West London Mental Health NHS Trust

Quality Matters

Meeting Date:	3rd October 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 up to the 28th September 2016.
What does the paper tell us about the quality of care being provided:	In September there were:- • 2 serious incident level 2s and 5 level 1 reviews commissioned. • 4 local team reviews were commissioned. • 15 deaths were reported. • 0 inquests were held, with 5 planned. • 13 information governance incidents reported. • There were 28 new complaints raised, with one not acknowledged within 3 working days. • 26 complaints were closed, 13 of which were closed in time. • 4 complaints were upheld, 7 not upheld and 15 partially upheld. • There were no complaints referred to the ombudsman. • 11 Patient Opinion stories were posted, 2 not responded to. • There were 3 new claims received, and 2 claims closed.
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
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1. Serious Incidents reported onto Steis in September

Level of review	Level of harm	Details/ comments
Not yet levelled	None	Patient assaulted a staff member.
Level 1	Moderate	Patient tried to physically assault another patient.
Not yet levelled	None	Patient transferred to general hospital for further treatment.
Not yet levelled	None	Patient complained of swollen ankle.
Level 1	Death / Catastrophic	Patient died at home address, cause of death currently unknown.
Level 1	Moderate	Staff found patient bleeding following a self-harm attempt.
Level 1	Moderate	Patient reported to have jumped from a height sustaining injuries.
Level 1	None	Patient made an unprovoked attack on two nurses.
Level 2	Death / Catastrophic	Informed that patient had passed away suspected self-inflicted.
Level 2	Suspected homicide	Patient arrested for alleged murder.

2. Local Team Reviews Commissioned in September

Level of harm	Details/ comments
None	Patient assault on staff.
None	Patient on escorted leave absconded from staff.
None	Patient punched the alarm monitor.
None	Patient pushed his way into the MDT room.

3. Mortality data for September

Cause of death	Place of Death	Detail
Apparent Natural Cause (Unexpected)	Hospital	Patient death suspected natural causes
Unknown	Hospital	Patient death causes unknown
Unknown	Hospital	Patient death causes unknown
Natural Cause (Expected-palliative care)	Home address	Patient death suspected natural causes
Natural Cause (Expected-palliative care)	Hospital	Patient death suspected natural causes
Unknown	Hospital	Patient death causes unknown
Apparent self-inflicted	Home address	Patient death causes self inflicted.
Apparent self-inflicted	Unknown	Staff informed by family patient died causes self-inflicted.
Apparent Natural Cause (Unexpected	Hospital	Patient death suspected natural causes
Apparent self-inflicted	Public Place	Patient death causes self inflicted.
Unknown	Home address	Informed by family that patient had died, cause of death unknown but suspected natural cause.
Unknown	Home address	Patient death causes unknown
Natural Cause (Expected-palliative care)	Home address	Patient death suspected natural causes
Natural Cause (Expected-palliative care)	Home address	Patient death suspected natural causes
Apparent Natural Cause (Unexpected	Hospital	Patient death suspected natural causes

4. Future Coroners Inquests

September 2016	Patient admitted. Difficult to engage and was only taking restricted food/fluids. Suffered a cardiac arrest on 01/01/16 and subsequently died.
October 2016	Patient was found lying in his flat following a welfare check by Police. This had been requested by the family as they had not seen patient for 9 days. Last seen by Trust on the 2015.
November 2016	Patient died by jumping in front of a train.
January 2017	Staff unable to wake patient, he was breathing but unresponsive. Duty doctor and site management attended. Physical observations taken, patient taken to General Hospital as an emergency, where later died.
March 2017	Patient found sitting in a chair in room non-responsive. Staff unable to rouse patient or find a pulse. CPR performed until paramedics arrived, all attempts unsuccessful and patient pronounced dead.

5. Information Governance Incidents reported in September

Category of IG Incident	Total
Breach of patient confidentiality	4
Lost RiO cards	3
Misdirected patient data	2
Other	1
Non-secure management of confidential data	3
Total =	13

Category	Detail	Actions Taken
Misdirected Patient Data	Patient email sent to the wrong address	Email recovered, staff refreshed information governance training.
Non Secure Management of confidential data	Contact details for patient not updated leading to an incorrect disclosure of information over the phone	Patient informed of disclosure and contact details updated

Loss of RIO Smart Card	Smart card lost	New card issued
Breach of Patient Confidentiality	2 patients with same name and NHS number, letter sent to the wrong patients GP as a result	Written and verbal apology to the patient, correct GP surgery provided with the information NHS spine contacted to fix the issue.
Breach of Patient Confidentiality	Patient data sent in error to third party	Patient apologised to and issue raised in staff supervision.
Loss of RIO Smart Card	Smart card lost	New card issued
Breach of Patient Confidentiality	Patient information shared with external agent without consent	Patient informed and apologised to, staff member reminded on procedures for sharing information and obtaining consent.
Other	Email address and password for a member of staff were found amongst a dataset on the open market	Password change immediately, no other email addresses found to be compromised.
Non Secure Management of confidential data	Email sent via nhs.net to nhs.uk so not encrypted during a reply all exchange	Email deleted and staff reminded to check all addresses before sending
Breach of Patient Confidentiality	Email containing limited patient information accidently sent to member of staff's private email account	Email deleted, staff refreshed IG training
Non Secure Management of confidential data	A bundle of confidential waste paper found in the shredder	Information disposed of correctly, memo sent to all members of staff reminding of the importance of disposing of data safely
Misdirected Patient Data	Doctor not informed of patient move, update send to wrong ward	Discussed in clinical team meeting – staff reminded to update all members of the team
Loss of RIO Smart Card	Smart card lost	New card issued

6. Complaints raised between 1st September – 26th September 2016

28 complaints were raised in total, 15 in Local Services, five in High Secure Services and six in West London Forensic Services. This information within this report has been taken directly from the Trusts complaints database.

