NHS
East London
NHS Foundation Trust

REPORT TO QUALITY ASSURANCE COMMITTEE
17 SEPTEMBER 2020

Title	Patient Safety Learning from Serious Incidents Annual Report 2019/2020
Period covered	01 April 2019- 31 March 2020
Author	Duncan Hall, Incidents & Complaints Manager, Abiola Ajayi-Obe, Associate Director Governance and Risk
Accountable Executive Director	Paul Gilluley, Chief Medical Officer

Purpose of the Report

To provide the Trust Board with an overview of the Trust's management of incidents and Serious Incidents over the past financial year.

Summary of Key Issues

Part 1- Service developments and improvements

- Introduction of Datix Action Module
- Introduction of support networks & psychological supervision for the corporate review team
- Covid-19 fostered changes to incidents management in conjunction with the CCGs and NHS England/Improvement including; Introduction of table top/focused SI Reviews
- Introduction of Patient Safety Learning Event inclusive of themed learning from incidents, serious incident reviews and complaints.

Part 2- Incident Metrics Updates[1]:

- Total number incidents reported by the Trust in this reporting period was **23,708**
- In this reporting period the Trust uploaded **12,296** incidents to the National Reporting & Learning System
- Of the 23,708 reported incidents, **135*** (0.6%) were escalated to Serious Incidents.

Table 1:

SI review Top ten Learning themes:
➢ Delays in obtaining treatment ➢ Discharge issues / Lack of joined up working with external agencies ➢ Poor record keeping / connectivity to IT Systems ➢ Lack of engagement / communication with patients/ involvement with carers, families, friends ➢ Non - availability of staff ➢ Communication factors (internal and external) ➢ Delayed escalation of concerns/patient deterioration ➢ Gaps/delays in following up on clinical plans and or appointments ➢ Risk assessment related issues ➢ Documentation issues including quality, timeliness and uploading documents to RiO

[1]All data was run at a point in time; variants may occur if re-run owing to removed duplicated incident reports, deescalated serious incidents and withdrawn complaints.

Committees/Meetings where these items have been considered

- Serious Incident Committee
- Grading Meetings

Implications

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	This report provides assurance that incidents are appropriately reported and investigated, robust actions taken where necessary and learning is gained from investigations
Service User/Carer/Staff	The recommendations and action plans pertaining to the incidents investigated as serious incidents have implications for service users, carers, staff and services across the organisation
Financial	There are financial implications regarding resource management & potential for litigation

Supporting Documents and Research material

NHS England Serious Incident Reporting Framework 2015
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Glossary

Abbreviation	**In full**
CHS	Community Health Services
Datix	Trust incidents and complaints reporting and management system
ELFT/ The Trust	East London NHS Foundation Trust
MHS	Mental Health Services
NHSE/I	NHS England/Improvement
QI	Quality Improvement
SI	Serious Incident(s)
StEIS	Strategic Electronic Incident System (National SI reporting system)

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 and complaints activities for the defined reporting period and overtime.

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 we 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 and 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 personally oversees incident management and the approval of all reviews.

1.3 This report covers the period from 1 April 2019-31 March 2020.

2.0 Learning from incidents

2.1 Incident themes

The main catagories of incidents reported in this reporting period were:

Care & Treatment

Violence & Aggression

Death

Health, Safety & Security

Information (IG, IM&T, Systems, Hardware etc.)

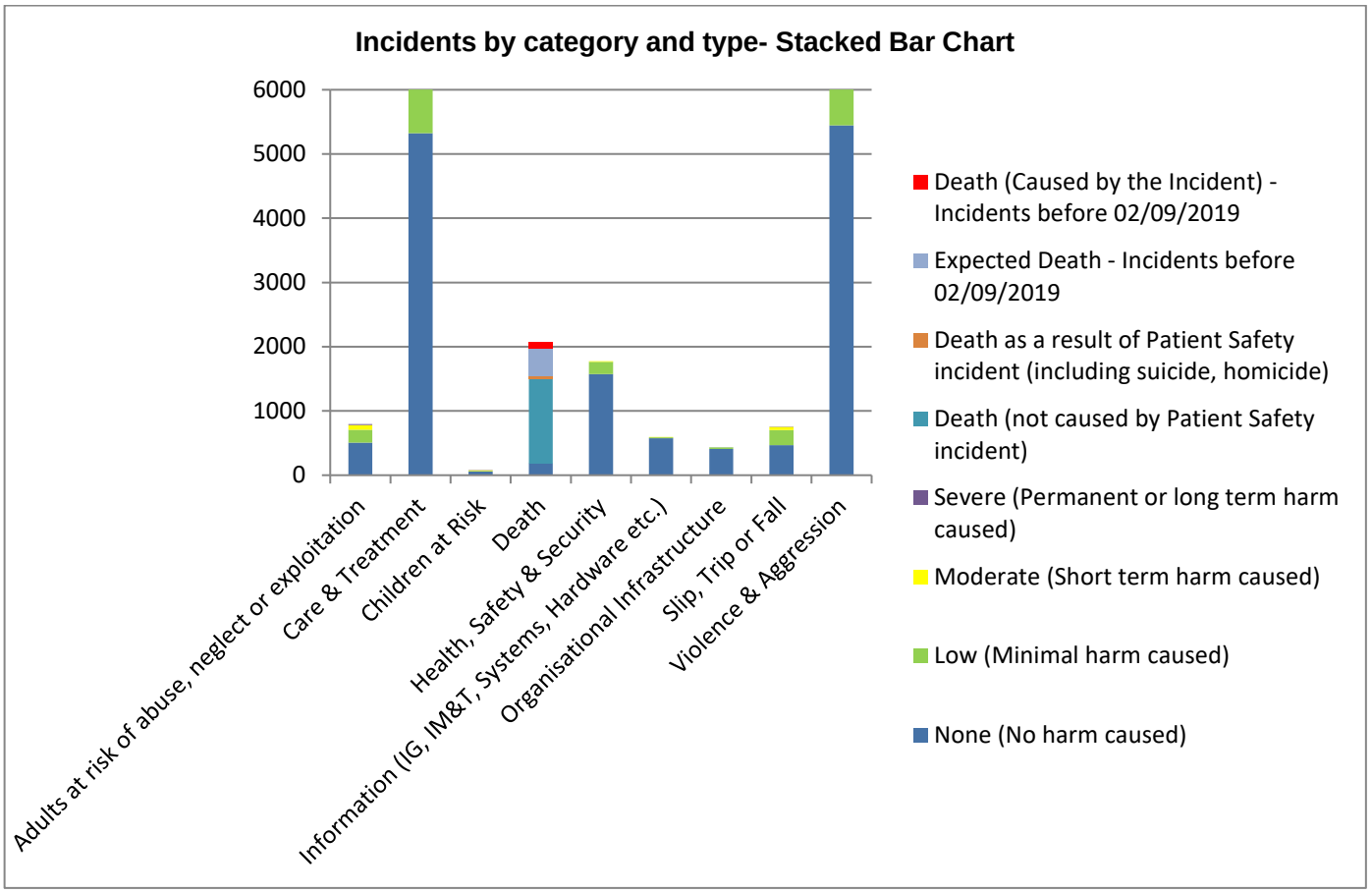
Adults at risk of abuse, neglect or exploitation

