NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
25 July 2019

Title	**Serious Incidents Annual Report 2018/19**
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Purpose of the Report:

To provide an analysis of serious incidents occurring in East London NHS Foundation Trust between 1 April 2018 to 31 March 2019

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 2018/19 to address the major themes emerging from serious incidents in the previous annual review.

New Patient Safety Strategy was recently released by NHS England (NHSE). The accompanying revision to the 2015 NHSE SI Framework is expected to be released in the late summer/early autumn of 2019. NHSE have renamed this as the Patient Safety Incident Response Framework (PSIRF).

In 2018/19 there has been an increase in incidents reported within the Trust in direct correlation to organisational growth and an increased reporting culture.

Over the last year there has been a 26% increase in the number of incidents that have been investigated as Serious Incidents (SI).

Over the last year there has been noted a trend in a reduction of Panel led SIs and an increase in Corporate Led SIs.

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 provide.
Improved health of the communities we serve	☒	To reduce avoidable incidents of harm occurring to the service users we serve and provide improved health outcomes to our populations.
Improved staff experience	☒	To enable staff to learn from outcomes, extend their knowledge base and improve the experience of staff in providing high quality care.
Improved value for money	☒	Reducing incidents of avoidable harm will directly reduce the number of legal claims the Trust receives and any associated compensatory settlements.

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	Learning from outcomes and the associated improvements made to services, positively impact; service users, their families and carers and overall 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 act as drivers for quality improvement work.

Supporting Documents and Research material

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

Glossary

Abbreviation	In full
CHS	Community Health Services
ELFT	East London NHS Foundation Trust; also referred to throughout the report as 'The Trust' and or 'Trust'
MHS	Mental Health Services
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.)
PSIRF	Patient Safety Incident Response Framework
NRLS	National Reporting and Learning System

1.0 Background / Introduction

1.1 East London NHS Foundation Trust (ELFT/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, i.e. where the harm suffered results in irreversible consequences or catastrophic, i.e. where the harm results in a fatality

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.

*A new Patient Safety Strategy was released by NHS England (NHSE) at the Patient Safety Congress on 2 July 2019. The accompanying revision to the 2015 NHSE SI Framework is expected to be released in the late summer/early autumn of 2019. NHSE have renamed this as the Patient Safety Incident Response Framework (PSIRF).

According to NHS Improvement, the PSIRF:

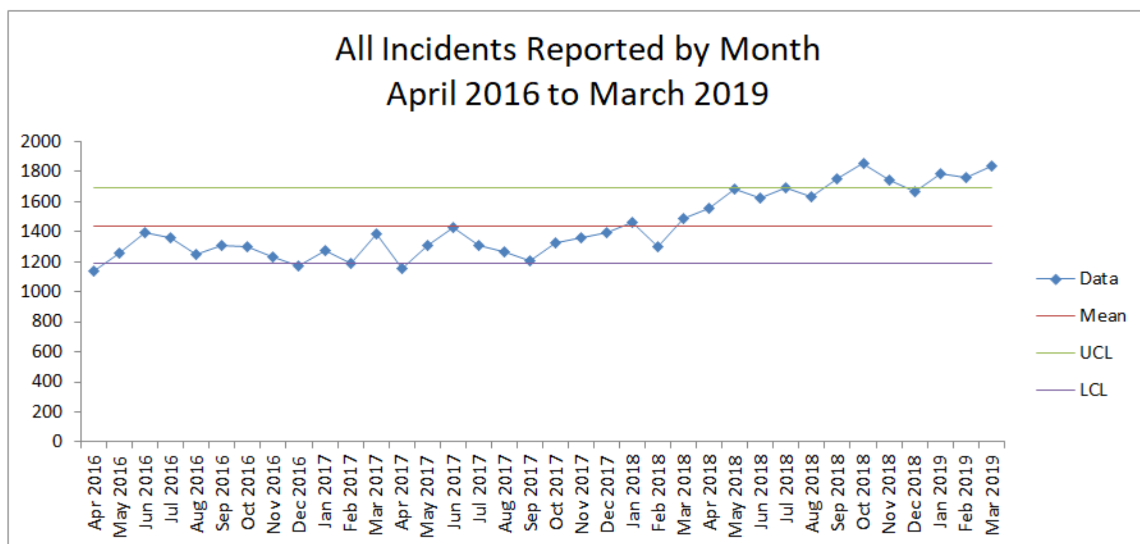
- Moves away from the current individual incident management thresholds and provides a broader scope: as part of a broader systems approach, for responding to patient safety incidents.
- Provides greater transparency and support for those affected: with the setting of expectations for informing, involving and supporting patients, families, carers and staff affected by patient safety incidents.
- Includes a more focused risk-based approach: requiring organisations to develop a local patient safety incident review and investigation strategy to allow for the use of a range of proportionate and effective learning responses to incidents.
- Decisions made regarding incidents for investigation will now be based on the opportunity they provide for systems learning and the ability to implement improvements that address investigation findings.
- Reinforces the purpose of patient safety investigations, insulating it against 'scope creep' and no longer requiring patient safety investigations to judge; avoidability, predictability, liability, fitness to practice or cause of death as part of the investigation remit.