Subject of complaints

	Total
Admissions, discharge and transfer arrangements	**1**
All aspects of clinical treatment	**8**
Appointments, delay/cancellation (outpatient)	**2**
Attitude of staff	**10**
Communication/information to patients (written and oral)	**2**
Failure to follow agreed procedures	**2**
Hotel services	**1**
Other	**1**
Patients property and expenses	**1**
Total =	**28**

Source	Detail	Acknowledged within 3 working days
Patient	Complaint about report and concerned about Treatment	Yes
Patient	Complaint about the standard of food in the café.	Yes
CQC	Patient made a number of allegations related to abuse by staff.	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
SEAP	Complaint about staff not keeping patients details confidential	Yes
Patient	Staff attitude/behaviour	Yes
Other External Source	Staff attitude/behaviour	Yes
Patient	Complaint about appointments	Yes
Patient	Staff attitude/behaviour	Yes
Family	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Complaint about treatment plan	Yes
Family	Allegation of assault by another patient	No
Family	Staff attitude/behaviour and complaint about treatment plan	Yes
Patient	Staff attitude/behaviour	Yes
Family	Complaint about treatment plan	Yes
Patient	Complaint about delays and admin	Yes
Patient	Complaint about legal correspondence	Yes
Patient	Referral letter to the GP was delayed and did not contain	Yes

	information on medication required as expected.	
Other External Source	Formal complaint made as GP was asked to fax a letter to the clinic requesting that the senior specialist psychology associate.	Yes
Patient	Complaint about the care of patient	Yes
Patient	Allegation of stolen property	Yes
Family	Complaint about not being informed well	Yes
Other External Source	Complaint about transfer of Ward	Yes
SEAP	Patient bruised during restraint	Yes
SEAP	Staff attitude/behaviour	Yes
SEAP	Staff attitude/behaviour	Yes

7. Complaints closed

Number of complaints closed	**26**
Number of complaints closed in time	**13**
Number of complaints closed outside of time	**13**
Number of overdue complaints	**8**
Number of complaints withdrawn	**3**
Number of complaints referred to Ombudsman	**0**
Number of complaints upheld	**4**
Number of complaints not upheld	**7**
Number of complaints partially upheld	**15**

8. Parliamentary & Health Ombudsman (PHSO)

No referrals made to the ombudsman

9. Patient Opinion

11 stories have been posted; 63% of the stories were written by the patient/service user, 9% from a parent/guardian, 9% from a staff member posting for a patient/services user, 9% from a relative and 9% unknown. Of the 11 stories, 55% (n=6) received a response within three working days. Three stories are awaiting a response (AR).

Author	Detail	Date posted	Date responded to
Staff	My story	14/09/2016	16/09/2016
Patient	I was shocked by their manner	02/09/2016	02/09/2016
Patient	Occupational therapy	01/09/2016	06/09/2016
Service User	We are grateful to IAPT for giving us an opportunity to improve our relationship	16/09/2016	AR
Patient	I am on that road named recovery	13/09/2016	15/09/2016
Patient	CBT Therapy	14/09/2016	15/09/2016
Service user	It has helped me on many different levels	18/09/2016	22/09/2016
Patient	Having problems "touching base" with anyone from Ealing IAPT	24/09/2016	26/09/2016
Patient	Be a very patient, patient	17/09/2016	AR
Parent/guardian	Kestrel ward deserve recognition for the work they do	01/09/2016	01/09/2016
Relative	As yet, still not told decision made about care	16/09/2016	26/09/2016

10. Claims

There were three (3) new claims received in September 2016:

Type	Category	Description	Incident Date
Non-Clinical	Assault on staff by patient	Patient threw hot drink on staff	26/05/2016
Non-Clinical	Assault on staff by patient	Patient assault on staff	01/02/2016
Non-Clinical	Assault on staff by patient	Patient assault on staff	14/01/2016

There were two (2) claim closed in September 2016:

Type	Cost of Case	Description	Incident Date
Clinical	£4434.70 (Defence costs)	Whilst on unescorted leave, patient jumped off a bridge (Breach of duty of care)	09/10/2012
Non-Clinical	0 (Zero)	Claimant was struck twice on the head by another patient with a weapon. (Assault to patient)	27/05/2015

There are three (3) claims overdue for evidence gathering in September 2016:

Type	Description	Incident Date	Evidence Deadline	Portal case	Portal deadline
Non-clinical	Trapped finger in the door	30/07/2015	24/8/2016	Yes	05/09/2016
Non-clinical	Patient assault on staff	07/12/2015	23/09/2016	Yes	07/10/2016
Non-clinical	Staff member slipped and fell on a flooded floor.	24/07/2016	15/09/2016	Yes	29/09/2016
Non-clinical	Patient assault on staff	01/04/2015	29/09/2016	Yes	22/09/2016

Janet Bell
Head of Governance
October 2016