S

Leicestershire Partnership NHS Trust

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

Purpose of the report

This report for July and August 2023 provides assurance on LPTs incident management and Duty of Candour compliance processes. The process 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.
There are multiple examples in the news currently where data around poor outcomes for patients and staff concerns have not been responded to. In the trust we are reviewing our data with the questions 'is this data sufficiently detailed to identify any areas that are an outlier' and do we have both the culture and the processes to identify and review the data'
The whole of the NHS is challenged in this area, as a result of the amount of data sets mandated and the manual process for a lot of this data.
There are three key areas that we need to concentrate on

1. Incident reporting/investigation and triangulation
2. Listening and responding to concerns when there may not be an 'incident' but a level of concern
3. Robust Leadership and governance

The culture must be 'problem sensing and not comfort seeking' this mind set is characterised by actively seeking out weaknesses in the system from multiple data sources and seeking any evidence that there is an incipient risk of complacency.

Where incident investigations identify areas of learning not previously known or reported, this is considered in relation to ongoing governance oversight 'how could we have known?'
Teams are also working closely to ensure the relationship between investigation findings and key priorities are identified for quality improvement projects and support, with strengthened oversight.

World Patient Safety Day 17th September

This year the theme is 'Engaging patients for patient safety' This has been designed to show world solidarity and amplify the role that patients and their families play in their safety. This year we are coming together with partners across the ICB to meet with patients to hear from them about what makes them feel safe when receiving healthcare.

Patient Safety Strategy (NHSE 2019) with Links to CQC domains:

Patient Safety Partners (*involving everyone*)–we are pleased to say we had excellent

candidates apply for these posts and have recruited two patient safety partners. They have started to familiarise themselves with the current patient safety priorities and are meeting members of the Patient Safety Team.

Change Leaders – (***importance of culture***) Our Future Our Way change leaders have now analysed their data and have identified key areas to work on. The patient safety team are involved with the work in relation to psychological safety. Supporting the culture where staff are invited to identify concerns and be part of designing safety systems.

Patient Safety Training – (*building expertise*) National training modules and our internal human factors skills and knowledge training will support delivery of change across the organisation.
As part of PSIRF we have identified two methodologies we will focus on and train our staff. These are; System Engineering Initiative for Patient Safety (SEIPS) and After Action Reviews (AAR)
A further Trust Board development session undertaken by HSIB is being planned; this will discuss the responsibilities for oversight in this new framework. This will be an opportunity to challenge ourselves on whether we have an open and transparent and improvement focussed culture, and develop ideas to strengthen our approach.

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'. There is a follow up session planned around checking and searching to really focus on what can be done, the limitations of our processes and how can improve consistency.

Learning From Patient Safety Events (LFPSE) –This is a new system that has been developed to replace the National Reporting and Learning System (NRLS). This system has more modern functionality 'machine learning' and has been introduced to enhance and speed up the opportunity for system learning. LPT have gone live with this and are working with the national team to check that everything is working. The ICB will also now have 'read only' access to all incidents.

Patient Safety Incident Response Framework (PSIRF) -

- The Patient Safety Incident Response Plan (PSIRP) (in your papers pack) has now been through our internal governance process and has been submitted to LLR ICS System Quality Group for final sign off in September 2023.
- Directorates have also developed their plans to manage the two priorities that were not identified as the final six PSIRF priorities.
- There are also plans to develop the cross cutting themes identified across the three directorates that include; Electronic systems and their ability to support staff to do their best work. This includes supporting staff to easily engage across trust teams when patients are being cared for by more than one team. There is also a need to support the analysis of our safety data in relation to patients protected characteristics to ensure that we can identify and address health inequalities in a timely way.
- The aim is to start working to our plan from the 1st November 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 graphs in slides) We are now reporting on this data weekly so that teams can see their progress.
As we move closer to transitioning to PSIRF LPT are looking at more efficient ways to investigate and therefore beginning to reduce the number of lengthy reports required.
The Patient Safety Team together with the We Improve Q Team have developed a training

session for staff around action planning based on the Hierarchy of Effectiveness and describing the links between actions/system thinking and quality improvement; this will commence for all directorate management teams in September 23.

Royal College of Psychiatrists Serious Incident Review Accreditation Standards (SIRAN) –now – **Safety Incident Response Accreditation Network**
LPT continue to be represented on the SIRAN accreditation committee and have supported the committee to develop their standards to ensure that they are transitioning to support the PSIRF. Our Head of Patient Safety has been appointed in the Deputy Chair role for the Royal College of Psychiatrists Combined Committee for Accreditation- this is a great opportunity to both share our learning and to also bring learning back to LPT.

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 – There are no significant changes in the number of Category 3 or Category 4 incidents, however it is noted that there has been an increase from July to August 2023. The Category 4 multi-disciplinary investigation process has identified contributory factors and themes for improvement which have shaped actions for improvement and quality improvement, these have been agreed as:

- Category 2 pressure ulcer review and management
- Holistic assessment completion and review
- Wound photography
- Mental capacity act training and implementation

The team are looking at measurable outcomes for each of the projects to ensure that we have quantifiable data to share going forward. From a holistic and Human Factors point of view we need to consider how the work combines to not be individual tasks but rather a holistic collaborative and individualised plan of care to prevent pressure ulcers or further deterioration.

Falls Incidents

It is noted that the number of falls across the trust has remained raised, which has been reviewed and can be attributed to a small number of patients having repeat falls. The falls group are working to develop a process where patients are having repeat falls that teams can ask for expert and MDT support with ‘fresh eyes’ to try to identify any other interventions to reduce patients risk. This is a challenge in areas such as Mill Lodge: The nature of Huntingdon’s disease is that most patients will have a period of deteriorating balance and co-ordination before their mobility deteriorates to a point they are not able to move independently and consequently their falls risks decreases.

Deteriorating Patients – TOR for group have been adapted and accepted. 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 group are also looking at the model for their agenda to ensure that it follows the model of the Patient Safety Strategy -Insight -Involvement – Improvement, this will ensure that directorates are bringing appropriate data and ensuring that appropriate staff are involved.
The group have been asked to develop a process for the oversight of managing the risk of Venous Thromboembolism that will assess both the compliance and effectiveness of trust policy and report through to PSIG. The collaboration between DPRG at LPT and NHFT continues with further meetings arranged.

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 August 2023, the Recording Incidents and Creating Best Practice group leads merged the workstreams focusing on updating handover guidance with the role of the nurse in charge. The engagement workstream are in the data analysis phase and the views of patients, staff and carers are expected to be ready in September 23. The second event in August 2023 identified some good practice quality improvements to take forward - those finally agreed will commence at the end of September 23. A clinical and management team visited Oxehealth in August 23 to discuss safety measures added to the system to further progress across the Trust.

Checking and searching
There is a task and finish group looking at our processes around checking and searching of patients within our Mental Health Wards. The group ran a learning lessons community of practice during May 2023 to give staff the opportunity to discuss any barriers and 'human factors' to searching patients, these included the potential loss of a therapeutic relationships and concern around 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.

Medication incidents – The patient safety team are working with the medicine safety groups to align the model with the patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates. The group are working up a job description for a Medicines Safety Officer. This important role is essential to build on the improvement work in relation to medicines safety.

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, moving from relying on Serious Incident reports as we move closer to implementing PSIRF.

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. The group have for the first time been able to access their EDI data and will now work with expert colleagues to analyse this in future reports. The ME process is to be extended further to all community patients and we are working with UHL colleagues to ensure that we do not use the opportunity for learning.

Patient Stories/Sharing Learning - Patient stories are used to share learning Trust-wide to ensure focused learning is 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. The patient safety team are developing a masterclass to write these stories in a patient centred/outcome way and to ensure that the learning is based on human factors and therefore transferrable.

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:	18/09/2023	
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:		

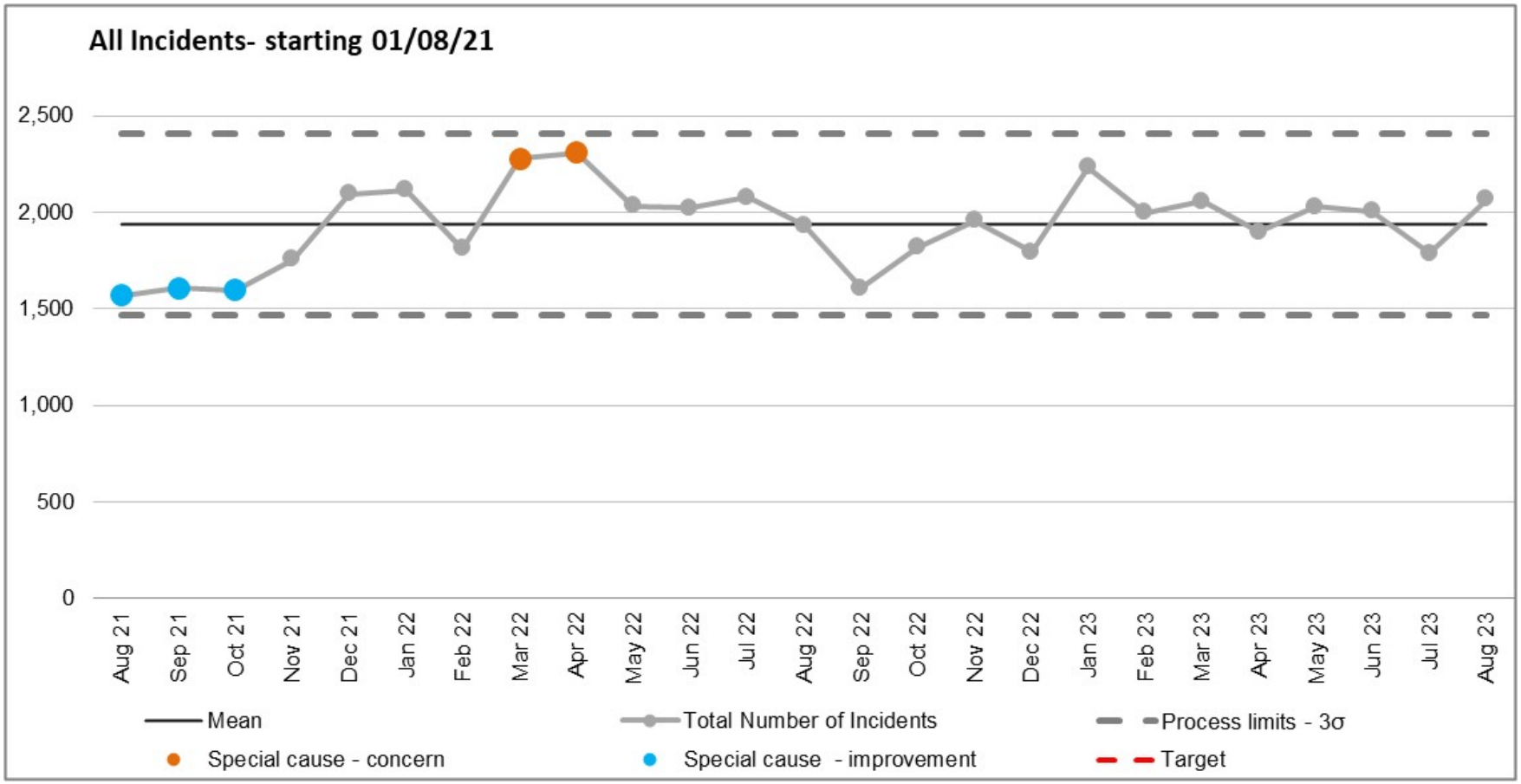
Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during July August 2023

