Northumberland Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 January 2017

Title and Author of Paper: Safety Report - July - December 2016
Author of Paper in response to this report – 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 report contains all the safety related incident and complaint activity for the period July- December 2016.
- This report acknowledges that a separate report is to be presented to Board of Directors as part of today's agenda, that will cover the recent publication of the Care Quality Commission's – Death Review Report, "Learning, Candour and Accountability. Future updates on the action plan attached to that report will come to the board on a quarterly basis and as part of regular updating the board on the areas of safety it should have sight of, listed in one of the recommendations.
- Serious Incident Activity included.
- Incident Activity included.
- Complaints and PHSO activity Included.

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

NTW FT – Board Cycle – Safety Reporting

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: None

Does this affect any Board Assurance Framework/Corporate Risks? No

Equal Opportunities and Legal and Other Implications: None

Outcome required: Noted for Information

Date for completion: N/A

Links to Policies and Strategies:

- Reference this month to separate Reported Physical Assault Report, and Learning from Deaths Report, also on Agenda.
- Incident Policy
- Complaints Policy
- Claims Policy
- Health & Safety Policy
- Security Management Policy
- Central Alert System Policy

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Safety Report
January 2017
Reporting Period: July - December 2016

Shining a light on the future

Introduction

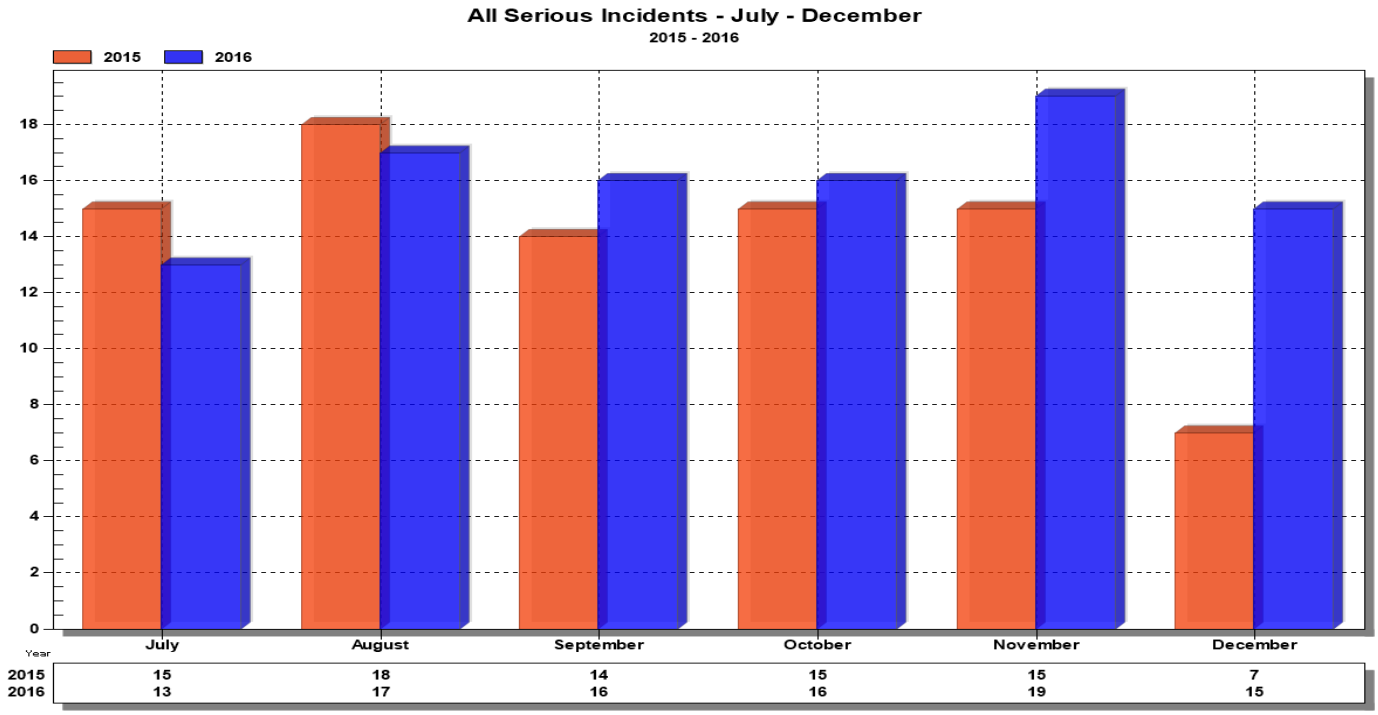
The following information is the activity that has been reported for the period July 2016 – December 2016, this will be directly compared to the activity in the previous year. Where possible and the information is available at this time, the immediate reflection of learning will be included, where there 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 as 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

