Northumberland Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 27 July 2016

Title and Author of Paper: Safety Report - January – June 2016
Tony Gray - Head of Safety & Security
Dr Damian Robinson – Group Medical Director

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

Paper for Debate, Decision or Information: Information

Key Points to Note:

- This is the first report in the new cycle of reporting on different aspects of safety within the Trust.
- Since the last Safety report presented to the board of directors in June the Safety Team, have been working on a new reporting structure that will expand the reports coming to board, and separate reporting and learning activity.
- All of the reports will sit under the banner of safety, as all the reports give the board of directors, an insight of different aspects of the Trust's safety systems, and will provide assurance that these systems are working as planned, or will indicate where concerns have been identified and where remedial action has been taken.

Northumberland, Tyne & Wear NHS Foundation Trust – Safety Reporting Cycle.

NTW FT – Board Cycle – Safety Reporting – July 2016 onwards

Report Title	**Board Date**
Unexpected Deaths Report – 6 monthly report	April
Security Management Annual Report	May
Complaints Annual Report	June
Safety Report – Jan – June – 6 monthly report	July
Learning and Improving from activity - 6 monthly report (Serious incidents, Complaints, Claims, Disciplinary, Grievances, Tribunals)	September
Unexpected Deaths Report – 6 monthly report	October
Reported Physical Assaults on Staff – NHS Protect	November
Safety Report – July - December – 6 monthly report	January
Lone Working Annual Update	February
Learning and Improving from activity - 6 monthly report (Serious incidents, Complaints, Claims, Disciplinary, Grievances, Tribunals)	March

Risks Highlighted to Board : No specific risk

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

Equal Opportunities, Legal and Other Implications: None

Outcome Required: For information and discussion. The Board of Directors are also asked to comment on the revised format of the report.

Link to Policies and Strategies:	Incident Policy Complaints Policy Claims Policy Health & Safety Policy Security Management Policy Central Alert System Policy

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

NHS
LEARNING FROM MISTAKES LEAGUE
Good

Safety Report
July 2016
Reporting Period – January - June 2016

Shining a light on the future

Introduction

The Trust has reviewed its governance arrangements, which resulted in the transfer of governance from the Executive Medical Director to the Executive Director of Nursing and Operations. As part of this review and in line with the completion of implementation of Transforming Corporate Services in relation to governance. A new Safety and Clinical Risk structure has been created, with implementation from the 1st July 2016, which allows for a more streamlined and integrated approach to the management of the following corporate responsibilities, which all sit within the Executive Director of Nursing and Operations Portfolio.

- Health, Safety & Security (including Lone Working)
- Serious Incident, Incident Management including Never Events
- Learning from Activity
- Claims Management
- Complaints Management
- Central Alert System and safety information cascade and dissemination
- Policy Governance and Management
- Safeguarding processes

With this more integrated approach this report is now produced in line with the previously identified schedule, which allows safety specific information to be presented to the Board of Directors every time it meets. This will allow robust reporting, and all current safety activity to be actively communicated in a well-managed and organised way.

This reporting cycle also allows for a strategic and measured view on all aspects of safety that have been previously been reported to the Board of Directors to provide assurance , but have previously occurred out of actions identified from other reports.

In developing this reporting cycle, the Safety Team have researched the approach of other organisations reporting to their Boards of Directors, and cannot find this style of reporting has been mirrored, and Trusts are still traditionally reporting on existing Incidents, Complaints and Claims activity, which was a pre-existing approach dating back to when Trusts were assessed by the National Health Service Litigation Authority.

The change in this Trust has been based on learning and what the specialists in the Safety Team having been planning for a number of months, and builds on historic reports that have been transparently reported to the Board of Directors.

Following the review of the Mazar's report into Southern Health NHS Foundation Trust, it was apparent that Northumberland Tyne & Wear NHS Foundation Trust has been reporting it's safety activity to its open board for a significant period of time. The first unexpected death reports were reported in 2009. Some Trust's still do not report this activity transparently, and this was a finding in the Mazar's report around Board oversight, and assurance.

