Agenda item 8 iii)

Northumberland Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 October 2017

Title and Author of Paper: Quarter 2 – Safer Care Report (Including Learning from Deaths) July - September 2017

Author of Paper in response to this report:
Tony Gray, Head of Safety & Security
Vicky Clark, Incidents, Complaints and Claims Manager
Craig Newby, Patient Safety Manager

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 July - September 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 July - September.
- This report will contain any lessons learned from the activity reviewed in the months July - September, which occurred in the previous quarter.
- Final update provided in line with the "Learning from Deaths" action plan.
- Update provided about approved "Learning From Deaths Policy – Link Here

Report Title	Board Date
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
Safer Care Report Q1	July
Physical Assaults on Staff Annual Report	September

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
October 2017
Reporting Period: July - September 2017

Shining a light on the future

Introduction

This Safer Care Report includes activity relating to quarter 2 – July – September, 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.

Incident Reporting and Management

Serious Incidents Reported – Quarter 2
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 2

	Q2			Q3			Q4			Q1			Q2		
Incident Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Death	9	11	8	5	12	15	19	13	15	13	18	8	11	13	18
All Other Serious Incidents	3	7	3	6	6	1	1	5	7	5	1	4	7	3	2
Totals	12	18	11	11	18	16	20	18	22	18	19	12	18	16	20
Quarterly Totals	41			45			60			49			54		

The average rate for incidents that are subject of a review in line with the serious incident framework for each quarter is 50.

There have been 54 serious incidents and deaths subject to a review in Quarter 2, it is acknowledged that depending on the timing of the production of reports, and discussion with Directors on a Friday at Business Delivery Group, the number of incidents may increase based on the information received. It is acknowledged that more deaths than ever before are subject to a review, as this is part of the implementation of the Learning From Deaths Policy.

Now the policy has been approved and is currently being implemented, the levels of investigation from this guidance and the Trust's Incident Policy for which there is a direct relationship is as follows:-

