NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
29 JUNE 2017

Title	Serious Incidents Annual Report 2016/17
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Purpose of the Report:

To provide an analysis of serious incidents occurring in East London NHS Foundation Trust between April 2016 to April 2017

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 2016/17 to address the major themes emerging from serious incidents in the previous annual review.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☒	The focus of this paper is to provide data by which learning and improvement can be based.
Improving staff satisfaction	☐	
Maintaining financial viability	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	This report has not been considered by any other Trust Committees

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	The focus of the process for managing serious incidents is learning and improvement, which will positively impact the service user, carer and staff experiences.
Financial	There are no financial implications directly associated with the report.
Quality	The themes arising from serious incidents and the work being done to address these themes, set out in the report, have clear quality implications. Serious incidents are drivers for quality improvement work.

Supporting Documents and Research material

None

Glossary

Abbreviation	In full
None	

1.0. Introduction

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 NPSA 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 or catastrophic under the standard rating scales agreed by the Trust.

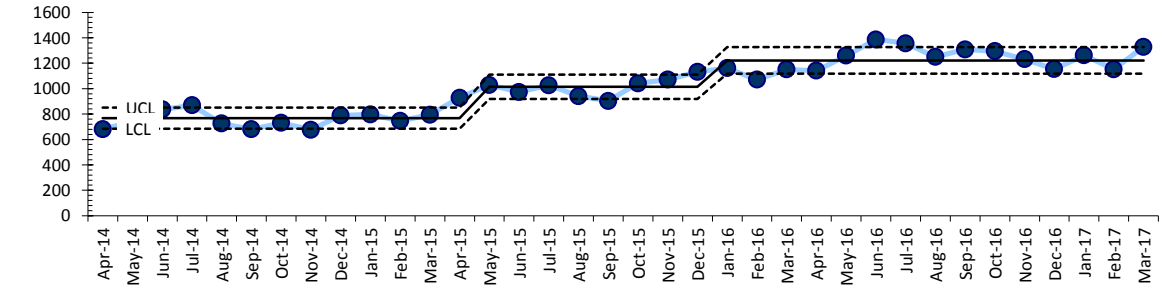
The objective of this paper is to provide a clear overview of serious incidents across the Trust, identifying areas for improvement and supporting action against these by outlining specific focus areas or areas of concern through data analysis. This paper has been developed through a process of analysis 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.

2.0. Incident analysis

2.1. Trust wide incident rates

The number of incidents reported across the trust has remained within normal variation since the last annual report (Chart 2.1a)

All Reported Incidents by Month
Chart 2.1a – April 2014 to March 2017



Work to develop a healthy reporting culture continues across the Trust and can be considered to continue to impact the number of incidents reported. This work includes the development of more transparent data reporting systems, such as the organisation Quality and Safety dashboards and the spread of quality improvement work across the Trust.

2.2. Trust wide numbers of Serious Incidents (1a and 1b combined)

The number of Trust-wide Serious Incidents (SIs) continues to remain within expected limits of variation (Chart 2.2a). This is the same in London services (chart 2.2b).

Trust wide Serious Incidents by Month
Chart 2.2a – Trust-wide April 2014 to March 2017

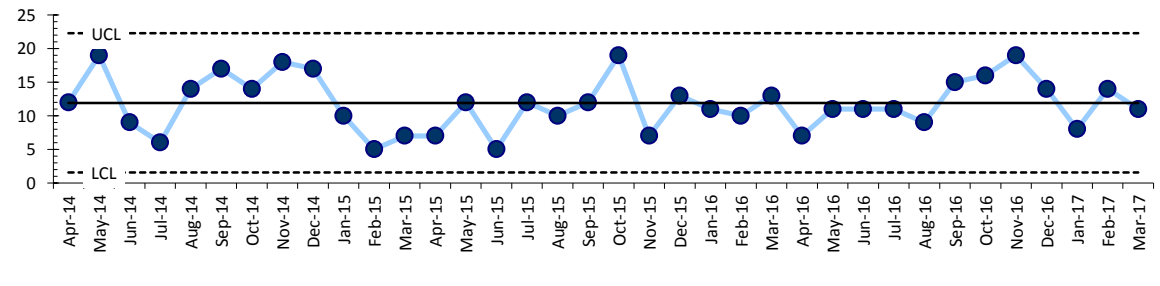
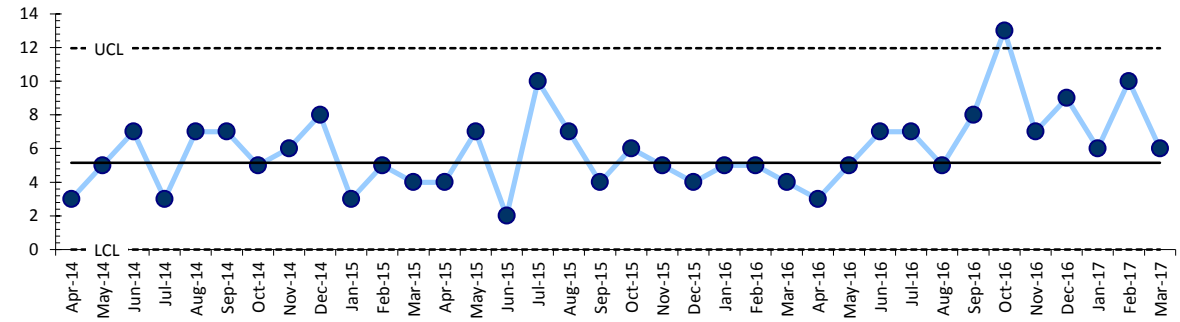


Chart 2.2b – London April 2014 to March 2017



Between April 2016 and March 2017, there have been 118 incidents graded as 1B and 16 graded as 1A.

2.3. Trust wide incidents by investigation grade

Chart 2.3a presented below indicates a continued trend of low numbers of 1a incidents across the whole trust per quarter. On average 3.3 1A SIs occur each quarter.

