NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETTING

Meeting Date: 26th July 2017

Title and Author of Paper: Quarter 1 – Safer Care Report - April – June 2017
Author of Paper in response to this report –
Tony Gray - Head of Safety & Security
Claire Taylor – Head of Clinical Risk and Investigations
Vicky Clark – Incidents, Complaints and Claims Manager
Dr Damian Robinson – Deputy Medical Director - Safety

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 activity for the period April – June 2017, this report will contain the formal reporting mechanism to the Board relating to what the Trust is "Learning from Deaths".
- The cycle of reporting is included as reference below, the Q4 safer care report will act as annual report in relation to incident and complaint activity.
- This report will cover the activity reported in the months April – June.
- This report will contain any lessons learned from the activity reviewed in the months April – June, that occurred in the previous quarter.
- Update provided in line with the "Learning from Deaths" action plan.

Report Title	**Board Date**
Safer Care Report Q1	July
Physical Assaults on Staff Annual Report	September
Safer Care Report Q2	October
Mortality Report	November
Safer Care Report Q3	January
Lone Working Annual Report	February
Safer Care – Forward Plan – Annual Review	March
Safer Care Report Q4	April
Annual Security Management Report	May
Positive & Safe Annual Update	June

Risks Highlighted to Board: None

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

Equal Opportunities and Legal and Other Implications: None

Outcome required: Noted for Information

Date for completion: N/A

Links to Policies and Strategies:

- Incidents Policy
- Complaints Policy
- Claims Policy
- Health & Safety Policy
- Security Management Policy
- Central Alert System Policy
- Safeguarding Policy

Northumberland, Tyne and Wear NHS Foundation Trust

Safer Care Report
July 2017
Reporting Period: April - June 2017

Shining a light on the future

Introduction

This is the first Safer Care Report to be received by the Board of Directors, this report builds on the monthly report that is produced for the organisation and Clinical Commissioning Groups every month and is presented to the Corporate Decisions Team – Quality and to the Board of Directors – sub committee – Quality and Performance on a bi-monthly basis. These reports will produce more detailed analysis, down to service line, so that trend analysis and any hot spot activity can be explored and understood.

Incident Reporting and Management

Serious Incidents Reported – Quarter 1

The following information gives a detailed breakdown of the serious incidents that have occurred in the Trust in the last quarter, in comparison to the quarters before.

Table 1 – Serious Incidents Reported – Quarter 1

	Q1			Q2			Q3			Q4			Q1		
Incident Type	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Death	8	9	12	9	11	8	5	12	15	19	13	15	13	18	8
All Other Serious Incidents	11	6	5	3	7	3	6	6	1	1	5	7	5	1	4
Totals	19	15	17	12	18	11	11	18	16	20	18	22	18	19	13
Quarterly Totals	51			41			45			60			49		

It can be seen in the above information that the serious incident rate is similar to Quarter 1 for the previous year, however there has been an increase in those incidents of death we are classing as serious and reviewing. This is to be expected, given the greater level of scrutiny and discussion we are having with Services and Directors around deaths that occur.

There have been 40 deaths investigated as serious Incidents for Quarter 1 an increase of 11 for last Quarter 1, there have been 10 other categories of incidents investigated as serious for Quarter 1 a reduction of 10 from the last Quarter 1.

The levels of investigation are as follows, all of these incidents are discussed in detail with Directors at the Business Delivery Group Meeting on a Friday morning and the level of investigation agreed in line with the following definitions:-

Serious Incident Framework Level 1 – Concise internal investigation – Trust equivalent in Policy – After Action review.
Serious Incident Framework 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.

Serious Incident Framework 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.

The detailed analysis of the activity by service is provided in the monthly Safer Care report that is produced for the Corporate Decisions Team- Quality Meeting, and shared with Commissioners as part of the NHS Contract on a monthly basis.

In the first quarter from the information reported, there is no concerns identified in any particular service.

Learning From Deaths

As part of the developments following the publication of the National Quality Board Report into investigation and learning from deaths, the Trust is now considering a greater level of detail in relation to those deaths that are undergoing a mortality review. This information is provided as an update to the Business Delivery Group every week, to track the progress.

