West London NHS Trust

Report summary

Trust board meeting: Part 1 (Public)

December 2020

Report title:	Review of Serious and Patient Safety related incidents reported during October 2020
Executive lead:	Stephanie Bridger, Director of Nursing and Patient Experience
Report author:	Gordon Turner, Associate Director of Clinical Governance
Report discussed previously at:	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 October 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, as well as any inquests that have been held.

The key points to note are:

- 6 SIs were reported – including one death and one severe physical assault
- 23 deaths were reported, with one reported as '*apparently self-inflicted'*
- There are 28 ongoing SI Reviews
- 3 key incidents were reported and reviewed, but not yet raised as SIs in October
- 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-incidents/

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-incidnt-framwrk-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 October 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 October 2020. This paper also provides a high-level synopsis of some key incidents and the opportunities for early learning that have occurred in November 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 Six SIs were reported to the Strategic Executive Incident System (STEIS) database during October 2020, and investigation reports have been commissioned. Table 1 and Table 2 summarise the SIs that have been reported.

4.2 Nine Local Team Reviews (LTR) were commissioned.

	Level 1	Level 2	LTR
AMHS	2	1	-
CID	-	-	1
CRMHS	-	3	2
PMS	-	-	1
WLFS	-	-	5
Total	**2**	**4**	**9**

Table 1. Summary of incidents reported on STEIS during October 2020. (AMHS = Acute Mental Health Services, CID = Older Peoples Services, CRMHS = Community & Recovery Mental Health Services, PMS = Psychological Medicine Services, WLFS = West London Forensic Services)

4.3 The six SIs reported during the period are shown in Table 2 below, and the trend in Sis being raised is shown in Figure 1.

No.	Category	Summary	Service / Team
1	Level 1	Alleged Abuse to Patient whilst on ward	AMHS
2	Level 1	Physical Injury to Patient (# arm) whilst on ward	AMHS
3	Level 1	Patient alleged that they were physically assaulted by staff	CRMHS
4	Level 2	Patient allegedly stabbed his father in the chest	CRMHS
5	Level 2	Patient fell from window of the building he lives in.	CRMHS
6	Level 2	Apparent death by suicide	CRMHS

Table 2. Summary of SIs reported during October 2020.

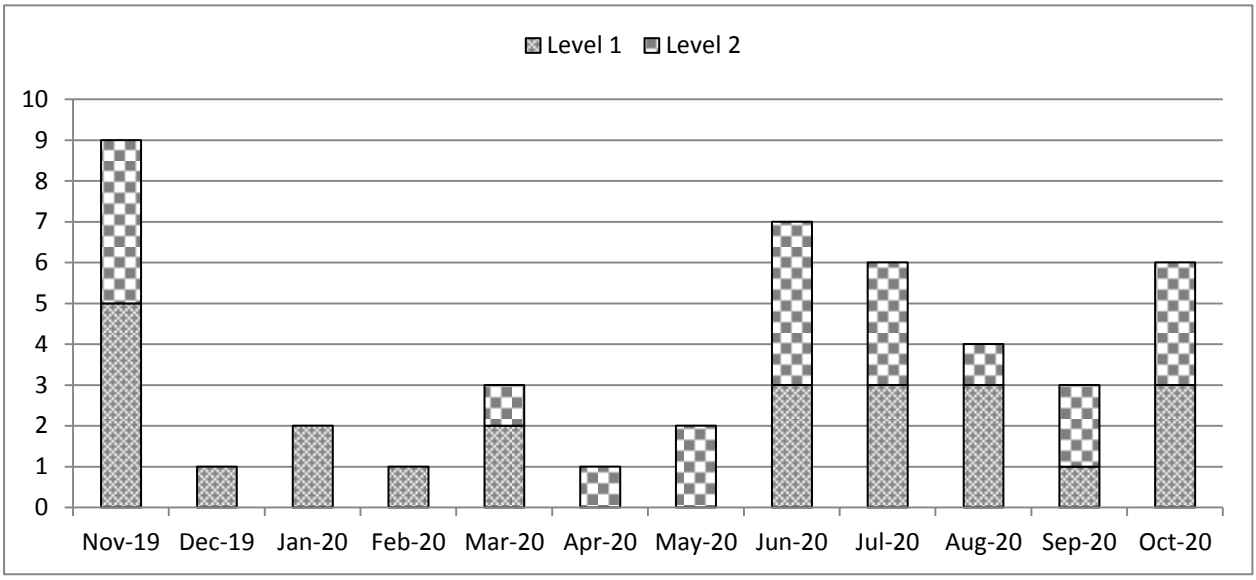

Figure 1. Trend in SI Reviews commissioned. November 2019 to October 2020 inclusive.

4.4 There were 28 SI Reviews underway at the end of October 2020; with 17 having exceeded the Trust's 60 day turnaround target, due to delays resulting from operational changes during the Covid-19 pandemic. Details are shown in Appendix 1.

4.5 There were also 3 key incidents which was reported and reviewed to extract early learning. The details are shown below.

	Date of Incident	Service	Summary	Notes
1	07/10/20	Ealing Recovery Team East	Assault Physical to Others. Use of weapon (edged/blunt/firearm).	Entered on STEIS. Early learning shared amongst team and service
2	09/10/20	Single Point of Access	(IR1 – 225570) – Suspected Death by Suicide	Entered on STEIS. Early learning shared amongst team and service
3	09/11/20	Ealing Recovery Team West	(IR1 - 226764). *Death: Apparent Self-Inflicted*.	Awaiting further detail.

Table 4. Key Incidents currently under review.

5. Mortality

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

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.

6. Inquests

6.1 There was one key inquest heard in October 2020 which is detailed below.

STEiS Ref	Level	Service	Headline
2018-28813	2	Hope Ward	MD inquest. 5th-8th October 2020. Jury inquest at West London Coroners Court. The coroner was satisfied that progress has been made in areas of patient's safety. So there will be not direction for the rider of neglect or PFD.

7. Conclusion

7.1 This paper summarised the SIs that were reported during October 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
27th November 2020