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NHS
Leicestershire Partnership
NHS Trust

Trust Board - 27th October 2020

Patient Safety Incident and Serious Incident Learning Assurance Report for August and September 2020

Purpose of the report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed to assure that systems of control continue to be robust, effective and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction.

The report also provides assurance around 'Being Open', numbers of serious incident (SI) investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

The Corporate Patient Safety Team (CPST) continues to work to support the governance of patient safety improvement.
The data presented in relation to incidents is considered in the specialist groups and the learning and actions required to improve are led there and monitored through the governance route.
Serious Incident (SI) investigations have continued throughout the challenges of COVID19. There has been a deterioration of compliance with the 60 working day deadline for submission to the CCG. The team are working with directorates to recover and strengthen processes to sustain this position. There has also been a deterioration in the timely closure of serious incident action plans and this is part of the recovery work We have continued to ensure that all SI's declared since COVID-19, have included in the terms of reference a consideration of the impact of COVID-19 on the patient/family and service provision. Also an additional question has been added since July 2020, asking if the patient was on a waiting list in relation to LPT care at the time of the incident in relation to waiting time recovery and harm review plan as part of the COVID19 recovery response

Analysis of Patient Safety Incidents reported

Appendix 1 contains all of the Statistical Process Control (SPC) charts utilising the NHSI Toolkit that are shared to support the narrative and analysis below and local speciality incident information.

All incidents reported across LPT in August and September 2020

The use of numbers related to patient incident reporting are not seen as a good single indicator of safety, however, these are monitored. We have now seen incident reporting gradually returning to

the previous ‘normal’ for what is expected in the Trust following a decrease in the initial Covid19 pandemic in March/April as services changed and staff were redeployed.

Review of Patient Safety Related Incidents

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care

In August and September 2020, no patients were affected by a ‘hospital acquired’ grade 4 Pressure Ulcers; those reported were ‘acquired’ or ‘deteriorated from a lesser grade’ in the community. The previous reports identified a reduction in patients affected by Grade 4 Pressure Ulcers however; there has been an increase in reporting giving an unpredictable trend in the trajectory. There was significant decline in category 2 pressure ulcers reported in June/July 2020; this decrease has not continued for the months of August/September 2020 with similar numbers as reported in March 2020. Evidence continues to illustrate that the acuity of patients on community nursing caseloads is increasing due to the transfer from inpatient hospital care.

Falls

Across the Trust there has been an overall increase in the number of falls reported, likely related to the acuity of patients in particular in the clinical areas delivering care to patients with chronic debilitating disease. The falls group continue to meet and monitor all falls and the CPST support this work offering additional scrutiny.

The compliance of falls huddles continues to be variable across all specialities; there continues to be a drive by senior clinicians to focus on not only the fall huddle happening, but a focus on the conversation around additional interventions to reduce the risk of further falls.

All Self- Harm including Patient Suicide

There was a sharp rise in self-harm ‘moderate and above incidents’ in January 2020, with a decline in February. August/September 2020 has seen a reduction in self-harm incidents but an increase in ‘moderate and above’ self-harm incidents in September. Many incident investigations/reporting are still continuing to report ‘COVID19’ as a contributory factor due to change in access/support/isolation. There is a task and finish group (sub of self harm group) who are working to produce a case for a model for supporting our patients to reduce self harming incidents.

Suicide Reduction

LPT continue to be contributing to the LLR multi agency approach to suicide prevention which focusses on patients in the wider community, as well as being under the care of LPT. During this unprecedented time the Suicide Prevention lead is ensuring that we are working with partner agencies to support patients/staff and the wider community.

Zero Suicide for In-Patient Ambition Plan 2019/20

NHSE have worked with NHS Trusts to support and develop a zero approach to in-patient suicides resulting with a Trust-wide plan. This includes patients on authorised and unauthorised leave. Whilst developing this and on review of our local data, the focus of this work has been extended to include patient’s within 10 days of discharge and patients under the care of the Crisis Team.

The group are aligning their work with the learning from the National Confidential inquiry into suicide and as such, are concentrating on collaborative care planning with patients and including families where appropriate to create robust networks for patients. The plan will be governed by the Suicide Prevention Group and monitored against progress by the Learning from Deaths Group. This alignment and process for review continues.

In August we reported the death of a patient who met the criteria for ‘in-patient suicide’; this is currently under investigation with an Executive led panel and an independent chair from NHFT.