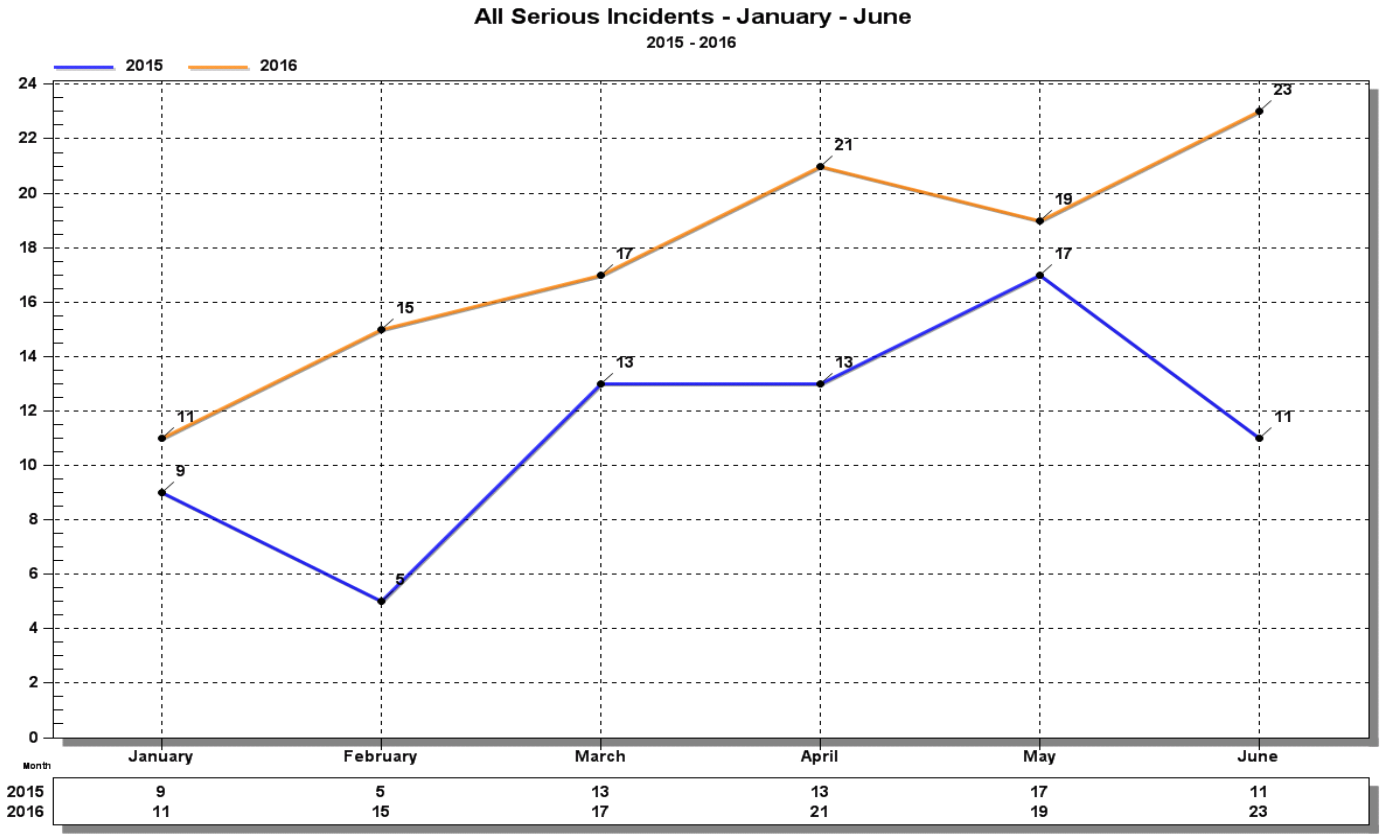
The following information is the activity that has been reported for the period January 2016 – June 2016, this will be directly compared to the activity in the previous year. Where possible and the information is available at this time, the immediate reflection of learning will be included, where there is nationally comparable data, this will also be included, but it is acknowledged that benchmarking due to the significant differences in Trust make up and services offered makes this difficult.

Also to acknowledge that on occasion due to organisational change both internal such a service movement, re-alignment this will impact on any type of activity, as well as commissioning and provision of new services.

Incident Reporting and Management

The following information gives a detailed breakdown of the serious incidents that have occurred in the Trust in the last 6 months and compares the activity to the previous year.

Graph 1



The first consideration in the above graph, shows a significant increase in serious incidents from 2015 to the same period in 2016, this could be seen as a concern, however the Safety Team expects this activity as it directly correlates to the changes made in the Trust with the implementation of the NHS England – Serious Incident Framework of March 2015, which allowed for a more reflective view of serious incidents, the following table shows the difference of the types of incidents from 1 year to the next, all of these incidents are discussed in detail with Directors at the Group Business Meeting on a Friday morning and the level of investigation agreed in line with the following definitions:-

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

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

Table 1 – Serious Incident by Classification

Classification of Incident	January – June 2015	January – June 2016	Comment
AA09 Absented Themselves From Hospitals	0	2	
AA10 Absented Themselves During Escorted Leave	1	1	
DE01 Unexpected Death	26	29	Comparable activity for previous year, relates to suicides , or unknown causes
DE08 Unexpected Death - Natural Causes	8	4	This will not be a reduction as many will be awaiting coroner conclusion for 2016 activity
DE16 Alleged Homicide By A Patient To A Patient	1	0	
DE18 Unexpected Death Local AAR	20	36	Increase due to SI framework changes, the majority of these deaths are related to addictions services
DE19 Alleged Homicide Not In Receipt Of Services	1	0	
F01 Actual Fire - Patient Area	1	3	Increases being seen relating to implementation of the full no smoking policy
IN05 IT Network Failure	0	1	
IT04 16-17 Admitted To Adult Ward	1	2	
ME01 Adverse Drug Reaction	0	1	
PA04 Patient Fall From Height	0	1	
PA26 Fracture Neck Of Femur	2	8	This increase has been explored and no unusual or previously unknown issues have been identified
PI01 Unexpected Deterioration In Health	0	2	
PI02 Patient Choking	1	0	
S23 Weapon Discovered/Found	0	1	
SH01 Actual Self Harm	1	9	Increase due to SI framework changes
SH02 Attempted Suicide	1	2	
SH05 Attempted Self Harm	1	0	
V01 Physical Assault Of Staff By Patient	0	1	
V02 Physical Assault Of Visitor/Gen.Pub. By Patient	1	1	
V03 Physical Assault Of Patient By Patient	2	0	
V26 Allegation-Sexual Assault Of Patient By Other	0	1	
V36 Aggressive Behaviour To Staff	0	1	
Total	68	106	

Developments relating to understanding death activity – Care Quality Commission Deaths Review – Potential to learn together.

The CQC is carrying out a review of how NHS trusts identify, report, investigate and learn from deaths of people using their services.

This follows a request from the Secretary of State for Health, which was part of the Government's response to a report into the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust.

CQC's review will consider the quality of practice in relation to identifying, reporting and investigating the death of any person in contact with a health service managed by an NHS trust; whether the person is in hospital, receiving care in a community setting or living in their own home. The review will pay particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem.

