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NHS
Leicestershire Partnership
NHS Trust

Trust Board – 27th September 2022

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

Purpose of the report

This document is presented to the Trust Board bi-monthly for July and August 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

The challenges in relation to compliance with serious incident and internal investigations timescales continue. The position had deteriorated over the course of the COVID19 pandemic partly due to staff being rediverted to clinical work and latterly because of staff illness and operational staffing challenges. This was quickly identified, and an improvement plan developed.

Actions in place

- The Governance of the Incident Review Meeting (IRM) to only escalate incidents if it is considered 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 investigators to support 'blockages' (time, confidence to access to information or the right people)
- Report at the point of sign off is to be of a good standard and compassionate to allow focus on robust recommendations and for sharing with patients, families, and staff
- Continue to promote the timely completion and ownership of an improvement plan in response to well considered recommendations.

- Promote combined learning and actions from recommendations across the trusts incident reviews to link into quality improvement
- Corporate patient safety incident investigators continue to focus on complex incidents

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. Challenges continue in all directorates in relation to compliance and timely completion; this is also across corporate investigations, in relation to capacity. The agreement and completion of action plans post incident investigation also remains an area requiring further improvement, which is being addressed. All three directorates have different plans/timescales for this part of the investigation process and are continuing to work on strengthening processes to oversee the implementation of actions. The Quality Improvement (QI) methodology to track and strive to work towards 'Zero' delayed reports by the end of June 2022 has made several improvements across the Trust in terms of pace and grip on investigations, however due to significant complex cases and capacity challenges this position has not achieved the target outcome and therefore this project continues (current position provided in appendices). The actions are being well managed via IOG and 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 was shared at the end of August 2022. Many tools, early adopter feedback, webinars/meetings have taken place in a very short time with the sharing of the framework and its expected roll out across organisations delivering NHS care. From a patient safety perspective this is long awaited and will be of great benefit for sustained learning building on a just culture and improving engagement with patients, families, and staff.

The new PSIRF is a real shift in thinking, and it is anticipated that organisations will take up to 12 -18 months to transition to this model. Within the Trust, we continue to promote the foundations for this new model by implementing and developing our IRM, moving away from Root Cause Analysis (RCA) and instead using a patient safety evidence base of new thinking around human factors and system thinking as an investigation response. This approach has been adopted and is supported in our Patient Safety Incident Investigation Training which is delivered on a regular basis by the corporate patient safety team. Our early thinking and actions taken to recruit independent incident investigators from a range of backgrounds has been 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 the Trust Board at a recent development session and there is commissioner facing link from the Lead Nurse in the corporate patient safety team.

We continue to test 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 despite individual action plans being developed and implemented. It is being well received and promotes 'everyone's contribution'. This was reported in the previous months report, and we would actively support once this pilot is completed, the outcome, learning and developments will be shared with the Community Health Services (CHS) Directorate and Families and Young People/Learning Disability Directorate (FYPC/LD) for similar cross Trust learning and consideration within DMTs.

