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Leicestershire Partnership NHS Trust

Public Trust Board – 22nd December 2020

Patient Safety Incident and Serious Incident Learning Assurance Report for October and November 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 the expectation is that they are owned and monitored through the directorate 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. CPST are working with directorates to recover and strengthen processes to sustain this position. The timely closure of SI action plans continues to be challenging and as such we have compiled and agreed register a risk on the Trust's risk register and directorates are developing action plans.

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 October and November 2020

The use of numbers related to patient incident reporting are not seen as a good single indicator of safety, however, these are monitored. Incident reporting is 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; as we continue with the 2nd wave we will continue to monitor this on a weekly basis through the Incident Review Meeting.

Review of Patient Safety Related Incidents

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

In October and November 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 October/November 2020 with similar numbers as reported in March 2020; however showing a downward trend again for November 2020.

Falls

Across the Trust there has again 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. MHSOP have seen an increase in 'in-patient falls', offset by a decrease in the community. 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. October/November 2020 has seen a reduction in self-harm incidents of 'low harm' but an increasing trend upwards in 'moderate and above' self-harm incidents. 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 Suicide Prevention) 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.

Suicide Prevention

***'Reaching Zero Inpatient Suicide'* (RZIPS) ambition**

The Zero Suicide for In-Patient Ambition Plan 2019/20 has been updated to the *"Reaching Zero Inpatient Suicide"* (RZIPS) ambition. In order to organise and adhere to recommendations for improvement, RZIPS is presented as framework which presents 4 key agendas:

Collaboration

Informed clinical practice, competence, and pathways

Safety Thinking

Education for prevention

The RZIPS ambition ensures the implementation of Patient Safety Strategy (2019) in our suicide prevention work. Safety Thinking in RZIPs (and Trust-wide), encompasses a wider scope for safety which includes a patient safety system, culture, and staff safety rather than limiting to behavioural safety characteristics. Directorates have been provided with Suicide Prevention Template packs with guidance to provide a bottom-up approach to suicide prevention.

Learning from Deaths (LfD)

In line with LPT's 'Step Up To Great' (SUTG) agenda, improving quality is about continuously evaluating and iteratively improving to ensure sustainable high standards are achieved on a trust-

wide level. A bottom up collaborative approach has been taken to ensure best practice; an example of this is reviewing, updating, and implementing qualitative learning themes recommended by the Royal College of Physicians (2016).
To enhance the LPT LfD agenda, learning for improvement is being implemented by networking closely with Northamptonshire Healthcare and University Hospitals Leicester.
A qualitative scoping exercise has been carried out to map out current practice in the LfD process at LPT. Findings have been presented to Directorates to highlight variability and how this can be standardised in order to streamline the LfD process throughout the Trust.

Violence, Assault and Aggression (VAA)

There continues to be high 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.

Medication incidents

Medication incidents are reviewed locally and the use of the BESS medication error tool (stored in Ulysses) to facilitate learning and a fair approach to supporting and managing staff following medication errors is well established; however recent scrutiny has identified that the BESS Tool is not always utilised or attached as part of the incident review. This is an area that we need to promote with the directorates and understand why this is inconsistent and to promote the value of learning and reflecting following medication errors. The patient safety team are working with the medicine risk reduction group to support this.

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.

Queries Raised by Commissioners / Coroner / CQC

The CCG are concerned about timeliness of reports and we have shared actions in place at directorate level in order to address this. We are also including immediate actions in our monthly report.

The CQC are also requesting sight of individual risk assessments and care plans for individual patients before the completion of the SI (Following submission of 72 hour report).

Learning Lessons and Action Plan Themes

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.