Following the publication of the report, Tees, Esk and Wear Valleys NHS Foundation Trust, in partnership with Mazars, organised an event to reflect and review on the report, and see if a number of Trust's in the north could start to work together to evaluate, understand and align their serious incident and mortality review processes.

The 2nd meeting took place in June, and the following Trusts agreed a number of actions:-

In communication terms moving forward the Trust's for this piece of work and possibly other developments agreed to be defined as the "Northern Alliance".

Bradford District Care NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Humber NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Rotherham and Doncaster NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Tees, Esk & Wear Valleys NHS Foundation Trust

Share their data requests in advance of submission to the Care Quality Commission – Deaths Review in advance of the submission date of 25th July 2016.
Include both figures for the CQC submission from both the electronic care record and the incident system for all Trusts.
Agree some definitions moving forward on types of deaths that occur.
Align their terms of reference for mortality review.
It was acknowledged from the outset as some Trusts are partnership trusts, they would have a higher reported rate of death, due to the fact that they provide community services including such things as health visiting etc.

2 questions that all Trust's agreed to go away and consider as follows:-

- Should all deaths be reported as incidents? And if not
- Should we review a sample of those not reported as part of the mortality review process.

The CQC are taking the opportunity to use all available systems to understand death reporting and have identified 12 Trusts who will take part in a survey between July and August, they will interview the Board lead , Governance lead, and investigation / clinical lead. The CQC are also taking the opportunity to use their existing inspection processes to understand how deaths are reported, categorised and investigated. A significant number of data requests were provided by the Trust and senior staff from the Safety Team were interviewed to give an insight into our processes.

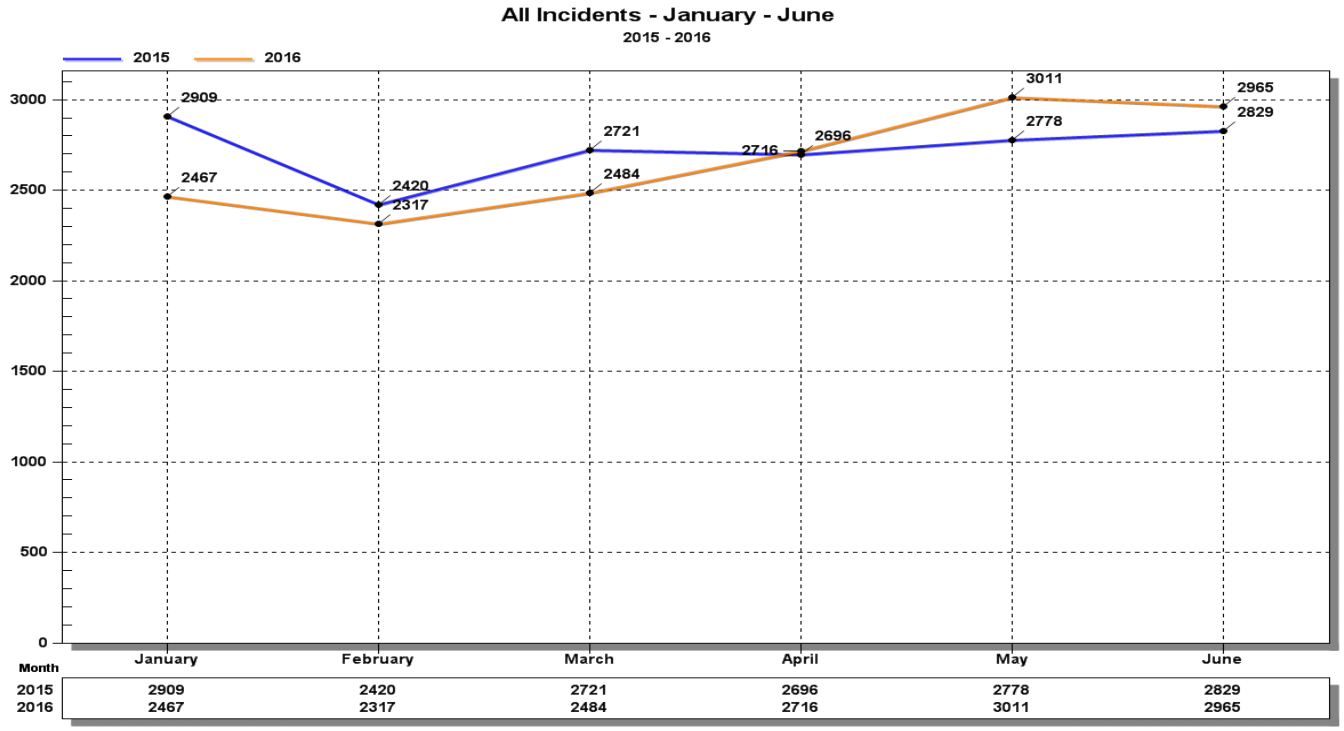
The CQC are also examining how many complaints relating to deaths are received, NTW already records this information and the Complaints section of this safety report will include this information.

More information will be reported to the Board of Directors in subsequent reports, including any changes that need to be made from any recommended changes, it is likely that the CQC will not be in a position to provide this information until December 2016.