Slip, Trip or Fall

Organisational Infrastructure

Children at Risk

Chart 1



2.2 Serious incidents by type

SIs by type

- Death
- Care & Treatment
- Violence & Aggression
- Adults at risk of abuse, neglect or exploitation
- Information (IG, IM&T, Systems, Hardware etc.)
- Slip, Trip or fall

2.3 Serious incident review learning themes

Top Ten SI Review Learning Themes

- Delays in obtaining treatment
- Discharge issues / Lack of joined up working with external agencies
- Poor record keeping / connectivity to IT Systems
- Lack of engagement / communication with patients/ involvement with carers, families, friends
- Non - availability of staff
- Communication factors (internal and external)
- Delayed escalation of concerns/patient deterioration
- Gaps/delays in following up on clinical plans and or appointments
- Risk assessment related issues
- Documentation issues including quality, timeliness and uploading documents to RiO

3.0 Service developments

3.1 Team and process developments

Throughout the year we have looked to strengthen and improve team capacity and systems and processes in place to undertake and coordinate learning from incidents including:

- The introduction of a variety of staff support programmes including; psychological clinical supervision, group supervision and peer support
- Team members have attended training on human factors methodologies and refresher/bespoke root cause analysis training
- Holding Department and Team Away Days which have focussed on developing and strengthening team relations and fostering greater self-awareness of the teams' strength and weaknesses
- Refining the process around quality assuring concise (directorate led) reviews
- Streamlining the process for managing CCG further information requests pertaining to SI Reviews
- Implemented clearer processes for monitoring actions resultant from SI Reviews including the introduction of an action plan module on Datix
- Providing trust-wide root cause analysis training

3.2 The Trust has worked on improving Family liaison in serious incident reviews, namely in cases of unexpected deaths. This has included reviewing the initial family/next of kin contact and the sending out of an introductory letter to all families where a service user has died unexpectedly. This aims to ensure timely notification of the SI Review process and to ensure involvement of patients, families and carers in

the reviews. This has included a 'sense' review of the template letter by service user to ensure communication is clear, compassionate and sensitive.

3.3 Duty of Candour Quality Improvement Project

The Trust has developed and 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.

This QI Project's Change Ideas include;

Identifying Agreed Leads for DoC across Trust Services – *Currently DoC Champions are being trained and identified at local services level. However, DoC leads have been identified across, Mental Health, Community Health and Corporate Directorates via the Governance Network.*

Completion of DoC Guidance Letters on Datix – *This is now 100 completed.*

Training to Correctly Identify DoC Applicability - *A Duty of Candour Training Webinar, 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. The Webinar is currently being delivered virtually and will be made available on the intranet.*

