Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 30th April 2014

Title:	**Monthly Incident and Complaint Report**
Item:	**008**

Executive Director lead and presenter	**Interim Director of Nursing**
Report author(s)	**Head of Patient Safety Systems**

History:	*Critical Incident Overview Group*

This report is for:	
Decision	
Discussion	
To Note	X

The following impacts have been identified and assessed in relation to this report:	
Equality	
Quality	
Privacy	

Executive Summary of key issues

There were 9 externally reportable incidents in March 2014. Each incident is subject to an incident report within 24 hours to identify any immediate actions required, and a Management Report within 72 hours to determine the level of further review at root cause analysis level.

There were 32 formal complaints received in March 2014, all of which are being subjected to an independently led investigation.

This report addresses these Strategic Priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1. Purpose of Report

The purpose of this report is to brief the Board on incident and complaints activity during March 2014.

2. Background

Board members are reminded about the classification of serious untoward incidents:

- Grade 0 – reported for information only and no investigation required by AWP, eg, death of a prisoner
- Grade 1 – root cause analysis investigation required within 45 days, eg, infection control incident, fire, etc.
- Grade 2 – root cause analysis investigation required within 60 days, eg, homicide, in-patient suicide, etc.

3. Incident Activity

2.1 Incident Numbers

The table below shows the number of externally reported (red) incidents:

Grade	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
0 (for information)	0	1	3	4	4	0	1	2	1	0	3	1
1 (45 day investigation)	13	5	9	10	12	5	6	5	4	9	4	7
2 (60 day investigation)	1	0	1	2	2	0	0	0	0	2	0	1
TOTAL	**14**	**6**	**13**	**16**	**18**	**5**	**7**	**7**	**5**	**11**	**7**	**9**

Trend data for externally reportable incidents is shown in the table below. There has been an increase

Grade	11/12	12/13	13/14 YTD
0	15	13	20
1	50	81	89
2	9	8	9
TOTAL	**74**	**102**	**118**

2.2 February Incidents

There was one grade 2 incident in March 2014, relating to an incident on Sycamore Ward. A patient made a serious suicide attempt using a ligature and died some days later. The initial management report has been scrutinised by the Critical Incident Overview Group and particular follow-up attention is being given to the resuscitation response.

There were seven grade 1 incidents:

- A patient known to Bristol North Recovery Team was found dead at home following a Welfare visit. The cause of death has yet to be determined.
- A patient known to South Gloucestershire Recovery Team was found dead at home and suicide is suspected.
- A patient on Sycamore Ward had essential physical health medication omitted in error on two occasions.
- A patient on Ward 4 fell as she stood up from a chair, sustaining a fracture.
- Another patient on Ward 4 was found on the floor with a cut to his head, and subsequently died in hospital.
- A patient known to North Somerset Recovery Team made a serious suicide attempt involving medication, requiring admission to hospital.
- A patient known to North Somerset Intensive Team died from suspected suicide.

There was one grade 0 reportable incident, relating to an allegation of serious misconduct against a staff member on Hazel Ward.

A RCA investigation has been commissioned in all relevant cases and the lessons learned will be uploaded to STEIS as well as disseminated internally. Local delivery units review grade one incidents at their local governance meetings, escalating any concerns via the Critical Incident Overview Group (CIOG). An action plan is developed to implement the recommendations from each of the cases. CIOG directly reviews all grade 2 investigations.

4. Complaints Activity

3.1 Complaint Numbers

The table below shows the number of formal complaints received by Local Delivery Unit, and shows significantly monthly variability:

LDU	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
BaNES	2	3	4	1	1	4	2	3	1	1	1	3
Bristol	7	4	7	6	5	4	8	5	9	7	4	8
N Som	1	4	2	2	6	2	4	1	3	2	7	3
S Glos	0	2	2	1	0	1	0	2	0	0	1	3
Swindon	0	1	2	2	0	4	2	2	1	2	5	7
Wiltshire	2	4	0	2	3	4	7	4	4	5	4	4
SSS	5	6	4	2	3	5	3	4	5	1	5	4
Other	2	0	0	1	0	1	0	0	0	1	0	0
Total	**19**	**24**	**21**	**17**	**18**	**25**	**26**	**21**	**23**	**19**	**27**	**32**

3.2 Complaint Issues

There were no red graded complaints this month. Examples of moderate graded complaints include:

- The complainant's mother was a patient on Ward 4 and felt that her mother's treatment lacked respect and dignity.
- A breach of third party confidentiality was reported.
- A mother called very upset by a 'catalogue of errors' since her son discharged himself from Juniper Ward.

Investigations for all complaints received in March have been commissioned by the LDU's. The recommendations arising from these complaints are added to the Patient Safety Development Plan and the actions taken and changes to practice made are scrutinised by the Critical Incident Overview Group.

5. Commissioner Review of Incidents

There are a significant number (@85) of AWP incidents that remain open on STEIS pending commissioner review and closure. The Trust has formally requested the support of the Lead Commissioner to address this backlog as well as continuing to work closely with individual clinical commissioning groups to achieve this.

6. Conclusion

This report provides a high level overview of activity in relation to incidents and complaints, alongside some end of year charts showing themes and trends. Detailed information is considered by the Critical Incident Overview Group and Quality and Standards Committee. In accordance with the Trust's governance framework, the Chair of the Quality and Standards Committee will feedback to the Trust Board information from the Committees' deliberations.