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Leicestershire Partnership NHS Trust

Trust Board - July 2022

Report title - Patient Safety Incident and Serious Incident Learning Assurance Report for Trust Board July 2022

Purpose of the report

This document is presented to the Trust Board bi-monthly for May and June 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 during the COVID19 pandemic, due to staff being rediverted to clinical work or because of staff illness and operational staffing challenges.

Actions in place

- The Governance of the Incident Review Meeting (IRM) agreed to only escalate incidents if considered there is a real opportunity for learning identified (support of commissioners and regulators for this approach)
- Prompt allocation to either corporate investigators or Directorate Teams
- Regular 'check in' with investigators to support 'blockages' (time, confidence to access to information or the right people)
- Senior Directorate staff commitment and availability to support and provide leadership when required
- Report at the point of sign off to be of a good standard to allow focus on robust recommendations and for sharing with patients, families, and staff
- Continue to promote the timely completion of an improvement plan in response to well considered recommendations

- More robust actions should reduce repeated incidents with the promotion to link into quality improvement
- Monitoring the timeliness and quality of initial service managers reports and backlog ensures impact

Incident Oversight and action plans post investigation

The incident oversight group (IOG) continues to monitor the whole incident management process. From the local management of incidents, completion of patient safety incident investigation reports, and action plans. There continues to be challenges in relation to capacity of staff to undertake the improvement work in a timely way to manage action plans post incident investigation. However, all three directorates have plans in place and have been strengthening processes to robustly oversee the implementation of actions. These foundations are slowly starting to show some signs of improvement.
We have been using QI methodology to track and working towards Zero delayed reports by the end of June 2022; although we have not achieved (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 because of the Covid-19 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 by the end of summer 2022. 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 continue to promote the 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. This approach is taught at our Patient Safety Incident Investigation Training which is delivered on a regular basis by the corporate patient safety team. 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 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 and there is commissioner facing link from the Lead Nurse in the corporate patient safety team.

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. It is being well received and promotes 'everyone's contribution'. 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 to be 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.

Involving patients in patient safety

There are two areas to this:

Part A – involving patients in their own safety; this requires further consideration. However, for many clinicians this is often done without 'thinking' and is part of their holistic approach to caring. We need to build on this and learn from good practice and bespoke record keeping in relation to this.
Part B – to continue the journey for 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 Team are working to develop the introduction of this to LPT staff. We are also working together to develop change leaders who will support and promote this

Summary
The implementation of the patient safety strategy (PSS) has been delayed across the NHS by the Covid-19 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 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 possible with an ambition to adopt across all staff. The introduction of the PSIRF over the next 12 months working with system partners to achieve this. Our aim is to get to a 'place' where the PSS is part of our everyday business and considered in our clinical and operational decision making.

Analysis of Patient Safety Incidents reported

Appendix 1 contains all 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. **NB** the data is live and will therefore be subject to fluctuation as incidents are updated and validated (the PU data is trust wide so will be different to any other specific directorate reports)

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 continue to be above the previous mean and can be seen in our accompanying appendices. Most of the increase continues to be related to staff reporting Covid-19 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 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 developed a whole bed management policy to support staff to make informed decisions around keeping patients safe who may be at risk from falling from bed. While falls remain a consistent concern for clinical areas there has been a significant and sustained reduction from Feb 2022, and we have seen a reduction in falls with harm reported as serious incidents in Q1 for 2022-23.

Deteriorating Patients

This is the term used to describe a clinical physical deterioration in patients, often initially unrecognised in patients with complex co-morbidities. 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 (particularly out of hours), the management of observations and management of fluids and we are working to support staff with a range of tools and competencies to deliver a higher level of care and escalate concerns earlier.

All Self-Harm including Patient Suicide

In May we saw steep increase in 'reported suicides', several being younger/middle-aged women. We continue to report and see a high numbers of self-harm incidents resulting in moderate harm, and above which has peeked in May 2022. 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 CAMHS has seen a dramatic fall in June influenced by individual patients either in recovering or transferred to more appropriate in-patient settings than our acute admission unit at the Beacon. In addition, there has been a continued focus on supporting our young people when they are distressed and equipping staff with better skills and support to do.

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.

Suicide Prevention

The suicide prevention lead has retired and DMH are recruiting to this role whilst reviewing suicide prevention models to consider best 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 is in progress within DMH and continued feedback is positive. Funding has been secured to extend the scheme and purchase more to roll out in additional areas. This is a positive support for staff and can afford us learning and reflection when reviewing incidents involving violence and aggression in the clinical areas. Incidents of violence and aggression have seen a downward trend in both May and June 2022 overall.

Medication incidents

There has been an increase in the number of medication incidents reported. This is felt to be a result of a focus on medication incidents. There is a task and finish group for the management of controlled drugs in the community. Early review continues to suggest that this is a system error. There is now a pharmacist member of the IRM which is providing that important link and oversight. The medicines risk reduction group are working with directorates to consider the increase in medicines related incidents and having a particular focus on omitted doses. Patient safety are working with pharmacy to develop a case of need for a Medicines Safety Officer (MSO) which is a requirement of the patient safety strategy.

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. We continue to have a backlog of learning from deaths yet to be reviewed and each directorate has a recovery plan to manage this.

Learning Lessons Exchange

Patient safety is working with the Comms team to re brand the learning lessons exchange into a group working to foster a 'learning culture' to ensure that staff have the skills to identify learning and implement necessary changes.

The next meeting will consider the learning from complaints/the complaints process

Sharing Learning and hearing the patient story from incidents

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.

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 26.7.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward (Head of Patient Safety) Sue Arnold (Lead Nurse / PSII Lead CPST)	
Date submitted:	17/07/2022	
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	
Equaliy considerations:		