Updated Being Open / DoC Policy – *The Policy has been updated.*

3.4 Covid-19 response

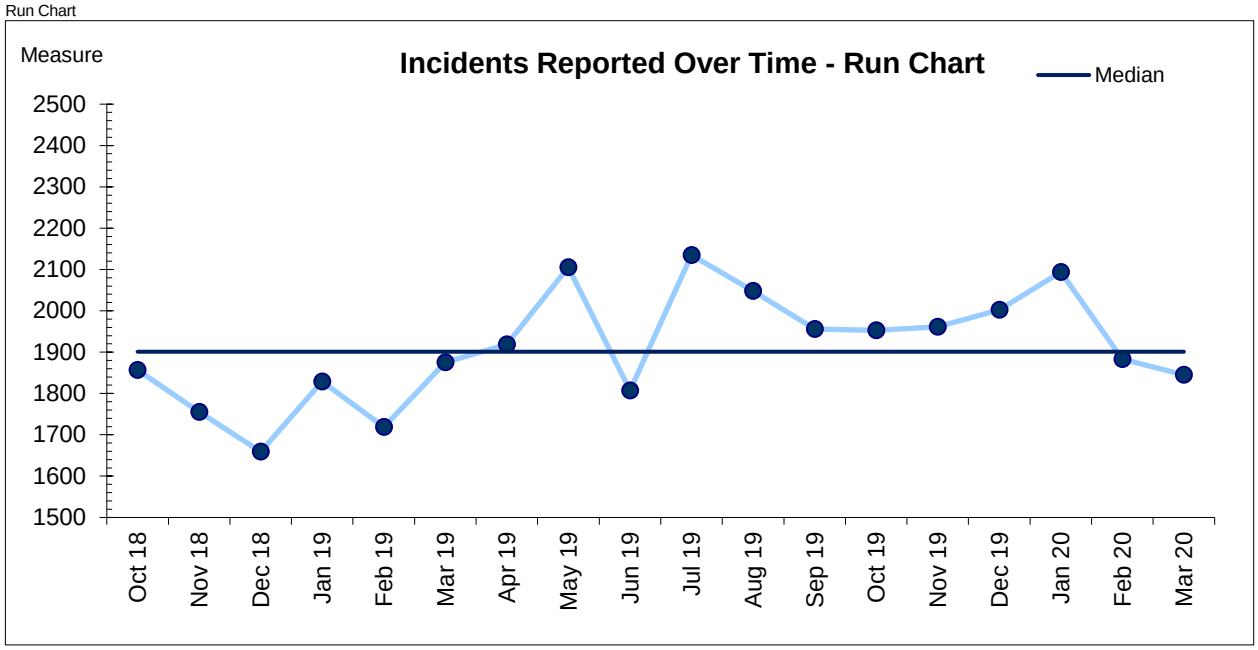
In response to the challenges of Covid-19 and the pressures on clinical staff to deliver safe care, the Trust temporarily revised the investigation thresholds for incident management and SI review processes to enable staff to focus on the provision of front line patient care. The revised thresholds and investigation parameters focussed solely on conducting reviews into all cases of unexpected deaths through table top reviewews. The aim of this approach was to ensure a balance between maintaining higher level Patient Safety Reviews 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 the most serious of incidents were appropriately managed and safe patient care maintained.

4.0 Incidents

4.1 Incidents reported monthly over time

Chart 2



23,708

New incidents were reported across the Trust between April 2019 and March 2020

During the reporting period covered in this report, a total of 6139 incidents were reported within ELFT.

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

Directorate	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Bedfordshire MHS	228	162	139	174	142	131	163	134	125	172	144	161	154	203	146	147	188	168
City & Hackney MHS	145	162	154	188	174	212	203	182	156	211	240	178	171	191	265	227	172	195
CHS Combined	600	512	370	591	563	628	632	774	692	795	646	698	723	715	688	790	687	703
Corporate	3	8	5	9	4	6	7	2	4	5	3	2	4	2	3	2	3	2
Forensic Services	270	254	281	291	249	260	184	243	245	275	263	205	235	231	251	271	233	232
Luton MHS	97	115	127	161	123	151	142	141	151	155	170	170	162	135	176	180	171	125
Newham MHS	169	191	148	144	179	137	192	240	143	178	200	148	166	182	157	137	135	142
Specialist & CHN Children's Services	139	155	106	89	136	143	153	142	106	119	126	138	143	96	134	129	86	99
Tower Hamlets MHS	206	196	229	182	149	207	143	247	185	225	256	256	195	206	182	211	208	179
Total	**1857**	**1755**	**1659**	**1829**	**1719**	**1875**	**1919**	**2105**	**1807**	**2135**	**2048**	**1956**	**1953**	**1961**	**2002**	**2094**	**1883**	**1845**

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

Period	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Population (approx.)	1,659,900																	
Total Incidents	1857	1755	1659	1829	1719	1875	1919	2105	1807	2135	2048	1956	1953	1961	2002	2094	1883	1845
Ratio:100,000	112	106	100	110	104	113	116	127	109	129	123	118	118	118	120	126	113	111

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 23,708 incidents reported on Datix in this reporting period, (77%) were approved by the manager within 48 hours.

18,186

Table 4- Overdue incident approvals

Directorate	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Bedfordshire MHS	112	87	65	36	35	56	31	22	41	44	66	64	39	84	32	21	17	38
City & Hackney MHS	60	67	71	37	60	64	91	41	59	72	73	47	50	64	67	29	19	63
CHS Combined	325	265	285	149	141	116	143	181	216	161	167	147	122	161	87	83	78	139
Corporate	0	0	0	0	0	0	0	0	0	0	7	8	8	4	1	0	0	0
Forensic Services	136	94	115	46	59	59	23	47	30	36	58	29	38	24	40	20	14	94
Luton MHS	35	41	32	50	27	38	47	51	51	34	69	55	28	43	41	17	13	19
Newham MHS	69	65	48	55	55	24	57	65	40	38	52	39	35	61	25	26	14	65
Specialist & CHN Children's Services	63	104	71	28	24	29	25	25	29	39	27	37	32	28	36	35	15	24
Tower Hamlets MHS	113	96	96	68	66	55	91	107	107	75	60	68	60	50	52	44	36	95
Total	**913**	**819**	**783**	**469**	**467**	**441**	**508**	**539**	**573**	**499**	**579**	**494**	**412**	**519**	**381**	**275**	**206**	**537**

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.