Any detail that requires further clarity please contact the Corporate Patient Safety Team

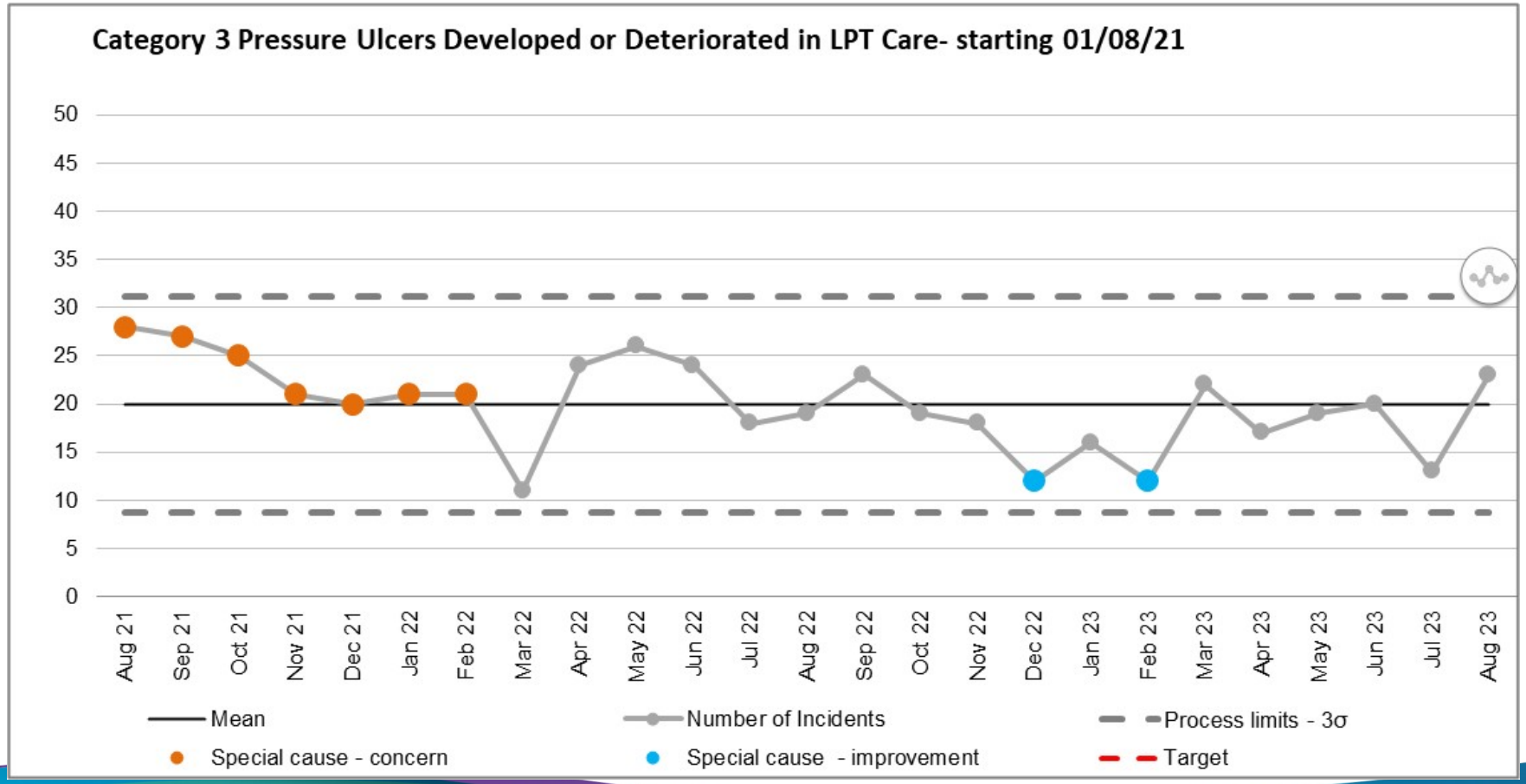
WeAreLPT
compassion respect
integrity trust

1. All incidents



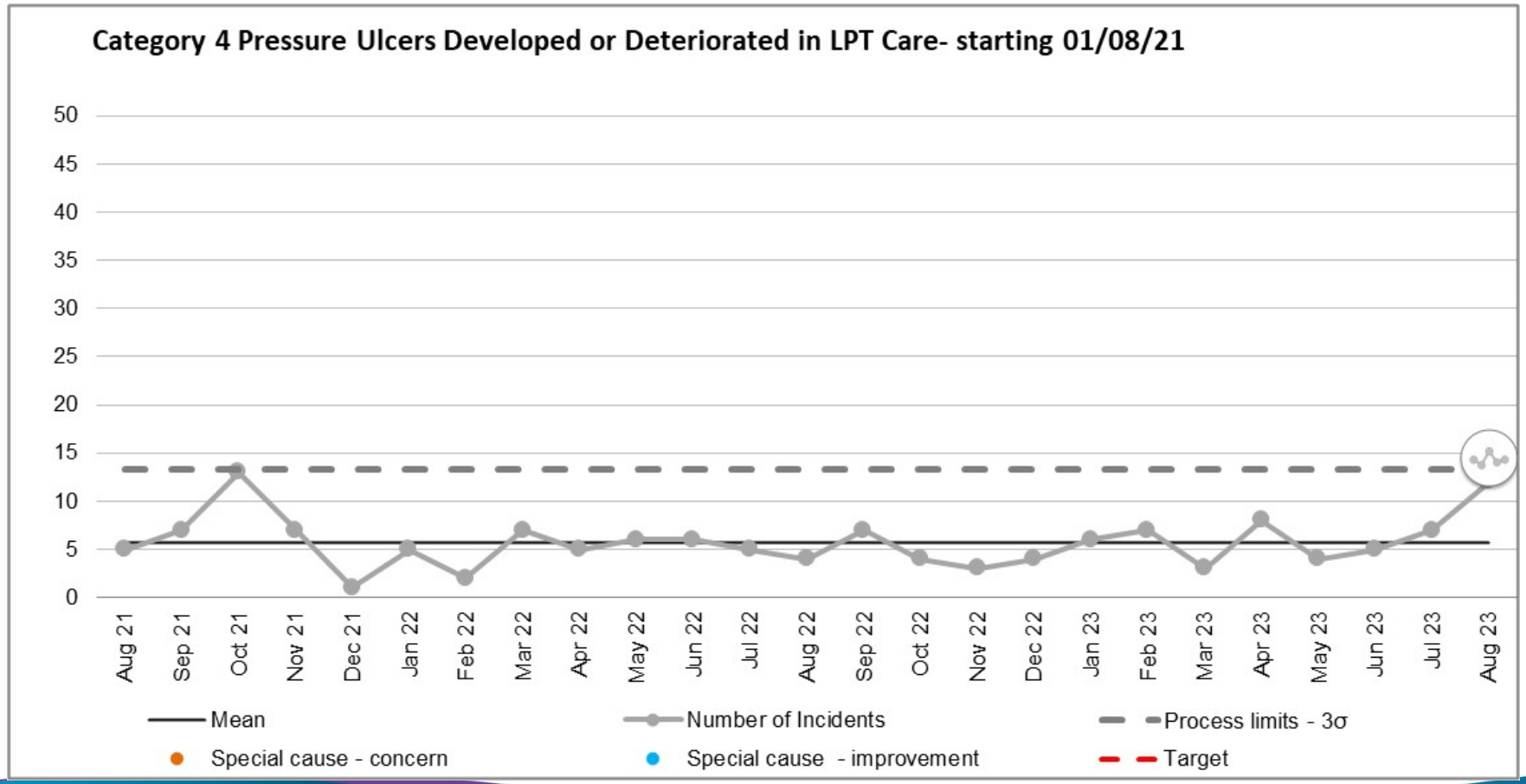
WeAreLPT
compassion respect
integrity trust

3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



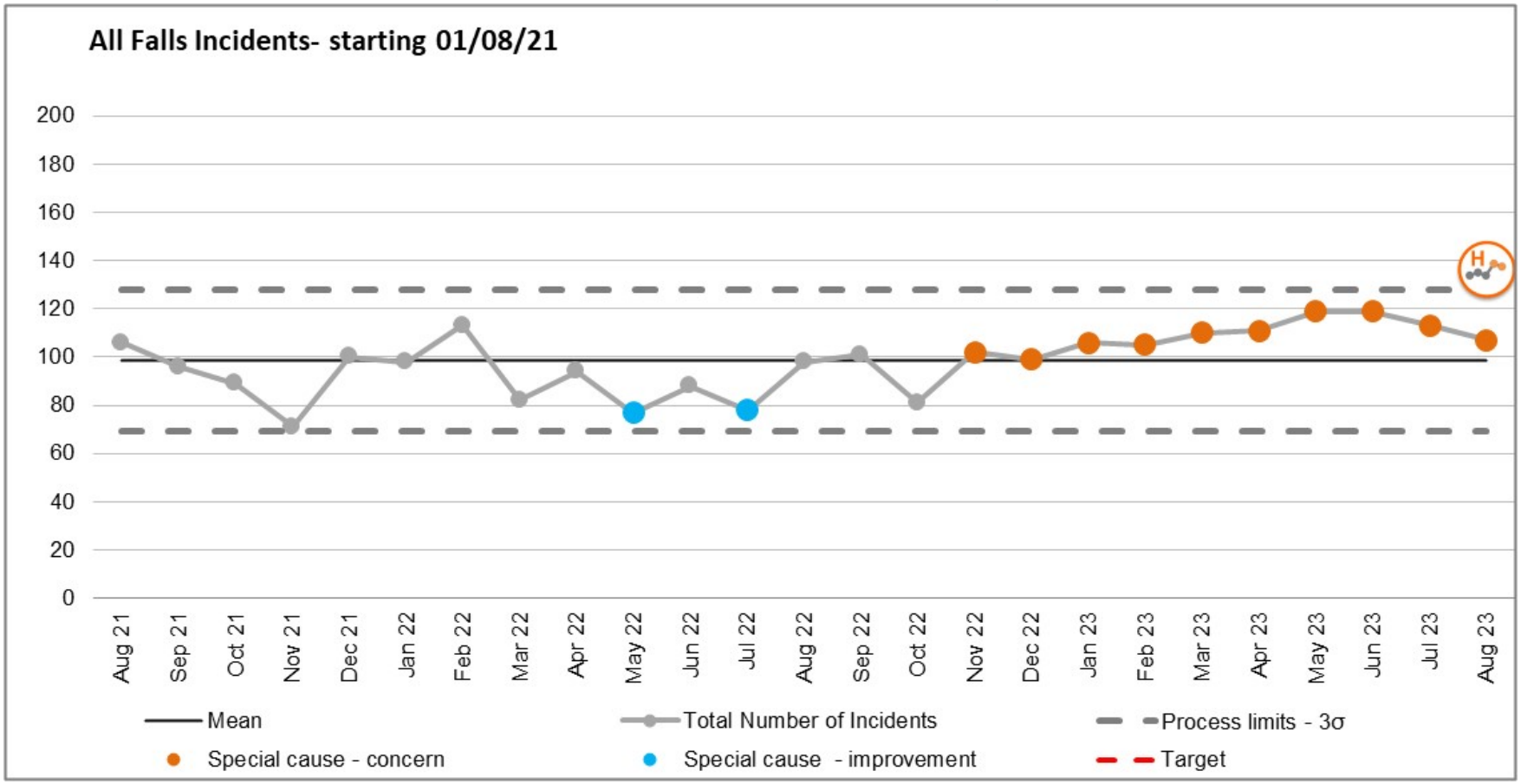
WeAreLPT
compassion respect
integrity trust

