NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: Wednesday 24th January 2018

Title and Author of Paper: Safer Care Report - Quarter 3 – (Including Learning from Deaths) – October - December 2017
Author of Paper in response to this report –
Tony Gray - Head of Safety & Security
Claire Taylor – Head of Clinical Risk and Investigations
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Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:
- This report contains all the safety related activity for the period October – December 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 October - December.
- This report will contain any lessons learned from the activity reviewed in the months October - December, that occurred in the previous quarter.

Report Title	Board Date
Safer Care Report Q3	January
Lone Working Annual Report	February
Safer Care – Forward Plan – Annual Review	March
Safer Care Report Q4	April

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

NHS
Northumberland,
Tyne and Wear
NHS Foundation Trust

Safer Care Report
January 2018
Reporting Period: October - December 2017

Caring | Discovering | Growing | Together

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Introduction

This Safer Care Report includes activity relating to quarter 3 – October - December, 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.

Incident Reporting and Management

Serious Incidents Reported – Quarter 3

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 3

	Q3			Q4			Q1			Q2			Q3		
Incident Type	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Death	5	12	15	17	10	18	11	18	7	11	13	18	11	25	15
All Other Serious Incidents	6	6	1	1	6	2	5	2	4	7	3	3	8	1	4
Totals	11	18	16	18	16	20	16	20	11	18	16	21	19	26	19
Quarterly Totals	45			54			47			55			64		

The average rate for incidents that are subject of a review in line with the serious incident framework for each quarter is 55. Quarter 3 saw a sharp rise of serious incidents in November, predominantly related to deaths, these deaths were evenly spread across the 3 clinical business units and mostly in Access and Community Services. Nothing at this stage links any of the deaths. December returned to an average month for deaths, but this month saw an unusual increase in under 18 admission to adult wards, with 3 in the same month, with a total for 5 for the financial year, the previous 2 were clinically appropriate admissions. The 3 current incidents are under review, but nothing at this stage has raised any clinical concerns.

There have been 21 serious incidents and deaths subject to a review at the serious incident panel in Quarter 3, the themes from these reviews, which are reported through to the clinical groups on a monthly basis are included at appendix 1.

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.
- 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 dashboard of this activity has been created and is available at appendix 2.

Table 2 – Deaths Recorded, Reported, Reviewed and Investigated

Category	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul 17 – Sep 17	Oct 17 – Dec 17
	Q3	Q4	Q1	Q2	Q3
Death as Serious Incident (Level 3) Homicide by a Patient	1	1	0	0	0
Death as Serious Incidents (Level 2) i.e. self harm related, community deaths of unknown nature, in-patient deaths, detained patient deaths	13	16	20	20	28
Deaths as Serious Incidents (Level 1) i.e deaths related to alcohol or substance misuse services, or requiring a low level investigation.	18	28	19	22	19
NRLS reportable deaths	26	37	21	16	9
LEDER reportable deaths	N/A	N/A	7	6	9
Deaths subject to mortality reviews	N/A	N/A	11	15	16
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*	1	1	1	2	4
All other deaths not subjected to review or investigation**	251	234	165	224	186

****It is acknowledged that natural deaths of those patients not on Care Programme Approach at the time of death, would not be subject to a review unless, there was concerns identified around care and treatment by the family.**

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.

Learning from Deaths – A Case Example

The Learning process within the Trust can be two-fold how we learn from adopting the new process, the tools that are used to learn and disseminate the information we have learned, and the improvements it makes to practice as well as the individual learning from each death, where we would respond to families concerns and reflect on whether anything clinically or operationally could or should have been different, acknowledging that similar to serious incident outcomes it may not have prevented the death, but is nonetheless an opportunity to improve practices and processes within the Trust.

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 through our Duty of Candour responsibilities 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, serious incident process and newly developed mortality process achieves in bringing about changes to care and treatment within the Trust.

This reports Learning from Deaths activity relates to Drug related deaths.

Context

Drug related deaths in England and Wales have increased year on year over the past three years, and are now at the highest rate since comparable recording began in 1993. The latest figures show the drug-related mortality rate among adults in the United Kingdom (aged 15 to 64) at almost 3 times greater than the average European rate, with similar increases being experienced in Scotland (15% increase since 2014) and Northern Ireland (11% increase since 2011).
The mortality rate in England and Wales increased significantly between 2014 and 2015 from 59.6 to 65.1 deaths per million population. This upward trend is driven by a sharp increase in heroin/morphine related deaths, particularly in men.
Although other regions have increased at a higher rate, the North East has the highest mortality rates (68.2 deaths per million population).

What is Naloxone (Prenoxad)

Naloxone is an emergency antidote to opiate overdose. It blocks opioid receptors to counteract the effects of opioid drugs (such as heroin, methadone and morphine), reversing the life-threatening effects of an overdose such as depressed breathing. Currently in emergency, Naloxone is given in non-medical settings as an IM injection. It has no psychoactive properties and “no intoxicating effects or misuse potential”. It is injected directly into the body so is quick to take effect.

Background

Recognising the importance of preventing deaths from opioid-related overdose, legislation was changed in 2005, and in 2012 Prenoxad Injection became the world’s first licenced emergency treatment for acute opioid-related overdose for use at home or in a non-medical setting
There are other naloxone products available, but Prenoxad Injection is the only product specifically licenced for use in a non-medical setting.

