Q

Leicestershire Partnership NHS Trust

Public Trust Board

Patient Safety Incident and Serious Incident Learning Assurance Report for February - March 2021

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, the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned. This report will also briefly describe recent advancement in investigation methodology.

Analysis of the issue

The Patient Safety Team (PST) continues to work to support the governance of patient safety improvement and early recognition of trending incidents across the trust to offer early insight for leaders. The data presented in relation to incidents is considered in the specialist groups and the learning and actions required to improve patient care and staff engagement in the investigation process; 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 and availability of suitably qualified staff to undertake investigations in conjunction with clinical workloads and staff absence. There continues to be variable compliance with the 60 working day deadline for submission to the CCG and this in turn means a delay in sharing with our patients/ families and the CQC. This challenge has also been seen in the timescale compliance of internal investigations of 40 days; these have been extended to 50 working days.

The PST are working with directorates to recover and strengthen processes to improve these positions and the timely closure and enactment of SI action plans to close the investigation process. There has been additional constructive scrutiny and support from the Trust senior team and our CQC colleagues and in addition to the risk detailed on the Trust's risk register we have local monitoring processes and expectation of the directorates to take additional ownership and control of the backlog reporting regularly into local and Trust wide governance groups. Internal investigation action plans continue to be supported with upload via Ulysses by the PST as they do for SI's to ensure learning and sharing.

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 February and March 2021

Using numbers related to patient incident reporting is not seen as a good single indicator of safety, however, these are monitored and can provide an early indication of incident change in specialities or even across the trust. Overall Incident reporting has shown a gradual increase and is considered to be related to notable increases in Covid19 infection in February reporting across staff and

patients; however, we have seen a steep decline in this reporting in March which is in line with national reporting. The PST continues to share and monitor incidents all patient and non-patient safety incidents 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

Previous reports have identified a small reduction in patients affected by Grade 4 Pressure Ulcers there continues to be inconsistent trend in the trajectory. There did appear to be a downward trajectory in category 2 pressure ulcers reported in June/July 2020; however the position has not maintained and we report an increase in numbers; which is being reviewed within the directorate.

We are preparing the reporting of Category 3 pressure ulcers that have developed in LPT care as this is the focus for preventative care planning to understand why pressure ulcers then further deteriorate to category 4 for our patients in our care.

Investigations continue to identify a lack of individualised care planning as a key theme.

From 1st November 2020 community acquired category 4 pressure ulcers are no longer registered on StEIS they are managed as 'internal' incidents meeting 'moderate harm' using the pressure ulcer template. All inpatient acquired category 4 pressure ulcers are reported as SI's, the Director Nursing notified and an additional sharing with the CQC.

Falls

Across the Trust, the number of falls reported is gradually returning to the consistent lower trend seen in summer 2020. The falls group continue to meet and monitor all falls and the PST support this work offering additional scrutiny including discussion of next steps of requesting initial reviews and sharing with CQC & CCG. A 72hr report has been developed in conjunction with the group and health and safety for use with all falls where patients have been harmed with fracture/head injury/significant tissue injury that would meet SI criteria. No patient during February/March 2021 fell and sustained serious harm which is a positive safety improvement.

All Self- Harm including Patient Suicide

We have seen a decrease in all self-harm incidents; however the community mental health access services consistently reports an increasing number of patients in crisis who have allegedly self-harmed who then are escalated into acute care. Self-harm reporting has demonstrated that it can fluctuate depending on individual patients and the incident profile can see a significant decline with patient movement.

Violence, Assault and Aggression (VAA)

There continues to be high numbers of VAA across the Trust. Unfortunately 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 will be 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; continued scrutiny identifies that the BESS Tool is not always utilised or attached as part of the incident review. The PST will be linking into the Pharmacy led groups who have oversight of these errors to promote the value of learning and reflecting following medication errors. The PST are also working with the medication governance meetings to begin to implement the principles of the Patient Safety Strategy.

Directorate Incident Information

Appendix 1 details 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 on SI Reports Submitted

February & March 2021 has continued to see requests from the CQC for information in relation to serious incident notifications through 72hr reports, online review of our incidents uploaded to NRLS and from reporting from 3rd party to the CQC in relation to aspects of care delivered to individual patients. The CQC has requested update to information relating to timeliness of receipt of 72hr reports, completed SI reports and action plans along with evidence. The PST have ensured that their oversight of this is strengthened and in return reporting and sharing with directorates.

Learning Lessons and Action Plan Themes

The learning lessons exchange group (LLE) is working together as a community of practice to achieve true identification and 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 April meeting will consider the transferrable learning from the Ockenden review. The learning disability matron has also introduced the LLE model within the LD service governance process

The key learning themes from SI's:-

- Lack of risk assessments review and putting actions into place to reduce the risk remain an area across the serious of incidents that are a recurrent theme through all types of incidents.
- Self harm using prescribed medication. Considering limited dispensing – This work is linked into the self-harm group.

Focussed themes and learning on Pressure Ulcers

The Pressure Ulcer Scrutiny Template enables the Pressure Ulcer Group to capture themes from lessons learnt for all pressure ulcers developed / deteriorated in 'our care'.