Trust wide Level 1a Incidents by Quarter
Chart 2.3a – April 2014 to March 2017

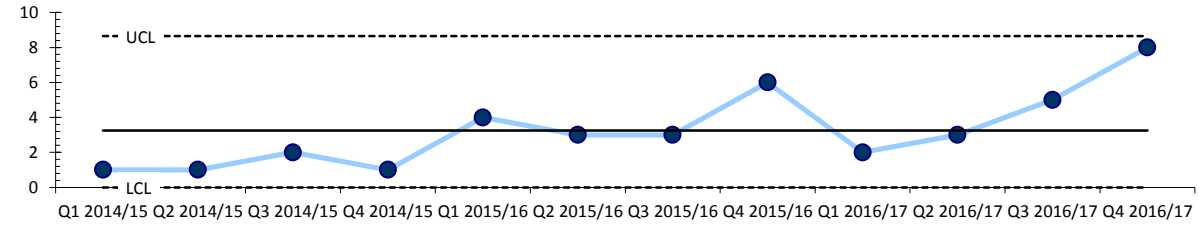
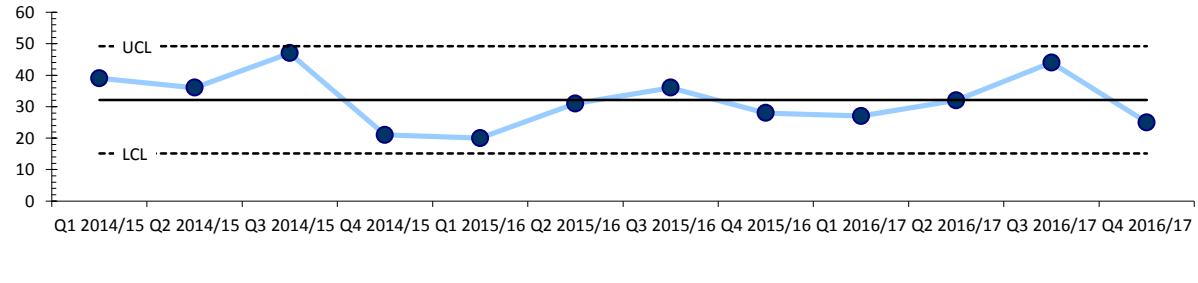


Chart 2.3b below presents data regarding number of level 1b SI's across the Trust. As can be seen, there are no indications of special cause variation over this period of time. On average 44 1B SIs occur each quarter.

Trust wide Level 1b Incidents by Quarter
Chart 2.3b – April 2014 to March 2017



2.4. Incidents by directorate

The Pareto chart below (Chart 2.4a) indicates that serious incidents occurring since April 2016 are most commonly situated within Specialist and CHN Children's Services.

Pareto of Serious Incidents by Directorate

Chart 2.4a April 2016 – March 2017

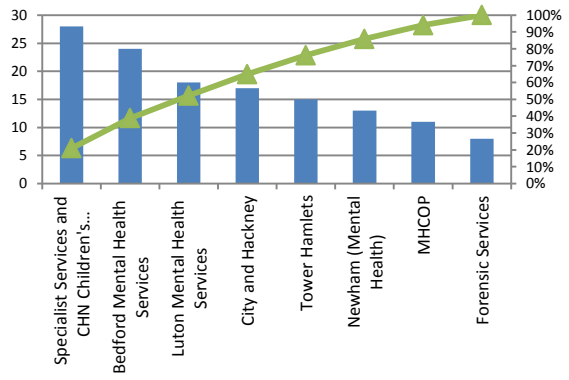
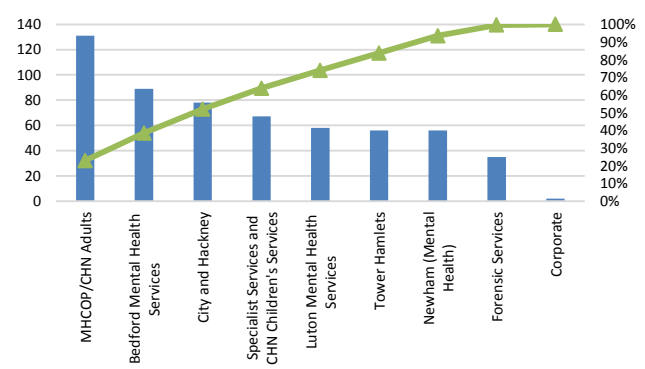


Chart 2.4b April 2014 – March 2017



This shows an increase in the proportion of serious incidents occurring in Specialist/CHN Children services during 2016/17 in comparison to accumulated 2014-17 figures (2.4b). As mentioned in the SI mid-year review, the work to reduce pressure ulcers has particularly impacted on the number of incidents occurring in MHCOP.

The highest numbers of incidents during 2016/17 have occurred in Specialist and CHN Children Services. When breaking these down (chart 2.4c-2.4f), the data shows that all areas of Specialist and CHN Children services have seen an increase in activity over the past year. Each chart shows frequent special cause variation with data points often above upper control limit.

