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Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for June – July 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.

Analysis of the issue

The Corporate Patient Safety Team (CPST) 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 and working closely with the Directorates.

The data presented in relation to incidents is considered in the specialist groups with 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.

As we continue recovery from Covid19, our management and compliance with NHS framework timescales of Serious Incident (SI) investigations continue to be challenging with variable compliance with the 60 working day deadline for submission to the CCG. Mainly due to investigations that are required to be resubmitted to satisfy closure, following feedback (both internal and CCG feedback) We are slowly progressing with planned changes to patient safety incident investigations with an improved focus on the quality of the reports and learning, working collaboratively with families/patients and our staff involved; 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 and the increasing challenges of clinical workload and investigating.

CPST continue to work with directorates to recover and strengthen processes to improve the position. The timely closure and enactment of SI and internal action plans to close the investigation process continues to be challenging, particularly in the Directorate of Mental Health. However, the Directorates have embraced ownership and are working hard to improve. The backlog position continues to be monitored and scrutinised both internally and externally with robust oversight of the specific risk detailed on the ORR and local monitoring processes regularly reporting into local and Trust wide groups.

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. We

have now included the overall position of all investigations and action plans previously unreported through the bi-monthly board report.

All incidents reported across LPT in June and July 2021

In the Patient Safety arena, incident reporting is not seen as a good single indicator of safety in the clinical environments, however, these can provide an early indication of incident change in specialities or trust-wide. Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS), which, over the next 18 months, is in a period of transition to a more robust and advanced database system allowing for improved and quicker identification of national/regional trends in themes, earlier national escalation and eventually learning.

Review of Patient Safety Related Incidents

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

There continues to be an inconsistent trend in the trajectory and the impact on patients with category 4 Pressure Ulcers; this is also mirrored in category 2 pressure ulcers which showed a sharp decline in June 2021 from May 2021; however, there has been an upward trajectory in July 2021.

We continue to share 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.

Within the category 4 pressure ulcer domain, we saw a downward trajectory in June 2021, however, July 2021 has seen similar numbers for this time in July 2020.

All inpatient acquired category 4 pressure ulcers are reported as SI's and both the Executive Director of Nursing and the CQC are notified; there were none reported for June/July 2021.

Falls

Across the Trust, we noted an increase in the number of falls reported in June 2021,returning to a lower trend in July 2021, as seen in summer 2020. The falls group continue to meet and monitor all falls and the CPST support this work, offering additional scrutiny with increased focus on work promoting the importance of accuracy with falls risk assessment to inform and proactively manage the required nursing and therapy intervention in the clinical area.

We are now noting continued success with early recognition of gaps in care and learning form the bespoke reporting of falls with harm. These are some of the most serious incidents affecting our patients in both physical injury and requirements of additional unplanned NHS care as a result; many never returning to their pre-fall wellbeing. We continue to share the bespoke 72hr falls with harm report that has proved to be successful and promoting transparency with the CCG, CQC and reporting to the Trust Executive team through a new bulletin approach.

LPT Falls Steering group have been working across the directorates to improve the safe management of patients who are at risk of falling.

Initiatives include:

- Promoting learning culture by supporting directorates to improve the scrutiny of incidents at ward level
- Implementation of patient centred interventions and utilisation of learning to improve practice
- Utilising available data to undertake deep dive on inpatient sites, e.g. mapping times and location of falls to inform service improvement
- Rolling out use of 'Flat lifting' equipment to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury

- Development of a clinical reasoning tool to support safe management of people who are at risk falling out of bed. The 'Safe Bed Management tool' supports sound decision making around use of bed rails, low beds or increased supervision.
- Electronic Patient Record processes related to falls risk assessment and management of falls are being reviewed to ensure they are user friendly to support staff compliance with policy
- Planning event to develop role of Falls Champions across all inpatient and community adult teams