This indication is supported by the Advisory Committee on the Misuse of Drugs (ACMD) which recommended in 2012 that naloxone should be made more widely available, to tackle the high numbers of fatal opioid overdoses in the UK.
Most importantly, because of MHRA regulatory changes as of 1st October 2015, this is now possible as naloxone is made exempt from prescription only medicine requirements when supplied by a commissioned drug service (Via NHS or Local Authority).
This means it can be supplied to:

- Someone using or previously using opiates who is at risk of overdose
- A carer, friend or family member to use in case of overdose
- A named individual in a hostel, or other facility where drug users may be present

And :

- Supply is on the grounds of making naloxone available for life saving emergencies
- There is no need for POM requirements, just a requirement that the supply is suitable recorded

NTW Addictions

Since the changes in regulation, all NTW addiction services have now been commissioned to supply Naloxone, albeit in different ways. All Naloxone information is contained within the Addictions Recovery Optimisation Map for staff and there are regular training updates.
Appropriate changes were made to effectively record the supply of naloxone on the Electronic patient record (RIO).

Central – Newcastle Services were the first to start supply of naloxone following the changes and all staff have been trained in Drug Related Death, Naloxone and administration of naloxone so they can supply to patients and demonstrate how to use it – staff have been provided with demonstration kits to undertake this role.
Newcastle Public Health Commissioners also requested that addiction services developed and delivered training for Hostel staff (due to the high number of overdose incidents and deaths in supported accommodation). This has been successfully running for almost 2 years as a joint venture between NTW and North East Ambulance Service (NEAS) where NTW deliver training on Drug Related Death, Naloxone and administration of naloxone and NEAS provides training on life saving skills. Newcastle Addiction services also supply Naloxone to all hostels in the city and replenish stocks following use.
Central services have distributed 353 naloxone April-December 2017.

South – Sunderland commissioners have asked for Naloxone to be distributed by the service to service users. All staff have been trained in Drug Related Death, Naloxone and administration of naloxone so they can supply to patients and demonstrate how to use it – staff have been provided with demonstration kits to undertake this role. There is no current distribution to hostels in this area.

North – Northumberland and North Tyneside commissioners have asked for Naloxone to be distributed by the service to service users. All staff have been trained in Drug Related Death, Naloxone and administration of naloxone so they can supply to patients and demonstrate how to use it – staff have been provided with demonstration kits to undertake this role. There is no current distribution to hostels in this area.

Case Vignette – Learning From Deaths

This months case vignette is from the review of a serious incident where an in-patient became seriously ill on a ward but didn't die, but the learning if implemented would prevent future deaths.

Preventing Deaths: The use of Naloxone within in- patient settings and the community.

In-patient learning outcomes following serious incident investigation

In-patient requiring titration of methadone, this was commenced and the following day the patient was found unresponsive in his bedroom. Immediate life support was commenced and paramedics called.
On arrival they identified the patient was experiencing an opiate overdose and they immediately administered naloxone. The patient was transferred to the acute hospital and made a full recovery.

Learning Outcomes

When this case was fully investigated/reviewed several areas for learning were identified:

- There were lapses and errors in the prescribing and administration of methadone, a lack of awareness of policy and correct practice
- Prescribing guidelines for use of opiate substitution therapy to be developed to support the prescribing and administering clinicians
- Staff were not confident in clinically identifying a patient experiencing an opioid overdose, did not know that in-patient wards stocked naloxone, or how to use it.
- The use of and administration of naloxone to be included in all anaphylaxis training and added to the Resuscitation Policy NTW (C) 01.
- CAS alert 2017/57 issued on the 4 September 2017 to alert staff of all the learning, where naloxone is stocked and the storage locations.

Learning from Deaths

Coroner - Regulation 28 of the new Coroners Act

Regulation 28 of the Coroners Act 2009, is termed a prevention of future deaths report, and allows the Coroner to direct a corporate body to make changes following the conclusion of an inquest. Any Regulation 28 reports the Trust receives will be included in the monthly Safer Care report, following the month it has been formally received. – From the Trust's experiences. The last Regulation 28 report received by the Trust was in March 2015. This evidences that for NTW, this is an extremely rare event, but another opportunity to learn and reflect.

The Trust received a Regulation 28 into the organisation on the 19 December 2017 following the conclusion of the Inquest into the death of a patient on the 30 November 2017.
The matters of concern for the Coroner were threefold:

The first point was for both NTW and City Hospitals, Sunderland NHS Foundation Trust, this was that patients such as GM having been admitted for medical care to an acute hospital but identified as having a related mental health condition are not discharged

from the acute hospital without their medical condition both mental and physical having been holistically considered and determined.

Secondly, specific to NTW relates to the manner and method of communication between hospital based psychiatric liaison services and the community based crisis resolution treatment teams.

The third area of concern relates to the nature and quality of the SI report and the basis of investigation which preceded the preparation of the report. The Coroner didn't like the approach of the AAR reflective discussion and felt people should be interviewed on an individual basis.

The trust has a duty to respond to this within 56 days of receipt (15th February 2018).

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.

