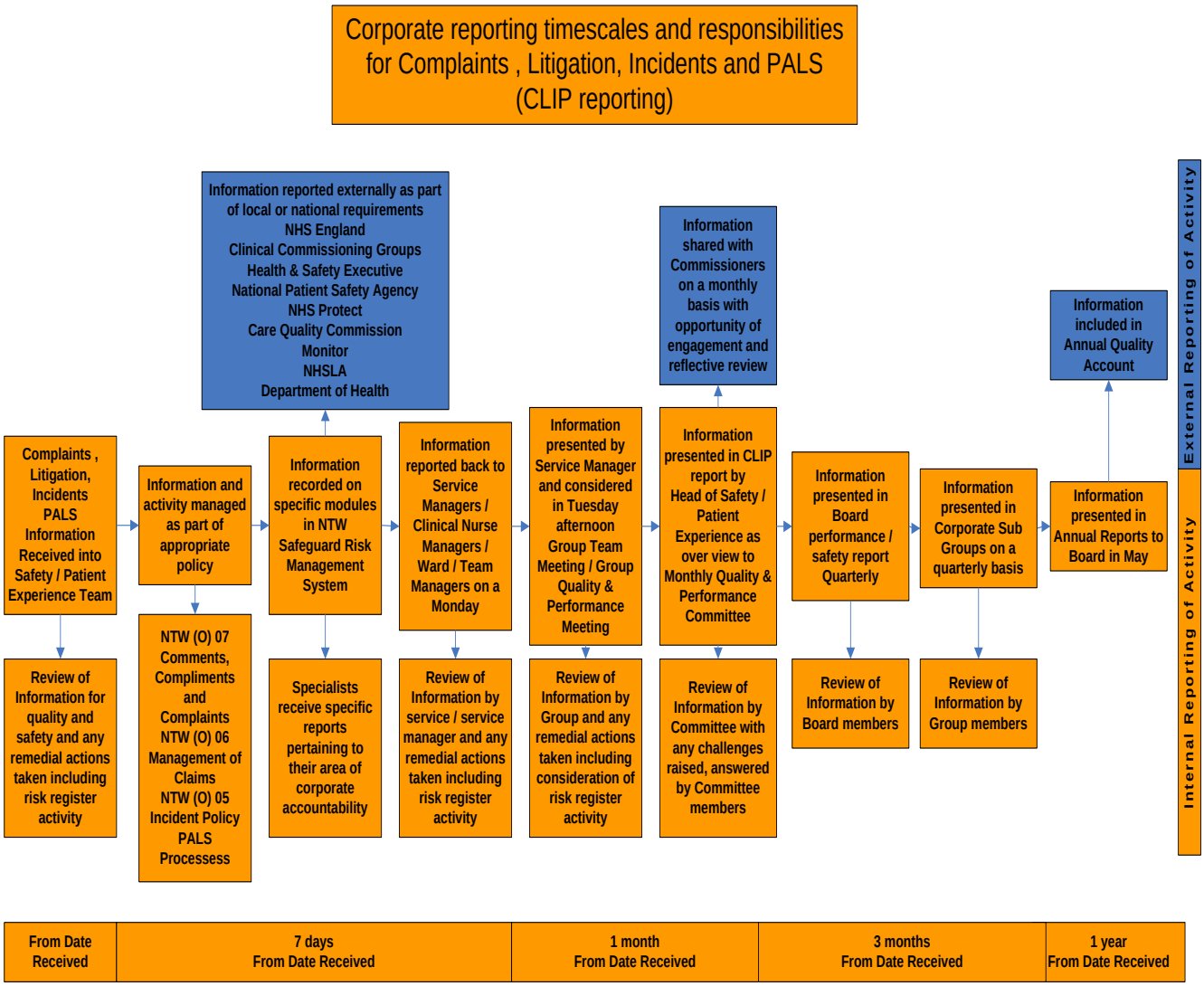
Whilst the number of reviewed incidents has reduced, this is in line with the reduction in the need for serious incidents to be reviewed by the full panel, many are completed with the local after action review only, and any supplementary actions picked up by individual services.

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.

## Identification of issues and Learning from Incidents

When activity is reported, in line with Trust policies, the learning from incidents occurs at different stages depending on the context and severity of incidents, the following chart gives an indication of the processes in place from the first 24 hours up to a full year review of incident activity, some based on review of 1 incident and annually more globally in comparison to year on year activity and in line with national reports and information.




Following this process, it can be seen how the Trust has implemented a number of activities to evaluate whether policies are working as intended to keep people safe and improve quality and safety of care. It is worthwhile mapping out the process when an incident occurs:-

**Learning within 24 Hours**

- The incident is reported through the web based interface in the majority of incidents within the Trust. The only incidents that occur are those that have been reported to the Trust directly from a Coroner's Officer prior to the team being informed, this only occurs for about 50 incidents out of 31,000 per year. This allows managers and any specialists who need to be notified that an incident has occurred.
- The nature of the incident will directly impact on the follow up action, for example a serious incident of unexpected death in Community Services, the immediate action is through our Duty of Candour processes, support families, carers and staff to come to terms with the loss, and support any agencies that are currently involved to understand the circumstances. However if there has been an in-patient unexpected death greater level of support may be required due to ongoing Police and possible Health & Safety Executive investigations.
- Within the first 24 hours, systems should have been stabilised, an assessment will have been carried out of whether there is a need to urgently communicate across the Trust through the Central Alert System, to inform other services of the risk of the incident re-occurring, there may be a consideration of creating a new risk through the risk management processes of the Trust. For any serious incident the service team are required to complete a 24 hour report, this indicates what they have done, who they have supported, how our responsibilities under Duty of Candour have been fulfilled. This report is sent to Group Directors so they are fully briefed about the incident.
- For any other incident managers will provide an update as they authorise the web based incident and submit it within the system, this provides assurances that all incidents within the Trust are being considered by managers, and appropriate action being taken, this is also an opportunity to see which patients may need more clinical support on in-patient wards, this is important as this is where 98% of the Trust's activity originates, and it is well recognised both locally and nationally that over 30% of this activity relates to aggression and violence.
- As part of immediate actions managers in partnership with the Safety Team of the Trust, can decide that it is important to cascade an outcome of the incident to other areas and teams. Examples of these alerts , are included in the Safety Messages section, but can also include CAS alerts to cover the following areas:-
    1. Any new type of illicit substance / Novel Psychoactive Substance ( legal high) that is currently circulating and the risks they pose.
    2. Any new type of ligature risk following a self harm episode, with advice / guidance and support.
    3. Issues to do with clinical practice following the review of an incident or number of incidents.
    4. Clarification to clinical teams about standards and practice where it is found that clinical standards have not been complied with i.e. observation, seclusion etc.
    5. Standardisation of incident collection, in order to inform other agencies of risks such as ambulance delays etc.

**Learning within 7 days**

- Reports are produced for clinical teams relating to all their incidents and disseminated by the electronic risk management system on a Monday morning, this gives managers an insight to the incidents that have occurred in the previous week in their services, so they can look for trends or increases in their activity.
- Every Friday the Trust's serious incidents, safeguarding issues, complaints and complex clinical issues are discussed with the Group Directors and the Executive Director of Nursing at the Group Business Meeting. The same information has been shared electronically and anonymously with operational leads, so teams are aware of the types of serious incidents and complaints that have occurred within the Trust.
- The same reports are shared with the Operational Groups, so the focus is then on their own activity and any initial concerns can be discussed and shared with the Service / Directorate Managers.
- Investigations for serious incidents commence and plans for After Action Reviews start to take place, to inform of other team focussed issues.

