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 October.
What does the paper tell us about the quality of care being provided:	In November there were:- • 5 serious incident level 2s and 8 level 1 reviews commissioned. • 15 local team reviews were commissioned. • 19 deaths were reported. • 1 inquest was held, with 4 planned. • 29 information governance incidents reported. • There were 42 new complaints raised, with 3 un-acknowledged within 3 working days. • 32 complaints were closed, 19 of which were closed in time. • 4 complaints were upheld, 12 not upheld and 16 partially upheld. • 1 complaint was referred to and accepted for investigation by the ombudsman. • 17 Patient Opinion stories were posted, 3 not responded to. • There was 1 new claim received, 1 claim closed and 1 overdue for submission of evidence.
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

Level of review	Level of harm	Details/ comments
Level 1	Death / Catastrophic	Patient found death at home. Suspected self-inflicted.
Level 2	Death / Catastrophic	Patient was found deceased at home address. Cause and circumstances of death not known.
Level 1	Death / Catastrophic	Patient death. Cause and circumstances of death not currently known.
Level 1	No Harm	Under 18 admission to adult ward.
Level 1	No Harm	Inpatient set fire.
Level 2	Death / Catastrophic	Patient’s suffered a cardiac arrest.
Level 2	Death / Catastrophic	Patient suspected of murder.
Level 1	Severe	Allegation of sexual assault.
Level 2	Victim	Patient died of a drug overdose.
Level 2	Death / Catastrophic	Patient death suspected self-inflicted.

Level 1	Moderate	Undiagnosed fracture.
Level 1	No Harm	Allegation of sexual abuse.
Level 1	No Harm	Staff attending serious incident left pan on the hob which ignited.

Level of harm	Details/ comments
No Harm	Unprovoked patient on patient assault.
No Harm	Non-physical assault- patient to patient.
No Harm	Patient made verbal threats to staff member.
Low	Patient self-harmed.
No Harm	Patient threw cup of team.
No Harm	Unprovoked physical assault, patient to patient.
No Harm	Patient missing.
No Harm	Patient absconded from escorting nurse.
Moderate	Patient threw hot drink.
No Harm	Patient forced open the locker of another patient.
No Harm	Patient did not return from unescorted ground leave.

No Harm	Shattered the window.
No Harm	Patient made an unprovoked attack on a staff member.
Low	Patient made an unprovoked attack on another patient.
No Harm	Patient walked through the double doors leading to reception unescorted.

3. Mortality data for November

19 deaths were reported during the month of November.

Cause of death	Place of Death	Detail
Unknown	Hospital	Died in cardiac arrest.
Natural Cause (expected – palliative care)	Care Home	Patient had passed away from terminal cancer.
Apparent Natural Causes (unexpected)	Home address	Patient found dead at home address. Suspected natural cause.
Unknown	Supported accommodation	Patient found dead at home address.
Apparent Natural Causes (unexpected)	Nursing Home	Patient passed away.
Natural Cause (expected – palliative care)	Unknown	Patient died of terminal cancer.
Unknown	Hospital	Patient passed away.
Apparent Natural Causes (unexpected)	Nursing home	Patient passed away.
Apparent Natural Causes (unexpected)	Care home	Patient death suspected natural cause..
Apparent Natural Causes (unexpected)	Home address	Patient death suspected natural cause.

Apparent self-inflicted	Public Place	Passed away following an overdose.
Unknown	Hospital	Died in ITU.
Apparent self-inflicted	Home address	Found dead at home address.
Unknown	Unknown	Informed patient passed away, no further details known at present.
Apparent Natural Causes (unexpected)	Hospital	Patient passed away.
Apparent Natural Causes (unexpected)	Care home	Patient died of suspected natural cause.
Natural Cause (expected – palliative care)	Care home	Passed away at home.
Apparent self-inflicted	Unknown	Details of death currently unknown but suspected self-inflicted.
Apparent Natural Causes (unexpected)	Hospital	Informed patient died of terminal cancer.

4. Inquests

Inquests held in November

Inquest November 2016	Patient found dead at home address. Police found needles in the room which he assumed was for the administration of illicit drugs. Ambulance and police called and confirmed that the patient had passed away	Coroner's Conclusions***: Drug and alcohol related death*** The Coroner did not issue a PFD (Prevent Future Death) and there were no care or service delivery issues identified from the SI report at the inquest.

Future Coroners Inquests

PIR to be held on 05/12/16 – inquest scheduled for February 2017	Suffered a cardiac arrest and subsequently died 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.
PIR held on 14/11/16 – inquest scheduled for 4-6th January 2017	Patient died by jumping in front of a train on 07/01/16. 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
23rd- 26th January 2017	Patient found unresponsive. Transferred to Hospital as an emergency, where they subsequently died.
20th – 23rd March 2017	Patient found non-responsive. CPR performed, paramedics arrived, all attempts unsuccessful.