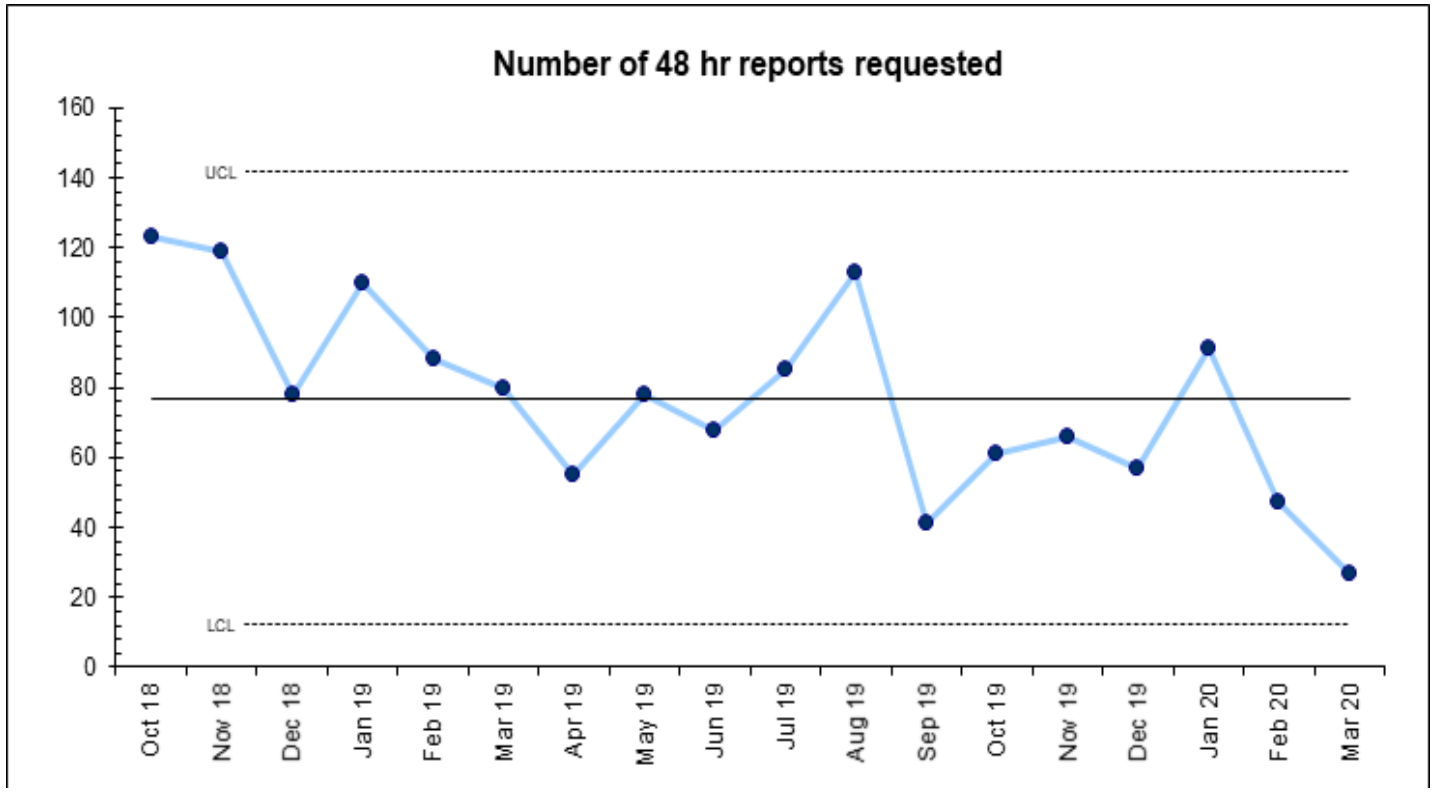
Table 5- 48hr reports status

48hr reports	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Total requested	123	119	78	110	88	80	55	78	68	85	113	41	61	66	57	91	47	27
Received on time	94	85	59	73	60	61	38	58	55	57	86	27	41	27	31	54	31	14
Received overdue	29	34	19	37	28	19	17	20	13	28	27	14	20	39	26	37	16	13

Table 6- Overdue 48 hour reports by Directorate

Directorate	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Bedfordshire MHS	8	5	3	11	7	1	3	5	4	9	4	**2**	6	10	3	5	4	3
City & Hackney MHS	5	4	2	4	6	4	1	3	1	5	4	**1**	0	5	3	7	3	2
CHS Combined	4	8	3	6	6	4	4	3	1	1	1	2	0	7	8	4	2	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0
Forensic Services	3	3	2	2	0	4	0	0	1	1	5	**1**	0	3	1	3	1	0
Luton MHS	1	4	0	4	2	2	6	4	2	4	4	**1**	3	4	7	8	2	2
Newham MHS	2	6	5	3	5	1	3	1	2	3	4	**0**	5	5	1	2	2	1
Specialist & CHN Children's Services	2	0	1	3	2	0	0	1	0	4	4	**1**	4	2	2	4	0	2
Tower Hamlets MHS	5	4	3	4	0	3	0	3	2	1	1	**6**	2	3	1	4	2	2
Total	**29**	**34**	**19**	**37**	**28**	**19**	**17**	**20**	**13**	**28**	**27**	**14**	**20**	**39**	**26**	**37**	**16**	**13**

Chart 3



Of the 23,708 incidents reported in this reporting period only

3.3%

(789) were escalated to 48 hour reports of which 270 were received on time.

4.4 Concise reviews & reports

Concise reviews are an option 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.