Incident Reporting

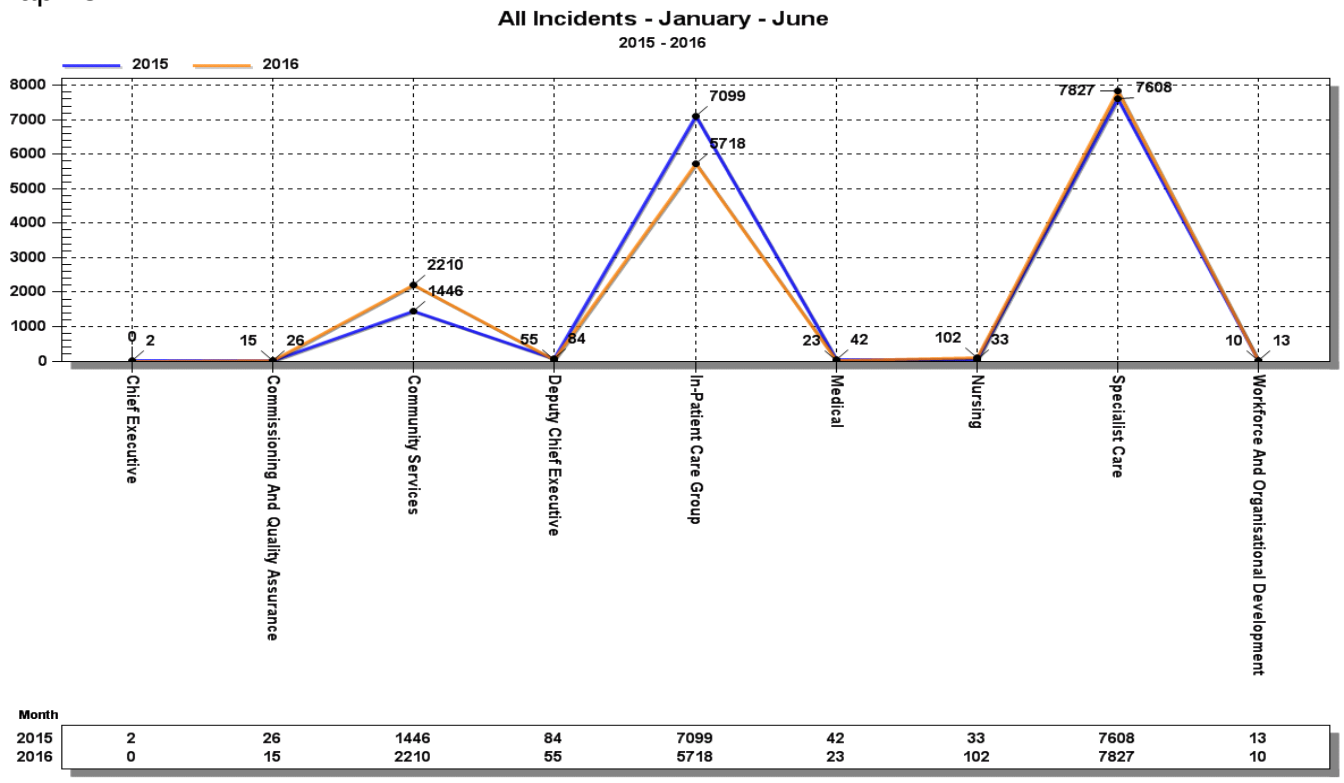
The following information gives a detailed breakdown of the incidents that have occurred in the Trust in the last 6 months and compares the activity to the previous year.

Graph 2



Month	January	February	March	April	May	June
2015	2909	2420	2721	2696	2778	2829
2016	2467	2317	2484	2716	3011	2965

Graph 3



Month	Chief Executive	Commissioning And Quality Assurance	Community Services	Deputy Chief Executive	In-Patient Care Group	Medical	Nursing	Specialist Care	Workforce And Organisational Development
2015	2	26	1446	84	7099	42	33	7608	13
2016	0	15	2210	55	5718	23	102	7827	10

The trend of incident reporting over the 2 data periods can be seen in the above graphs, it has been known for some time that individual patients and their clinical risk activity can have a direct impact on incidents in a service and across a clinical group, there has been an increasing trend in incident reporting, with a greater than normal rise from March 16 onwards, this is due to increased reporting of incidents relating to smoking in in-patient wards, since the no smoking policy was implemented. There is also an increase in fire and false alarm activity on in-patient wards, this risk is being currently clinically managed supported by Estates and Facilities and the Trust's Fire Officers.

Incident reporting trends relating to Patient Safety Incidents, are quality checked and assessed through the NEQOS report, which is produced on an annual basis and presented to the Trust's Quality and Performance Committee, this allows a reflection of all patient safety incidents reported by the 55 Mental Health and Learning Disability Trusts in the Mental Health Cluster, and allows interrogation into the data to see where the Trust appears. In the last report presented it indicated that the Trust is in a strong position of reporting in line with national systems, and that it was achieving the quality standards set by the National Reporting and Learning System, this was also confirmed in the "Learning From Mistakes League" data published by Department of Health earlier this year.

In line with the assessment of the CQC – Brief Guide – Interpreting and Reporting Incident Data, the Trust reported its activity in preparation of the CQC inspection in June, and confirmed that there were no concerns in the reporting of incident activity, through NRLS, STEIS and internally within the governance structure of the Trust.

With the sharing of the Pre-Inspection Intelligence Pack, prior to the CQC inspection, no concerns were identified by the CQC in their 316 page document. This was also confirmed through the inspection, however the Trust will need to await the final draft report due in September 2016.

The following 3 graphs are broken down by the 3 clinical groups for comparative purposes, and the increases and decreases in the services activity.

It is important to consider the safety systems the Trust has invested in based on historic learning to counteract and mitigate the known risks that present in certain groups. This is evidenced by the incidents being reported and managed.