	Q3	Q4	Q1	Q2	Q3
Incident Type	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	Oct – Dec 17
Aggression And Violence	3158	3216	3637	3146	3418
Inappropriate Patient Behaviour (Including smoking)	908	743	526	532	688
Safeguarding	834	1335	1456	1628	1682
Self Harm	1649	1676	1395	1201	1193
Security	495	475	600	552	529
Totals	**7044**	**7445**	**7614**	**7059**	**7510**

All Other Incidents	2289	2117	2145	2164	2431
Totals	**9333**	**9562**	**9759**	**9223**	**9941**

It can be seen from the above table incident reporting has increased from the previous periods and is the highest quarter ever reported, incidents have increased across a range of different categories including aggression and violence, Safeguarding and total incidents. Incidents that have decreased include self harm and security related activity, but it can be seen that the trend is on an upward curve.

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

Service User /Peer Support Workers

The positive and safe (POS) Service User Project Coordinator post has now been appointed into.

The post is a 12 month secondment and will bring an enhanced ability to ensure additional support is available to all inpatient teams.

Paul Sams is the successful candidate and will be taking up post soon. Paul is currently a peer support worker based on Aldervale Ward , Hopewood Park.

Audit and Policy

Following the publication of quality standards 154 (NICE Violent and aggressive behaviours in people with mental health problems) this is related to NG10, a Trust wide audit has been undertaken in order to gain assurance of levels of compliance with the five standards outlined in the document.

It is expected the first phase of the audit will be completed by December 2017. In order to support the roll out of the positive and safe strategy two policies have been developed this month:-

- Positive and Compassionate Management of Self-Harm
- Positive and Safe Management of post incident Support and De-Brief

The policies are currently within the trust governance process.

Innovation and Research

Dr Keith Reid has recently joined the positive and safe team on a sessional basis as Associate Medical Director positive and Safe Care. A number of research proposals are being developed and it is envisaged that as our work progresses we will build upon the already strong track record of undertaking research within NTW, specifically increasing violence and aggression related work across the organisation.

Talk 1st

Talk 1st is NTW's restraint reduction program all 55 inpatient teams participate in the program along with the two Trust drug and alcohol services.

The teams are involved in robust plan, do, study, act cycles all teams have now completed at least one cycle, great enthusiasm for the work has been constantly exhibited, the monitoring of activity relating to restraint is demonstrating a broadly downward trend, with some exceptions particularly within autism and functional older peoples services in the north.

NTW has been approached by the Bright organisation and will be collaborating to develop Star Wards products nationally for CYPS and Neuro Rehab services.

Group Strategies

As a component of the POS strategy each group is expected to produce an action plan to support successful implementation. The POS team will be working closely with the groups following reorganisation to ensure 2018 action plans are in place.

Monitoring

Current data analysis shows a positive forecast position for all Talk 1st incident metrics except violence and aggression, which is predicted to be higher than last year.
Trust restraint numbers are forecast to be slightly less than last year; however increases have been noted in autism services and older peoples organic and functional (north). These increases are in relation to a small number of highly complex patients as well as a higher level of admissions into the new Mitford ward at the beginning of the year.
The current data forecast positions are shown below.

Incident data is shared externally on a regular basis to local and national commissioners via QRG's. In addition to this 2016/17 benchmarking data has been submitted for adult mental health and CYPS mental health beds to support NHS Benchmarking reports due out towards the end of 2017.

Internally all clinical staff have access to Talk 1st dashboards and this information forms part of regular clinical discussions including CPA reviews, CTR's and ward rounds. In addition to this ward based data is scrutinised and discussed at every Talk 1st cohort review date, which every ward attends on a three monthly basis.

Further work has been identified to potentially collate qualitative information in relation to the Positive and Safe Strategy, which would provide a more rounded and comprehensive analysis of its effectiveness.

During December the Trust received the 16-17 Mental Health Services Dataset (MHSDS) report titled Restrictive Interventions in Inpatient Services. This was released by NHS Digital and showed the Trust to be an outlier in a number of areas, primarily restraint (including prone). The national return was low with only 44% of MH Trusts responding, making it difficult to accurately benchmark from a national perspective.

Forecast Information
The information used for this report incorporates data over the three most recent financial years. The forecast is a direct comparison of day rates between 2016-17 and 2017-18.
So for example:
2016-17 restraint figures = 7904÷365= 21.7 per day
2017-18 restraint figures = 4031÷187 days = 21.55 per day (1st April to 4th October)
The forecast works out the difference as a percentage of last year's figure.
Confidence in this figure grows each month until the end of the financial year.

Whilst the Trust wide data is very useful to look at the overall position, the ward based information helps clinical managers to identify hotspot areas as well as areas where incident rates have fallen significantly. Used in conjunction with ward based dashboards, this information is proving to be incredibly useful to front line clinicians in formulating patient centred approaches in reducing incidents and improving patient experience.
Work is under way with NEQOS to identify a qualitative audit tool to add further context and feedback to the positive and safe approach adopted by the Trust over recent years.

Use of Restraint

Restraint	2015/16	2016/17	2017/18	Forecast
Trust Total	8772	7905	6103	2.1%

Prone Restraint	2015/16	2016/17	2017/18	Forecast
Trust Total	3193	2393	1567	-13.40%

Restraint total reduced last year by 10% which is in line with other organisations who have introduced restraint reduction programmes. The forecast for this year is that at the current rate we should see a potential increase of 2.1%. The numbers for this year have not reduced as much given the increased number of restraints in Autism and OPS. One out of area patient within autism accounts for 1570 restraints over the period. Removing this restraint data from the overall figures would show the trust as having a 24% decrease over the year and highlights the impact individuals can have on incident frequency. Incident numbers for this patient peaked in October 17 and have subsequently reduced.