Number of Serious Incidents in Specialist Services/CHN Children Services

Chart 2.4c – All services; April 2014 – March 2017

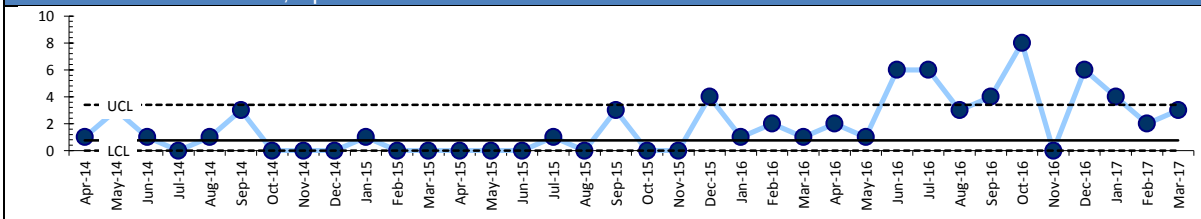


Chart 2.4d – Children's services; April 2014 – March 2017

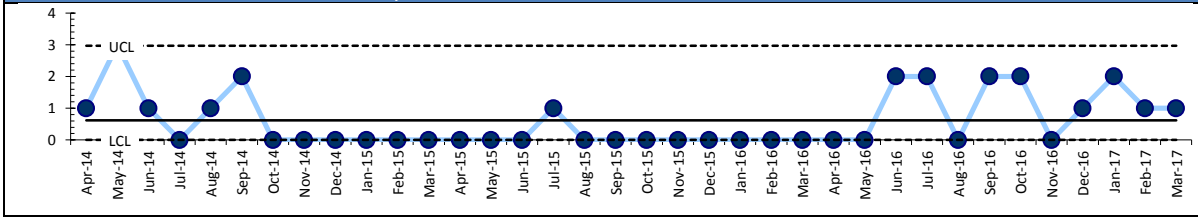


Chart 2.4e – Addictions services; April 2014 – March 2017

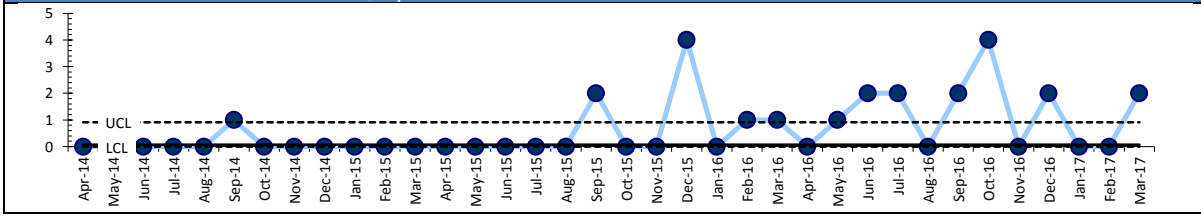
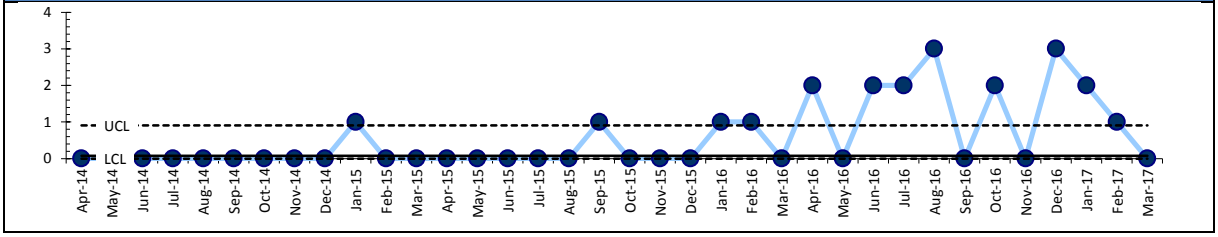


Chart 2.4f – IAPT services; April 2014 – March 2017



Learning in relation to the serious incidents in Specialist Services has led to a number of initiatives and changes in practice to take place over the next few months including:

- **Children's services**
  - Sharing of case studies through lessons learned seminars across the services
  - Exploration of support options for administrative staff to improve record keeping
  - Review and ratification of policies e.g. CCNT operations policy
  - New methods of referral communications explored with external partners
- **Addictions services**
  - Audits conducted in conjunction with service-users to better understand pathway effectiveness
  - Exploration of systems to support flagging of missed contact/care
- **IAPT services**
  - The development of joint protocols between ELFT services to support transfer and handover
  - Training provided for staff e.g. Datix completion, record keeping policies
  - Localised audits conducted to ensure activities such as supervisions were undertaken as planned and effective

Bedfordshire and Luton remain high on the list both in 2016/17 and in the accumulated 2014-17 figures. Special cause variation is shown in November in both directorates, with the data point above or close to the upper control limit (charts 2.4g and 2.4h).

Luton & Bedfordshire

Chart 2.4g – Bedfordshire April 2015 – March 2017

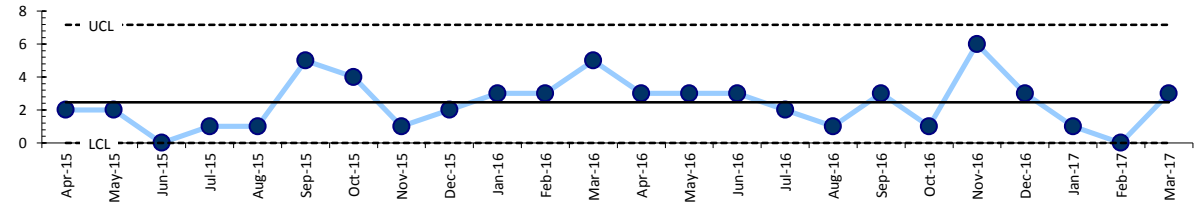
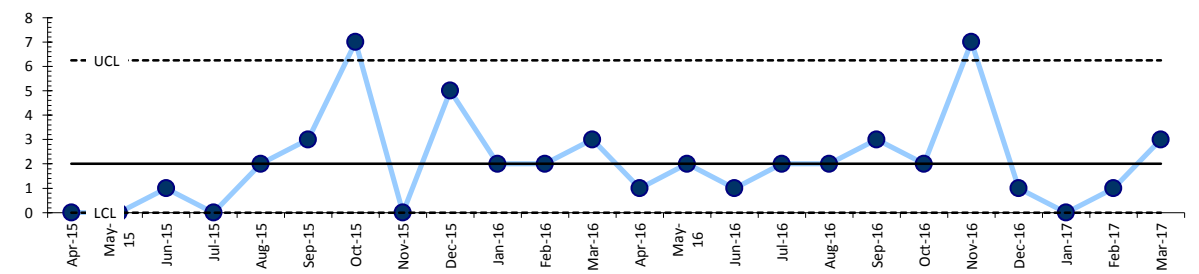


Chart 2.4h – Luton April 2015 – March 2017



The incidents during this month are predominantly deaths in the community (79%) and it is therefore unlikely this special cause variation is due to changes or anomalies within ELFT systems due to the nature of these incidents.

2.5. Incidents by type

Chart 2.5a overleaf indicates that the most common types of serious incidents that have occurred across the Trust since April are Death, making up 64%, this has risen from 51% in the accumulated 2014/2017 figures. This increase may be impacted by a an improved focus on identifying and investigating unexpected deaths following the review of care experienced at Southern Health NHS Foundation Trust, bringing about a healthier reporting culture and improved information sharing between health care services in contact with patients experiencing mental health difficulties.

Pareto of Serious Incidents by Type

Chart 2.5a April 2016 – March 2017

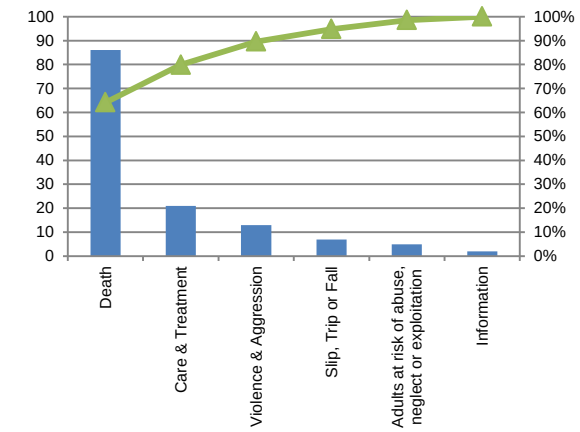
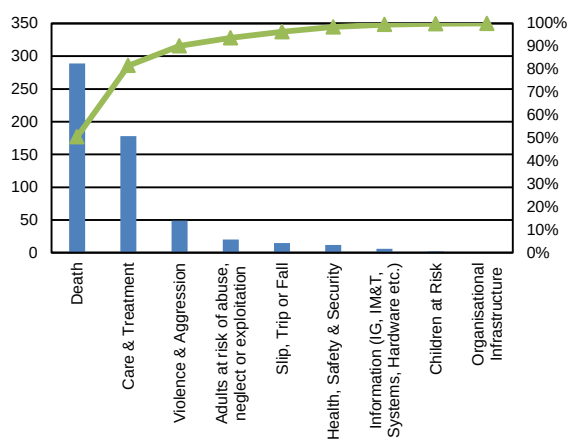