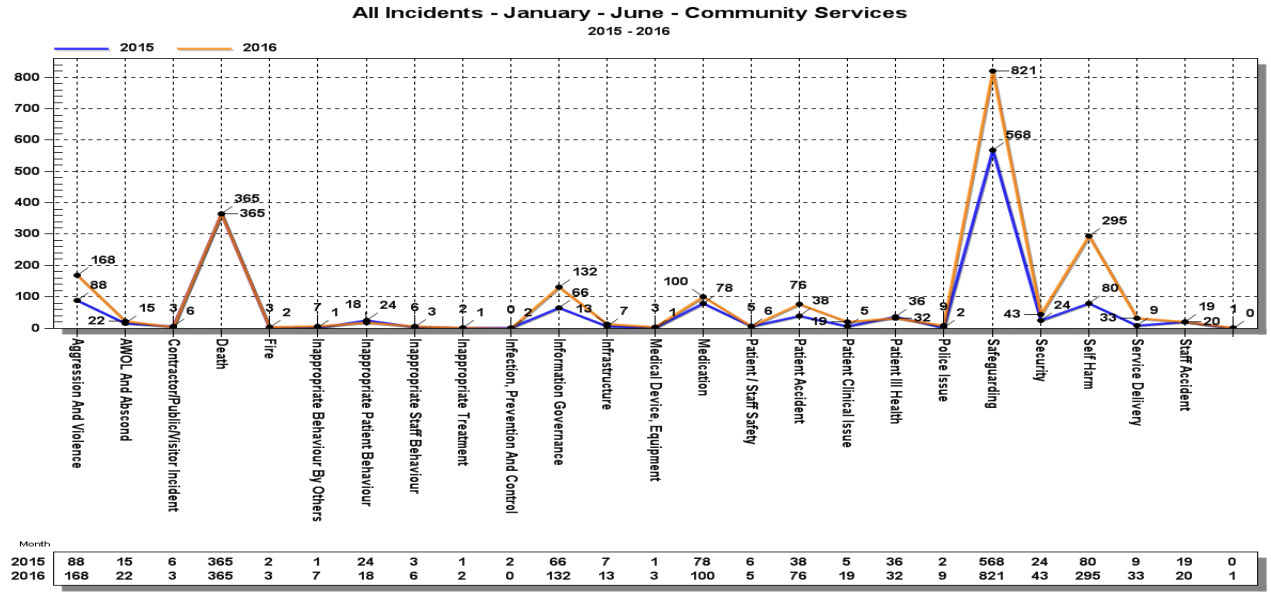
Community & Specialist Community Services

The provision of a robust lone working system covering 20% of the workforce predominantly in the community allows an extra layer of support for those staff at increased risk or violence and aggression, this can be evidenced in the increased in reported incidents, however it is important to acknowledge the low number of serious incidents, due to the escalation processes in place within the system, and the prompt response of the Police when required.

In-Patient and Specialist In-Patient Services

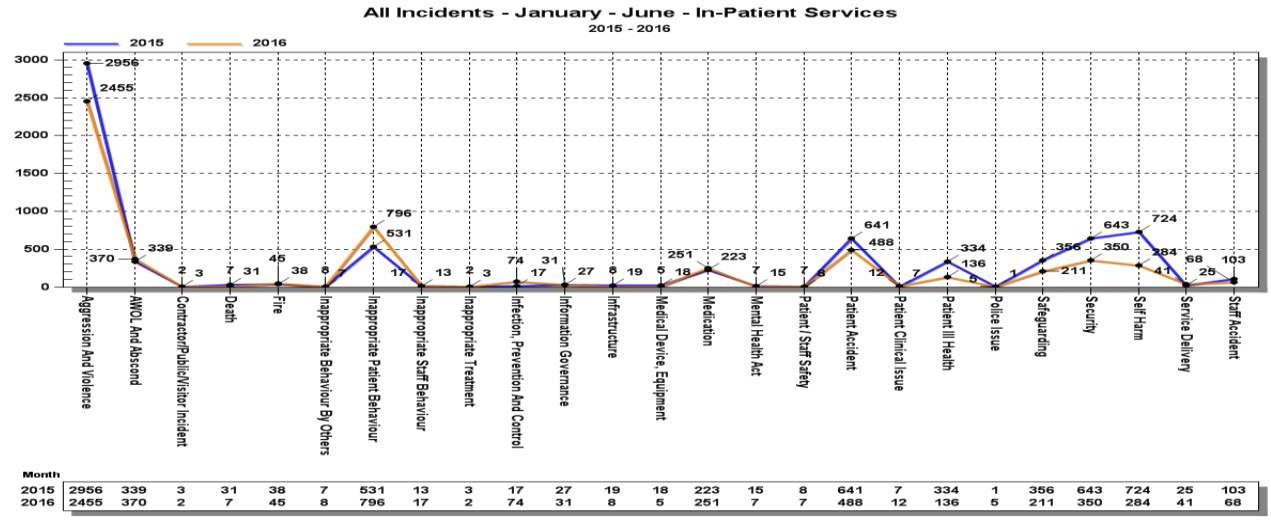
The provision of staff attack systems, Closed Circuit Television Systems, Walkie Talkies, Ligature Cutters and Mechanical Restraint Equipment, have been provided to clinical teams on wards to support effective management of safety for both patients and staff, these systems of safety , have vastly reduced the serious incidents on in-patient wards, whilst acknowledging that due to an increase in acuity of patients and detentions under the mental act to keep patients and staff safe.

