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Leicestershire Partnership NHS Trust

Public Trust Board – October 2021

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for Aug – September 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.

With the continued recovery from the Covid19 Pandemic our management and compliance with NHS framework timescales of Serious Incident (SI) investigations continues to be challenging with variable compliance with the 60 working day deadline for submission to the CCG; frequently investigations are being required to be resubmitted to satisfy closure with some, requiring submission twice with increasing feedback. Some feedback has been outside the scope of the investigation and directorates have required corporate support to challenge this.

We are slowly progressing with planned changes to patient safety incident investigations with an improved focus 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 and the increasing challenges of clinical workload and investigating. CPST continue to work with directorates to recover and strengthen processes to improve these positions. The timely closure and enactment of SI and internal action plans to close the investigation process continues to be challenging; however clinical Directorates have embraced ownership and are working hard to improve this. Additional scrutiny from the Trust senior team and CQC and the risk detailed on the Trust's risk register continues with local monitoring processes for backlog reporting regularly 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 August and September 2021

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 even across the trust or a wider healthcare system. Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS). The NHS is awaiting the transition to a database that is more robust and advanced system allowing for improved and quicker identification of national/regional trends in themes, earlier national escalation and eventually learning. Trust-wide incidents are uploaded at least once a week to the current NRLS database; this is to avoid 'peaks and troughs' on our nationally reported incident profile.

There are occasions when our incidents that are reported as 'moderate harm and above' are uploaded to NRLS before local review of harm/incident; these are then seen by NHSE/CQC and can be included on the national NRLS reports. We have the ability to flag incidents for re-upload to NRLS once we have reviewed the level of harm.

The CPST acts as a 'safety net' to the process regularly reviewing /escalating any outstanding incidents still flagging at 'moderate harm and above' and encourage this review through the incident review process, or by checking and challenging harm levels not reviewed in conjunction with incident review and/or closure of incidents at directorate level.
The importance of directorate and speciality ownership for timely review of incidents and the harm level assigned to them is paramount; this requires focus and senior oversight in Directorate.

Review of Patient Safety Related Incidents

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

There continues to be inconsistent trend in the trajectory and the impact on patients with category 4 Pressure Ulcers has increased in August/September 2021; this is also mirrored in Category 2 pressure ulcers that are now showing special cause variation since February2021.

We continue to share the reporting of Category 3 pressure ulcers that have developed in LPT care as this should be the focus for preventative care planning to understand why pressure ulcers then further deteriorate to category 4 for our patients in our care leading to significant harm, distress and an increase in healthcare resources.

Category 4 pressure ulcers continue to be of concern since May 2021 with increasing trajectory. Concerns have been raised by clinical teams due to changes in visiting schedules; initial information has identified the reduction in visits and inconsistent visiting approach has been implicated in the deterioration of patient's existing pressure ulcers to category 4, directly aligned to the staffing risk. These have been reported as serious incidents via StEIS with full investigation, instead of the case review that since November 2020 has been the agreed approach to investigation.

All inpatient acquired category 4 pressure ulcers are reported as SI's, the Director of Nursing notified and an additional sharing with the CQC; there were none reported to date for August/September 2021.

Falls

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.

Staff are continuing to report the 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 local CCG, CQC and reporting to the Trust Executive team through a bulletin approach, which, has previously not been undertaken. Patient Safety Incident Investigations regarding all falls with a degree of harm resulting, are also now directly shared with the Executive Director of Nursing, AHP's and Quality for review and sign off before sharing with CCG. This enables greater information in understanding challenges of inpatient falls prevention and how patients and families are affected.

LPT Falls Steering group continue to link in with the directorates to improve the safe management of patients who are at risk of falling. We are receiving regular monthly evidence of the scrutiny, reflection and learning from the directorates, and planning, once a quarter, to focus on the 3 key area, CHS, MHSOP, DMH and LD to reflect and review how learning is being embedded.