Chart 2.5b April 2014 – March 2017

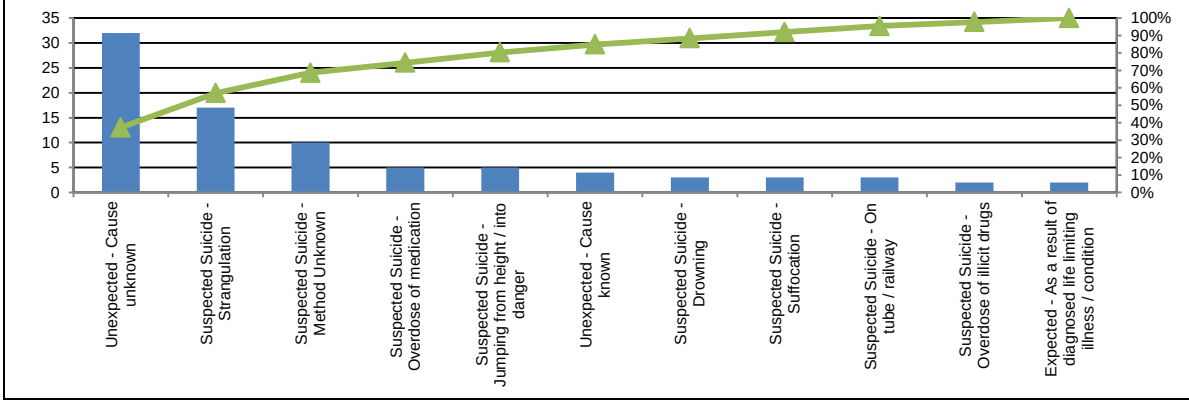


These figures correlate again to the accumulated 2014-17 figures (chart 2.5b) with the exception of care and treatment serious incidents. This reduction in care and treatment SIs can again be explained by the QI work around pressure ulcers, as this is the most common form of care and treatment SI.

Charts 2.5c below shows which subcategories the death incidents are in.

Breakdown of Death Incidents

Chart 2.5c Death Incidents April 2016 – March 2017



3.0. Learning from serious incidents

3.1. Analysis of incident types

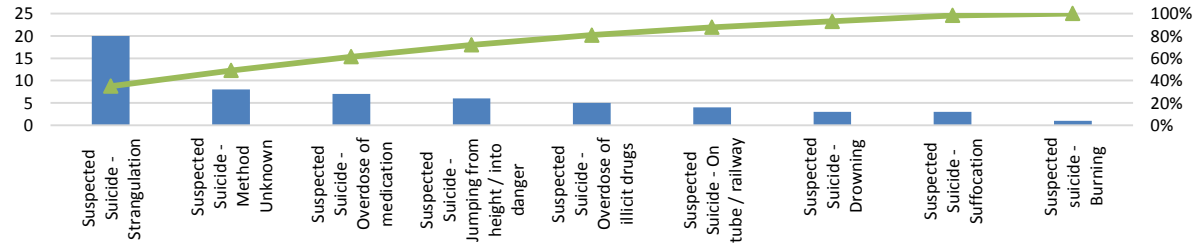
3.1.1. Focus on suicide in the community

Table 2.3a – Breakdown of Cause of Death	
Cause of death	**Number of incidents**
Suspected Suicide - Drowning	3
Suspected Suicide - Jumping from height / into danger	6
Suspected Suicide - Method Unknown	8
Suspected Suicide - On tube / railway	4
Suspected Suicide - Overdose of illicit drugs	5
Suspected Suicide - Overdose of medication	7
Suspected Suicide - Strangulation	20
Suspected Suicide - Suffocation	3
Suspected Suicide - Burning	1
Unexpected - Cause known	10
Unexpected - Cause unknown	9

Of the 86 unexpected deaths in the Trust, 76 were situated in community services. 57 of these incidents have been identified as suspected suicide (table 2.3a). The majority of these suicides occurred within Specialist and Children's Services (33%) and the most common form of suicide is by strangulation (35%) – please see charts 2.3b and 2.3b overleaf for a full breakdown.

Chart 2.3b – Community suspected suicides by Directorate April 2016-March 2017

Chart 2.3c – Community suspected suicides by method April 2016-March 2017



9 reports had not been finally completed and 10 reports found no significant service or care delivery issues. The most common identified care and service delivery problems were a lack of documentation completeness (17 instances), lack of information sharing with external healthcare providers (16), missing documentation (10), lack of adherence to policy (8) and lack of documentation/follow up of MDT and other clinical meetings (6).

3.1.2 Suicides in Addictions services

Chart 2.3d – Breakdown of Addictions suicides care and service delivery problems	
Care and Service delivery problem sub-themes	**Number identified**
Documentation lacked completeness	3
Lack of adherence to policy/procedure	2
Lack of appropriate care	2
Lack of information sharing with external HCP	2
Documentation lacked accuracy	1
Final report not completed	1
Lack of communication/information sharing with ELFT	1
Lack of documentation/follow up of MDT meetings	1
Lack of information sharing with family/caregiver/friend	1
No problems identified	1

Of the 57 incidents of suicides in community services, 6 occurred within specialist addictions services. The main care and service delivery issues identified within these incidents remains in line with suicides across community services: lack of documentation completeness, lack of adherence to policy/procedure, lack of appropriate care and lack of information sharing with external HCP. Contributory factors identified include: inconsistency in policy implementation during policy updates/renewal, multiple versions of forms on the system, leading to the completion of out of date referral forms for example and confusion as to who takes ownership for specific tasks.

3.1.3 Focus on falls

During 2016/17, there were 494 falls incidents within the Trust, 9 of which were patient related and classed as serious incidents. 7 of these incidents were related to frailty/clinical condition of the service user and 2 were related to a hazard or health and safety risk. 4 service users died as a result of their fall; each of these deaths were related to subdural haematomas following falls, each of these were due to clinical condition/frailty. The falls relating to three of these incidents were experienced while the service-user was in the care of ELFT staff, the third was experienced, according to details recorded on the Datix system, at home and reported and managed by Luton & Dunstable Hospital.

- Fall on Fountain's Court
  The service and care delivery problems that were considered to lead to the fall included two rounds of eye observations carried out against policy due to shortages of staff on the ward, a lack of completeness and accuracy within both MDT notes and food and fluid charts, the provision of the wrong patient's medication to the service-user and a lack of identification of deterioration.

  Staff shortages, a lack of understanding regarding the deterioration of the service user and a lack of knowledge regarding involvement during attendance at A&E were all considered contributory factors to the service and care delivery problems.

- Fall on Townsend Court
  Following an unwitnessed fall on Townsend Court, it was found that the Inpatient Slips, Trips and Falls policy was not adhered to, as neurological observations were conducted 6 hours after the fall. The Falls Risk Assessment and Multi-Factorial Risk Assessment both contained a number of errors, omissions and instances of inaccuracy.

  While it was not possible for investigators to determine why the neurological observations were not taken in line with ELFT policy, handwriting notes and the existence of two risk assessment forms are considered contributory factors to the care delivery problems.