**Learning within 1 month**

- Serious incident investigations and After Action Reviews will be well underway, with teams considering local learning after reflection, at any point to this learning CAS alerts or Safety Messages can be sent out.
- Every month reports are produced that highlights the Trust activity from individual teams and clinical groups that are considered through the Clinical Groups Quality and Performance processes, as well as corporately through the Trust's Board Sub Committees such as Quality and Performance, this allows a monthly reflection , and a discussion around trends acknowledging that the detail and outcomes of incidents , complaints and claims may not be known at this stage.
- The Trust's Corporate Decisions Team, sub group that looks at quality, will review any significant issues arising from the Trust's activity.

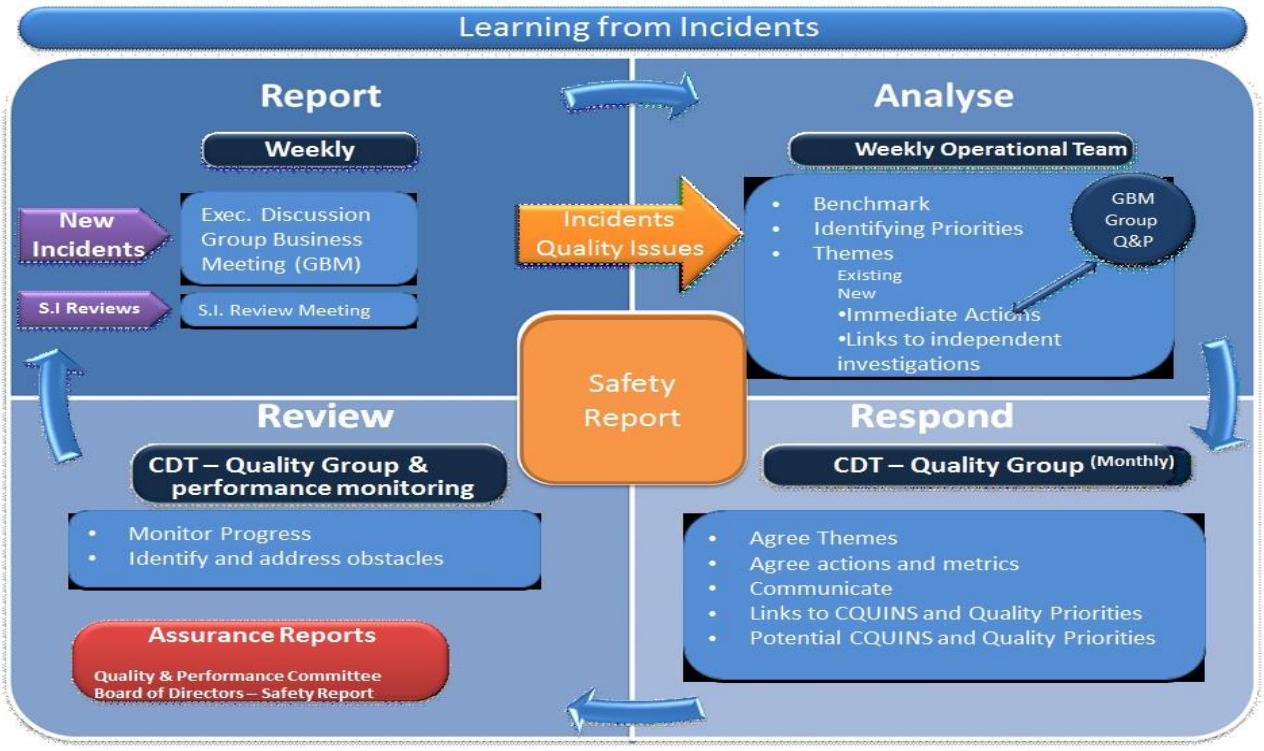
**Learning within 1 – 3 months**

- Many serious incidents and complaints investigations will be completed, with information fed back to families and carers, relating to the outcomes of the investigations. Action Plans will have been created and action will be actively managed within the services, along with discussions with Directors about the opportunities for improvements.
- Corporate meetings will have considered quarterly updates around incident activity in line with their terms of reference, such as Health , Safety and Security reviewing the physical assaults on staff, and other security related incidents. Medical Devices, Infection, Prevention and Control, Seclusion, Management of Violence and Aggression groups will also consider their specific incident information and consider any changes to policy and practice required.
- The Board of Directors receive this report, which outlines the activity for the last period, acknowledging the systems and processes in place within the Trust, and an update around increases or decreases to specific serious incident activity over the last quarter , but also with a longer look back of 5, 3 and 2 years specific to historical data.

**Learning annually**

- The Trust considers its activity in line with national data such as the National Reporting Learning System, with reports produced by the North East Quality Observatory every year and presented to the Quality and Performance Committee, this compares, loosely the activity of the Trust in comparison to other Trust's in the Mental Health Cluster.
- The Trust provides and update on the annual figures of Reported Physical Assaults in the month of January to the Board of Directors, so the Board can assess and understand the Trust's activity in respect of similar sized Trust's and understand why the Trust reports the high level of activity it has.
- The Board of Directors receives and annual report in respect of Security Management , to understand the types of security incidents the Trust gets exposed to and the role of the Local Security Management Specialists in aiming prevent and deter further incident activity, utilising such things as CCTV, Security Systems, Lone Working Devices etc.
- The Quality and Performance Committee receives annual information relating to Claims and benchmarking from the National Health Litigation Service, relating to the Trust's Claims profile.
- The Quality and Performance Committee receives annual information relating to the Parliamentary Health Service Ombudsman reported and investigated complaints, with detail around whether they have independently upheld complaints received.
- The Trust reflects on its incident activity in its annual quality account received by all members of the Trust, to review the culture of reporting. This allows for independent scrutiny from external stakeholders.

All of the above information and learning that takes place at every level, allows the external Commissioners to be assured that we have robust systems in place for reflection and learning, and the necessary improvements to quality and safety of care.
**The following chart indicates visually the learning systems following the path of incidents and complaints.**



**Issues Identified from Serious Incident Panels following review throughout Quarter 3.**

Issues can be defined through review of incidents, complaints or from other sources of information, judged to be a suitable areas for improvement actions, which can potentially lead to quality and safety improvements.

Throughout 2015/ 16 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 issues.

There are a number of recurring issues 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 issues 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 27 serious incidents reviewed for 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. , The Trust has 40,000 patient contacts 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 issues if they are only identified in a small number of reviewed incidents.

For quarter 3 reviews out of the 27 serious incidents there were 11 key areas where issues were identified as below:-

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

All Aspects of Clinical Treatment

All aspects of clinical treatment was an issue in 9 of the 27 serious incidents, 6 of which were unexpected deaths, 2 of which were alleged homicides by patients, and 1 of which was an unexpected deterioration of a patient physically.

Communication

Only 4 incidents in the quarter relate to issues of communication, this is an improving picture. 1 of the incidents was and alleged homicide by a patient, and there were 3 unexpected deaths.

