K

Leicestershire Partnership NHS Trust

Trust Board 25th January 2022

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report

Purpose of the report

This document is presented to the Trust Board bi-monthly *(just for the month of Dec this time to align reporting*) 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; these are owned and monitored through each directorate's governance route.

There has been a significant impact of the current national and local spread of the Omnicron variant of Covid19 infection on our patient's environment. This has also resulted with significant staffing challenges which is reflected in our compliance with NHS framework timescales of Serious Incident (SI) investigations which continues to be really challenging with the continued variables in compliance with the 60 working day deadline for submission to the CCG/other commissioners.

We continue to see reallocations of investigations due unplanned absence, increasing workloads and the increasing for the need of the CPST to support staff due to lack of training/experience as part of the operational teams juggling investigations for other investigations such as complaints and human resources. With sustained CPST input we are trying to reduce the investigations being required to be resubmitted to satisfy closure along with challenging of the feedback if it is outside the scope of the investigation. CCG delays continue due to their safeguarding and the national teams processes creating lengthy feedback delays. Our local LLR CCG patient safety team is currently affected by deployment to assist in the Covid19 booster vaccination response. The delays have also caused an increase in the requests from the Coronal service who require the report as part of their review process. The Legal team are appraising HM Coroner of our current position and the steps we are taking to maintain/address.

The national picture around patient safety incident investigation progress is unchanged due to the impact of Covid19 with planned changes through the patient safety investigation framework.

Internal investigations timescale compliance of remains extended to 50 working days, with many not completed before 60 days due to the increasing challenges of clinical workload and investigating to ensure local learning.
The CPST key message has been 'keep families and patients informed of the delays in investigations and them included in the investigation'; and, on many occasions now driving the sharing of the report at point of sharing with CCG to ensure they have right to reply earlier on.

The 8 Corporate investigators are all now in post (ranging from 3 months to one month in post). They are all undertaking investigations and this is starting to impact on Directorates releasing clinical staff back to care.

As described the above Covid19 situation has an added 'knock-on' for the timely closure and enactment of SI and internal action plans to close the investigation process continues to be challenging. Where reports have been significantly delayed for submission and closure to commissioner's request for action plan evidence/assurance that there is good progress has been requested; this is not unreasonable and the drive at the CPST investigation training has been 'if you identify an action that needs addressing or commencing before the completion of the report feed that back to the responsible senior team at that point'.

The Directorates have embraced ownership and are continuing to work hard to improve this. Additional scrutiny from the Trust senior team, 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. Continuing scrutiny at local level for managing the action plan progress formerly at governance meetings needs to commence with pace and be the same across all directorates included as a standing agenda item.

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 October and November 2021

CPST continue to describe 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. This is evident by the significant increase in incidents reported in December 2021 (& likely January 2022) due to Covid19 and its impact on our staff and services.

Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS). The NHS continues to await 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; this has been interrupted by the Covid19 pandemic. CPST continues to upload trust wide incidents at least once a week to the current NRLS database; this is to avoid 'peaks and troughs' on our nationally reported incident profile with corporate monitoring of NRLS reports via NHSE/I website and to manage the incident management database Ulysses.

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 reported. We have the ability to flag incidents for re-upload to NRLS once we have reviewed the level of harm.

The CPST Lead Nurse and Incidents Officer continues to act as a 'safety net' regularly reviewing and additional monthly 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. This is in addition, to where possible, daily review of all the previous incidents via a triage report. CPST this is also a support action for depleted senior teams where managing there incidents is often delayed over providing direct patient care. This however does not remove the directorate and speciality ownership for timely review of incidents and the harm level assigned to them is paramount.
The ORR risk has been updated to reflect the challenges at every level of the incident reporting process and the risk increased from 12 to 16 to reflect the deteriorating position. There will be a quality summit early in February to consider further actions required

Review of Patient Safety Related Incidents
The overall numbers of reported of all incidents have increased above the expected range based on previous reporting patterns and can be seen in our accompanying appendices. Covid19 has increased the reporting pattern by 300 such incidents in just 2 weeks (latter of December 2021) which equates to approximately 20 incidents per day. This has also had the incidental effect of there being 2086 incidents reported last month, which is the first time we've had incident numbers above 2000. For comparison; in November there were 1788 incidents reported, and the previous highest month ever reported (January 2021) had 1936. The reporting for infection control appears for all services Top 5 incident category for the first time ever in December 2021.

