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Leicestershire Partnership NHS Trust

Public Trust Board 31 May2022

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

Purpose of the report

This document is presented to the Trust Board bi-monthly for March and April 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.

This report will concentrate on the work in relation to the patient safety strategy including the investigation of incidents. To accommodate this less information has been included around individual incident categories.

Investigation compliance with timescales

There continues to be challenges in relation to compliance with serious incident and internal investigations timescales. The position has deteriorated over the course of the COVID19 pandemic partly due to staff being rediverted to clinical work and then as a result of staff illness.

At the end of March 2022 teams from across the Trust, came together in a 'Quality Summit' style to look at the challenges we face and to discuss a range of possible solutions. The Summit was well attended and whilst there were not any new/innovative actions identified on top of the work in place it was more about a coming together, acknowledgement of the need to improve and consider the use of marginal gains at all stages of the process to improve the position. Ultimately the summit concluded that senior Leadership is essential, as is thinking differently which aligns with national thinking as best practice

Actions in place

- The Governance of the Incident Review Meeting (IRM) to only escalate incidents if absolutely necessary or there is a real opportunity for learning identified (support of commissioners and regulators required for this approach)
- Prompt allocation to either corporate investigators or Directorate Teams
- Regular 'check in' with authors to support 'blockages' (time, confidence access to information)
- Senior Directorate staff commitment and availability to support and provide leadership

- Report at the point of sign off - good standard to allow focus on robust recommendations
- Prompt completion of an action plan in response to well considered recommendations.
- More robust actions should reduce repeated incidents
- Corporate investigation team focusing on complex incidents - as the backlog reduces will have more impact

Incident Oversight and action plans post investigation

The incident oversight group (IOG) 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. There remains a challenge for the completion of action plans post incident investigation. All three directorates have plans in place and have been strengthening processes to robustly oversee the implementation of actions. These foundations should start to show an improvement. We are using QI methodology to track and work towards Zero delayed reports by the end of June 2022- (current position provided in appendices). The actions are managed via IOG, and actions are described as part of the ORR.

Patient Safety Strategy

The implementation of the Patient Safety strategy has been delayed nationally as a result of the COVID pandemic. In relation to the management of incidents the Patient Safety Incident Response Framework (PSIRF) final publication nationally has also been delayed.
This PSIRF is a real shift in thinking and because of this has been trialled at earlier adopter sites. Their feedback has been evaluated by NHSE/I and changes made and we are expecting publication of the final PSIRF imminently. It is anticipated that organisations will take up to 12 months to transition to this model. The evidence from early adopters is that it is important that we do not try to slot this new process into 'old thinking'. Within the Trust, we have been, where possible, creating foundations for this new model by implementing and developing IRM, moving away from Root Cause Analysis (RCA) and instead using human factors and system thinking as an investigation response. The recruitment of independent incident investigators from a range of backgrounds is fundamental to the change in thinking and is a key strategy as part of PSIRF. The Patient Safety Strategy advises that such investigators must be appropriately trained, suitably independent, and overseen by appropriately qualified leaders. Within LPT, we have appointed 8 new investigators who are suitably trained and offer a level of independence due to centrality and nature of their portfolios.

The success of this model relies on those responsible for commissioning and overseeing and receiving these investigations also having awareness of this new thinking. This was shared with Trust Board at their development session.

The Patient Safety Strategy works on a model of Patient Safety being everyone's business. It moves us away from Safety I (reacting only to incidents) to Safety II (considering what goes well and doing more)
The model works on three stages

- **Insight** (what data/information do we have, how do we use it, triangulate it present it)
- **Involve** (do we involve the right people -most importantly our patients and their families)
- **Improve** (do we use robust methodology to agree what to improve and how)

The model also describes that organisations must use their 'insight' to develop their approach and cautions against having too many projects underway and not successfully implementing them.

The PSIRF recommends that we analyse carefully our incident profile, consider what we know to be appropriate tested and evidence-based interventions and implement them and focus our investigation efforts where there is the maximum opportunity for learning. The preparation for this cannot commence unto the updated model is published.

We are currently testing an aligned model to the PSIRF recommendations within DMH to identify the 'themes' coming out from serious incident and internal investigations that continue to feature in spite of individual action plans being developed and implemented.
The themes are gathered from a range of senior participants who attend the fortnightly sign off meeting – this allows a wide range of input from individuals who have read and heard the stories from incident investigations as well as the investigators themselves. These themes are collected over a quarter using key theme titles and logging of incident numbers against it to build up the strength of the theme. This reduces the risk of bias. There is then an extended meeting to discuss the emergent themes and agree those that need onward escalation to DMT for consideration for a Quality improvement project supported by the Improvement Knowledge Hub and with oversight and scrutiny of progress at DMT. Once this pilot is completed, the outcome, learning and developments will be shared with CHS and FYPC/LD for similar cross Trust learning and consideration within DMTs.

The strategy also requires organisations to have a Medical Devices Safety Officer (MDSO) and a Medication Safety Officer (MSO). The MSO is currently the Head of Pharmacy. This role was introduced in a patient safety alert in 2014. The patient safety strategy has re described and refreshed the role in the model of the strategy and the Heads of Patient Safety and Pharmacy have been discussing the need for this role to have more independence and dedicated time to proactively approach medication safety (Safety II).