- Provides oversight and assurance to include an emphasis on the role of provider boards and leaders in overseeing individual investigations.
- Terminology change to 'systems-based patient safety investigation', not 'root cause analysis', to reflect the 'systems' approach to safety.

2.0 Incident Analysis

2.1 Trust-wide Incident Reporting Rates

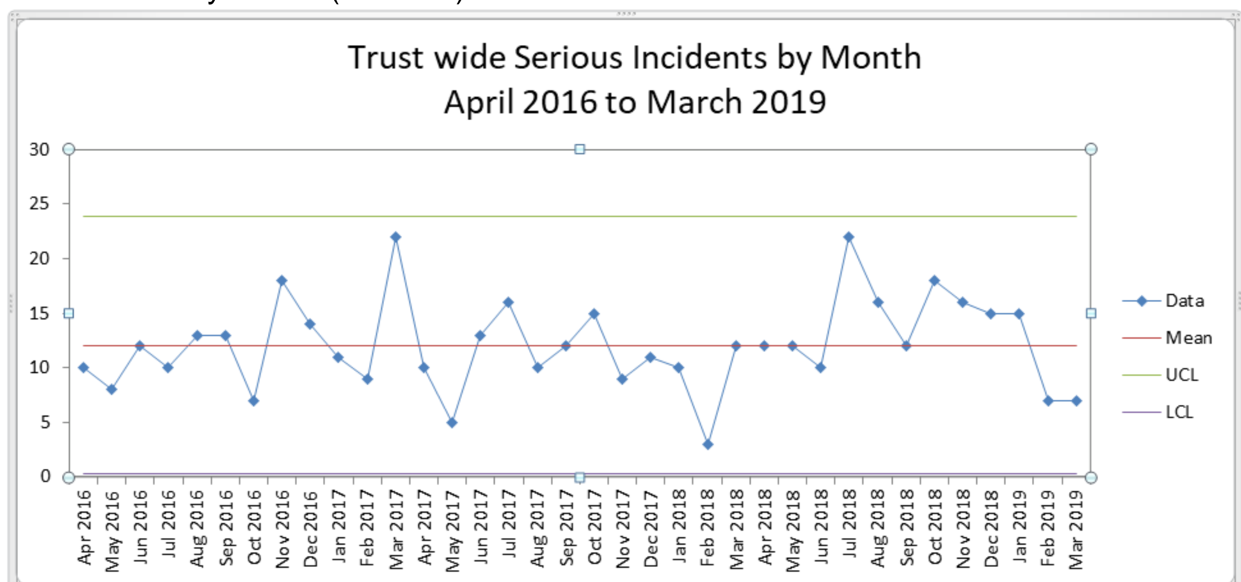
As demonstrated in chart 1 below, the number of incidents reported across the Trust in 2018/19 has seen an upward trend compared to 2017/18. This has been reflected in the numbers of incidents reported externally to NHS England via the National Reporting and Learning System (NRLS). This increase is in direct correlation with the organisational growth of ELFT and an increased reporting culture. Enhanced reporting has been supported by training provided by the Governance & Risk Department alongside local governance facilitators/teams encouraging staff to report incidents. 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.

