West London Mental Health NHS Trust

Quality Matters

Meeting Date:	9th January 2017
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 for the month of December.
What does the paper tell us about the quality of care being provided:	In December there were:- • 2 serious incident level 2s and 9 level 1 reviews commissioned. • 11 local team reviews were commissioned. • 22 deaths were reported. • 0 inquests were held, with 5 planned. • 16 information governance incidents reported. • There were 44 new complaints raised, with 4 not acknowledged within 3 working days. • 37 complaints were closed, 23 of which were closed in time. • 7 complaints were upheld, 13 not upheld and 17 partially upheld. • 0 complaints were referred to the ombudsman. • 16 Patient Opinion stories were posted, 5 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

NHS Trust

Level of review	Level of harm	Details/ comments
Level 1	Death / Catastrophic	Patient death.
Level 1	Death / Catastrophic	Patient death.
Level 1	Death / Catastrophic	Patient death.
Level 1	No Harm	Safeguarding issue.
Level 1	Moderate	Inpatient took overdose.
Level 1	No Harm	Under 18 admission to adult ward.
Level 1	No Harm	Under 18 admission to adult ward.
Level 1	Moderate	Patient injured, self-inflicted.
Level 2	Death / Catastrophic	Patient passed away, suspected self-inflicted.
Level 2	Death / Catastrophic	Patient death.
Level 1	Low	Patient damaged hospital property and attempted to assault staff.

2. Local Team reviews commissioned in December

Level of harm	Details/ comments
Moderate	Patients health deteriorated.
Moderate	Patient made unprovoked attack on staff member.
No Harm	Patient verbally and physically aggressive towards staff.
Low	Patient assaulted staff member.
No Harm	Patient alleged derogatory comments were made about them.
Death / Catastrophic	Patient passed away of terminal cancer.
No Harm	Allegation of sexual assault.
No Harm	Patient tried to assault a relative.
Moderate	Staff found patient injured.
No Harm	Patient absconded.
No Harm	Patient damaged Trust property .

3. Mortality data for December

22 deaths were reported during the month of December.

Cause of death	Place of Death	Detail
Natural Cause (expected –	Hospital	Patient death suspected natural cause

palliative care)		
Apparent self-inflicted	Unknown	Patient death, suspected self-inflicted.
Apparent Natural Causes (unexpected)	Hospital	Patient death.
Apparent Natural Causes (unexpected)	Unknown	Passed death suspected natural cause.
Natural Cause (expected – palliative care)	Hospital	Patient death.
Natural Cause (expected – palliative care)	Nursing home	Patient death suspected natural cause.
Unknown	Home address	Found death at home cause unknown.
Natural Cause (expected – palliative care)	Unknown	Patient death suspected natural cause.
Apparent Natural Causes (unexpected)	Hospital	Patient death.
Apparent Natural Causes (unexpected)	Hospital	Patient death suspected natural cause.
Apparent Natural Causes (unexpected)	Hospital	Patient death suspected natural cause.
Apparent Natural Causes (unexpected)	Hospital	Patient death.
Apparent Natural Causes (unexpected)	Hospital	Patient death
Natural Cause (expected – palliative care)	Care home	Patient death suspected terminal cancer.
Natural Cause (expected – palliative care)	Unknown	Patient death, cause of death unknown

Apparent Natural Causes (unexpected)	Care home	Patient death, cause of death unknown.
Apparent Natural Causes (unexpected)	Care home	Patient death, cause of death unknown
Apparent Natural Causes (unexpected)	Care home	Patient death of terminal cancer.
Apparent Natural Causes (unexpected)	Home address	Patient death of terminal cancer.
Unknown	Unknown	Patient death, cause of death unknown.
Unknown	Home address	Patient death, cause of death unknown.
Apparent Natural Causes (unexpected)	Hospital	Patient death, suspected cardiac arrest.