Involving patients in patient safety

There are two areas to this:

Part A – involving patients in their own safety - this requires further consideration.

Part B - recruiting two Patient Safety Partners for two of our safety related committees.

We are working with patient experience to recruit to these posts. It is essential that we ensure we have the culture, framework, training, and support structure in place for this to be successful. The time scales have been extended for our patient safety partners to be in place to the end of September 2022.

Patient Safety Training
The patient safety training level 1 and 2 has been published and the Patient safety team and Comms are working to develop the introduction of this to LPT staff

Summary
The implementation of the strategy has been delayed across the NHS by the pandemic. We have, however, been working towards the principles and developing the right systems and processes and culture and thinking so we have not lost this time. The cultural foundations of just culture and learning are key to the success of the rest of the strategy. We have work underway in various stages of maturity in all of the areas required of the strategy. The key deadlines being recruitment of our patient safety partners by 2022, the embedding of the patient safety training level 1 + 2 as soon as possibly with an ambition to adopt across all staff. The introduction of the PSIRF over the next 12 months.

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, we continue to describe that incident reporting should not be 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' continues and is an improving picture with senior support and oversight. The position will have governance and oversight through IOG. The prompt oversight and management of incidents is part of a strong safety culture. We also have a robust 'safety net' system in place to regularly review and 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.

Review of Patient Safety Related Incidents

The overall numbers of all reported incidents remain above the previous mean and can be seen in our accompanying appendices. The majority of the increase is due to staff reporting COVID positive.

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

There continues to be no discernible reduction in the number of pressure ulcers reported. The in-depth review and listening events undertaken in CHS has elicited areas for improvement that were previously unseen. These have been worked into QI projects and these projects have recently been re invigorated and detail shared at both Quality Forum (QF) and at Quality Assurance Committee (QAC). CHS Director and HON meet regularly with the QI lead and workstream lead to receive feedback on progress and support as required.

Areas of focus are

- initial assessment -ensuring it is a qualified nurse is allocated to the first visit.
- ensuring patients/carers are enabled to be involved in their own care and understand the risks
- equipping staff with the skills and confidence to undertake Mental Capacity Assessments to support the above
- ensuring all staff are familiar with all of the equipment/interventions available to support patients

In addition to the work in CHS, the trust wide pressure ulcer prevention group is being re invigorated and will now be chaired at Deputy Director of Nursing Level. Progress will be reported via Patient Safety Improvement Group (PSIG) and updates provide through future reports.

Falls

The falls group have struggled with membership/attendance during the pandemic due to the key members of staff working clinically. The Terms of Reference for the group have been refreshed and the membership updated, and they are working to build on the work started. The group have developed a whole bed management policy to support staff to make informed decisions around keeping patient safe who may be at risk from falling from bed. It has become custom and practice to lower the patient's bed to reduce the risk of falling however, patients who can stand independently can be at more risk from standing from this low level.

Deteriorating Patients

This is the term used to describe a clinical physical deterioration. The numbers of incidents relating to this are not easy to quantify as they are often reported under different categories. The deteriorating patient group are working to develop a process so that they consider our recognition and response post any cardiac arrest, when patients are unexpectedly transferred back to the acute trust and from any relevant SI's. This focus is identifying some emerging themes around delayed escalation of patients who are deteriorating, the management of observations and management of

fluids. The Deteriorating patient group direct task and finish workstreams to strengthen staff knowledge and process and oversight of these areas and will report progress via PSIG.

All Self-Harm including Patient Suicide

We continue to report 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 may have contacted CAP have 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.

Suicide Prevention

The suicide prevention lead has retired and DMH are recruiting to this role whilst reviewing suicide prevention models to consider bets practices nationally.

The suicide prevention group has re-established and is re looking at their work program and membership.

Violence, Assault and Aggression (VAA)

The trial of body worn cameras has now commenced within DMH and early feedback is positive. Already funding has been secured to extend the scheme and purchase more to roll out in more areas.

Medication incidents

There has been a theme identified around the management of controlled drugs in the community. Early review suggests that this is a system error, and a task and finish group has been convened to consider the system and support a Human Factors approach to support staff to administer and document controlled drugs safely in the community. There is now a pharmacist member of the IRM which is providing that important link and oversight.

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. We continue to work with our other commissioners to provide assurance around our improvement work and progress towards the implementation of the patient safety strategy

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. We do have a backlog of deaths yet to be reviewed. Each directorate has a recovery plan.

Learning Lessons Exchange

The Learning Lessons exchange group joined together with the FYPC/LD group in April to consider the CQC Out of Sight report- this report looks at the use of restraint, seclusion, and segregation in care services for people with a mental health condition, a learning disability, or autistic people. The group considered the report and its recommendations using their multidisciplinary/speciality experience to consider the current position. An improvement plan is being developed

Sharing Learning

Through PSIG we are using patient stories to use within directorate and to share learning across directorate. These stories are discussed at PSIG to ensure we are really focussing on what the learning is. This is part of our culture and new way of thinking. An example of stories is shared as an appendix to this report Appendix 2

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:	Public Trust Board 31.5.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward (Head of Patient Safety)	
Date submitted:	18/05/2022	
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:		