- Fall at Royal London Hospital
  Following an unwitnessed fall at Royal London Hospital, it was found that clinical notes regarding observations and medication were not maintained to the level expected within the Trust. While the report outlines many issues, the contributory factors for these care and service delivery problems are not clear, however training regarding record keeping was recommended.

3.2. Thematic analysis of all serious incidents 2016/17

To develop a clearer understanding of where improvement work may wish to be focused, thematic analysis of all serious incident reports from 2016/17 was conducted. Care and service delivery problems were focused upon and grouped into themes and subthemes to support organisational learning.

Of the 138 serious incidents reported, 38 reports were not yet complete to analyse and 18 reports highlighted that investigations found no service or care delivery problems.

82 serious incidents were therefore analysed and 250 identifiable individual service and care delivery problems were identified. Each serious incident therefore has on average, 3 service or care delivery problems related to it.

Breakdown of service and care delivery problems

Chart 2.1.a – Service and care delivery problems by directorate

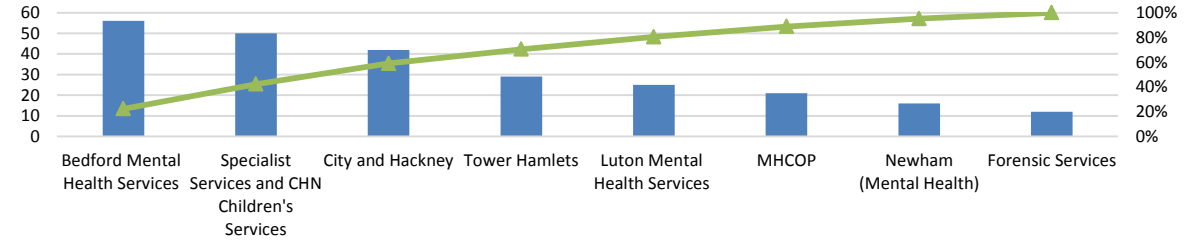
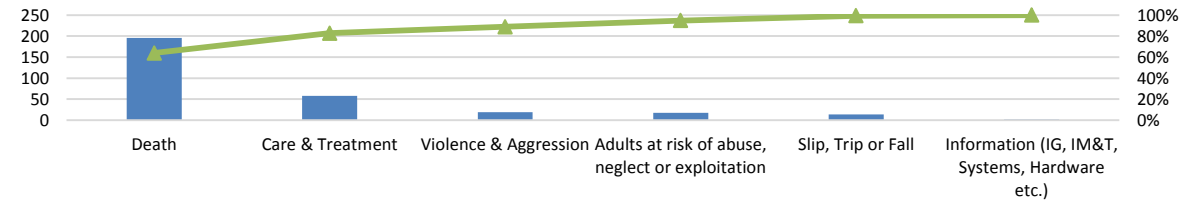


Chart 2.1b - Service and care delivery problems averaged

Directorate	Number of Service/Care Delivery Problems per serious incident
City and Hackney	2.5
Bedford Mental Health Services	2.2
Tower Hamlets	1.9
Specialist Services and CHN Children's Services	1.9
MHCOP	1.8
Forensic Services	1.5
Luton Mental Health Services	1.4
Newham (Mental Health)	1.1

Chart 2.1c – Service and care delivery problems by category

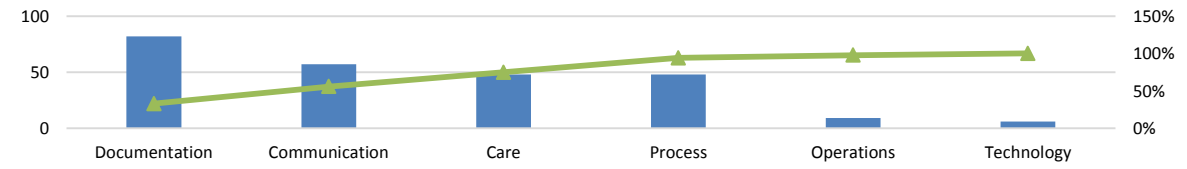


Bedfordshire witnessed the highest number of individual care and service delivery problems with 22% identified here, however City and Hackney experience a higher number of service and delivery problems per incident, with each serious incident review identifying an average of 2.5. problems.

Each of the service and care delivery problems fit into one of the following themes: documentation, communication, care, process, operations and technology. Documentation is the most common theme, with 33% of problems identified sitting under this theme.

Breakdown of service and care delivery problems

Chart 2.1d – Service and care delivery problems by theme



The six wider themes are underpinned by 24 sub-themes.

Themes & Subthemes
Care
Delay in care
Inappropriate assessment/diagnosis/discharge
Lack of appropriate assessment/diagnosis/discharge
Lack of appropriate care

Lack of appropriate care plan
Communication
Lack of communication/information sharing within/across ELFT
Lack of contact with patient
Lack of information sharing with external HCP
Lack of information sharing with family/caregiver/friend
Documentation
Delay uploading documentation
Documentation lacked accuracy/clarity
Documentation lacked completeness
Documentation lacked detail
Documentation missing/not uploaded
Lack of documentation/follow up of MDT meetings
Operations
Lack of material resources
Staff shortage/under resourcing
Process
Lack of adherence to policy/procedure
Lack of clear policy/procedure
Lack of knowledge/training (staff)
Lack of sufficient knowledge management
Security issues
Technology
Flagging system not in place/not working
No access to electronic records

3.3. Most common sub-themes

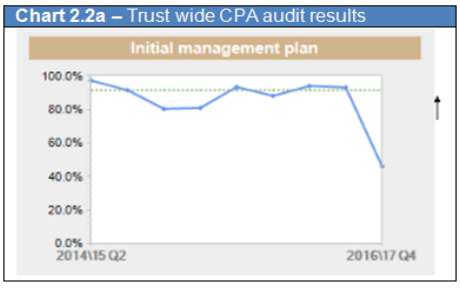
These sub-themes have been analysed and a deeper dive carried out into the top five sub-themes, and are looked at in more detail below.

- *Adherence to policy*

30% of those service and care delivery problems that related to a lack of adherence to policy occurred within Bedfordshire. This may reflect the continued improvement required in merging old systems and processes in Bedfordshire with those in London services. Lack of adherence to policy care problems often related to the carrying out of observations and the reporting of concerns or incidents, particularly of a safeguarding variety.

- *Completeness of documentation*

27% of all service and care delivery problems that related to a lack of documentation completeness occurred within Specialist and CHN services. Documents specifically mentioned within the reports include care plans, progress notes, and risk



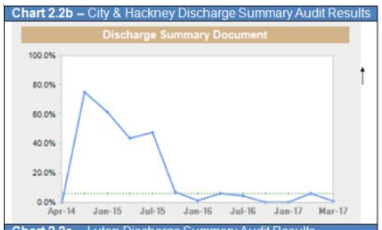
assessments therefore cannot be specifically attributed to any particular form or process. Contributory factors related to lack of documentation completeness include confusion regarding which forms to use, lack of knowledge on the part of staff and completion of documentation by new/agency staff.

