NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
11 July 2018

Title	**Serious Incidents Annual Report 2017/18**
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Purpose of the Report:

To provide an analysis of serious incidents occurring in East London NHS Foundation Trust between April 2017 to April 2018. The report includes quantitative analysis of incidents reported, together with themes and learning drawn from those incidents.

Summary of Key Issues:

The report provides an update on the work being undertaken throughout 2017/18 to address the major themes emerging from serious incidents in the previous annual review.

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	Aim is to learn from incidents to improve patient safety and quality of care we provides.
Improved health of the communities we serve	☒	From learning, the aim is to reduce harm incidents occurring in the communities we serve and provide improved health outcomes.
Improved staff experience	☒	Aim is to learn from experience and improve the experience of staff in providing high quality care.
Improved value for money	☐	

Committees / Meetings where this item has been considered:

Date	Committee / Meeting
	N/A

Implications:

Equality Analysis	The report does not include equalities analysis.
Risk and Assurance	Monitoring and understanding the occurrence of serious incidents, and learning from them is a central governance and quality improvement function. The report provides assurance that this is being effectively carried out.
Service User / Carer / Staff	The focus of the process for managing serious incidents is learning and improvement, which will positively impact the service user, carer and staff experiences.
Financial	No financial implications.
Quality	The themes arising from serious incidents and the work being done to address these themes, set out in the report, have quality implications. Serious incidents are drivers for quality improvement work.

Supporting Documents and Research material

a. ELFTS Serious Incidents Policy
b. NHSE SI framework 2015

Glossary

Abbreviation	In full
NHSE SI framework 2015	NHS England Serious Incident Framework 2015 (National Guidance for Providers and Commissioners on the management of serious incident investigations)
SI	Serious Incident
StEIS	Strategic Executive Information System (The system for facilitating the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners.)

1.0 Background/Introduction

1.1 The Trust has a serious incident (SI) framework, which is outlined in the SI policy. The SI policy defines the term “incident” to refer to any event which gives rise to, or has the potential to, produce unexpected or unwanted effects involving the safety of service users, staff, visitors on Trust premises or employed by the Trust, or loss or damage to property, records or equipment, which are on Trust premises or belong to the Trust. The NHSE SI framework 2015 defines an SI as ‘something out of the ordinary or unexpected, with the potential to cause harm, and/or likely to attract public and media interest’. The term covers incidents/near misses, which generally meet the criteria, as severe or catastrophic under the standard rating scales agreed by the Trust.

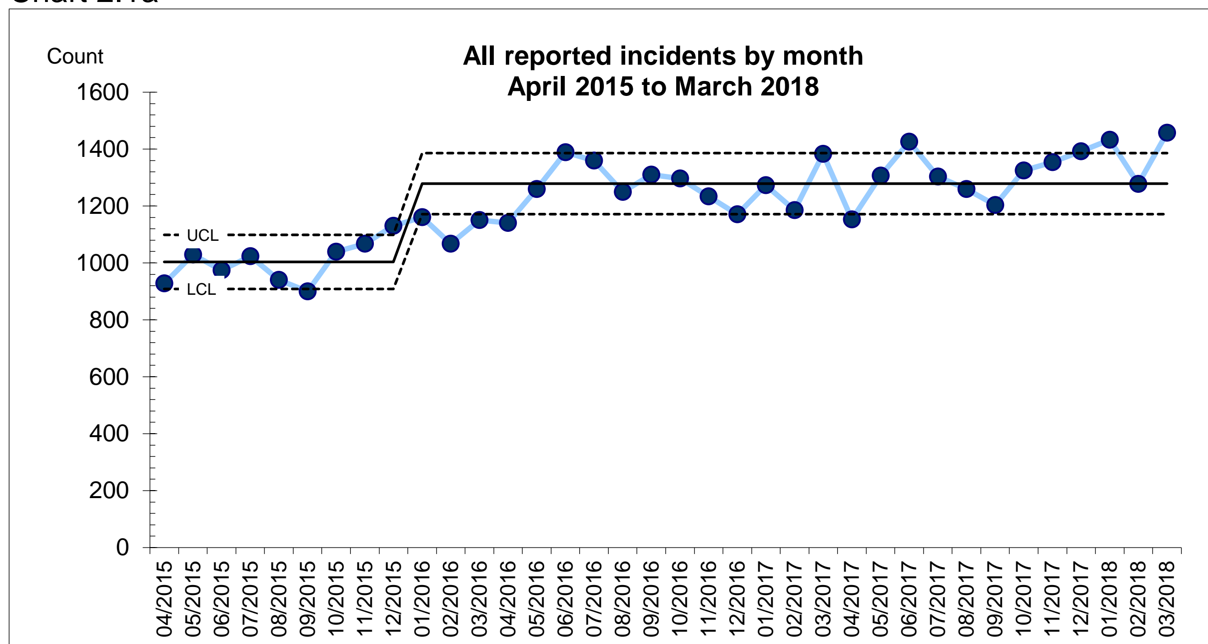
1.2 The objective of this paper is to provide an overview of serious incidents across the Trust, identifying areas for improvement and supporting action against these by outlining specific focus areas or areas of concern through data analysis. This paper has been developed through a process of analysis of Trust wide, directorate and where necessary team level data, including incident and serious incident data, clinical and service-user led audit data, external and internal patient experience data, external recommendations from regulators and coroners and performance data.

2.0 Incident Analysis

2.1 <u>Trust wide incident rates</u>

2.1.1 The number of incidents reported across the trust has remained within normal variation since the last annual report (Chart 2.1a)

Chart 2.1a

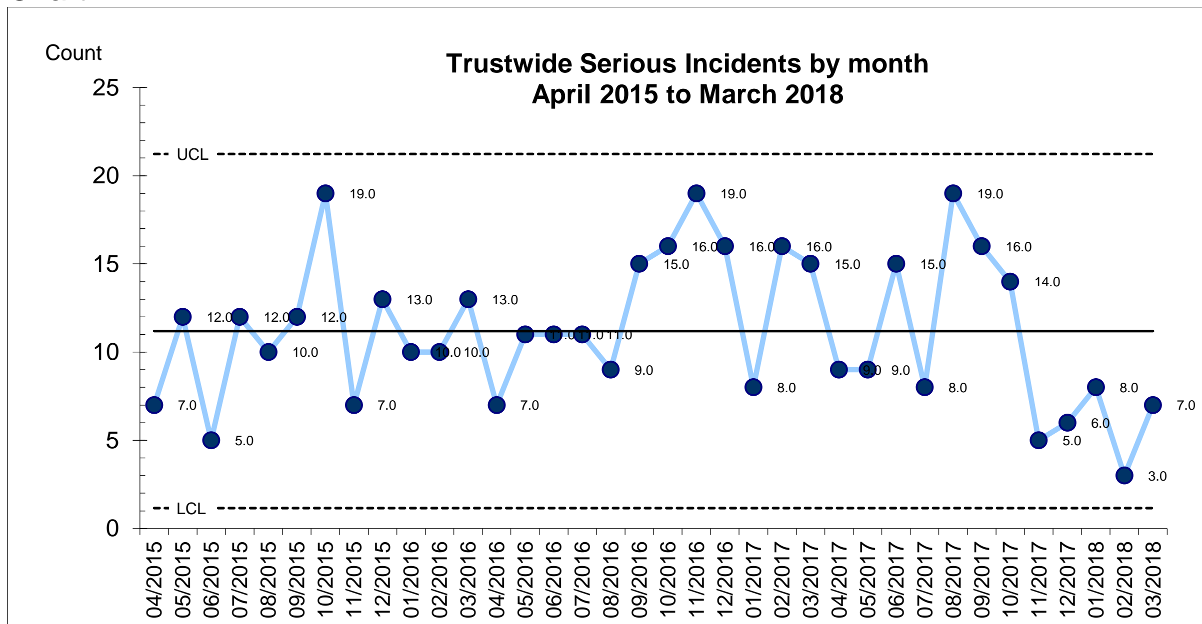


2.1.2 Work continues within the Trust to develop and encourage incident reporting. The spread of quality improvement processes throughout the Trust has supported increased awareness and development of incident reporting.

2.2 Trust wide number of Serious Incidents

2.2.1 The number of Trust-wide Serious Incidents (SIs) continues to remain within expected limits of variation (Chart 2.2).

Chart 2.2



2.2.2 Between April 2017 and March 2018, there have been a total of 119 incidents of which 104 were graded as 1B* and 15 graded as 1A* (133 were reported in total with 14 that were subsequently downgraded/withdrawn as on further investigation they were found not to meet the SI threshold/criteria). The previous year there was a total of 154 serious incidents of which 135 were graded as 1B* and 19 graded as 1A*.

2.3 Trust wide incidents by investigation grade

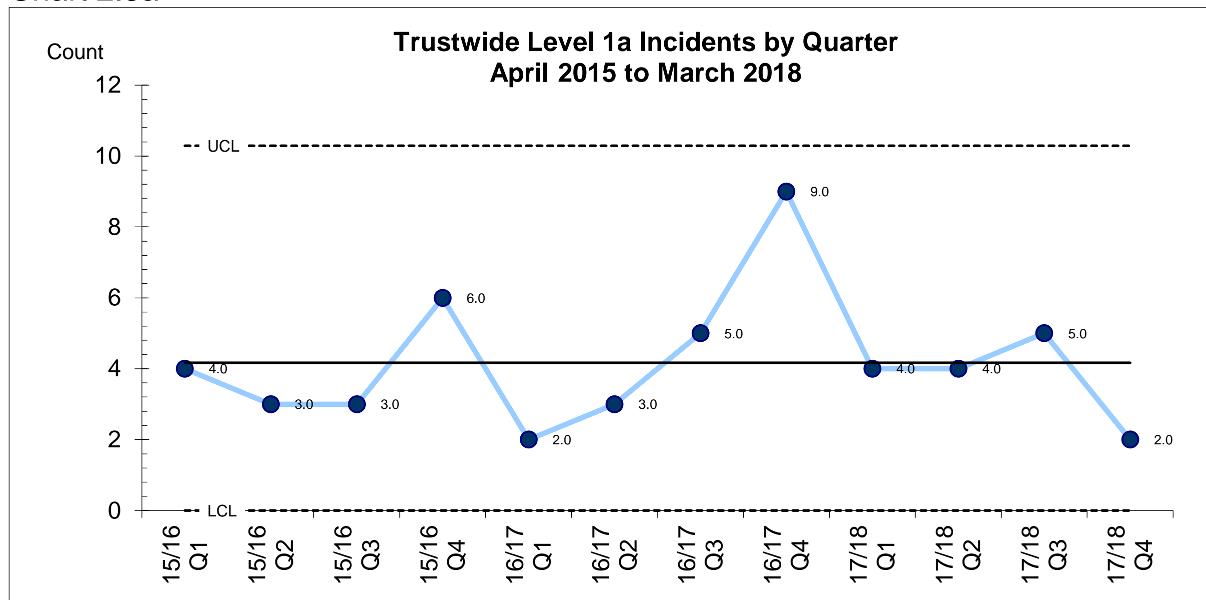
2.3.1 The NHSE SI framework 2015, describes three types of SI investigations; Concise Reviews- internal reviews not reported to the commissioners; Comprehensive Reviews- those declared as SIs and are uploaded to the Strategic Executive Information System StEIS); and External reviews, those commissioned outside of the provider services such as homicide reviews (typically commissioned by NHSE). Historically, ELFT has subdivided comprehensive reviews into two types, 1B* (the majority of SIs such as unexpected community deaths), and 1A* (typically pertaining to incidents including inpatient suicides or the unexpected death of patients detained under the mental health act). 1A* reviews are conducted slightly differently from 1B* investigations, with the notable difference being 1A* investigations were reviewed by a panel review team made up of clinical experts in the subject matter pertinent to the incident, led by a retired consultant psychiatrist who formally worked for ELFT. 1B* investigations consist of one lead review and a

co-reviewer. To the commissioners/outside agencies, both 1A*'s and 1B*'s are reported under the same 'Comprehensive Review' heading.

2.3.2 Following an internal review aimed at bringing ELFT closer in line with the NHSE SI Framework definitions, the terms 1A* and 1B* were discontinued from June 2017. So as to continue to identify the internal differences, 1B* reviews are referred to as 'comprehensive corporate reviews' and former 1A* reviews are now referred to as 'comprehensive panel-led reviews'. This will be the final report where incidents are referred to as 1A* or 1B*. Future reports pertaining to SIs will reference the new internal terminology as described above.

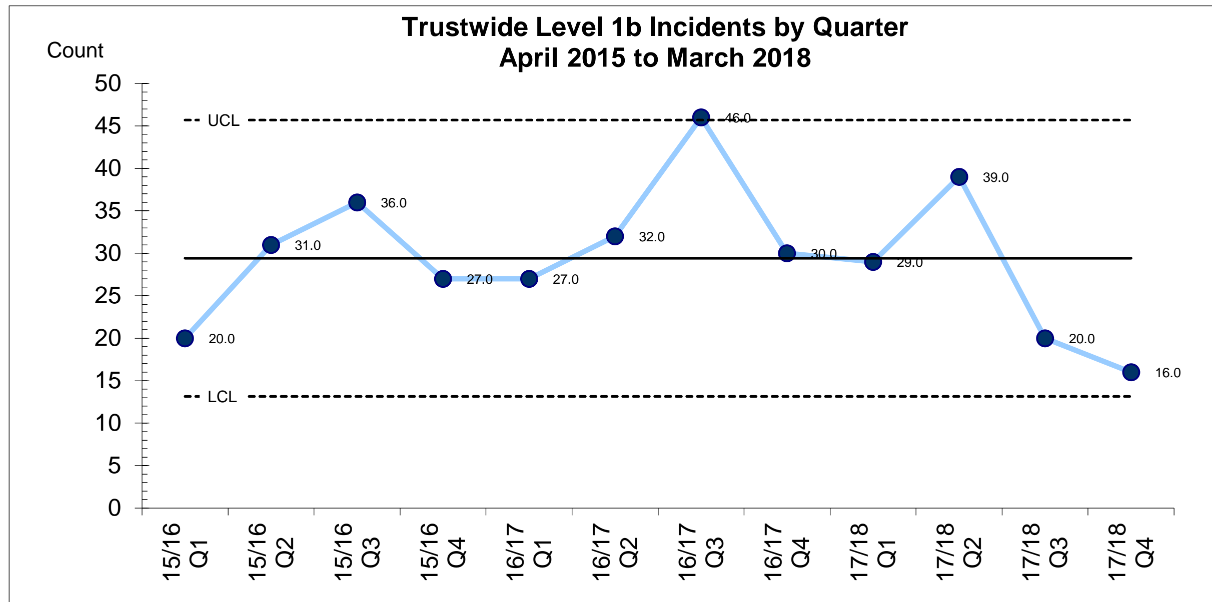
2.3.3 Chart 2.3a presented below indicates a continued trend of low numbers of 1A* incidents across the whole trust per quarter. On average 4.25 1A* SIs occur each quarter.

Chart 2.3a



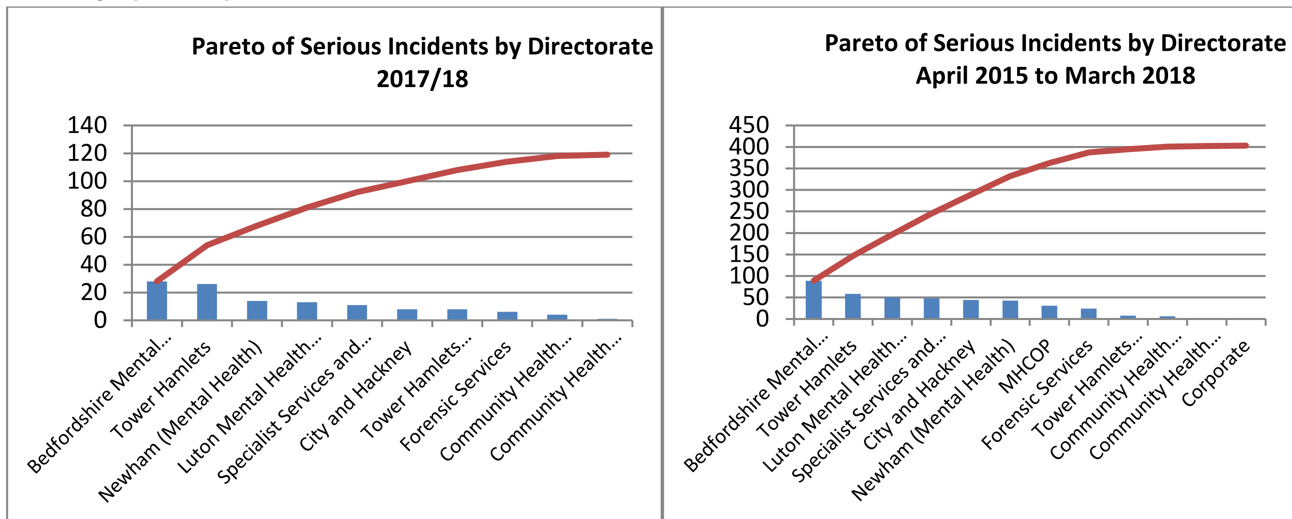
2.3.4 Chart 2.3b below presents data regarding number of level 1b SI's across the Trust. As can be seen, there are no indications of special cause variation over this period of time. On average 26 1B SIs occurred each quarter in 17/18. This compares to an average of 33 each quarter last year.

Chart 2.3b



2.4 Serious Incidents by Directorate

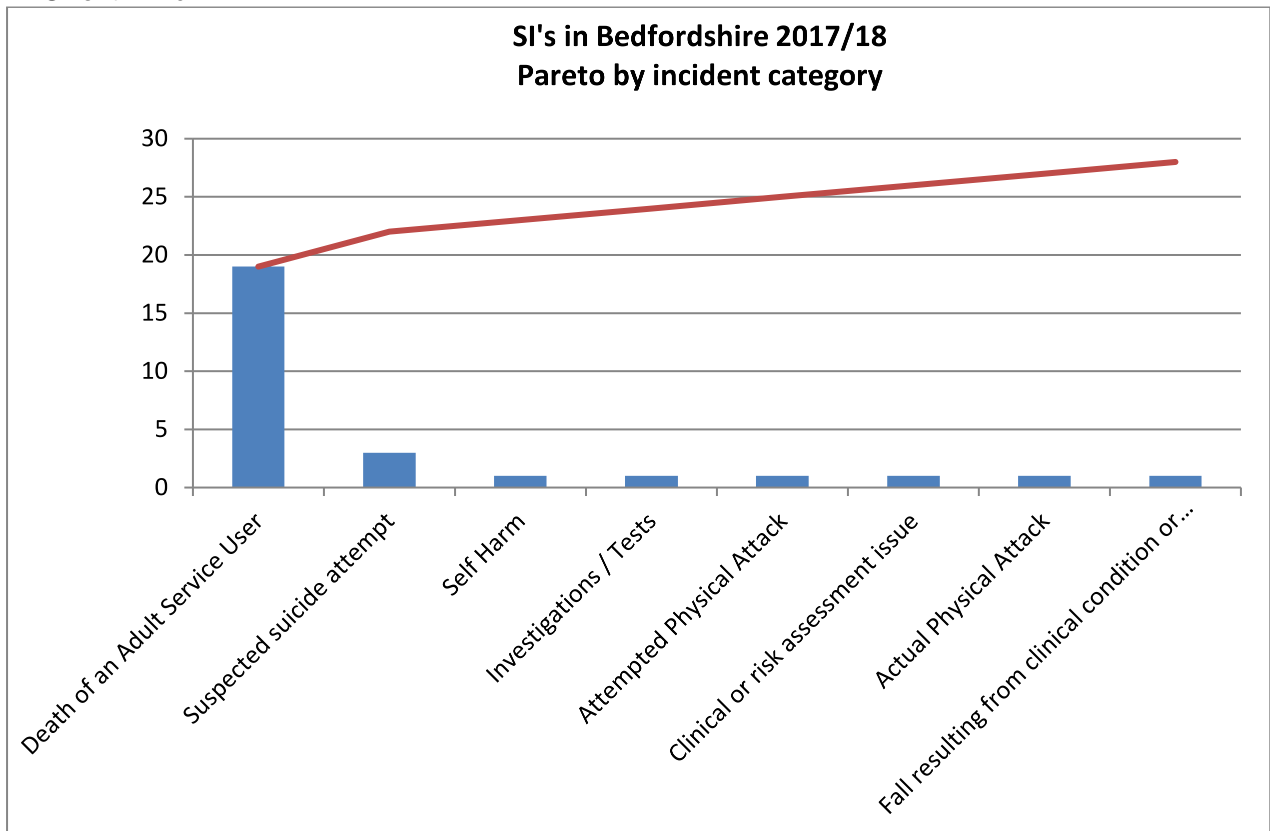
Chart 2.4a



2.4.1 This shows the largest number of incidents occurring within the Bedfordshire Mental Health Services during 2017-18. Work has been ongoing with Bedfordshire services to address safety issues and there is an overarching action plan in place to improve patient safety including the following.

2.4.2 Table 2.4c shows the SIs that occurred in Bedfordshire graded by type.

Chart 2.4c



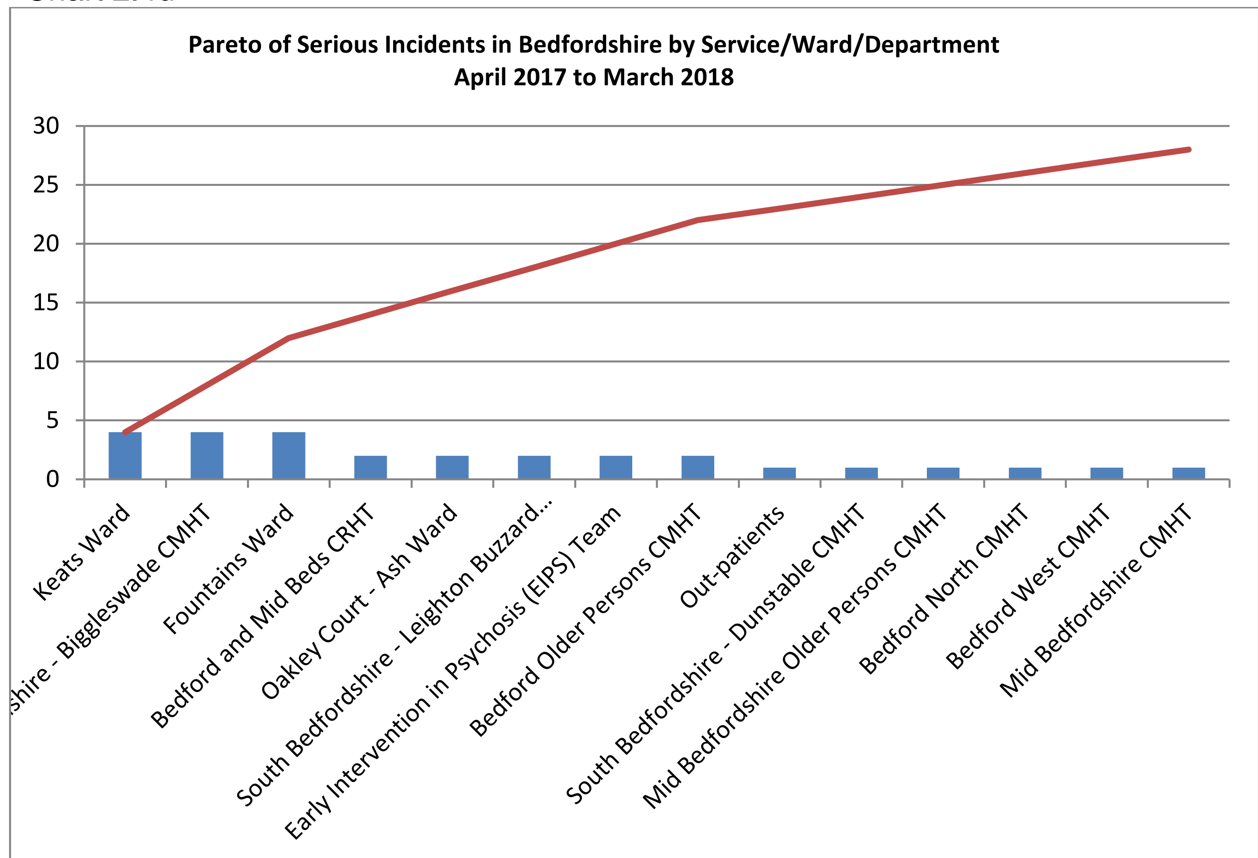
2.4.3 A thematic review of deaths in Bedfordshire was undertaken by the interim Medical Director for Bedford & Luton which highlighted comorbid substance misuse as relevant in majority of cases of patient deaths with the majority not open to substance misuse services. Bedford's Deputy Service Director is leading on work to improve collaborative working and partnership between our Community Mental health teams and our Addictions service (P2R) and there are now regular interface meetings with CMHT and P2R clinical leads. Our CMHT team managers regularly meet with Crisis Home Treatment team leads to improve interface working.

2.4.4 There is ongoing development of our Community Mental Health teams in Bedfordshire with changes to team structure and development of staff by way of enhanced training and skills. There is a rolling programme of training on suicide risk assessment and risk mitigation using the Safety Tool as an enhanced method of co-producing safety plans.

2.4.5 There is work on improving care pathways across acute and community services for patients with emotionally unstable personality disorder. Increase in provision of primary care liaison nurses to actively treat early on in patient's illness and reduce pressure on the community mental health teams so they can work in more recovery orientated manner. Quality improvement training and development of staff to work on improving access to treatment.

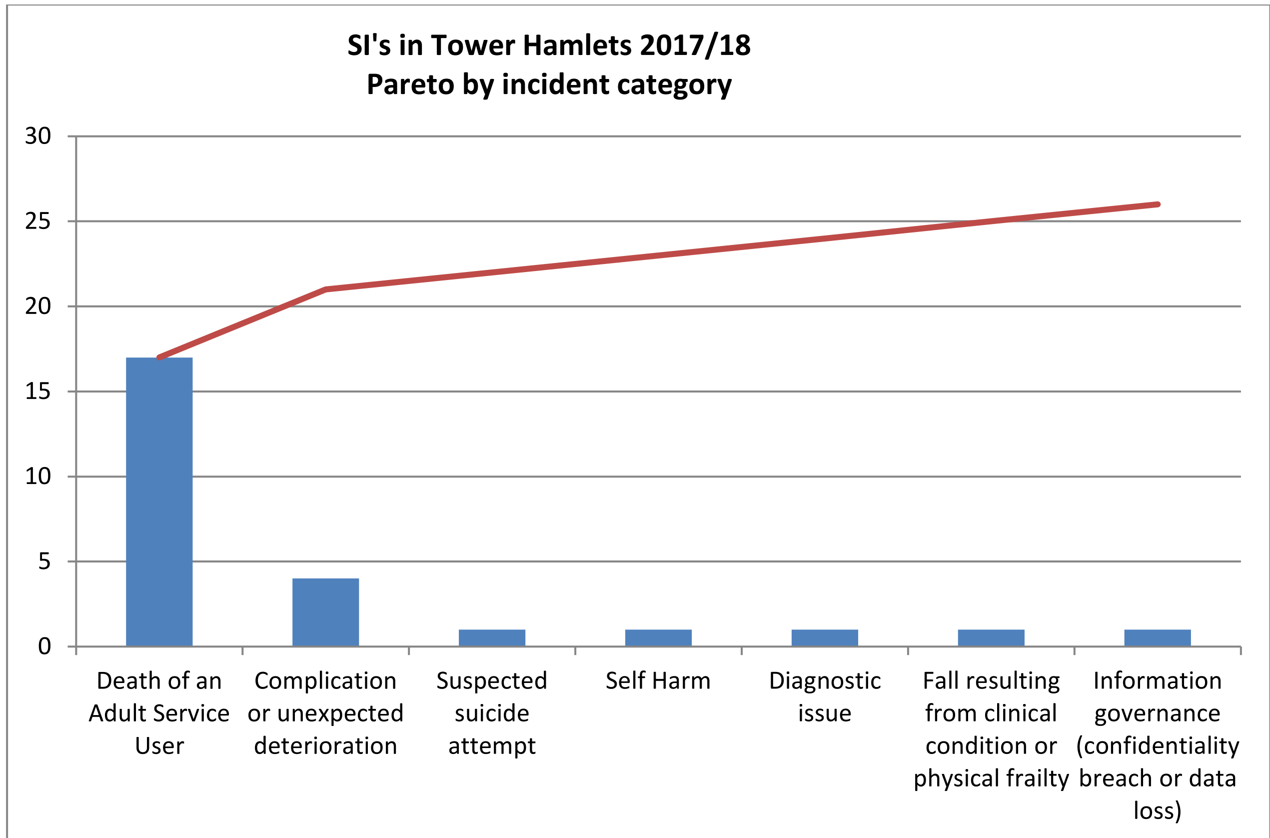
2.4.6 The following chart (2.4d) provides a breakdown of SI's by service area in Bedford.

Chart 2.4d



2.4.7 An increase of SIs is also noted in Tower Hamlets over the last reporting period. Table 2.4e shows the SIs that occurred in Tower Hamlets graded by type.

Chart 2.4e

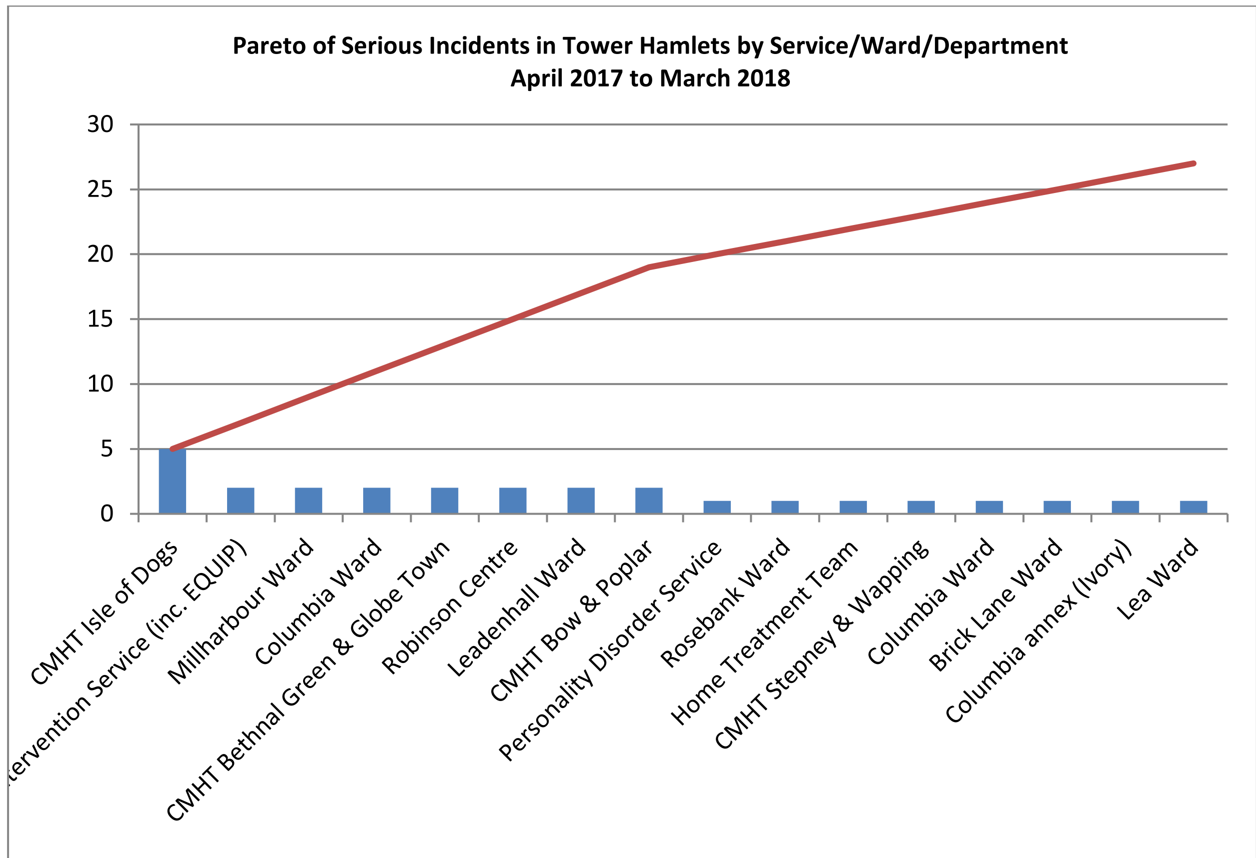


2.4.8 To encourage and facilitate learning throughout the directorate, Tower Hamlets (TH) has continued to have learning lessons incidents on an approximately quarterly basis over this period. These have been 2 hour sessions including a space for discussion of a clinical topic, DMT report on complaints and incidents and discussion of a SIR led by a reviewer. The feedback has helped modulate the content and format of the sessions trust wide, including in TH.

2.4.9 The Clinical Director of Tower Hamlets has carried out further work on the deaths in the area and looked at common theses and lesson learnt.

2.4.10 The following chart 2.4f provides a breakdown of SIs by service area in Tower Hamlets.

Chart 2.4f



2.5 Serious Incident by Type

Chart 2.5a

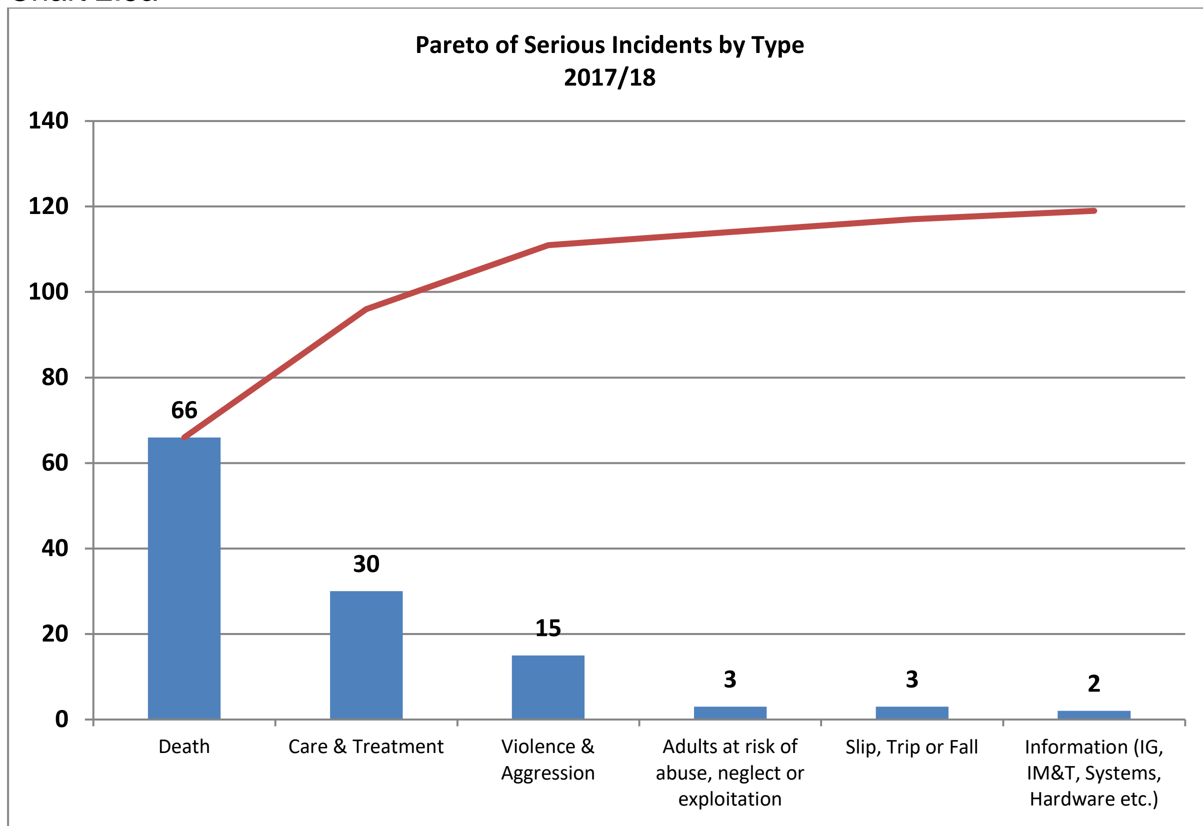
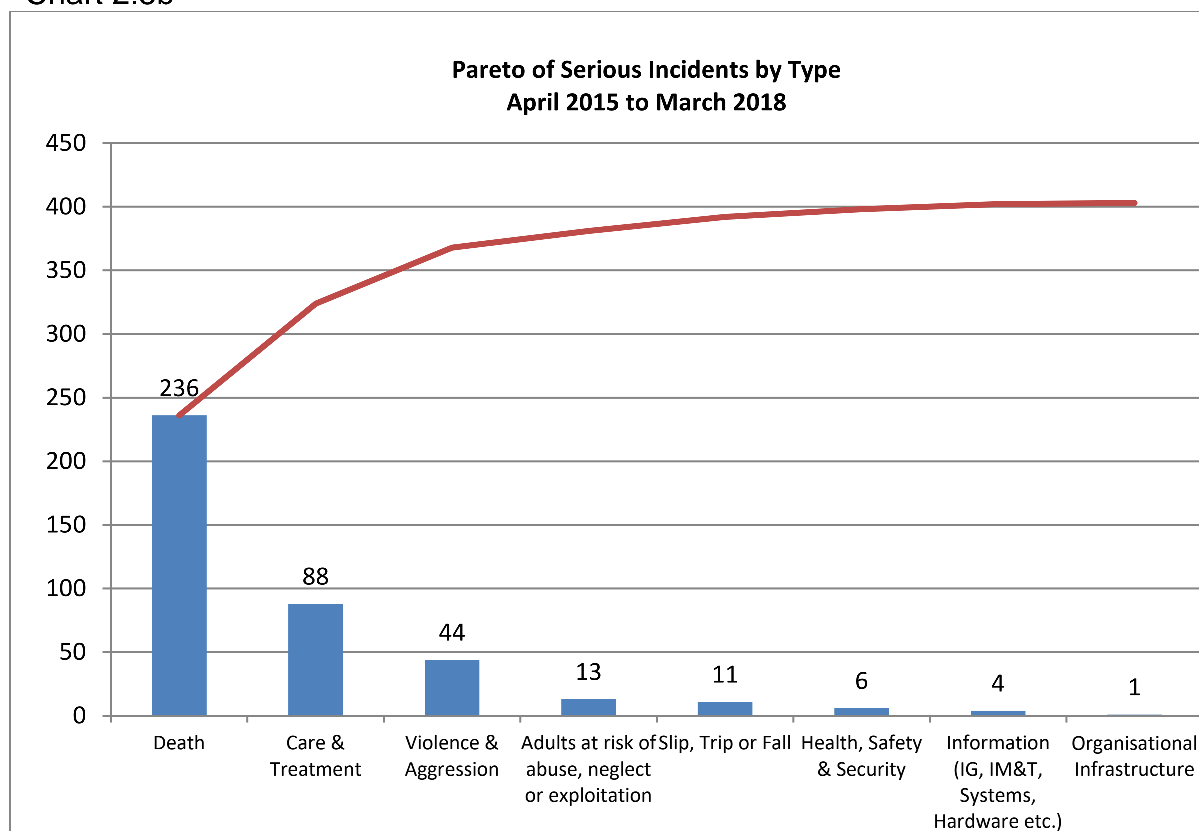


Chart 2.5b



2.6 Chart 2.5a indicates that the most common types of serious incidents that have occurred across the Trust from 2017/18 are Death, making up 55% (66 SIs categorised as death). This has decreased from 64% in the accumulated 2015/2017 figures (chart 2.5b) where an average of 85 SIs were categorised as death.

2.7 Themes from the SI reviews

2.7.1 We completed a thematic review of the care and service delivery problems identified in the SIs that were carried out. There were five main themes as given in table below.

Record keeping	Lack of clarity/accuracy Not undertaken in a timely manner Missing information Entries not 'approved'
Communication	Between colleagues/handover Between teams With other agencies or organisations
Risk Assessment	Unclear or inaccurate Not kept up to date Risk information not acted on appropriately

	Not recording significant events
Referral process	Delay in initiating referral process Lack of clarity in process Delay in assessment
Discharge planning	Delay in communication of discharge information Poor contingency planning Quality of discharge summary

2.7.2 Actions plans to address these locally have been carried out. The themes are consistent with themes that have occurred in previous years in the Trust and a programme of Trust wide learning lessons seminars in planned over the next year.

2.8 Coroner's recommendations

2.8.1 Over the last year there have been a total of three Prevention of Future Deaths Notice issued by the Coroner. They had the following themes and responses:

Coroner PFDN	Trust Response
Lack of communication with the Leaving Care team.	Team had lack of knowledge of the role and function of the Leaving Care Team. Details and information regarding the Leaving Care Team has now been included in the Trust Safeguarding Children training.
Concerns regarding the monitoring of work by care coordinators within CMHTs.	The issue was the follow up of a patient discharged from hospital into the community. Systems now in place for monitoring the discharge plans of patients and clear definition of the roles and responsibilities of the care coordinator in this process.
Concerns regarding the monitoring of work by care coordinators within CMHTs.	The issue related to lack of clinical discussion with others by care coordinator. Poor supervision was in place within the team. This was addressed to ensure supervision takes place. Clear guidance given that within supervision there should be clinical discussion of cases.

2.8.2 The re occurring theme her is communication and ensuring this occurs between teams and within teams,

3.0 Recommendations

3.1 Over the next year, Trust-wide Learning Lessons seminars will be held with the themes of Communication, Record Keeping and Discharge Planning. This will allow sharing and dissemination of good practice within the Trust as well as looking at other organisations out with the Trust.

3.2 More in depth work has already been carried out in both Bedfordshire and Tower Hamlets to look at unexpected deaths. Lessons learnt from this work will be disseminated within the Directorate.

4.0 Action being requested

4.1 The Board is asked to RECEIVE and NOTE the report for information.