Graph 4



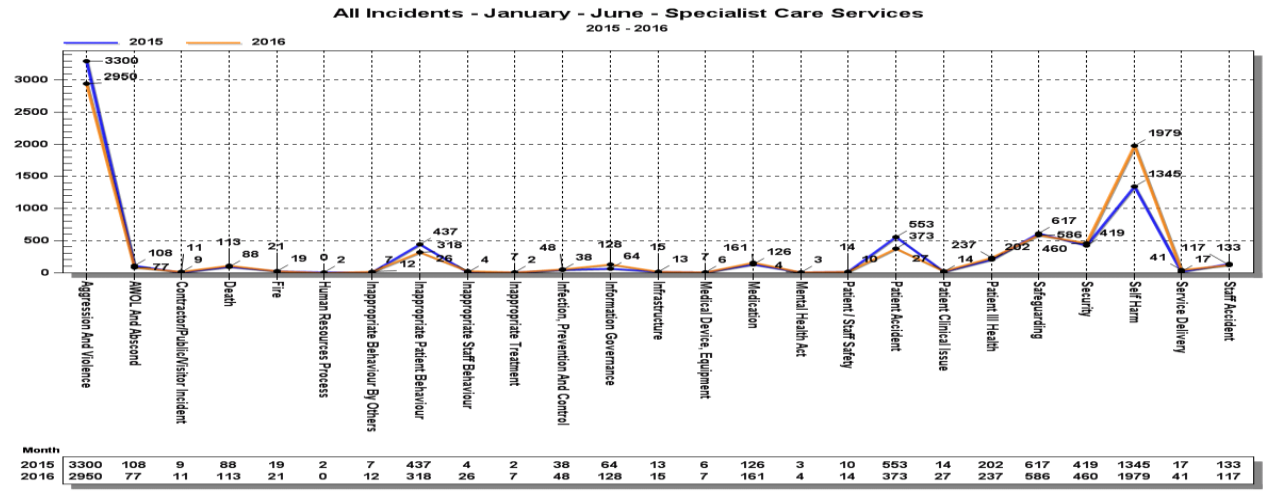
Month																									
2015	88	15	6	365	2	1	24	3	1	2	66	7	1	78	6	38	5	36	2	568	24	80	9	19	0
2016	168	22	3	365	3	7	18	6	2	0	132	13	3	100	5	76	19	32	9	821	43	295	33	20	1

Graph 5



Month																									
2015	2956	339	3	31	38	7	531	13	3	17	27	19	18	223	15	8	641	7	334	1	356	643	724	25	103
2016	2455	370	2	7	45	8	796	17	2	74	31	8	5	251	7	7	488	12	136	5	211	350	284	41	68

Graph 6



Month																									
2015	3300	108	9	88	19	2	7	437	4	2	38	64	13	6	126	3	10	553	14	202	617	419	1345	17	133
2016	2950	77	11	113	21	0	12	318	26	7	48	128	15	7	161	4	14	373	27	237	586	460	1979	41	117

Complaints Reporting and Management

It has been acknowledged that reporting to the Board of Directors has been restricted to informing the Board of the highest level of Complaints that are currently under the scrutiny of the Parliamentary Health Service Ombudsman. The changes to this report allow for more detailed information to be presented to the Board whilst acknowledging that information is considered by the Quality and Performance Committee which is a sub-committee of the Board.

The Trust's Complaints Policy was re-written in March 2016, with a specific emphasis on devolvement of complaints management into the clinical groups to take greater clinical ownership of complaints, and seek to achieve a greater level of local resolution, with only the most complex complaints having an independent investigator. The policy has also strengthened areas where there needs to be senior clinical oversight of the complaints process and this was in parallel to changes that were made in the Safety and Clinical Risk functions of the Trust as part of Transforming Corporate Services. The Executive Director of Nursing and Operations has overseen these changes and ensured that continuity of process has been maintained whilst this transition has taken place.

The following changes have been implemented since the policy has been adopted.

- Triage system of complaints, which sees the Executive Medical Director, Executive Director of Nursing and Operations, Nurse Director (Safety) and Deputy Medical Director (Safety) take the lead to review all complaints received and decide on the investigation level and plan.
- The Head of Clinical Risk and Investigations to take over the operational aspects of Complaints Management within the Trust, to give clinical support to investigations, but also to align any processes that may also be subject to serious incident investigation and coronial process.
- Extension to complaint investigations only to be granted following discussion with the complainant and with an express agreement of the Head of Clinical Risk and Investigation.
- A Rapid Process Improvement Workshop (RPIW) to be carried out on the complaints process, in the new way of working in line with policy.