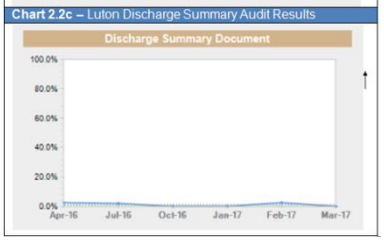
Lack of documentation completeness is clear when considering the CPA audit conducted Trust wide, with no sections of the CPA meeting 100% completion, with significant drops in compliance across each standard in January 2017 – this drop may be related to the testing of a new CPA process within a selection of services across the Trust.

A lack of specific carer views (13.3% compliance in January) and concerns expressed by the family or carers (32% compliance in January) is also a concern as a lack of communication with family/carers made up 4% of all service and care delivery problems.

- *Documentation not present*

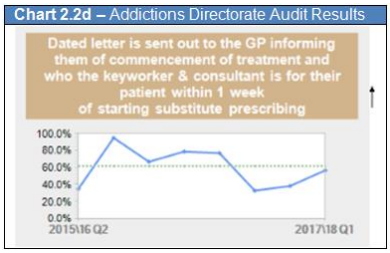
Both City and Hackney and Luton services experienced 21% each of the missing documentation care and service delivery problems. Documentation most commonly missing include risk assessment documentation and documentation regarding capacity assessment. Contributory factors related to this include time pressures for staff, procedures of uploading relying on the presence of individual members of staff and a lack of confidence using systems.





Missing documentation has been identified as a significant issue across the Trust through the record keeping audit, with the presence of discharge summary sheets remaining at a low compliance of 20% throughout 2016/17.There have also been various instances of special cause variation during 2016/17 with points below the lower control limit. This average is even lower in City & Hackney (6%) and Luton (1%) (charts 2.2b and 2.2c).

- *Communication with other healthcare professionals and agencies*



The majority of service and care delivery problems were witnessed in City and Hackney and CHN Specialist and Children's services. 96% of these service and care delivery problems were related to deaths, indicating a high level of harm related to instances where communications with other healthcare professionals, particularly GPs, do not occur or are delayed. These care and service delivery problem were most often related to referral and discharge information, frequently leading to a lack of appropriate and timely care between services. Addictions services audit results show a low average compliance (62%) with communications with GPs with a number of data points across 2016/17 falling below this average.

Referral information recorded on the CPA has shown an average of 62% compliance, with compliance dropping to 35% in January 2017.

- *Provision of care required*

A quarter of care issues occurred in Specialist and CHN Children's services, these are most frequently care not being delivered due to a lack of routine contact between service user and service or specific elements of care not occurring. Examples here include appointments

cancelled and Health Care Assistant visits not occurring, or specific reviews not happening e.g. pressure sore. Contributory factors include staff shortages, informal methods of raising cancelled/unattended appointments and issues regarding handover.

3.4. Coroner's recommendations

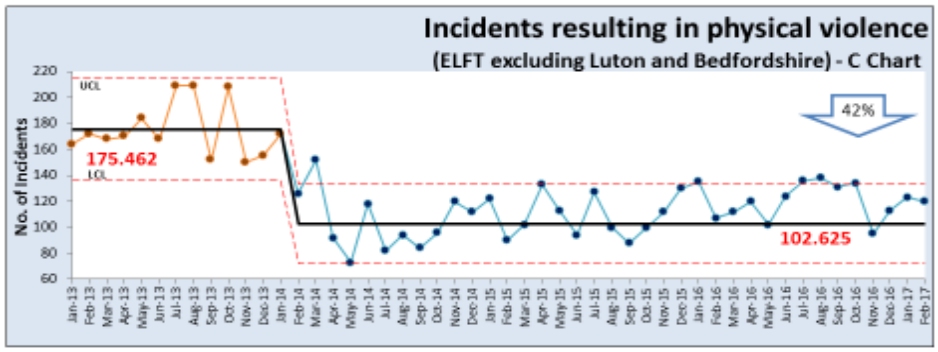
Since the mid-year review in July 2016, the Trust has received one 'Regulation 28 Prevention of Future Death Report's, outlining Coroner concerns and relevant recommendations. The response is due in late May, with recommendations from the Coroner outlined below.

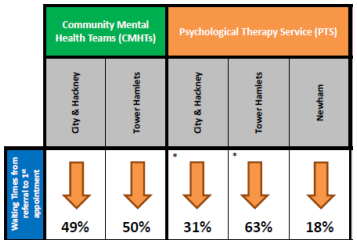
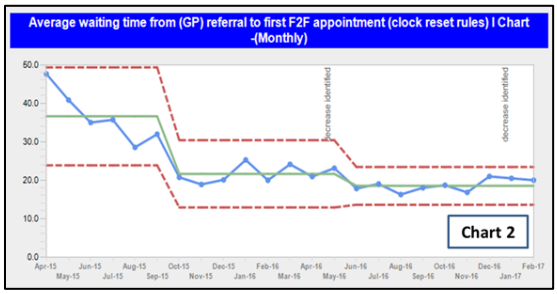
Death of service user by suicide

A service user committed suicide following a visit to the emergency department. During the course of the inquest, the evidence led to the coroner raising areas of concern:

- There was a lack of communication regarding expected illness progression were not communicated effectively to the family to enable them to identify unexpected deterioration
- The home treatment team were inflexible regarding the time of the home visit; even though the patient's partner had contacted them requesting support as the situation had become urgent
- The patient's husband was not advised to contact the emergency services in absence of the home treatment team and the emergency services were not contacted by the home treatment team