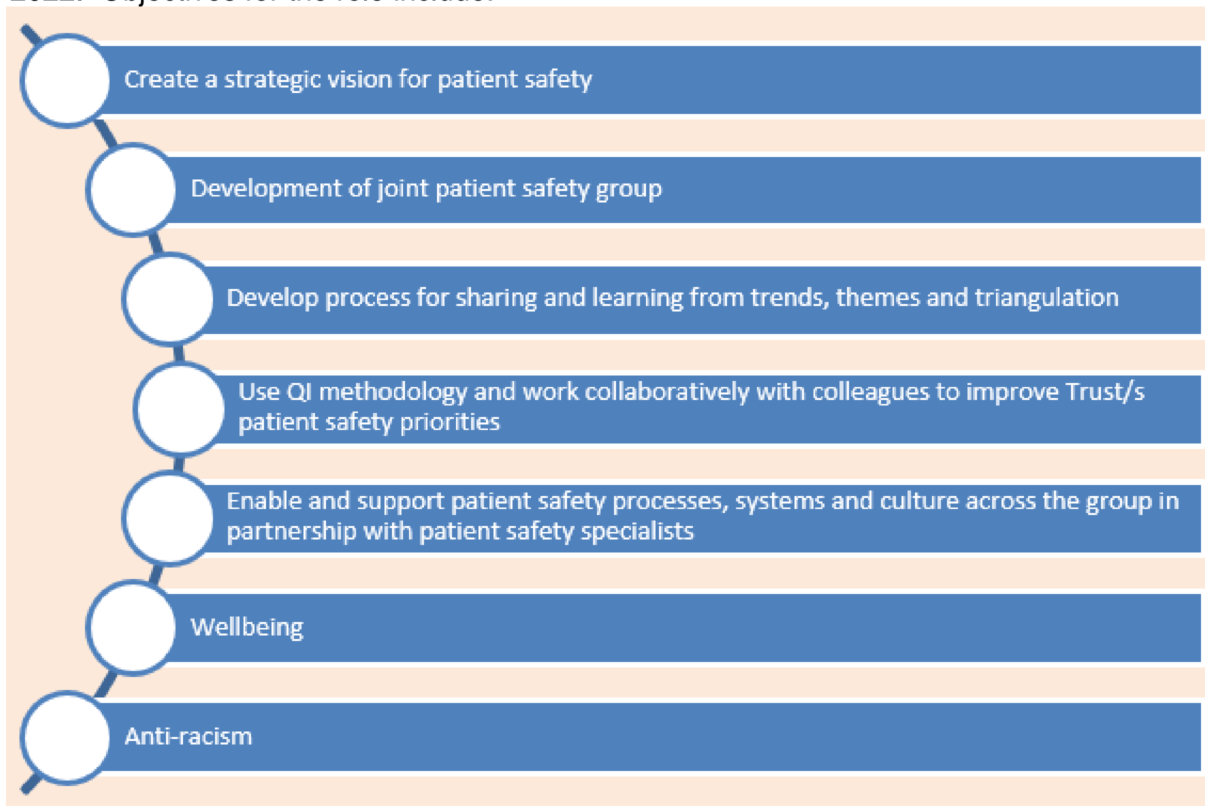
A key PSIRF action project plan has been developed by the newly appointed Group (NHFT & LPT)Interim Director of Patient Safety, and it is expected that engagement with key stakeholders will gather pace. The implementation of the PSIRF will occur individually in each trust with a group approach wherever possible/

Patient Safety Training

The patient safety training level 1 and 2 has been published and the corporate Patient safety team and Comms Team are working to develop the introduction of this to LPT staff. Patient Safety Incident Investigation Training and ISMR continues on a monthly basis with good feedback

Group Director for Patient Safety

The Group Director of Patient Safety for NHFT & LPT commenced in post in August 2022. Objectives for the role include:



The Group Director will provide strategic direction to both organisations and work collaboratively with St Andrews Healthcare as part of the buddy arrangement. A key component will also be to work with system partners in both the Northamptonshire and Leicestershire & Rutland ICS'.

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. The overall position is also included for 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 continue to be above the previous mean and can be seen in our accompanying appendices.

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

We have seen a reduction in the number of pressure category 4 ulcers reported for July/August 2022; however, overall, the desired decrease with patient harm remains unchanged. QI projects related to pressure ulcer learning has recently been re invigorated and detail shared at both Quality Forum (QF) and at Quality Assurance Committee (QAC). The Community Health Services (CHS) Executive Director and Head of Nursing (HON) meet regularly with the QI lead and workstream lead to receive feedback on progress and support as required.

Areas of continued 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 now being chaired at Deputy Director of Nursing Level. Progress is being 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 continue to see a fall 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 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 and supporting staff with a range of tools and competencies to deliver a higher level of care and escalate concerns earlier continue to be of concern.

A theme of acute patients transfer due to deterioration in physical health has been revisited in CHS to identify learning through case review with introduction of new category and

reporting in the Ulysses incident reporting system. This may also provide opportunities for other directorates to follow this approach which is in its infancy.

All Self-Harm including Patient Suicide

We continue to see within the community mental health access services reporting of increasing numbers of patients in crisis who may have contacted CAP who 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. There has been a continued increase in moderate harm and above reporting of self-harm incident over July and August 2022, along with an increase in total self-harm incidents reported.

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 the Directorate of Mental Health (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 going well within DMH and continued feedback is positive. Funding has been secured to extend the scheme and purchase more to roll out in additional areas and we await feedback. 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. Unfortunately, there was a significant incident in August 2022 resulting in significant injuries to 2 visiting staff in the community.

Medication incidents

World patient safety day is the focus of medication error, so we are working with our pharmacy colleagues to undertake work and promote initiatives to support learning from local projects.

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 deaths yet to be reviewed and gradually each directorate has a recovery plan to manage this. Good reviews have taken place with request to review care using a structured approach of the ISMR being requested where further review has been of benefit.

Learning Lessons Exchange

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 with a request for the directorates to proactively own these. 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 27.09.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold (Lead Nurse / PSII Lead CPST)	
Date submitted:	15/09/2022	
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:		