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 that significantly increased in October 2021 prompting a quality summit; this is also mirrored in Category 2 pressure ulcers that have sat consistently above trajectory since February2021. December 2021 has identified the highest ever reported numbers of category 2 pressure ulcers that have affected patients and have developed whilst in LPT care.

We continue to share the reporting of Category 3 pressure ulcers that have developed in LPT care and the continued plan 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 a significant increase in reported injury in October 2021 with many escalated to StEIS for openness and transparency due to very early identification of significant care gaps mirroring the concerns raised by clinical teams due to changes in visiting schedules, reducing staff, changes to operational practice. We have continued to see the reduction in visits and inconsistent visiting approach implicated in the deterioration of patient's existing pressure ulcers to category 4. We have continued to have category 4 pressure ulcers that have developed in LPT care and impacted on our patients wellbeing that have been previously manage through local review escalated to StEIS due to the concern and learning identified. December 2021 identified a further downward trend alike November, from October 2021.

(NB the service have informed us that due to the challenges in the tissue viability team there may be a lag in confirming Category 4 pressure ulcers for December)

All inpatient acquired category 4 pressure ulcers are reported as SI's, the Executive Director of Nursing notified and an additional sharing with the CQC; there have been none reported for December 2021.

Falls

Inpatient Falls with harm Incident Investigations continue to be reviewed at incident review meeting (IRM), a 72hr report developed and are reviewed by the Executive Nurse and her before sharing with CCG. This provides information in understanding challenges of inpatient falls prevention and how the patients and families are affected.

The 'flat lifting' equipment that has been successfully rolled out in many inpatient areas over the previous few months to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury. These have been described as being used appropriately in falls incidents and feedback is positive from the clinical staff.

Our falls across the organisation in patient areas have unfortunately shown an increase in the month of December 2021; the likely impact from challenges with staffing, patient acuity and the increased reliance on temporary staffing due to the challenges of managing the current Covid19 response.

All Self-Harm including Patient Suicide & Progress

We continue to see an increasing numbers of self-harm incidents resulting in moderate harm and above with a significant increase in November and even further increases way above our' expected baseline' in December 2021. The picture continues within the community mental health access services who are continuing to report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This is so distressing for patients, their families and the staff trying to offer support and share coping strategies.

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. CAMHS inpatients have seen increased incidents of inpatient self-harm and are linked to a few patients only in December. The incidents are impacted by one young person who requires significant input and interventions due to her eating disorder. These continue to 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, ingestion of foreign objects and ligature attempts being common themes, some patients requiring review by our acute care colleagues.

'STORM' a bespoke Training package for training 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 awaits approval in adult mental health with a need to recognise this across directorates.

Violence, Assault and Aggression (VAA)

The worrying trend of high numbers of VAA across the Trust continues with significant increase December 2021 incidents of moderate harm.

Unfortunately, this category of incident features continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. Our position is not unique as VAA have featured nationally across all aspects of the NHS in particular access services; however, this should not be accepted as the 'norm'. LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

LPT security specialist is continues to provide expert support to those incidents being investigated under the serious incident framework supporting our corporate investigators. CPST looks forward with working with other key staff to run a live trial by March 2022 on body worn cameras similar to other NHS Trusts, Emergency departments and emergency workers as a deterrent and also to positively improve staff safety and training.

Medication incidents

December 2021 has seen a significant increase in medication incidents, in particular related to prescribing concerns this is following the combined work of the CPST lead nurse, incidents officer & pharmacy to alter the reporting criteria to make prescribing errors easier/clear to report for the

nursing teams. AMAT audit project related to medication safety compliance in the clinical areas continues to demonstrate encouraging involvement and results across the Trust that are regularly reviewed by directorates and by the medicines audit group. The CPST and senior pharmacy team look forward to the Trust moving forward with the establishment of a dedicated medication safety officer posts to allow the Trust to move to a more proactive footing on medicines safety and also provide medicines expertise to support incident follow-up to maximise learning from patient safety incidents.

Directorate Incident Information

Appendix 1

This details the top 5 reported Incidents for each Directorate speciality illustrating the level of diversity. Violence and Aggression continues to be 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.

