Safer Services Report

Introduction

This report includes information relating to Q2 (July – September) and supports the report produced for the board quarterly.

Incident Reporting and Management

The following gives a breakdown of the incidents that occurred within NAViGO in line with the serious incident framework in Q2 17/18

Serious Incidents reported in Q2 (compared to Q1)

	Q1 17/18			Q2 17/18		
	April	May	June	July	Aug	Sept
Death	1	2	0	0	3	1
Other Serious Incident	0	0	0	1	1	0
Total	1	2	0	1	4	1
Quarterly total	**3**			**6**		

There have been 6 serious incidents subject to review in Q2.

Deaths that are subject to review in line with our serious incident policy are as follows:

Where NAViGO is the main provider of care if at the time of death the service user was subject to:

- An episode of inpatient care in our services
- An episode of community care under the Care Programme Approach
- An episode of community care due to identified mental health, learning disability or substance misuse needs
- A Community Treatment Order (CTO)
- A Conditional Discharge
- A Guardianship
- An inpatient episode or a treatment package within the six months prior to their death
- Where an episode of care occurred longer than six months prior to the death we will review the case on an individual basis or if requested by the family/carer, staff or external agencies such as the CCG or the CQC

In addition to the above NAViGO are following the guidance set by the Northern Mental health trusts and will investigate a death where the following circumstances are evident:

- Where a family member/carer or staff member raises concern about care provided
- Where medication with known risks such as Clozapine was a significant part of the care package
- From causes or in clinical areas where concerns had already been flagged
- Where Electro Convulsive Therapy (ECT) or rapid tranquillisation was involved

- Where the service user was particularly isolated with no active family or friends to act on their behalf
- Where there had been previous safeguarding and protection concerns
- Where there had been known delays to treatment provided by NAViGO (assessment taken place or GP referral made but care and treatment not provided or where there was a gap in services)
- Particular causes of death e.g. epilepsy

Each month NAViGO receives notice of all deaths within NEL and checks to see whether any have received care from NAViGO. We complete a case record review of all cases where the cause of death has not yet been determined so we can establish if they fall under the serious incident framework for investigation. 10% of all deaths reported to NAViGO who have received a service from us, will be subject to a case record review.

NAViGO follows the LeDeR program in relation to deaths of those with a diagnosed learning disability in order that a specialist review of the death can occur.

NAViGO follows the Child Death Review for all cases where a young person is receiving care from NAViGO.

All Deaths Reported and Level of Investigation

Deaths may be reported through the following systems dependent upon their nature and some may fall under multiple processes.

- STEIS – Strategic Executive Information System – as a serious incident under the Serious Incident and overseen by the Clinical Commissioning Group (CCG)
- NRLS – National Reporting and Learning System (NHS Improvement) – as a reportable incident for any immediate learning
- CQC – Care Quality Commission
- LeDeR – Learning Disability Mortality Review – for all deaths where the deceased service user has a diagnosed learning disability
- Through safeguarding adults and children's processes
- The Coroner
- Health and Safety Executive for all workplace fatalities

Where it is identified that a service user has died through natural causes we will not normally complete a serious incident investigation unless the family/carer or staff raise concerns relating to the care that was provided.

Deaths Recorded, Reported, Reviewed and Investigated

	Q1			Q2		
	April 2017	**May 2017**	**June 2017**	**July 2017**	**Aug 2017**	**September 2017**
Level 1 death	0	1	0	0	0	0
Level 2 death	1	1	0	0	3	1

Level 3 death	0	0	0	0	0	0
Non SI death	3	3	1	5	7	5
Natural Causes	84	85	81	91	77	88
Delogged	1					
LeDeR deaths	0	0	0	0	0	0
Deaths investigated due to family concerns raised not subject to any of the above	0	0	0	0	0	0
Serious Incidents not yet categorised					1	
Safeguarding	0	0	0	1	0	0

Key

Level 1 deaths - Deaths relating to substance misuse or requiring low level investigation

Level 2 deaths - self-harm related deaths, inpatient deaths, detained patient deaths

Level 3 deaths - Homicide by a service user

Non serious incident deaths are where it is not clear from the information provided to us that the death was due to natural causes, for all these deaths the Quality team complete a case record review, they contact the GP and coroner for more information to determine if this is a death that requires investigation under the Serious Incident framework. The figures in these boxes are the cases that were not investigated due to not falling under the Serious Incident framework and were deemed as not being a result of problems with care delivery.

The de-logged case in April 2017 was reported by NAViGO under STEIS, however further information gathered confirmed that this case was not subject to investigation and the CCG confirmed that this case should be de-logged.

Currently NAViGO investigate all deaths under the comprehensive investigation framework, however, we are currently in discussion with our commissioners to introduce 2 levels of investigation in order to maximise the resource relating to investigations.

<u>Themes and Issues identified through review and investigation</u>

The main themes identified are:

- Communication - we feel that we have improved services due to the identified issues in relation to communication through these investigations.

- The volume of cases presenting to the crisis team – this has significantly increased and as such adult acute services are conducting a review of the current crisis model and looking at better ways to meet the needs of people presenting in crisis.

How we have used investigations and reviews to improve quality

The aim of completing serious incidents is to continually improve our services. The quality improvement that has resulted from the investigations in Q2 are as follows:

- Improved care planning following episodes of care
- Improved recording of mental health review tribunals and hearing in the electronic record
- Improved communication to the GP following their service user accessing crisis services
- Disseminating more information in public areas promoting mental health and advising where to go for services (this was a specific request from a relative)
- To review the current working model of the crisis service which is currently a 'walk-in' model
- Recommendations for the new electronic record system (to be in place in 2018) to improve safety and risk management for those presenting regularly to the crisis service
- We have initiated a new suicide risk assessment and management framework (CAMS), this is different to other risk assessments in that it not only assesses risk but reduces risk.

Incident Reporting

The following table gives a breakdown of the incidents that have occurred within NAViGO in Q2 as compared to previous quarters. There is a detailed review weekly by the quality and performance team to identify any trends or incidents for follow up.

	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
ACCIDENT	48	56	44	18	27	23
SELF HARM	24	19	35	25	48	38
VIOLENCE & AGGRESSION TO STAFF	31	41	25	17	28	31
MEDICATION	25	26	31	19	25	16
RESTRAINT	16	10	17	5	8	11
VIOLENCE & AGGRESSION - OTHER	18	26	24	11	19	21
DEATH	7	9	3	3	3	5
OTHER INCIDENT CATEGORIES	45	44	46	66	38	43
Total	**214**	**231**	**225**	**164**	**196**	**189**

Comparison of Q2 16/17 and Q2 17/18

NAViGO have made reductions in all incident categories other than self-harm which has significantly increased and restraint which has had an increase by one case.

In Q2, 2016-17 there were 19 Self Harm incidents reported, these were split between 9 different service users with 1 service user recording 10 separate incidents.

In Q2, 2017-18 there were 38 Self Harm incidents reported, these were split between 7 different service users with 1 service user recording 32 separate incidents. The incidents of self-harm were reviewed and it was not felt that there needed to be any service intervention due to this increase. If the 2 service users data was removed from both 16/17 and 17/18 figures for self-harm then there would have been a reduction of 9 to 6 incidents of self-harm.