As previously reported from November 1st 2020 the reporting of all community acquired category 4 pressure ulcers to StEIS was altered to being managed locally. Statutory Duty of Candour still applies and will be monitored by the PST for compliance as will timescales for investigation and any learning requiring action plans support. To date this process is working well with significant improvement in duty of candour communication with patients/families, compliance and final information sharing.

The PST Lead Nurse has been working with key team members in CHS in relation to improving the category of pressure ulcer confirmation used by tissue viability leads in the service.

Learning and continued themes identified

For those of which were reported and concluded during this reporting time are unchanged from previous reports.

Focused themes and learning themes from Pressure Ulcer category 4

- Lack of timely holistic patient assessments and updating of a personalised care plan
- Mental capacity assessments on initial admission to caseloads and when patient's conditions change featuring where 'patient compliance' has been described
- Communication with care givers

Focused themes and learning from falls with harm

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

1. **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.
2. **Huddles - Post Fall Huddles** should be carried out as soon as practicality possible following a patient fall. This is an area continues to be a challenge to consistent in the use of this tool. Compliance is variable across the directorates with continued focus on improvement from the matrons.

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.

February and March 2021 has seen continued and concentrated support from PST to support the teams to improve the standard of the letters used and increased support and challenge around timeliness and the persons responsible for undertaking this. Best practice is the person who knows the patient/family not the investigator. The final duty of candour apology is to be undertaken by director level. This is seen a positive change to demonstrate the importance placed on this for our patients, their families and will improve the quality of the letters. We have been able to secure an external facilitator to undertake compassion workshops to support staff who write SI's complaints and Duty of Candour for sixty of our staff.

Incident Review & Investigation Process

The PST 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. There remains a challenge for senior clinical team members attendance and lacks the inclusion of medical colleagues which will be explored to further develop this.

In February the PST has revisited the additional choice of investigation methods by rejuvenating the 'REFLECT' investigation tool by including guides for staff and investigators, timeline tips. National feedback related to investigations has identified that many staff have not felt involved in investigations and felt 'done to' the 'REFLECT' method is an excellent way of engaging staff and a method not frequently used. One directorate has piloted this; it has been very successful obtaining learning and good engagement/ownership with staff involved and also was completed to high standard well within SI timescales.

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 some challenges faced by all directorates in relation to compliance and timely completion; however much progress has been made recently.

There is regular sustained commitment from the PST and the directorate teams in working to address and embed this change in ensuring robust oversight of action plan ownership and completion with a member of the team designated to undertake this. In addition there has been senior scrutiny and support for making improvements in delivering on timely action plans and to improve the learning. Directorates have all reported the need to ensure there is opportunity for appropriate level oversight of this in their directorate governance process.

Learning from Deaths (LfD) - Progress update

In order to provide timely information, automatic alerts have been set by the PST to provide monthly as well as quarterly information to individuals following the submission of an incident form

Services are continuing to enhance the work with LPT information team to ensure that demographic data is completed within services.

In terms of the modified Structured Judgement Review: FYPC/LD has adapted the form to contain learning themes which are discussed in LfD meetings. DMH/MHSOP has requested the form to be adapted and have provided directorate wide feedback to enhance it.

Directorates are currently reviewing deaths from Q4 (Jan-Mar 2021). In CHS the quality of respect forms has been discussed. An excellent respect form was used as to exemplify how End of Life Care can be adapted to provide the highest quality of compassionate care. In FYPC/LD good practice has been identified in respiratory physiotherapists recognising deterioration in a patient and rapidly escalating this to acute care.

In DMH/MHSOP the consequences of patients who 'Do Not Attend' (DNA) appointments are being discussed, an outcome of this is to strengthen links between the LfD process and communication with the Coroners officer to ascertain the cause of death of patients who DNA, so that DMH/MHSOP can thoroughly review whether voids in the mental healthcare provided to patients contributed to their deaths and how to reduce this.

Suicide Prevention – Progress update

Updates include:

- **Collaboration:** DMH suicide prevention lead nurse continue to work with multidisciplinary colleagues (academics from Leicester University and Leicestershire Police force) to further progress Real Time Surveillance.
- **Domestic abuse/violence (DVSA):** There is currently scoping exercises being undertaken by key team members to understand the unmet mental health needs amongst patients experiencing domestic abuse/violence (DVSA). There is national concern around the impact of DVSA, homicides and the rise in female suicide. Increased public attention has been provided following International Women's Day, the death of Sarah Everard and associated policing.
- **Staff Well-Being and Suicide Prevention (Workforce):** the LLR Staff Mental Health & Well-Being Hub was launched on 5th March 2021. Further work is ongoing between LPT and the wider LLR Core Clinical Reference Group in April to raise issue of staff suicide.
- Work continues in FYPC/LD with support from PST to promote the development and introduction of a clinical pathway to assist in providing consistent guidance on managing non-fixed ligatures and patients at risk from this self-harm.

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:	19/04/2021	
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:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		