4. Future Coroners Inquests

PIR held on 05/12/16 – inquest to be heard 20/03/17 – 29/03/17 (excluding 28/03/17)	Patient suffered a cardiac arrest and subsequently died on 09/01/16. The family and Trust are being legally represented. The family solicitor has requested an article 2 inquest (with Jury)- waiting for information from Trust legal team. The Trust is in the process of providing the relevant evidence to the court prior to inquest.
PIR held on 14/11/16 – inquest to be held 4-6th January 2017	Patient died by jumping in front of a train. The family and Trust are being legally represented. Trust Solicitors have requested adjournment due to non-received submissions from the coroner's office. Awaiting court response. All staff have attended pre-inquest session with CG Lead and Trust Solicitor. Media interest. Communications Department are aware and have been briefed.
PIR held on 02/12/16 – inquest scheduled for 30/01/17 – 31/01/17	Patient found collapsed. Emergency response initiated and paramedics called. Inquest to be held under Article 2 as the patient's family have concerns regarding the psychiatric drugs prescribed and possible counter indications with the patient's physical health care diagnosis.
23rd- 26th January 2017	Patient taken to General Hospital as an emergency, where they later died.
20th – 23rd March	Patient found non-responsive. Staff unable to rouse patient or find a pulse.

2017	CPR performed until paramedics arrived, all attempts unsuccessful and patient pronounced dead on 11/12/2014.

5. Information Governance Incidents reported in December

Category of IG Incident	Total
Breach of patient confidentiality	2
Lost RiO cards	8
Misdirected patient data	1
Non-secure management of confidential data	1
Other	4
Total	16

Incident Date	Category	Detail	Actions Taken
20/12/2016	Misdirected Mail / Papers	Email containing log in information sent to incorrect recipient on NHS.NET	Recipient asked to delete the email and staff member reminded to check details closely before sending
20/12/2016	Non-Secure management of personal confidential data	Loss of RiO Card	New card issued
14/12/2016	Other	Service user left telephone off the cradle for over 25 minutes	Incident discussed with service user during session
13/12/2016	Loss of RIO Smart Card	Staff member lost Rio Card	New card issued
05/12/2016	Loss of RIO Smart Card	Staff member lost Rio Card	New card issued
11/12/2016	Loss of RIO Smart Card	Staff member lost Rio Card	New card issued
29/12/2016	Breach of Patient Confidentiality	Donation page set up for sponsored event, all donations should have been anonymous however one name from a member of the public shown	Page taken down to prevent incident from reoccurring
02/12/2016	Other	Information relating to patient A	Reflective conversation with trainee undertaken to consider

		accidently included in Patient B's records	contributory factors and measures to prevent it from happening again
28/12/2016	**Loss of RIO Smart Card**	Staff member lost Rio Card	New card issued
15/12/2016	**Other**	Smart card damaged	New card issued
02/12/2016	**Loss of RIO Smart Card**	Staff member lost Rio Card	New card issued
19/12/2016	**Loss of RIO Smart Card**	Staff member lost Rio Card	New card issued
13/12/2016	**Other**	Incorrectly logged as Information Governance incident	Request made for incident to be reallocated
22/12/2016	**Loss of RIO Smart Card**	Staff member lost Rio Card	New card issued
21/12/2016	**Breach of Patient Confidentiality**	Email containing patient information from a team meeting accidently sent to another member of staff within WLMHT	Mailing list reviewed and updated
04/12/2016	**Loss of RIO Smart Card**	Staff member lost Rio Card	New card issued

6. Complaints

Complaints raised between 1st – 31st December 2016

44 complaints were raised in total, 20 in Local Services, 18 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 arrangement	4
All aspects of clinical treatment	16
Appointments, delay/cancellation (outpatient)	1
Attitude of staff	7
Communication/information to patients (written and oral)	3
Complaints handling	1
Consent to treatment	1
Failure to follow agreed procedures	1

Other	**5**
Patients privacy and dignity	**1**
Patients property and expenses	**3**
Patients records (including medical and/or complaints)	**1**
Total =	**44**

Source	Detail	Acknowledged within 3 working days
Patient	Staff/behaviour	Yes
Family	Complaint regarding the treatment	Yes
SEAP	Staff/behaviour	Yes
SEAP	Complaint about claim not being investigated properly	Yes
Patient	Complaint regarding the treatment.	Yes
Patient	Complaint about communication between staff and patient	Yes
Patient	Complaint about access to facilities	Yes
Patient	Complaint that false statements were made in on the referral	Yes
SEAP	Complaint on confidentiality breach.	Yes
Family	Patients property transferred incorrectly on discharge	Yes
SEAP	Staff/behaviour	Yes
SEAP	Staff/behaviour	Yes
SEAP	Patient was injured during treatment	Yes
Patient	Staff/behaviour and complaint regarding the treatment	Yes
SEAP	Complaint about treatment	Yes
SEAP	Staff/behaviour	No
Patient	Complaint about treatment	Yes
Patient	Staff/behaviour	Yes
Family	Complaint about treatment	Yes
SEAP	Complaint about treatment	Yes
Solicitor	Complaint about treatment	Yes
SEAP	Complaint about treatment	Yes

