West London Mental Health NHS Trust

Being Open report

Meeting Date:	8th August 2016
Title of paper:	Being Open Report
Who is presenting paper:	Janet Bell Head of Governance
Lead ED	Beverley Murphy Director of Nursing & Patient Experience
Why is the paper being presented:	This paper is to brief the meeting of the serious incidents, coroner's inquests, information governance incidents, complaints, patient opinion and claims received during the month of July 2016.
What does the paper tell us about the quality of care being provided:	In July there were:- • 2 serious incident level 2s and 12 level 1reviews commissioned. • 2 local team reviews were commissioned. • 18 deaths were reported. • 1 inquest was held, with another 2 planned. • 23 information governance incidents reported. • There were 30 new complaints raised, of which all were acknowledged within 3 working days. • 42 complaints were closed, 24 of which were closed in time. • 7 complaints were upheld, 18 not upheld and 16 partially upheld. • There were no complaints referred to the ombudsman. • 13 Patient Opinion stories were posted. • There was one new claim received.
What is the committee/meeting being asked to do:	To note and take action where required
Does this link to an existing BAF risk?	Yes- 4217
Does the BAF need amending in light of this paper?	No

West London Mental Health NHS Trust

Level 1 & Level 2 Serious Incident Reviews Commissioned in July

Level of review	Level of harm	Details/ comments
1	No harm	Medication - patient had been given 40 units instead of 4 units of actrapid
1	Unknown	Allegation of staff misconduct raised during Level 2 review
1	Death	Patient found deceased at home address, cause and circumstances of death not known.
1	None	17 year old patient admitted informally to adult ward of mental health unit as no Tier 4 bed available. Transferred to a private sector Tier 4 bed the following morning.
1	None	Records found in community
1	Death- suspected suicide	Patient found deceased in the community, cause and circumstance of death unknown.
1	None	Allegation of staff misconduct reported to the Matron.
1	None	Patient placed under S5 of the Mental Health Act, not allowed out for a cigarette, after review this was identified as an illegal detention.
1	None	Patient detained under section 3 of the Mental Health Act absconded from escorted section 17 leave. Police informed.
1	Unexpected death	Patient died in Hospital, had undergone emergency and died of complications.
1	Unexpected death	Trust informed by patients GP that the patient died, cause and circumstances of death not yet known.
1	Moderate	Allegation of patient to patient assault Police investigation underway.

2	Death-suspected suicide	Apparent patient suicide
2	Death-unexpected	Patient found deceased in his bed in his home, cause of death not known.

Local Team Reviews Commissioned in July 2016

Level of Harm	Detail
No harm	Self Injury to PATIENT - Patient inserted pen into their body
No Harm	Medication Storage Controlled Drug, methadone ordered was found to be short by 26mls.

Mortality data for July 2016

18 deaths were reported for the month of July

Cause of death	Place of Death	Detail
Natural causes. (expected palliative care)	WMUH	Suffered a fall, secondary pneumonia. Triggered seizures, suspected cause of death Infection & uncontrolled seizure.
Apparent natural cause (unexpected)	WMUH	Suspected cause of death given as Pneumonia.
Natural causes. (expected palliative care)	EGH	Suffered a MI at home address, admitted to Hospital where they later passed away. Suspected cause of death Multiple organ failure.
Unknown	C&WH	Suspected Cardiac arrest.
Apparent natural cause (unexpected)	WMUH	Admitted to A&E with suspected bleed on the brain where they later passed away.
Unknown	Unknown	Details of death unknown.
Apparent self-	Home address	Taken to Hospital following a self-inflicted wound to the neck where

