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# Trust Board Patient Safety Incident and Serious Incident Learning Assurance Quarter 4 Report May 2023

## Purpose of the report

This report for March and April 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 it is essential that we attract and renumerate suitable candidates, this recruitment has now commenced.

**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. They will be supporting our culture change as we implement PSIRF and our journey to a learning organisation across all areas.

**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 was held in April to look at the Patient Safety Incident Response Framework (PSIRF) and a further Trust Board development session with the Healthcare Safety Investigation Branch is 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'. The next session at the end of May will explore checking and searching and the human factors that are affecting effective searching.

**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 have now 'gone live'. Initial glitches have been ironed out and we continue to monitor and understand how this new process can support with the analysis of our incidents.

**Patient Safety Incident Response Framework (PSIRF) -** The project group are now working towards our data synthesis day on the 19th June 2023, where multi- disciplinary staff from across the Trust will collaborate to review the analysis of our data and agree our Patient Safety Incident Response Plan (PSIRP). We are 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 our efforts. Commencing in May a proposed new streamlined process will be in place to better support timelines.

**Royal College of Psychiatrists Serious Incident Review Accreditation Standards (SIRAN)** – As part of the process, further evidence has been provided with the outcome due in May; the achievement would be an excellent foundation of quality in our process to further 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 sit just above or on the mean and can be seen in our accompanying appendices.

**Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care** –
Quality improvement projects continue and are embedding across teams. Current data is not yet showing statistically significant improvement. However, Category 2 incidents are at their lowest compared to previous months. There are no significant changes in the number of Category 3 incidents. Category 4 incidents have increased compared to previous months. The Category 4 multi-disciplinary investigation process was introduced in March 2023 and will identify contributory factors and any additional themes for improvement. Key pieces of work include understanding barriers or myths around obtaining pressure relieving equipment in a timely way and related to how the risk of pressure ulcer is assessed.
The group are also looking at one initiative based on learning from another organisation, which involves seating clocks to alert staff when patients need to be re positioned.

**Falls –** It is noted that there has been an increase in repeat falls due to a small number of patients who have had repeated falls in April 2023. Review has shown that each present with individualised issues, for example one patient in Mill Lodge who is mobile but has poor balance and wishes to remain as independent as possible, another patient on North ward who presented with behavioural issues. Staff work with the patients to develop individualised care plans to reduce the risk of injurious falls.
Other Updates: Flat lifting has been made role essential training for all inpatient staff to ensure moving and handling post fall is as safe as possible and the Falls Champions groups have been relaunched across inpatients and community settings to promote good practice.

**Deteriorating Patients –** We have reviewed the Trust-wide group membership and one of our Deputy Medical Directors will co-chair with current medical leadership of this group, to ensure Senior Executive oversight. This review has offered an opportunity to re-assess and agree the TOR whilst also re-aligning the agenda to allow directorates to confirm assurances to the group around policies pertaining to the deteriorating patient. This mirrors efforts being made in PSIG to allow better sharing of information and a deeper understanding of any issues. The collaborative with NHFT has commenced with a view to develop

a joint work programme for improvement between both Trusts.

**All Self-Harm including Patient Suicide –** Inpatient self-harm behaviours continue to range from low harm to multiple attempts. The MH Safe Observation Improvement Group workstreams have commenced alongside national workstreams. The best practice workstream has an associated quality improvement project on the use of high levels of observation on MHSOP wards aimed at reducing the use of observations that are overly restrictive.

**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. Progress has been delayed whilst recruitment takes place for the Trust-wide joint Suicide Prevention and Self-harm Lead which is expected in June 2023

**Medication incidents –** In response to learning from incidents there are a number of workstreams looking at improved medicines safety. These include insulin prescribing/administration and monitoring. The prescribing of benzodiazepines as 'when required' to consider how to monitor amount administered, the monitoring of patients who are newly prescribed or had dose change of antidepressants.

**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. The patient safety team are working with all commissioners to keep them updated and work with them as to how they will receive assurance rather than relying on Serious Incident reports

**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

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|---|---|---|
| **For Board and Board Committees:** | Public Trust Board 30.5.23 | |
| **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 |
| | **T**ransformation | |
| | **E**nvironments | |
| | **P**atient Involvement | |
| | Well **G**overned | X |
| | **R**eaching Out | |
| | **E**quality, Leadership, Culture | |
| | **A**ccess to Services | |
| | **T**rust 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.<br>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:** | | |