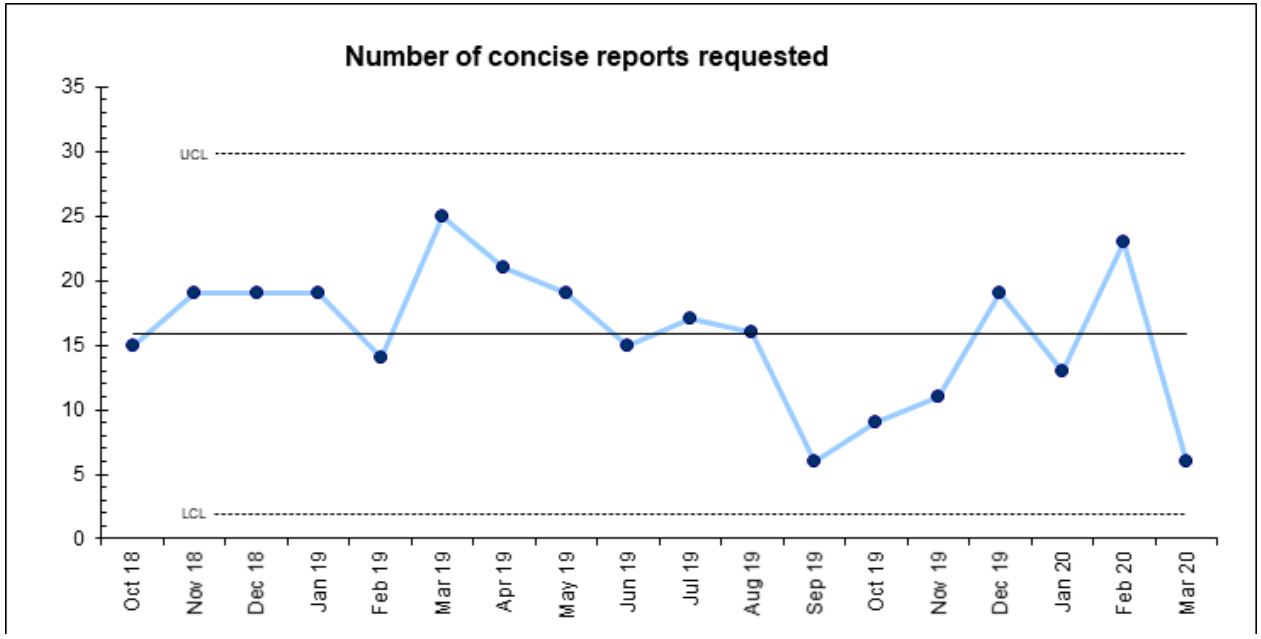
Table 7- Total Concise reviews/reports requested by Directorate

Concise reports	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Total requested	15	19	19	19	14	25	21	19	15	17	16	6	9	11	19	13	23	6
Received on time	5	7	11	9	5	15	12	8	6	5	6	0	5	2	8	10	12	1
Received overdue	10	12	8	10	9	10	9	11	9	12	10	6	4	9	11	3	11	5

Table 8- Overdue Concise reviews/reports by Directorate

Directorate	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Bedfordshire MHS	3	4	1	3	4	3	1	1	2	4	3	0	1	4	1	1	4	0
City & Hackney MHS	0	2	2	1	0	2	2	1	2	1	1	4	0	0	2	1	1	1
CHS Combined	0	0	0	1	0	0	2	0	0	0	0	1	0	1	4	0	3	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services	1	0	0	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0
Luton MHS	2	2	1	1	0	0	1	4	2	3	3	0	0	0	1	0	0	3
Newham MHS	1	2	1	1	3	1	2	1	2	2	1	0	1	2	2	1	0	0
Specialist & CHN Children's Services	2	1	0	1	2	1	0	1	0	0	1	0	0	1	0	0	3	1
Tower Hamlets MHS	1	1	3	2	0	2	1	3	1	2	1	1	1	0	1	0	0	0
Total	**10**	**12**	**8**	**10**	**9**	**10**	**9**	**11**	**9**	**12**	**10**	**6**	**4**	**9**	**11**	**3**	11	0

Chart 4



175

Concise reviews were requested in the reporting period (0.7% of the total incidents reported), of which 75 (43%) were completed to timescale.

Serious incidents reported monthly

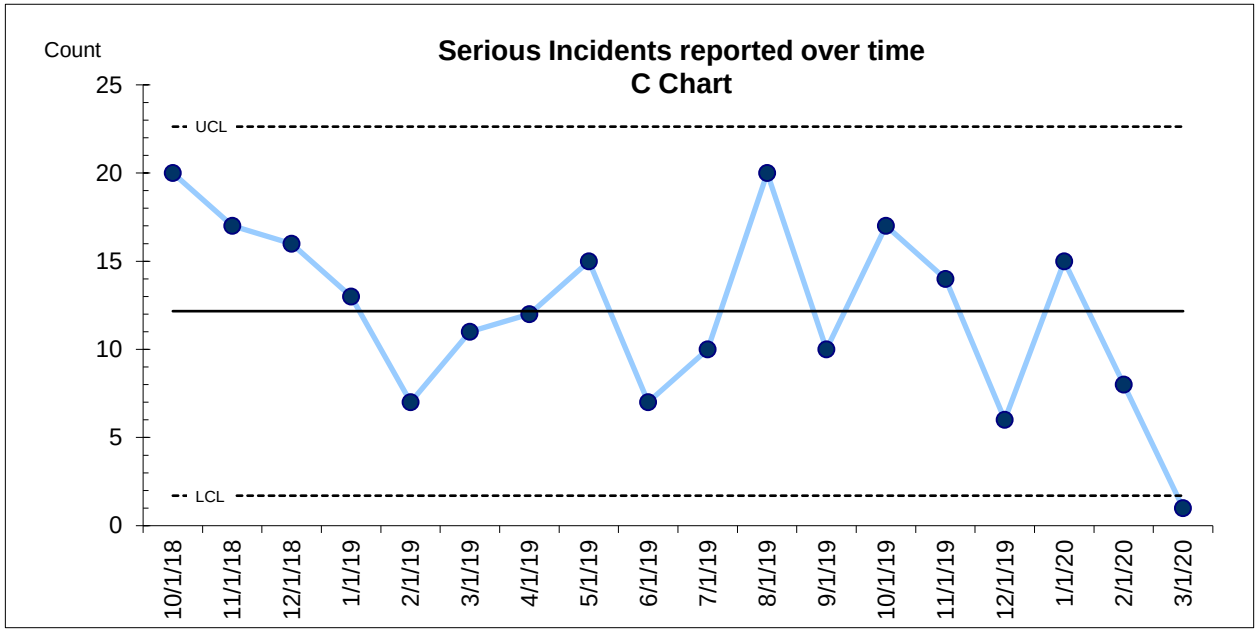
Table 9- SIs reported monthly by directorate (over time)