Currently the Trust is piloting a mortality review tool based on the Structured Judgement Review method used within acute Trusts. Deaths which are being reviewed using this tool are those which fall into the following categories but which are not also reviewed as serious incidents.

- The service user had a learning disability or received care from a learning disability service
- The death occurred while an in-patient
- The service users was aged under 55years of age at the time of death
- The service user was subject to detention under the Mental Health Act
- The death occurred following an intervention, including ECT
- The family or carer or staff have expressed concern about the death
- The death has been selected for review by BDG/CDT

All deaths of service user with a learning disability are reported to LeDeR in order that a specialist review of the death can occur.

The following table gives the full information relating to deaths and gives a breakdown of those deaths that are either subject to an investigation or mortality review in the previous Quarter, and which type of death they relate to. This also gives a breakdown of those death that have been referred into the LEDER process for the review of Learning Disability Deaths.

This development helps to support the first action that deaths are correctly identified for investigation.

All deaths reported and level of investigation

When considering this information it is acknowledged that some deaths will fall into multiple processes due to their nature, for example a learning disability death of a detained patient, on an in-patient ward where there are safety concerns, would be reported through the following systems:-

- STEIS – Strategic Executive Information System – as a serious incident and in line with the Serious Incident Framework, overseen by Commissioners
- National Reporting and Learning System (NHS Improvement) – as a reportable incident for any immediate learning
- Care Quality Commission – Due to the death of a detained patient and to notify of the safety concerns from a registered location.
- To LEDER as a learning disability death
- Through Safeguarding Adult's and Children's processes as identified.
- To the Coroner – via the Police when the incident is discovered.
- NHS England – Mental Health Homicide Investigations.
- Health & Safety Executive – Workplace fatality.

On this basis it is acknowledged that the total numbers and length of investigations for a number of deaths will vary depending on which processes they go through.
It is also acknowledged that due to information gathered, where patients have died naturally from a known illness, which was being clinically managed, will not result in any type of investigation unless there are concerns identified by the family relating to the care prior to death.

A full update on the Learning From Deaths Action Plan is included at Appendix 1.

Table 2 – Deaths Recorded, Reported and Investigated

Category	Apr – Jun 16	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17
	Q1	Q2	Q3	Q4	Q1
Death as Serious Incident (Level 3) Homicide by a Patient	0	0	1	1	0
Death as Serious Incidents (Level 2) i.e. self harm related, community deaths of unknown nature, in-patient deaths, detained patient deaths	18	16	13	16	20
Deaths as Serious Incidents (Level 1) i.e deaths related to alcohol or substance misuse services, or requiring a low level investigation.	11	12	18	28	19
NRLS reportable deaths	24	22	26	37	21
LEDER reportable deaths	N/A	N/A	N/A	N/A	5
Deaths subject to mortality reviews	N/A	N/A	N/A	N/A	11
Deaths being investigated due to family concerns that are not part of any investigation process above	0	0	0	0	0
Deaths subject to a Safeguarding Process	N/A	N/A	N/A	N/A	0
All other deaths not subjected to review or investigation*	237	238	251	234	165*

*** The reduction in deaths reported from April onwards will be monitored from quarter to quarter as itis likely that deaths have not all been recorded yet for June.**

Learning from Deaths – A Case Example

The above table indicates the numbers of deaths the Trust records in each of the previous quarters, but it is the individual cases where true learning and improvement are identified.

It is acknowledged that there is a patient at the centre of each of the reviews the Trust undertakes with the full involvement of family and carers to identify and appropriately answer any questions they may have around care and treatment prior to death, even if the death is deemed as a natural occurrence.
The following case vignette, outlines the details of the incident, the care provision and the reflection and learning from the case. This acknowledges that this level of activity is replicated for each death that is investigated, but gives the Board of Directors an insight into what the Incident Policy and serious incident process and newly developed mortality process achieves in bringing about changes to care and treatment within the Trust.