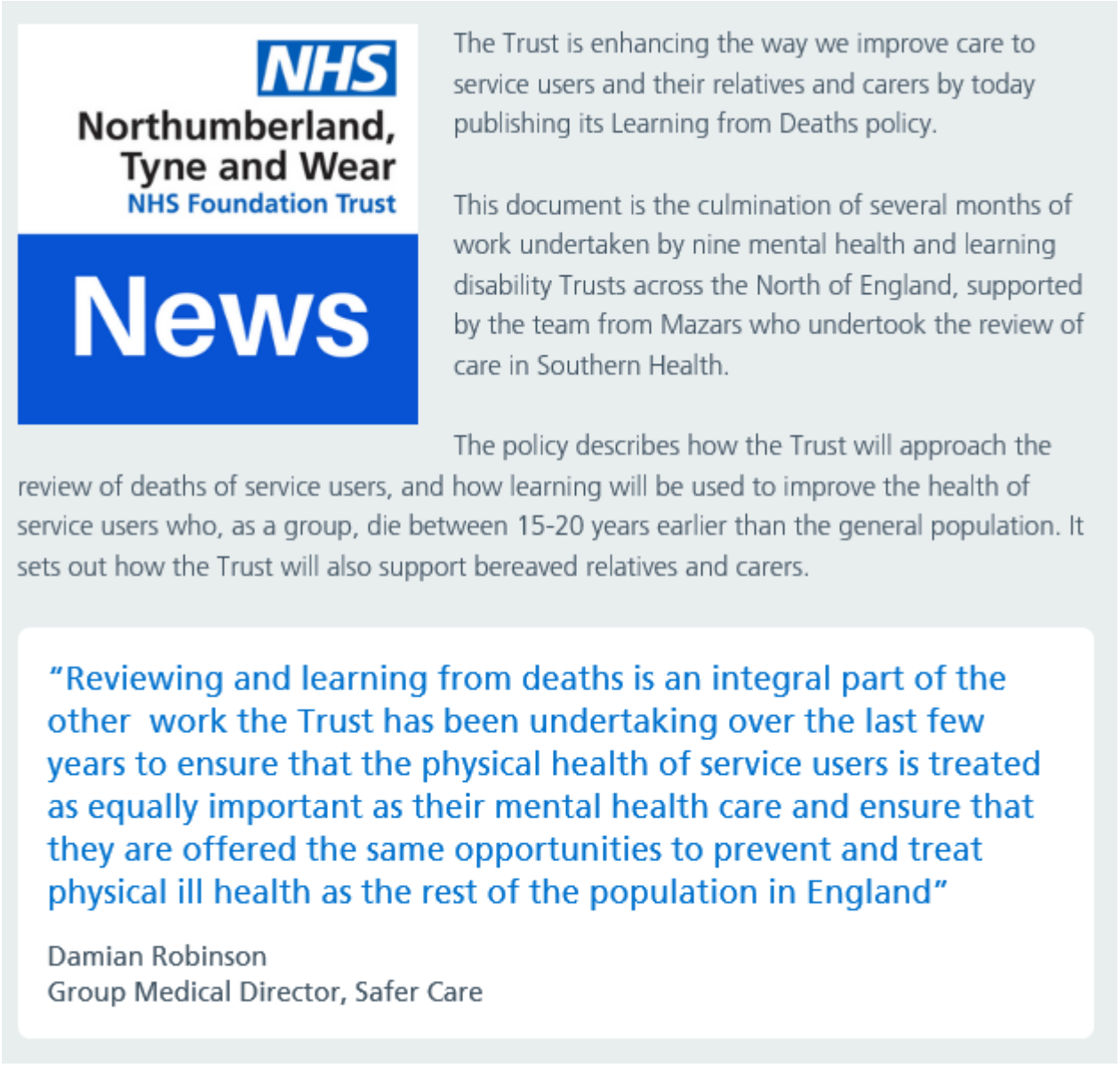
Trust Incident Policy – NTW (O) 05

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.

Learning From Deaths Policy – NTW (C) 12

The policy was ratified by Business Delivery Group in September 2017, and as a requirement was published to the Trust's Intranet and Internet, so that families and carer's have access. A new story was also published to introduce the policy for information this is included below.



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News

The Trust is enhancing the way we improve care to service users and their relatives and carers by today publishing its Learning from Deaths policy.

This document is the culmination of several months of work undertaken by nine mental health and learning disability Trusts across the North of England, supported by the team from Mazars who undertook the review of care in Southern Health.

The policy describes how the Trust will approach the review of deaths of service users, and how learning will be used to improve the health of service users who, as a group, die between 15-20 years earlier than the general population. It sets out how the Trust will also support bereaved relatives and carers.

"Reviewing and learning from deaths is an integral part of the other work the Trust has been undertaking over the last few years to ensure that the physical health of service users is treated as equally important as their mental health care and ensure that they are offered the same opportunities to prevent and treat physical ill health as the rest of the population in England"

Damian Robinson
Group Medical Director, Safer Care

The classifications of deaths that will now be subject to a review in line with the policy is in line with the 8 other Trusts across the North East and North West and are included below:

We are the main provider if at the time of death the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment under Care Programme Approach.

- An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
- A Community Treatment order.
- A conditional discharge.
- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.
In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under duty of candour. However there will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.

Services provided by the Trust where we are not classed as the main provider.
For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- District Nursing
- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Macmillan Nurses
- Health Visitors
- Podiatry

Exception
In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust.

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?
- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems and processes?
- In addition the Northern Mental Health trusts have identified a number of potential triggers for a Review / Investigation. These include deaths:
- Where a Family / clinical staff / risk management staff flag or raise a concern
- Where medication with known risks such as Clozapine was a significant part of the treatment regime

- From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data)
- Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilisation
- Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns
- Where there had been previous safeguarding and public protection concerns.
- where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services
- Associated with known risk factors / correlations

Also:

- Particular causes of death e.g. epilepsy
- Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner
- Random sampling.

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 deaths 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.
- 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.

Table 2 – Deaths Recorded, Reported, Reviewed and Investigated

Category	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul 17 – Sep 17
	Q2	Q3	Q4	Q1	Q2
Death as Serious Incident (Level 3) Homicide by a Patient	0	1	1	0	0
Death as Serious Incidents (Level 2) i.e. self harm related, community deaths of unknown nature, in-patient deaths, detained patient deaths	16	13	16	20	20
Deaths as Serious Incidents (Level 1) i.e deaths related to alcohol or substance misuse services, or requiring a low level investigation.	12	18	28	19	22
NRLS reportable deaths	22	26	37	21	16
LEDER reportable deaths	N/A	N/A	N/A	5	8
Deaths subject to mortality reviews	N/A	N/A	N/A	11	15
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	TBC	TBC
All other deaths not subjected to review or investigation**	238	251	234	165	224

***Deaths subject to a Safeguarding Process will be included from Q3 and will be populated from Q1 to give a full years view.**

****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.**

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.