Serious Incidents

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 previous safety report for the period January – June 2016, comparing against the previous years data, showed a significant increase in our serious incident rate, this was based on the implementation of the NHS England – Serious Incident Framework of March 2015, which allowed for a more reflective view of serious incidents. In the current reporting period, it can be seen with full implantation the activity between July – October is fairly static year on year, however there have been increases in November and December, some of these increase were in in-patient services with an increase in unexpected deaths, and self harm, a thematic review was carried out by a Senior Clinical Nurse around these incidents, each of which is subject to a serious incident investigation, this report was discussed in detail at the In-Patient Operational Management Group and fed back through the Directors meeting, no themes spanned these incidents and the outcomes of each review report will be picked up and managed in appropriate action plans

following serious incident panel review. The rise in serious incidents in December 2016 looks stark but is based on the low number reported for December 15 the year previous, which was unusual against average monthly activity for the Trust. Further analysis on this activity is reported to the Board of Directors in the Unexpected Death report.

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 by 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.

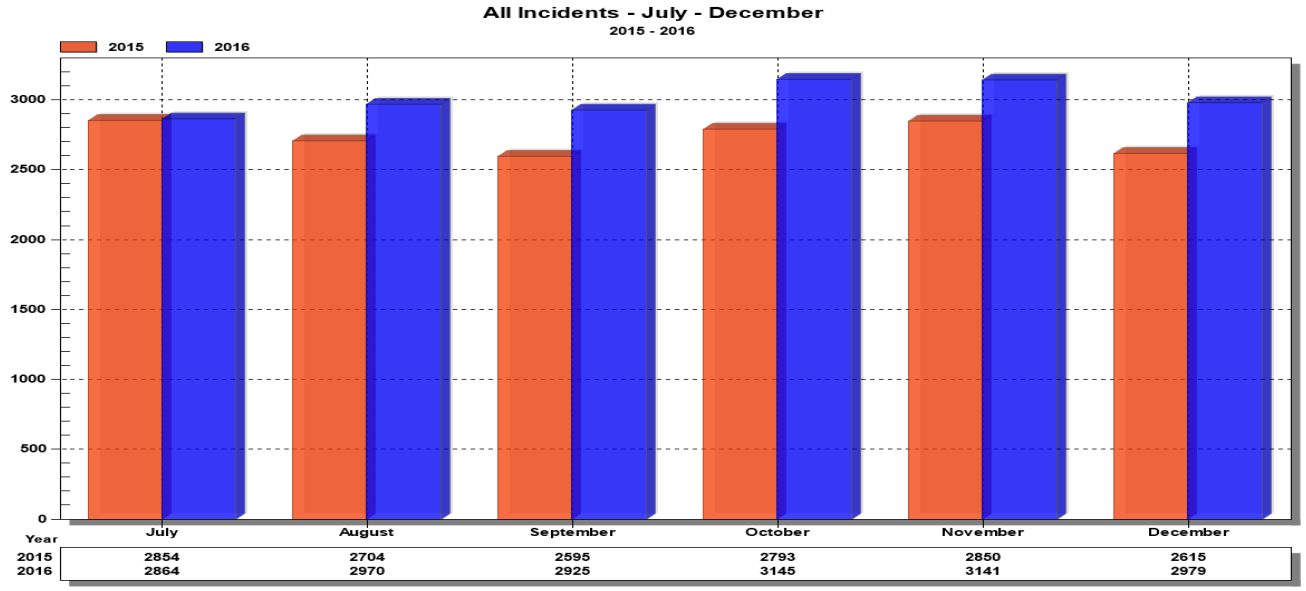
Table 1 – Serious Incident by Classification (detailed information relating to the deaths are included in the separate Board report on Unexpected Deaths)