4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



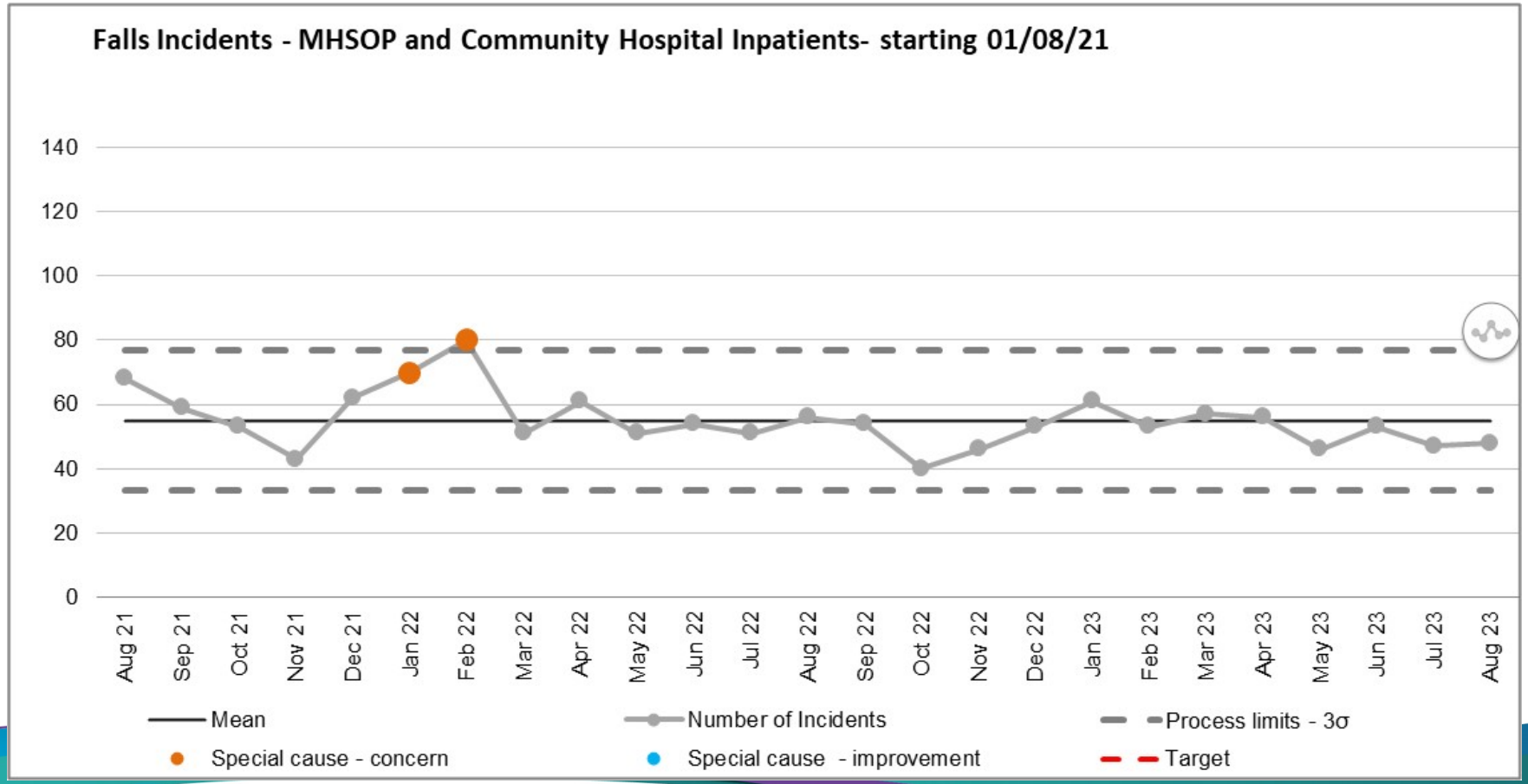
WeAreLPT
compassion respect
integrity trust

5. All falls incidents reported



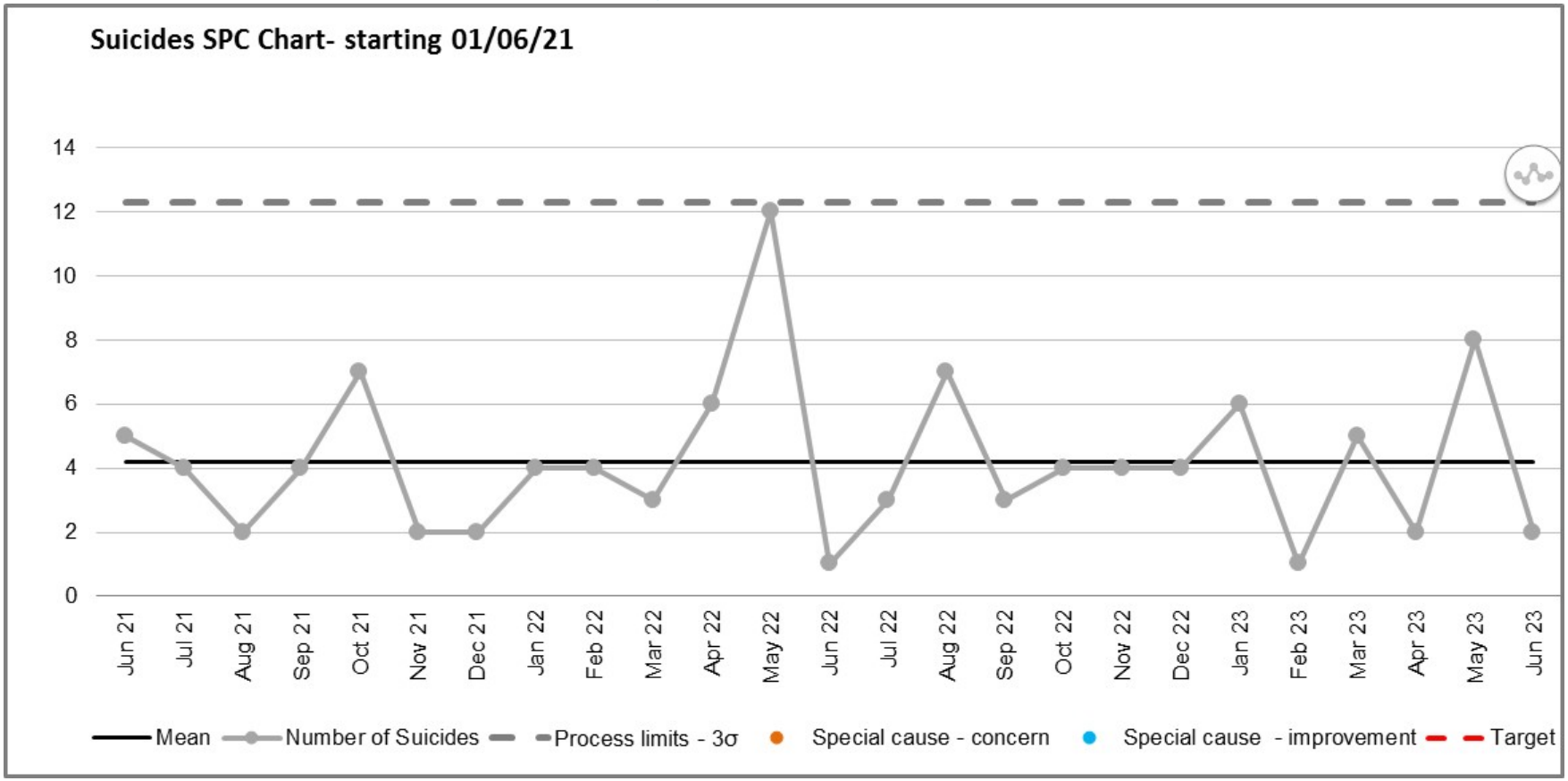
WeAreLPT
compassion respect
integrity trust