Falls

The Trust continues to monitor the management of falls in line with the Falls Policy, and review serious incidents such as fractures, only 1 incident relating to falls was reviewed in this quarter. This is a significant reduction of previous quarters and indicates not only a reduction of fractures but also a reduction of issues relating to fractures.

Good / Appropriate Practice

For 10 of the serious incidents good / appropriate practice was noted in the serious incident review which resulted in no further actions for the services that provided the care.

Incidents with External Issues

For 5 incidents there were external issues, this can be a range of issues relating to GP engagement, acute Trust engagement and also third sector / voluntary and housing issues and identifies the close working relationship the Trust has with external partners when it is provided co-ordinated care for patients.

Individual Practice Issues

It is acknowledged that irrespective of the value and behaviours within the Trust, our systems of reflection will identify where clinicians and other staff have not achieved the standards we would expect of them. For quarter 3 this only occurred in 1 out of 27 incidents, and the operational aspects of this have been picked up and actioned.

Medicines Management

There were 3 out of 27 incidents where medicines management issues were identified and appropriately addressed, again this area has seen a significant reduction of issues from those previously reported, and is a positive, given all patients are generally prescribed medication as part of their treatment.

Record Keeping

Record keeping issues were identified in 5 of 27 serious incidents, and were not serious by their own nature, or they would have shown equally in the practice issues above, none the less each issue where appropriate clinical standards for recording have not been met are picked up in individual clinical supervision sessions.

Risk Assessment and Management

Risk assessment and management issues is always likely to feature in incident reviews and improvements, given the difficulty of predicting risk, and the dynamic nature in each patients care, this issue featured in 12 out of 27 incidents, all but 1 were community related incidents further indicating the difficulty to predict and manage risk in community services, and included 2 homicides by patients, 6 unexpected deaths, 1 physical assault and 1 self harm episode. It is widely acknowledged the difficulty both in local and national investigation reports of fully mitigating this issue when providing care to complex patients who are high violence or suicide risk.

Safeguarding

Safeguarding was identified in 4 out of the 27 cases, however as an assurance it is also one of the most increased types of incidents reported in the Trust, which would then seem s likely that issues relating to safeguarding are going to present.

Staffing levels

Staffing levels was identified in 2 out of 27 incidents, which is a reduction from previous quarters, and these serious incidents were in different clinical Directorates, so there was nothing to relate to the identified issues.

All of the above issues are included in the appropriate action plans, which are governed by the sub groups of the clinical groups, before sign off and sent to the Patient Safety Group for assessment and closure prior to sending to the Clinical Commissioning Groups.

**Independent Investigations Summary**

The Trust is awaiting the final publication dates of 2 independent investigations from NHS England, these have already been considered by the Clinical Groups of the Trust and the Trust's Quality and Performance Committee. The provisional publication date for the reports relating to Mr A and Mr B is Monday 25th January 2016.

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

## 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.

## 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

## 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.

The initial draft of the plan has been discussed through the Corporate Decision Team – Quality Sub Group and the final version is due to be submitted by the end of March 2016.

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 7 open cases.

**1** request was made for information in December 2015

| Case number | PHSO reference | Opened | Current Status | Trust Outcome | Current Update |
|---|---|---|---|---|---|
| **IP 2385** | 236833 | 07.12.15 | Request for further info | Partially upheld then re-opened and partially upheld | By 08.01.16 |

**6** cases are currently under review and the Trust awaits the outcome.

| Case number | PHSO reference | Opened | Current Status | Trust Outcome | Current Update |
|---|---|---|---|---|---|
| C 2604 | 236129 | 11.11.15 | Request for files | Not upheld and partially upheld | Sent 19.11.15 |
| C 2571 | 233304 | 18.11.15 | Request for files | Partially Upheld | Intention to Investigate 18.11.15 |
| | | | | | |
| 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 2620 | 235697 | 26.10.15 | Request for files | Not Upheld | Sent 10.11.15 |
| | | | | | |
| IP 2084 | 199797 | 17.10.14 | PHSO Open | Upheld | Draft Report received 23.10.15 – Partially Upheld – Awaiting final report |

There were 2 cases closed in December 2015.

| Case number | PHSO reference | Opened | Closed | Trust Outcome | PHSO Outcome |
|---|---|---|---|---|---|
| S 2535 | 221171 | 30.06.15 | 29.12.15 | Partially Upheld | Closed – not upheld |
| C 1942 | 209870 | 25.02.15 | 24.12.15 | Partially upheld then re-opened and partially upheld | Closed – upheld |

**Appendices**:

Appendix 1 Glossary of Terms
Appendix 2 Safety Messages and Internal CAS Alerts – October - December 2015
Appendix 3 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.

**Issue –** A recurring or emergent issue of notable concern identified from a reflection of a single serious incident or a number of less serious incidents.

## *Reconciliation of RiO medication, Sensitivities & Allergies form and the kardex prescription chart at the point of discharge from in-patient wards*

***Reference No.*** NTW/INT/2015/031 ***Date Issued*** 01/10/2015

Internal CAS Safety Alert; NTW/INT/2015/031
Reconciliation of RiO medication, Sensitivities & Allergies form and the
kardex prescription chart at the point of discharge from in-patient wards
Sent on behalf of;
Dr Damian Robinson
Group Medical Director - Inpatient Services
Director for Infection, Prevention & Control and EPRR
Service Managers; please circulate the below CAS message to all your clinical staff.

Dear colleagues

You may recall that in June of 2014 a message was sent to all clinical staff regarding the reconciliation of the RiO Medication, sensitivities and allergies form and kardex prescription charts for in-patients at the point of discharge. This was followed in August by a further message advising that, as a result of an audit, the link between the RiO Medication form and the discharge summary/letter was being temporarily broken, and that medication on discharge would have to be manually entered. It was also noted that the requirement to maintain accurate reconciliation of the RiO Medication form and the kardex remained unchanged.

It has become apparent that that link was re-established on 27th July 2015 as part of preparations for the introduction of the electronic transfer of the discharge letter to the GP which is due to start on 1st October 2015 (faxes are no longer permitted).

Since that reintroduction there have been further incidents where the RiO Medication form has not been reconciled at the point of discharge and therefore incorrect medication information has been pulled through to the printed discharge letter. Reconciliation becomes all the more important with the introduction of electronic transfer of the discharge letter as there may be less of an opportunity to spot or correct an error before sending.

Following a review of the risks which this issue and any remedial actions might present to services users, a decision has been made to continue with the active link currently, although some minor changes are being made to make it clearer that the Current Medication link must be used to update medication.

Therefore, it is very important that the following guidance is followed immediately.

All qualified clinical staff on in-patient wards, and particularly senior and junior medical staff, must ensure that the following actions take place:-

1) The Medication, sensitivities and allergies page of RiO is updated whenever the kardex is changed but, as a minimum, at the point of admission and discharge from any inpatient ward.

2) Check that the medication information pulled through to the printed mental health discharge letter is correct. The information on the printed discharge letter, prescription kardex and the medication, sensitivities and allergies page of RiO must be identical and must be reconciled at the point of discharge.