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.

Case Vignette – The Learning From Deaths Process – Pilot of Mortality Reviews

Clinical summary

In the last quarter supported by the Group Medical Director for Safer Care, one the Trust's dedicated Investigating Officers was allocated 6 deaths that had occurred across different services in the Trust, that would not be subject to a serious incident investigation, this was to test out the principles of the Learning From Deaths Policy prior to implementation, and ensure that the learning system was suitably robust, and would stand up to scrutiny, with a template that offered an ability to learn and create improvements across the Trust and in individual specialised services.
The 6 deaths were all of a natural cause and were reported following contact with 6 services listed below:-
Brain Injury Service
Psychiatric Liaison Service
Previous in-patient who was open to Community Mental Health Services at the time
Addictions Service x 2
Neuro Rehabilitation Service

Learning

One of the major difficulties in reviewing deaths of a natural cause is the fact that the reporter of the death may not know the cause of death and indeed the death has been notified from a third party where there is not recent contact. It is not possible to get the cause of death from a Coroner's office which is the normal route for unexpected deaths, as natural deaths are not referred. The Trust currently does not have a robust system to work with those who certify deaths, but work is underway to create some joint mortality processes with our acute trust colleagues, and in future with the newly appointed medical examiners who will be coming into post over the next year.

Other issues of learning relate to physical health monitoring and management of those patients who are frequently cancelling appointments, this was more noticeable in the addictions service, and the physical health issues related directly to their substance misuse issues such as alcohol or drug related issues such as liver / kidney problems or injection site management.

Another process issue was that of the specialism / skill set of the investigator / reviewer, due to the diverse services the Trust offers, it was evident that one investigator who works clinically in one service of the Trust, could not easily investigate incidents across all services. One of the outcomes to be taken forward was to mirror a lead clinician support, for the review similar to that already in place for serious incident investigations.

There were a number of incidental learning points relating to record keeping for each of the deaths, but again none of these issues impacted on the incident.

In 2 of the cases based on the care provided to the current patient, in partnership with other organisations, care was timely and appropriate, with post death family support provided.

Actions Taken

A number of developments were considered for further implementation including adjusting the mortality tool to make completion easier, and to keep this under review as more mortality reviews are carried out.

To strengthen the partnership working with Acute Trusts who have developed their policies separately.

To continue to work with the other Trusts, to expand the learning from implementing the policy, and to share wider learning from incidents that occur.

Broader context

It was agreed across the 9 Northern Trusts who are working in partnership with Mazars that the Learning from Deaths Policy would be subject to review in 6 months after approval, so these issues will be picked up and the policy amended in line with any other nationally published information by the end of March 2018 in Quarter 4.

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.

	Q2	Q3	Q4	Q1	Q2
Incident Type	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17
Aggression And Violence	3029	3158	3216	3637	3146
Inappropriate Patient Behaviour (smoking)	543	908	743	526	532
Safeguarding	837	834	1335	1456	1628
Self Harm	1578	1649	1676	1395	1201
Security	564	495	475	600	552
Totals	**6551**	**7044**	**7445**	**7614**	**7059**
All Other Incidents	2217	2289	2117	2145	2164
Totals	**8768**	**9333**	**9562**	**9759**	**9223**

It can be seen from the above table incident reporting had decreased for the first time since Q3 of 2016/17, the notable decreases are for aggression and violence and self-harm, which account for a reduction of 685 incidents combined. Safeguarding concerns have continued to rise, and are nearly double the same activity for Q2 in 2016/2017 this is to be commended and greater detail on this increase is provided in the monthly safer care report provided to Corporate Decisions Team – Quality.

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) agenda maintains at its core the amplification of the service user voice, Christopher Gibbs, Service User Lead for positive and safe and peer worker within the Trust is currently developing examples of positive practice in relation to the POS agenda with service users, clinicians, and clinical teams.

  The examples are taking the form of animated vignettes and will be available on the Talk 1st web page the 'Good Stuff'.

  The examples will be used as training materials and a vehicle for sharing best practice across the organisation.