We will consider our care against the findings of the confidential inquiry particularly in relation to observation as the patient absconded from an inpatient facility

Violence, Assault and Aggression (VAA)

There continues to be an increase in numbers of VAA across the trust this category of incident features in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. The Mental Health Directorate are developing a multi-faceted Quality Improvement approach to address this area and plan to share Trust-wide learning; the final report has been shared with QAC. The patient safety team and Health and Safety team are working together to review incidents were staff have been harmed.

Medication incidents

Medication incidents are reviewed locally and the use of the BESS medication error tool to facilitate learning and a fair approach to supporting and managing staff following medication errors is well established. It is however essential that some incidents are reviewed in relation to the system rather than the action of individuals The Insulin Incident review undertaken by CHS was presented to PSIG in August 2020. This was a very detailed and thorough piece of work which identified difference in the way insulin was written up for nurses to administer. This meant that sometimes it was not clear for staff who are busy and may be distracted. Furthermore, staff who work between teams were having to use different processes. It was also identified that the electronic visit allocation system was sometimes overridden by staff as they were not clear how it was set up. There are established QI projects to address both of these areas. Staff have embraced these methodologies and are leading the changes. The methodology is to be used to develop a model for deep dive's/scoping exercises to provide consistency to this too.

Directorate Incident Information

Additional slides for information are included within Appendix 1, which detail the top 5 reported Incidents for each Directorate speciality illustrating the level of diversity. Violence and Aggression has been reported in the top 5 reported incidents across Mental Health, CAMHS and Learning Disability specialities, which demonstrates some of the challenges that the clinical teams face across the Trust as they interact and deliver care to our patients. We have also seen a small increase in 'patient on patient' VAA which is challenging for our teams to manage. With these incidents they are supported by the safeguarding adults team with reviewing risk assessments and ensuring that the 'victim' is safe and supported.

Queries Raised by Commissioners / Coroner / CQC on SI Reports Submitted

Time delays between submission and response related to 'non closure' from the CCG has improved following discussion and LPT feedback, the CPST are working closely with the CCG to facilitate and actively chase feedback following their sign off process. A member of the CPST continues to attend their report sign off meetings. The CPST continue to liaise directly with the CQC to respond to queries as they arise; this continues to work well.

Learning Lessons and Action Plan Themes

Research suggests that learning is not achieved by simply sharing learning, as this does not necessarily result in the behaviour change required. The learning lessons exchange group is working together as a community of practice to achieve true sharing of learning and extended the invitation to those in roles were patient safety improvement work takes place.

Learning will often mean the need for a system change rather than individual change and this group is learning together to spread and implement this thinking. System thinking and Human factors are naturally 'Just'. Learning from SI's is spread over multiple specialties.

The key learning themes from SI's:-

- Increase in allegations of abuse of staff on patients- There is a proposal for CCTV expansion within the Unit (and other areas) to support both staff and patients.
- Link between bank staff and their training to care for patients with complex and highly specialised needs - Work is being undertaken by Lead Nurses and professional standards group to focus on this point.
- Suicides where patients have been assessed as low risk –The suicide prevention group is focusing on this learning.
- Non fixed ligature incidents, particularly CAMHS in patients-Self harm and ligature reduction groups (sub group of self harm and suicide prevention group) considering.
- Increase in Aggression and Violence –multifactorial programme details within DMH
- Non recognition of high risk families in health visiting –identified not as a result of training but rather the connection of whole family and the thought process to increase the level of support offered –as well as the communication between multiple teams were the information held in each team may not indicate 'high risk' all the information together may suggest this. –working to consider an easier way to share information that is not being 'escalated' and a 'prompt' for staff to keep considering "Are this family having the right level of support does this new information change their requirement"

Focussed themes and learning on Pressure Ulcers

The Pressure Ulcer Scrutiny Template enables the Nutrition and Pressure Ulcer Group to capture themes from lessons learnt for all pressure ulcers developed / deteriorated in 'our care'. The previous theme of completion and review of SSKIN has seen some improvement and has been a focus on the action plan. An ongoing review of any pressure ulcer serious incident investigation reports is routinely undertaken by lead nurses within the CHS Directorate along with the CPST and any key identified new issues are also added to the action plan. The action plan was reviewed in August 2020 in a Quality Summit to which the CCG were invited. A new QI approach has been agreed and quarterly progress reports will be sent to PSIG and CQRG. New Patient Safety Huddles are being introduced which ensures MDT discussions for all patients with newly developed Category 2 and 3 pressure damage. The aim of the MDT is to ensure a full patient review of all risk factors and agree a joint plan of care.