Classification of Incident	July - Dec 2015	July - Dec 2016	Comment
AA09 Absented Themselves From Hospitals	1	0	
DE01 Unexpected Death	31	36	Equates to one extra per month, normal variation
DE04 Alleged Homicide By A Patient	2	1	
DE08 Unexpected Death - Natural Causes	0	3	
DE14 Unexpected Death NTW Not Main Care Provider	1	0	
DE16 Alleged Homicide By A Patient To A Patient	0	1	
DE18 Unexpected Death Local AAR	25	34	Increase due to SI framework changes, the majority of these deaths are related to addictions services
F01 Actual Fire - Patient Area	0	1	
F02 Actual Fire - Non Patient Area	0	1	
IG03 Breach Of Patient Confidentiality	1	0	
IG15 Wilfull Removal Of Identifiable Data	0	1	
IN01 Loss Of Telecommunications	2	0	
IN02 Loss Of Electricity	1	1	
IT04 16-17 Admitted To Adult Ward	1	0	
ME02 Contra-Indication-Use Of Medication	1	0	
ME07 Wrong Drug/medicine	1	1	
ME20 Medication Other	0	1	
PA01 Patient Fall On Same Level	1	0	
PA04 Patient Fall From Height	1	0	
PA08 Patient Found On Floor - Not Witnessed	1	0	
PA16 Struck By Moving Vehicle	0	1	
PA18 Injury Cause Unknown	0	1	
PA26 Fracture Neck Of Femur	5	5	
PI01 Unexpected Deterioration In Health	1	0	
PI12 Delay In Treatment	0	1	
S61 Bomb Threat	0	1	
SG37 Safeguarding Adults	0	2	
SH01 Actual Self Harm	6	1	From October 1st 2016 the categorisation of Self Harm was changed in the Trust, to bring in line with other organisations and national benchmarking, which is why in this section Actual Self Harm has decreased, but the detail of self harm such as ligature use has increased
SH02 Attempted Suicide	1	2	
SH06 Suspected Self Harm	0	1	
SH13 Head Banging	0	1	
SH17 Ligature: No Anchor Point	0	2	
SH20 Overdose	0	1	
V01 Physical Assault Of Staff By Patient	1	0	
V03 Physical Assault Of Patient By Patient	1	0	
V04 Threatening Behaviour By Patient To Staff	0	1	
V38 Threatening Behaviour With Weapon To Staff	1	0	
V41 Threatening Behaviour With Weapon To Others	1	1	
Totals	**87**	**102**	

Incident Reporting

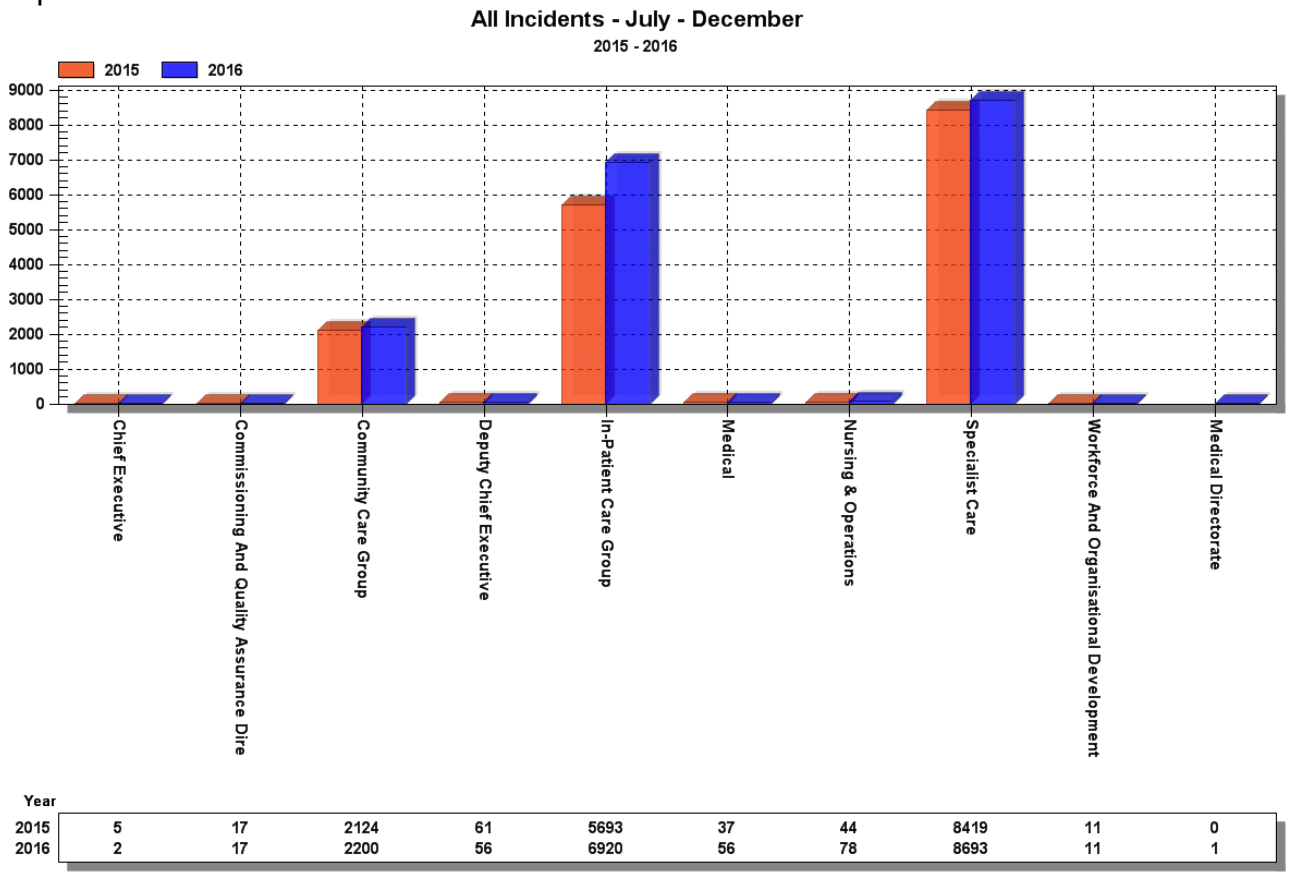
The following information gives a detailed breakdown of the incidents that have occurred in the Trust in the last 6 months and compares the activity to the previous year. It can be seen that incident reporting has as increased in each of the months, which in part is due to the ease of web based incident reporting implemented in October 2015.