Directorate	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Bedfordshire MHS	5	3	3	7	1	2	3	3	1	2	3	1	4	3	0	5	3	0
City & Hackney MHS	4	2	0	1	2	2	1	0	1	3	5	0	1	3	1	2	0	1
CHS Combined	3	2	4	2	1	4	2	2	0	2	4	1	2	5	2	2	1	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services	1	1	1	0	0	1	0	0	1	1	2	0	0	2	0	1	0	0
Luton MHS	2	4	0	0	1	0	2	4	2	1	1	1	2	0	2	4	0	0
Newham MHS	0	1	6	2	0	1	0	3	1	0	3	2	2	1	1	0	1	0
Specialist & CHN Children's Services	3	1	1	1	1	0	2	2	0	0	0	2	2	0	0	0	0	0
Tower Hamlets MHS	2	3	1	0	1	1	2	1	1	1	2	3	4	0	0	1	3	0
Total	**20**	**17**	**16**	**13**	**7**	**11**	**12**	**15**	**7**	**10**	**20**	**10**	**17**	**14**	**6**	**15**	**8**	**1**

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

Period	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Population (approx.)	1,659,900																	
Total SI	20	17	16	13	7	11	12	15	7	10	20	10	17	14	6	15	8	1
Ratio:100,000	1.2	1.0	1.0	0.8	0.4	0.7	0.7	0.9	0.4	0.6	1.2	0.6	1.0	0.8	0.4	0.9	0.5	0.06

Chart 5



127

Incidents (0.6% of total incidents reported) were raised to serious incidents. 135 were initially raised as serious incidents with 8 being subsequently withdrawn/deescalated.

Only one incident was raised to an SI in March which is understood to be a reflection of the early Covid-19 Pandemic impact.

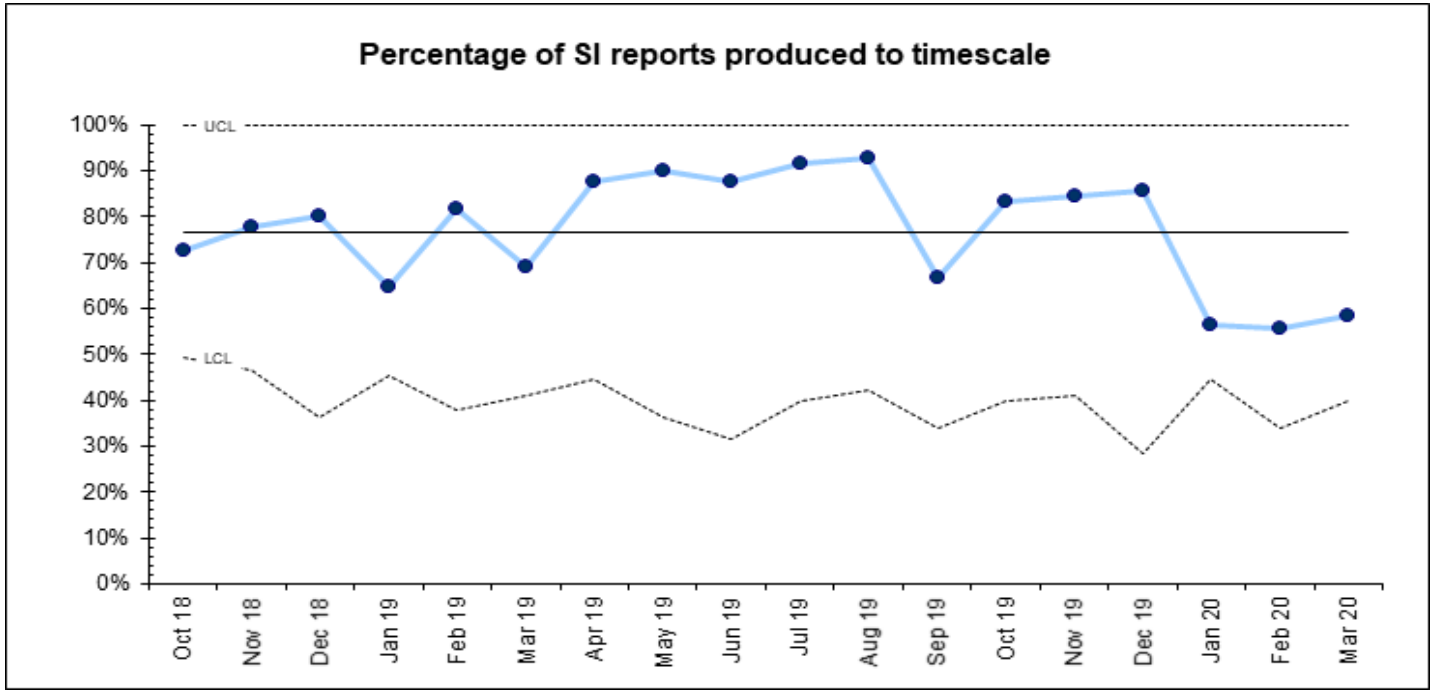
4.6 Adherence to SI review process and timescales

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).

Table 11- SI reports- adherence to timescales

	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Total SI due in month	22	18	10	17	11	13	16	10	8	12	14	9	12	13	7	16	9	12
Produced to timescale	16	14	8	11	9	9	14	9	7	11	12	6	10	11	6	9	5	7
Overdue	6	4	2	6	2	4	2	1	1	1	1	3	2	2	1	7	4	5

Chart 6



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 2019 to 31 March 2020.

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
624	1278	644	535	928	1212	1433	1557	1410	1247	842	488

The graph at Chart 7 details the numbers of incidents reported to the NRLS over a 3 year period from 2017 to 2019 and the bar chart at Fig x by severity for the same period.

The number of incidents uploaded to the NRLS has risen significantly from 5984 in 2017, to 8496 in 2018 and finally 12198 in 2019.