6. Falls incidents reported – MHSOP and Community Inpatients

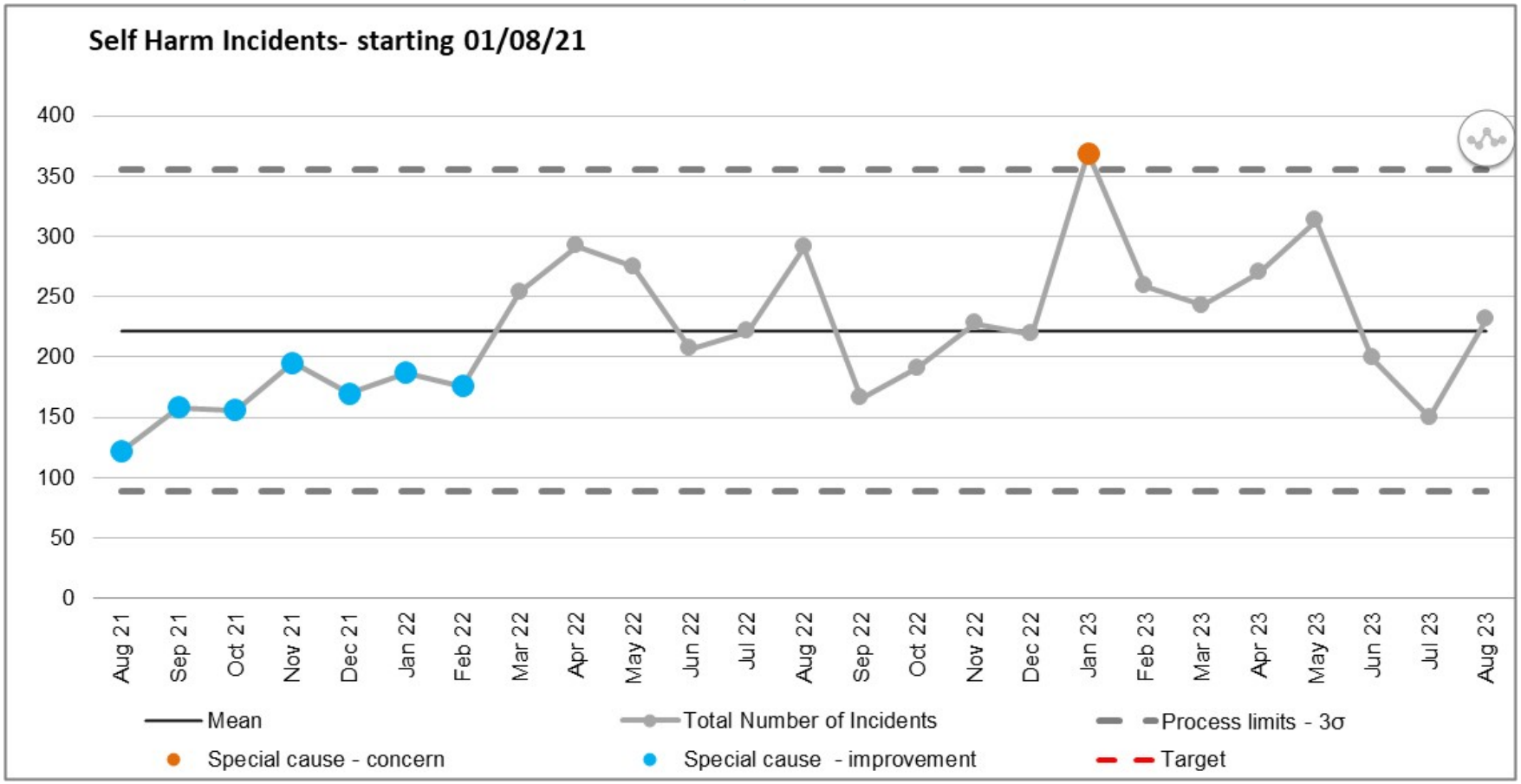


WeAreLPT
compassion respect
integrity trust

7. All reported Suicides

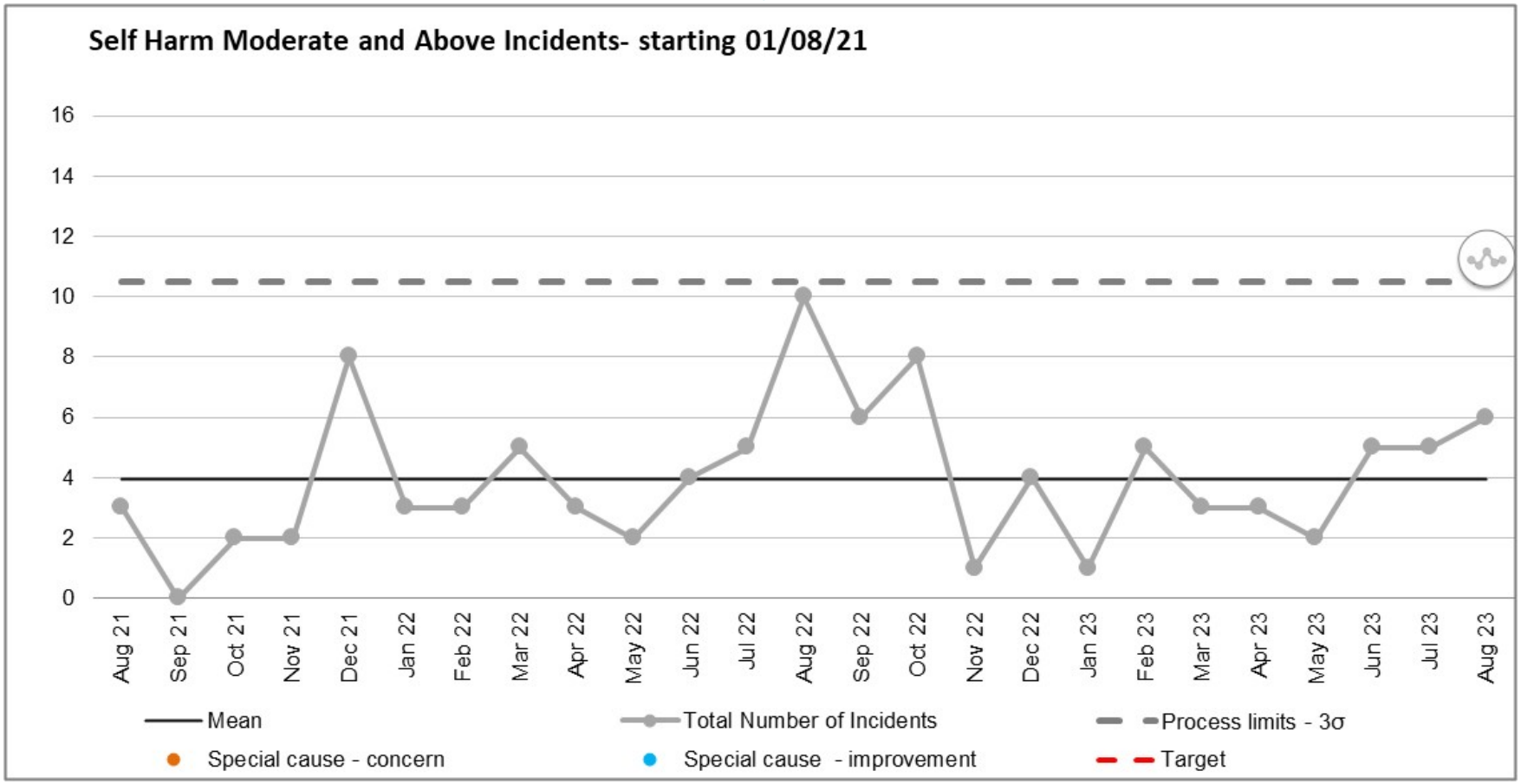


8. Self Harm reported Incidents



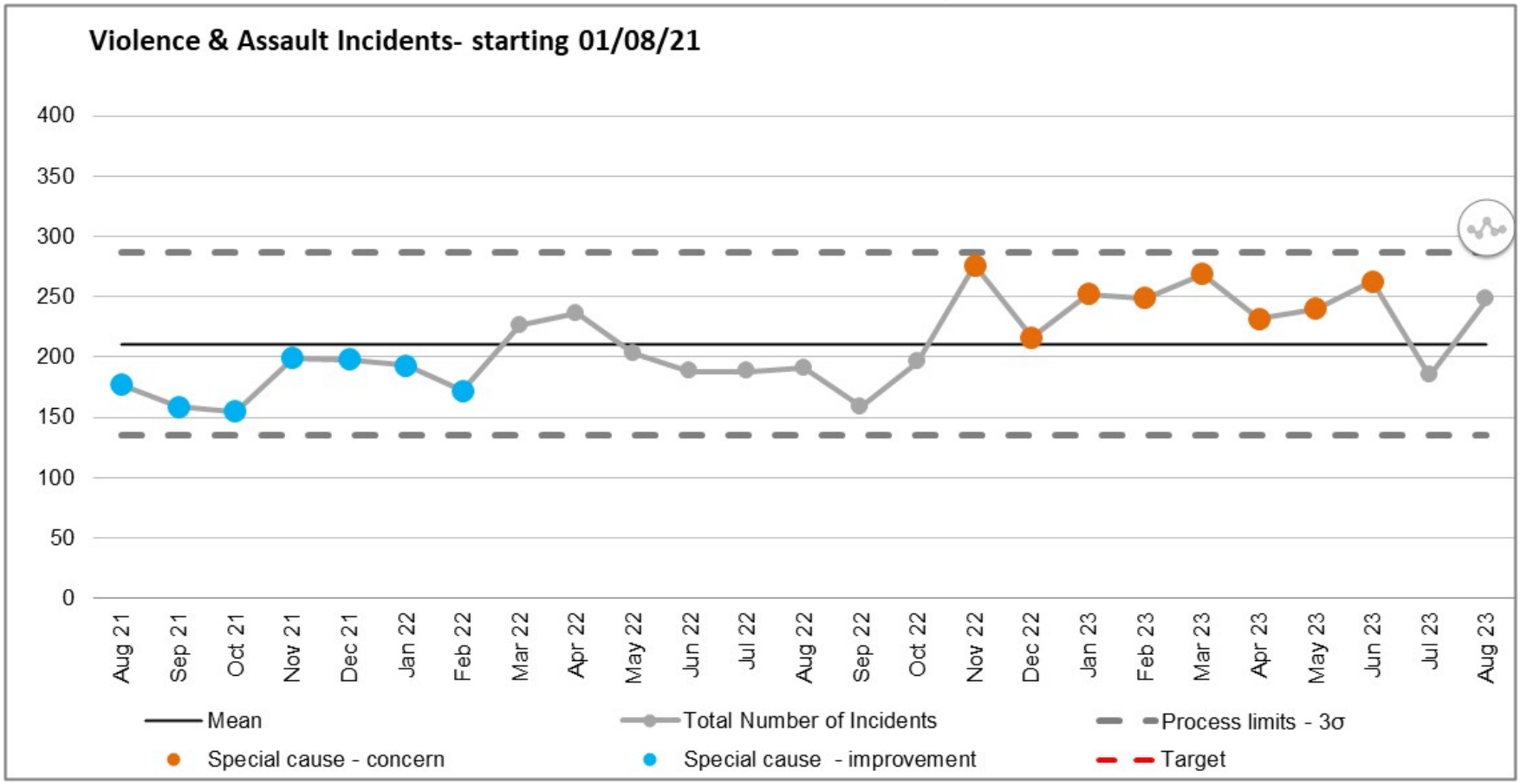
WeAreLPT
compassion respect
integrity trust