3) Consultant medical staff on in-patient wards must ensure that all discharge summaries and letters sent since 27th July 2015 have been checked and reconciled with the kardex at the time of discharge to identify any errors which may have occurred. A list of such patients will be produced centrally and sent to individual consultants. This task can be delegated to junior medical or senior nursing staff.

4) Any potential errors or confusion identified must be checked with the GP or prescriber since discharge. Any errors identified must be reported on an IR2 form or through electronic Safeguard reporting.

Please note that it is the professional responsibility of the person signing off or sending the discharge letter to ensure that all of the information contained within it is correct.

Please urgently share this alert with other staff involved in producing discharge letters/summaries.

## *Drug alert warning - 'Pinkies' and Concerns around the use of benzodiazepines*

***Reference No.*** NTW/INT/2015/032 ***Date Issued*** 13/10/2015

Internal CAS Safety Alert; NTW/INT/2015/032
Drug alert warning
'Pinkies' and Concerns around the use of benzodiazepines
For Information
Service Managers; please circulate this message and attached posters to all staff in your clinical areas.
Dear colleagues
Please find attached 2 drug warning posters, received from Northumbria Police.
Please print as required and display the posters in staff and public areas in your work place.
Regards.
CASNTW@Ntw.Nhs.Uk

## *Samaritans launches new free helpline phone number*

***Reference No.*** NTW/INT/2015/033 ***Date Issued*** 14/10/2015

Internal CAS Safety Alert; NTW/INT/2015/033
Samaritans launches new free helpline phone number
Sent on behalf of;
Claire Taylor
Clinical Risk Manager
For information
Service Managers; please circulate this message to all staff in your clinical areas, who can offer out this information as required.
Dear colleagues
Calling Samaritans is now free of charge from a landline or mobile.
Their new number is;

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116123
For further information on the Samaritans, please use the following link to their website.

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http://www.samaritans.org/
Regards.
CASNTW@Ntw.Nhs.Uk

## *Reporting of staff suspensions on incident forms*

***Reference No.*** NTW/INT/2015/034 ***Date Issued*** 16/10/2015

Internal CAS Safety Alert; NTW/INT/2015/034
Reporting of staff suspensions on incident forms
Sent on behalf of;
Tony Gray
Head of Safety and Patient Experience
For information
Service Managers; please circulate the below information to clinical and admin staff in your service areas.
Dear colleagues
With the full rollout of web based incident reporting, we need to ensure that confidentiality is maintained for the reporting of staff suspensions on an incident form.
Whilst the Safety and Project Teams work on a way to facilitate this through the web, can all Service Managers continue to report staff suspensions on the electronic version of the IR1 (attached) and email through to incidentandclaimsdepartment@ntw.nhs.uk
Any queries relating to this, please contact Tony Gray in the first instance.
Regards.
CASNTW@Ntw.Nhs.Uk

***Purchasing of Medical Devices***

***Reference No.*** NTW/INT/2015/035 ***Date Issued*** 21/10/2015

Internal CAS Safety Alert; NTW/INT/2015/035
Purchasing of Medical Devices
Sent on behalf of;
Tony Gray
Head of Safety and Patient Experience
Would Service Managers circulate the below information to all staff in their service areas please
Dear colleagues
Following discussion at the recent Medical Devices Safety Management Group, it became apparent that some wards or departments may still be ordering medical devices from non-Trust approved areas, separate to the normal supplies route.
Advice relating to the specification and ordering of medical devices, within the Trust, can be obtained by contacting;

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Donna Stanley, Medical Devices Safety Manager, through the Trust email; donna.stanley@ntw.nhs.uk or alternatively; MedicalDeviceADM@ntw.nhs.uk
All purchasing will be organised as standard through our supplies team and further advice on this can be obtained from Bob Waddell, Supplies Manager, or a member of his team.
Regards.
CASNTW@Ntw.Nhs.Uk

***MAC 800 ECG Unit***

***Reference No.*** NTW/INT/2015/036 ***Date Issued*** 21/10/2015

Internal CAS Safety Alert; NTW/INT/2015/036
MAC 800 ECG Unit
Sent on behalf of;
Kevin Crompton
Specialist Trainer
For information
Would Service Managers circulate the below information to clinical staff in their service areas please
Dear colleagues
NTW has removed the ECG save function on all ECG models across NTW and expect staff to follow the standard information governance protocol to delete the service users details following ECG acquisition.
This is covered in all NTW ECG training sessions:

1 Individual service user details matches the ECG request
2 Check the ECG unit has no previous/current stored service user details
3 Input the service users details
4 Perform the ECG recording and print tracing
5 On successful completion of ECG recording delete the service users details

We are aware however that potentially in some ECG Units following individual ECG acquisition the 'Delete Function' randomly may not work and if this is occurring clinically in your area you may need to repeat the above functions:
2. Check the ECG unit has no previous/current stored service user details
5. On successful completion of ECG recording delete the service users details in the protocol.
Further you will need to identify as an IR1 and contact:
John Riddle
Clinical Technologist H&S Coordinator/Risk Manager
Medical Physics Dept. Freeman Hospital. NE7 7DN
Tel 0191 2826485/ 48056
This issue is currently being reviewed by G.E. Medical Systems but if you require any further information contact:
Kevin Crompton
Kevin.crompton@ntw.nhs.uk
Regards.
CASNTW@Ntw.Nhs.Uk

***Recording information re; other attendees at patient appointments***

***Reference No.*** NTW/INT/2015/037 ***Date Issued*** 27/10/2015

Internal CAS Safety Alert; NTW/INT/2015/037
Recording information re; other attendees at patient appointments
Sent on behalf of;
Vida Morris
Group Nurse Director, Inpatient Care
For information
Would Service Managers circulate the below CAS message to all clinical staff in their service areas please.
Dear colleagues
It is extremely important that frontline clinical staff record information pertaining to patients who have given consent for other attendees to be at their appointments with them, whether this is in a clinical setting, the patient's own home and in all other environments where patients are seen.
This 'intelligence' might be critical to informing the Risk Assessment.
Of particular importance is the documentation of consent provided, the name of the individual(s) nature of their relationship and whether they might be living in the same household.
The need for this has been reinforced through findings from Incident and Serious Case review, where opportunities to assess potential risk were missed, as this information was not recorded and/or not able to be shared with other key agencies.
In situations where this information is refused, then this refusal should then be recorded in the clinical record.
Regards.
CASNTW@Ntw.Nhs.Uk

## *RiO Notification of Planned System Downtime*

***Reference No.*** NTW/INT/2015/038 ***Date Issued*** 06/11/2015

Internal CAS Safety Alert; NTW/INT/2015/038
RiO Notification of Planned System Downtime
Sent on behalf of;
Lynsey Howe
Project Lead
Customer Operations Team, Informatics Department
Service Manager; please circulate this important message and attached document to all staff in your clinical areas
Dear colleagues
This is to confirm the RiO downtime next weekend for the archive of audit trail information.
We expect that there will be approximately 24 hours of downtime, starting at 2pm on Saturday 14th November.
Regards.
CASNTW@Ntw.Nhs.Uk

