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Leicestershire Partnership NHS Trust

Trust Board 25th July 2023 - Patient Safety Incident and Serious Incident Learning Assurance Report July 2023

1.0 Purpose of the report

This report for May and June 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.

2.0 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) with Links to CQC domains:

Patient Safety Partners (*involving everyone*)– We have had an excellent response to applications for these posts and recruitment is progressing.

Change Leaders – (***importance of culture***) Our Future Our Way change leaders continue to work through their data using a safety lens of Human Factors, System Thinking and Quality Improvement. They will be synthesising their feedback together with the themes from the Patient Safety data.

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 further Trust Board development session undertaken by HSIB is planned for August 2023. This will discuss the responsibilities for oversight 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 is working as a 'Community of Learning' using Community of Practice methodology, consisting of a diverse range of colleagues with expertise/understanding of 'learning'. The session at the end of May 2023 explored checking and searching and the human factors that are affecting effective searching.

Learning From Patient Safety Events (LFPSE) –a new system that has been developed to replace the National Reporting and Learning System (NRLS). The LFPSE team is working with vendors in LPTs case Ulysses to resolve some issues relating to external organisations and as a result LPT will not be fully live until the 1st September 2023.As required by the LFPSE team test incidents continue to be uploaded to fully test the system.

Patient Safety Incident Response Framework (PSIRF) - The PSIRP planning day was held on 19th June 2023 at the NSPCC Training Centre and was attended by staff representatives from across the trust, patient partners, commissioners (Integrated Care Board (ICB), Provider Collaboratives (PCs) and Public Health Local Authority (PHLA)

as well as members of our Trust Board and executives. The trust's directorates presented a review of their patient safety information and identified patient safety priorities following analysis and synthesis of the data. These priorities were triangulated and challenged where appropriate and have informed our six local patient safety priorities for comprehensive patient safety incident investigations under PSIRF, described under the new methodology as PSII (Patient Safety Incidents requiring Investigation).

Work is underway with directorates to agree the final version of our priorities and the methodologies to be used for reviewing non-PSII incidents. A series of cross cutting themes were also identified; staffing, electronic systems and the ability to communicate across organisation when patients/families are receiving care from more than one team in LPT. There was also acknowledgment that LPT needed to strengthen data on patients protected characteristics to make it easy to identify and potential areas of health inequalities. Work has commenced to identify work streams for each of these cross-cutting themes and will be reported through the appropriate governance route. The draft plan was presented to the ICB on the 27thJune 2023 and ICB colleagues were assured by the processes.
The PSIRP is currently being drafted and will have appropriate governance and sign off during August 2023.

Investigation compliance with timescales set out in the current serious incident framework – Challenges continue with compliance with timescales. This is however an improving picture (see appendix) As we move closer to transitioning to PSIRF, we are looking at more efficient ways to investigate and therefore beginning to reduce the number of lengthy reports required.

Royal College of Psychiatrists Serious Incident Review Accreditation Standards (SIRAN) –
The Board had a verbal update at last the meeting confirming that we had received SIRAN accreditation. This was an excellent achievement particularly as this was our first submission of evidence. This is a good position to work from as we move into PSIRF.

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 –
Current data is not yet showing statistically significant improvement; however, category 2 incidents are at their lowest point since July 2022 and in comparison, to previous months. There are no significant changes in the number of Category 3 incidents or Category 4 incidents.. The Category 4 multi-disciplinary investigation process introduced in March 2023 has identified contributory factors and themes for improvement which have shaped actions for improvement and quality improvement projects including MCA training roadshows, equipment task and finish group, face to face training and moisture associated skin damage care pathways. Further work to strengthen the quality improvement outcome measures to understand impact and outcomes for patients.

A pressure ulcer deep dive was presented to the Quality and Safety Committee on 27 June 2023 and the Trust Strategic Pressure Ulcer Group 5 July 2023. The high level messages are that we have a good reporting culture for pressure ulcer incidents relating to care and treatment, and a large proportion of incidents reported are no or low harm. There is also a recognition of themes and learning from previous incidents, risks to delivery and impact of the programmes associated with transient workforce in the wider system, staffing capacity in the community nursing teams due to vacancies and increasing acuity and complexity and system pressures.