Case Vignette – Incident 244817

Clinical summary

In the last quarter the Trust undertook a review of the care of a young service user who died from diabetic ketoacidosis while a hospital in-patient. The service user had a diagnosis of paranoid schizophrenia and was receiving high dose antipsychotic treatment (HDAT) to manage their severe and complex presentation. The normal physical heath checks were difficult to undertake due to their mental health state and lack of co-operation. Nonetheless, blood tests had revealed high blood sugar levels. The service user had a high body mass index (BMI) and was noted to be consuming an excessively high calorie diet. They were observed to drink multiple cartons of fruit juice and eat take away meals several times each week; even in one evening on occasion.

The service user would not allow staff to regularly check their blood sugar with BM stix. Due to their acute mental state they received an injection of a sedative anti-psychotic and slept for much of the subsequent 48 hours. They were found unresponsive in their bedroom and, despite attempts by staff and emergency services including transfer to an acute hospital, died a short time later. The underlying cause of death was diabetic ketoacidosis.

Learning

While diabetes mellitus was diagnosed by the clinical team it was not monitored or treated according to best practice. In part this was due to lack of co-operation from the service user.

Symptoms indicative of ketoacidosis were missed by the team. This was due to a combination of a lack of knowledge around diabetes and its management, the service user's history of excessive drinking and the sedative effects of medication clouding the clinical presentation.

There were issues with the monitoring of HDAT prescribing noted despite the issue being raised by the pharmacy department.

Although the physical health record had been completed it had not been adequately reviewed in light of subsequent changes.

The ineffective use of the daily reviews as a communication structure, especially with regard to the identification and management of risks, was identified.

Actions Taken

A small team has been established to review all the above areas and develop a programme of training to be delivered to all staff on the ward. This programme will include a specific session on diabetes awareness raising and lessons learned from this review.

Several workshops have already been held with more being planned at the time of the last update. This programme of training is then to be rolled out to cover all inpatient ward areas.

Broader context

A number of incidents have been reported relating to the use of insulin and other medicines used for the treatment of diabetes. Reviews have also raised concerns and developed action plans relating to the management of diabetes of individual patients.

A number of actions have been taken in response to these incidents.

- A CAS alert has been issued to all staff reminding them of their responsibilities in the management of diabetes and hypoglycaemia.
- At a local level, individuals and ward teams have had diabetes training (face to face or via eLearning packages).
- The practice guidance note for the Safe Prescribing and Administration of Insulin (NTW(C) 38 - PPT-PGN-06) has been reviewed by a multi-disciplinary group and has been expanded to include all medicines used for the treatment of diabetes. It also includes information of how to recognise and treat hypoglycaemia, hyperglycaemia and ketoacidosis.

In addition, the concern about obesity in service users with severe mental illness is being addressed on a regional basis through the development of an obesity strategy covering both mental health trusts in the North East. This work has been supported by Public Health registrars working within NTW and follows the implementation of the regional smoke free strategy in March 2016. The obesity strategy includes interventions on physical activity and diet, including the concern about access to high calorie take away meals, both of which are contributory factors in the development of diabetes.

Incident Reporting

The following information gives a detailed breakdown of the incidents that have occurred in the Trust in the last quarter, in comparison to the previous year, there is detailed analysis of this information every month through the Trust's governance systems as well as the monthly reports which gives a greater level of analysis down to service line.

	Q1	Q2	Q3	Q4	Q1
Incident Type	Apr – Jun 16	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17
Aggression And Violence	2936	3028	3157	3216	3626
Inappropriate Patient Behaviour (smoking)	663	543	907	743	535
Safeguarding	853	835	829	1335	1446
Self Harm	1487	1578	1648	1676	1395
Security	464	563	495	475	597
Totals	6403	6547	7036	7445	7599
All Other Incidents	2320	2220	2293	2114	2129
Totals	**8723**	**8767**	**9329**	**9559**	**9728**

It can be seen from the above table incident reporting has increased steadily over the last year, the main areas are identified below.

Notable increases / decreases are as follows:-

- Aggression and Violence has increased by 690 incidents over the same quarter last year and by 410 incidents over the previous quarter, it has increased in each for the last 4 quarter and evidences the complexities of the in-patient population.
- Inappropriate patient behaviour (smoking) has decreased from the same quarter last year and its lowest quarter in each of the last 5, this is very much dependant on the patient population at the time and their compliance with the Trust Smoke Free Policy.
- Safeguarding has increased as expected with the changes made to the Trust's Safeguarding Triage system, which was implemented in January 2017, from both the internal safeguarding team's perspective and Safeguarding Boards external to the Trust this has been seen as a positive and giving a true perspective of the activity of the Trust.
- Self Harm activity has decreased significantly in quarter 1 and is 92 incidents lower that the same quarter last year and is the lowest of the last 5 quarters, again this is directly related to the activity created by individual patients, and can rise significantly at point of admission.

