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Leicestershire Partnership NHS Trust

Trust Board 29th March 2022

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for Trust Board March 2022

Purpose of the report

This document is presented to the Trust Board bi-monthly for January and February 2022 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

We continue 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 staff within 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 continues to be significant challenges in relation to allocation of investigations and completion of both serious incident and internal investigation; this is reflected in our compliance with NHS framework timescales of Serious Incident (SI) investigations which continues to be really challenging with almost all reports not compliant with the 60 working day deadline for submission to the CCG/other commissioners to a varying degree.

We continue to see reallocations of investigations due significant staffing challenges; such as unplanned sickness/absence, increasing workloads. This is resulting in an increasing requirement to support and further train staff in order that operational teams can juggling all necessary investigations e.g complaints and human resources. Delays are occurring within directorates around agreement with 'recommendations into actions' causing significant further delays in the completion of draft report for sharing with commissioners and patients/families.

The national picture around patient safety incident investigation progress in conjunction with the patient safety strategy is unchanged due to the continuing impact of Covid19 with planned changes through the patient safety investigation framework. The CPST key message has been 'keep families and patients informed throughout investigations and any delays in investigations and include them meaningfully in the investigation'; this is recognised as needing 'sustained improvement' in all directorates. We are actively promoting sharing of the report at point of sharing with CCG as a 'final draft' to ensure they have right to reply earlier on. The Directorates are continuing to work hard to

improve this. Additional scrutiny from the Executive 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.

The 8 Corporate investigators are all now in post and undertaking investigations, some very complex and this is starting to have a positive impact on Directorates requirement to investigate.

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

As previously reported the CPST continue to describe incident reporting should 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.

Work related to 'open incident backlogs' linked to CQC request for improvement and request for daily data, has impacted on incident reporting to the national reporting and learning system (NRLS), although plans are in place to rectify. Unfortunately, the transition to a new improved national 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 continues to be interrupted by the Covid19 pandemic.

We have a robust 'safety net' system in place to regularly review 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. Where possible, weekly review of all incidents via a triage report however the directorates need to be managing their incidents from review to closure within the allocate 15 days; training of key staff has been delivered over eight separate sessions as part of CQC request to action along with updating senior frontline clinical staff in relation to culture of candour.

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 March 2022 to consider further actions required to manage incidents, investigations and the actions/learning from them.

Review of Patient Safety Related Incidents

The overall numbers of reported of all incidents continued to be above the expected range based on previous reporting patterns and can be seen in our accompanying appendices in January 2022 with Covid19 influencing incidents. This has also had the incidental effect of there being > in January 2022 still not returning to our baseline for our trust in February. The reporting for infection control continues in the majority of services 'Top 5 incident' category which corroborates to individual and outbreak reporting.

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 February 2021. December 2021 identified the highest ever reported numbers of category 2 pressure ulcers that have affected patients and have developed whilst in LPT care his has reduced for January and February 2022 however, still remains well above the trajectory.

Category 3 pressure ulcers that have developed in LPT care have unfortunately shown an increasing trend in January and February 2022 with the continued focus on the prevention to deteriorate to category 4 for our patients in our care leading to significant harm, distress and an increase in healthcare resources.

Concern with regards to the distressing development of category 4 pressure ulcers remain of concern with an increase in February 2022 with several 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 the continued significant challenges affecting 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.

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 January/February 2022. One investigation report related to the care of a patient whose exiting pressure ulcer on transfer further deteriorated to a category 4 pressure ulcer and acquired Covid19 as an inpatient in LPT was completed in February 2022 and has resulted in a significant sharing/learning exercise with staff involved in the lady's care. We have used 'Gloria's' story with the 'brave & continued' involvement of her family during the investigation and development of the training/feedback sessions **– Appendix A**

Falls

Our falls across the organisation in patient areas have continued to show an increase in the month of February 2022 with increasing incidents in MHSOP approaching that seen back in April/May 2020. We continue to consider that the impact reduced staffing, patient acuity and the increased reliance on temporary staffing due to the challenges of managing the current Covid19 response. Inpatient Falls with harm Incident Investigations continue to be reviewed at incident review meeting (IRM), a 72hr report developed and shared with commissioners with completed report reviewed by the Executive Nurse before sharing with CCG. However, we do continue to see the lack of adherence to practice of 'specialling' for falls prevention being an influence in many patient falls in conjunction with risk assessment review and regular review/stop and pause.