4.0. Progress to date in addressing the key issues identified in last year's (2015/16) report

Progress from last year's SI actions	
Violence	Trust-wide numbers of reported violent incidents has been gradually increasing for the past year and a half, signifying a healthy reporting culture. This increase has now also been witnessed in East London during 2016/17 and as it has not been witnessed Trust wide, can be attributed to the scale up of QI work across London services, most notably across five forensics wards. While the number of incidents recorded has increased, the number of incidents resulting in physical harm has been reduced across London services by 42%. 
Suicidality in inpatient wards	The annual ligature assessment is due to be completed within the Trust and lessons learned seminars also continue throughout the Trust. The number of suicides in inpatient wards has reduced to 6 and is now more commonly witnessed during a patient's leave or following discharge rather than on the wards themselves.
Patient physical health	Resuscitation has been rolled out across the Trust to support staff to build confidence and competence in managing medical or cardiac emergencies. 53 mock medical emergencies were also carried out between August 2016 and March 2017, involving over 250 staff including registered nurses, doctors and

	unregistered staff. Management of Intoxication and Sepsis protocols have been developed to support staff to identify and manage such situations. The Veinous Thrombo Embolus policy has also been reviewed and e-learning training is underway. Physical health form templates have also been developed in RiO to support staff in obtaining and recording physical health information. A number of care and service delivery problems identified within this report are related to physical health checks such as observations, whether these fail to be taken according to policy or procedure, missing records related to observations, or inaccurate information and communication regarding observations between services and health care professionals.
Pressure ulcers	There was only one serious incident relating to a pressure ulcer in 2016/17, with the ongoing QI and Tissue Viability work across the Trust, it is no longer a Trust-wide priority for improvement work.
Risk assessments	The CQC inspection in 2016 identified the quality and accessibility of risk assessments as a key concern and whilst the CPA quarterly audit signifies a peak in activity following the in line Rio Risk Assessment form going live in April 2016, the percentage of Risk Assessment sections completed are currently the lowest since July 2014 at 60%. Actions from the audit process have shown an increase in internal team and directorate training for staff regarding this area, however due to issues related to documentation and recording keeping being identified as a key concern in this report, this will be discussed further in section 4.
Waiting times	Quality improvement work across the Trust is progressing well, with the Access to Services Collaborative reducing waiting times by up to 63% in Psychological Therapy Services and 50% in Community Mental Health Teams.  These improvements have been achieved by implementing change ideas including weekly referrals meetings, the management of referrals centrally using a database enabled with a trigger system and communications to improve awareness raising of the waiting times target.  The City & Hackney access QI project has seen a reduced average waiting times from GP referrals to first face to face appointment of over half, from over 36.6 days in 2015 to 18.5 days. 5% of service/care delivery problems identified through the thematic analysis of 2016/17 incidents were connected to delays in care; as improvement work in now underway across the Trust, this will be monitored via the QI programme board.
Absconds from Forensics	Communication arrangements with local police services and electronic monitoring work across the Trust has led to a clear reduction in SIs related to absconding from Forensic Wards. This will therefore continue to be monitored through the Quality Control section of the board's quality report and will not be carried forward as a concern here in 2017/18.
Record keeping	The CQC inspection highlighted record keeping as a key concern across the Trust, within various service or care provision types (e.g. Forensics, Community Nursing) and across a number of the five key questions. Trust wide and directorate audits supports the identification of ongoing issues and local data

	quality reports are sent to teams to ensure compliance with reporting standards, however audits such as the record keeping and directorate audits, in addition to the analysis of serious incidents and compliance with performance requirements each signify this remains an ongoing issue. CQUINs in relation to physical health record keeping are now in place in London boroughs and the move to the new eCPA will support increased monitoring of documentation completeness. With that said, with three of the most common sub-themes being documentation related, record keeping will be discussed with a focus in section five.
Improving communications with patients	The extensive people participation programme continues across the Trust with work over the past financial year focusing on improving interaction with and understanding of care plans and the use of digital platforms to support communication with patients. This work involves the redesign of the CPA process, the exploration of mobile apps to support access to care (the REFRAME project) and the use of digital platforms to support online care plan portals in conjunction with NHS Digital. QI work across the Trust continues to be informed and driven forward by service-users, including an overhaul of the complaints procedures in Tower Hamlets.

5.0. Priorities for action in 2017/18

Following the analysis of all serious incidents occurring within 2016/17, coroner's recommendations and triangulation of other internal and external data sources, and taking into account the work undertaken following the previous report, several potential areas of focus emerge. The analysis indicates the greatest recurrence and the strongest association with outcomes of severe harm or death. Further detail regarding the constitution of these fairly broad issues is set out in section 3.2.

- High quality of Record Keeping
- Effective Communication with other healthcare professionals and providers
- Consistent provision of the right care at the right time
- Awareness. knowledge and reliable implementation of Trust policy and procedure

It is apparent that these are not novel findings, and that there is some duplication of, or a strong relationship with, issues identified in the report produced at the end of 2015/16.

It is apparent when considering these issues, and indeed evident from reviewing the reports collectively, that there is an interconnectedness between these issues. Often this forms a compounding effect which can appear to increase risk and influence on outcome.

Whilst a clear recommendation of this report is to consider these issues in some detail, and at local level, in order to achieve the most profound understanding of them, and therefore identify the most effective solutions, it is important that the tackling of the issues takes place in a concerted fashion where interactions and causation can be understood and responded to.

There have been significant developments during the past 12 months, and subsequent to the reporting period covered in this report, that have a bearing on the issues identified, most notably:

- Implementation of new electronic patient records systems, in particular the roll out of RiO in Bedfordshire and Luton

- Implementation of a new CPA process, supported by the electronic patient records system

The impact of these developments on quality of care should be monitored on an ongoing basis.

There are relevant streams of Quality Improvement work already in place, with improvement work ongoing, most notably the access to services collaborative. Within the strategic Trust-wide priorities for quality improvement work for 2017/18, we will be focusing on improving access and flow within community teams, and redesigning community mental health care to be more recovery-oriented and efficient

As already stressed, a co-ordinated approach is required, but the following immediate actions are proposed:

- Detailed analysis of these issues to be conducted at Directorate level
- Subsequent utilisation of the findings in Directorate planning cycles
- Consideration of the issues by Directorates in planning their quality assurance and quality improvement activity
- Each issue to be considered in detail collectively at the Trustwide Quality Committee (Part 2)
- Feedback on progress to the Trust Board in the form of a mid-year Serious Incident report

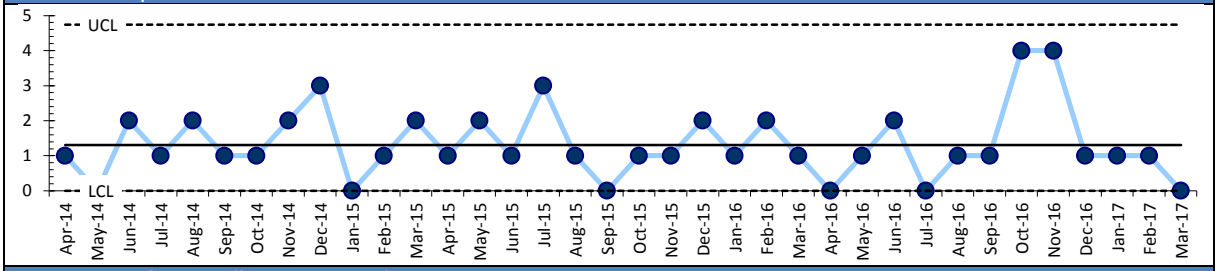
6.0. Action being requested

The Board is asked to **RECEIVE** and **DISCUSS** the report.