8a. Self Harm reported Incidents



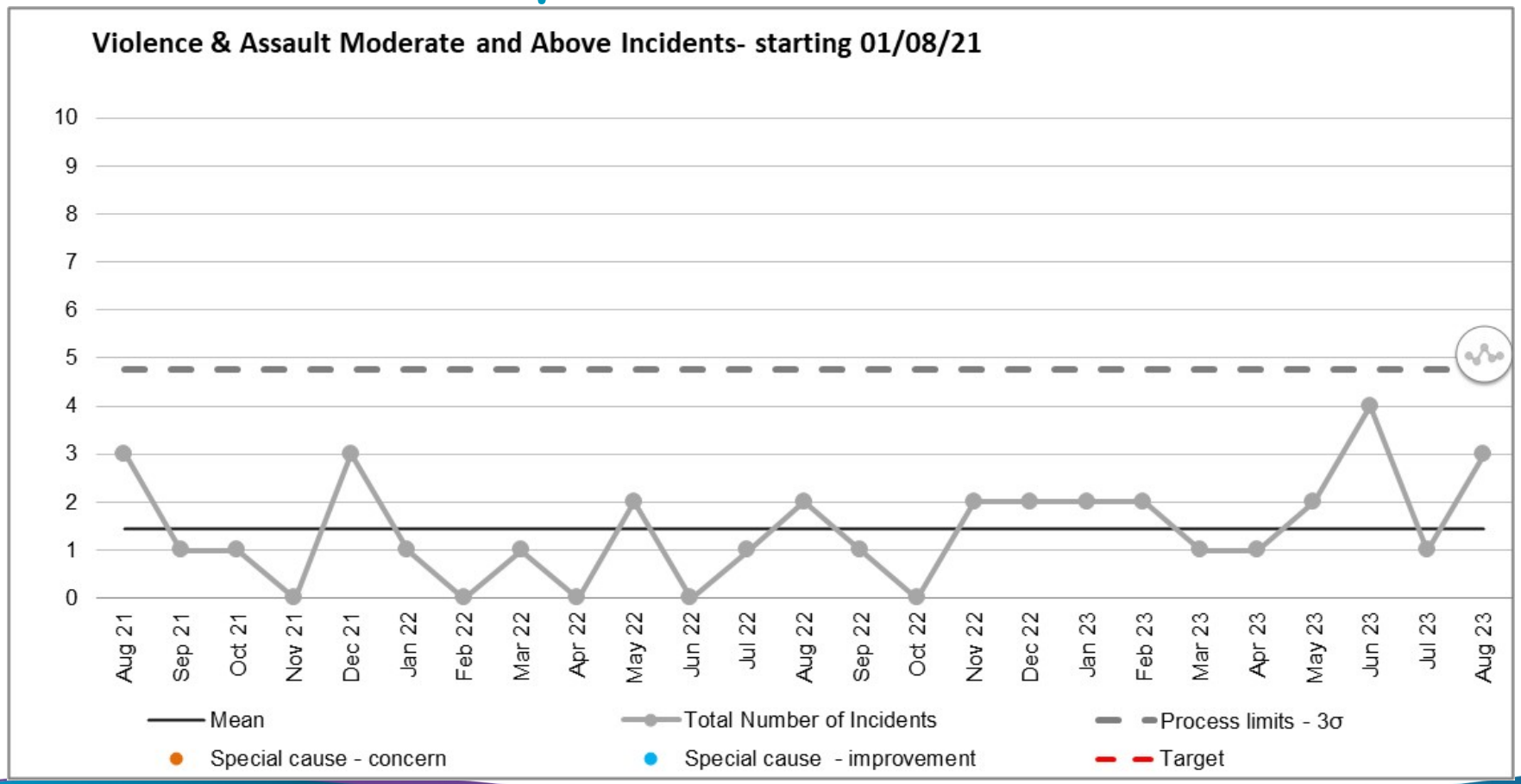
WeAreLPT
compassion respect
integrity trust

9. All Violence & Assaults reported Incidents



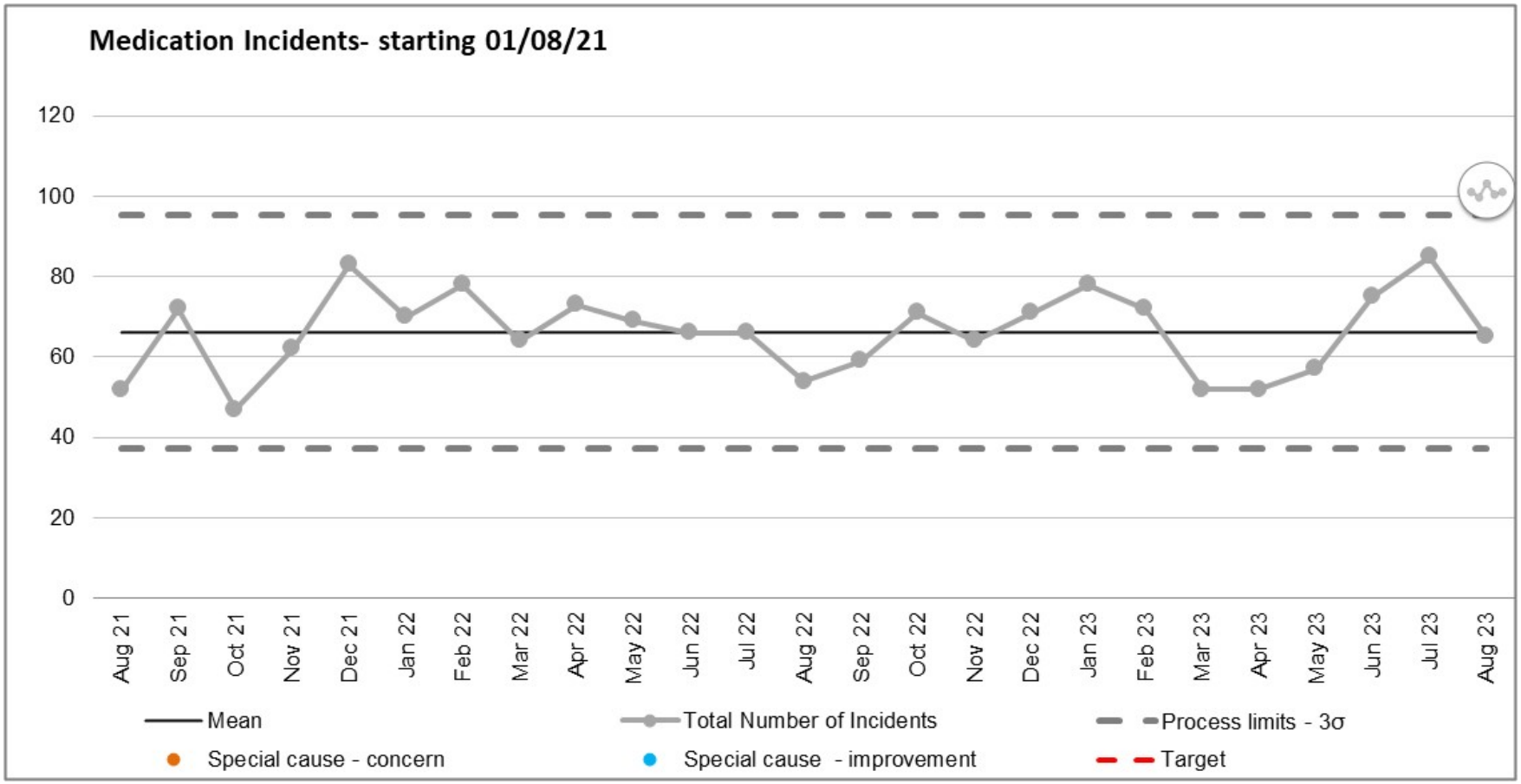
WeAreLPT
compassion respect
integrity trust

