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Leicestershire Partnership NHS Trust

Trust Board - November 2022

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

Purpose of the report

This document is presented to the Trust Board bi-monthly for September and October 2022 to provide assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. Incident reporting. 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 by 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 also assure the Trust Board of the work in relation to the patient safety strategy and now the Patient Safety Incident Response Framework (PSIRF) published in August 2022. The overview of which was shared at August Board, which has been described as a whole culture change in how the NHS manage and investigate/review and learn from incidents. It places greater emphasis on learning and the engagement and involvement of both staff and patients and away from counting numbers and focussing on bureaucracy such as simply compliance with timescales.
To accommodate this within our reporting, less information is reported around individual incident categories.

Patient Safety Incident Response Framework (PSIRF)

The patient safety incident response framework (PSIRF) is a new approach to responding to patient safety incidents, will replace the current Serious Incident Framework (2015) and was published in August 2022; implementation is expected to take 12 months as outlined in the table below:

Phase	Duration	Purpose
PSIRF orientation	Months 1–3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4–7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
Governance and quality monitoring	Months 6–9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7–10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9–12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.

PSIRF represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:
Compassionate engagement and involvement of those affected by patient safety incidents
Application of a range of system-based approaches to learning from patient safety incidents
Considered and proportionate responses to patient safety incidents
Supportive oversight focused on strengthening response system functioning and improvement

LPT are engaged with the ICB and system partners to co-produce a plan in relation to incident investigations, in addition to developing our own response plan; this is to ensure that the needs of the county population are considered, in addition to the Trust's identification of emerging themes and learning opportunities. The first 3 months of PSIRF have been allocated for NHS Trusts to:
Start with reading and understanding the framework and associated documents.
Engage with all parts of the system – MH, LD, Community, Acute, Maternity, ICB, Coroner.
System PMO workbook – A workbook which sets out the plan over the next 12 months and this will be adapted to support with a system wide approach to learning and quality improvement.
Connect with leads across the East Midlands region and nationally.

Patient Safety Strategy

Patient Safety Partners
As part of the Patient Safety Strategy requirements, we are initially planning to recruit two patient safety partners to support two of our quality groups; the Patient Safety Improvement Group (PSIG) and the Quality Forum (QF). We plan to advertise these posts over the next two months.
The patient safety partners will have a robust induction into the aims of the strategy and modern safety science and quality improvement and as their ability develops will work with teams on Quality Improvement projects

Patient Safety Training
In line with the new Strategy, the patient safety training level 1 and 2 has been published and the corporate Patient Safety Team and Communications Team are working together to develop the introduction of this to LPT staff. This is already available on U learn within LPT and is being introduced as part of our Patient Safety Incident Investigation Training which is available monthly and has received some good feedback so far.

Change Leaders
The success of the patient safety strategy relies on a mature safety culture resulting in being a learning organisation where all staff are seen as, and empowered to be learners, and system thinking is normal, and the culture is open and fair. The patient safety team are working as part of the programme to work in collaboration with our change leaders to enable and empower. The change leaders are coming together at Our Future Our way change leaders launch event on Friday 25th November

Learning From Patient Safety Events (LFPSE)
The Learning from Patient Safety Events (LFPSE) is a new system that has been developed to replace the National Reporting and Learning System (NRLS). The purpose of the change is to improve real time information and allow for 'machine learning' at a national level to more rapidly identify and react to themes. The implementation date has been extended as most NHS Trusts and the incident reporting system providers have been challenged in making the necessary preparations for the change. Within LPT we are working with Ulysses, our incident reporting system, to understand what is required to successfully transition to this.

Group Director update

The Group Director of Patient Safety for NHFT & LPT commenced in post in August 2022. The role provides strategic direction to both organisations and works collaboratively with St Andrews Healthcare as part of the buddy arrangement. A key component for this role is to work with system partners in both the Northamptonshire and Leicester, Leicestershire & Rutland ICB's on patient safety and quality improvement workstreams.
To align with group quality improvement objectives, the following work has begun:

- Joint strategic pressure ulcer group
- Joint strategic mental health safe and therapeutic observation improvement Group
- Joint strategic group for care of the deteriorating patient

The two Trusts are also implementing:

- A joint approach to using the Life QI database for quality improvement programmes and projects
- A group learning lessons exchange that includes our buddy partner, St Andrews Healthcare
- An aligned approach to a quality & safety review, led by the Group Director, in response to the letter requesting the review by the National Director for Mental Health and following the BBC panorama programme focussed on the Edenfield Medium Secure Service in Greater Manchester. This work has also involved joint working on closed cultures.

Patient Safety Congress October 2022

The key themes from patient safety congress this year were around the developments described above in relation to the patient safety strategy.
In addition, there was much discussion around 'why are we not learning' this related to the many public inquiries and the similarity in their findings.

At LPT we have previously taken the learning from the Ockendon review and taken the transferrable learning and are currently considering the learning from Bill Kirkup's review into East Kent. This will be presented at QAC in December 2022

In relation to 'why we are not learning' there was a call for more research to be focussed on this rather than specific subjects.
There was a focus on staffing and the importance of this being addressed and the need to ensure that while recruitment/retention is being addressed it is essential that systems of working are as safe and easy for staff and patients to navigate. We are working on this through our serious incident actions focussing on systems.
There was also a lot of discussion around health inequality and listening to patients and in particular, women. The importance of the quality of our data to ensure that we can monitor and identify where inequalities are present. We are working to improve our data particularly

- Protected characteristics.
- Triangulation of data
- Listening to patients
- Quality dashboards

The features of the safest organisations are 'problem seeking' and not 'comfort seeking'.

There was a strong focus on system thinking and brave leadership focussed on sustained improvement rather than quick fixes.

Investigation compliance with timescales

We continue to face a challenge in relation to compliance with serious incident and internal investigations timescales. This current requirement of investigating fully all incidents is part of the reason for the national move to PSIRF. This will allow us to identify and agree what to investigate within our resource while allowing more focus on quality improvement.
Operational staffing challenges continue; however, we have an improving picture and an improvement plan in place.

Actions in place

- The Governance of the IRM to only escalate incidents if it is considered there is a real opportunity for learning identified (we are working with commissioners and regulators to support this approach as we transition to PSIRF)
- Prompt allocation to either corporate investigators or Directorate staff trained in investigating (more complex reports being undertaken by corporate investigators
- Regular 'check in' with investigators to support 'blockages' with support from senior leaders in directorate to unblock (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. This has been highlighted as a particular challenge in recent months and directorates are working to address this to minimise delays

- Promote combined learning and actions from recommendations across the trusts incident reviews to link into quality improvement
- Further to the test in DMH all three Directorates now have sign off meetings and are using PDSA cycles to improve to ensure that there is the right attendance with the right emphasis to learn and improve – these meetings allow for theming of system issues rather than outcomes (incidents are reported as outcomes) and therefore agree robust quality improvement/system actions

Outcomes

- Incident discussions at IRM are more open and transparent with focus on learning and improvement.
- The CQC and the ICB have commented on the improvement in the quality of both our reports and the robustness of the actions to improve system and process rather than focus on individuals
- Reduction in concerns/complaints from patients/families in relation to the SI process due to enhanced communication and involvement in the process with the opportunity to review the report in a final draft stage and therefore contribute to the content.
- In the main there is a reduction in our late reports or a holding position (we are of course always adding incidents and action plans) (see appendix for position)

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. The collaborative care planning and shared decision making group are going to pick up the linked work of updating patients risks and care plans in response to reported incidents 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

There has been no statistically significant improvement in the overall number of pressure ulcers despite the focus and ongoing QI projects. The trust strategic pressure ulcer group has been reinvigorated to re base and re focus closely on prevention of pressure ulcers using the pressure ulcer prevention standards to frame the agenda and work plan. As part of this the pressure ulcer prevention policy has been reviewed and has been much improved and now includes many useful tools to support staff. The group have introduced Trust wide reporting for all categories using SPC charts.

As part of this work there has been a review and consideration of themes identified through investigations and the November 2022 meeting focused on medical devices and seating.

A theme identified that currently has no workstream relates to the timing of ordering of pressure ulcer prevention equipment. Report findings suggest that this is ordered late and often when the patient already has some skin damage. A workstream has commenced to understand what is driving this and to review the process from decision to order to acceptance of order to delivery of the equipment. Following this review appropriate improvement actions will be developed.

Falls

The falls group reported at August board that they had developed a whole bed management policy and they are monitoring the impact of this newly launched policy– this was developed to support staff to choose the safest bed position i.e., standard height or low position and when the use of bed rails is appropriate.

An emerging issue has been identified that not all staff are trained to use the flat lifting equipment. LPT purchased this to comply with NICE guidance in relation to the lifting of patients from the floor who were suspected to have an injury. This is because using a hoist can exacerbate any injury and impact on the outcome for patients. There has been a targeted effort to increase the numbers of staff trained.

This has also prompted a piece of work around ensuring we have visible oversight of training figures and senior oversight

The Falls group together with patient safety are undertaking a thematic review to ensure their QI work is aligned to the current themes from falls.

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 to the deteriorating patient.

There are three main areas that learning is obtained

- Review of care post any cardiac arrest
- Review of care post any re admission to an acute trust
- Incidents reported in relation to deterioration

Themes identified are around:

- Delayed escalation of patients who are deteriorating
- The management of physical observations and escalation
- Management of fluids
- 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.

The focus of our review is on the human factors of why staff do not escalate. We are exploring this to understand what is driving the delayed escalation.

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 our Mental Health Central Access Point (MHCAP) 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, along with an increase in total self-harm incidents reported.

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.

There is a theme identified in 'In patients' who self-harm on the wards involving the undertaking of therapeutic observations. This is around who undertakes them and what model is used. Early review has identified that this is a wider issue that other Mental Health trusts are working to understand. The national confidential inquiry into suicide suggests the requirement for training and competency of staff undertaking this important intervention. The Deputy Director of Nursing is establishing a trust wide group to consider this.

The execution of our checking and searching of patient's policy has also been identified as a concern; patients have been able to obtain items and have then gone on to use them to harm themselves and staff have not searched the patient despite knowing this is the policy. We are working to understand the human factors around this in that staff are reporting not wanting to disrupt their therapeutic relationship. Alternative strategies are being considered and a trust wide task and finish group will be led by the Head of Nursing for DMH

Suicide Prevention

The suicide prevention lead initially funded by the Directorate of Mental Health (DMH) has retired and a joint Suicide Prevention and Self-harm Lead job description is being developed. The Deputy Head of Nursing for the Urgent Care Services in DMH is covering the essential elements of this role and reviewing suicide prevention models to consider best practices nationally. The trust 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 been evaluated for the 4 wards in DMH and initial feedback is positive regarding detering violence or aggression. Funding has been secured to purchase the existing camera's, supporting equipment and licences and the use of the cameras will be extended and evaluated in the new year before considering roll out to further wards. 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 incident in August 2022 resulting in significant injuries to two staff visiting a forensic patient in the community; staff do have interactive lone worker devices available to them to support getting prompt assistance.

Medication incidents

Patient safety and pharmacy are working together to maximise the learning from medication related incidents to ensure that learning themes are identified, and system actions implemented. This relies on a change in culture from incidents being related to systems rather than individuals. The addition of a pharmacist attending the weekly IRM is enabling the focus on medication incidents and bringing closer links with the Medicines Governance. The inclusion of named pharmacist in providing valuable oversight and review as part of the investigation process.

Queries Raised by Integrated Care Boards, Collaboratives, 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 a process whereby they ask for additional

information in relation to reported incidents which we provide in a timely manner. 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 including the PSIRF.

Learning from Deaths (LfD)

The LfD process is well supported by a Trust coordinator. The previously reported backlog of deaths for review has been cleared and teams are again reviewing deaths in real time.

Learning Lessons

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.

The next meeting of the Community of Practice will focus on learning from complaints – this will be run jointly by complaints and patient safety

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	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward Head of patient safety	
Date submitted:	15/11/22	
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
	Single Patient **R**ecord	
	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:		