At the beginning of the year Autism also had a high number of new admissions, which have driven their numbers up. It must be noted that the overall restraint numbers include low level supportive care where staff hold patients to aid in toileting and other personal needs. Analysis of this type of activity shows around 78% of OPS restraints are low level interventions. A draft practice guidance note has recently been developed, which looks to ensure this type of activity is recorded in the patient notes rather than recording as a restraint incident.

Prone restraint has reduced more significantly. Last year we saw a 25% decrease in prone restraint and the forecast shows the potential for a further 13% reduction this year too. Positive and Safe interventions, such as Safe Wards, Star Wards and introduction chill out rooms (plus many more initiatives) will have helped to reduce the amounts of prone restraint. This year we will see the introduction of alternative injection sites for rapid tranquilisation and the use of seclusion chairs, both of which will help to reduce prone restraint even further. It must be noted we record all prone restraint, including unintentional, where a patient may fall to the floor in that position. We know other trusts record this differently, which may be one reason why we are noted as an outlier.

Some of our biggest reductions in restraint have been in CYPS Inpatient services. Whilst part of this may be in relation to lower admission rates and discharges on some wards, this still remains a very challenging patient group and primary intervention work is proving to be very successful. On average children's inpatient units are forecast to see restraint reductions of around 41% and prone restraint reductions of around 55%.

Seclusion

	2015/16	2016/17	2017/18	Forecast
Trust Total	2004	1411	877	-17.8%

The number of seclusions reduced last year by 30% and this year we have a potential forecast to reduce by a further 18%. A further iteration of the Talk 1st Dashboard is about to be released, which also shows the duration of seclusion and gives a far more accurate reflection of seclusion use over the year. Primary phases of intervention such as access to chill out rooms, distraction techniques, activities, peer support workers, etc have helped to reduce the number of times seclusion has been required. In addition to this a number of discharges and the closure of female LD low secure will also have an impact on the numbers. We currently have 35 accessible seclusion suites across all main sites, which all meet our minimum environmental standard.

Assaults on Staff

	2015/16	2016/17	2017/18	Forecast
Trust Total	3705	3815	2808	-2.69%

For the period April 2016 – March 2017 there were 3,815 reported physical assaults, this is an increase of 110 incidents or 1% of the activity from the previous year, it is important to acknowledge that all incident reporting has increased by 13.5% due to the full embedding of an electronic reporting system. There is now no national comparison for our data following the demise of NHS Protect earlier this year. Inpatient and Specialist Care have very comparable numbers for last year. Like other metrics staff assaults have reduced significantly in certain areas this year; particularly in CYPS Inpatient who have a forecast at current rates to see a reduction of 19%. This needs to be balanced against increases in Autism and OPS as identified in other metrics above. If we achieve a reduction this year it would for the first time since merger in 2007.
Patient on patient assault increased last year; however the forecast at present rates is a year-end reduction of 14%. Most activity can be found on older peoples wards and the Talk 1st feedback sessions have highlighted a number of effective interventions in these areas that appear to be very effective. Further influencing factors to consider would be the decrease in bed numbers within OPS, which may be impacting on the number of incidents.

Mechanical Restraint Use (MRE)

	2015/16	2016/17	2017/18	Forecast
Trust Total	369	433	113	-65.49%

MRE use can include the use of either emergency response belts, handcuffs or a combination of both of these. The numbers shown above do not include those deployed by either the police or secure transport services. The biggest reductions during 17-18 can be found in CYPS inpatient services where numbers are forecast to reduce by approximately 85%. This results from a combination of patient discharge, lower admission rates, primary intervention work and the development of the new quiet rooms and seclusion at Ferndene. Recent analysis of MRE use shows its deployment primarily being in relation to hospital / dental transfers and the safe movement of patients to seclusion. All MRE use is subject to strict governance, which includes director approval and monthly scrutiny at the Trust Positive and Safe Implementation Group.

Self-Harming Behaviour

	2015/16	2016/17	2017/18	Forecast
Trust Total	4542	6370	3780	-21.52%

Following the escalation in this type of behaviour last year, it's encouraging at this point to see a forecast reduction of around 21%. Areas of high activity continue to be CYPS Inpatient, Forensic LD and Autism services, driven by a small number of patients. Significant decreases this year have been monitored in both CYPS Inpatients (forecast 40% reduction on average) and Forensic services (forecast 50% reduction on average); however increases in Autism are accounted for in relation to higher admission rates at the start of the year.

Violence and Aggression

	2015/16	2016/17	2017/18	Forecast
Trust Total	12543	12303	10226	9.92%

The current forecast for violence and aggression rates remains higher than last year by nearly 10%. A small increase in community services requires further analysis but could be accounted for by improved reporting cultures following the introduction of web based incident reporting. The more significant increases can be found in Autism services, Woodhorn, Hauxley, Lamesley and Lowry. Positive forecasts again are identified in CYPS Inpatient services where violence and aggression rates have historically been higher than other clinical areas, for reasons highlighted above a current potential reduction of 19% is forecast.

Central Alert System – Exception Report

This report will in future contain where there has been any non-compliance with the CAS system for the Trust, this is a nil report for this quarter.

Complaints Reporting and Management

Complaints Received

The following table gives a breakdown of the Trust activity for all complaints received.

Complaints have increased in Quarter 3 by approximately 15% in comparison to the same quarter last year; this is currently under close scrutiny by the Executive Director of Nursing and Chief Operating Officer and the operational directors.

