Serious Incidents and Mortality Improvement Action Plan

Version No 16.95

Date 31/05/2017

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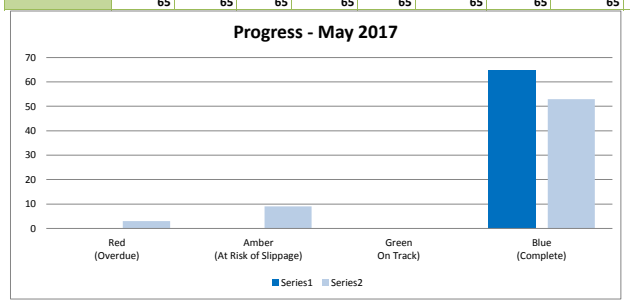
Completion 90%

RAG status	December		January		February		March		April		May		June	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	3	4	3	1	0	1	0	4	0	4	0	3		
Amber (At Risk of Slippage)	0	0	0	0	0	0	0	9	0	9	0	9		
Green On Track)	7	28	7	32	8	32	0	0	0	0	0	0		
Blue (Complete)	55	33	55	32	57	32	65	52	65	52	65	53		
TOTAL	65	65	65	65	65	65	65	65	65	65	65	65		



NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
27.04.17	B Cooper	v16.91	All	Set up change record and version number system
27.04.2017	B Cooper	v16.92	master pl	exception of spec services; 16.1 48 hour reporting onto StEIS target not met (36% in March); 18.7 Duty of
9.5.17	L. Connor	v16.93	All	5/5/17 Chased for updates, 9/5/17 . 11b physical health percentages added, 16 Childrens compliant,
25.5.17	Lconnor	V16.94	MP	Updated evidence on 9, 10, 11, 12, 16, 18.7, 18.9 for 26th May Evidence review panel
31.5.17	B Cooper	v16.95	All	18.7 changed from overdue to completed following evidence review panel

