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Leicestershire Partnership NHS Trust

Report for Trust Board 29th June 2021

Report title: Patient Safety Incident and Serious Incident Learning Assurance Report for April - May 2021

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, the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned. We will also share briefly with you 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, early recognition of trending incidents across the trust and offer early insight for leaders by working closely with the directorates. The data presented in relation to incidents is considered in the specialist groups alongside 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 to ensure learning is embedded.

As we approach recovery from the Covid19 pandemic, our management and compliance with NHS framework timescales of Serious Incident (SI) investigations continue to be offer challenges with variable compliance with the 60 working day deadline for submission to the CCG. However, as we progress with planned changes to patient safety incident investigations our focus should now be on quality of reports and the learning from them working collaboratively with families/patients and our staff involved and less focussed on timescales. Timescale compliance of internal investigations of 40 days currently remains extended to 50 working days to assist teams in local learning and pandemic recovery.

The Patient Safety Team continues to work collaboratively with directorates to recover and strengthen processes to improve these positions. The timely closure and enactment of SI action plans to close the investigation process continues to be challenging; however, the directorates are making progress with clearer oversight and ownership. There remains a risk detailed on the Trust's risk registers with local support and monitoring processes for improving performance.

Analysis of Patient Safety Incidents reported

Appendix 1 contains all of the Statistical Process Control (SPC) charts utilising the NHSI Toolkit. These are shared to support the narrative and analysis below and local speciality incident information. In addition, we have now included Category 3 Pressure Ulcer incidents across the organisation, previously unreported at board level.

All incidents reported across LPT in February and March 2021

Incident reporting is not considered as a single indicator of safety in the clinical environments, however, these can provide an early indication of incident change in specialities or even across the Trust. There was an increase in incident reporting considered to be related to notable increases in Covid19 infection in February 2021. However, reporting across staff and patients has now subsided and the data in April/May is in line with LPT expected and national reporting.

Review of Patient Safety Related Incidents

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

The previous reports have identified a small reduction in patients affected by Grade 4 Pressure Ulcers there continues to be inconsistent trend in the trajectory and the impact on patients. There was a significant decline in category 2 pressure ulcers reported in April/May 2020; the position is not reflected a year on with reporting numbers of patients who have developed category 2 pressure ulcers continuing at a level not seen before.

We have added 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.

Category 4 pressure ulcers continue on an upward trajectory reaching similar numbers for this time in 2020.

All inpatient acquired category 4 pressure ulcers are reported as SI's, the Director Nursing, Allied Health Professionals and Quality and CQC are notified. There were none reported for April/May 2021. There is a quality improvement plan in place to address prevention of pressure ulcers led by Community Health Services.

Falls

Across the Trust, number of falls reported is continuing to gradually return to the consistent lower trend seen in summer 2020. The falls group continue to meet and monitor all falls and the Patient Safety Team support this work offering additional scrutiny. A bespoke 72hr falls with harm report that was developed in March 2021 has proved to be very successful in identifying teams much earlier learning where harm has occurred. This allows for improved promoting transparent notification to the CCG and CQC which has previously not been undertaken.

All Self- Harm including Patient Suicide

We have seen an increase in all self-harm incidents from Feb/March 2021; the community mental health access services continue to report increasing numbers of patients in crisis who have allegedly self-harmed who then are escalated into acute care. Self-harm reporting continues to demonstrate that it can fluctuate depending on individual patients and their

individual risk profile. These incidents range from very low harm to multiple attempts by inpatients during individual shifts posing significant challenge to staff to keep them safe and supported. The patient safety team is supporting individual specialities to understand triggers by sharing incident details including information such as time of day, area, method of self-harm.

Violence, Assault and Aggression (VAA)

There continues to be high numbers of VAA across the Trust. This has increased sharply during April & May 2021 including one incident that has been escalated to an SI. Unfortunately, this category of incident features in all mental health, Children and Adolescent Mental Health Service (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 the Quality assurance Committee.

In addition, the patient safety team have now requested an agenda item on the Health & Safety Committee to discuss the ongoing concerns in relation to VAA across LPT.

Medication incidents

Medication incidents are reviewed locally and the use of the Bennion Error Scoring System (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 consistently utilised or attached as part of the incident review. The patient safety team continues to work closely with pharmacy led groups who have oversight of these errors to promote the value of learning and reflecting following medication errors.

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 continue to face across the Trust as they interact and deliver care to our patients.

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

The CQC has continued to request update to information relating to some 72hr reports for newly notified SI's, completed SI reports and action plans along with evidence.

In April 2021 the patient safety team saw new arrangements reporting for SI's to 'provider collaboratives' for low secure services, CAMHS and Eating Disorders. This has meant additional 3 login processes for the national SI database StEIS and varying or yet to be established reporting/updating requests along with our well established and supportive reporting process into Leicester, Leicestershire and Rutland Clinical Commissioning Groups. IMPACT collaborative (low secure) is providing good network and process sharing opportunities between Trusts which is positive.

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 these groups are learning together to spread and implement this thinking along with sharing what already exists at Foundation for Great Patient Care meetings. System thinking and Human factors are naturally 'Just'.

This is also supported with a common goal for excellence at the Foundations of Great Patient Care Group.

The key learning themes from SI's:-

There is a recurrent theme across incidents around:

- Ensuring risk assessments are reviewed and actions are put into place to reduce the risk. This remains a recurrent theme across different categories of incidents.
- Sharing the outcomes of risk assessments amongst teams and ensuring an integrated approach to patient care

Focussed themes and learning on pressure ulcers

The reporting of all community acquired category 4 pressure ulcers to StEIS was altered in November 2020 to being managed locally. This process is working well with significant improvement in duty of candour communication with patients/families, compliance and final information sharing. There is a planned alteration to the verification and investigation template and update training for staff undertaking these investigations in collaboration with the CPST Lead Nurse and the teams involved.