Complaint Type	Q3 Oct – Dec 16	Q4 Jan – Mar 17	Q1 Apr – June 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	Total
Complex	43	40	59	47	51	240
Joint Not Lead	1	1	1	1	2	6
Joint NTW Lead	0	1	0	2	1	4
Non-Clinical Complaints	1	0	0	0	0	1
Standard	64	73	85	87	74	383
Total	**109**	**115**	**145**	**137**	**128**	**634**

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. In line with national reporting to NHS Digital which occurs every quarter, the following is the category of complaints. Communications, patient care and values and behaviours account for 63% of all complaints received.

A recent analysis of complaints related to staff attitude (under values and behaviours) between November 2016 and November 2017 were analysed to see if this was an issue for the Trust. Out of the 52 complaints examined, 27 were upheld or partially upheld. However on further analysis it became clear that the majority of these related to communication and staff attitude was only upheld as an issue in two complaints.

Work is currently ongoing to make categories and sub categories more meaningful by asking the appointed investigating officer to state what they think are the correct categories after they have made contact and have had a conversation with the complainant.

Category Type	Q3 Oct – Dec 16	Q4 Jan – Mar 17	Q1 Apr – Jun 17	Q2 July – Sep 17	Q3 Oct – Dec 17	Total
Access To Treatment Or Drugs	3	3	3	1	3	13
Admissions And Discharges	6	7	14	9	5	41
Appointments	7	3	9	5	7	31
Clinical Treatment	7	4	1	5	9	26
Communications	14	21	23	25	17	100
Consent	0	0	0	0	1	1
Facilities	10	6	2	2	1	21
Other	5	2	4	6	1	18
Patient Care	31	34	45	32	42	184
Prescribing	0	7	9	12	4	32
Privacy , Dignity And Wellbeing	3	3	1	1	1	9
Restraint	0	0	0	1	0	1
Staff Numbers	0	0	0	1	1	2
Trust Admin/ Policies/Procedures Including Rec Man	5	5	4	3	4	21
Values And Behaviours	17	18	26	29	28	118
Waiting Times	1	2	4	5	4	16
Total	**109**	**115**	**145**	**137**	**128**	**634**

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, the base line over the last 3 years the Trust has averaged 11 complaints per year, for the last 3 quarters and the first 9 months of 2017/ 2018 the Trust has received 7 complaints. 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. It is also hoped that with the full implementation of Learning From Deaths Policy, that if family and carer's want to answers to care and treatment issues, we can do so through the mortality review process, acknowledging that we would always investigate complaints received.

Services	Q3 Oct – Dec 16	Q4 Jan – Mar 17	Q1 Apr – Jun 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	**Total**
Crisis Response & Home Treatment GHD Tranwell	0	1	0	0	0	1
Crisis Response & Home Treatment SLD HWP	1	0	0	0	1	2
CYPS Community NLD ADHD NGH	0	1	0	0	0	1
EIP NLD Greenacres	0	0	1	0	0	1
EIP North Tyneside Benton View	1	0	0	0	0	1
GHD Community Non Psychosis Team Dryden Rd	0	0	0	0	0	0
GHD Community Psychosis Team Tranwell	0	0	1	0	0	1
Information Department SNH	0	1	0	0	0	1
Lamesley	1	0	0	0	0	1
North Tyneside Recovery Partnership Wallsend	0	0	0	1	0	1
S Tyneside Psychosis/Non Psychosis Palmers	0	0	0	1	0	1
SLD North Psychosis / Non Psychosis MWM	0	1	0	0	0	1
SLD South Psychosis/Non Psychosis Doxford	1	0	0	0	0	1
Street Triage North of Tyne	0	0	0	0	1	1
Totals	**4**	**4**	**2**	**2**	**2**	**14**

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 500 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 is the current and ongoing complaint activity with the PHSO.

North Locality Care Group

Opened	Complaint Number	PHSO Reference	Current Status	Current Position	Trust Investigation Outcome
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 19/09/2017 Answers to 9 questions requested by PHSO -response sent to CE who raised additional queries	Partially upheld

				now addressed	
04.07.2017	3263	C2013664	PHSO – intention to investigate	Files and records sent 18.07.17 PHSO investigator identified. Additional information requested and sent back on 09.08.17	Partially upheld

Central Locality Care Group

Opened	**Complaints Number**	**PHSO Reference**	**Current Status**	**Current Update**	**Trust Investigation Outcome**
02.08.2016	3033	262023	PHSO – intention to investigate	Scope of investigation identified. Comments sent back on 28.07.17. 19/09/2017 NTW complaint correspondence sent to former Consultant to review his notes before providing response to PHSO	Partially upheld
06.02.2017	3582	C2019050	PHSO – intention to investigate	26.09.17 Informed by PHSO of their intention to investigate 12.12.17 scope of investigation identified	Not upheld
26.10.2017	3776	C2027320	PHSO – intention to investigate	26.10.17 informed by PHSO of their intention to investigate	Partially upheld

South Locality Care Group

None

Claims

Claims received by Case Type

Case Type	Q3 Oct – Dec 16	Q4 Jan – Mar 17	Q1 Apr – Jun 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	Total
Claims Not Covered By NHSLA	0	0	0	0	0	0
CNST	3	3	3	3	1	13
Employers Liability	8	8	4	3	3	26
Ex-Gratia	15	13	15	20	12	74
Ex-Gratia PHSO	1	0	1	0	0	2
Public Liability	4	0	1	0	1	6
Third Party Claim	2	3	2	1	1	9
Total	**33**	**27**	**26**	**27**	**18**	**131**

Ex gratia claims predominantly make up the largest proportion of claims and the numbers remain fairly consistent quarter on quarter. Employer liability claims are the second largest group however there has been a gradual reduction in the number of employer liability claims but the reason for this is not clear. This will be kept under review, and we will await annual information from NHS Resolutions around the national picture of claims activity.