We continue to see the use of the 'flat lifting' equipment that has been successfully rolled out in many inpatient areas enabling staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury and minimising moving and handling risks to staff. These have been described as being used appropriately in falls incidents and feedback is positive from the clinical staff. The publication of the national inpatient falls data demonstrates a good link with sharing the introduction of this useful piece of equipment across the NHS in England.

All Self-Harm including Patient Suicide & Progress

We continue to report as before and see a high numbers of self-harm incidents resulting in moderate harm and above. The picture continues within the community mental health access services who report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This continues to be 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 remains unchanged with the influence of individual patients and their risk profile affecting incidents. Self-harm behaviours

continue to range from very low harm to multiple attempts by inpatients during individual shifts of head-banging, ingestion of foreign objects, cutting with any implement and ligature attempts being common themes. We have seen many patients escalated for review by our acute care colleagues and the request of the support of EMAS colleagues as first line assistance.

Violence, Assault and Aggression (VAA)

The worrying trend of high numbers of VAA across the Trust continues with significant increase in February incidents of moderate harm to the highest ever reported.

Violence, Assault and Aggression continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. Our position is sadly not unique with VAA featuring 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.

Promotion of using lone worker devices continues following learning from a serious incident in community mental health with direct feedback with/from the colleagues involved with the investigator and CPST Lead Nurse. CPST looks forward to the outcome of the body worn camera trial in LPT. Other NHS Trusts, Emergency departments and emergency workers have had success and reported them working as a deterrent and also to positively improve staff safety and training.

Medication incidents

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 915 (846 in community setting) 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 CQC have not raised any concerns

Our compliance with timely submission of 72hr reports from CHS & FYPCLD to commissioners has reduced over January and February 2022 with lack of staffing being the main influence and return by CPST for incomplete information. The provider collaboratives have raised concern around compliance with timescales.

Learning Lessons and Action Plan Themes

Learning Lessons Exchange

The Learning Lessons exchange group has not met due to the ongoing staffing pressures

Key learning themes from SI's:-

Emerging and Recurring themes (some remain unchanged):

- Record keeping consistently highlighted across all directorates due to timing of entries (i.e. not contemporaneous), standard of record to provide a flow of knowledge this is corroborated with shared analyses with LLR CCG
- Lack of updated risk assessments, personal safety plans and their application to clinical practice and from an MDT approach
- Mental Capacity and safeguarding knowledge with Mental Capacity Assessments and overall care plans and risk assessments not considered or completed
- 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 makes assessment more difficult especially when these reviews take place without the 'seeing' of the patient
- The inconsistent use of data to monitor quality and performance
- Not listening to patients/families
- Action Plans tend to be ward or person specific rather than taking a wider approach corroborated with shared analyses with LLR CCG

Focused themes and learning themes from Pressure Ulcer category 4 (again remain unchanged)

- 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
- Inconsistent approach to photography/documentation of wounds and to use the photography to inform care/escalation
- 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. **Nursing observation intervention** – not being adhered to or not assessed correctly/timely when there are patient changes and adhering to 'specialling' to prevent falls
2. **Monitoring of physical health status** – i.e., lying and standing blood pressure and recognition that change in wellbeing/medication matters
3. **Use of low beds** -staff are using low beds inappropriately as a falls reduction strategy when actually a bed at standard height may be safer depending on the patients mobility and cognitive status.

Culture of Candour

There have been no Statutory breaches of Duty of Candour.

We 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. There are some challenges in the 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 weekly incident review meeting process continues and 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. Other provider collaboratives attend for incidents in services that they commission. 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 and as part of induction. As part of supporting an open learning culture and responding to feedback, we have developed a guide to attending the IRM for staff that is embedded in the agenda at the point of sharing.

We continue 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.

We also continue 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 and staff have cancelled at short notice. Our training programme is continuously evolving based on feedback and also increasing the use of real-time patient experience with investigations utilising the training tools available via NHSE/I.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of PSSI investigation reports, action plans, monitoring on the timeliness and quality of initial service managers reports and management of incidents; there continues to be challenges faced by all directorates in relation to compliance and timely completion.

Learning from Deaths (LfD)

The LfD process is well supported by a Trust coordinator. 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.