Theme	Mazars Recommendations	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Progress Update	Outcome Measure	Expected Outcome
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	31.07.16	**Complete**	Evidence required: Course content and learning outcomes (11.1a) Percentages of for the staff who have undertaken it by service (11.b) Attendance registers (11.1c)	Divisional and service level training records to that staff have been trained. (11.1b & 11.1c) Achieve of 90% compliance to clinical audit of physical health needs. (11.1a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (11.1a)	30.11.16	26.05.17 revised recovery date tbc	**Overdue**	11.1a Course content reviewed by the ADoNs from AMH and LEaD. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & c Training records being obtained by L Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options October 2016: 5 day physical health course reviewed. The duration of the course does not make it a feasible option for inpatient staff. AMH, Specialised Services & LD Plan - Agreed all qualified nurses and HCSW's working in inpatient services will need to demonstrate competency in the following; - Physical Observations, - Track and Trigger Tool and SBAR(d), - Blood Glucose Monitoring . LEaD practice educators will assess the competency of senior nurses. Nurses achieving level 4 competency will then cascade assessments. LEaD will be introducing 3 skill buttons for the competencies on the training accounts of all staff in the target group on 25/10/16. Staff will be required to e-verify via the LEaD system when they have achieved each competency. All verifications will require manager authorisation. Target is for 80% of staff to be deemed competent in Track and Trigger and SBAR(d) by end of December 2016. Training/education is available via face to face or electronic delivery to support staff to acquire the knowledge and skills in physical health assessment and monitoring. LH meeting Kathy Jackson, Head of Nursing Inpatients (OPMH) 25/10/16. KJ is aware of this action. LH will present plan (as per action 11 above) to the ward managers at the meeting and arrange roll out of assessments for senior nurses. 11/10/16 A summary recovery plan was submitted by Steve Coopey for all actions: - 11.1a Discussions held with divisional leads to agree actions and attendance at physical health steering group commenced. Carole Adcock completed the review of 5 day physical health course. Divisional leads to agree actions following review, share work drafted on education pathway for registered staff and to confirm use of core physical health training workbook which supports competency assessment in practice. - 11.1b To agree which staff require core + additional training and confirm % targets trained in physical observations for mental health inpatients by 31.12.16 - 11.1c Louise to provide on-going attendance data on request or in line with agreed targets 17.10.16 11.a The risk related to physical health training in the MH inpatient units has been added to the divisional risk register (for MH) following discussion at AMH MOM in October 2016. Risk no.1100 - AMH - management of physical health care of service users. Risk states that currently the 5 day course is not attended and is being replaced with other training options. 20.10.16 11.1a Specialised Services have devised a project called improving access to physical health for the forensic patient; course developed - trainee advanced nurse practitioner masters pathway. 03.11.16 Further update re OPMH physical health course (CUSP) rolled out. 05.01.17 Update on 11.1d - Physical health assessment and monitoring policy now updated and circulated to the Resuscitation Committee for comments due back by 06.01.17. Task and finish group to be formed once the policy is agreed. A physical health strategy for AMH has also been drafted to ensure staff recognise and respond to patients' physical health needs, and work with service users in the community and look to reduce the incidence of premature mortality. Further update to be received from physical health task and finish group which will convene on 06.01.17	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20feb17 data - T&T 87%, Phys obs 84%, Blood Gluc 81% March 2017 agreed that target training figure should be 90% trained. Results of the physical health audit of AMH sites (11.1a) 11.1a. physical health clinical audit report - MH (nov16). 11.1a nov16 audit results 93% - Helen Alger - full physical health review completed within 7 days of admission Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d) AMH Physical Health Strategy (11.1d) Nov16 draft already saved.	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. Reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	30.06.16	**Complete**	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (16.1a) Dashboard monitoring reporting to StEIS within 48 hrs (16.1a) 48 hour panel process (16.1b)	Timescale calculation - percentage of SI's reported on to StEIS within 48 hrs of reporting to be presented as a Key Performance Indicator on the dashboard. Please note that the timescale for measuring success is: (16.1a) 31.03.16 (16.1b) 30.06.16	31.03.16 30.06.16	30.06.17	**Overdue**	March 2017 : 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) Levels of compliance with the mortality panels being held within 48 hours is monitored through Tableau on a daily basis and this is actively discussed at the MF. The compliance to the requirement to report onto StEIS withi 48 hours is monitored on a monthly basis and whilst improvement has been seen in the pressure ulcers, compliance to other serious incidents has deteriorated. It is recommended that this action remains red until indicators have reached the required trajectory. Further discussed at QIP Delivery Group the need for divisions to telephone the central SI team at end of 48 hour panel so can put any SI onto STEIS within deadline. Need to continue to monitor. A recovery date for this action has been set for June 2017. 27.04.17 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 36% (Mar) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) 82% (Mar) 48 hour panel guidance for ISD been amended to highlight that panel needs to call central SI team if decided that incident is SI. Performance discussed at QIPDG on 25.04.17 with ISD flowcharts/guidance shared for MH division to use if helpful. 5.5.17 Chased for status - Kay and Divisional leads / Requested summary recovery plan - Liz Taylor 8/5/17. We have not breached this in children and Families and are within compliance for reporting - updated divisional leads AMH was Mary Kloer - now David Kingdon, ISD Was Peter Hockey now Rachel Anderson. 25/5/17 evidence review panel - target not met. A change in process has ocurred with SI team attending/linking into 48 hour divisional panels to get immediate update re decision making re whether incident is SI.	Evidence required: 95% compliance to reporting to StEIS within 48 hrs - dashboard (16.1a) Compliance to 48 hr panels being held within 48 hrs (16.1b)	Prompt notification of SI's will aid the prompt commencement of an investigation . This will lead to timely information being gathered regarding causes and an opportunity for earlier patient safety recognition by discussing the immediate patient safety actions which require attention.
Involvement of Families	18. The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready (18.1a, 18.2a, 18.5a) b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams (18.3a, 18.4a, 18.5a) c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation (18.1a, 18.3a, 18.3b)	31.10.16	**Complete**	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.9b)	An informatics report will provide a base of line of recorded next of kin details which can be improved through a targeted unit based communications and monitoring supported by the record keeping group.	31.10.16	30/09/2017	**Overdue**	04.08.16 New action to address the lack of next of kin details for some patient / service users. 06.09.16 Specialised Services - maintained on Rio- Next of Kin, on details where available (18.9a) 09.10.16 (18.9a and 18.9b due 31 October) showing 80% of patient records have a next of kin listed and SI investigations where next of kin details have been obtained through an alternative means Recommendation – Action to remain red until required trajectory is achieved. Currently discussions are progressing whether the Next of Kin field in Rio could be changed to a mandatory field. 05.01.17 100% (24/24) involvement of families/next of kin in serious incidents. 100% trajectory achieved since October 2016: - Oct 100% (15/15) - Nov 100% (10/10) - Dec 100% 24/24) Outcome status changed from overdue (red) to on track (green). Continue monitoring status of the action until 31 March 2017 and ensure that the process has been embedded. 15.03.17 record keeping guidance in place. Next of kin not always being recorded - new tableau report showing % with N of K recorded - 80% not met therefore changed to red. There is evidence that Nof K information is sought from other sources e.g. coroner (18.9b). 27.04.17 100% compliance with families or next of kin being involved in SI where possible: -Jan 100% 24/24 - Feb 100% 16/16 -Mar 100% 30/30 Tableau report as at 27.04.17 shows that 80% target of next of kin or other relationship being recorded not yet met. AMH 64.9% LD 87.6% ISD physical health 59.5% ISD OP therapy 38.5% OPMH Community 76.7% **5.5.17** Requested summary recovery plan from Divisional owners (Not LD)	Evidence required: Informatics report showing that 80% of patient records have a next of kin listed (18.9a) Serious incident investigation report where next of kin details have been obtained through an alternative means (18.9b)	Early contact with families will be in place due to the correct contact details being recorded.