S

Leicestershire Partnership NHS Trust

Trust Board – January 2023

Patient Safety Incident and Serious Incident Learning Assurance Report for Trust Board January 2023

Purpose of the report

This is the Trust Board bi-monthly report for November and December 2022 providing assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. This report also reviews our systems of control which 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.

Triangulation of concerns already takes place between patient safety, legal team, and complaints. To improve this triangulation and to identify any 'hot spots' patient safety is also working with the Freedom to Speak Up Guardian and Compliance Team. 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.

Patient Safety Incident Response Framework (PSIRF)
The patient safety incident response framework (PSIRF), published in August 2022, is a new approach to responding to patient safety incidents and it will replace the current Serious Incident Framework (2015). 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 as a key part of the NHS patient safety strategy. We are working through the discovery phase of the PSIRF and have established an internal project group working through the documentation to understand the project collaboratively with ICB colleagues. We recognise the importance of clear and consistent communication for the success of this important change and ensuring good communications internally and across the system; with key principles of the PSIRF shared internally to ensure staff are prepared.

Patient Safety Strategy:

Patient Safety Partners - posts to be advertised in January 2023.

Change Leaders - Our Future Our way change leaders launch event on Friday 25th November 2022 was an excellent event with a commitment to work together to support and strengthen a learning culture. There will be a series of opportunities for Change Leaders to

access learning to support this such as Quality Improvement methodology and Human Factors.

Patient Safety Training - The change leaders are going to undertake level 1 and 2 national training modules to positively support the introduction in their own areas.

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). Within LPT we are working with Ulysses, our incident reporting system, to understand what is required to successfully transition to this.

Learning Lessons -The Learning Lessons group has been re launched as a 'Community of Learning' this is using community of practice methodology. The core group consists of a diverse range of colleagues with expertise/understanding of 'learning' - membership will flex depending on the subject.

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 patient safety journeys and collaborative approach. A key component is to work with system partners in both the Northamptonshire and 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 observations group
- Joint strategic group for care of the deteriorating patient
- 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 was reported to SEB & QAC in December and published on the LPT public website. A paper outlining the timescales and actions will be presented to SEB in February 2023.

The two Trusts are also implementing:

- A joint approach to using the Life QI database for quality improvement programmes and projects.

Investigation compliance with timescales

We continue to face challenges in relation to compliance with serious incident and internal investigations timescales; however there is an improving picture and an improvement plan in place We have also been working hard to improve the quality of our reviews including how we engage and support patients/relatives and staff, as well as the quality of the investigations to ensure we are identifying stronger more robust actions to manage the system issues that have contributed to the incident. As part of this we have been working to the Royal College of Psychiatrists – Serious Incident Review Accreditation Standards (SIRAN). During December 2022 we submitted our physical evidence, with planned virtual visits from members of the accreditation panel in January 23 to further accredit. The achievement of this accreditation will be an excellent foundation to build on as we develop our processes and Governance to transition to the PSIRF.

Actions in place

- Governance of the IRM - only escalate incidents if considered there are real opportunities for learning identified (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 (complex reports being undertaken by corporate investigators).
- Regular 'check in' with investigators to support 'blockages' with support from senior leaders in directorate to unblock.
- 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 challenge in recent months and we are working to minimise delays.
- Promote combined learning and actions from recommendations Trust wide. Further to piloting DMH all three Directorates 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 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 systems and processes.
- 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 contribute to the content.
- A reduction in our late reports or a holding position (see appendix slides 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.

All incidents reported across LPT - 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 has governance and oversight through IOG as prompt oversight and management of incidents is part of a strong safety culture. The collaborative care planning and shared decision-making group are leading 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 escalate any outstanding incidents still flagging at 'moderate harm and above'.

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.
The trust strategic pressure ulcer group met in January and noted that data reported up until November 2022 showed all pressure ulcer incidence were within the control limits with both Category 3 and 4 incidences reducing compared to previous month, but no noted statistically significant improvement. The group reviewed data from the last published national in-patient audit and noted similarities relating to prevalence and categories and themes in relation to risk assessment completion, repositioning, and patient information, all of which triangulates with themes from local incident review. The current workplan reflects these priorities The inaugural Joint LPT/NHFT Pressure Ulcer Prevention Collaborative was held in November 2022, focusing on shared learning and joint quality improvement opportunities, scoping improvement ideas linked to our incident themes, and has a carer with lived experience on the group.

Falls - The group have reviewed the new National Audit for Inpatient Fractures Report and are benchmarking LPT practice against the findings and recommendations. Several opportunities have been identified including strengthening the risk assessment process for example by embedding vision assessments and also improving the guidance for post falls checks. The group are looking to improve the communications out to wards and teams through our champion networks and, working with Health and Safety and Moving and Handling teams, to undertake a Chair Audit in CHS and MHSOP, which will help to inform us if we can reduce the risk of some patients slipping out of the chair.

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. The current work includes understanding Human Factors in relation to understand the barriers to escalating patients who are triggering on their National Early Warning Scores (NEWS). A recent review undertaken in CHS has identified that 50% of patients are transferred back to the acute trust during the out of hours period and a group is being convened to review this to understand any learning.

All Self-Harm including Patient Suicide - 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. The national confidential inquiry into suicide suggests the requirement for training and competency of staff undertaking this important intervention. The Executive Director of Nursing/AHP's and Quality has established a trust-wide group to review training, competency assessments process, recording tool, patient engagement during observation and policy. A Group partnership focusing on sharing best practice and quality improvement is commencing with NHFT and representatives from the trust will be joining a national improvement programme. There have been some further incidents regarding delayed disclosure by patients of paracetamol ingestion; the learning themes are highlighted in the Appendices.

Suicide Prevention - A joint Suicide Prevention and Self-harm Lead role has been developed and the Deputy Head of Nursing for the Urgent Care Services in DMH 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, membership and is completing the self-assessment of our provision against the National Confidential Inquiry into Suicide in Mental Health (NCISH), safety and self-harm toolkits.

Violence, Assault and Aggression (VAA) - There was an increase in incidents of violence and aggression in November and December 2022 resulting in patient and staff harm; this is being reviewed by the trust Least Restrictive Practice Group to explore themes and learning. The incidents have resulted in significant injuries to two staff in acute/ PICU inpatient wards.

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, changing culture from incidents being related to systems rather than individuals.

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 to request 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. We still have a vacancy for a .5 WTE learning from deaths clinical lead which is out for recruitment. We have also recruited a bereavement support nurse who will contact all families following all in patient deaths. This is to support the bereavement process however will also invite feedback around the care of loved ones. This is an opportunity for increased quality of after care as well as an opportunity to learn from both positive feedback and areas to improve. This feedback will be shared at the end-of-life steering group in the main and patient safety as appropriate.

Learning Lessons

Sharing Learning and hearing the patient story from incidents - Through PSIG patient stories are used to share learning across directorates. These 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 for learning will focus on learning from complaints this will be run jointly by complaints and patient safety on 23rd January.

Patient Stories - Research has demonstrated that staff learn from patient stories. We are increasingly trying to produce storyboards following an incident to ensure that the learning is available to a wider group of staff. There is an opportunity to learn when things don't go so well and equally from when they do go well. Both need us to 'investigate/review' to understand why. What were the system issues circumstances that meant an incident occurred or that care went well. Where there was an incident what is our learning and what do we need to do differently where care went well what is our learning and what do we need to do more of. The Appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning.

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:		
State which Board Committee or other forum within the Trust's governance structure.	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	
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 QI	X
Organisational Risk Register considerations:	List risk number and title of risk	1.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. 2. Trust may 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:		