'Flat lifting' equipment is being rolled out to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury. 'Raizer chairs' are also being supplied to some wards e.g. Mill Lodge, as a less invasive way of lifting patients from the floor following a fall when no injury has occurred. In both examples the patient's experience of being lifted off the floor is far better than when using a hoist.

Our falls across the organisation have not shown any positive downward trajectory and further initiatives are being explored through QI and PDSA processes to see if this approach can positively influence this. However, it is currently challenging due to operational pressures to find clinical staff that can be released to support the progression of these initiatives due to current staffing pressures.

All Self-Harm including Patient Suicide and Progress

There has been a decline in all self-harm incidents resulting in 'moderate harm' and above in August 2021; however this is not reflected in September 2021 along with an increase in patient death considered to be due to suicide. The picture remains the same with the community mental health access services continuing to report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to.

Inpatient self-harm reporting across both CAMHS and adult mental health 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; head-banging and ligature attempts being common attempts by many distressed patients. ' STORM' a bespoke Training package for raining Suicide Awareness, Prevention and Postvention to support our staff to deliver high quality interventions and support patients in distress by thoughts to end their lives is a priority for the trust with a options appraisal paper being planned in adult mental health with a need to recognise this across directorates.

World Suicide Prevention Day (WSPD) on September 10th 2021 had a theme of 'Creating Hope through Action'. There were several workshops delivered by LPT as part of the LLR 'Start a Conversation' online offer. It was notable across the week that attendance was much lower than last year; it was observed that there were a high number of regional and national events to attend for people and very conscious that people are stretched and tired. A session to explore the needs of staff and suicide prevention will be rescheduled and after discussion at the LLR strategic Suicide Prevention and Audit Group meeting in October 2021.

'Rapid clinical reviews' continue to be undertaken as part of the initial response to a patient who appears to have taken their life by suicide to gain initial learning in relation to mental health wellbeing, social, physical, family and emotional aspects of that person's life.

Violence, Assault and Aggression (VAA)

There is a continuing trend of high numbers of VAA across the Trust. Incidents of moderate harm and above showed a sharp rise and again have also included incidents that have been escalated to an SI and those with significant staff injury. An identified theme is that of individual patients on the low secure forensic unit awaiting transfer to medium secure facilities. This has meant that staff are managing patients who poses significant risk to staff, self and others.

Unfortunately, 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 increasingly worrying incidents. Our position is not unique as VAA have featured nationally across all aspects of the NHS in particular access services; however, we do not accept this as the 'norm'. LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

In addition CPST have linked with Health and Safety colleagues to discuss the ongoing concerns in relation to VAA across LPT to facilitate partnership working of the various work streams.

Medication incidents

Medication incidents have shown an upward trend in September 2021; none have been of significant harm and have been reviewed and managed locally as it is well recognised that medication errors, aside, from the obvious patient safety risks can have a significant impact on staff confidence. Promoting the use of the BESS medication error tool (stored in Ulysses) to facilitate learning and a 'just' approach to supporting and managing staff can help a reflective approach for both, staff, teams and manager. There continues to be room for improvement in utilising the BESS Tool as part of the incident review and supporting staff.

CPST is on track to explore and implement the delivery of a short training session supporting Band 6 and above clinical staff in improved reporting and management of medication errors following the review of the BESS medication error tool and electronic incident reporting amendments and cross referenced to patient identification in conjunction with link pharmacist.

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 continues to receive 72hr reports for newly notified SI's, completed SI reports and action plans along with evidence.

The new provider collaboratives have not developed their working processes; and none have a consistent approach to feedback/documentation to completed submitted Patient safety incident investigation (PSII) reports. The CPST are working with the collaboratives and local teams to agree processes that provide the required assurance without being onerous.

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 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 next session is planned to explore the features of an outstanding organastions.