Claims received by Category

Category	Q3 Oct - Dec 16	Q4 Jan – Mar 17	Q1 Apr – Jun 17	Q2 Jul – Sep 17	Q3 Oct – Dec 17	Total
Accidental Injury	3	6	6	1	2	18
All. Of Failure To Provide Approp. Care	1	1	3	3	1	9
Allegation Of Harrassment	0	1	0	0	0	1
Assault On Other	0	0	0	0	1	1
Assault on Staff	3	3	1	4	2	13
Carpal Tunnel Syndrome	1	0	1	0	0	2
Damage To Patient Property (Accident)	1	1	1	2	0	5
Damage To Patient Property (Violence)	0	0	1	0	1	2
Damage To Staff Property (Accident)	3	1	0	3	1	8
Damage To Staff Property (Violence)	4	7	7	9	2	29
Damage To Visitor Property	1	1	0	0	0	2
Expenses Incurred Due To A Trust Process	2	0	1	1	1	5
Exposure To Hazard	1	0	0	0	0	1
Information Governance	1	0	0	0	0	1
Injured During Restraint	4	0	0	0	0	4

Loss Of Patients Property	4	3	5	4	7	23
Loss Of Staff Property	1	0	0	0	0	1
Medical Treatment	1	0	0	0	0	1
Sharps/Needlestick	1	0	0	0	0	1
Stress Suffered by Staff	0	1	0	0	0	1
Unexpected Death	1	2	0	0	0	3
Total	**33**	**27**	**26**	**27**	**18**	**131**

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.

Serious Incidents reviewed at panel in October 2017

Eight incidents were reviewed at panel during October, all were STEIS reported, 7 were deaths and 1 attempted murder/ arson.

Of the 8 reviewed at panel all reports went to the Commissioners within the 60 day timescale bar 1, for which an extension was requested and approved because of quality issues with the report.

Learning identified from Serious Incidents and Deaths reviewed in October 2017

Discharge Planning of the 8 incidents reviewed discharge planning required improvement in 4 of the cases:

Joint discharge planning was not evident between the Crisis Team and the CTT.

Maintaining communication with external providers to ensure continuity of care at discharge was not done.

Discharge planning did not include all services involved who the patient it was expected would come into contact with (risk history).

No evidence that the decision to discharge the patient from services was reviewed or discussed in the wider multi-disciplinary team.

Documentation Documentation issues featured in 3 of the incidents reviewed, this included individual errors, validation which meant under scrutiny the Trusts standards in relation to record keeping were not adhered to.

Incident Reporting This was raised as a learning point in 2 of the cases reviewed . the first was in reports not being completed which in turn then didn’t provide an accurate picture, the second was in relation to reporting Safeguarding in accordance with the Trusts Safeguarding Adults at Risk Policy –V04.

Carers Assessment/ Carer Support This was raised in two incidents, carers not being offered an assessment in 1 incident and the use of the Getting to Know You process/documentation.

Risk Assessment This was specific to 1 incident where the change in risk assessment had not been communicated to all agencies involved in the care/support/treatment of the patient and had also not been updated accordingly.

Medication During investigation it became apparent that some unqualified members of the crisis team were not aware of the side effects of Lithium or the symptoms of Lithium toxicity, training and awareness via Medicines Management Newsletter to be provided.

Physical Health Baseline physical investigations not carried out in 1 incident reviewed as per trust standards, this related to an ECG not being carried out for over 5 years.

Communication This related to one investigation where the GP had not received a letter from the service since 2014 and appointment letters to the patient were not concordant with the NTW Addictions Optimisation Recovery Map standards.

Administration Difficulties This was one case reviewed where admin difficulties potentially impacted on clinical care and this was raised with the Group Director who was arranging to meet with the team and support contingency plans.

Good Practice This was identified in 1 case and letters were sent to the Care Coordinator and Consultant recognizing the high standard of work, and compassion shown to an extremely challenging individual.

Serious Incidents reviewed at panel in November 2017

Ten incidents were reviewed at panel during November, 8 were STEIS reported (all 8 were deaths), 1 incident was wrong sited administration of injection and 1 was a self-harm incident combining a concern raised by a relative.

Of the 8 STEIS reported incidents reviewed at panel all reports went to the Commissioners within the 60 day timescale.

Learning identified from Serious Incidents and Deaths reviewed in November 2017

CCTV Staff not fully aware of the detail with the Trust Search Policy relating to CCTV and CCTV not functioning at the time of the incident (only apparent post incident).

Staff to ensure they are aware of the policy and detail and a review of the quality of the system, its coverage to be carried out.

Documentation and Record Keeping This featured in several of the incidents reviewed:

Records were not maintained to trust standards relating to :
Discharge planning
Diagnosis not being recorded
Care planning/assessment/risk assessment
Clustering
Physical health
Clinical rationale
Planned interventions
This was being addressed with specific individuals and teams specific to each incident.