Self-harm continues to feature across CAMHS and inpatient adult mental health remains a feature in the top 5 along. As previously reported, worryingly, the tissue viability incidents reported across CHS account for a significant number of the incidents with 531 of the 774 being reported related to these incidents affecting our patients.

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 position with 'new' provider collaboratives remains unchanged with no current documented formal processes with us with continued inconsistent approach to feedback/documentation to completed submitted Patient safety incident investigation (PSII) reports.

This also creates a challenge around agreeing appropriate Terms of Reference and ensuring that the focus remains in achieving learning and supporting families/patients and staff.

Learning Lessons and Action Plan Themes

Learning Lessons Exchange

The Learning Lessons exchange group has not met due to the current challenges and changes in the governance rhythm, however will get back on track once routine governance rhythm returns.

Key learning themes from SI's:-

Emerging and Recurring themes (some remain unchanged):

- Record keeping consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide a flow of knowledge
- Updated risk assessments and their application to clinical practice and from a MDT approach, emerging theme in outpatient mental health
- Mental Capacity and safeguarding knowledge
- Lying and standing blood pressure and medication reviews in falls with harm
- Feedback related to changes from face to face to virtual appointments has been feedback identified from patients/families as a challenge for some patients and also makes assessment more difficult

- Involving families in care decisions related to consent, confidentiality & information sharing in mental healthcare and suicide prevention which very topical following the publication of a national report form Zero Suicide Alliance in August 2021.
- The inconsistent use of data to monitor quality and performance

- **Focused themes and learning themes from Pressure Ulcer category 4 (unchanged)**
- Inconsistent approach to photography/documentation of wounds and to use the photography to inform care/escalation
- 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
- Timeliness of obtaining equipment to assist in prevention of further tissue injury
- 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.
- The allocation of visits and working processes needs to be streamlined to maximise nursing time to care

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 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. **Monitoring of physical health status** – i.e. lying and standing blood pressure and recognition that change in wellbeing/medication matters

Culture of Candour

There have been no Statutory breaches of Duty of Candour.

CPST continue to report continued improvement across all directorates in the timeliness (<10days of recognition of 'moderate harm' and above (in Directorate and via IOG to QF)) and quality of letters/communication with our patients and families. Services continue to embrace the practice of the person who knows the patient/family should initiate the process of candour and openness. We have seen some challenges in Directorate of Mental Health due to complex incidents whereby next of kin and Police investigations have impacted on best practice compliance times.

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. We are promoting a change in culture amongst existing investigators of much earlier family/patient contact to increase their voices in reports and earlier 'right to reply' at point of sharing with CCG or earlier.

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 and does add a positive contribution to the group; there has been request by other provider collaboratives to attend with variable contribution. The meeting has seen an increased attendance and presentation by key staff in directorates including those who are wanting to 'listen and learn' as part of their next step patient safety incident investigation training. Feedback is good and should be seen in a gradual change in cultural towards safety investigations and the decision making involved. We continue to see more team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation and that is despite the challenges of staffing and impact of Covid 19. The provision of allocated timed slots makes this easier for this to be undertaken

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. In addition to working with Directorate of Mental Health inpatient teams on Incident management as part of their leadership/safety function.

The CPST continues to deliver a PSII training programme which commenced back in September 2021 for band 7 staff allocated by directorates to assist in the timely undertaking of investigations and supporting learning. Planned programmes will continue well into 2022 along with refresher training for existing staff who have previously undertaken investigation training. Directorates have however not always been able to release staff to attend.

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. There continues to be a proposed planned quality summit in early February to further explore the challenges around completion, quality and oversight.

In addition we are now monitoring on the timeliness and quality of initial service managers reports that inform next steps decision making for investigation.

Learning from Deaths (LfD)

The LfD process is now supported by a newly appointed Trust coordinator. Her expertise from the acute provider aspect of the NHS and the LFD process has allowed her to quickly settle and start familiarising herself with the process in LPT. A process mapping exercise of the individual directorates has been completed as part of the next steps to inform working plan going forward in 2022 to streamline processes to ensure robust reporting, ability to further learn and share information against the national expectations and local policy.

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 25.1.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	16/01/2022	
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	One –off monthly reporting as part of required reporting to executive team	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	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:		