5. Information Governance Incidents reported in November

Category of IG Incident	Total
Breach of patient confidentiality	12
Lost RiO cards	10
Misdirected patient data	1
Non-secure management of confidential data	3
Lost or stole ICT/Paperwork	3
Total	29

Category	Detail	Actions Taken
Non-Secure management of personal confidential data	Email received by the Trust from Solicitors containing identifiable	Solicitors reminded to only use secure email addresses to transmit confidential data

	information	
Breach of Patient Confidentiality	Paperwork relating to another patient accidently included in patients assessment letter	Information returned immediately patient provided with an apology.
Loss of RIO Smart Card	Card misplaced	New card issued
Loss of RIO Smart Card	Card misplaced	New card issued
Breach of Patient Confidentiality	Folder containing patient information left in staff restaurant	Information returned to ward and incident raised
Non-Secure management of personal confidential data	Patient details emailed to non secure email address	Staff member set up with NHS.NET account
Loss or stolen confidential paperwork	Complaint letter misplaced	Thorough search undertaken complainant apologised to, internal process for receiving post within the team reviewed and changed
Breach of Patient Confidentiality	Letter received with NHS number missing, confidentiality of patient breached when GP surgery contacted for number	Breach explained to the patient with apology.
Loss of RIO Smart Card	Card misplaced	New card issued
Loss or stolen IT equipment	Staff member misplaced work mobile phone	Staff reminded to keep all devices in locked rooms when unattended.
Non-Secure management of personal confidential data	Concerns raised over the disposal of bag labels containing patient data	Action plan drafted for team to ensure all confidential information is disposed of correctly and all staff undertake information governance training
Loss or stolen confidential paperwork	Patients drug chart misplaced	Previous recommendations to prevent incident not followed, staff reminded to follow recommendations
Loss of RIO Smart Card	Card misplaced	New card issued
Loss of RIO Smart Card	Card misplaced	New card issued
Loss of RIO Smart Card	Card misplaced	New card issued
Breach of Patient Confidentiality	Patient information sent to incorrect GP	All information returned admin staff reviewed and strengthened procedure for searching and checking patients RiO numbers and addresses

Breach of Patient Confidentiality	Patent letter not properly sealed	Staff advised to be more thorough when sending out correspondence, quality checking to be undertaken by managers
Breach of Patient Confidentiality	Patient letter sent to the incorrect address (wrong house number)	Assumption made that address on system was current, if uncertainty patients should be contacted via other means.
Loss of RIO Smart Card	Card misplaced	New card issued
Loss of RIO Smart Card	Card misplaced	New card issued
Loss of RIO Smart Card	Card misplaced	New card issued
Breach of Patient Confidentiality	Patient provided with incident report which contained the name(s) of other patients	Staff reminded that all IR1 forms should not contain patient names and should be reviewed before being shared outside the Trust.
Breach of Patient Confidentiality	Patient information accidently included in minutes of a meeting – not anonymised	Email recalled and staff who had opened the email asked to delete its content
Breach of Patient Confidentiality	Patient information sent in error to the CQC during a routine data request	Information recovered staff reminded to send all information to the CQC via the dedicated email address so it can be reviewed before sending
Loss of RIO Smart Card	Card misplaced	New card issued
Mis-directed Patient Data	Email containing patient NHS number sent to incorrect recipient	Staff member reminded to thoroughly check all email addresses before sending
Breach of Patient Confidentiality	Letter sent to incorrect address	Patient informed and internal process reviewed to prevent reoccurrence
Breach of Patient Confidentiality	Information relating to another patient included in patients archived notes due to incorrect filing	Information placed in correct file, medical records staff informed
Breach of Patient Confidentiality	Patient information sent to incorrect email address	Patient informed, recipient asked to delete email

6. Complaints

Complaints raised between 1st – 30th November 2016

42 complaints were raised in total, 22 in Local Services, 15 in High Secure Services and 5 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	2
Aids and appliances, equipment, premises (including access)	2
All aspects of clinical treatment	10
Appointments, delay/cancellation (outpatient)	1
Attitude of staff	14
Communication/information to patients (written and oral)	2
Failure to follow agreed procedures	3
Hotel Services	1
Other	4
Patients property and expenses	2
Patients records (including medical and/or complaints)	1
Total =	42

Source	Detail	Acknowledged within 3 working days
CQC	Complaint about treatment and missing possessions.	Yes
CQC	Complaint about confidentiality breach.	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Complaint about low staffing level	Yes
SEAP	Complaint about confidentiality breach	Yes
SEAP	Staff attitude/behaviour	Yes
Solicitor	Staff attitude/behaviour	Yes
SEAP	Complaint about medication	Yes
Patient	Various issues around his access to a telephone, television, shower and diagnosis	Yes

SEAP	Complaint regarding a delay in receiving post	Yes
Patient	Several complaints about attitude/behaviour and confidentiality.	Yes
Patient	Complaint about external orders made by patients taking too long to arrive.	Yes
SEAP	Patient disputes an IR1 and staff attitude/behaviour	Yes
SEAP	Concerns about an IR1 and how this may have repercussions with his application for a green ground access	Yes
Patient	Staff attitude/behaviour	Yes
SEAP	Staff attitude/behaviour	Yes
CQC	Complaints about facilities provided not sufficient and attitude/behaviour	Yes
Family	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
CQC	Staff attitude/behaviour	
Other External Source	Staff attitude/behaviour	Yes
CQC	Staff attitude/behaviour	No
CQC	Staff attitude/behaviour	Yes
CQC	Staff attitude/behaviour	Yes
Family	Complaint regarding the treatment	Yes
Family	Complaint regarding the treatment	Yes
Patient	Complaint about the length of time the data is circulated to GP's and consent required on disclosing confidential information.	Yes
Patient	Staff attitude/behaviour and confidentiality breach	Yes
Other External Source	Staff attitude/behaviour	Yes
Patient	Complaint regarding the treatment.	Yes
Patient	Staff attitude/behaviour.	Yes
Patient	Complaint regarding the treatment	Yes
Solicitor	Complaint regarding the treatment	No
Patient	Complaint regarding the treatment	Yes
Patient	Complaint regarding the treatment	Yes
Patient	Complaint regarding the treatment	Yes

Patient	Staff attitude/behaviour	No
Patient	Staff attitude/behaviour	Yes
Patient	Complaint regarding the treatment	Yes
CQC	Complaint regarding the treatment	Yes
Other External Source	Complaint regarding the treatment	Yes

Complaints closed

Number of complaints closed	**32**
Number of complaints closed in time	**19**
Number of complaints closed outside of time	**13**
Number of overdue complaints	**11**
Number of complaints withdrawn	**6**
Number of complaints upheld	**4**
Number of complaints not upheld	**12**
Number of complaints partially upheld	**16**
Number of complaints referred to Ombudsman	**1**

Parliamentary & Health Ombudsman (PHSO)

One complaint regarding the Gender Identify Clinic has been referred to the PHSO and they have informed us that they are going to be investigating.
The complaint is regarding a decision that was made that has prevented the complainant from starting her medication/transition process.

7. Patient Opinion 1st – 30th November

Of the total 17 stories posted; 71% of the stories were written by the patient and 12% by staff on behalf of the patient or carer, 6% by the carer, 6% by the parent/guardian and 6% from other. Of the 17 stories, 35% (n=6) received a response within three working days. Two stories are awaiting a response (AR). 56% of the total (n=10) were positive feedback

Author	Detail	Date posted	Date responded to
Patient	Good experience in recovery house	10.11.2016	15.11.2016
Staff for a patient	She knows my history and has cared for me well	10.11.2016	21.12.2016

Carer	Unreceptive to criticism	12.11.2016	AR
Patient	Long term anxiety	01.11.2016	08.11.2016
Parent/Guardian	Amazing care at Lakeside Mental Health Unit	10.11.2016	11.11.2016
Staff for a Carer/relative	For probably the first time I felt listened to	02.11.2016	04.11.2016
Patient	Really poor service	22.11.2016	21.12.2016
Patient	No disability access	17.11.2016	21.12.2016
Patient	Amazing, supportive and listens	23.11.2016	25.11.2016
Patient	Counselling at Ealing IAPT service after below knee amputation	15.11.2016	05.12.2016
Patient	Valued support from Ealing Perinatal Mental Health Service	25.11.2016	01.12.2016
Patient	Cancelled appointment interpreted as missed	11.11.2016	15.11.2016
Patient	Poor communication	14.11.2016	15.11.2016
Patient	Claybrook Mental Health experience	16.11.2016	21.12.2016
Other	Parking Problems	08.11.2016	16.11.2016
Patient	Brilliant staff at Lakeside - West Middlesex Hospital	13.11.2016	AR
Patient	Brilliant staff at Lakeside - West Middlesex Hospital	13.11.2016	AR

8. Claims

There was one (1) new claim received in November 2016:

CSU	Type	Category	Description	Incident Date
WLFS	Non-Clinical	Assault on staff by patient	Patient assault on staff member	4/5/2016

There was one(1) claim closed in November 2016:

CSU	Type	Cost of Case	Description	Incident Date

HSS	Non-Clinical	£0(Zero)	Lift floor was higher than the ground floor and staff tripped and fell	9/10/2014

There was one (1) new claim overdue for evidence gathering in November 2016:

CSU	Type	Description	Incident Date	Evidence Deadline	Portal case	Portal deadline
LS	Non-clinical	Patient assault on staff	30/07/2015	22/11/2016	Yes	22/11/2016 But extension is requested due to claimant not giving us the correct incident date

Janet Bell
Head of Governance
Novemebr 2016