inflicted		they later died.
Apparent natural cause (unexpected)	WMUH	Suspected cause of death pneumonia.
Unknown	Unknown	Referred to but not seen by GIC. No details of death known. GP contacted for further detail.
Apparent natural cause (unexpected)	Nursing Home	Admitted to Hospital following a fall. Treated for UTI & discharged back to care home where they died in their sleep.
Apparent natural cause (unexpected)	WMUH	Suspected cause of death, Sepsis
Unknown	Home address	Found dead in bed by a friend.
Apparent natural cause (unexpected)	WMUH	Cause of death recorded as natural cause due to old age after a brief illness.
Unknown	Home address	Found dead at home address, cause of death unknown.
Natural causes. (expected palliative care)	Nursing home	Patient transferred back to nursing home for palliative care following treatment in hospital.
Natural causes. (expected palliative care)	Hospital	Passed away in hospital whilst receiving palliative care for terminal illness.
Natural causes. (expected palliative care)	Home address	Discharged home from hospital to receive palliative care.
Apparent natural cause (unexpected)	Nursing Home	Patient died of Metastatic Bowel Cancer before the initial assessment was undertaken.

Coroner's Inquests held in July

A&UC	1 July 2016	Patient was under the care of Ealing Assessment Team, had had telephonic communication with them but was awaiting a face to face assessment appointment. It would appear that the patient took his own life by suspension at his home address.	The Coroner concluded that the cause of death was hanging and the verdict was that the patient took his own life. The Serious Incident review was referred to and HM Coroner had no concerns around the care and treatment provided to the patient by WLMHT.

Future Coroners Inquests

Date planned	Detail
Inquest scheduled for August 2016	Community patient in receipt of services provided WLMHT by was found hanged at his home address on 8th August 2015.
September 2016	Patient admitted and fell in January 2009, later died in a nursing home with another provider in September 2009.

Information Governance Incidents reported in July

Category of IG Incident

	Total
Breach of patient confidentiality	0
Lost RiO cards	12
Misdirected patient data	3
Lost or Stolen confidential paperwork	5
Other (no access to NHS. Net)	2
Non-secure management of confidential data	1
Lost or stolen ICT equipment	
Total =	23

Category	CSU	Detail	Actions Taken
Misdirected patient data	LS	Safeguarding alert sent in error to patient's family member.	Patient informed and an apology given. Provided with details of how to make a formal complaint
Loss or stolen confidential paperwork	LS	Referrals Book, containing information missing from the office.	Book replaced with electronic system to record data. Extensive search conducted to locate book but it is believed to have been disposed of accidentally.
Non-Secure management of personal confidential	LS	Patient medication chart misplaced	Replacement chart created original chart not found, lead practitioner to conduct audits on charts for 3 weeks

data			
Loss of RIO Smart Card	LS	Smartcard missing from office	New card issued
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss or stolen confidential paperwork	LS	Staff member unable to find a working folder	
Loss or stolen confidential paperwork	LS	Patient medication chart misplaced	Replacement chart created. Original not found despite extensive search
Loss of RIO Smart Card	WLFS	Staff member lost smartcard	New card issued
Mis-directed Patient Data	LS	Patients appointment letter was sent to the wrong address	Patient informed, letter sent to correct address RiO record updated
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss of RIO Smart Card		Staff member lost smartcard	New card issued
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Other	LS	Records containing WLMHT logo found in private residence	Records to be collected via courier and returned to WLMHT for further investigation.
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss of RIO Smart Card	WLFS	Staff member lost smartcard	New card issued
Loss or stolen confidential paperwork	LS	Patient medication chart misplaced	Replacement drug chart created, original not found
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss or stolen confidential	LS	Case file of patient missing	Extensive search conducted file not found

paperwork			
Mis-directed Patient Data (Letter, Fax or Email)	LS	Patient letter sent to the wrong address	Information on RiO updated service user informed letter sent to correct address
Loss of RIO Smart Card	LS	Staff member lost smartcard	New card issued
Loss of RIO Smart Card	HSS	Staff member lost smartcard	New card issued
Other	WLFS	Patient blood results incorrectly recorded on EMIS	Patient informed and record amended

Complaints raised between 27th June – 31st July 2016

30 complaints were raised in total, 16 in Local Services, 10 in High Secure Services and four in West London Forensic Services.

