

# Report summary

## Trust board meeting: Part 1 (Public)

November 2020

<b>Report title:</b>	Review of Serious and Patient Safety related incidents reported during September 2020
<b>Executive lead:</b>	Stephanie Bridger, Director of Nursing and Patient Experience
<b>Report author:</b>	Gordon Turner, Associate Director of Clinical Governance
<b>Report discussed previously at:</b>	n/a

### Purpose and action required

For approval	
For discussion	
To note	✓

### Relationship to board assurance framework?

Are any existing risks in the Board Assurance Framework affected?	No
If yes, insert relevant risk reference:	
Do you recommend a new entry to the Board Assurance Framework (i.e. Trust-wide level 1 risk) is made?	No

### Relationship to trust strategic objectives?

Outstanding	We coordinate and collaborate – to deliver holistic care We innovate – to turn research into practice	✓
Improving quality	We invest – in people, estates, technology We listen and learn – from patients, carers, staff, the public	✓
Compassionate care	We work together – and implement the principles of recovery We are recommended – by patients, carers, friends and families	✓

## Summary

The following paper summarises the Serious Incidents (SI) and related patient safety episodes that have been reported during the month of September 2020. The paper also provides a high-level synopsis of the incident investigations commenced in the period, and the themes and the opportunities for learning from completed SI reviews.

The key points to note are:

- 3 SIs were reported – including two deaths
- 19 deaths were reported, with a slight decrease in '*unexpected deaths*'
- There are 30 ongoing SI Reviews
- 1 key incident was reported and reviewed, but not raised as SIs in September
- Service Lines continue to report and investigate incidents using normal protocols

There continues to be a number of directions and guidance being issued by NHSE/I and other bodies in relation to clinical governance processes and expectations during the current Covid-19 pandemic. The Trust has noted and complied with these.

The use of the Datix incident reporting system is being expanded across the Trust.

The Board is requested to review the attached paper and note the findings

## Supporting documents and/or further reading

Improving quality and safety in healthcare: learning from incidents. NHS Improvement.  
<https://improvement.nhs.uk/resources/improving-quality-and-safety-healthcare-learning-from-incident/>

Draft Health Service Safety Investigations Bill, September 2017.  
<https://www.gov.uk/government/publications/health-service-safety-investigations-bill>

Serious Incident Framework. Supporting learning to prevent recurrence. NHS England. 2015.  
<https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

## 1. Purpose

- 1.1 To provide the Trust Board with an overview of the Serious Incidents (SI) that have been reported during the month of September 2020.
- 1.2 To provide the Trust Board with a high-level synopsis of the incidents.

## 2. Recommendations

- 2.1 The board is asked to:
  - Review the paper
  - Discuss some of the highlighted incidents.

## 3. Introduction

- 3.1 The following paper summarises the Serious Incidents (SI) that have been reported during September 2020. This paper also provides a high-level synopsis of some key incidents and the opportunities for early learning that have occurred in October 2020, but are under review as part of normal Trust governance processes.
- 3.2 There continues to be directions and guidance issued by NHSE/I and other bodies, in relation to clinical governance processes and expectations during the current Covid-19 pandemic. The Trust has noted and complied with these.

## 4. Serious Incidents

- 4.1 Three SIs were reported to the Strategic Executive Incident System (STEIS) database during September 2020, and investigation reports have been commissioned. Table 1 and Table 2 summarise the SIs that have been reported.
- 4.2 Five Local Team Reviews (LTR) were commissioned during the month.

	Level 1	Level 2	LTR
AMHS	1	1	-
PMS	-	1	-
WLFS			5
<b>Total</b>	<b>1</b>	<b>2</b>	<b>5</b>

**Table 1.** Summary of incidents reported on STEIS during September 2020. (AMHS = Acute Mental Health Services, PMS = Psychological Medicine Services, WLFS = West London Forensic Services)

- 4.3 The three SIs reported during the period are shown below.

No.	Category	Summary	Service / Team
1	Level 1	A number of staff assaulted by patient, on ward	AMHS
2	Level 2	Apparent death by suicide	PMS
3	Level 2	Patient death on ward, due to respiratory arrest.	AMHS

**Table 2.** Summary of SIs reported during September 2020.

- 4.4 There were 30 SI Reviews underway at the end of August 2020; with 18 having exceeded the 60 day target, due to delays resulting from operational changes during the Covid-19 pandemic.
- 4.5 There was also 1 key incident which was reported and reviewed to extract early learning. The details are shown below.

	Date of Incident	Service	Summary	Notes
1	20/09/20	HSS (Broadmoor)	Staff working on ward at Broadmoor Hospital prevented a serious patient safety incident occurring. The patient safety incident was prevented by our staff being diligent in the performance of the patient and patient's property search procedures during room search (S16b). The staff found a quantity of tablets in patients clothing.	Patient Safety Alert Raised and Circulated

**Table 3.** Key Incidents currently under review. HSS = High Secure Services

## 5. Mortality

- 5.1 There has been a slight decrease in the number of 'Unexpected Deaths' reported during the period, when compared to the previous month. Further analysis is underway to provide further detail and ensure data validity and reliability.
- 5.2 Further detail is shown below. The data includes 'Unexpected Deaths' from ICS for the first time, following the successful integration of the new Mortality Datix (incident reporting system) module.

Deaths	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
'Expected'	1	4	3	5	10	6	10	5	1	1	2	3
'Unexpected'	3	6	4	8	6	8	32	11	10	5	12	7
Self-Inflicted (Apparent)	-	1	2	1	1	-	4	-	2	2	2	-
Unknown	5	7	6	5	4	6	4	3	6	3	7	9
<b>Total</b>	<b>9</b>	<b>18</b>	<b>15</b>	<b>19</b>	<b>21</b>	<b>20</b>	<b>50</b>	<b>19</b>	<b>19</b>	<b>11</b>	<b>23</b>	<b>19</b>

**Table 4.** Reported Deaths. Includes ICS 'Unexpected Deaths' data from April 2020.

- 5.3 The weekly Mortality Review Group continues to review all deaths reported across the Trust. LeDeR reporting continues as normal. Covid-19 related deaths are reported via Datix and IR1 using the NHSE/I COVID-19 Deceased Notification Form.

## 6. Conclusion

- 7.1 This paper summarised the SIs that were reported during Septmebr 2020, and provided a high-level synopsis of the incidents, the themes and the opportunities for learning.

7.2 The measures the Trust is taking relating to clinical governance and patient safety during the Covid-19 pandemic have been outlined.

## **10. Recommendation(s)**

10.1 The Board is requested to review the attached paper and discuss the content.

**Gordon Turner**  
**Associate Director of Clinical Governance**  
**6<sup>th</sup> November 2020**