All the activity is suitably considered at the Corporate Decision Team's – Quality Meeting and through the Trust's Quality and Performance Committee, where the themes and trends are analysed and understood. The clinical groups also provide an update through the Quality and Performance Committee on a 6 monthly rotational basis, exploring their own activity and the reasons for it.

Positive and Safe Care

An update on the Trust's strategy in relation to positive and safe care will be provide in Q2 Safer Care Report.

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

There have been a number of changes in the complaints process over the last year. The following table gives a breakdown of the Trust activity for all complaints received over the last 3 years, with reasons and rationale for the increase.

Complaints have increased during 2016/17 with a total of 437 received during the year (during which time we provided care and treatment for more than 81,000 people). This is an increase of 74 complaints (or 20%) from 2015/16, and the increase can be seen across many categories. Note there has been a reduction in complaints relating to restraint, which may be linked to the implementation of the Positive and Safe Strategy.

Complaints have also increased in Q1 in comparison to the same period last year, this is currently under close scrutiny By the Executive Director of Nursing and Operations and the Operational Directors.

When considering the themes arising from complaints, it is clear to see that waiting times for Children and Young Peoples' Services features within this. Also there are several complaints in relation to the new ways of working and the promotion of episodic care to aid recovery and the associated impact this has had on patient's benefit claims. There has also been an increase in complaints relating to facilities which often relate to the no smoking policy and parking issues around major hospital sites.

Table 4

Complaint Type	Q1	Q2	Q3	Q4	Q1	Total
	Apr – Jun 16	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	
Complex	26	44	43	40	59	212
Joint Not Lead	2	0	1	1	1	5
Joint NTW Lead	3	0	0	1	0	4
Non-Clinical Co	1	3	1	0	0	5
Standard	65	68	65	73	86	357
Total	97	115	110	115	146	583

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. Complaints are increasing across all the category types.

Table 5

	Q1	Q2	Q3	Q4	Q1	**Total**
Category Type	Apr – Jun 16	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	
Access To Treatment Or Drugs	0	1	3	3	3	10
Admissions And Discharges	4	4	6	7	14	35
Appointments	5	5	7	3	9	29
Clinical Treatment	4	3	7	4	6	24
Commissioning	0	1	0	0	0	1
Communications	21	21	14	21	24	101
Facilities	7	6	10	6	2	31
Other	0	5	6	2	4	17
Patient Care	23	37	31	34	41	166
Prescribing	10	9	0	7	9	35
Privacy , Dignity And Wellbeing	1	5	3	3	1	13
Restraint	3	1	0	0	0	4
Trust Admin/ Policies/Procedures Including Rec Man	5	2	5	5	4	21
Values And Behaviours	14	15	17	18	25	89
Waiting Times	0	0	1	2	4	7
Total	**97**	**115**	**110**	**115**	**146**	**583**

Complaints Relating to Death

The table 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. This information has been included as it directly correlates to the Learning from Death activity , and guages family and carers responses of the care provided priro to the death of a patient irrespective of cause.

In collecting this data, it can be seen over the last 3 years we have averaged 11 complaints per year, this is mirrored in the activity for the last 4 quarters, acknowledging that we saw an increase in Q3 and Q4, this is still an extremely small number in comparison to the deaths that are reported in the Trust. This also acknowledges that many families and carers seek answers around concerns relating to care which are responded to as part of the serious incident investigations under the Trust's Duty of Candour processes.