Graph 2



Year	July	August	September	October	November	December
2015	2854	2704	2595	2793	2850	2615
2016	2864	2970	2925	3145	3141	2979

Graph 3



Year	Chief Executive	Commissioning And Quality Assurance Dire	Community Care Group	Deputy Chief Executive	In-Patient Care Group	Medical	Nursing & Operations	Specialist Care	Workforce And Organisational Development	Medical Directorate
2015	5	17	2124	61	5693	37	44	8419	11	0
2016	2	17	2200	56	6920	56	78	8693	11	1

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.

For the 2 data periods we have seen an increase from 16,425 incidents in 2015/16 to 18,043 in 2016/17.

The areas of increase are as follows:-

- Inappropriate patient behaviour - smoking – increased from 983 incidents to 1,452 after the implementation of smoke free sites.
- Increase in self harm incidents from 2,413 to 3,227 incidents, this activity is being reviewed in line with the positive and safe strategy, as part of the roll out of the “talk first initiative”.
- Other increases have been seen in awol and absconds, deaths (natural and expected), Infection , Prevention and Control, Information Governance and Security, this is most likely based on the implementation of web based reporting as paper reports were still being completed for 4 out of the 6 months in 2015 / 16.
- Clinician feedback indicates that the electronic system, allows for more incidents to be reported more easily, with instant feedback and support by managers who have been automatically notified by the system.

Now that the web based system has been running for over a year, an expected annual out-turn of activity can be predicted.

For the full financial year, April 2015 – March 2016 there were 32,014 incidents reported across the Trust. A projected figure for April 2016 – March 2017 is 35,000 incidents. This is a significant shift in transparency since the start of the organisation, when the Trust reported 20,000 incidents per year. Staff are more confident and conscious to report incidents , knowing that it aids learning at every level.

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. The next report is due to the Quality and Performance Committee in March 2017.