Subject of complaints

	Total
Admissions, discharge and transfer arrangements	1
Aids and appliances	2
All aspects of clinical treatment	11
Appointments, delay/cancellation (outpatient)	1
Attitude of staff	6
Communication/information to patients (written and oral)	1
Failure to follow agreed procedures	2
Patients privacy and dignity	1
Patients property and expenses	4
Personal records	1
Total =	30

Source	Detail	Acknowledged within 3 working days
CQC	Following surgery patient would like to revisit surgeon	Yes
Patient	Complainant states that patient feels they have been secluded for too long	Yes
SEAP	Staffs management of patients incompatibilities with another patient	Yes
Patient	Property has gone missing	Yes
Patient	Four staff members left their shift early causing ward shortages	Yes
SEAP	Staff attitude	Yes
SEAP	Allegations that the ward is being mismanaged	Yes
CQC	Complaint made about the second opinion doctor interview and the outcome	Yes
SEAP	Staff behaviour	Yes
SEAP	Staff behaviour	Yes
Other External Source	Allegation of physical assault	Yes
Patient	There are no provisions; specifically no lounge area on the ward.	Yes
Other External Source	Lack of provision for people with physical disabilities, staff behaviour	Yes
Other External Source	Lack of response to letters, no information provided regarding ward moves and the overall treatment provided on the ward	Yes
Patient	Loss of personal belongings	Yes
Family	Staff behaviour	Yes
Family	Staff behaviour	Yes
Patient	Lack of Braille signage for access to the unit by blind users.	Yes
Patient	Complaint about lack of treatment from the GIC.	Yes
Patient	Complainant felt patronised and interrogated by clinician during assessment	Yes
Family	Complaint about appointments and care given at the GIC	Yes
Patient	Staff attitude	Yes
Patient	Length of time waiting for appointments following cancellations	Yes
Patient	Allegation that three doctors have entered false information on medical records	Yes
Family	Lack of care and feeling ignored	Yes
Patient	Attitude of the receptionist and a doctor's secretary	Yes

Family	Re-investigation of previous complaint plus; a further complaint of named members of staff being rude	Yes
Other External Source	Significant delays in the assessment and lack of communication.	Yes
Patient	Missing property	Yes
Patient	Complainant felt he was left without adequate funds	Yes

Complaints closed

Number of complaints closed	42
Number of complaints closed in time	24
Number of complaints closed outside of time	17
Number of complaints withdrawn	1
Number of complaints referred to Ombudsman	0
Number of complaints upheld	7
Number of complaints not upheld	18
Number of complaints partially upheld	16

Patient Opinion

13 stories have been posted; 10 stories written by the patient, two unknown and one from a relative. Of the 13, 46% (n=6) received a response within three working days.

Author	Detail	Acknowledged within
Unknown	Unhappy with telephone call from mental health professional.	no response to date (posted 19.07.16)
Patient	With help I found myself again	1 working day
Patient	Honoured to be on ward.	3 working days
Patient	The clinic is the very best place for a patient	5 working days
Patient	Helped me to see a way forward for the future	1 working day

Patient	OCE (intrusive thoughts, checking, rituals) my therapist immediately put me at ease.	3 working days
Patient	Person centred therapy helped me relaxed and listen.	7 working days
Patient	I was put at ease straight away	1 working day
Patient	Life changing experience of counselling at Ealing IAPT	2 working days
Family	From the very start, they have shown mum respect	1 working day
Patient	I am really unhappy about the delays to my treatment	4 working days
Unknown	Worst gender clinic ever	no response to date (posted 11.07.16)
Patient	I am now in the community doing really well	14 working days

Claims

There was 1 new claim made in July:-
Local Services- Non-clinical- Member of staff trapped their thumb in the door.

Janet Bell
Head of Governance
August 2016