From April 2019 the Trust fully implemented NHS Improvement requirements to report all pressure ulcers including those acquired outside of the Trust; as a result this significantly increased the number of moderate rated incidents uploaded to the NRLS.

Further work was also undertaken on Datix to review the deaths categories to support robust mortality reporting. Following Quality Committee approval these changes were implemented during September 2019 resulting in improved data quality and positive feedback from clinical and support staff.

Chart 7:- The number of Incidents exported to the NRLS for the period of 01 April 2017 to 31 March 2020

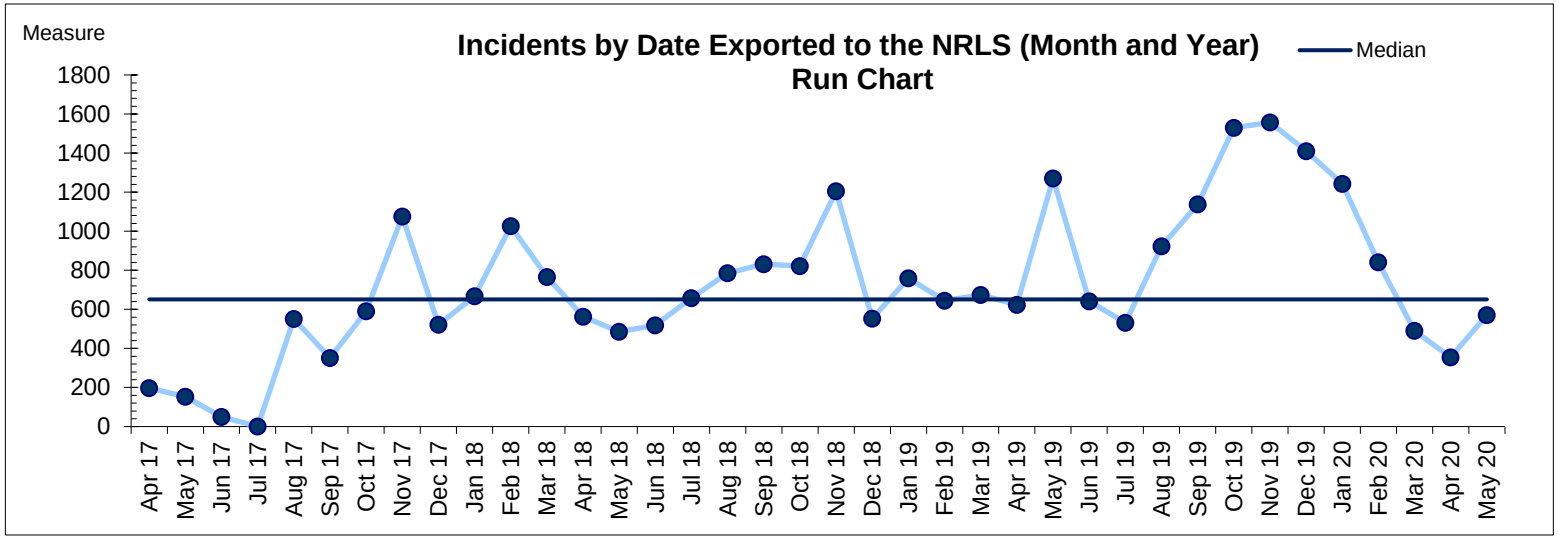
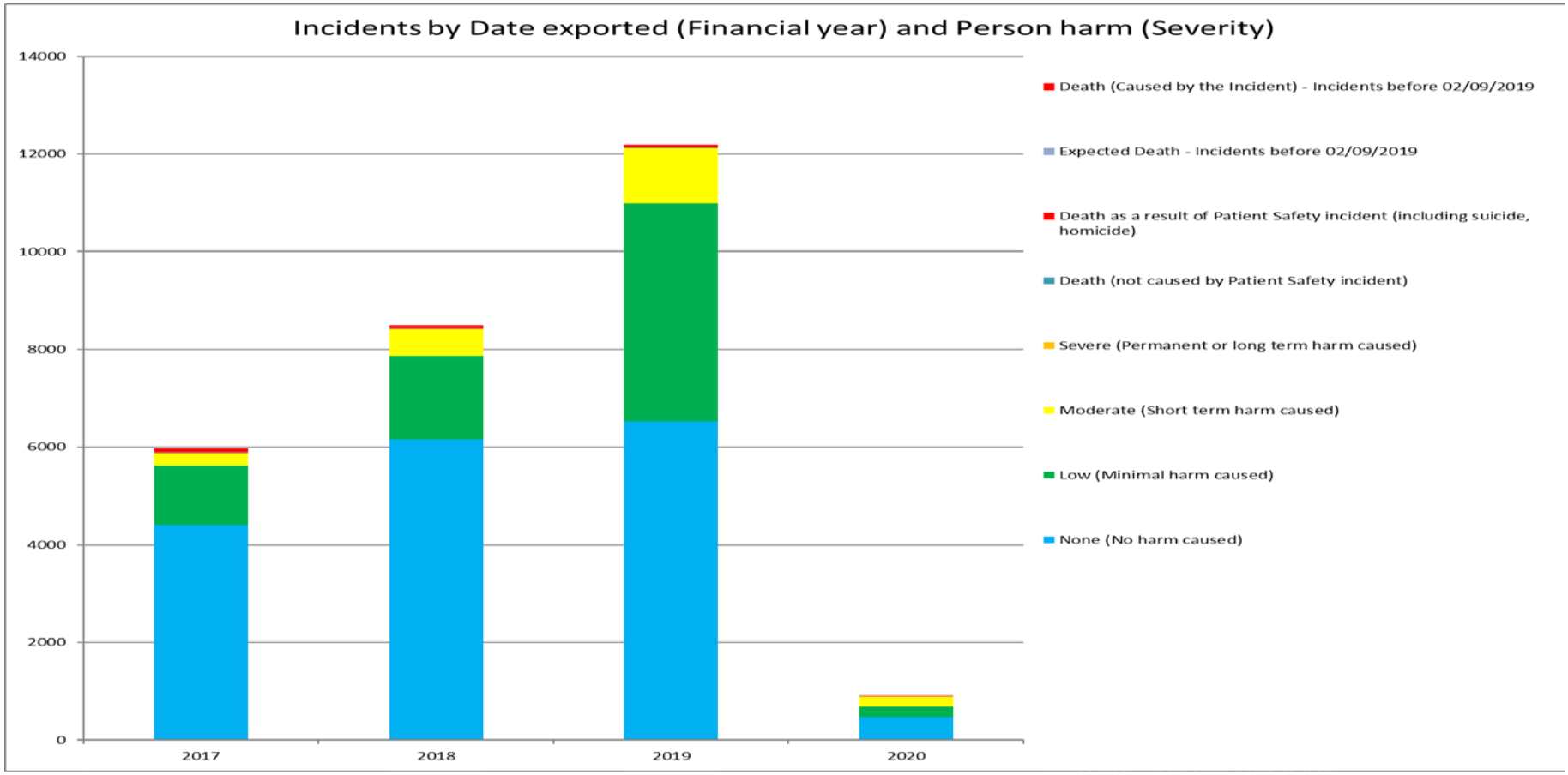
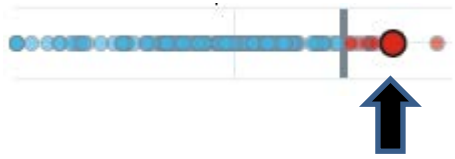