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

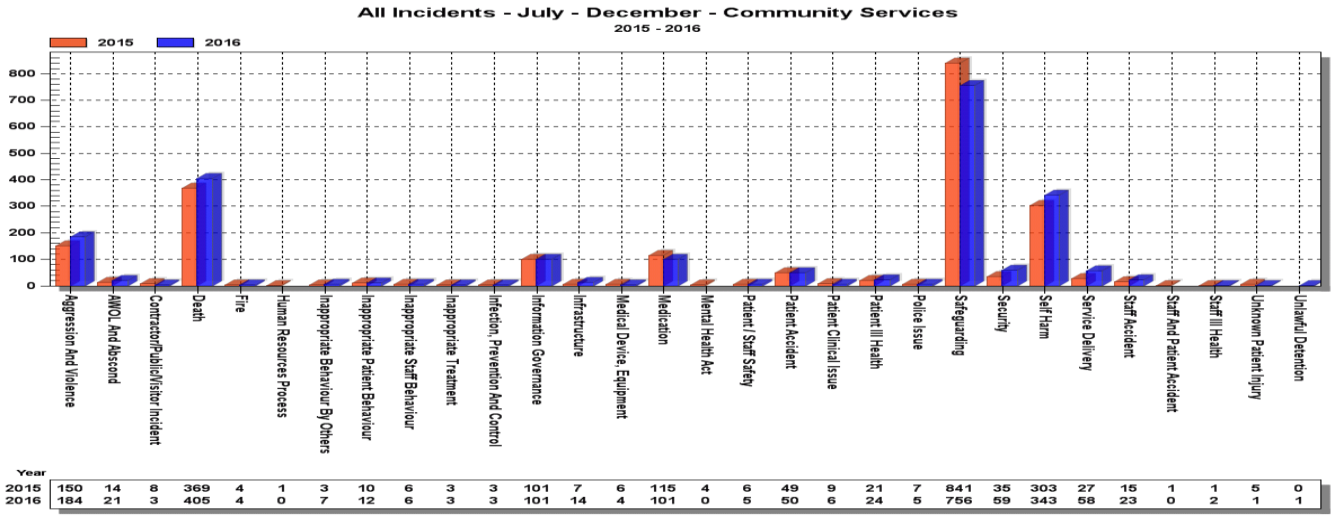
Since the last report the continued roll out of the lone working system is now covering 25% of the workforce. Predominantly in the community this allows an extra layer of support for those staff at increased risk of violence and aggression, this can be evidenced in the increased in reported incidents, 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. Previously reported to the Board of Directors there were concerns around usage of the devices, but this is an improving picture, and the current draft internal report is evidencing a good standard, still with some issues of note, which will be actioned accordingly. A full report will be presented to the Board of Directors at February 2017 Board, in line with current safety reporting.

In-Patient and Specialist In-Patient Services

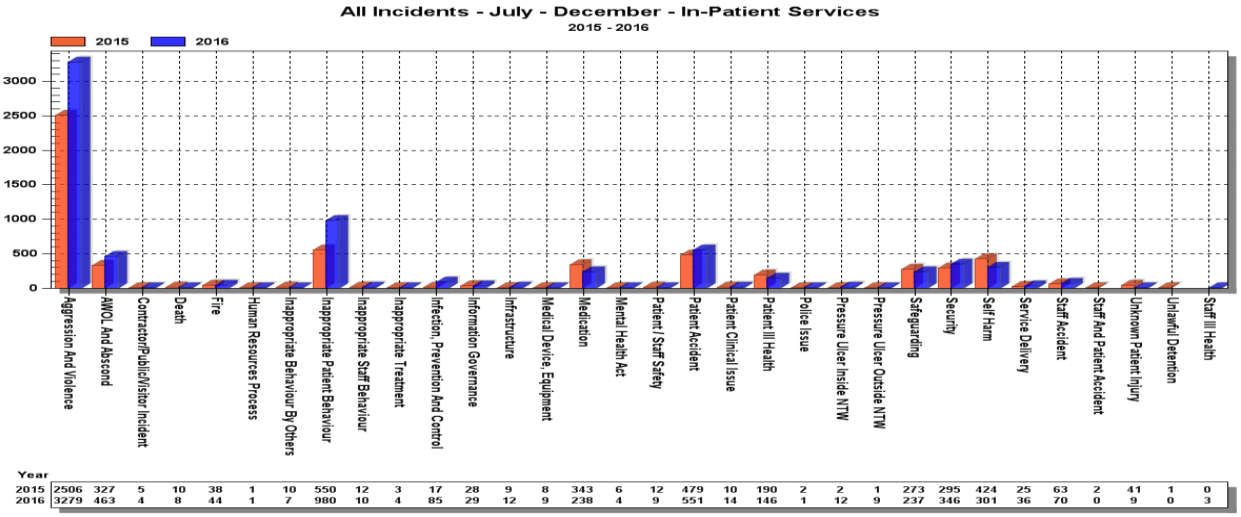
The provision of staff attack systems, Closed Circuit Television Systems, Walkie Talkies , Ligature Cutters and Mechanical Restraint Equipment, have been provided to clinical teams on wards to support effective management of safety for both patients and staff, these systems of safety , have vastly reduced 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.