Chart 1- all incidents (2016/19)



2.2 Trust wide number of Serious Incidents (SIs)

Chart 2- SIs by month (2016/19)



Between April 2018 and March 2019, there have been a total of 179 reported SIs of which 18 were subsequently deescalated/ withdrawn as on further investigation they were found not to meet the SI threshold/criteria. Of the remaining 161 serious incidents, 152 were graded as Corporate Led Reviews (former 1bs) and 9 graded as Panel Led Reviews (former 1as). The previous year there were a total of 119 serious incidents of which 104 were graded as Corporate Led Reviews and 15 Panel Led Reviews. This demonstrates an increase of 26% of SIs investigated by the Trust in 2018/19 compared to 2017/18.

2.3 Trust wide incidents by investigation grade

Chart 3, below, indicates a continued trend of low numbers of Panel Led SI Reviews across the whole Trust per quarter. On average 2.25 Panel Led SI Reviews occur each quarter compared to an average of 4.25 per quarter in 2017/18.

Chart 3- Panel Led SI Reviews (2016/19)

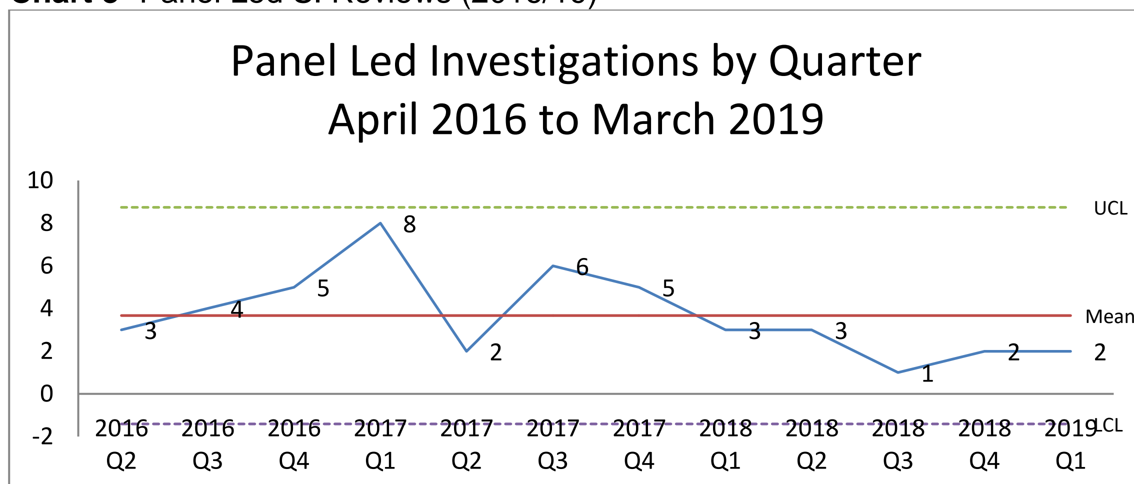
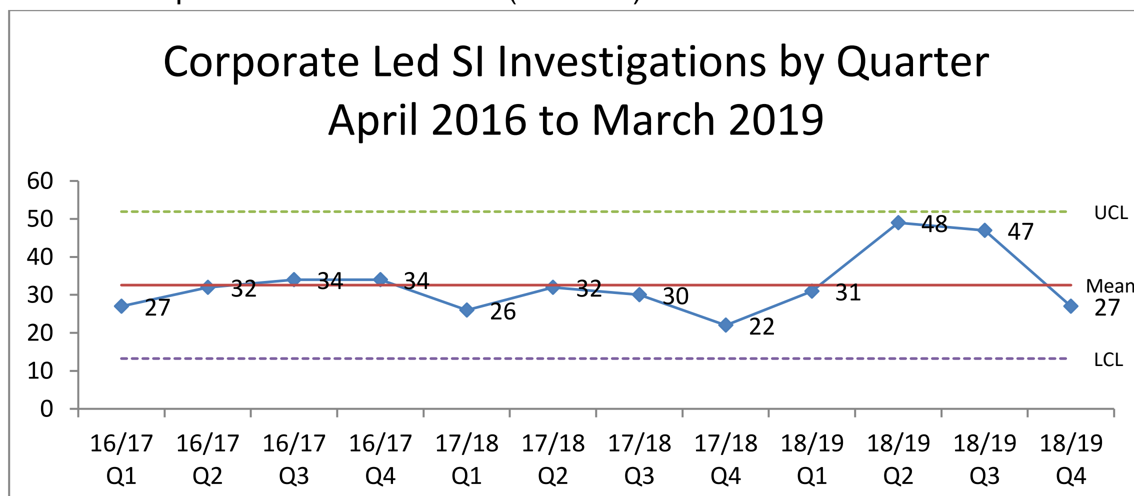