9. Violence & Assaults moderate harm reported Incidents



WeAreLPT
compassion respect
integrity trust

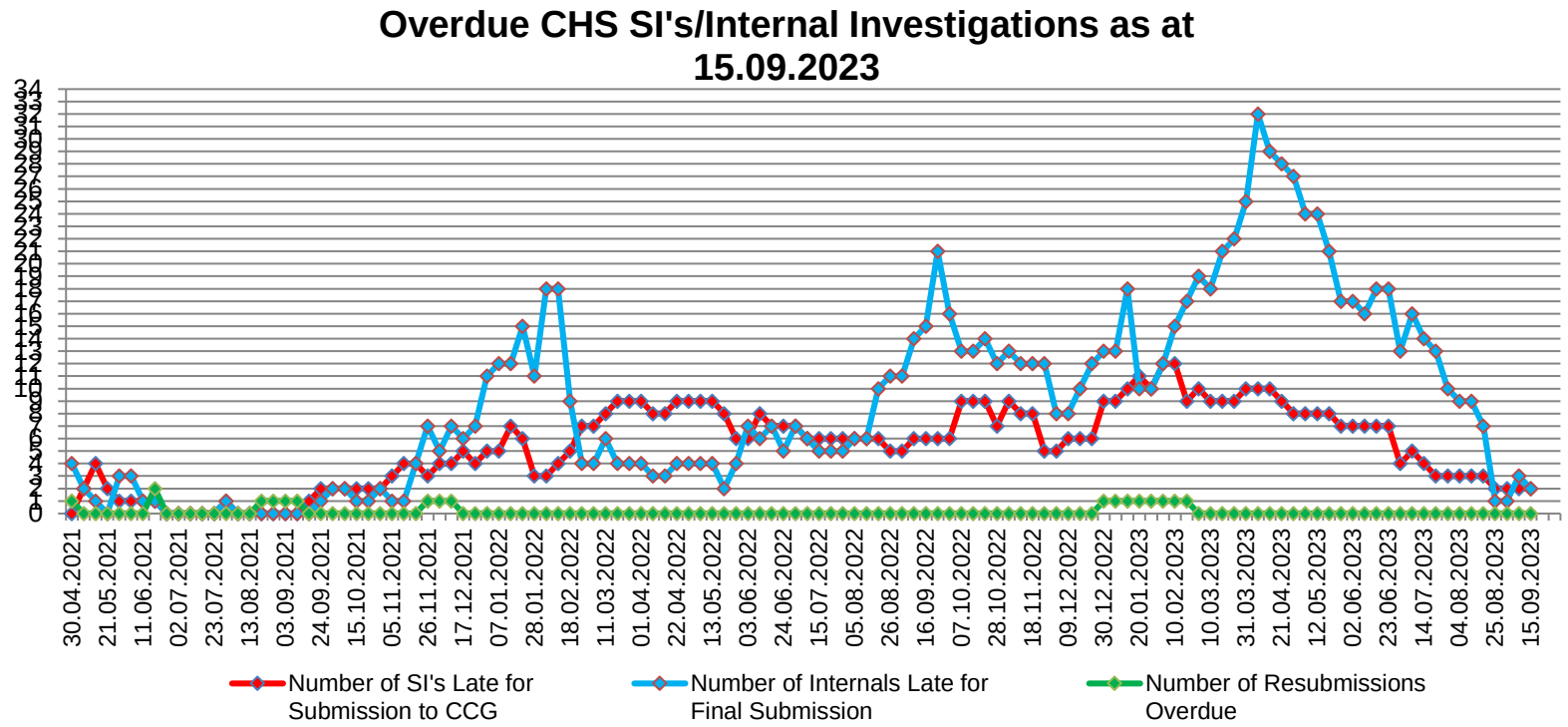
10. All Medication Incidents reported



11. Ongoing - StEIS Notifications for Serious Incidents

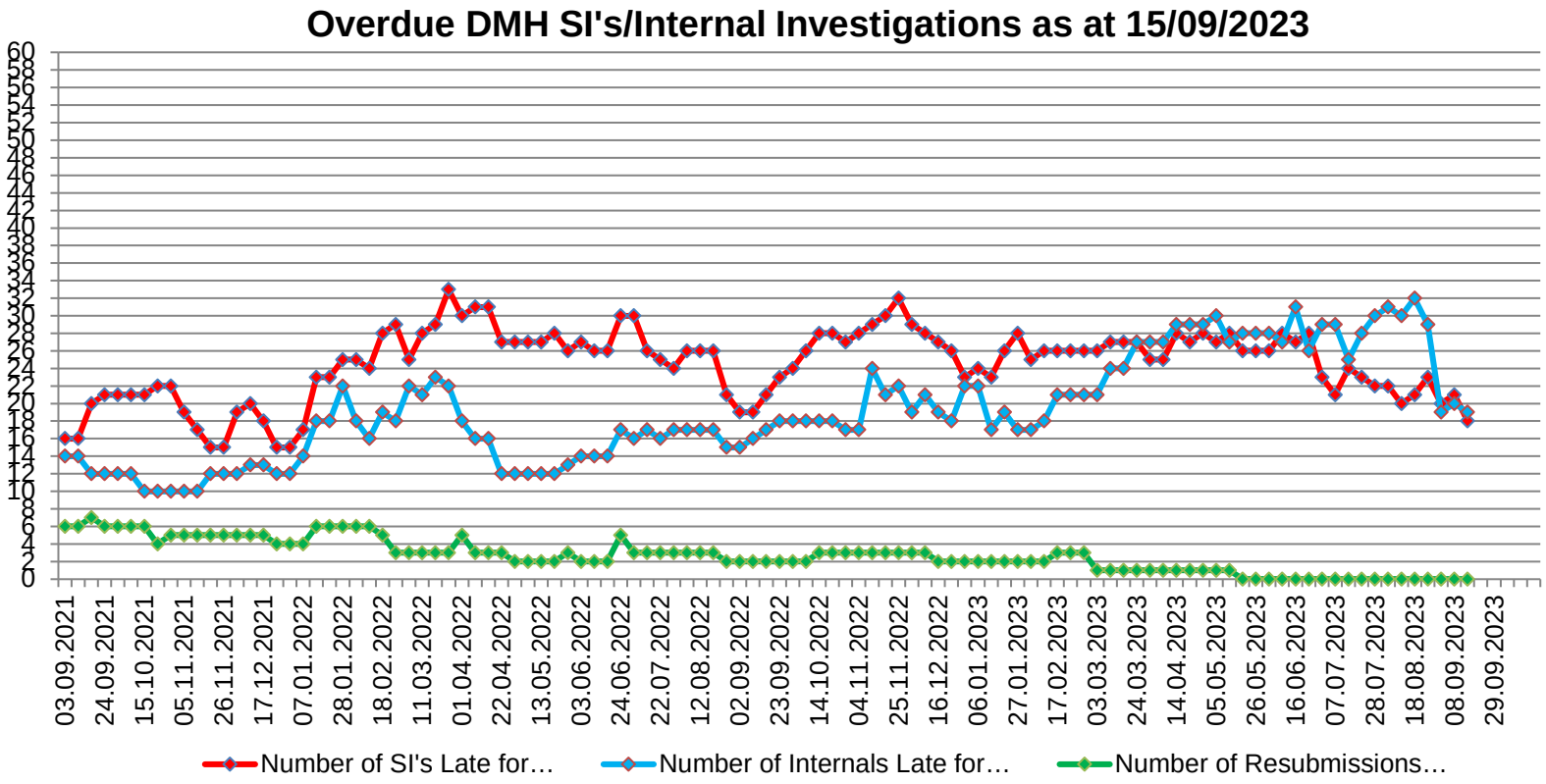
2022-2023 StEIS Notifications and Internal Investigations								
	StEIS Notifications	SI INVESTIGATIONS				Internal Investigations		
	Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2022-2+5:17023								
April	0	2	0	2	10	3	3	3
May	0	3	0	0	12	5	0	4
June	0	4	1	2	7	2	1	3
July	0	4	1	4	8	4	1	6
August	0	7	1	1	7	5	2	2
September	0	3	1	3	10	8	2	9
October	0	4	0	3	4	4	4	11
November	0	6	0	1	4	6	0	8
March	0	1	0	0	11	9	1	5
2023-2024								
April	0	3	1	1	4	8	2	2
May	0	4	0	2	4	7	2	3
June	0	2	1	1	9	2	4	6
July	0	1	0	0	10	3	1	5
August	3	1	0	0	4	6	4	13
	3	58	8	24	126	88	31	106

12. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) – CHS as at 15.09.2023



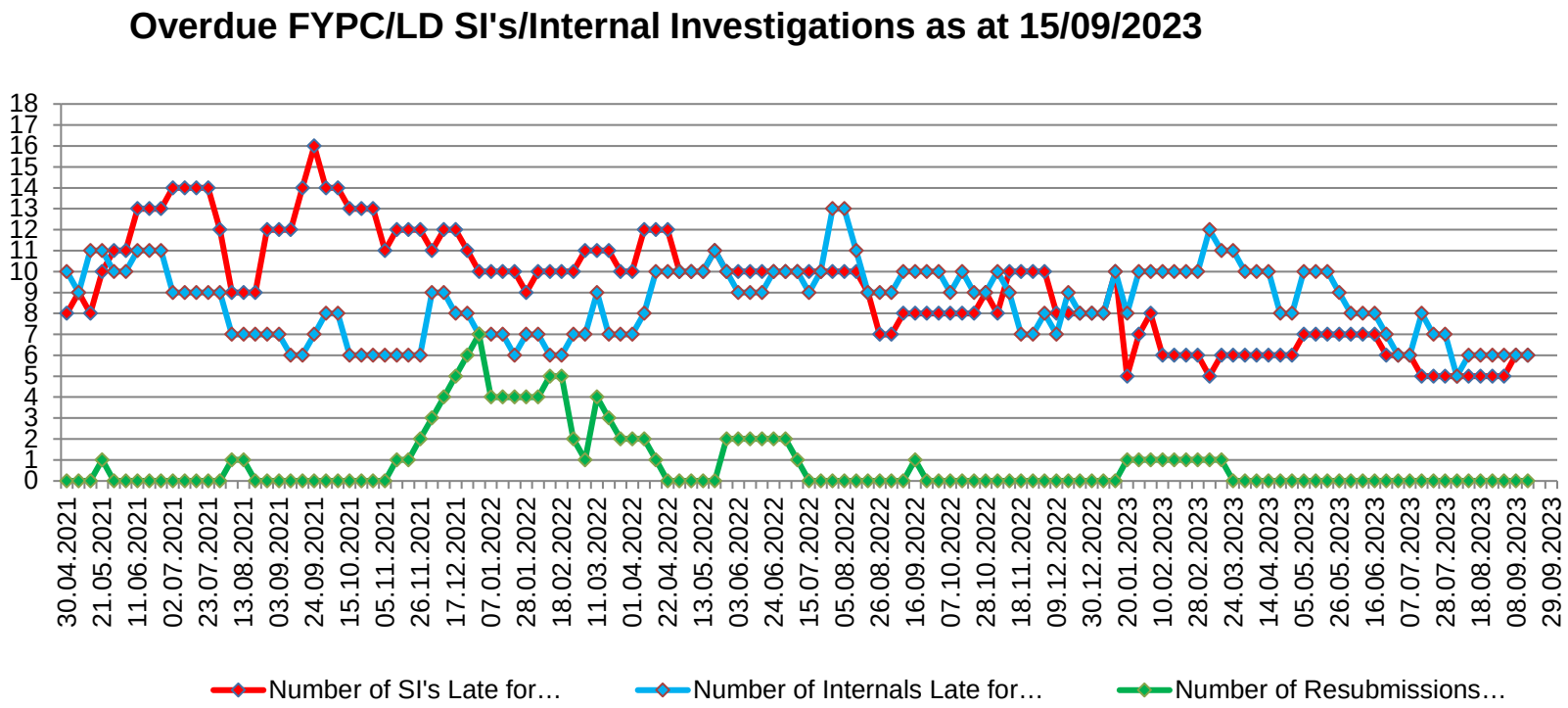
WeAreLPT
compassion respect
integrity trust

12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH as at 15.09.2023



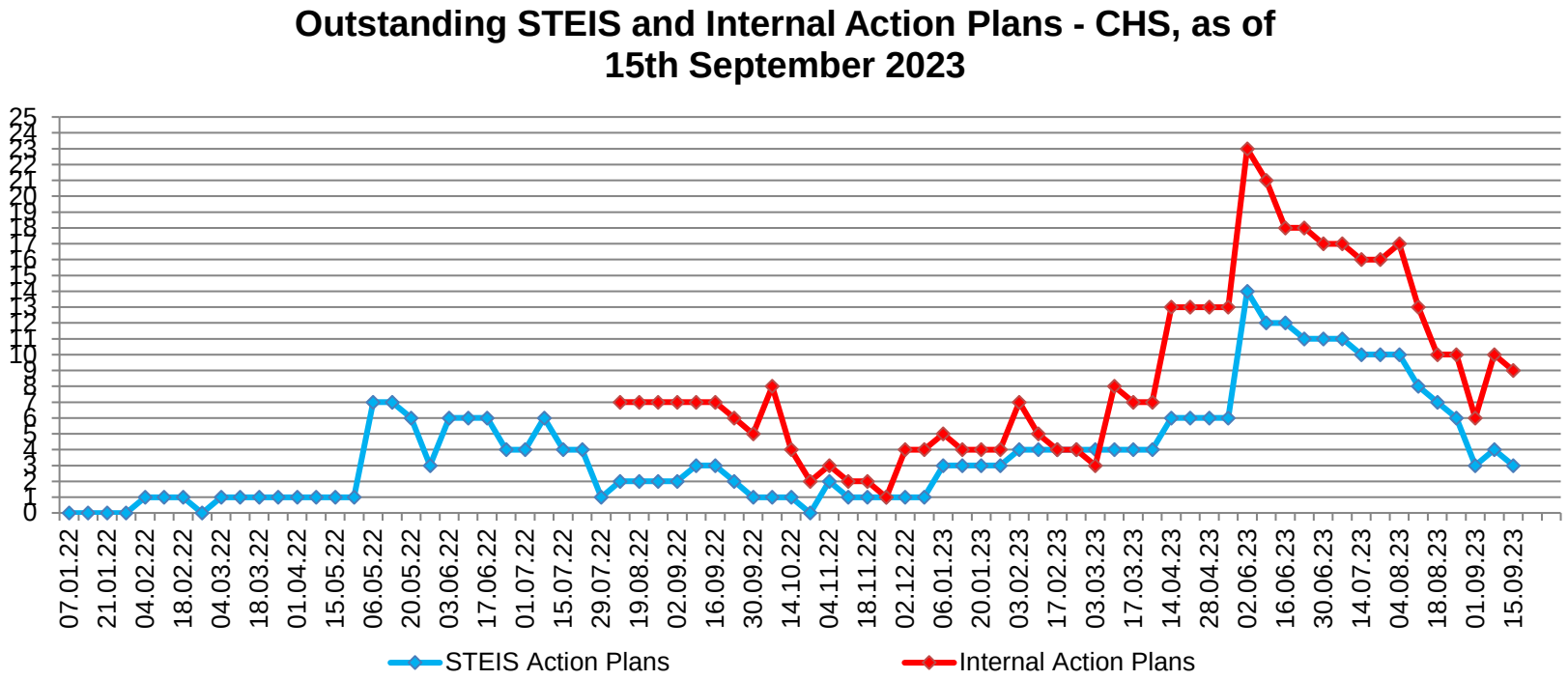
WeAreLPT
compassion respect
integrity trust