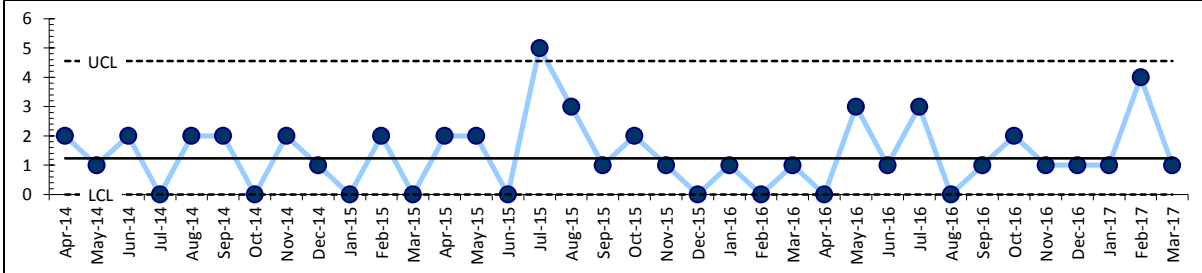
Appendix A – Directorate serious incident numbers

Number of Serious Incidents by Directorate (C-Charts)

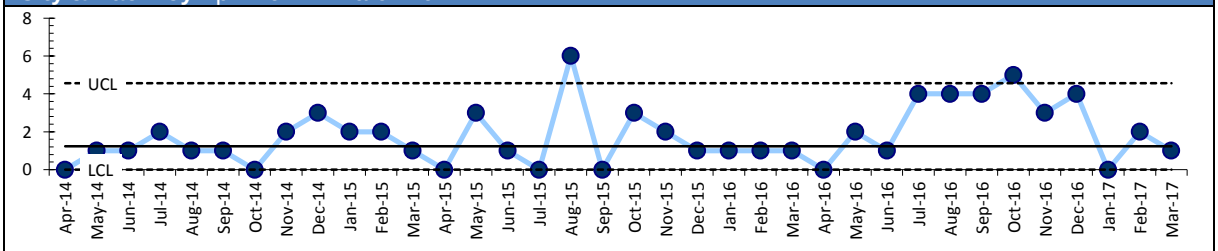
Newham April 2014 – March 2017



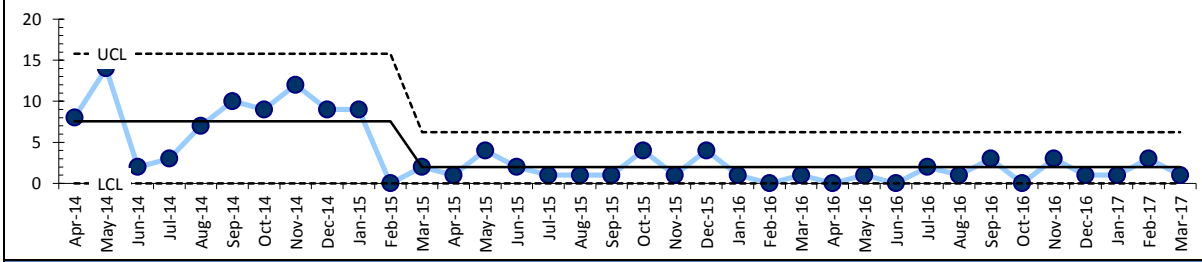
Tower Hamlets April 2014 – March 2017



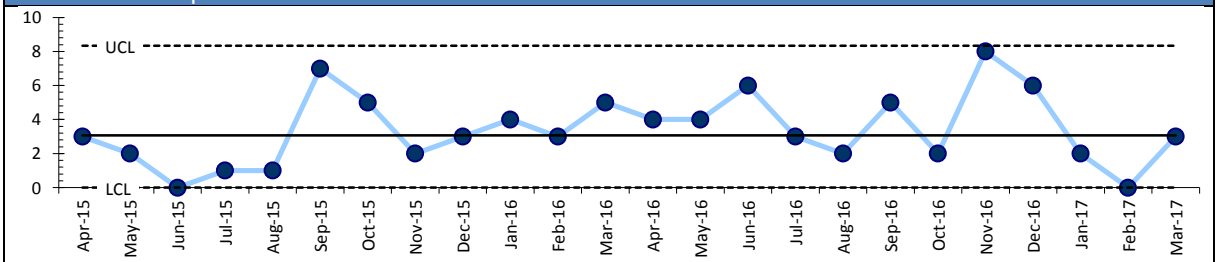
City & Hackney April 2014 – March 2017



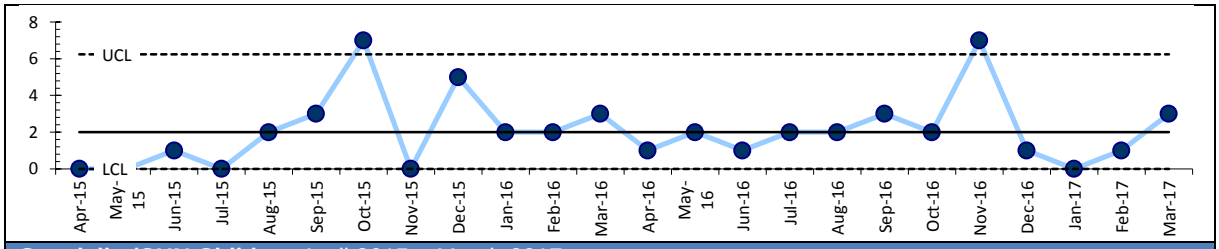
MHCOP/ CHN Adults April 2014 – March 2017



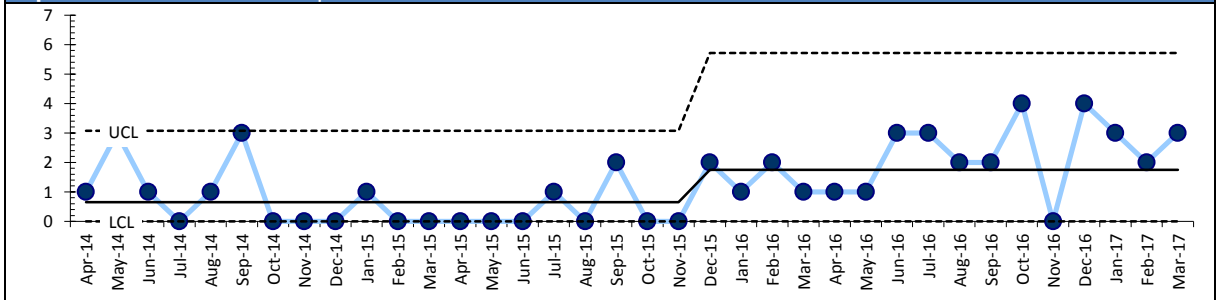
Bedfordshire April 2015 – March 2017



Luton April 2015 – March 2017



Specialist/CHN Children April 2015 – March 2017



Forensics April 2015 – March 2017