- 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 and 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.

- 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	7904	4031	-0.46%

Prone Restraint	**2015/16**	**2016/17**	**2017/18**	**Forecast**
Trust Total	3193	2393	995	-18.84%

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 further reduction of 0.46%. The numbers for this year have not reduced as much given the increased number of restraints in Autism and OPS. At the beginning of the year Autism 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. Work is ongoing to disaggregate this type of activity.

Prone restraint has reduced more significantly. Last year we saw a 25% decrease in prone restraint and the forecast shows the potential for a similar level of 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 further. It must be noted we record all prone restraint, including unintentional, where a patient may drop to the floor in that position. We know other trusts record this differently, which may be one reason why we are seen 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.

- Seclusion

	2015/16	2016/17	2017/18	Forecast
Trust Total	2004	1412	586	-18.99%

The number of seclusions reduced last year by 30% and this year we have a potential forecast to reduce by a further 19%. Whilst these numbers have reduced significantly we haven't yet introduced a metric around the duration of seclusion, which may have increased as a total. 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. This year we intend to include overall duration of seclusion as an additional metric to Talk 1st Dashboards. 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	1922	-1.66%

For the period April 2016 – March 2017 there were 3,825 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 22%. 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 15%. 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. The other thing 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	75	-66.19%

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 90%. 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.

- Self-Harming Behaviour

	2015/16	2016/17	2017/18	Forecast
Trust Total	4542	6370	2621	-19.69%

Following the escalation in this type of behaviour last year, it's encouraging at this point to see a forecast reduction of around 20%. 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 and Forensic services; 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	12302	6867	8.95%

The current forecast for violence and aggression rates remains higher than last year by nearly 9%. 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.

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 Q2 in comparison to the same period last year, this is currently under close scrutiny by the Executive Director of Nursing and Chief Operating Officer 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	Q2	Q3	Q4	Q1	Q2	Total
	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	
Complex	44	43	40	60	46	233
Joint Not Lead	0	1	1	1	1	4
Joint NTW Lead	0	0	1	0	3	4
Non-Clinical Complaint	3	1	0	0	0	4
Standard	68	65	73	84	88	378
Total	**115**	**110**	**115**	**145**	**138**	**623**

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

	Q2	Q3	Q4	Q1	Q2	**Total**
Category Type	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	
Access To Treatment Or Drugs	1	3	3	3	1	11
Admissions And Discharges	4	6	7	14	9	40
Appointments	5	7	3	9	5	29
Clinical Treatment	3	7	4	6	7	27
Commissioning	1	0	0	0	0	1
Communications	21	14	21	23	25	104
Facilities	6	10	6	2	2	26
Other	5	6	2	4	6	23
Patient Care	38	31	34	40	31	174
Prescribing	9	0	7	9	12	37
Privacy, Dignity And Wellbeing	4	3	3	1	1	12
Restraint	1	0	0	0	1	2
Staff Numbers	0	0	0	0	1	1
Trust Admin/ Policies/ Procedures Including Rec Man	2	5	5	4	3	19
Values And Behaviours	15	17	18	26	29	105
Waiting Times	0	1	2	4	5	12
Totals	115	110	115	145	138	623

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 gauges 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 2 quarters and the first 6 months of 2017/ 2018 the Trust has only received 4 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 carers want answers to care and treatment issues, we can do so through the mortality review process, acknowledging that we would always investigate complaints received.

Table 6

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

North Locality Care Group

Opened	**Complaint Number**	**PHSO Reference**	**Current Status**	**Current Position**	**Trust Investigation Outcome**
28.09.2016	2926	268846	PHSO – final report received	Final report received – complaint partially upheld. *Records do not support that sufficient efforts were made to try and determine the causes of the patient's symptoms. As a result there was a missed opportunity to provide clarify around these.*	Partially upheld

				Letter of apology and action plan sent to complainant and PHSO 05.06.17.	
20.10.2016	3269	272208	PHSO - enquiry	PHSO still considering this case for investigation.	Not upheld
07.11.2016	1722	270818	PHSO – draft report received	Complaint not upheld	Unable to investigate
20.02.2017	3144	C2003388	PHSO – intention to investigate	Files sent 01.03.17, Investigator identified	Partially upheld
04.07.2017	3263	C2013664	PHSO – intention to investigate	Files and records sent 18.07.17 Additional information requested and sent back on 09.08.17	Partially upheld