Chart 4 below presents data regarding the number of Corporate Led SI Reviews across the Trust. As can be seen, the mid two quarters of 2018/19 neared the upper control line. On average 38.25 Corporate Led SI Reviews occurred each quarter in 2018/19. This compares to an average of 26 each quarter last year demonstrating an increase of more than 12 per quarter.

Chart 4- Corporate Led SI Reviews (2016/19)



2.4 Serious Incidents by Directorate

Chart 5 below shows the numbers of SIs across the different directorates over the last three financial years (2016/19). Chart 6 shows the numbers of SIs across the directorates for the current reporting period (2018/19).

Chart 5- SIs by directorate (2016/19)

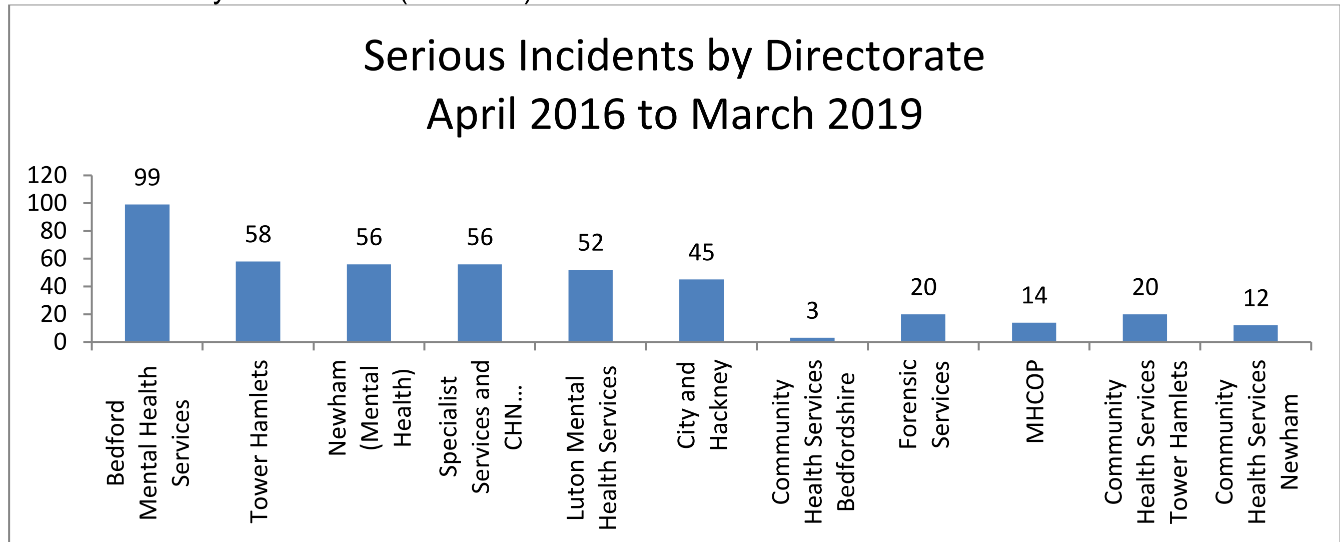


Chart 6- SIs by directorate (2018/19)