Suicide Prevention – key sharing

NHSE has commissioned the Samaritans to develop NHS Postvention Guidance – due to be published in Spring 2022 which supports the 'Staff Well-Being and Suicide Prevention (Workforce)' we have ongoing work to identify support needed for our staff following incidents of significant self-harm by patients known to them this will include specific postvention and will be linked into the work being undertaken by the De-Briefing Working Group; there is a key link in DMH; however this work extends for staff support across the trust.

The 'East Midlands Patient Safety Collaborative' has identified a key ambition with the aim of 'Reducing suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings' and is rolling out a programme that aims to reduce unwarranted variation and providing a high-quality healthcare experience for all the people across the system by March 2024. Key individuals have been identified in DMH to facilitate this programme in LPT.

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, concerns through incident reporting and management and patient safety improvements

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	14/03/2022	
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		
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:		

APPENDIX A
Patient Safety - Learning from incidents

About Gloria:

Gloria is a 79 year old lady who lived alone with daily family support since her husband died four years ago. She took great pride in her house being kept clean, tidy and used to love watching the birds in her garden.

She underwent abdominal surgery in July 2021 which resulted in a week in intensive care. She was almost fully recovered although had background physical health conditions and medications to support these.

In Sept 2021 Gloria fell at home & broke her hip requiring admission to acute hospital & transferred for ongoing recovery to LPT in early October with the aim of returning home. The day before her fall she appeared in a 'Tik Tok' video dancing in her kitchen.

What happened to Gloria:

Gloria developed a category 2 sacral pressure ulcer in the acute hospital. Following transfer this was reassessed and considered to be category 3. Five days later she had developed a category 2 pressure ulcer on her left heel.

Five days later her sacral pressure ulcer was deteriorating, she was unwell, not eating/drinking well and four days later, although showing few symptoms, she was Covid19+ve and was transferred to a 'red ward'.

Six days later her sacral pressure ulcer was reviewed (five days after the last review) & identified as category 4 along with likely infection & bone involvement, symptomatic of infection she was transferred to acute hospital for treatment for acute wound infection.

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Patient Safety - Learning from incidents

Effect on Gloria:

She was already weak from her fall, surgery & recovery. It was her 2nd acute health episode in less than six months. She was struggling to mobilise/move/work with therapy teams often due to pain and exhaustion. Standing was difficult due to deconditioning/muscle strength and she was requiring significant nursing intervention for ADL's.

Gloria's sacral pressure ulcer deteriorated to category 4. She acquired Covid19 in our care and moved wards as a result. Her pressure ulcer became infected further debilitating her, necessitating transfer to acute hospital.

Gloria returned to LPT on Christmas Day, unable to stand due to pain, lack of strength, frailty and bedbound, unable to progress in rehabilitation following her hemiarthroplasty due to nerve impingement in her left leg causing pain.

Gloria has not been able to improve her sitting tolerance due to the fact that she is unable to sit out in her chair due to the pain from her pressure ulcer. She was also confirmed as Covid19 +ve again four days later.

Gloria was transferred to a local nursing home late January 2022 and is not likely to return home.

Effect on Gloria's daughter:

She felt she had to raise her concerns with CQC to get her mother's voice & hers heard. She was unhappy about transfers, different ward moves and not being informed of deterioration of pressure ulcer to Cat 4.

Her mum had caught Covid and as result due to Covid rules she was not able to visit her mum. She had a loss of trust in NHS care, both LPT & acute provider.

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Patient Safety - Learning from incidents

Learning:

LPT only became aware of the care concerns when Gloria's daughter raised it directly with the CQC. The key points were :

- Pressure ulcer plan lacked detail for dressings & management.
- No contact with TVN
- Lack of detailed records
- PU was not seen/evaluated daily, plan not followed, not photographed weekly
- Waterlow score not assessed weekly
- Staff training not in date with pressure ulcer care
- Food, fluid & FIR charts not consistent
- Lacked leadership oversight

Actions & Transferable Learning:

- Strong Leadership & oversight of the quality of care & appropriate delegation, develop a robust & open culture of incident reporting & management
- Promoting training compliance as a measure of strong safety culture, promoting a strong culture of communication with families and local reporting of all incidents
- Foster a strong open culture for multidisciplinary working & promoting a culture of positive and timely record keeping
- Recognising the positive impact of effective pain management for patients.
- Recognition & escalation of the deteriorating patient by adherence to NEWS2.
- Processes for measuring for the success of the above.

March 2022

For further information please contact the patient safety team at lpt-patientsafety@leicspart.nhs.uk