12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) – FYPCLD as at 15.09.2023



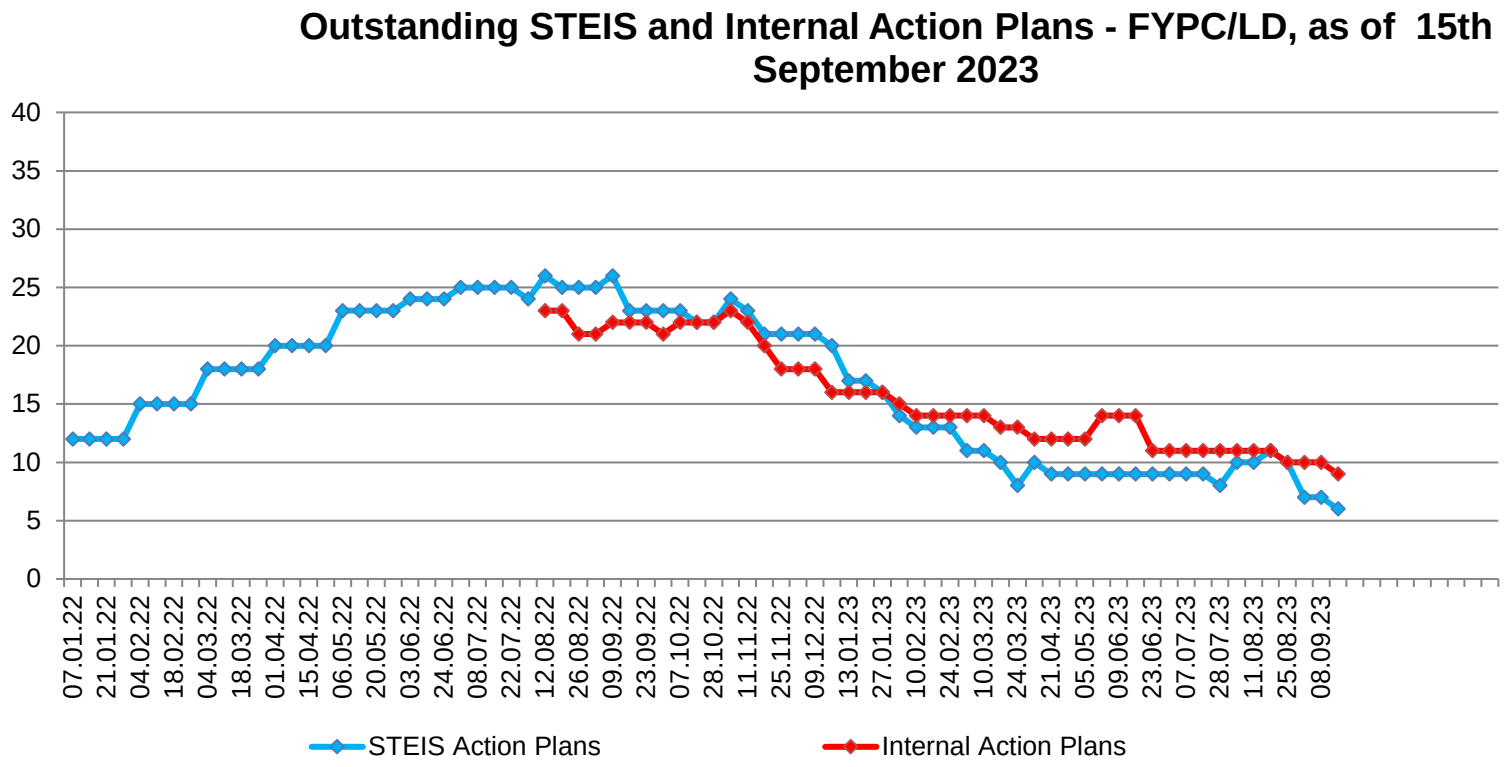
WeAreLPT
compassion respect
integrity trust

12b. Directorate SI Action Plan Compliance CHS Status 2021/22 as at 15.09.2023



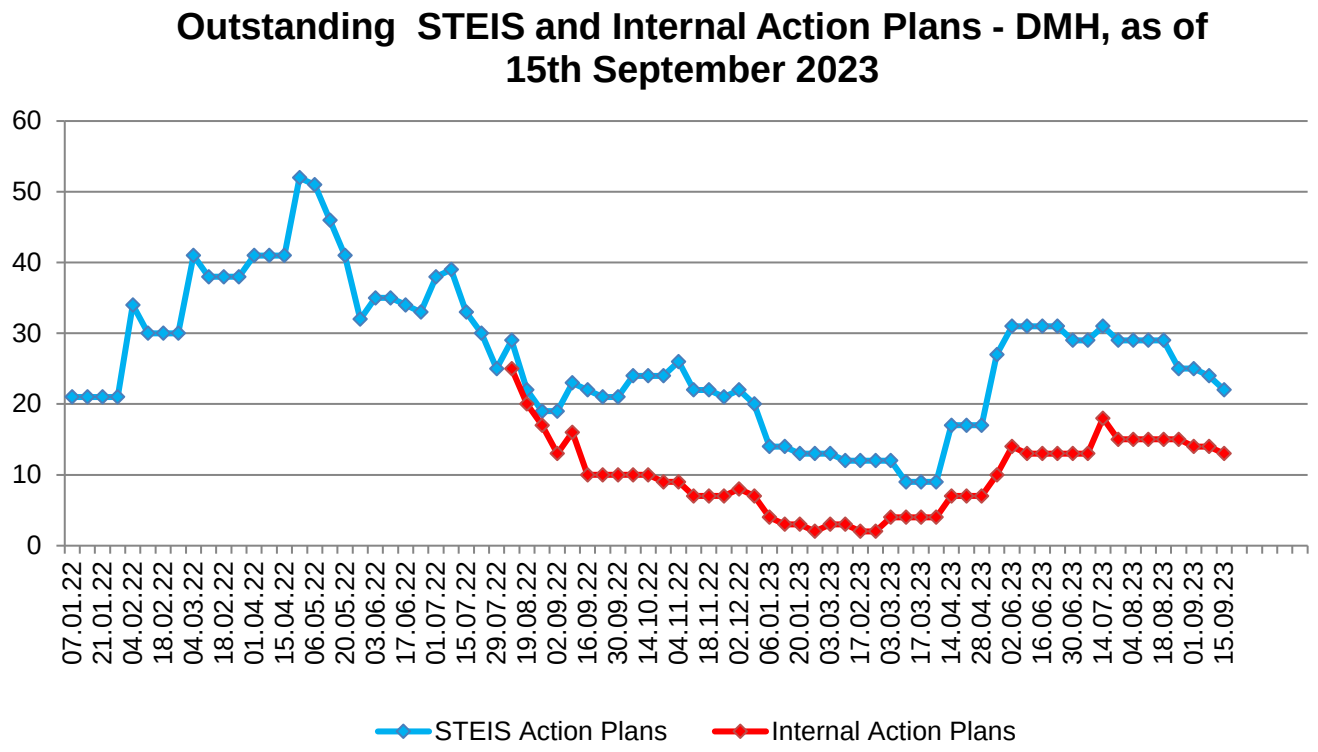
WeAreLPT
compassion respect
integrity trust

12b. Directorate SI Action Plan Compliance FYPC/LD Status 2021/22 as at 15.09.2023



WeAreLPT
compassion respect
integrity trust

12b. Directorate SI Action Plan Compliance DMH Status 2021/22 as at 15.09.2023



WeAreLPT
compassion respect
integrity trust

13. Learning from the SI process

We are working hard to build on the quality of our reports.

The introduction of PSIRF is approaching and we are working to skill wider groups of staff to use system thinking to consider incidents.

- Teaching methodology for After Action Review (AAR) and System Engineering for Initiative for Patient Safety (SEIPS)

- Strengthening processes for engaging with clinicians who may have been temporary staff or have left the organisation

14. Learning July/August 2023

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

- The undertaking of physical health observations and escalation of refusal and alternative planning
  Action-working group to consider appropriate policy for DMH staff and patients

- The function of the MDT meeting –in particular how patients are chosen for discussion – the documentation of the discussion and the management of actions to completion
  Action-QI work to simplify and standardise this process

15. Learning July/August 2023

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

- CHS staff are not thinking patient 'pressure ulcer prevention' – they are focussing on individual processes but not thinking individualised pressure ulcer prevention for each patient
  Action – the pressure ulcer prevention group are reviewing and considering the QI projects in place and how staff can be supported to think prevention

- FYPC/LD have identified a challenge where patients are under multiple services how to recognise the need for and identify a lead professional to ensure their overall care has oversight. Action – teams are working through how this can be introduced so that it is easily navigated for staff, patients and their families

Learning Board

Summary

Background: The patient is Well known to mental health services with a previous diagnosis of simple schizophrenia changed in the community to personality disorder with Fabricated illness with hoarding disorder. Admitted to BMHU in April 2023 after MHA was requested by ASC after they received concerns from the community about her well-being as well her risk to her mother. She was initially brought to the Place of Safety Unit and then admitted to Ashby Ward under Section 2 and it was not realised that a previous S3 gave eligibility automatically to s117 aftercare. When discharged there were concerns by social care that she posed a risk to her mother.