Table 6

	Q1	Q2	Q3	Q4	Q1	**Total**
Services	Apr – Jun 16	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	
In-Patient Services	1	0	1	0	0	**2**
Crisis Response and Home Treatment	0	0	1	1	0	**2**
CYPS Community Services	0	0	0	1	0	**1**
Adult Community Services	0	1	2	1	2	**6**
Information Department	0	0	0	1	0	**1**
Older Adults Community Services	1	0	0	0	0	**1**
Totals	**2**	**1**	**4**	**4**	**2**	**13**

Parliamentary Health Service Ombudsman

The following information is the current activity that has been reported / requested via the 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 if they are still dissatisfied. The following are the on-going complaint activity with the PHSO.

Opened	Complaint Number	PHSO Reference	Current Status	Current Position	Trust Investigation Outcome
26.05.2016	2919	16000490	PHSO – draft report received	Complaint **not upheld**. Awaiting copy of final report.	Partially upheld
22.08.2016	2972	262641	PHSO – final report received	Complaint **upheld**. Revised action plan as requested by PHSO circulated	Upheld
15.09.2016	3024	266719	PHSO – final report received	Complaint **partially upheld**. Revised action plan as requested by PHSO circulated	Partially upheld
23.09.2016	2878	267570	PHSO – intention to investigate	Files sent 07.10.16 Email received 25.01.17 requesting Trust comments on scope of their investigation. Email reply sent 01.02.17.	Not upheld
20.10.2016	3269	272208	PHSO - enquiry	PHSO still considering this case for investigation.	Not upheld
20.02.2017	3144	C2003388	PHSO – intention to investigate	Files sent 01.03.17, Investigator identified	Partially upheld
06.03.2017	2982	C2008097	PHSO – intention to investigate	Files and records sent 15.03.17	Not upheld
02.08.2016	3033	262023	PHSO – Intention to investigate	Files sent 17.08.16. Investigator identified.	Partially upheld
28.09.2016	2926	268846	PHSO – final report received	Final report received – complaint **partially upheld**. Letter of apology and action from recommendation due out by 06.06.17	Partially upheld
26.03.2015	2664	210865	PHSO – revised draft report received	Revised draft report received – complaint is now **upheld**. PHSO advised Trust has no comments 13.04.17	Not upheld
30.09.2016	3062	161003-122905	PHSO – request for files	Files sent 04.11.16	Partially upheld
07.11.2016	1722	270818	PHSO – Intention to investigate	PHSO investigator appointed 01.03.17. Draft report anticipated July 2017	Unable to investigate

Claims

Claims received by Case Type

Case Type	2016-17 (1)	2016-17 (2)	2016-17 (3)	2016-17 (4)	2017-18 (1)	Total
CNST	4	0	3	3	3	13
Employers Liability	3	10	8	8	5	34
Ex Gratia Complaint	0	1	0	0	0	1
Ex-Gratia	13	19	15	13	15	75
Ex-Gratia PHSO	0	0	1	0	1	2
Public Liability	1	1	4	0	1	7
Third Party Claim	0	3	2	3	2	10
Total	**21**	**34**	**33**	**27**	**27**	**142**

There is nothing remarkable about these figures, either by total amount or number per claim type. Ex gratia claims predominantly make up the largest proportion of claims, followed by employer liability claims.

Claims received by Category

Category	2016-17 (1)	2016-17 (2)	2016-17 (3)	2016-17 (4)	2017-18 (1)	Total
Accidental Injury	0	6	3	6	6	21
All. Of Failure To Provide Approp. Care	3	0	1	1	3	8
Allegation Of Harrassment	0	0	0	1	0	1
Assault on Staff	1	6	3	3	1	14
Carpal Tunnel Syndrome	0	0	1	0	1	2
Damage To Patient Property (Accident)	1	2	1	1	1	6
Damage To Patient Property (Violence)	0	0	0	0	1	1
Damage To Staff Property (Accident)	0	1	3	1	0	5
Damage To Staff Property (Violence)	8	4	4	7	7	30
Damage To Visitor Property	0	0	1	1	0	2

Expenses Incurred Due To A Trust Process	1	1	2	0	1	5
Exposure To Hazard	0	0	1	0	0	1
Industrial Deafness	0	0	0	0	1	1
Information Governance	0	0	1	0	0	1
Injured During Restraint	3	2	4	0	0	9
Loss Of Patients Property	3	10	4	3	5	25
Loss Of Staff Property	0	1	1	0	0	2
Loss Of Visitor Property	0	1	0	0	0	1
Medical Procedures/Operations	1	0	0	0	0	1
Medical Treatment	0	0	1	0	0	1
Sharps/Needlestick	0	0	1	0	0	1
Stress Suffered by Staff	0	0	0	1	0	1
Unexpected Death	0	0	1	2	0	3
Total	**21**	**34**	**33**	**27**	**27**	**142**

The highest ex gratia claim categories are damage to staff property and loss of patient property. The damage to staff property claims relate to clothing or spectacles damaged by patients either due to assault on the staff member or damage sustained in the course of restraining a patient.