## *RiO Notification of Planned System Downtime*

***Reference No.*** NTW/INT/2015/040 ***Date Issued*** 13/11/2015

Internal CAS Safety Alert; NTW/INT/2015/040
RiO Notification of Planned System Downtime
Sent on behalf of;
Lynsey Howe
Project Lead
Customer Operations Team, Informatics Department
Service Manager; please circulate this important message and attached document to all staff in your clinical areas.
Dear colleagues
This is to confirm the RiO downtime this weekend for the archive of audit trail information.
We expect that there will be approximately 24 hours of downtime, starting at 2pm on Saturday 14th November. Please contact RiOsupport@ntw.nhs.uk or 07919 881 439 if you have any queries.
Regards.
CASNTW@Ntw.Nhs.Uk

## *Controlled Drugs (Schedule 2,3 and 4 Part 1) - New method for destruction*

***Reference No.*** NTW/INT/2015/041 ***Date Issued*** 16/11/2015

Internal CAS Safety Alert; NTW/INT/2015/041
Controlled Drugs (Schedule 2,3 and 4 Part 1)
New method for destruction
Sent on behalf of;
Tim Donaldson
Chief Pharmacist/Controlled Drugs Accountable Officer
For Information and action
Would Service Managers please circulate the below CAS Safety Alert message and attached memo to all clinical staff in their service areas.
Dear colleagues
In accordance with changes recently made to Medicines Management Policy guidance on controlled drugs UHM-PGN-04, the way we destroy expired or part-used stock Controlled Drugs (Schedule 2, 3 and 4 Part 1) in clinical areas is changing. These changes are required to ensure improved security of controlled drug management and to protect staff and patients.
Regards.
CASNTW@Ntw.Nhs.Uk

***TAeR System Downtime***

***Reference No.*** NTW/INT/2015/042 ***Date Issued*** 16/11/2015

Internal CAS Safety Alert; NTW/INT/2015/042
TAeR System Downtime
Sent on behalf of;
Deborah Campbell, Project Lead
Informatics Customer Operations Department
For information
Would Service Managers please circulate the below CAS Safety Alert message and attached information to all staff in their inpatient service areas.
Dear colleagues
This is to confirm the TAeR (Time Attendance and eRostering) system downtime next week for the system upgrade.
We expect that there will be approximately 6 hours of downtime, starting at 10:30am on Tuesday 24th November 2015 until approximately 4:30pm on Tuesday 24th November 2015.
Regards.
CASNTW@Ntw.Nhs.Uk

***Novel Psychoactive Substance (so called 'legal high') - 'Sweet Leaf obliteration'***

***Reference No.*** NTW/INT/2015/039 ***Date Issued*** 16/11/2015

Internal CAS Safety Alert; NTW/INT/2015/039
Novel Psychoactive Substance (so called 'legal high')
'Sweet Leaf Obliteration'
For information
Would Service Managers please circulate the below CAS Safety Alert message and attached warning notice to all staff in their service areas.
Dear colleagues
We have had reports from providers and Northumbria Police about an Novel Psychoactive Substance (so called 'legal high') - 'sweet leaf obliteration' which is stated to be linked to a number of issues with clients - including overdose, suspected psychosis, and other health issues.
A drug warning is attached for you to display in relevant areas, share with staff or share with relevant organisations.
The substance is a synthetic cannabinoid and is said to drop blood sugar levels to a very low level and effects include racing heartbeat, palpitations, chest pain, users may also experience central nervous system effects including tremor, agitation or drowsiness, anxiety, changes in perception, psychosis as well as difficulty breathing, dilated pupils, vomiting, and visual disturbances.
Regards.
CASNTW@Ntw.Nhs.Uk

## *Web-based incident reporting of pressure ulcers*

***Reference No.*** NTW/INT/2015/043 ***Date Issued*** 18/11/2015

Internal CAS Safety Alert; NTW/INT/2015/043
Web-based incident reporting of pressure ulcers
Sent on behalf of;
Kevin Chapman
Tissue Viability - Modern Matron
For information
Would Service Managers please circulate the below CAS Safety Alert message and attached document to all clinical staff in their service areas.
Dear all
On Thursday 19th November 2015 the Web-based Incident Reporting of pressure ulcers will go live across all sites with additions below to the reporting framework.
Staff reporting pressure ulcer damage will have a pictorial / visual based aid to help them identify more accurately the classification / staging of pressure ulcers.
Regards.
CASNTW@Ntw.Nhs.Uk

***Antibiotics Awareness***

***Reference No.*** NTW/INT/2015/044 ***Date Issued*** 18/11/2015

Internal CAS Safety Alert; NTW/INT/2015/044
Antibiotics Awareness
Sent on behalf of;
Anne Moore, DIPC
Group Medical and Nursing Directors and Pharmacy
Important message for action
Would Service Managers please circulate the below CAS Safety Alert message and attached documents to all clinical staff in their service areas.
Dear colleagues
In the modern clinical environment we, as practitioners, recognise the importance of the range of antibiotics available to us. In order to protect the value of these medications as weapons in the fight against infectious disease we must extend this recognition to the importance of appropriate use and the implications of ignoring good practice.
In order to help prevent the development of antibiotic resistance we employ various procedures to ensure good practice is being followed and undertaken. Measures that are expected of prescribers working within NTW include:

- Prescribing antibiotics only when a bacterial infection has been established or is strongly suspected (IPC team or microbiologist advice should be sought as soon as possible)
- Prescribing antibiotics according to sample cultures where possible as opposed to 'blind' prescribing of broad-spectrum drugs
- Documenting clearly the name, dose, frequency, route and duration of therapy. Stop-dates or review-dates (every five days maximum) must be agreed from the initiation of treatment and kardexes annotated to reflect such decisions
- Kardexes annotated to state the reason for antibiotic prescription (within reason - for example 'UTI' or 'LRTI')
- Use of Trust documentation to record use of restricted antibiotics and their indications for therapy

More information may be found via the Trust intranet in the Antibiotic Prescribing Guide (IPC PGN-15) and a handy reminder checklist for prescribers encouraging us all to 'Start Smart Then Focus' is attached to this email. Please contact the Infection Prevention and Control team or the Pharmacy team for any further information required.
Finally, please have a go at the attached quiz regarding antibiotic prescriptions. And don't be fooled by the easy start!

***Cold weather alert - escalation to Level 2 of the National Cold Weather Plan for England - Alert and Readiness***

***Reference No.*** NTW/INT/2015/045 ***Date Issued*** 19/11/2015

Internal CAS Safety Alert; NTW/INT/2015/045
Cold weather alert - escalation to Level 2 of the National Cold Weather Plan for England
Alert and Readiness
Sent on behalf of;
Russell Patton
Director of Emergency Preparedness, Resilience and Response
For information
For circulation to all staff in all units, wards and departments
Dear colleagues
This is to advise of the escalation to Level 2 of the National Cold Weather Plan for England, with a 60% probability of severe cold weather and icy conditions between 2100 on Friday 20 November and 0900 on Monday 23 November.
This weather could increase the health risks to vulnerable patients and disrupt the delivery of services. At risk groups include over 75's and those with severe mental illness, dementia or learning difficulties.
All Operational Managers are asked to ensure that the following actions are undertaken:

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Ensure that all those at high risk from cold weather have been identified and that arrangements are in place to visit or contact them and take appropriate action to protect them against severe weather.

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When visiting clients check room temperature to ensure that clients are warm. Ensure that they have at least one room which meets recommended room temperatures (21°C degrees day and 18°C night)

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Also check that clients have supplies of food and medication.

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Remind clients of the action they can take to protect themselves from the effects of severe cold.

_
Consider how the forecast weather conditions might impact on your work (for example, snow and icy roads delaying home visits).
Advice for ensuring patients and residents remain warm is available at www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx

***Industrial Action; Tuesday 1st December 2015***

***Reference No.*** NTW/INT/2015/046 ***Date Issued*** 30/11/2015

Internal CAS Safety Alert; NTW/INT/2015/046
Industrial Action; Tuesday 1st December 2015
Sent on behalf of;
Amanda Venner
Medical Workforce Manager
Medical Education, Development & Workforce Team
Workforce & OD Directorate
For action
Would Service Managers please read the below CAS message and action the appropriate points as requested.
Dear colleagues
Industrial Action Tuesday 1st December 2015
Actions needed by Service Managers
Although talks have resumed between the BMA and the Government we are still planning for 24hrs of strike action by Junior Drs on 1st December. Those Junior Drs attending work will provide emergency cover only.
This alert provides further information and instructions for managers on how to feedback information to the command centre and contact information. Please note that some action is needed by no later than 9.30 am on Tuesday morning.
Could all service managers respond to the following three questions for each area within your scope of responsibility by e-mailing to eoc@ntw.nhs.uk

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Have you had to close or suspend any services?

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Are there any Jnr Dr's on site in your area and if so who?

_
Have there been any adverse effects on services to date?
Responses are required at the following times:

_
Position at 9.00 am on Tuesday - to be e-mailed to eoc@ntw.nhs.uk by 9.30 am as this needs to be reported nationally no later than 10.30 am.

_
Position at 5.00 pm on Tuesday - to be emailed to eoc@ntw.nhs.uk by 5.30 pm as this needs to be reported nationally no later than 6.30 pm.
Please see attached a Link to the list of those doctors who have indicated that they intend to be at work on Tuesday and their current rota/work areas. (This information can only be accessed by the Service Managers and a number of delegated senior & medical managers) The command centre will notify you of any changes which come to our attention as soon as possible on Tuesday.
Contact Information
Command Centre (0191 2466801 / 0191 2466803) Ground Floor Meeting Room at St Nicholas House. Main Switchboard (0191 213 0151)
The Command Centre will be operational from 9.00 am on Tuesday.

***Spotlight on Information Governance; keeping patient and staff personal information confidential***

***Reference No.*** SMIG65/241115 ***Date Issued*** 24/11/2015

The routine promises we make to keep our patients' and our staffs' personal information confidential are key to the trusting relationship we need to have with them. If we break that promise we risk losing that trust permanently. Consequently, Dr Douglas Gee, Caldicott Guardian and Lisa Quinn, Security Information Risk Officer (SIRO), regularly review the information governance incidents that staff report every week, they examine these for themes which might show areas where the Trust can improve.

Over the next few weeks we will be focusing on a different theme and providing advice and guidance so that we can all work towards reducing the risk of an IG incident occurring together. Our first theme was chosen due to the high number of IG incidents which have been reported where by person identifiable information has been inappropriately disclosed due to incorrect addresses being used or incorrect information being recorded into a patient's health record or a staff personal file.

This identifies two key factors:

? The need for quality, up to date and accurate information in our RiO system (Patient Information System) and ESR system (Electronic staff record) at all times.

? For staff to be vigilant when entering information into these systems to ensure they are entering the correct data into the correct person's records.

Both the above can cause issues if the incorrect address is used or incorrect data is included in a record and could have the potential to result in an IG breach. No other systems should be used to record contact details apart from the RiO system for patients and ESR for Staff.

Care should be taken when addressing letters to ensure that the correct contact details are used. In the case of contacting patients it is possible by using the pull-through functionality of RiO and the use of windowed envelopes to minimise this risk. Remember, windowed envelopes reduce the risk of a letter being misdirected and should be used for all correspondence whether it is patient or staff. Below is a reminder of what staff should be following when sending out personal correspondence via post.

We all have a legal requirement under the Data Protection Act 1998 for personal information and duty of care to our patients to ensure that the information we are trusted with is kept secure, up to date and accurate therefore please ensure you take the time to validate the information we hold and use.

If you have any queries or suggestions about Information Governance please contact the Information Governance Department on extension 66892 or the Caldicott Team on extension 56688.

## *Spotlight on Information Governance; Data Protection Act 1989 and a person's right to access their health records*

***Reference No.*** SMIG66/011215 ***Date Issued*** 01/12/2015

Data Protection Act 1998 and a person's right to access their health records.
Under the Data Protection Act 1998, an individual can request access to all their health records held by a NHS organisation. This is called a 'subject access request' and the NHS organisation must ensure that they adhere to the legislated time scale of 40 days in replying to the request. Therefore, the Trust must ensure that where possible the 'subject access request' process for our service users is easy to follow and that they receive the information they have requested within the time scale of 40 days subject to certain exemptions.
This type of 'subject access request' is processed by the Disclosure Team who are based within the Records Department at St Nicholas Hospital.
To assist with the process, any requests for health information relating to a service user received by a team or department, either via post or email should be forwarded to the Disclosure Team as soon as possible. If the request is by letter, then we would appreciate if you could scan the letter along with any attached documents (e.g. consent forms) and forward it to the Disclosure Team via email. Then post the original letter and attached documents to the Disclosure Team, (contact details below). This means the process can be started without any delays as the 40 day time rule starts the day the request is received into the Trust. Requests for access to health information are also received into the Trust which have been made by persons acting on behalf of a service user (third parties). These are usually relatives, solicitors or advocates.
If you have any questions around the process or are not sure whether it is a health information request you have received, then please contact the Disclosure Team using the contact details below.
If you are approached by a service user who would like to access their health records and is unsure of the process, you can contact the Disclosure Team who will provide you with advice on what information they require to start the process off. All requests for access to health information must be made in writing and to assist with the process the Disclosure Team will ask the service user to complete an application form. There is also a patient information leaflet which you can provide the service user to assist with their request and this can be found on the Patient Information section of the Trust's Internet site.
Any requests for health information requested by the Police, Courts or Local Authorities should be sent to the Caldicott and Legal Affairs team, who are based at St Nicholas House, St Nicholas Hospital.
Contact details:
For Service User and Third party requests
Disclosure Team, Records Department, St Nicholas Hospital, Jubilee Road, Gosforth, NE3 3XT
Internal Email Address: Disclosures@ntw.nhs.uk
External Email Address: NTAWNT.Disclosures@nhs.net
Telephone number: 0191 246 6896 (Internal 66896)
For Police, Court and Local Authority Health information requests
Caldicott and Legal Affairs Team, St Nicholas House, St Nicholas Hospital, Jubilee Road, Gosforth, NE3 3XT.
Telephone number: 0191 245 6688 (Internal 56688)