Complaints Received

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

Old Policy – Descriptors

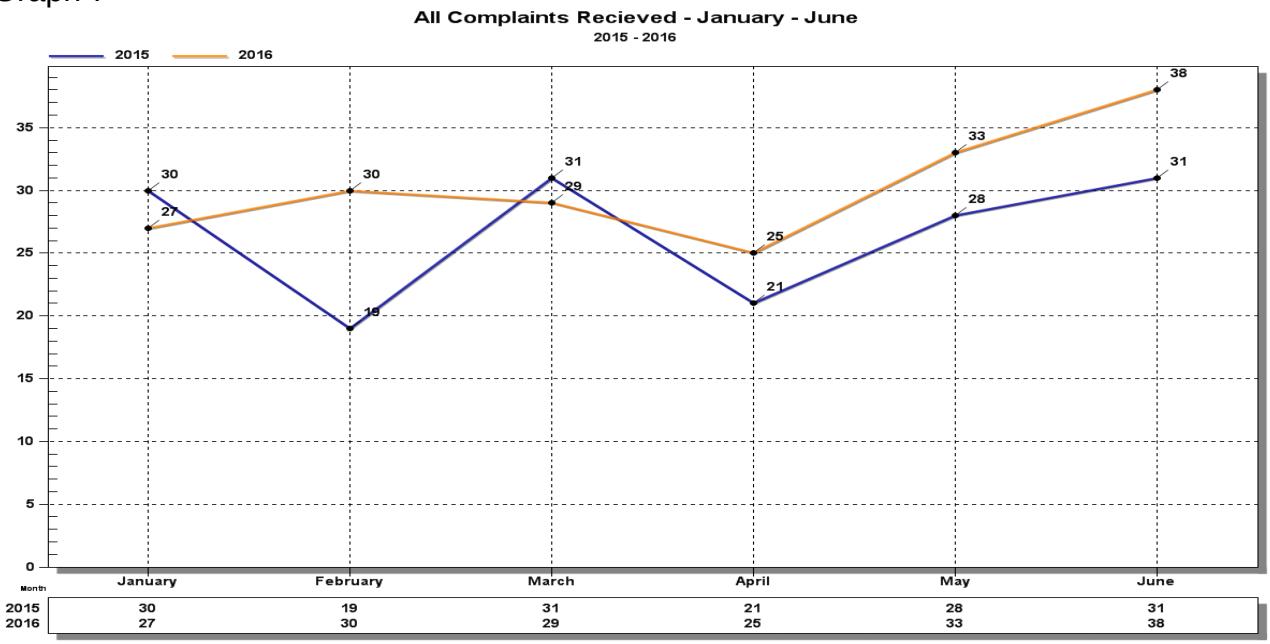
- Category 1
- Category 2
- Category 3
- Joint Complaint – NTW Not Lead
- Joint Complaint – NTW Lead

New Policy – Descriptors

- Informal
- Formal
- Joint Complaint – NTW Not Lead
- Joint Complaint – NTW Lead

Over the last 6 months, with most of the changes implemented complaints have increased by 22 up from 160 in 2015 to 182 in 2016. In graph 7 below it can be seen that more complaints have occurred in the same period for April to June and this will be kept under close observation. It is also acknowledged that some of the increase is due to greater awareness of complaints procedures for staff with the review and publication of the new policy , as well as increased awareness for patients, through CQC posters.

Graph 7



Complaints by Category

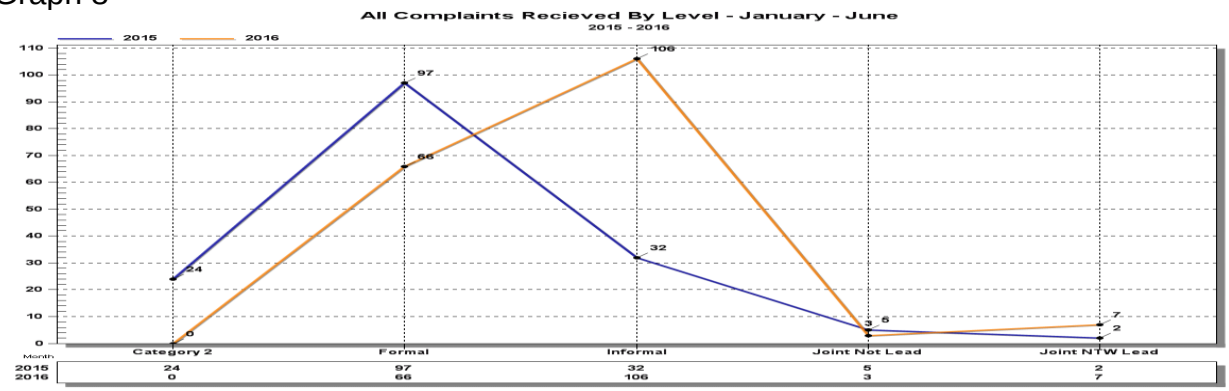
The following table gives a breakdown of complaints received by category, these categories are nationally approved, and information is sent to NHS Digital on a quarterly basis.

Table 2

Category Type	2015	2016
Access To Treatment Or Drugs	4	0
Admission, Discharge & Transfer Arrangements	10	0
Admissions And Discharges	5	11
All Aspects Of Clinical Treatment	22	0
Appointments	5	16
Attitude Of Staff	17	0
Clinical Treatment	3	6
Communication / Information To Patients	6	0
Communications	16	37
Facilities	2	10
Other	2	0
Patient Care	17	47
Patient Privacy & Dignity	1	0
Patient Status / Discrimination	3	0
Personal Records	3	0
Prescribing	3	13
Privacy , Dignity And Wellbeing	2	4
Restraint	4	3
Transport	8	0
Trust Admin/ Policies/Procedures Including Rec Man	5	8
Values And Behaviours	18	24
Waiting Times	4	3
Totals	**160**	**182**

In graph 8 below when looking at the specific categories of complaints, far more complaints are being dealt with informally, in the first 6 months of 2016 than ever before, this is a positive, as it also means complaints can be fed back more quickly for lower level activity, which can receive quicker resolution. Also to note in graph 8 are the joint complaints where NTW takes the lead, the reason for this is to support patients through our process, rathe than leave the complaint process in other organisations.