All Self- Harm including Patient Suicide

We have seen a significant increase in all self-harm incidents resulting in moderate harm and above in July 2021 along with an overall increase in patient death, considered to be due to suicide. Community mental health access services continue to report increasing numbers of patients in crisis who have allegedly self-harmed many who, are 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. CPST continues supporting individual specialities, CAMHS & LD inpatients and recently added Belvoir and Low Secure services 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. These incidents have increased sharply during June 2021 for incidents of moderate harm and above; some have these have been escalated to an SI and staff injury. This category of incident features in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. There has been a 'deep dive' to understand the nature, place, time of incidents and tools available to our staff to support them in managing these incidents. Our position is not unique as VAA have featured nationally across all aspects of the NHS in particular access services; LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

In addition the Health & Safety Committee will now also discuss the ongoing concerns in relation to VAA across LPT to facilitate partnership working. 360 Audit are planning an audit and the Terms of Reference are being considered. There are new National Standards and Health and Safety are carrying out a self assessment.

Medication incidents

Medication incidents are reviewed/managed locally, with the use of the BESS medication error tool (stored in Ulysses) to facilitate learning. A 'just' approach to supporting and managing staff following medication errors is well established; there is room for improvement in utilising the BESS Tool as part of the incident review & supporting staff. The CPST Lead Nurse has been involved with pharmacy colleagues in the review of the Trusts Medication Error Policy and also supporting easier incident reporting. Next steps in autumn 2021 is to explore supporting Band 6 and above clinical staff in improved reporting and management and learning from medication errors.

CPST are working with clinical and pharmacy colleagues to consider the system in relation to medication errors rather than the individual.

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.

Infection control has featured for CHS in relation to spike in Covid19 infections amongst the staff in line with national reporting.

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.

New provider collaboratives plan to share processes over the next quarter.

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, the membership has also been extended to roles where patient safety improvement work takes place. Learning will often mean the need for a system change rather than individual change and these groups is learning together to spread and implement this thinking along with sharing what already exists at foundation of great care. System thinking and Human factors are naturally 'Just'. The group recently looked at the transferrable learning from both the Ockenden Review and the Cumberledge.

These were particularly

- Teams learning and training together
- Investing resource in analysing data
- Culture-psychological safety of speaking up

This is also supported with a common goal for excellence at the Foundations of Great Care group,

The key learning themes from SI's:-

This continues to highlight the following recurrent themes which remain unchanged:

- Lack of risk assessment reviews and putting actions into place to reduce the identified risk remain an area across are a recurrent theme through multiple incident categories eg falls, self harm.
- Communication between and across teams of patients identified risks (hand over)
- Communication and understanding of common processes linked to this in speciality teams

Focussed themes and learning on Pressure Ulcers

Continued 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 has been an alteration to the verification and investigation template in collaboration with the CPST Lead Nurse and the teams involved to improve earlier learning/information. We are now undertaking a rigorous case review and short report for 4 out of 5 patients affected by category 4 pressure acquired in LPT care and a full investigation for every5th patient.

Learning and continued themes identified

Themes remain unchanged from previous board reports and the QI work has been re focussed to take a more pragmatic approach to the implementation of improvements.

Focused themes and learning themes from Pressure Ulcer category 4

- No individualised care plan
- Recognition and timely escalation for additional supporting pressure ulcer relieving equipment
- Lack of timely holistic patient assessments and updating
- Mental capacity assessments on initial admission to caseloads and when patient's conditions change featuring where 'patient compliance' has been described as a factor in ulcer development/decline.

Focused themes and learning from falls with harm

The key early learning from recent falls has been,

- Selection of appropriate interventions in relation to low beds/bed rails and crash mats **Action** total bed management protocol in final stages
- 1:1 supervision of patients at risk of falls- staff are sometimes called away **Action** guidance to be developed to allow permission for the staff to not leave the patients side

The group continue to work on

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. **Nursing observation intervention** – not being adhered to or not assessed correctly/timely when there are patient changes
3. **Huddles - Post Fall Huddles** should be carried out as soon as able following a patient fall and as part of the wider team discussion. There continues to be one pilot area in acute mental health. MHSOP is demonstrating continued sustained improvement along with a focus on improvement from matrons/ward managers in these areas and early escalation into CPST for falls with concern for harm. However inconsistent adherence/embedding to falls huddles remains a challenging across all areas.