Learning and continued themes identified:

- There continues to be a delay in the formulation of risks into a personalised care plan.
- Accuracy and timeliness of Waterlow scoring is not always reflecting all patients' risk factors and therefore not resulting in appropriately targeted preventative measures.
- There are many patients who have not been assessed using the mental capacity assessment tool to be enable to tailor explanations for the patient to understand their role in their pressure ulcer care plans.
- A quality improvement plan is being used to drive improvement in these key areas identified.

Focused themes and learning on Falls

There continue to be 5 key learning themes from the Falls Steering Group:

1. **Bed Rails / Low Bed Assessment** – the combining of the assessment of these two interventions is well under way.
2. **Use of Crash Mats or Mattress** - For frail patients who are unlikely to try to get out of bed normally but at risk of rolling and falling from bed consider the use of a mattress rather than normal crash mats.

3. **Reassessment of Patients who Fall** - Consider reassessing a patient who has fallen, even if they did not incur harm, 24 hours after their initial fall to check for delayed pain or change of condition.
4. **Huddles - Post Fall Huddles** should be carried out as soon as practicality possible following a patient fall. This is an area that is yet to be fully embedded and is challenged by the questionnaire for the falls huddle being stored in the Ulysses database with speculation that this needs further work to truly make this a team approach post fall.
5. **Falls CQUIN Goals (CHS)** - requires all patients to have a lying to standing Blood pressure recorded and a medication review during their stay and to ensure that each patient receives a mobility assessment within 24 hours of admission; a focus of the Falls Steering Group. This remains a gap in assessment and is frequently been identified as a lapse in care approach in investigations.

Duty of Candour

We treat all incidents under the principles of Being Open and Duty of Candour. We measure timescales and breaches of these timescales are usually as a result of confusion not in an intention not to share.

There was one confirmed breach of initial Duty of candour (DoC) and twelve confirmed breaches of DoC in relation to sharing the final report, this was mainly as staff were confused as who was to complete.

The CPST continue to monitor the application of duty of candour and support staff to ensure this is compassionately applied. 360 Audit are currently auditing our application of Duty of Candour; early results indicate the need to strengthen processes and the Patient Safety team will be offering face to face training to support this as well as developing a video message.

Incident Review Process

The CPST continue to facilitate the weekly incident review meeting process that is shared with all three directorate governance teams, Safeguarding Team, Health and Safety Team and the Patient Involvement and Experience Team. The meetings enable incidents or complaints that may meet the criteria for a higher level of investigation following triage. It is considered that this has been a successful intervention and support mechanism as demonstrated by many other organisations encouraging multi-professional discussion and a more structured approach to identifying appropriate investigation methodology.

The incident oversight group continues to monitor the completion of serious incident reports and action plans; there continues to be challenges faced by most directorates in relation to compliance and timely completion. There is regular sustained commitment from the CPST in working to address and embed this change in ensuring robust oversight of action plan ownership and completion.

Safeguarding and patient safety – linking the two teams

Triage of potential safeguarding incidents and escalation continues by the CPST with a developing and insightful learning. . Both teams are working closely together to reduce duplication and ensure appropriate information is shared.

National Incident development

The new SI framework has been published (Patient Safety Incident Response Framework). It is very different to previous frameworks and is encouraging a focus on inquisitive examination of a wider range of patient safety incidents in the spirit of ‘reflection and learning’ rather than as part of a ‘framework of accountability’ anchored in the principles of openness, accountability, learning and continuous improvement.

The Patient Safety Strategy

The launch has been delayed by COVID19 and the CPST are now working through the strategy to develop an implementation plan. The strategy describes that patient safety is a specialist area and the focus must not simply be on Serious incidents and the counting of numbers.

This will be shared with the directorate Governance teams in November for their input. The underpinning principle of the plan is the patient safety culture. The HOPS and Director of HR and OD have a workshop planned in November to work with our change champions to develop our Just Culture. This will provide the foundations for the Learning Organisation work under way with the HOPS and the AD for QI.

Decision required

- Review and confirm that the content and presentation of the report of the incident provides assurance around all levels and categories of incidents and proportionality of response.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.

Governance table

For Board and Board Committees:		
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward and Sue Arnold (Patient safety team)	
Date submitted:	17/10/2020	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	PSIG-Learning from deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Bi Monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	1 – There is a risk that the Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 3-- There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

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