## Reporting Ambulance Delays

**Reference No.** NTW/INT/2015/047 **Date Issued** 04/12/2015

Internal CAS Safety Alert; NTW/INT/2015/047
Reporting of Ambulance Delays
Sent on behalf of;
Tony Gray
Head of Safety / Patient Experience
Would Service Managers / Managers please read the below CAS message and ensure action the appropriate actions are put in place to ensure that incidents of ambulance delays are reported through the Trust's web based reporting system.
Dear Colleagues
It has been known for some time that on occasion when staff have dialled (9)999 for an emergency ambulance, there has been a significant delay in attendance for a number of external factors.
It has been decided that in order for the organisation to know the scale and impact of this issue, to report these delays as a separate incident.
From today can all services who experience a delay in any ambulance attendance report the delay through the web based incident reporting system using the following codes:-
Cause Group = Service Delivery
Cause = SD15 Delay in Ambulance attendance
Within the detail of the incident please indicate the time the ambulance was called and the time the ambulance attended the unit. The ambulance Trust will have information in their electronic system if it comes to a formal review of the incident in line with the Trust's Incident Policy.
Give brief details of incident i.e. patient self harmed, patient fell, patient became unwell, patient was assessed under the MHA and required admission to hospital etc.
i.e. Ambulance called 12.15pm (please use 24 hour clock)
Ambulance arrived 14.57pm(please use 24 hour clock)
Types of incidents that have been reported previously with ambulance delays have been fractured neck of femur, delays of ambulances in the community for MHA assessments and physical health issues on in-patient wards.
For reporters it is imperative that the delay of the ambulance is reported separately to the actual incident that resulted in the ambulance being called.
So for a fracture, reporters , would report the fracture under PA26 - Fractured Neck of Femur, and then any delay in ambulance as a separate incident under SD15.
For a delay in an ambulance relating to MHA assessment only the delay needs to be reported under SD15, you do not need to report the assessment as a separate incident.
If any clarity is required , please contact Tony Gray - Head of Safety / Patient Experience for further information.
Regards.
CASNTW@Ntw.Nhs.Uk

***Ambulance Service under 'severe pressure'***

***Reference No.*** NTW/INT/2015/048 ***Date Issued*** 09/12/2015

Internal CAS Safety Alert; NTW/INT/2015/048
Ambulance Service under 'severe pressure'
Sent on behalf of;
Russell Patton
Director of Emergency Preparedness, Resilience and Response
For information
Would Service Managers please circulate the below CAS Safety Alert message to all staff in their service areas.
Dear colleagues
North East Ambulance Service NHS Foundation Trust has raised its operational status to "Severe Pressure" under a framework to protect core services for the most vulnerable patients in the region.
All ambulance services across the UK work to a national framework, called the Resource Escalation Action Plan (REAP), which has four levels designed to maintain an effective and safe operational and clinical response for patients. NEAS has declared its status at REAP level 3, 'Severe Pressure'. This means that while it attempts to operate a normal service, the Trust's response standard to potentially life-threatening calls has deteriorated.
As a result of raising the REAP level, clinically qualified managers will be made available for front line duties and will be deployed to A&E departments to manage turnaround. Winter resilience funds are being used to increase the operational resources available with additional overtime and the use of third party resources. Non-essential meetings and training has also been cancelled.
Paul Liversidge, Chief Operating Officer, said: "We are experiencing severe pressures in responding to emergency calls. With the shortage of paramedics and the additional pressures across the wider NHS network causing delays in ambulance turnaround times at hospitals, we have taken the decision to move the service to level 3 to protect our most vulnerable patients.
"Please help us reach those patients who need us most by using 999 wisely. Your call could potentially delay our response to someone else who might need us more.
"Please think before you pick up the phone; do you really need to go to hospital and if you do, is there anyone else who can take you? Turning up to hospital in an ambulance does not mean you will be seen any quicker."
NEAS has already implemented a number of other schemes to help ease pressure over winter, including increasing the number of clinicians in the control room to support 999 call-takers and offer advice for those patients who could be treated without the need to send an ambulance. Other initiatives are seeing Hospital Ambulance Liaison Officers support paramedic crews and emergency departments to minimise the delays in patient handover; and free paramedic time at hospital by using assistants to clean and re-stock an ambulance during patient handover.
Members of the public should only dial 999 for medical emergencies.
Examples of medical emergencies include:

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Chest pain;

_
Breathing difficulties;

_
Unconsciousness;

_
Choking;

_
Fitting;

_
Drowning

_
Severe allergic reactions
If it is not an emergency, members of the public are asked to seek help from their GP, pharmacist or local walk-in centre. Anyone unsure of where to go can call NHS 111.
For more information about how to stay well during winter, visit http://www.nhs.uk/LiveWell/Winterhealth/Pages/Winterhealthhome.aspx.
Regards.
CASNTW@Ntw.Nhs.Uk

***Changes to web-based incident reporting system; with immediate effect***

***Reference No.*** NTW/INT/2015/050 ***Date Issued*** 10/12/2015

Internal CAS Safety Alert; NTW/INT/2015/50
Changes to web-based incident reporting system; with immediate effect
Sent on behalf of;
Tony Gray
Head of Safety and Patient Experience
For Information
Would Service Managers circulate this CAS alert to all staff in all units, wards and departments please.
Dear colleagues
As from today, the 'saved for later' function for reporters on the web-based incident reporting system will be made inactive and will not be available as a choice in future.
Discussions will take place with Service Managers if this is to be made available in future.
The reasons for making this inactive are as follows;

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Serious Incidents have been recorded but then the incident record has been 'saved for later' so neither the Manager or the Safety Team have been informed automatically.

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Some incidents have been 'saved for later' by reporters and then just not submitted at all, despite several contacts with the individual reporter, which impacts on the incident reporting system.
The Safety Team do not foresee this being a significant issue as 'saved for later' incidents have only made up about 1% of the 11,500 incidents that have been successfully reported through the web portal since the start of the project in March 2015.
If, as a reporter, you have any incidents in your account 'saved for later', please arrange to have them submitted within the next 3 days.
In anyone has any queries or concerns relating to this change, please contact Tony Gray in the first instance by email; antony.gray@ntw.nhs.uk
Regards.
CASNTW@Ntw.Nhs.Uk

***Changes to Seclusion Policy and Documentation - effective from 1st January 016***

***Reference No.*** NTW/INT/2015/049 ***Date Issued*** 11/12/2015

Internal CAS Safety Alert; NTW/INT/2015/049
Changes to Seclusion Policy and Documentation -effective from 1st January 2016
Sent on behalf of;
Trust-wide Seclusion Steering Group
For information and Action
Would Service Managers please circulate the below CAS Safety Alert message and attached documents to all staff in their service areas.
Dear colleagues
There has been a review of the Seclusion Policy NTW (C) 10 - The new policy can be accessed here.
The new policy will be launched on the 1st January 2016.
To support this we have revised and updated the Trust's Key Card which is attached in readiness for the change.
This CAS alert will serve as a lead in time for clinical teams to develop their readiness for the new policy launch.
Key changes to policy are also attached in the summary list of changes and should be shared by Ward Managers to cascade throughout their teams.
A new training pack has been developed in line with the policy change and must be used for staff training when their training is due after the 1st January 2016
A new Record of Seclusion (triplicate) book will be introduced which should be used for recording all episodes of seclusion. There is also a revised Review of Seclusion (duplicate) book.
Please continue to use the current Seclusion Record of Observation (duplicate) books.
All previous Record of Seclusion books and Review of Seclusion books should be discontinued and retained for audit purposes.
Storage of seclusion documentation copies remains unchanged.
A web based incident report must be completed for each episode of seclusion; the Incident Reference number should be documented on the relevant section of the Record of Seclusion form.
Note to Clinical Nurse Manager, please ensure that on receipt of this CAS alert you arrange to collect your new books for your area of responsibility from the Patient Safety Team at St Nicholas House, St Nicholas Hospital by the 18th December 2015.
Note to Ward Manager if you have not received your books via your Clinical Nurse Manager by 22nd December 2015 then please contact Roy Pennington in Patient Safety on ex 56662.
Ward Managers are to ensure new books are available on their ward and staff are familiar with them, prior to the 1st January 2016 (using a local recording sheet) ready for implementation on the 1st January 2016
Regards.
CASNTW@Ntw.Nhs.Uk