Graph 8

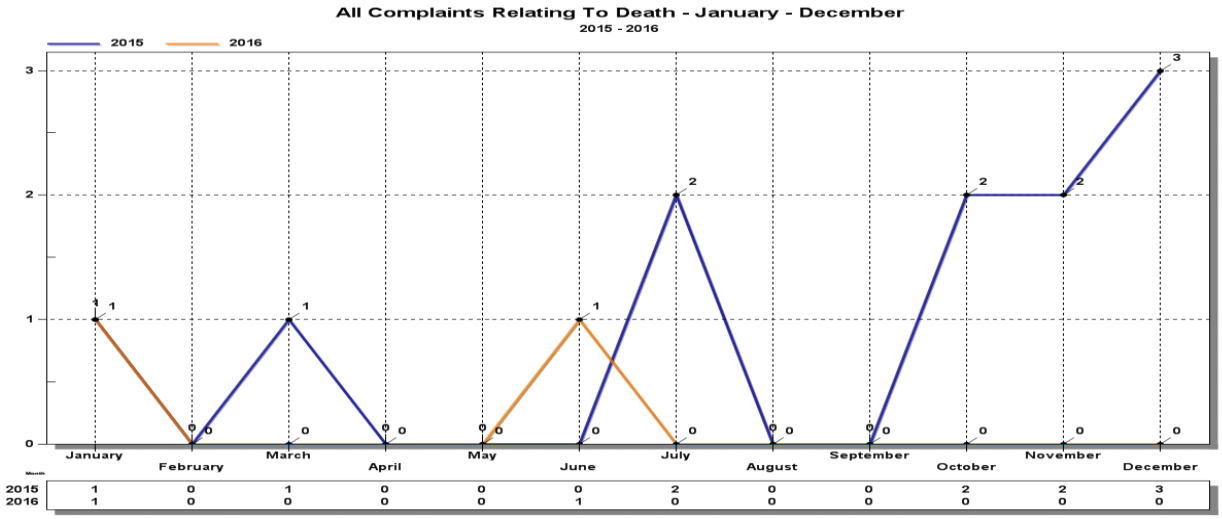


Complaints Relating to Death

Graph 9 below shows those complaints that have been received with the theme of the complaint is relating to the death of a patient. It also needs to be acknowledged that not all complaints relating to death are received straight after death, some are received following the outcome of a serious incident investigation, or the outcome of a coronial investigation, this can be six months after the death.

In reviewing the graph below, it can be seen that there were 11 complaints relating to death received in 2015, and currently only 2 for the first 6 months of 2016. This data will be included in the CQC Deaths review.

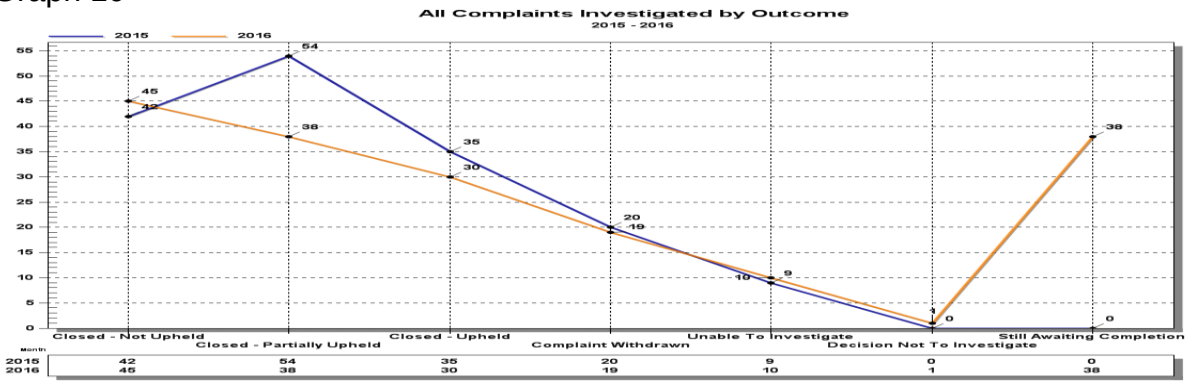
Graph 9



Outcomes of complaints received

For a board to receive activity on complaints, it also for assurance of a robust investigation and improvement system, must receive timely information relating to the outcomes of complaints. Graph 10 below gives a comparison of the complaints investigated that were received in the months January – June each year. It can be seen that there are still 38 complaint investigations to complete, and the trend line is expected to be comparable to previous years, which means the shift from dedicated investigators to investigations being carried out by fron line clinicians is not impacting on the outcome of complaints.

Graph 10



Timeliness of completion of complaints.

Timeliness of response to complaints is always a critical factor in the complaints process, and whilst historically, the Trust has reported through its complaints reports on compliance with policy , seeking extensions where required, this effectively masks the true timescales of complaints timescale completion.

The following table gives a breakdown of the timescales for all complaints that were investigated and completed for the 2 data periods.

Table 3

Date Range	Number of Complaints Completed	Average number of working days to complete
April – June 2015	160	47
April – June 2016	143	33

This evidences that the changes in the complaints policy, are resulting in quicker feedback to complainants, there is still more work to do, in this area, and there is also an acknowledgment that the policy implementation started fully in March 2016.

The themes and improvements from complaints will be reported to the Board of Directors in the Learning Report in September and the annual report in June, in line with the refreshed cycle of reporting.

External Reporting to the Parliamentary Health Service Ombudsman (PHSO)

The Trust as part of every response letter includes the PHSO contact details, in the last year the Trust responded to over 300 complaints. Complainants have the right to take their complaint to the PHSO even if the findings of the complaint are partially or fully upheld. The following are the on-going complaint activity with the PHSO.
A greater level of detail will be included in the Learning Report in September.

COMMUNITY SERVICES

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
26.05.16	2919	16001990	PHSO – Request for files	Files sent 7.6.16

IN-PATIENT SERVICES

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
22.04.2016	2443	253806	PHSO – Request for files	Files sent 19.05.16
25.04.2016	2762	253795	PHSO – Request for files	Files sent 7.6.16

SPECIALIST

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
26.03.2015	Local res 2664	210865	PHSO – Request for files	Update from PHSO 07.04.16 – Investigation ongoing
29.02.2016	2550	241648	PHSO – Intention to Investigate	Awaiting further instructions