The highest employer liability categories are accidental injury and assault on staff. Accidental injury claims include slips, trips and falls and also manual handling claims.

Appendix 1

Learning from Deaths / Mortality – Safety Team – Action Plan

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
Patients who have died under their care are properly identified.	• All deaths are reported through the Trust's Incident reporting system. • An analysis of this information from the national data submission shows a high concordance between incidents reported on the Trust Risk Management System (SafeGuard) and the Full Clinical Patient Record (RiO), which records all deaths reported through the national spine and available through Office for National Statistics around mortality.	• A mortality dashboard will be created which brings together both information systems to assess and analyse to give a zero attrition rate, based on patients that are current to services at death or have been recently discharged from services in the last 6 months. • Presentation of data will be compared to 2 other Trusts across the Northern Alliance to feedback to Mazars meeting in June 2017 (Sheffield Health and Social Care Trust, and South West Yorkshire Partnership Trust)	• Dashboard is live • Undergoing testing based on initial discussions with other Trusts • Meeting completed • Meeting took place and a number of similarities were discussed with the types of deaths that occur within Trusts, agreed where possible standardisation on reporting should occur, further discussion with all Trusts in July.	May 2017 Completed September 2017 June 2017 Completed July 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Kelly Collier – IT Project Team Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety
Case records of all patients who have died are screened to identify concerns and possible areas for improvement and	• Case records are screened as part of the established investigation processes in line with the NHS England Serious Incident Framework. This covers predominantly unnatural cause deaths	• The Trust Incident Policy will be reviewed to establish a mortality review process, supported by the Alliance Health Service Network and North East Quality Observatory. This will extend coverage to natural	• Trust Incident web form has been adjusted with questionnaire relating to deaths, testing to commence in August	August 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor

the outcome documented.		cause deaths • A new deaths policy / PGN will now be created to sit within the Trust's incident policy		September 2017	Head of Clinical Risk and Investigations
Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.	• This already occurs through established Duty of Candour principles, which has a 3 stage check, and is subject to quarterly monitoring and reporting to the Clinical Commissioning Groups as part of contractual obligations.	• These principles will be extended to all deaths following an assessment of any concerns identified for any non-SI related death, which may include natural and expected deaths following discussions with Directors after implementation of the new mortality review process.	• Trust incident system being used now for all Serious Incidents to report on Duty of Candour	June 2017 Completed With information now included in monthly safer care report.	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Appropriately trained staff are employed to conduct investigations.	• The Trust has a central dedicated team of serious incident investigators, supported by lead clinicians from services to review all unexpected deaths in line with the NHS England Serious Incident Framework. • This team has undergone routine investigation training as part of their appraisals and CPD requirements.	• A review of the levels of investigation for non-SI deaths will be agreed and capacity and demand including any increased costs will be reported through to the Trust's Business Delivery Group. • Investigators will be trained in the use of Human Factors Frameworks	• Mortality Review to be carried out on agreed deaths commencing April 2017 with position reported on in Q1 Safer Care report	June 2017 Completed Data now included in Q1 report. Findings on Mortality reviews to be included in Q2 September 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.	• Within existing serious incident processes wherever information comes to light, or there is concern relating to the true independence of investigation, this is escalated to the Executive Director of Nursing and Operations, to seek authorisation to allocate to an external investigator, supported by a lead clinician in the Trust.	• Capacity and demand fluctuates for this and likely this will be impacted by a small group of external professionals being available, and facing more request from a number of Trusts in future. • Demand and compliance will be reported through the Trust's Safety Report. • New reporting cycle -	• Month 1 report produced. • Q1 report produced detailing independent investigations.	July 2017 Completed	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations

	• The Trust has a panel of external investigators	Month1 for report to CDT-Q In May 17 and Safer Care Report – Q1 to Board in July.			
Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.	• The Trust reports on its compliance against current 60 working day timescales through the monthly All Incident report which is shared with Clinical Commissioning Groups. Extensions are agreed in advance and by exception. • For cases reviewed in December 2016, 86% complied with the 60 day timescale. In one case an extension had been agreed with the CCG.	• Monitoring of these timescales will continue to be shared with CCG's , but information will start to be included in the Safety Report for Board in the next reporting cycle. • Only deaths classified as serious incidents will be measured by the 2 / 60 working day timescales • New timescales will need to be agreed for other death reviews	• Mortality Review to be carried out on agreed deaths commencing April 2017 with position reported on in Q1 Safer Care report Whilst this action has been completed, it has identified a potential capacity issue which as been flagged to Directors and is now subject to a weekly update. This risk is currently being managed. • Timescale for completion of Mortality Reviews to be included in new policy.	July 2017 Completed September 2017 Completed	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
Families and carers are involved in investigations to the extent that they wish.	• Families and carers are involved at the outset in all investigations, where they are contactable following a death. • Extensions are agreed to delay the investigation at their request due to impact of bereavement. • Reports are shared that answer the specific questions they have, and agreements in place with all coroners where deaths are subject to inquest to direct concerns or questions to the Trust to be	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. • This approach will need to be adopted from April 1st and included in new policy / PGN by September 2017	• Mortality Review to be carried out on agreed deaths commencing April 2017 with position reported on in Q1 Safer Care report	June 2017 September 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations

	included.				
Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.	• The Trust has in place an effective dissemination process for learning, starting with the learning from activity update that is shared with all senior staff on a Thursday, which reflects on all the Serious Incidents, Complaints, Complex issues, Coroner outcomes, serious incident reviews of the previous week. This is shared through operational groups by Tuesday at the latest for information. • Other organisations involved in an incident are included once identified as part of the serious incident process, and invited to attend after action reviews and the SI panel discussions. Non-engagement is escalated to Clinical Commissioning Groups and included in SI reports as actions for improvements.	• This approach will need to be considered and included into the mortality review process for Non-SI deaths. • The current Patient Safety Group will be reviewed to create a Trust wide Learning Lessons Group. • A regular Learning Lessons newsletter will be established. • The Trust is working with other MH Trusts in the North/Mazars to develop cross organisational learning.	• Group to be reviewed in line with Clinical Group Changes • Review still on-going.	October 2017	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations Vida Morris – Group Nurse Director
Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.	• The Trust has a transparent and open approach to reporting and learning from deaths. • A six monthly analysis of deaths has been presented in the open part of the Board of Directors meeting since 2009. The last 4 years reports are publicly available for scrutiny	• A review of the unexpected death report will ensure that there is a learning and improving section within this, similar to the established safety report. • All Trust reporting is being adjusted from April 1st with the monthly report having a deaths section in it. • 16/17 quality account template will be populated with 16/17 deaths activity to give the Executive Director	• Plans in place	October 2017 April 2017 Completed April 2017 Completed	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations Vida Morris – Group Nurse Director

		and Non-Executive Director a first view of a future quality account • The Q1 – Safer Care report will include an introduction of the death data and any learning. • The Annual report on mortality to Board will be presented in September 2017 • Data will be reported in the Quality Account from June 2018, in line with DoH guidance		July 2017 Completed as part of this report September 2017 June 2018	
That particular attention is paid to patients with a learning disability or mental health condition.	• This recommendation is applied across all service providers, and by default would naturally apply to a Mental Health / Learning Disability Trust	• Work needs to be completed to improve the quality of diagnosis of all patients who die, to understand their diagnosis. • In particular, to clarify the recording of a diagnosis of LD where the person is in a non-LD service. • Current practice will remain of capturing all LD deaths in LD services.	• Mortality Dashboard to include Diagnosis of Patient to clearly identify Learning Disabilities.	October 2017	Executive Director of Nursing and Operations / Operational Director of Service Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety