East London NHS Foundation Trust

## 1.0 Background/Introduction

1.1 East London NHS Foundation Trust (ELFT) has contractual and statutory obligations to report on and appropriately manage all incidents reported to the Trust. This report provides Trust wide data on incidents for the defined reporting period i.e. 01.04.2020 to 31.03.2021 as well as over previous reporting time lines.

1.2 The Trust is committed to improving the services and care that we provide; learning from incidents and listening to feedback we receive from patients, their families and carers during serious incident reviews, helps us to identify the areas where patient safety can be improved and ensure that actions are taken to prevent the same things happening again.

All incidents are overseen and supported by a dedicated, corporate team to ensure that processes and investigations are impartial, open, candid and facilitate learning. The Trust works closely with its commissioners to ensure adherence to the NHSE Serious Incident Reporting Framework 2015.

The Trust's Chief Medical Officer oversees incident management and the approval of all reviews.

1.3 This report covers the period from 1 April 2020 to 31 March 2021.

## 2.0 Learning from incidents

2.1 Incident themes

**The main categories of incidents reported* in this reporting period were:**

- Care & Treatment (Pressure Ulcers/ Moisture associated skin damage at 4930, followed by Treatment/Procedure at 2936 and Self-Harm Incidents at 1134)
- Violence & Aggression (Service Users on Staff at 4238 incidents, SU on Service User at 1597 and Service User Damage to Trust Property at 702)
- Death (See Learning From Deaths 2020/21 Annual Report )
- Health, Safety & Security
- Adults at risk of abuse, neglect or exploitation
- Slip, Trip or Fall
- Information (IG, IM&T, Systems, Hardware etc.)
- Organizational Infrastructure
- Children at Risk

*In descending order.

(Information captured in brackets indicate incident category breakdowns for the top 3 categories)

2.2 Serious incidents by type

**SIs by type**

- Death
- Care & Treatment
- Violence & Aggression
- Adults at risk of abuse, neglect or exploitation
- Organizational Infrastructure

2.3 Serious incident review learning themes

**Top Ten SI Review Learning Themes**

- Admin/process tasks
- Issues with training, induction & supervision
- Issues relating to clinical care/failure to follow up
- Poor record keeping/ IT connection
- Poor transition between services
- Lack of engagement/involvement of carers / families
- Safeguarding
- Lack of engagement/communication with patients
- Discharge issues/ joint up working with external agencies
- Delays obtaining treatment

2.4 Sample of Trust wide learning from Serious Incidents

**1) Incident Summary:** During routine observations, patient was found unresponsive. Emergency protocols were instigated and CPR started, but the patient was declared deceased by paramedics attending the ward.

**Actions:** The Borough Lead Nurse will work with the ELFT Physical Health Lead regarding training delivery on the NEWS (NEWS2) score training for nursing staff.

Ensure there is standard approved equipment in place across the unit to enable good quality consistent physical health monitoring and to monitor its use. To introduce a uniform style of grab bag across the Unit to facilitate staff training around equipment and procedure.

Monitor use of the Broomwell monitor.

**2) Incident Summary:** Patient under the care of Perinatal Mental Health Team suffered a miscarriage, following which she was hospitalized for a mixed medication overdose. Patient suffered multi-organ failure secondary to the overdose, and cardiac arrest, resulting in a below knee amputation.

**Actions:** To feedback learning from the review to perinatal services Trust wide and with partner organisations, including NELFT with a particular emphasis on effective person-centred care to perinatal patients, to address how the Antenatal services can improve their communication regarding shared patients.

For the Trust wide Lead for Perinatal Mental Health to arrange a learning lessons seminar to share learning from the review across perinatal services.

As part of sharing learning, for the Trust wide Lead for Perinatal Mental Health to use the Strategic Transformation Partnership (STP) platform to raise issues of improved communication and ensure appropriate links are in place when planning the perinatal mental health pathway across East London.

**3) Incident Summary**: In-patient detained under Section.3 of the Mental Health Act (MHA) admitted from A & E following a relapse of treatment resistant schizophrenia with negative symptoms due to discontinuation of Clozapine. Patient treated for dehydration and transferred to the Homerton Ambulatory Medical Unit for IV rehydration, following which patient was transferred back (to a different ward) on the same day, with signs of improvement. The day before patient's death, vital observations, including heart rate and oxygen saturation, were deranged. In the hour period leading up to patient's death, they were

noted to have gone into progressive respiratory distress.

**Actions:** Review Clozapine Policy and disseminate to staff Trust wide.

Trust-wide learning lesson event to be held to demonstrate the need to continually strive to improve

services and acknowledge the needs of our most needy and vulnerable patients.

As part of the ELFT Trust-wide resuscitation equipment audit, the Resuscitation Lead has been looking at what types of AEDs ELFT have in use and where they are.

## 3.0 Service developments

3.1 Team and process developments

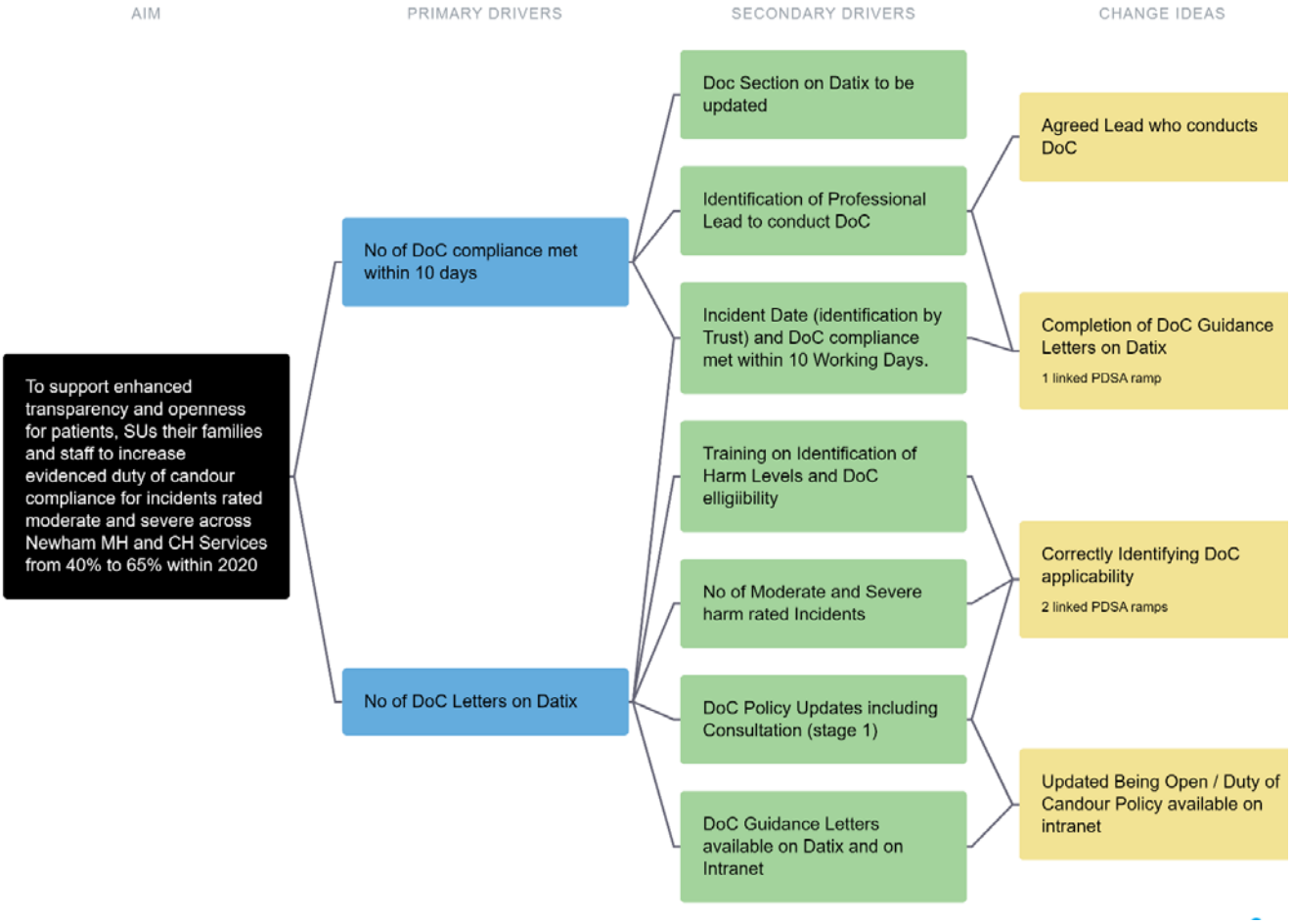
Throughout the year we have strived to continue providing robust reviews despite restrictions in investigative and feedback methods, as a direct result of pandemic management arrangements, and have continued to strengthen processes in place to coordinate learning from incidents including:

- Staff support programmes have continued throughout the year including; psychological clinical supervision, group supervision and peer support.
- Since January 2021 the Incidents and Complaints Manager has been seconded to provide clinical oversight during the Covid 19 vaccination programme. Two joint managers from within the team were appointed on an interim basis.
- In the event of an unexpected inpatient death, The Associate Director of Risk and Governance meets with ward staff, to gain a better understanding of the impact on staff and provide reassurance and support around the serious incident review process.
- Undertaking Specialist reviews from trends identified through incident reporting.
- 'Directorate Champions' have been introduced whereby reviewers and incident managers share a specialist knowledge of trends and wider issues within a team / service.
- Bi-monthly reviewer learning sets have been introduced to share case studies and understand how effectively past actions have worked.
- To contribute to the Trust's patient safety serious incidents knowledge, a Bank reviewer with particular expertise from organisations including the Healthcare Safety Investigation Branch (HSIB) has been appointed.
- A Trust wide Learning Lessons event was held in addition to Learning Lessons events held across London several Mental Health directorates.
- Staff attended inquests and family meetings online. Some feedback meetings continued in person, recognising that some service users and/or their families do not have access to online facilities.

3.1 Family engagement liaison, namely in cases of unexpected deaths, has been well received. Where possible, the family/next of kin contact is identified and an introductory letter is sent explaining that an SI Review will take place. This has ensured timely notification of the SI Review process and ensured involvement of patients, families and carers in the reviews.

31. The Datix action module has been in use since June 2020 and will be fully utilized to analyse trends and further scrutinize the efficacy of actions.

3.3 Duty of Candour Quality Improvement Project




The Trust has successfully implemented a Quality Improvement Project on Duty of Candour with the aim of supporting enhanced transparency and openness for patients, service users and their families by staff increasing 'evidenced' duty of candour compliance.

The rationale for the Duty of Candour Quality Improvement Project is to ensure that the Trust meets the regulatory requirements, for both stage 1 and 2 of duty of candour compliance. Although, the QI project is being tested in Newham Mental Health and Community Services the change ideas are being delivered Trust wide.

This QI Project's Change Ideas include;

Identification of Agreed Leads for DoC across Trust Services –

Update: DoC Champions have been identified across all Mental Health, Community Health Services and Corporate Directorates. *Local service DoC Champions are currently being trained.*

Completion of DoC Guidance Letters on Datix –
Update*:* This is now 100% complete*.*

Training to Correctly Identify DoC Applicability - *Duty of Candour Training Webinars, inclusive of 'good' and 'poor' examples of how to conduct Duty of Candour conversations to meet the stage 1 requirements of Duty of Candour has been developed. The Webinar also includes resources for Trust staff to use to ensure correct compliance with the regulatory requirements.*

Update*:* Training Webinars have been delivered Trust wide across Mental Health and Community Health Services. A total of 113 staff members attended Duty of Candour Train the Trainer sessions to enable them to facilitate and deliver DoC training to their teams. At the time of reporting, 95 staff within the directorates, have received Delivering DoC training.

Updated Being Open / DoC Policy

Update: The Policy has been updated and is available on the intranet.

3.4 Covid-19 response

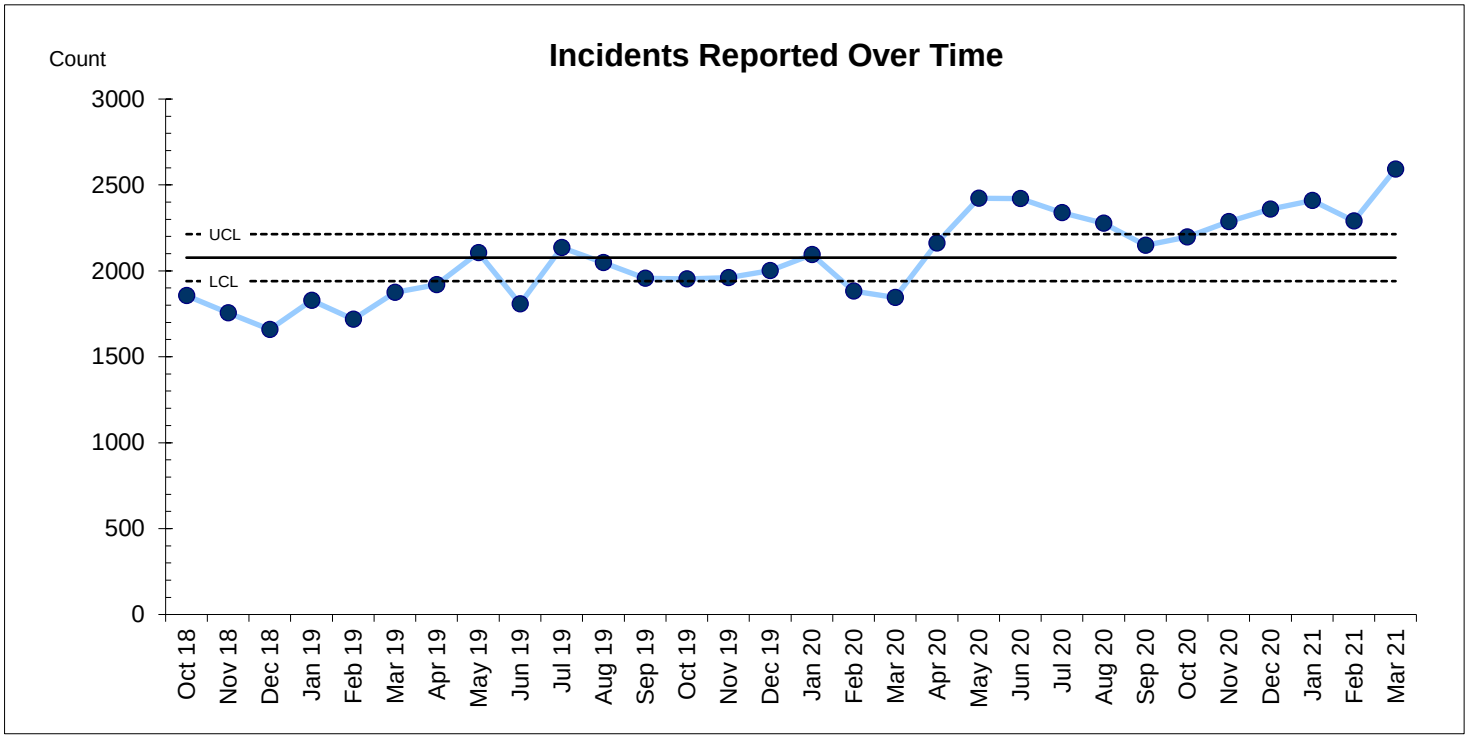
In response to the challenges of Covid-19 in both waves, and the pressures on clinical staff to deliver safe care, the Trust temporarily revised the investigation thresholds for incident management and SI review processes, with the agreement of Trust Commissioners, to enable staff to focus on the provision of front line patient care. The revised thresholds and investigation parameters included a focus on conducting reviews into all cases of unexpected deaths through table top reviews. The aim of this approach was to ensure a balance between maintaining higher level Patient Safety Review thresholds for investigations and supporting safe operational delivery.

Notably, throughout the pandemic, the Trust continued to triage all issues of patient safety, practitioner performance and safeguarding matters, on a daily basis with clear lines of escalation through to Trust Patient Safety Executives (Chief Medical Officer and Chief Nurse) to ensure that the most serious of incidents were appropriately managed and safe patient care maintained.

## 4.0 Incidents Data

4.1 Incidents reported monthly over time

**Chart 2**




**27,906**

New incidents were reported across the Trust between April 2020 and March 2021. In the 6 months between April and August 2020 there was a 368 increase in total incidents reported whilst the 6 month period between August 2020 and March 2021 there was a 380 increase in total incidents reporting. Showing a fairly standard increase across both 6 monthly reporting periods. Overall the level of incidents being reported is on the rise due to comprehensive Datix training delivered by the Risk and Datix team.

**Table 2-** Total incidents reported by Trust Directorate (historical data included)

| Directorate | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire MHS | 154 | 203 | 146 | 147 | 188 | 168 | 133 | 151 | 191 | 158 | 156 | 178 | 166 | 140 | 169 | 163 | 142 | 223 |
| City & Hackney MHS | 171 | 191 | 265 | 227 | 172 | 195 | 240 | 232 | 227 | 283 | 277 | 233 | 219 | 202 | 224 | 231 | 232 | 269 |
| CHS Combined | 723 | 715 | 688 | 790 | 687 | 703 | 1020 | 1051 | 1153 | 910 | 871 | 855 | 867 | 903 | 867 | 1000 | 889 | 941 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 4 | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 4 | 0 | 12 | 7 | 7 | 3 | 3 | 3 | 7 | 3 |
| Forensic Services | 235 | 231 | 251 | 271 | 233 | 232 | 243 | 338 | 223 | 297 | 269 | 223 | 265 | 232 | 265 | 254 | 227 | 311 |
| Luton MHS | 162 | 135 | 176 | 180 | 171 | 125 | 179 | 159 | 142 | 202 | 168 | 163 | 182 | 181 | 173 | 166 | 183 | 187 |
| Newham MHS | 166 | 182 | 157 | 137 | 135 | 142 | 130 | 128 | 152 | 180 | 148 | 162 | 155 | 189 | 229 | 206 | 184 | 182 |
| Specialist & CHN Children's Services | 143 | 96 | 134 | 129 | 86 | 99 | 102 | 211 | 154 | 134 | 211 | 125 | 178 | 227 | 238 | 199 | 212 | 218 |
| Tower Hamlets MHS | 195 | 206 | 182 | 211 | 208 | 179 | 111 | 151 | 171 | 167 | 160 | 179 | 153 | 195 | 186 | 177 | 208 | 229 |
| Primary Care | - | - | - | - | - | - | - | - | 4 | 7 | 6 | 22 | 5 | 15 | 6 | 10 | 7 | 29 |
| **Total** | **1953** | **1961** | **2002** | **2094** | **1883** | **1845** | **2161** | **2423** | **2421** | **2338** | **2278** | **2148** | **2197** | **2287** | **2360** | **2409** | **2291** | **2593** |

**Table 3-** Incidents to population ratio (incidents:100,000)

| **Period** | **Oct 19** | **Nov 19** | **Dec 19** | **Jan 20** | **Feb 20** | **Mar 20** | **Apr 20** | **May 20** | **June 20** | **July 20** | **Aug 20** | **Sep 20** | **Oct 20** | **Nov 20** | **Dec 20** | **Jan 21** | **Feb 21** | **Mar 21** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Population (approx.)** | 1,659,900 | | | | | | | | | | | | | | | | | |
| **Total Incidents** | 1953 | 1961 | 2002 | 2094 | 1883 | 1845 | 2161 | 2423 | 2421 | 2338 | 2278 | 2148 | 2197 | 2287 | 2360 | 2409 | 2291 | 2593 |
| **Ratio:100,000** | 118 | 118 | 120 | 126 | 113 | 111 | 130 | 146 | 146 | 141 | 137 | 129 | 132 | 138 | 142 | 145 | 138 | 156 |

4.2 Incident approval process and timescales

All incident reports require approval by the manager of the service submitting the form. This approval should take place within 48 hours of the incident being reported on Datix to ensure the quality, accuracy and completeness of incident reports. The incident approval process is an important part of the learning lessons process to allow managers to take action on any issues and identify areas of risk or weaknesses during the approval process.

Of the 27,906 incidents reported on Datix in this reporting period, (73%) were approved by the manager within 48 hours.

**Table 4-** Overdue incident approvals

| Directorate | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire MHS | 39 | 84 | 32 | 21 | 17 | 38 | 54 | N/A | 46 | 38 | 46 | 55 | 52 | 68 | 42 | 38 | 27 | 38 |
| City & Hackney MHS | 50 | 64 | 67 | 29 | 19 | 63 | 64 | N/A | 55 | 68 | 54 | 92 | 82 | 92 | 118 | 120 | 189 | 201 |
| CHS Combined | 122 | 161 | 87 | 83 | 78 | 139 | 139 | N/A | 399 | 285 | 212 | 223 | 120 | 111 | 129 | 114 | 168 | 172 |
| Corporate | 8 | 4 | 1 | 0 | 0 | 0 | 3 | N/A | 6 | 4 | 5 | 15 | 20 | 8 | 8 | 10 | 13 | 10 |
| Forensic Services | 38 | 24 | 40 | 20 | 14 | 94 | 95 | N/A | 39 | 30 | 30 | 33 | 37 | 65 | 38 | 29 | 32 | 33 |
| Luton MHS | 28 | 43 | 41 | 17 | 13 | 19 | 19 | N/A | 14 | 27 | 46 | 41 | 29 | 41 | 31 | 51 | 13 | 25 |
| Newham MHS | 35 | 61 | 25 | 26 | 14 | 65 | 65 | N/A | 36 | 27 | 34 | 60 | 28 | 36 | 61 | 43 | 28 | 30 |
| Primary Care Services | - | - | - | - | - | - | - | N/A | 1 | 2 | 3 | 2 | 21 | 6 | 5 | 13 | 1 | 10 |
| Specialist & CHN Children's Services | 32 | 28 | 36 | 35 | 15 | 24 | 24 | N/A | 30 | 40 | 54 | 43 | 43 | 120 | 226 | 162 | 148 | 137 |
| Tower Hamlets MHS | 60 | 50 | 52 | 44 | 36 | 95 | 95 | N/A | 59 | 59 | 42 | 97 | 49 | 37 | 38 | 33 | 84 | 108 |
| **Total** | **412** | **519** | **381** | **275** | **206** | **537** | **558** | N/A | **685** | **580** | **526** | **661** | **480** | **584** | **696** | **613** | **703** | **764** |

4.3 48hr reports

When an incident potentially meets the serious incident threshold or further information is required to ascertain the extent and harm caused by an

incident, the Chief Medical Officer, Chief Nurse or nominated deputies will request a 48 hour report. The fundamental purpose of the 48hr report is to obtain further information about the nature of an incident, the seriousness of the consequences, the remedial action taken, the learning that has taken place and identify any need for further investigation.

**Table 5-** 48hr reports status

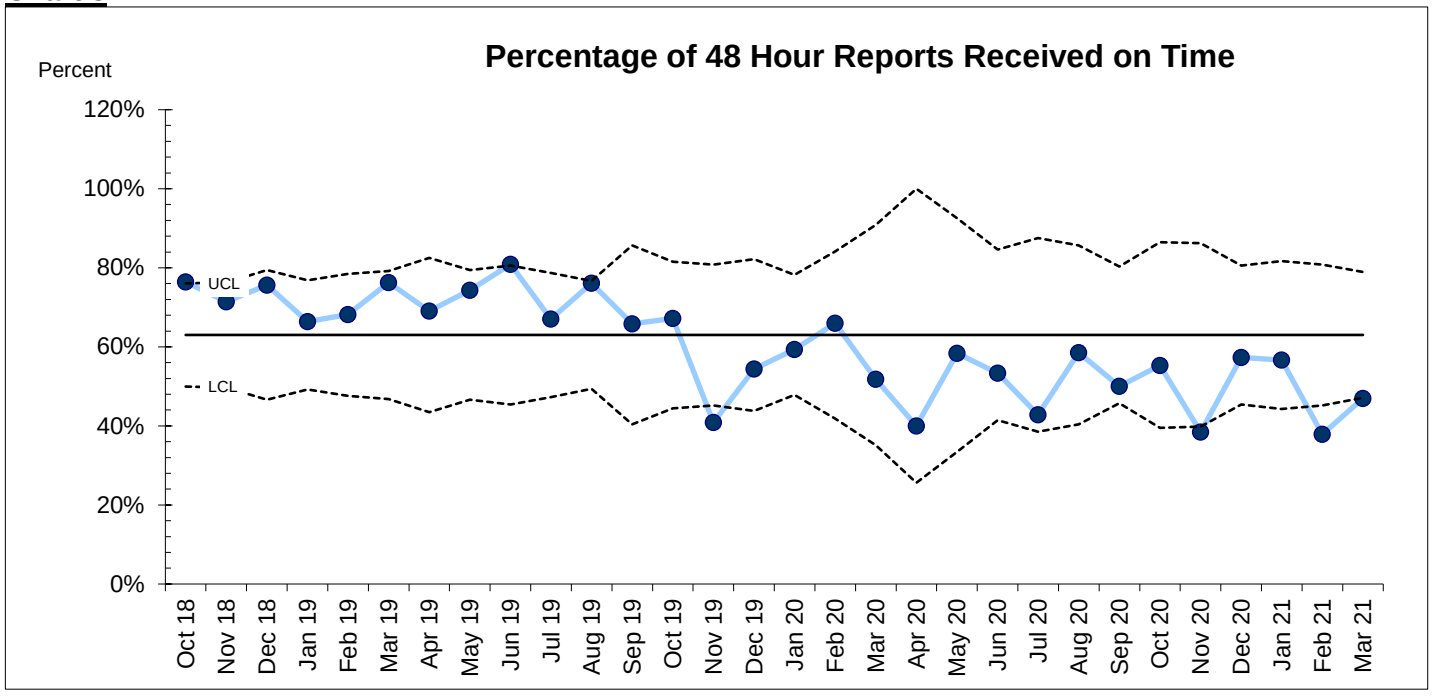
| 48hr reports | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total requested** | 61 | 66 | 57 | 91 | 47 | 27 | 15 | 18 | 45 | 35 | 41 | 70 | 38 | 39 | 68 | 60 | 66 | 83 |
| **Received on time** | 41 | 27 | 31 | 54 | 31 | 14 | 6 | 11 | 21 | 15 | 24 | 35 | 21 | 15 | 39 | 34 | 25 | 39 |
| **Received overdue** | 20 | 39 | 26 | 37 | 16 | 13 | 9 | 7 | 24 | 20 | 17 | 35 | 17 | 24 | 29 | 26 | 41 | 44 |

**Table 6-** Overdue 48 hour reports by Directorate

| Directorate | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire MHS | 6 | 10 | 3 | 5 | 4 | 3 | 2 | 1 | 5 | 4 | 3 | 9 | 8 | 3 | 3 | 4 | 2 | 8 |
| City & Hackney MHS | 0 | 5 | 3 | 7 | 3 | 2 | 5 | 2 | 4 | 2 | 3 | 8 | 1 | 1 | 5 | 2 | 5 | 9 |
| CHS Combined | 0 | 7 | 8 | 4 | 2 | 0 | 0 | 0 | 3 | 3 | 0 | 2 | 0 | 0 | 5 | 5 | 1 | 2 |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 2 | 0 |
| Forensic Services | 0 | 3 | 1 | 3 | 1 | 0 | 0 | 0 | 4 | 2 | 2 | 3 | 1 | 2 | 6 | 3 | 1 | 6 |
| Luton MHS | 3 | 4 | 7 | 8 | 2 | 2 | 0 | 1 | 2 | 4 | 4 | 2 | 1 | 3 | 3 | 3 | 8 | 5 |
| Newham MHS | 5 | 5 | 1 | 2 | 2 | 1 | 2 | 1 | 3 | 1 | 1 | 5 | 1 | 5 | 5 | 3 | 5 | 3 |
| Specialist & CHN Children's Services | 4 | 2 | 2 | 4 | 0 | 2 | 0 | 0 | 2 | 4 | 2 | 3 | 1 | 3 | 1 | 2 | 4 | 4 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tower Hamlets MHS | 2 | 3 | 1 | 4 | 2 | 2 | 0 | 2 | 1 | 0 | 1 | 3 | 3 | 6 | 1 | 4 | 10 | 6 |
| Primary Care Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| **Total** | **20** | **39** | **26** | **37** | **16** | **13** | **9** | **7** | **24** | **20** | **17** | **35** | **17** | **24** | **29** | **26** | **41** | **44** |

**Chart 3**




Of the 27,906 incidents reported in this reporting period only

**21%**

(578) were escalated to 48 hour reports of which 285 were received on time.

During Wave 1 and 2 of the Covid 19 pandemic the threshold for requesting 48 hour reports increased to only those where severe harm had been caused. This action resulted in an overall decrease in the total number of 48 hour reports requested.

4.4 Concise reviews & reports

Concise reviews are an opportunity for the Trust to investigate incidents that may not meet the NHSE SI framework criteria for a reportable serious incident but provide learning opportunities for the Trust. These are conducted by the directorates and consist of a review of the incident and preceding circumstances (patient details, care provided, who and what was involved etc.), an investigation report and a supporting action plan.

**Table 7-** Total Concise reviews/reports requested by Directorate

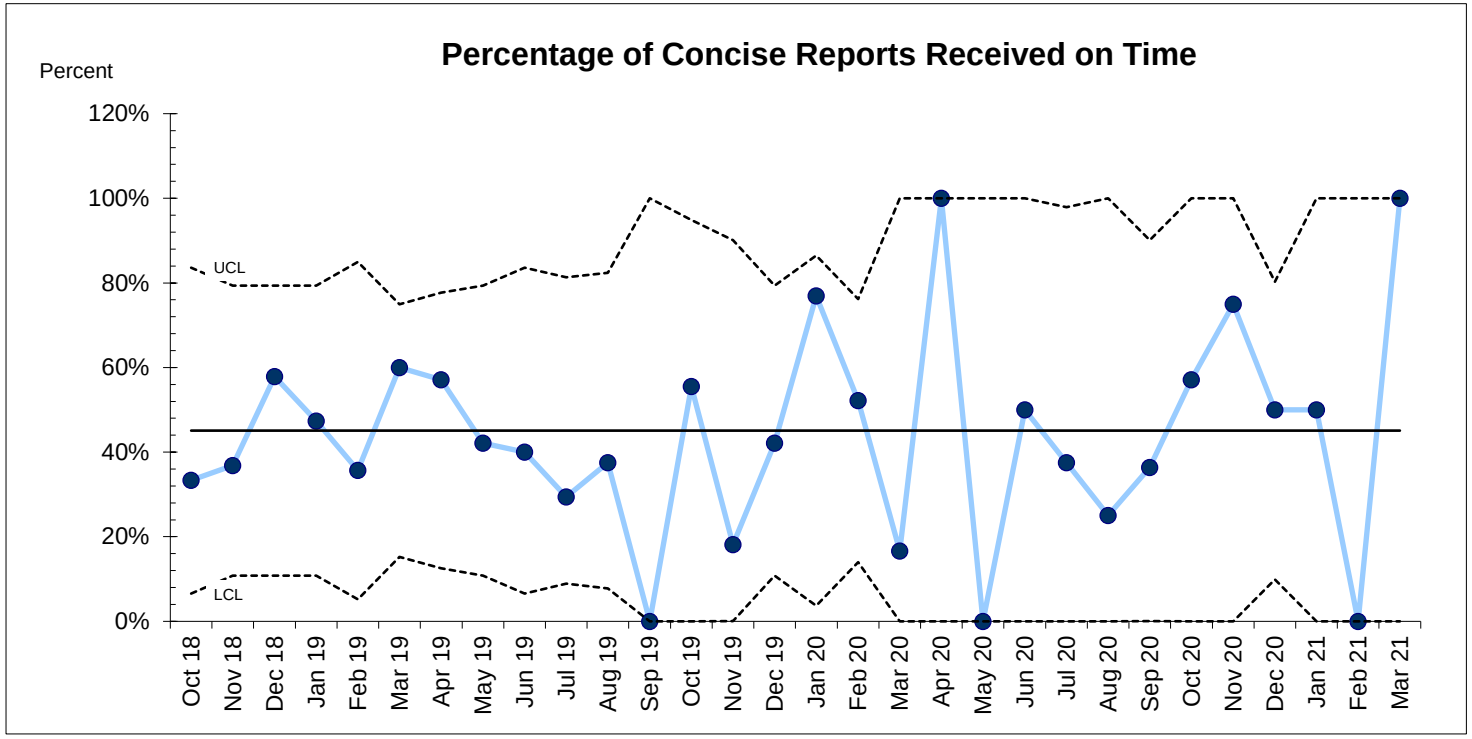
| Concise reports | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total requested** | 9 | 11 | 19 | 13 | 23 | 6 | 1 | 0 | 4 | 8 | 4 | 11 | 7 | 4 | 18 | 2 | 0 | 1 |
| **Received on time** | 5 | 2 | 8 | 10 | 12 | 1 | 1 | 0 | 2 | 3 | 3 | 7 | 4 | 3 | 9 | 1 | N/A | 1 |
| **Received overdue** | 4 | 9 | 11 | 3 | 11 | 5 | 0 | 0 | 2 | 5 | 1 | 4 | 3 | 1 | 8 | 1 | N/A | 0 |

**Table 8-** Overdue Concise reviews/reports by Directorate

| Directorate | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire MHS | 1 | 4 | 1 | 1 | 4 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | N/A | 0 |
| City & Hackney MHS | 0 | 0 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | N/A | 0 |
| CHS Combined | 0 | 1 | 4 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | N/A | 0 |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | 0 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forensic Services | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | 0 |
| Luton MHS | 0 | 0 | 1 | 0 | 0 | 3 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | N/A | 0 |
| Newham MHS | 1 | 2 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | N/A | 0 |
| Specialist & CHN Children's Services | 0 | 1 | 0 | 0 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | 1 |
| Tower Hamlets MHS | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 2 | 0 | N/A | 0 |
| Primary Care Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | N/A | 0 |
| **Total** | **4** | **9** | **11** | **3** | **11** | **0** | **0** | **0** | **2** | **5** | **1** | **4** | **3** | **1** | **8** | **2** | **N/A** | **1** |

**Chart 4**




# 60

Concise reviews were requested in the reporting period (0.2% of the total incidents reported), of which 34 (57%) were completed to timescale. The outstanding reviews were delayed due to the revised thresholds introduced during Wave 1 and 2 of the Covid Pandemic, aimed at reducing pressures on frontline staff in recognition of theCovid-19 pressures on staff time and availability

Serious incidents reported monthly

**Table 9-** SIs reported monthly by directorate (over time)

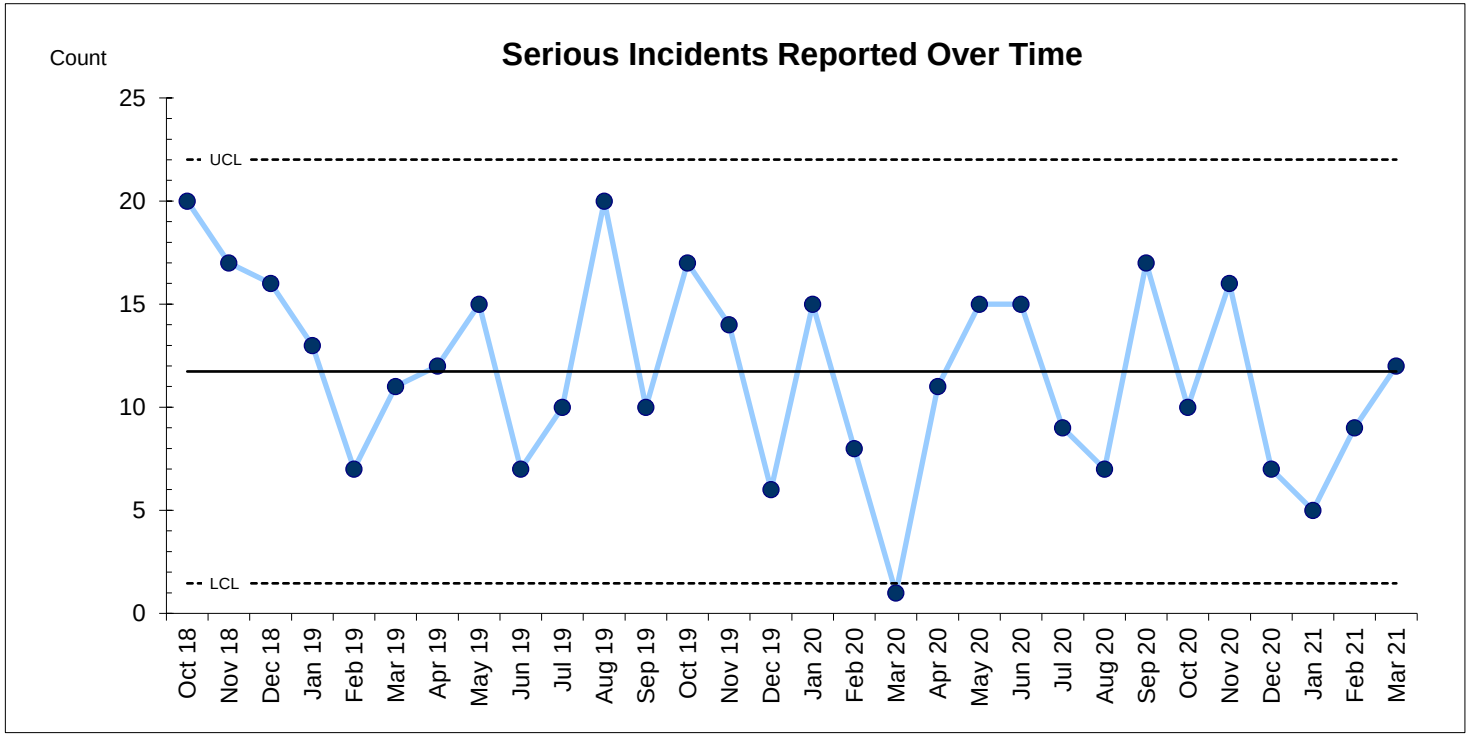
| Directorate | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bedfordshire MHS | 4 | 3 | 0 | 5 | 3 | 0 | 1 | 2 | 3 | 2 | 3 | 5 | 4 | 2 | 1 | 1 | 0 | 1 |
| City & Hackney MHS | 1 | 3 | 1 | 2 | 0 | 1 | 7 | 3 | 5 | 1 | 1 | 3 | 0 | 2 | 0 | 3 | 1 | 2 |
| CHS Combined | 2 | 5 | 2 | 2 | 1 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 0 | 2 | 1 | 0 | 3 | 2 |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Forensic Services | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 2 | 0 | 1 | 2 | 0 | 0 | 0 |
| Luton MHS | 2 | 0 | 2 | 4 | 0 | 0 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 0 | 1 | 2 |
| Newham MHS | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 4 | 1 | 0 | 0 | 3 | 2 | 4 | 1 | 0 | 0 | 2 |
| Specialist & CHN Children's Services | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 1 |  | 2 | 1 | 0 | 2 | 1 |
| Tower Hamlets MHS | 4 | 0 | 0 | 1 | 3 | 0 | 1 | 2 | 1 | 0 | 0 | 2 | 1 | 2 | 0 | 1 | 2 | 1 |
| Primary Care Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Total** | **17** | **14** | **6** | **15** | **8** | **1** | **11** | **15** | **15** | **9** | **7** | **17** | **10** | **16** | **7** | **5** | **9** | **12** |

**Table 10-** Serious Incidents (SI) to population ratio (SI:100,000)

| Period | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| **Population (approx.)** | 1,659,900 | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total SI** | 17 | 14 | 6 | 15 | 8 | 1 | 11 | 15 | 15 | 9 | 7 | 17 | 10 | 16 | 7 | 4 | 9 | 12 |
| **Ratio:100,000** | 1.0 | 0.8 | 0.4 | 0.9 | 0.5 | 0.06 | 0.7 | 0.9 | 0.9 | 0.5 | 0.4 | 1 | 0.6 | 1.0 | 0.4 | 0.2 | 0.5 | 0.7 |

**Chart 5**




**133**

Incidents (0.5% of total incidents reported) were raised to serious incidents. 135 were initially raised as serious incidents with 2 being subsequently withdrawn/de-escalated.

During Wave 1 and 2 of the Covid 19 pandemic corporate SIs were only requested where there was evidence that severe harm had been caused. Usually this would be due to an unexpected death or a homicide. Currently, an audit of those incidents which, outside of the pandemic, would have been formally reviewed is being undertaken to identify whether they should be investigated under the SI or Concise process, whichever is the most appropriate, to capture any learning from these incidents.

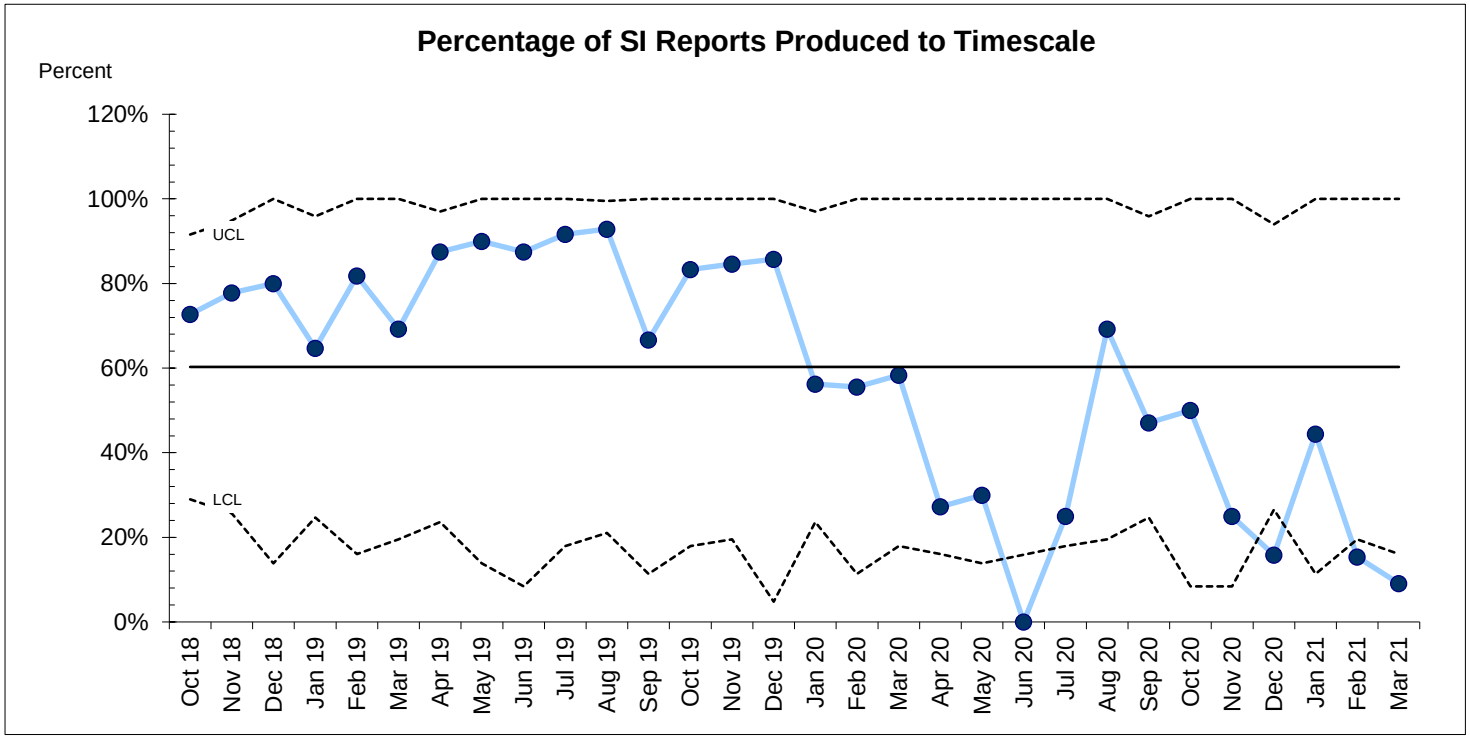
4.6 Adherence to SI review process and timescales

The time frame for completing a serious incident investigation is set by NHS Improvement at 60 working days as prescribed in the NHSE SIF. The Trust's Commissioners monitor compliance via the Strategic Executive Information System (StEIS). During Wave 1 and Wave 2 CCG's agreed to blanket extensions owing to the pressures on clinical staff.

**Table 11-** SI reports- adherence to timescales

| | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total SI due in month** | 12 | 13 | 7 | 16 | 9 | 12 | 14 | 10 | 0 | 12 | 13 | 16 | 9 | 8 | 19 | 9 | 13 | 11 |
| **Produced to timescale** | 10 | 11 | 6 | 9 | 5 | 7 | 3 | 3 | 0 | 3 | 8 | 8 | 3 | 2 | 3 | 4 | 2 | 1 |
| **Overdue** | 2 | 2 | 1 | 7 | 4 | 5 | 11 | 7 | 0 | 9 | 5 | 8 | 6 | 6 | 16 | 5 | 11 | 10 |

**Chart 6**




During Wave 1 and 2 of the COVID 19 pandemic staff ability to do extra duties i.e. act as investigators; give witness statements, conduct in patient safety investigations was severely limited and therefore achieving the 60-day investigation timeline was not always feasible. The CCGs agreed to a blanket reporting extension for SIRs and were notified of anticipated completion dates whenever it appeared that the 60-day deadline would not be met. No SIRs were due in June 2020.

Prior to the impact of COVID 19 in April 2020, several reports were delayed due to a lead reviewer's long-term sickness and a couple of other SIRs were also delayed due to high caseloads. Some cases were delayed due to the late receipt of evidence including; cause of death or Toxicology Reports. Additional, reasons for delays were noted to be staff sickness, delays liaising with families and external agencies, delays obtaining directorate feedback and report updates.

As at 31 March 2021 there was one SIR outstanding for the 60 Day submission. However, as the 60 day reporting timelines had been suspended with agreement from the Trust's commissioners, it was not considered as overdue for submission.

## 4.7 **National Reporting and Learning System (NRLS)**

The Trust has continued to submit patient safety incidents to the NRLS in line with national reporting requirements during the period 01 April 2020 to 31 March 2021.

Table 12 details the number of incidents exported from the Datix Risk Management system to the NRLS portal for each month, meeting the twice yearly NRLS May and November deadlines.

**Table 12** - Incidents submitted to the NRLS by month.

| Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | Jan 2020 | Feb 2020 | Mar 2020 | Apr 2020 | May 2020 | Jun 2020 | July 2020 | Aug 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Dec 2020 | Jan 2021 | Feb 2021 | Mar 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 624 | 1278 | 644 | 535 | 928 | 1212 | 1433 | 1557 | 1410 | 1247 | 842 | 488 | 611 | 1002 | 619 | 531 | 580 | 806 | 808 | 2461 | 784 | 707 | 651 | 958 |

The graph at Chart 7 details the numbers of incidents by severity reported to the NRLS over a 3 year period from 2018 to 2021.

The number of incidents uploaded to the NRLS has fluctuated from 8496 in 2018, 12198 in 2019 and 10515 2020 (for each financial year).

**Chart 7** - Incidents exported to the NRLS for the period of 01 April 2018 to 31 March 2021 by Severity

(To note moderate harms exported to the NRLS include pressure ulcers acquired outside of the Trust)

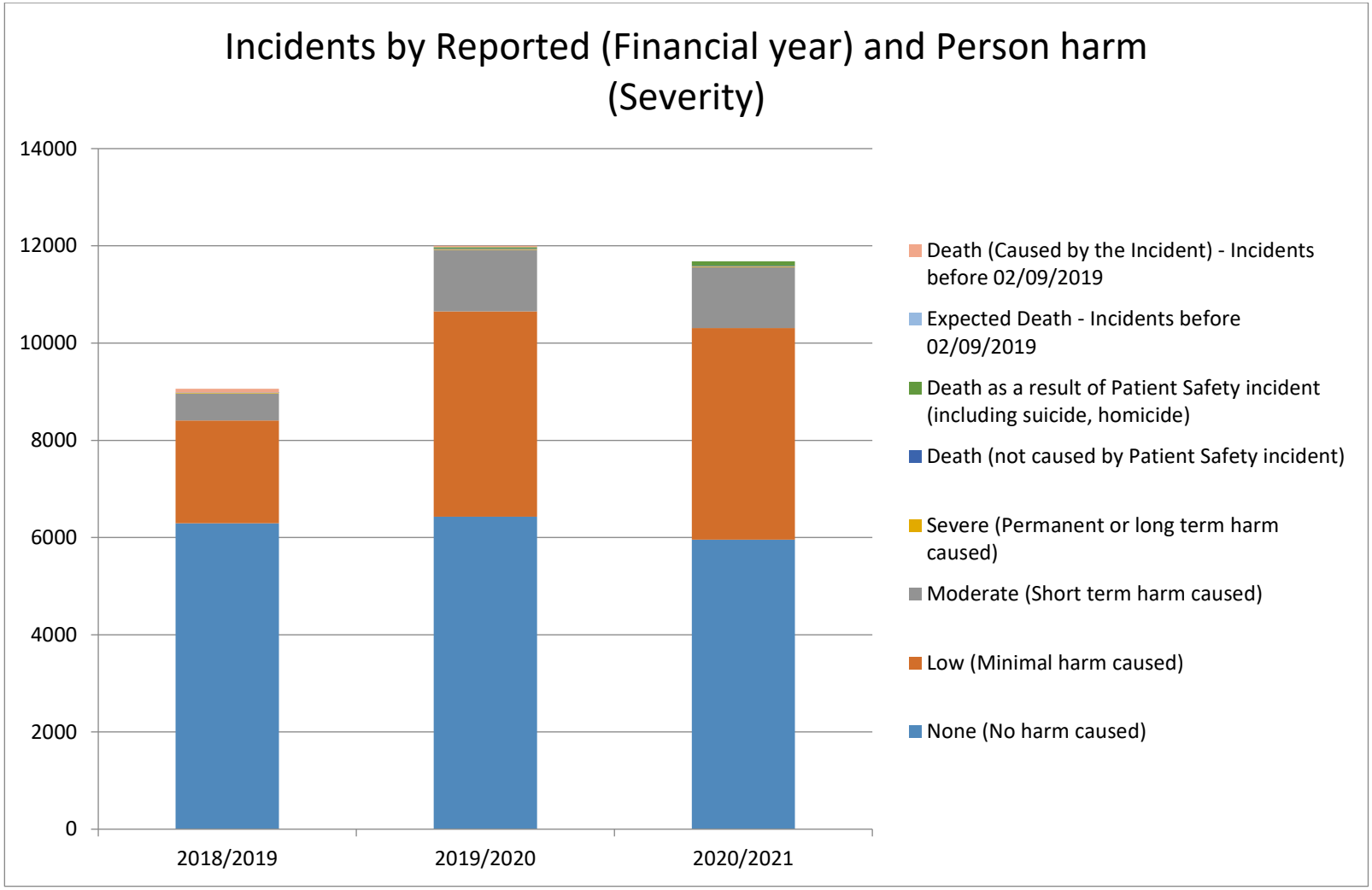
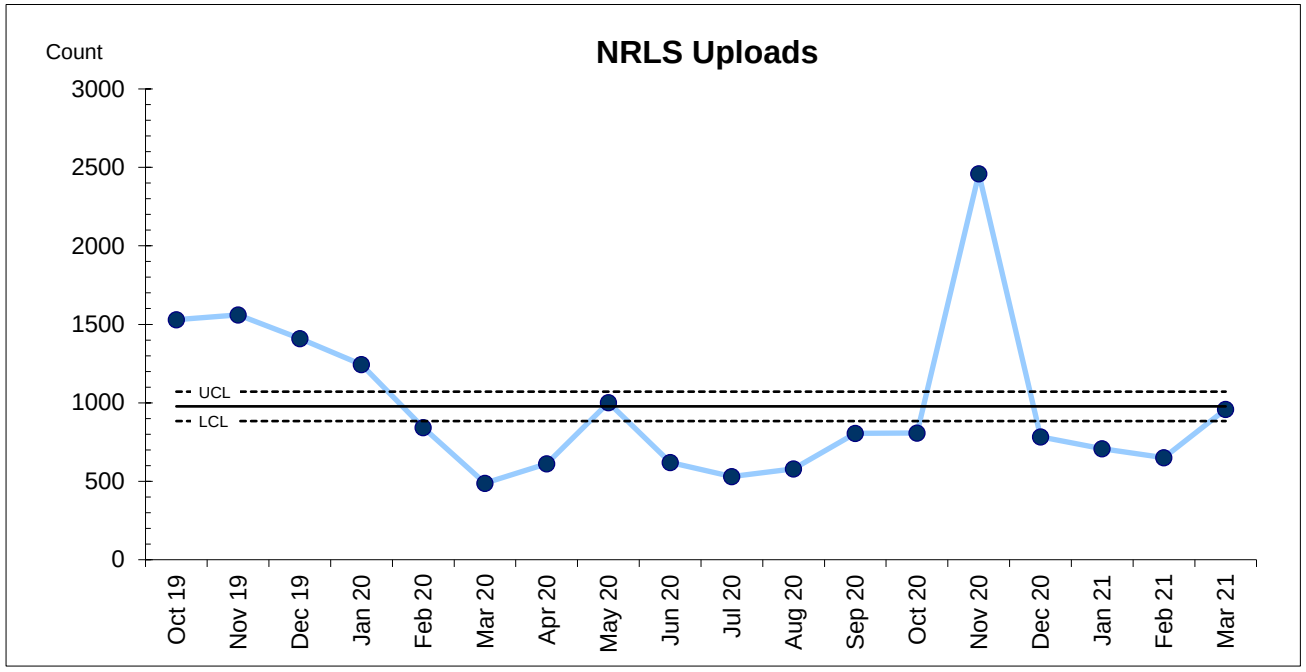


**Chart 9**




Of the 27, 906 reported incidents, the Trust uploaded

**10,515**(35%)

eligible patient safety incidents to the NRLS during the reporting period.

The number of incidents uploaded this year was reduced due to the Pandemic and the unavailability of staff to check and approve the harm levels of incidents to assure NRLS reporting. Of note the spike in uploads in May and November 2020 is directly correlated with the NRLS upload deadline dates at the end of May and November respectively.

**Table 12-** NRLS incident uploads by month

| Period | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | June 20 | July 20 | Aug 20 | Sep 20 | Oct 20 | Nov 20 | Dec 20 | Jan 21 | Feb 21 | Mar 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NRLS Incident Uploads** | 1530 | 1561 | 1410 | 1244 | 842 | 488 | 611 | 1002 | 619 | 530 | 580 | 806 | 807 | 2460 | 784 | 707 | 651 | 958 |