Key learning themes from SI's:-

Recurrent themes which remain unchanged:

- Record keeping has been consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide a flow of knowledge
- Lack of accurate risk assessments review and if undertaken the use of this in planning patients care.
- Sharing amongst teams outcomes of risk assessments and the integrated approach to patient care
- Communication and understanding of common processes linked to this in speciality teams
- Teams not having strong consistent approaches to processes which results in variability of outcome.

Focussed themes and learning on Pressure Ulcers

All community acquired category 4 pressure ulcers to StEIS was altered in November 2020 to being managed locally. This process has taken time to embed and has achieved significant improvement in duty of candour communication with patients/families, timescale compliance with letters and final information sharing. The changes to the verification and investigation template in collaboration with the CPST Lead Nurse are now well embedded with teams with an improvement earlier learning/ information. With changes to scheduling of visits in last 3 months we are starting to see a decline in care delivery with missed opportunities to further prevent deterioration and an identified in early contributing factor in deterioration in tissue viability and development of category 4 pressure ulcer.

Learning and continued themes identified remain unchanged from previous board reports.

Focused themes and learning themes from Pressure Ulcer category 4

The reviews are identifying a need to think prevention at an early stage

- Recognition and timely escalation for additional supporting pressure ulcer relieving equipment
- Lack of timely holistic patient assessments, updating and sharing care needs consistently with patients, carers and families
- Unchanged recognition by staff for the need of 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.
- Inconsistent approach to photography/documentation of wounds and to use the photography to inform care/escalation

Focused themes and learning from falls with harm

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

1. **Reassessment of Patients who have fallen** - Consider reassessing a patient who has fallen, even no 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. **Monitoring of physical health status** – i.e. lying and standing blood pressure and recognition that change in wellbeing/medication matters

The CPST Lead nurse has identified a theme of non-sign off first time by CCG of the PSII falls reports. A thematic analysis is being undertaken in October to understand the challenges to this and will work with the trust falls lead to review the information and identify solutions.

Culture of Candour

'Being Open and Duty of Candour' (Culture of Candour) and to continue to raise the profile of saying 'sorry' to patients and families when care or services have fell below expected standards with or without harm. It is the right thing to do for our patients and families.

CPST can continue to report continued improvement across all directorates in the timeliness (<10days of recognition of 'moderate harm' and above) and quality of letters/communication with our patients and families. Services have embraced the practice of the person who knows the patient/family should initiate the process of candour and openness. Trust board support for final duty of candour communication to be undertaken by directors of services has seen a sustained and positive change for our patients, their families and our staff. We continue to see 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.

There are no Statutory Duty of Candour breaches to report to Trust Board. Best practice timescale breaches/delays are monitored and escalated through our Patient Safety governance groups and the Quality Forum.

Incident Review and Investigation Process

The CPST continue to facilitate the weekly incident review meeting (IRM) process that is shared with all three directorate governance teams and other key stakeholders which was extended to LLR CCG in June 2021 and does add a positive contribution to the group; there has been request by other provider collaboratives to attend as part of their assurance. The membership will expand to include medical input which will be a positive addition.

CPST Lead Nurse continues to deliver a short training session for band 6 and above staff to promote the importance of initial incident reviews and the need for quality to better inform decision making for next steps investigation. This monthly training support continues to be well received.

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

September 2021 saw 4 corporate PSSI investigators join the trust who are in the early phases of induction and inclusion in investigations according to their individual needs. Two are new to the NHS with backgrounds in the Police and prison service/legal.

Also in September we also saw the second PSII training programme commence for band 7 staff allocated by directorates to assist in the timely undertaking of investigations and supporting learning. There are planned programmes to continue well into 2022 along with refresher training for existing staff who have previously undertaken investigation training.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of PSSI investigation reports and action plans; there continues to be challenges faced by all directorates in relation to compliance and timely completion. Progress is slow however, the teams are committed to improving this; the information is shared in the appendices.

FYPC-LD have struggled to complete pre-collaborative CAMHS reports; there are 3 outstanding which are being prioritised.

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.

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:	Trust Board 26th October 2021	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Jo Nicholls, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	15/10/2021	
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:		