Incident Reporting This was raised as a learning point in 5 of the cases reviewed. This was in reports not being completed which in turn then didn't provide an accurate picture, and in relation to reporting Safeguarding in accordance with the Trusts Safeguarding Adults at Risk Policy –V04. Also reporting incidents when aware of an incident occurring when the patient is on a waiting list for treatment (post assessment).

The reporting of Safeguarding concerns/incidents is being picked up with awareness training supported by the Safeguarding Team and through team briefs.

The reporting of IG incidents once an investigation has identified this.

Getting to Know You Process was raised in two incidents, as not being completed.

This has been a finding of several previous serious incidents and a trust wide RPIW is arranged for January 2018.

Risk Assessment This was a finding in 2 incidents, the first found the risk assessment had not been completed in a timely manner with further review, update and detail of risk not amended. The second found the risk scoring not reflecting the risk the team was managing.

This was picked up with the individual and reflected on by the team providing care and risk management.

Physical Health Monitoring This was a learning point in two incidents reviewed and related to not recording in the correct place and not being carried out at the frequency suggested in the care plan.

Communication This related to three incidents and covered letters not being sent to all care providers involved in the patients care, not communicating medication changes and returning telephone messages.

Two of these learning points were addressed in individual supervision and the returning of calls was discussed in team briefs.

Alcohol Audit This had not been completed, this is now a CQUINN and should be monitored more closely, the Crisis Team to discuss this within their Lessons Learned Group.

Benefits This learning point was raised by the family of the patient who believed a letter received from the Benefits Agency had contributed to their death.

Patient Safety to record within Safeguard when benefit issues are specifically raised, if information/ thematic analysis is required in relation to this.

Waiting Lists This learning point was about guidance for waiting list management and also raised was the demand and capacity requiring this risk to be placed on the service risk register.

Patient Safety have added this to “on waiting list at time of incident “ on Safeguard to allow recording if required for further analysis.

Change of Care Coordinator This was a finding and reflected upon that the Trust has a policy for change of consultant and that the principles of this could be considered for other staff groups.

RiO This related to one incident when RiO access was down and was a contributing factor to the incident, but during investigation it became apparent no record /log of this is kept. This has now been established.

Serious Incidents Reviewed at Panel in December 2017

Three incidents were reviewed at panel during December, all 3 were STEIS reported (all 3 were deaths), 1 death has since come back as a natural cause death from the Coroner and we have requested de- escalation from STEIS.

Of the three incidents reviewed all reports have gone or will go within the 60 day timescale.

Learning identified from Serious Incidents and Deaths reviewed in December 2017

Documentation and Record Keeping This featured in several of the incidents reviewed:

Records were not maintained to trust standards relating to:

Progress notes entries
Validation of notes
Capturing of contacts
Updating documentation
Documenting in the correct part of RiO
Delays between the patient being seen and entries made on RiO

This was being addressed with specific individuals and teams specific to each incident.

A local training package around good practice in Care Co-ordination and the use of documentation in RiO had been initiated by the Leadership team with a plan that all clinical staff should attend. The aim to improve the understanding of standards of documentation required within RiO.

Requesting historical paper records from secondary storage

As the team arranged to visit the patient very quickly, the day after the referral was made (identified as good practice) they did not follow the usual process to request historical records, neither were all staff aware to do this.

The team manager, in conjunction with the administrative lead to ensure that this established process is known and embedded within the team.

Getting to Know You Process

This has been a finding of several previous serious incidents and a trust wide RPIW is arranged for January 2018.

On this occasion the process had not been reviewed following the patients move from in patient to community.

Locally a new Carers' champion has been appointed, and will be reviewing the system of offering and actioning carers' assessments.

Communication

There were 2 incidental findings within the same incident,issues with administration arrangements which didn't support clinicians in ensuring letters to GP's were completed in a timely manner and informing patients in a timely fashion when appointments were cancelled.

There is a review of administration arrangements underway, including systems used.

Another incident review hi- lighted that letters were sent to the patient not using large print format despite the patient highlighting that he had a visual impairment.

The importance of checking this information and special request discussed in individual and team settings.

Medicines Reconciliation

There was no evidence in one case reviewed that there had any medicines reconciliation after 2012, and the medication page had not been updated on RIO.

The prescribing policy to be reviewed to ensure it provides support in medicines reconciliation in community teams.

Physical Health Monitoring/Treatment

Venlafaxine is contraindicated in patients in conditions associated with high risk of cardiac arrhythmia , however there was lack of clarity about the evidence base regarding the risk of venlafaxine-related cardiotoxicity at therapeutic doses and recommendations for ECG.

Literature review and person -centred risk assessment to be undertaken by pharmacy and shared with the team.

There was evidence of complex medical co-morbidity and polypharmacy which identified requirement for integrated clinical pharmacist support within the CMHT.

To identify clinical pharmacy service support and resource requirement.