Falls Incidents - It is noted that the number of falls across the trust has remained raised in May and June 2023. Again, on review of the incidents across the Trust, this can be attributed to a small number of patients having repeat falls. For example, since February 2023, Mill Lodge has seen an average of 16 falls per month, which is

reflective of the admission of two patients who are mobile but have deteriorating balance, in June 1 patient fell 7 times and another patient fell 5 times. The nature of Huntingdons disease is that most patients will have a period of deteriorating balance and co-ordination before their mobility deteriorates to a point they are confined to a chair or bed and consequently their falls risks decrease. There is also much work ongoing to ensure the appropriate risk assessments are carried out to keep our patients safe from falling.

: On average the Beacon Unit record one fall a month, however in May they recorded 12 falls, 11 of which were related to one patient. The cause was reported as being due to non-epileptic absences and placing self on the floor and this was managed through increased supervision, no harm occurred to patient.

Each directorate reports monthly to the LPT Falls Steering Group with analysis of the falls incidents in their services and report on themes and actions. Twice a year, a review of the directorate themes is undertaken to review effectiveness of actions

Violence and Assaults - There is a statistically significant increase in the number of incidents of violence and Assault incidents and there is a deep dive in progress to understand if this is in a particular area.

Deteriorating Patients – The TOR for the DPRG group has now been agreed. The Deteriorating Patient and Resus Policy for the Trust has been updated and aligned with national guidelines and this has been taken to PSIG for approval. The new agenda setting has been adopted and will be used going forwards. The collaboration between DPRG at LPT and NHFT continues with further meetings arranged this month.

Groups related to self-harm and suicide prevention.

MH Safe and Therapeutic Observations Task and finish group

The group consists of 5 work streams:

1. Learning from Incidents / SI's / CQC enquires / Complaints.
2. Engagement and co-production – patients, staff and carers.
3. Training and competency Assessments
4. Recording incidents.
5. Creating Best Practice Guidance

During June 2023 a thematic review was undertaken of 5 serious incident reports where patients came to harm whilst on therapeutic observations. Themes identified were in relation to the timing of observations and how they were recorded and understanding of the therapeutic nature of the intervention with patients, and a theme is emerging in relation to the knowledge and skills of a temporary workforce, however, the group are exploring options to address this. The engagement workstream are in the data gathering phase and surveys are with patients, staff and carers and focus groups are taking place.
In June 2023 there was an observation collaborative sharing event with Northamptonshire Foundation Trust aimed at understanding the use of observations and practices in the Trusts, exploring training for staff and learning from incidents. A follow-on event is planned for August 2023 aimed at identifying some good practice quality improvements to take forward between the Trusts.
The Oxevision Pilot remains paused at this time pending further assurances from the manufacturer regarding auditing and safeguarding, . and a review meeting has been arranged in August 23.

Checking and searching
There is a task and finish group looking at our processes for checking and searching – the group ran a learning lessons community of practice during May 2023, to give staff the opportunity to discuss the barriers 'human factors' to searching patients, these included the potential loss of a therapeutic relationship, concern about the searching of all patients being both time consuming and seen as a blanket restriction. A second session has been arranged for staff to come together and agree and set out a clear policy on who/how and when we will search. The group have also engaged with the mental health network to learn from others NHS providers in the East Midlands region.

The management of patients who overdose and then refuse treatment - A temporary process is being used in practice and a task and finish group are progressing a flowchart to support decision making and actions post overdose. This work is being complete with clinical support from UHL and any the draft versions will be shared with East Midlands Ambulance Service for review. It is anticipated this initial work will be complete by August 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 and this project is being extended to include shared decision making. The patient safety team are working with the medicine safety groups to align the model with the patient safety strategy.

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 – (see appendices) 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.

3.0 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 25.7.23	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	12/07/23	
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
	Reaching Out	
	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:		