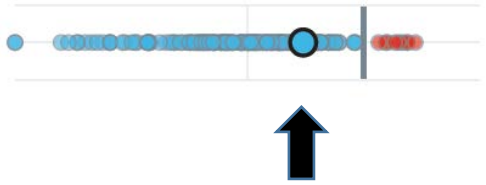
Chart 8 - Incidents exported to the NRLS for the period of 01 April 2017 to 31 March 2020 by Severity



Feedback reports are published bi-annually by the NRLS enabling limited comparisons against other NHS Trusts for reporting culture and reporting patterns. Our position at April 2017 to September 2017 was rated red.

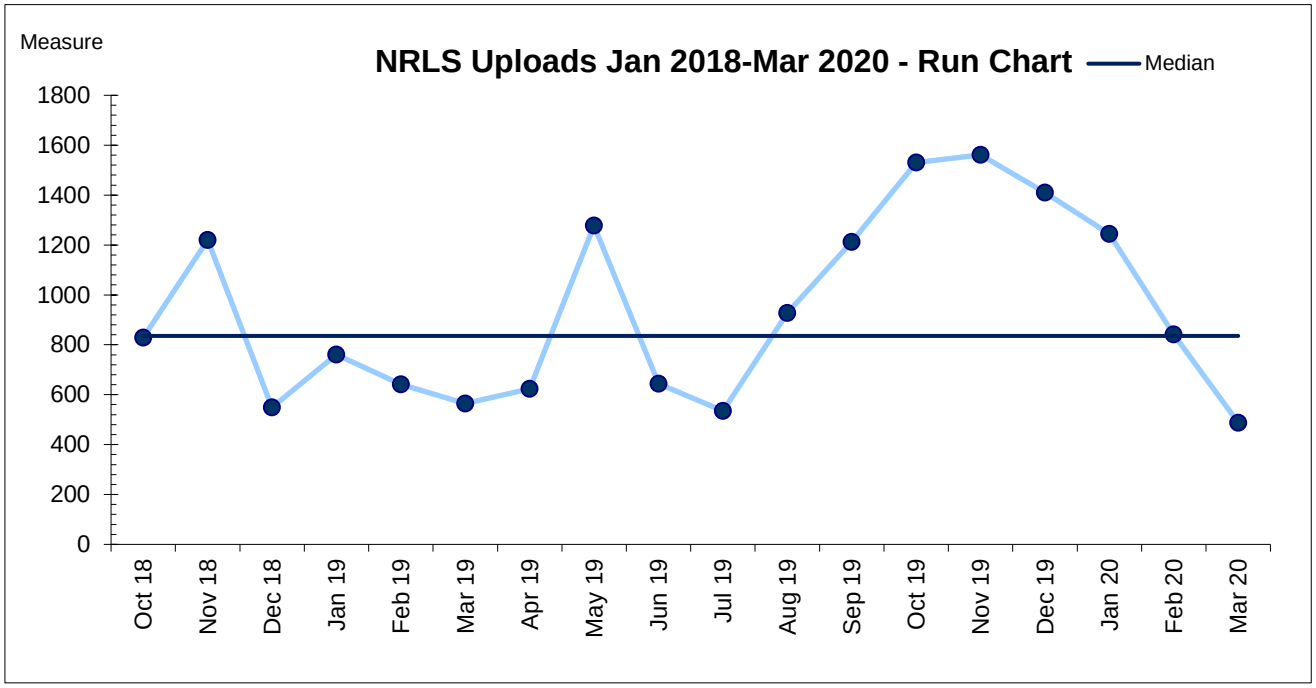


Our position at 01 April 2019 to September 2019 was rated blue “No evidence for potential under-reporting”



Significant work has been undertaken to improve incident reporting and this work continues through targeted training, induction and management leadership courses.

Chart 9



Of the 23,708 reported incidents, the Trust uploaded

12,296 (52%)

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

Table 12- NRLS incident uploads by month

Period	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
NRLS Incident Uploads	829	1220	549	761	642	565	624	1278	644	535	928	1212	1530	1561	1410	1244	842	488

5.0 Recommendations

5.1 The Board is asked to receive and approve this report.

6.0 Action being requested

6.1 For discussion.