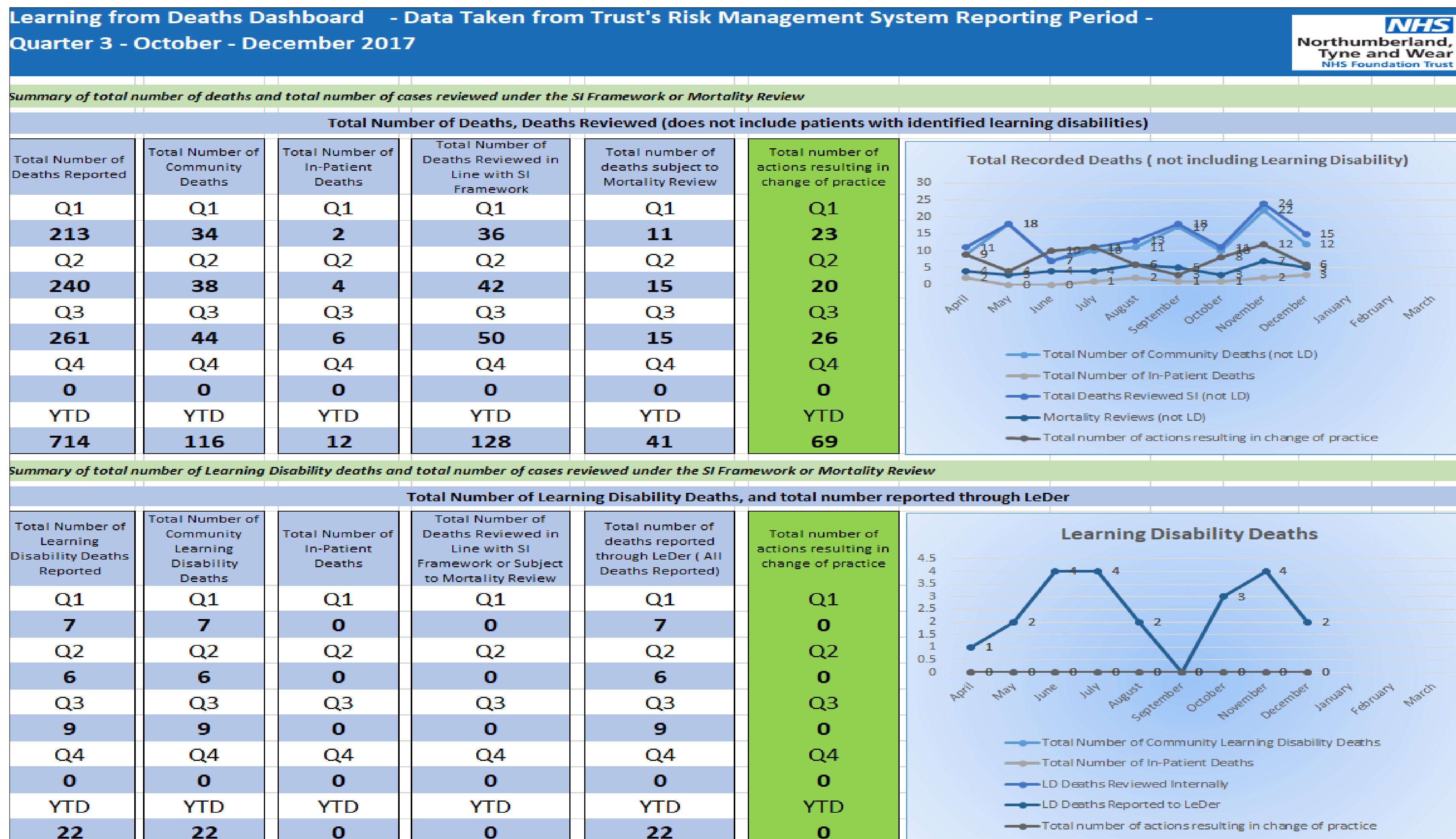
The Physical Health policy (NTW (C)29 recommends that the GP should be explicitly advised on what ongoing monitoring is required, rather than apparent assumptions.

Team leads to complete a reflective narrative on how evidence of psychotropic medication-related physical health monitoring is obtained and recorded within the team.

Learning From All Deaths - Within Mental Health And Learning Disability Services

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the north of England we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. We have decided not to initially report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

Learning From Deaths Dashboard – Quarter 3 – October – December 2017



Learning from Deaths Dashboard - Data Taken from Trust's Risk Management System Reporting Period - Quarter 3 - October - December 2017

NHS Northumberland, Tyne and Wear NHS Foundation Trust

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

Total Number of Deaths Reported	Total Number of Community Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework	Total number of deaths subject to Mortality Review	Total number of actions resulting in change of practice
Q1	Q1	Q1	Q1	Q1	Q1
213	34	2	36	11	23
Q2	Q2	Q2	Q2	Q2	Q2
240	38	4	42	15	20
Q3	Q3	Q3	Q3	Q3	Q3
261	44	6	50	15	26
Q4	Q4	Q4	Q4	Q4	Q4
0	0	0	0	0	0
YTD	YTD	YTD	YTD	YTD	YTD
714	116	12	128	41	69

Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

Total Number of Learning Disability Deaths Reported	Total Number of Community Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework or Subject to Mortality Review	Total number of deaths reported through LeDer (All Deaths Reported)	Total number of actions resulting in change of practice
Q1	Q1	Q1	Q1	Q1	Q1
7	7	0	0	7	0
Q2	Q2	Q2	Q2	Q2	Q2
6	6	0	0	6	0
Q3	Q3	Q3	Q3	Q3	Q3
9	9	0	0	9	0
Q4	Q4	Q4	Q4	Q4	Q4
0	0	0	0	0	0
YTD	YTD	YTD	YTD	YTD	YTD
22	22	0	0	22	0