During October 2020 there was a review of the current reporting of category 4 pressure ulcers; this was multi-disciplinary including the CCG. The question asked was there evidence of benefit and a consistent reduction in the development of category 4 pressure ulcers and would the time taken by clinical staff to undertake these investigations be better spent in supporting teams to prevent the development in first place. The reporting of all category 4 pressure ulcers was altered from the 1st November 2020 to internal review locally of all grade 4's (not reported on StEIS) and every 5th

Category 4 will have a full review and scrutiny at senior clinical team to check for new themes or evidence of success from the QI project (NB Duty of Candour still applies)

Learning and continued themes identified

Incidents reported and concluded during this reporting time, themes remain unchanged from previous reports:

- Delay in the formulation of risks into a personalised care plan.
- Patients' risk factors are not always accurately and timely reflected in the Waterlow scoring and therefore appropriately targeted preventative measures are not always put into place.
- Staff have not undertaken or considered the mental capacity assessment tool to enable the individualised explanations for the patient to understand their role in their pressure ulcer care plans.
- There is a continued quality improvement plan that is being used to drive improvement in these key areas identified.

Focused themes and learning on Falls

There continue to be 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 with a return to the group of the final draft in December after taking into account learning from investigations during September and October 2020.
2. **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.
3. **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 challenging, and requires further work. There is greater compliance in CHS than elsewhere in the Trust.
4. **Falls CQUIN Goals** - 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, nationally acquiring the name of 'Culture of Candour' to raise the profile of saying 'sorry' to patients and families when care or services have fell below expected standards with or without harm.

There was 4 (FYPC) confirmed breach of initial Duty of candour (DoC) and 7 confirmed breaches of DoC (1= CHS, 2 = FYPC, 4 = DMH) in relation to sharing the final report.

The CPST continue to monitor the application of duty of candour and support staff to ensure this is compassionately applied. 360 Audit have completed their auditing of our application of Duty of Candour; as a result there have been some minor amendments to our policy. There is a number of recommendations awaiting approval that describe our need to strengthen processes which CVPST has already started.

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. There is greater need to ensure oversight from senior clinical team members and lacks the inclusion of medical colleagues. This is being addressed through the directorate governance teams and Heads of Nursing.

Incident Oversight and action plans post investigation

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. As a result of continuing concern in relation to timely completion of actions a risk has been registered on the Trust risk register describing this gap in assurance in relation to learning.

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. There is now a weekly catch up between the two teams to foster that essential working relationship keeping patients safe.

The Patient Safety Strategy incorporating National Incident Reporting development

Currently Trusts who deliver NHS care undertake many investigations, often involving incidents of a very similar nature, generating similar actions plans and yet real learning and improvement is not embedded as a result of these. The NHS Patient Safety Incident Framework (PSIRF) sets out to reverse this situation and move towards a system with focuses on learning and improvement.

The original intent was for early adopters to implement PSIRF from April 2020 with all trusts coming on line from April 2021. Due to Covid-19 pandemic early adopters are now implementing from October 2020 onwards, with wider NHS implementation planned from April 2022. One of the key requirements of the implementation of the patient safety strategy is a robust and all staff approach to the incident reporting systems to improving learning through incidents which is often linked to service drivers. Staff time is precious; the ownership and understanding of the incident reporting system can assist teams locally to raise the profile of safety by knowing their local themes and triggers. In turn this will encourage important recognition of changes required in clinical areas through ward/team and them owning that change. Our training and support record for our teams in using Ulysses is very limited with no designated manager/trainer of the system; we are not using this to the full potential to support our staff.

There is a need for robust training and support & development plan for this system to help many key quality and safety information for the trust including driving towards a paperless system. A Business case will be presented in January 2021 for consultation and support decision. This will also help us to align what is required from the NHS Patient Safety Strategy.

Just culture and driving culture and safety change through human factors

The HOPS and Director of HR and OD chaired a workshop in November with our change champions to develop our 'Just Culture'. This was reported to be a success by attendees and explored number of aspects of how patient safety and culture are interlinked.

There was agreement that we would work towards a 'just and learning culture'

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:	Public Trust Board	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward and Sue Arnold (Corporate Patient Safety Team)	
Date submitted:	14/12/2020	
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:	Yes	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	NA	