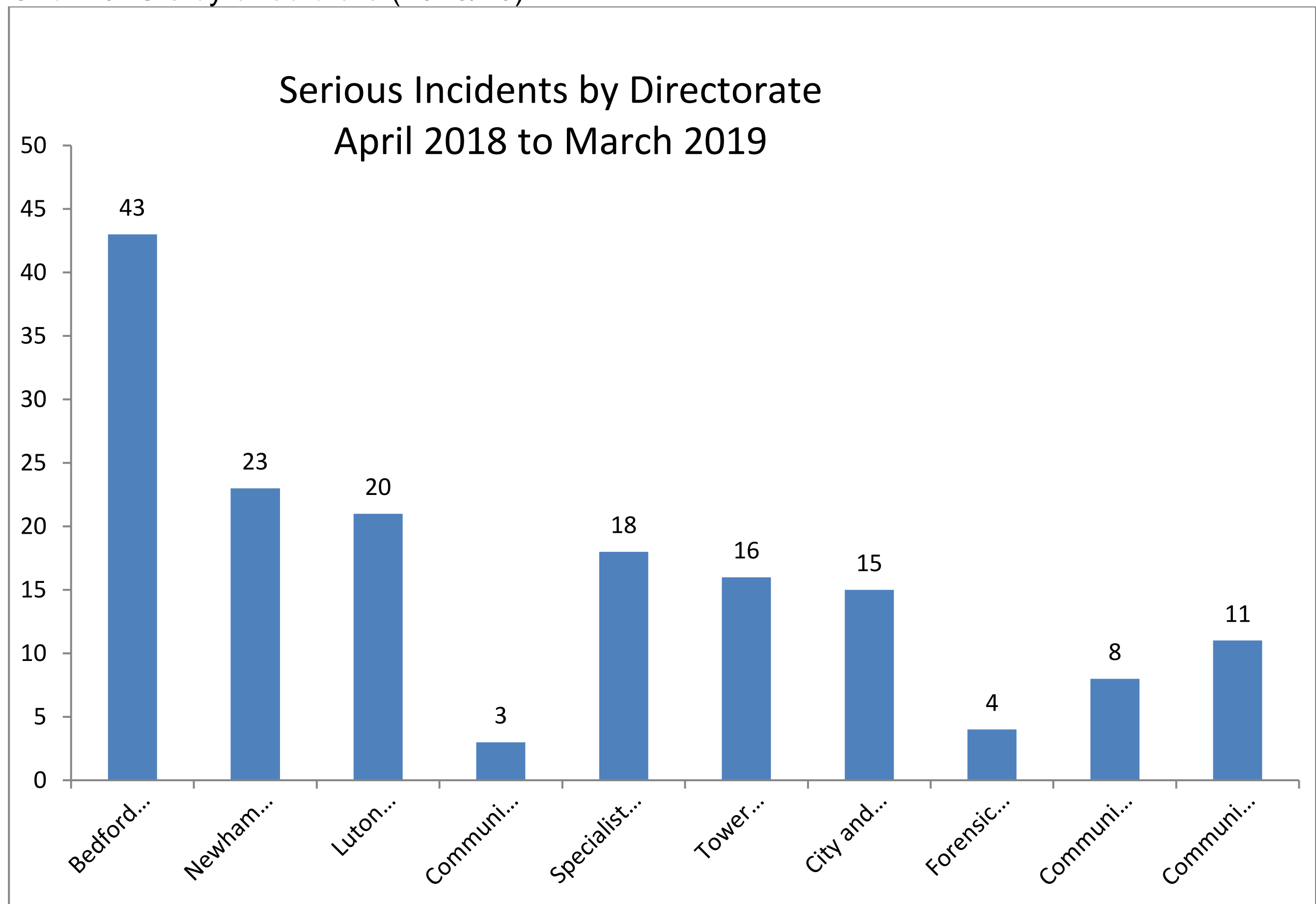


Table 1 below provides population data for the areas in which the directorates of ELFT operate and the numbers of SIs reported by ELFT in these directorates.

Table 1- Incidents per population

Incidents by directorate	SI totals (2018/19)	Population size	Occurrence per 10,000 population
Bedfordshire Mental Health Services (MHS) & Bedfordshire Community Health Services (CHS)	46 (43 MHS + 3 CHS)	437,509	1.05/10,000
City & Hackney MHS	15	323,620	0.46/10,000
Forensic Services	4	N/A	N/A
Luton MHS	20	220,134	0.90/10,000
Newham MHS & Newham CHS	31 (23 MHS + 8 CHS)	411,056	0.75/10,000
Specialist Services & CHN Children's Services	18	N/A	N/A
Tower Hamlets MHS & Tower Hamlets CHS	27 (16 MHS + 11 CHS)	335,573	0.80/10,000

2.5 Serious Incident by Type

Chart 7 below shows the SIs raised by ELFT by type over the last three financial years (2016/19). Chart 8 shows SIs by type for the current reporting period (2018/19).

Chart 7- Incidents by type (2016/19)