Learning and continued themes identified

The following themes continue to be a key focus for improvement.

Focused themes and learning themes from Pressure Ulcer category 4

- Inconsistent approach to photography/documentation of wounds
- The need to ensure timely holistic patient assessments and updating
- Mental capacity assessments on initial admission to caseloads and when patient's conditions change where 'patient compliance' has been described as a factor in ulcer development/decline. LPT Safeguarding Team is supporting additional learning with community teams.

Focused themes and learning from falls with harm

There continue to be consistent 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 able following a patient fall and as part of the wider team discussion. This continues to be a challenge to ensure consistent/timely use of this tool to improve safety by reflection/prevent further falls. Compliance is good within community health services. MHSOP is demonstrating continued sustained improvement along with a focus on improvement from matrons/ward managers in these areas and early escalation into the patient safety team for falls with concern for harm.

Culture 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 fallen below expected standards with or without harm. It is the right thing to do for our patients and families.

During April and May 2021 the Trust has seen a consistent improvement across all directorates in the timeliness and quality of letters/communication with our patients and families. There has been an acceptance and embracing of the practice of the person who knows the patient/family should initiate the process with less reliance on investigators in cases of SI's/internal investigations. The final duty of candour communication is now to be undertaken by directors of services and has seen a sustained and positive change for our patients, their families and our staff. This is significant and continues to allow our investigators to focus on describing investigation & inclusion in the process rather than having to undertake duty of candour. This is a significant and positive shift with evidence of many letters that are well written, demonstrating kindness, compassion, apology (saying sorry) and need for learning from incidents.

Incident Review & Investigation Process

There is a weekly incident review meeting process led by the patient safety team that is shared with all three directorate governance teams and other key stakeholders. The meetings enable incidents or complaints that may meet the criteria for a higher level of investigation following triage to be reviewed and discussed with decisions made for next steps for investigation. Strengthening the representation of medical colleagues will be explored further over June/July 2021 and seek the board and Medical Director support to begin to enable this. We are seeing more senior team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation.

In February, the patient safety team revised the additional choice of investigation methods by rejuvenating the 'REFLECT' investigation tool including guides for staff and investigators, timeline tips. National feedback related to investigations has identified that many staff have not felt involved and the 'REFLECT' method is an excellent way of engaging staff and a method not frequently used. We have seen increasing use of this method of investigation for both SI's and internal investigations which aligns itself to existing nursing, medical, allied health professional and psychology reflection methodologies with really good feedback and outcomes for learning. This approach has been shared across the East Midlands from an appreciative enquiry approach to be kinder to staff, inclusive and still hear the voice of the patient/family. Staff have embraced the change and have been supported by patient safety team lead nurse in initial steps in using the tool.

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 all directorates in relation to compliance and timely completion. Progress is steady however, the teams are committed and there is now clearer escalation and improved data monitoring within the directorates.

There continues to be regular sustained commitment from the patient safety teams in supporting the teams to address and embed this change in ensuring robust oversight of

action plans and completion with a member of the team designated to undertake this. Additional investigation leads are being recruited.

Learning from Deaths (LfD) - Progress update

We previously reported the automatic alerts have been set by the patient safety team to provide monthly as well as quarterly information to individuals following the submission of an incident form; this appears to be working well.

LPT are committed to ensuring learning form deaths is a robust process. There continues to be challenges and also well-established processes across the directorates with an appetite for learning and improving including:

- During Q4 2020/21 DMH identified a backlog in deaths requiring a review. DMH continue to review these deaths throughout Q1.
- FYPC/LD raised concerns about the logistics of their monthly LfD meetings and the challenges involved. These were escalated to the Associate Medical Director. A potential solution of meeting on a quarterly basis will be piloted in Q2.
- CHS continue to have robust monthly meetings as well as forum presentations to discuss exemplary learning.
- CHS and DMH are exploring ways to implement a bereavement letter into their LfD process

Suicide Prevention – Progress updates include:

- **Supporting staff after patient suicide:** work has begun across the disciplines in developing a simple model for supporting staff after death by suicide of patients they have cared for. There is an agreed trust wide debrief tool which can be used across all incidents.
- System-wide suicide prevention training for staff across the disciplines is actively being explored and developed
- **Domestic abuse/violence (DVSA):** the scoping exercises by key team members to understand the unmet mental health needs amongst patients experiencing domestic abuse/violence (DVSA) continues with an already known need for greater staff awareness.
- Development work has completed in FYPC/LD for the introduction of clinical pathways to provide consistent guidance on managing non-fixed ligatures and patients at risk from this self-harm. The key to success will be awareness and understanding of all staff, both substantive and temporary, and its use in clinical practice to improve patient care/safety and demonstrate learning from previous incidents.
- The launch of armed forces veterans 'buddy2buddy support' in June 2021 is planned and will be reported on trust wide

Patient Safety Team update: new NHS Patient Safety Strategy

External advertising and recruitment has begun for designated Patient Safety Incident Investigators to be employed across LPT; a new and exciting step forward for investigating our most serious incidents and supporting patients, families and staff in future approach to investigations. The team are continuing to work with our system partners on a Leicester, Leicestershire and Rutland wide approach to the implementation of the new strategy.

Decision required

- Review and confirm that the content and presentation of the report 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 and a just and open culture.
- To enable the Trust Board to be sighted on emerging themes through incident reporting and patient safety improvements

Governance table

For Board and Board Committees:	Public Trust Board 29th June 2021	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold (Patient Safety Team) Deanne Rennie	
Date submitted:	18/06/2021	
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:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None	