***Medical Devices***

***Reference No.*** NTW/INT/2015/051 ***Date Issued*** 14/12/2015

Internal CAS Safety Alert; NTW/INT/2015/051
Medical Devices
Sent on behalf of;
Tony Gray
Head of Safety and Patient Experience
For information / action
Would Service Managers please circulate the below CAS Safety Alert message to all staff in their service areas.
Dear colleagues
With effect from Wednesday 16th December until Tuesday 29th December please take the following action regarding orders for any medical devices:
Hire equipment:
Air flow mattress, Elite Cushion and Low Profile Beds with bumpers/crash mats
Please contact Park House direct on
0845 3442607 who will be happy to assist. You will need to give them the Patient Rio Number along with your contact details. Please follow up with an email to:
Medicaldeviceadm@ntw.nhs.uk so we can log your hire.
Park House will be operating an out of hours service throughout the holiday period so if you should happen to require this service please contact 0845 0600 333 and they will assist.
Urgent Equipment Orders
i.e. batteries for defib machines or batteries for suction machines - these items can be ordered directly from supplies via Online Requisitioning non stock online requisitioning.
Many items codes/suppliers can be found on the link below but if you are in any doubt please contact Supplies Department direct.
http://nww1.ntw.nhs.uk/spider/services/files/1440692233Common%20replacement%20parts%202.docx
Non Urgent Equipment Orders
If your order is not urgent we will be happy to assist with your enquiry after 29th December - please email your request to Medicaldeviceadm@ntw.nhs.uk and we will order on your behalf.
Repairs
If you have any medical device that needs servicing/repair please send an email to Medicaldeviceadm@ntw.nhs.uk so this can be logged.
Regards.
CASNTW@Ntw.Nhs.Uk

## MHDS - Medication Check by Community Team

***Reference No.*** NTW/INT/2015/052 ***Date Issued*** 15/12/2015

Internal CAS Safety Alert; NTW/INT/2015/052
MHDS - Medication Check by Community Teams
Sent on behalf of;
Damian Robinson, Deputy Medical Director - Quality & Safety
and
Jonathan Richardson, Group Medical Director - Community Services
Service Managers; please circulate the below CAS message to all your clinical staff. Kirsty Allen will circulate to medical staff.
December 2015
Dear colleagues
Firstly our sincere apologies in advance for any additional work created by this alert. A CAS alert was sent, in October 2015, regarding the re-establishment of an electronic link which automatically 'pulled' medication lists through from the RiO medication page into the Mental Health Discharge Summary (MHDS); consequently incidents were reported in which the printed MHDS had contained inaccurate medication lists. The alert asked all in-patient Consultants to ensure that discharge summaries/letters were checked and compared with drug kardexes at the time of discharge, to identify any errors which may have occurred. Secondly, in-patient teams were asked to check any detected or suspected errors with the patient's GP and to complete a medication incident report where inaccuracies had been identified.
Since that time, the findings from these checks have been reviewed by a multi-professional incident management group. This process has highlighted that, amongst the 383 patients discharged from 28 in-patient wards during this period, a significant proportion of discharge summaries included inaccurate medication lists. It also identified that, where inaccuracies were found, prompt action was taken by in-patient teams to inform the patient's GP practice and make arrangements for them to be corrected; It is important to note that, to date, there have no reported incidents in which patients having been found to have been harmed.
Nonetheless, given the importance of ensuring that information about medicines is accurately communicated during transfers between care settings, community team managers are asked to arrange a follow-up checks of the accuracy of prescribed medication for these patients. Team-specific lists of the relevant patients are attached.
It is recognised that, since discharge from hospital, further communications between community teams and GP practice may well have addressed any apparent discrepancies/confusion in discharge summary medication lists; however we would be grateful that you could assure us that the patients' current medication is safe and clinically appropriate by responding via email - to Judith Hope Judith.hope@ntw.nhs.uk - yes or no to each patient on the list within your respective area. We are very grateful for your help in resolving this issue and once again we apologise for any additional work related to this matter.
Regards.
CASNTW@Ntw.Nhs.Uk

## *Spotlight on Information Governance: sending emails*

***Reference No.*** SMIG67/151215 ***Date Issued*** 15/12/2015

Email is a valuable method of communicating internally within and externally from the Trust. It is probably now the most common method of communication and sharing of information between staff/teams and departments within the Trust. However the use of email comes with risks and may potentially breach legislation.

In our busy working lives most of us have quickly composed an email and then sent it to the recipient without really checking that is going to the correct person. These emails may contain person identifiable information or have attached to them documents of a sensitive nature.

There have been a number of IG incidents reported where the recipient has the same name as another member of staff and they have received sensitive information which they should not have had access to. In some cases an email has been sent to a person external to the Trust with sensitive information attached.

Where this occurs and the sensitive information is person identifiable, then this is reported as a breach of the person's confidentiality. We all have a legal requirement under the Data Protection Act 1998 for personal information and duty of care to our patients/staff to ensure that the information we are trusted with is kept secure and only shared with those staff that are authorised to have access to it.

To reduce the risk of IG incidents relating to emails occurring we would ask all staff who do send information via email to take the time and make sure the recipients email address is the correct one. Also remember to have updated any team email addresses where staff have either left the Trust or have moved to another team.

Guidance can be found in NTW(O)44 Acceptable Use of Email which is situated on the Trust intranet and can be accessed by clicking here. The policy contains information on how to use email, what can be shared and what security measures should be put in place.

If you have any queries about the above please contact the Information Governance Team on extension 66890.

***Amendment to requirement to supply original prescriptions to Pharmacy when ordering via fax or e-mail (non-controlled drug orders only)***

***Reference No.*** NTW/INT/2015/053 ***Date Issued*** 17/12/2015

Internal CAS Safety Alert; NTW/INT/2015/053
Amendment to requirement to supply original prescriptions to Pharmacy when ordering via fax or e-mail
(non-controlled drug orders only)
Sent on behalf of;
Steven Routledge
Lead Technician - Medicines Supply
For information
Would Service Managers please distribute the attached memo to all appropriate staff in their units, wards and departments/clinics.
Dear colleagues
Please find attached Pharmacy Memo for your information.
Please note; this instruction is with immediate effect.
Regards.
CASNTW@Ntw.Nhs.Uk

## Quality and Safety Metric Suite

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

| | |
|---|---|
| | Total Referrals triaged but awaiting booked appointment (or further intervention) |
| **Workforce** | Sickness<br>Use of Bank<br>Use of Agency<br>Use of Overtime<br>Use of Locums<br>Staffing Levels |
| **Organisational Capacity** | Vacancy Rate<br>Staff Turnover |