SEAP	Staff/behaviour	Yes
Patient	Staff/behaviour	Yes
Family	Staff/behaviour	No
Family	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Solicitor	Complaint about treatment	Yes
Patient	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Patient	Complaint about treatment	Yes
Patient	Complaint about treatment	Yes
Family	Complaint about treatment	Yes
Patient	Complaint about a report	Yes
Family	Complaint about treatment	Yes
Patient	Complaint about treatment	Yes
Patient	Complaint on information in medical records	No
CQC	Complaint about treatment	Yes
Patient	Complaint about treatment	Yes
Patient	Complaint about misdiagnoses	No
Family	Staff/behaviour and complaint about treatment	Yes

Complaints closed

Number of complaints closed	37
Number of complaints closed in time	23
Number of complaints closed outside of time	15
Number of overdue complaints	11
Number of complaints withdrawn	3
Number on hold due to another investigation	1
Number of complaints upheld	7
Number of complaints not upheld	13
Number of complaints partially upheld	17

Number of complaints referred to Ombudsman	0

Parliamentary & Health Ombudsman (PHSO)

No complaints have been referred during December 2016

7. Patient Opinion

16 stories have been posted; 69% of the stories were written by the patient/service user, 19% from the carer and 13% are unknown. Of the 16 stories, 50% (n=8) received a response within three working days. Five stories are awaiting a response (AR).

Of the total 16 stories 50% (n=8) were positive feedback

Author	Detail	Date posted	Date responded to
Service User	Mindfulness for carers Group	02.12.2016	AR
Anonymous	Totally failed my daughter	13.12.2016	16.12.2016
Patient	Assessment and crisis team at St Bernard Hospital/ ECT at Ealing Hospital	12.12.2016	19.12.2016
Anonymous	Watch yourself! There's agendas in the gender...	13.12.2016	20.12.2016
Patient	It was the care of staff that brought me back	01.12.2016	03.01.2017
Patient	Positive experience	08.12.2016	09.12.2016
Patient	Fantastic support	09.12.2016	12.12.2016
Patient	Hounslow Perinatal Mental Health Service	09.12.2016	12.12.2016
Patient	Extremely grateful for the incredible care	15.12.2016	20.12.2016
Patient	A&E referral	18.12.2016	20.12.2016
Patient	Mental health recovery	23.12.2016	AR
Carer	Poor meeting	28.12.2016	AR
Carer	Excluded from a meeting about my son	29.12.2016	30.12.2016
Patient	CX GIC First Assessment	30.12.2016	AR
Patient	Great service, care and friendship	21.12.2016	AR
Carer	A good experience, a good doctor	26.12.2016	28.12.2016

8. Claims

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

Clinical / Non-Clinical	Type / category	Date of Incident (if applicable)	Brief description of the claim particulars
Non-Clinical	Assault on staff by patient	11/07/2016	Patient attacked staff member
Non-Clinical	Assault on staff by patient	11/01/2016	Patient attacked staff member
Non-Clinical	Assault to patient	26/10/2015	Patient attacked patient

There were two(2) claims closed in December 2016:

Clinical / Non-Clinical	Date Open	Type / category	Date of Incident (if applicable)	Brief description of the claim particulars	Damages (£)	Claimant cost (£)	Defence cost(£)
Non-Clinical	15/07/2014	Security incident	Year 2008-2010	Patient confidential details leaked to the press	8,000.00	19,940.80	5,496.60
Clinical	03/05/2016	Breach of Duty of care	07/01/2015	Patient was on overnight leave and stepped in front of a train. This resulted in his death.	0	0	0

There were no claims overdue for evidence gathering in December 2016.

Janet Bell
Head of Governance
December 2016