N

Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Serious Incident Learning Assurance Report March 2023

Purpose of the report

This report for January and February 2023 provides assurance on our incident management and Duty of Candour compliance processes and reviews 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 on 'Being Open', numbers of serious incident (SI) investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

Teams are working together to continuously improve the review and triangulation of incidents with other sources of quality data. Where incident investigations identify areas of learning not previously known or reported, this is considered in relation to ongoing governance oversight. Teams are also working closely to ensure the relationship between investigation findings and key priorities are identified for quality improvement projects and support, with strengthening oversight.

Patient Safety Strategy (NHSE 2019): Recently the CQC have highlighted areas in regulation that will need to align with new thinking about safety in 5 key areas through ongoing monitoring and inspection:

- The importance of culture
- Building expertise – both internal and external
- Involving everyone
- Consistent oversight and support
- Regulating safety

Below are the work streams in place across the Trust linking to these areas:

Patient Safety Partners – (*involving everyone*) These posts are an important part of our future patient safety plan and culture and essential to attract and renumerate suitable candidates.

Change Leaders – (***importance of culture***) Our Future Our Way change leaders continue to work through the discovery phase, through a safety lens of Human Factors and system thinking and Quality Improvement.

Patient Safety Training – (*building expertise*) National training modules and our internal Human Factors skills and knowledge will support delivery of change across the organisation. A Trust Board development session with the Healthcare Safety Investigation Branch will be planned to present responsibilities in this new framework. This will be an opportunity to strengthen our approach and challenge ourselves on whether we have an open and transparent and improvement focussed culture.

Learning Lessons – (*involving everyone*) The Learning Lessons group has been re-launched as a 'Community of Learning' using Community of Practice methodology, consisting of a diverse range of colleagues with expertise/understanding of 'learning'. There was a very successful session exploring 'are we really learning from complaints or just responding' exploring the difference between 'explaining' vs 'finding out' and actually 'learning'.

Learning From Patient Safety Events (LFPSE) – LFPSE is a new system that has been developed to replace the National Reporting and Learning System (NRLS). Within LPT, working with Ulysses, our incident reporting system, we are in the testing phase currently which has identified some concerns with Ulysses, being worked through.

Patient Safety Incident Response Framework (PSIRF) - The project group continues to meet to understand the requirements of the PSIRF (discovery phase) and to review the available data and agree our Patient Safety Incident Response Plan (PSIRP). We are also benchmarking with Derbyshire Healthcare NHS Foundation Trust as early adopters of PSIRF, to learn from their experience and working with our Communications Team to ensure preparation for this new approach.

Investigation compliance with timescales set out in the current serious incident framework – Challenges continue with our compliance with timescales, although there have been a number of changes made in an attempt to address this with varying success. The Incident Oversight Group have proposed a QI project to closely consider which stages of the process are most delayed to target out efforts. Commencing in April a proposed new streamlined process will be in place to better support timelines.

Royal College of Psychiatrists Serious Incident Review Accreditation Standards (SIRAN) –We are working towards accreditation through SIRAN; their review visit in January was positive, with good feedback about the quality of our Duty of Candour, our family engagement processes, and our patient story format, which will be shared more widely with other organisations as good practice. The review also noted our compassion and the voice of the patient/families within our reporting, with a 'clear and well written SI policy'. As part of the process, further evidence has been provided with the outcome due in May; the achievement would be an excellent foundation to build on.

Analysis of Patient Safety Incidents reported - (Appendix 1 contains Statistical Process Control (SPC) charts utilising the NHSI Toolkit to support the narrative and analysis 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.

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** – Recent data (January 2023) showed all pressure ulcer incidences were within the control limits, however, Category 3 and 4 incidences have increased compared to previous months. Further review and investigation will identify contributory factors and additional themes for improvement. The strategic group have reviewed the current quality improvement projects and noted the improvement work, to ensure all substantive Healthcare Support Workers (HCSW) within the Community Nursing hubs have been appropriately trained. A more senior task and finish group will review local improvement actions and our new Group Quality Improvement Pressure Ulcer Prevention Collaborative has recently formed.

Falls – review continues against the National Audit for Inpatient Fractures Report, developing improved processes and resources to support staff to deliver best practice. An example is the review of post falls processes to improve the quality of checking and use of equipment. Falls incidents are reviewed each month, receiving feedback and assurance from the directorates on scrutiny of incidents.

Deteriorating Patients – Focused improvement work looking into the earlier recognition of deteriorating patients is developing across the Trust with a group focusing on reporting systems and consistency in practice, this will allow a deeper dive into learning and communication. A Group Collaborative with NHFT is also in development to ensure standardised practice and joint learning.

All Self-Harm including Patient Suicide – Inpatient self-harm behaviours continue to range from low harm to multiple attempts. A task and finish group are investigating how patients self-harm whilst under close observation; a national concern across Mental Health organisations, and our third group collaborative is focusing on sharing best practice and quality improvement within this area. We are represented within a new National group reviewing mental health safe and therapeutic observations, which will enable our workstreams to nationally align. There is also a task and finish group working to agree an

approach to patients who overdose and refuse to access treatment. Recent learning from incidents suggests there is lack of clarity for staff between life-saving treatment and the Mental Health Act/Mental Capacity Act. Whilst this work concludes, interim guidance has been provided.

Suicide Prevention - A recent National confidential inquiry has identified and reported a national increase in suicides in patients with a diagnosis of personality disorder; the Trust Suicide Prevention group will be reviewing the latest report to explore learning. The Trust group has re-established and is completing a self-assessment of our provision against the National Confidential Inquiry into Suicide in Mental Health (NCISH), safety and self-harm toolkits. To note, progress has been delayed whilst a Trust-wide joint Suicide Prevention and Self-harm Lead role is considered.

Medication incidents - Learning from medication related incidents is maximised to ensure learning themes are identified, system actions are implemented, changing culture from incidents being related to systems rather than individuals, in particular review of the safety actions for safe prescribing of Sodium Valproate. There has recently been an increase in incidents involving insulin in patients in the community with a task and finish group commenced to consider.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC - The CQC receives 72hr reports for newly notified SI's, completed SI reports/action plans/evidence and any additional information required. We continue to work with our other 'commissioners' to provide assurances.

Learning from Deaths (LfD) - This process is supported by a Trust co-ordinator and bereavement nurse, providing valuable service to our patients' families. Feedback from families is carefully gathered to understand where care has been good, allowing learning dissemination. Early themes identified: communication with families and information sharing on discharge to support ongoing care; both have actions in place and will be monitored and reported at the End-of-Life Steering Group.

Patient Stories/Sharing Learning - Patient stories are used to share learning Trust-wide to ensure focused learning, part of our culture and new way of thinking. Evidence suggests that staff learn better from patient stories, and storyboards post incident are developing. 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 28th March 2023	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	16/03/23	
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:		