Central Locality Care Group

Opened	Complaint 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 Further information requested by PHSO.	Partially upheld
15.09.2016	3024	266719	PHSO final report received	Complaint partially upheld. *Many aspects of the care provided were not in line with recognised quality standards and established good practice.*	Partially upheld
06.02.2017	3582	C2019050	PHSO – enquiry	26.09.17 Informed by PHSO of their intention to investigate	Not upheld

South Locality Care Group

Opened	Complaint Number	PHSO Reference	Current Status	Current Update	Trust Investigation Outcome
None					

Claims

Claims received by Case Type

	Q2	Q3	Q4	Q1	Q2	
Case Type	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	**Total**
CNST	0	3	3	3	3	12
Employers Liability	11	8	8	4	3	34
Ex-Gratia	20	15	13	15	20	83
Ex-Gratia PHSO	0	1	0	1	0	2
Public Liability	1	4	0	1	0	6
Third Party Claim	3	2	3	2	1	11
Total	**35**	**33**	**27**	**26**	**27**	**148**

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

	Q2	Q3	Q4	Q1	Q2	
Category	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	**Total**
Accidental Injury	7	3	6	6	1	23
All. Of Failure To Provide Appropriate Care	0	1	1	3	3	8
Allegation Of Harassment	0	0	1	0	0	1
Assault on Staff	6	3	3	1	4	17
Carpal Tunnel Syndrome	0	1	0	1	0	2
Damage To Patient Property (Accident)	2	1	1	1	2	7
Damage To Patient Property (Violence)	0	0	0	1	0	1
Damage To Staff Property (Accident)	1	3	1	0	3	8
Damage To Staff Property (Violence)	4	4	7	7	9	31
Damage To Visitor Property	0	1	1	0	0	2

	Q2	Q3	Q4	Q1	Q2	
Category	Jul – Sep 16	Oct – Dec 16	Jan – Mar 17	Apr – Jun 17	Jul – Sep 17	**Total**
Expenses Incurred Due To A Trust Process	1	2	0	1	1	5
Exposure To Hazard	0	1	0	0	0	1
Information Governance	0	1	0	0	0	1
Loss Of Patients Property	10	4	3	5	4	26
Loss Of Staff Property	1	1	0	0	0	2
Loss Of Visitor Property	1	0	0	0	0	1
Medical Treatment	0	1	0	0	0	1
Sharps/Needlestick	0	1	0	0	0	1
Stress Suffered by Staff	0	0	1	0	0	1
Unexpected Death	0	1	2	0	0	3
Total	**35**	**33**	**27**	**26**	**27**	**148**

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.	• Dashboard is live • Undergoing testing based on initial discussions with other Trusts	May 2017 Completed September 2017 Completed	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
		• 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)	• 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. • Standard dashboard to be used from Quarter 3	June 2017 Completed July 2017 Completed	

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.	• 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 cause deaths • A new deaths policy / PGN will now be created to sit within the Trust's incident policy	• Trust Incident web form has been adjusted with questionnaire relating to deaths, testing to commence in August. This is no longer required as mortality toolkit and changes to process will capture information. • Policy approved and available on internet.	August 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
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 Completed Information in Q2 report	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
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. • The Trust has a panel of external investigators	• 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 - Month1 for report to CDT-Q In May 17 and Safer Care Report – Q1 to Board in July.	• 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
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

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
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 included.	• 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 Completed	Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety Claire Taylor – Head of Clinical Risk and Investigations
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	• 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 Report to be included as final action plan in Quarter 3.	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

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
	discussions. Non-engagement is escalated to Clinical Commissioning Groups and included in SI reports as actions for improvements.				
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 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 November 2017 • Data will be reported in the Quality Account from June 2018, in line with DoH guidance	• Plans in place	October 2017 Report to be included as final action plan in Quarter 3. April 2017 Completed April 2017 Completed July 2017 Completed as part of this report November 2017 June 2018	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

Standard	Trust Position at Publication of Report	Future Direction	Current Position	Timescale	Responsibility
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 Report to be included as final action plan in Quarter 3.	Executive Director of Nursing and Chief Operating Officer / Operational Director of Service Tony Gray – Head of Safety & Security Dr Damian Robinson – Deputy Medical Director – Safety