The Patient Safety Group of the Trust is reviewing its' Term's of Reference to ensure that the learning from all activity in the Trust is in place, and it can start to form new safety standards , and review current safety standards for environments, some of which were created a number of years ago. All of this activity is formed out of learning that has come from Incidents, Complaints and Claims .

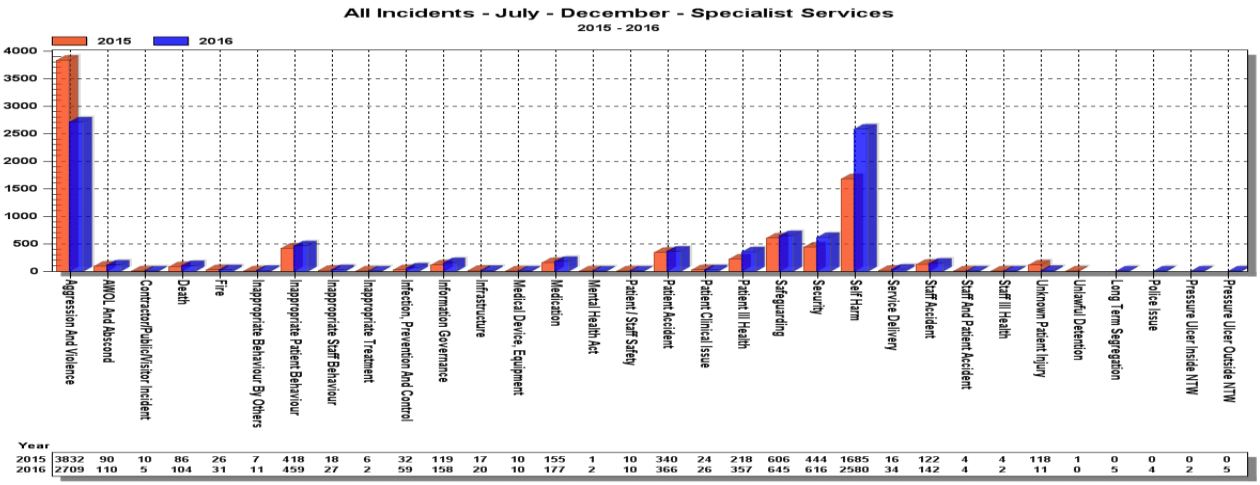
Graph 4



Graph 5



Graph 6



Complaints Reporting and Management

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

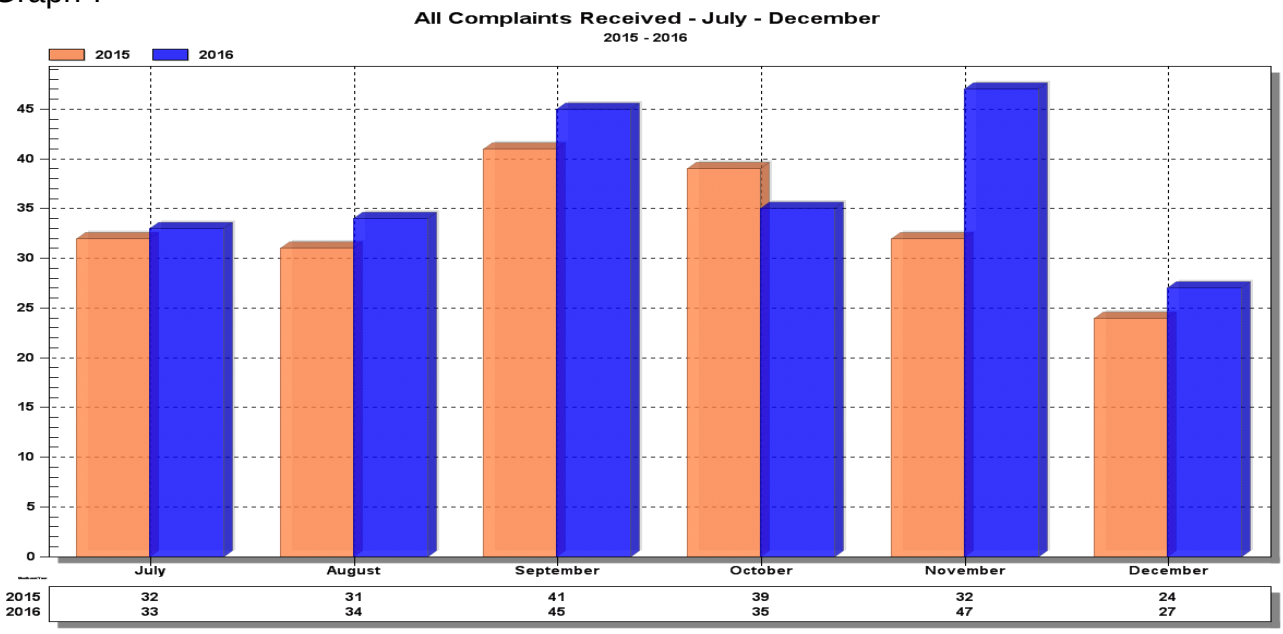
New Policy – Descriptors

- Standard
- Complex
- 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 199 in 2015 to 221 in 2016. This is the same increase as the previous 6 monthly report, which means there has been a total increase of 44 complaints in the year on year activity.

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

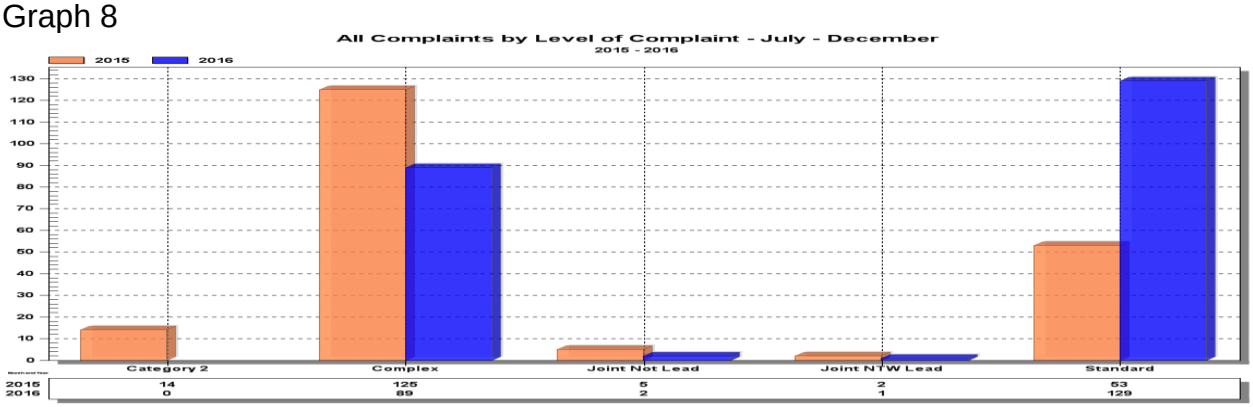
The following table gives a breakdown of complaints received by category, these categories are nationally approved, and information is sent to NHS Digital on a quarterly basis.

Table 2

Category Type	2015-16	2016-17
Access To Treatment Or Drugs	5	5
Admissions And Discharges	13	10
Appointments	7	12
Clinical Treatment	10	10
Commissioning	0	1
Communications	43	34
Consent	1	0
Facilities	1	13
Integrated Care	1	0
Other	1	11
Patient Care	52	68
Prescribing	18	9
Privacy , Dignity And Wellbeing	4	7
Restraint	4	1
Trust Admin/ Policies/Procedures Including Records Management	4	7
Values And Behaviours	32	32
Waiting Times	3	1
Totals	**199**	**221**

In graph 8 below when looking at the specific categories of complaints, far more complaints are being dealt with locally as standard complaints. Over the last 12 months there has been a complete reversal of complaints being dealt with locally , rather than having an independent investigator. Some of this would have been expected with the removal of the dedicated complaints investigators as part of the corporate re-organisation, but this should also be seen as 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, rather than leave the complaint process in other organisations. This is subject to a decision mad eby each complainant.

Graph 8

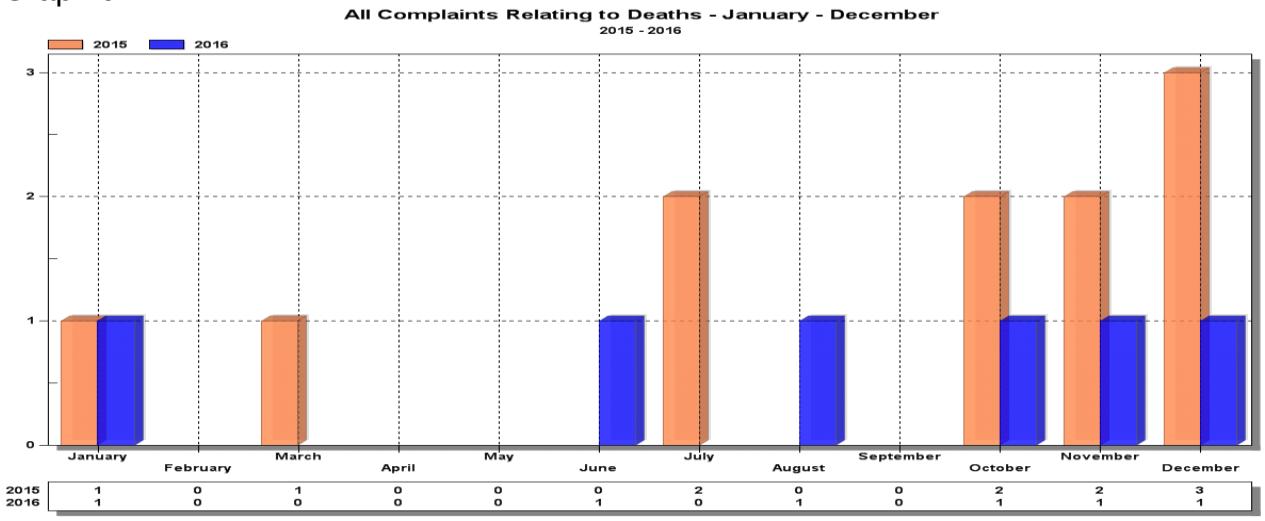


Complaints Relating to Death

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.

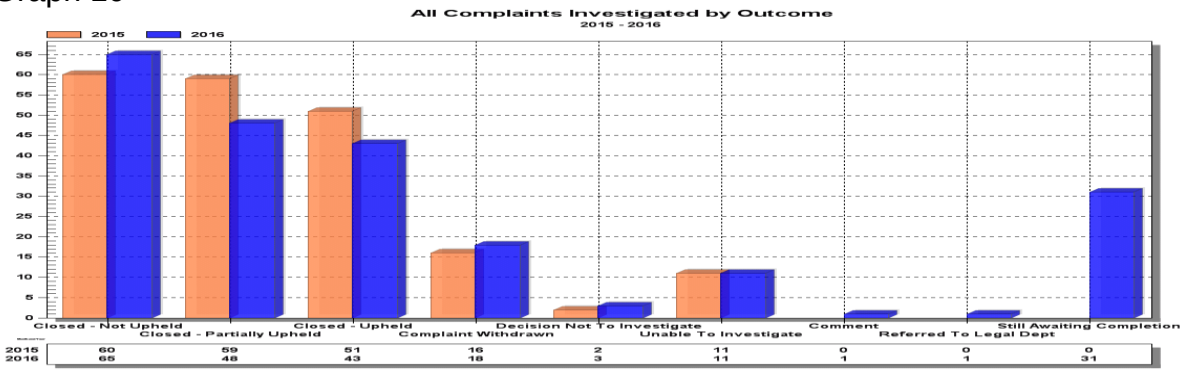
Graph 9



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



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.

The following is the breakdown of ongoing activity for the PHSO by the 3 clinical groups.

COMMUNITY SERVICES

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
26.05.2016	2919	16001990	PHSO – Request for files	Files sent 07.06.16
22.08.2016	2972	262641	PHSO – Final report received	Final report received and circulated. Cheque for £500.00 and apology letter sent. Action plan due out by March 2017
15.09.2016	3024	266719	PHSO – Intention to investigate	PHSO investigator identified
23.09.2016	2878	267570	PHSO – Intention to investigate	Files sent 07.10.16
20.10.2016	3269	272208	PHSO - Enquiry	PHSO still considering this case for investigation
07.11.2016	1722	270818	PHSO – Intention to investigate	Additional files sent to 15.11.16
02.12.2016	3294	2000977	PHSO – intention to investigate	Files sent 15.12.16

IN-PATIENT SERVICES

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
25.07.2016	2318	16003416	PHSO – Intention to investigate	Files sent 03.11.16
02.08.2016	3033	262023	PHSO – Intention to investigate	Files sent 17.08.16
28.09.2016	2926	268846	PHSO – Intention to investigate	Files sent 18.10.16

SPECIALIST

Opened	Complaints Number	PHSO Reference	Current Status	Current Update
26.03.2015	Local res 2664	210865	PHSO – Draft Report Received	Draft report received – complaint partially upheld. Comments sent back 15.09.16
30.09.2016	3062	161003-122905	PHSO – Request for files	Files sent 04.11.16