Culture of Candour

We consider this as a as a key driver for cultural change with all incidents under the principles of 'Being Open and Duty of Candour' (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. This is not only a national requirement, but the right thing to do for our patients and families.

During June and July 2021 we noted continued 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 a positive change in practice with less reliance on investigators in cases of SI's/internal investigations. The continued Trust Board support for final duty of candour communication to be undertaken by directors of services has also 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 and inclusion in the process, rather than having to undertake duty of candour. We are seeing a positive change with letters that are well written, demonstrating kindness, compassion, apology (saying sorry) and need for learning from incidents for both final and initial culture of candour letters.

Incident Review & Investigation Process

The CPST continue to facilitate the weekly incident review meeting process that is shared with all three directorate governance teams and other key stakeholders which was extended to LLR CCG in June 2021. We continue to promote the inclusion of medical colleagues in this process.

In mid May 2021 the CPST Lead Nurse introduced a short training session for all band 6 and above clinical staff to promote the importance of initial incident reviews and the need for quality to better inform decision making for next steps investigation. This training support has been well received and continues at least monthly along with bespoke sessions for individual teams.

We are seeing more team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation.

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. Whilst progress is slow all teams are committed to improving ; the information is shared in the appendices.

There continues to be regular sustained commitment from the CPST 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.

Learning from Deaths (LfD) - Progress update

There continues to be progress within the directorates in relation to managing the learning from deaths process.

- Q 1 there were a 121 deaths.
- During this period there were a total of 16 deaths which are linked to Serious Incident Investigation.
- There were 12 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and are to be reviewed using the mSJR case record review within FYPC.

We have successfully recruited to Governance and Quality Assurance Coordinator role for Learning from Deaths team; who should commence towards the end of October. Work is underway to standardise family feedback through bereavement letters or personalised phone calls, to do this we have set up a bereavement support inbox to learn and improve from feedback given by families. DMH/MHSOP has identified a number of themes which contribute to the deaths of patients which include: (1) Social Circumstance, (2) Chronic physical and mental health problems, and (3) Self-harm. These are now included in our updated theming as well as being embedded in the LfD Quality and Safety review forms.

Suicide Prevention – Progress updates include:

- **Supporting staff after patient suicide:** continues to be rolled out across the disciplines in developing a simple model for supporting staff after death by suicide of patients they have cared for.
- System-wide Suicide Prevention training for staff across the disciplines continues to be actively explored and developed
- 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. Assurance around training and embedding of these principles will be reviewed over the next couple of months.
- The launch of armed forces veterans 'buddy support' happened in June 2021 which is ever important following the sharing of the national report in relation to UK Armed Forces from The King's Centre for Military Health Research (KCMHR) that has found that more than two thirds (68%) of UK military personnel continue to misuse alcohol at levels that are hazardous to their health and wellbeing.
- STORM Training/Suicide Awareness, Prevention and Postvention has been well received in June 2021 as positive step forward for staff training and is planned for the future across the mental health specialities.

CPST update: new NHS Patient Safety Strategy

Outline of the short and medium term implications:

1. Just culture

2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning.

Serious Incident Investigators

The designated Patient Safety Incident Investigators have been recruited and are due to start at the beginning of September. This is a new and exciting step forward for investigating our most serious incidents and supporting patients, families and staff in developing our future approach to investigations.

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.
- To enable sighting of the senior Trust team of emerging themes through incident reporting and patient safety improvements

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Jo Nicholls, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	19/08/2021	
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:		