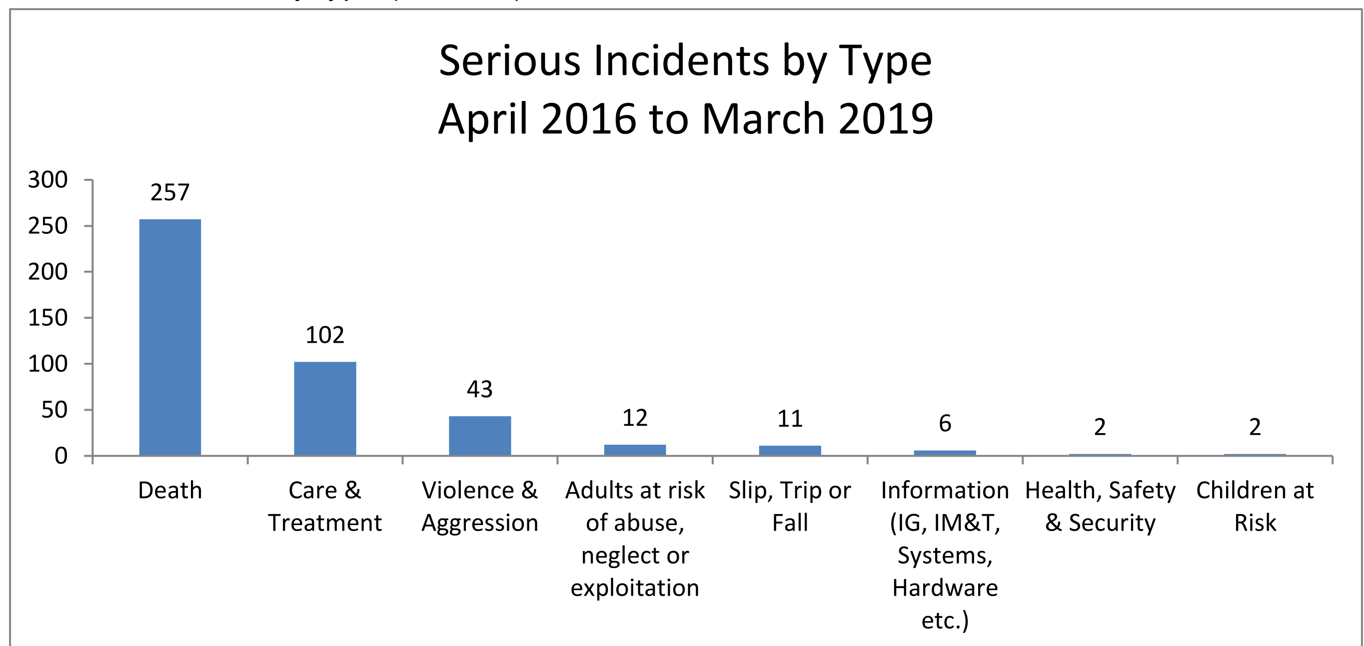
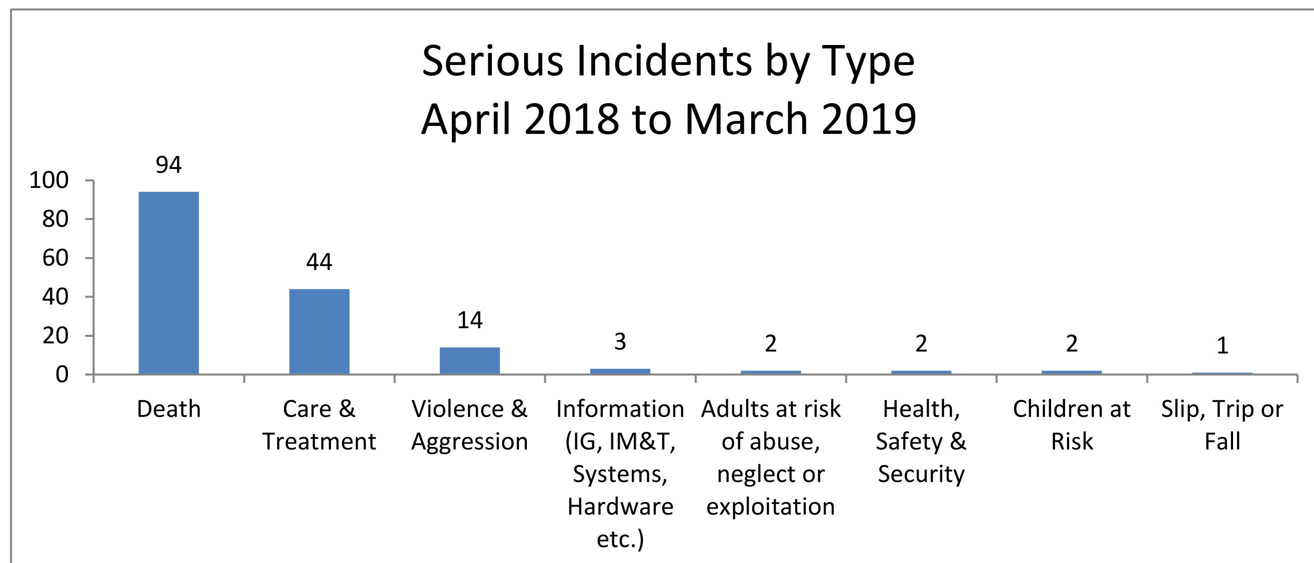


Chart 8 below indicates that the most common types of serious incidents that have occurred across the Trust in the last year (18/19) are Death, making up 58% (94/161) (SIs categorised as death), a slight increase from 55% recorded in the previous reporting period. Care and treatment was the second highest SI category accounting for 44 (34%) of reported SIs. All other categories are comparable with those reported in 2017/18.

Chart 8- Incidents by type (2018/19)



3.0 Action being requested

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