The ward did not include all agencies involved in providing care and support to the patient in the discharge planning process and safeguarding issues from social care were not fully understood and considered

Social care was not properly contacted and no Section117 aftercare meeting was held with social care to discuss any risks this led to social care raising concerns

Key Learning Points

- This happened due to the consultant planning discharge and the MDT not understanding the need for Section 117 meetings with social care to discuss risk
- The usual practice would be to invite those involved in a patient's care and support to a discharge meeting to plan discharge to ensure it is as safe as possible and hear any concerns that need to be planned around. On this occasion, this did not happen.
- The patient needed a VARM meeting was in the notes this should have been considered before discharge also
- Charge Nurse to ensure they have oversight of the care and treatment pathway of their patients throughout their journey to coordinate the right people being involved at the right time

Good Practice

- Patient was seen by the Crisis team.
- Consultant used least restrictive practice.
- Was referred to CMHT

What have we done/ are doing

- Discussion with Doctors and the manager of the ward on who is being discharged before ward rounds and who needs to be informed.
- To start to formalize discharge planning meetings at ward rounds at the start of admission.
- Team to invite all stakeholders to pre-discharge meeting when discussed in MDT
- if ready for discharge before discharge planning meeting can be held Consider leave until the meeting is held so the ward still holds responsibility and safeguards are in place.
- Education for teams around s117 aftercare entitlement

Discussion Point

- Discharges should be discussed with community social care .
- Consultants should discuss with nurses planned discharges and look at what social care needs are required.
- Challenge that patients no longer liable for detention can leave hospital prior to any plans being in place for discharge

Leicestershire Partnership NHS Trust

Patient safety – Learning from Incidents

301844 – Emily

About Emily

Emily was a 28-year-old lady who had been an inpatient on Langley Ward for an extended period where she was receiving treatment for Atypical Anorexia Nervosa, following traumatic life events. Emily had also been diagnosed with Post-Traumatic Stress Disorder and had a complex physical and mental health history, she frequently experienced episodes of anxiety that required her to be supported by staff.

Due to Emily's bladder being unable to consistently empty urine she inserted a latex free intermittent catheter on a daily basis, she was able to perform this independently, however on occasions she experienced difficulties with inserting these and then her bladder became extended and a Health Care Professional was required to insert a catheter to remain in place for a length of time, to allow both immediate drainage and monitoring of her urine output. Emily found this intervention distressing and required emotional support from staff when this was being completed.

Emily had been catheterised on 3 occasions prior to the incident with a latex catheter that had caused her localised symptoms of irritation, itching and physical discomfort, whilst she has declined specific allergy testing, due to the physical reactions that had been observed she was clinically assessed as having a Latex allergy, this was documented in her records and on the electronic medication system. Emily was not wearing a red alert band/bracelet prior to this incident to alert staff to her allergy.

What Happened

Prior to this incident Emily was unable to insert her own catheter and a bladder scan highlighted there was a large volume of urine in her bladder and a Health Care Professional was required to provide assistance to insert a catheter.

A catheter kit was not available on the ward and required to be sourced from another area. A Ward Doctor performed the catheterisation procedure, minutes after the catheter was inserted, Emily voiced she was experiencing itching around her perineal area and questioned if the catheter contained Latex. When the packaging was checked it became apparent that the catheter tube did contain Latex. Emily became distressed and began taking shallow breaths, started to scratch at her chest area and described that she had itching all over her body.

A decision was made to continue with the catheterisation to drain the large volume of urine and the Ward Doctor asked for antihistamines and an EpiPen to be located. Ward staff were unable to locate an EpiPen and after Emily's bladder had been emptied of urine the catheter was removed, the Ward Doctor asked for an internal emergency call to be put out. The ward could not connect via the 2222 system or through LPT switchboard, so a nurse went to another ward to make the call whilst staff continued to look for the EpiPen, this delayed the Emergency Team attending the situation. Ward staff continued to support Emily throughout the situation and physical health observations were undertaken and a 999 ambulance was called.

When the Emergency Team arrived, they took over Emily's care and administered a reduced dose of Adrenaline due to Emily's body weight. The Emergency Trolley did not contain a manual sphygmomanometer with an appropriately sized cuff which impacted on the Emergency Teams ability to take a full set of physical health observations. The Ambulance arrived and the crew completed Emily's physical health observations with their equipment.

The Ward Doctor requested for Emily's capillary blood glucose (CBG) to be measured during the incident. When staff went to use the Glucometer, they found that the batteries in the machine were flat and there was a small delay in being able to read Emily's CBG levels whilst new batteries were found.

Emily was advised to go to the Leicester Royal Infirmary for physical monitoring but she declined. Emily remained on the ward and with regular physical health observations taken to monitor her did not require any further treatment.

How did it affect Emily?

Emily's anxiety levels increased during any medical interventions, she also had experienced previous physical reactions following catheterisations from latex. When she was aware of the fact that a latex catheter had been inserted this was observed to cause her additional distress. A delay in obtaining the equipment and the treatment the Ward Doctor had requested may have increased her anxiety levels. Emily trusted and relied on the support of staff, this may impact on her future experiences and trusting of staff if future catheterisations were required to be performed.

Good Practice:

Nursing staff were aware of Emily's anxiety and distress that occurred during catheterisation procedures and were able to understand and provide the level of support to support her. It was evident that nursing staff acted as an advocate for Emily whilst she was very distressed and ensured that her voice was heard, and her wishes were taken into consideration.

What's our learning?

- If Emily had been wearing a red wrist band this would have provided a visual alert to staff of her latex allergy
- A risk assessment and care plan that detailed Emily's individualised plan for her allergy and what equipment and response was required if she experienced an allergic reaction would have informed staff that an EpiPen had not been prescribed, as previously Emily had only experienced localised reactions to latex. This information could have been shared with the Ward Doctor who may have requested adrenaline to be administered prior to the Emergency Team arriving. If the care plan had been updated following the previous physical symptoms Emily had experienced when she had been catheterised with a latex catheter this would have supported staff in their clinical assessments.
- As Emily was independent in using her intermittent catheters and these were stored in her room, if consideration had been given to also storing the catheters that Healthcare Professionals were required to use alongside these, including all of the relevant equipment needed for this procedure all of the equipment required would have been easily accessible. This would also have provided a visual prompt to staff to review and replace stock when used and would have eliminated the risk of staff selecting a latex free catheter from a selection of catheters in the store room.
- Adult eating disorder patients often require smaller sized blood pressure cuffs to ensure accurate readings can be taken, ensuring a variety of sized cuffs were available in the emergency trolley would have allowed immediate completion of Emily's physical health observations.

- The emergency trolley was missing equipment that was required to be used, a robust process to check this equipment to review stock levels, expiry dates and perform visual inspections of the equipment would have ensured that all equipment to support Emily's physical health deterioration was accessible.
- The Patient Identity Policy is being updated to ensure it is clear that all LPT inpatients wear red identity wristbands if they have a recorded allergy, this requirement has been shared with all of the multidisciplinary team. Frequent spot checks of this is being completed by the Senior Nursing Team to ensure compliance.
- To support nursing staff to be able to perform catheterisations and reduce the need for medical staff intervention training sessions and competency assessments are being arranged. The ward are also agreeing a process to ensure that staff are able to access suitable trained staff to perform and manage clinical skills outside of what would be usual practice on the ward.
- A weekly audit of Glucometers is being completed to ensure calibration of this device and spare batteries are kept with each Glucometer.
- Latex free equipment is stored in a designated area and is clearly labelled.
- The Process of summoning the Emergency Response Team is being reviewed to ensure that when the internal telephone system cannot be activated there is a contingency plan to ensure there is no delay in obtaining emergency support to the inpatients in DMH inpatient wards.
- A Trust Wide review is being completed to review and decide what specific information will be included on all Emergency Trolleys relating to Anaphylaxis assessment and treatment to support clinical decision making.

NHS
Leicestershire Partnership
NHS Trust

Patient safety – learning from incidents.

Mrs E's story

Mrs E was transferred to CHS Inpatients from the University Hospitals of Leicester (UHL) where she had been treated for an episode of rectal bleeding and also received treatment for alcohol withdrawal. Mrs E also lived with anxiety and Post Traumatic Stress Disorder and prior to her admission to UHL had unfortunately been made homeless.

Prior to the Incident Mrs E voiced she had pain and requested additional analgesia, nursing staff had been unable to administer this as the maximum level of her prescribed analgesia for that day had been administered, this caused Miss E some anxiety, just prior to the incident Miss E had taken her prescribed analgesia and sleeping tablet, both of these may have caused Mrs E to experience some drowsiness. Mrs E had an unwitnessed fall at 22.00 hrs and was found naked on the floor by a member of staff who noted she was bleeding from an area of her face. Physical health observations were completed that highlighted Mrs E had a slightly raised pulse rate and reduced blood pressure, she was observed to be fully conscious and alert. A visual assessment was performed by an RN that highlighted Miss E had a cut to her lip and contusion to her head. Mrs E was able to stand independently from the floor and was supported back to her bedside.

Nursing staff contacted the Out of Hours Service (OOH) promptly following the incident and informed them of Miss E's physical health observations and facial injury. The OOH Doctor stated he would arrange an emergency ambulance to transfer Miss EC to the UHL for a medical review. At 01.05 hrs when the ambulance had not arrived nursing staff contacted the 999 service to escalate, at 04.50 hrs Paramedics arrived to transfer Mrs E to UHL, she voiced she was feeling dizzy and nauseous.

At UHL Mrs E was assessed to have a facial fracture and also required sutures to her lip, following this treatment she was transferred back to CHS.

Good Practice identified.

- Prompt response from nursing staff to attend to Mrs E following her fall, visual assessment and physical health observations completed and repeated frequently prior to arrival of the paramedics. Glascow Coma Score observations recorded.
- Mrs E was covered by a sheet immediately following her fall to protect her dignity.
- Prompt escalation to the Out of Hours Service
- Escalation to 999 when there was a delay in the ambulance arrival.
- A Falls Huddle was completed allowing staff to discuss the details of Mrs E's fall and a falls checklist was completed to record accurate information relating to her fall.
- Mrs E's falls care plan was update following the incident to highlight her increased risk.

What is our learning focus?

- As staff were aware Mrs E had episodes of anxiety and was observed to be distressed prior to her fall consideration could have been given to increasing her frequency of safety monitoring, completing a pain score and discussing with her pain management with the Out of Hours doctor to establish if additional analgesia could be prescribed.
- Mrs E had not had a lying and standing blood pressure completed prior to her fall, had this been completed it may have provided information if Mrs E's blood pressure was affected by her standing that required escalation for a medical review. A process has now been put in place to ensure all patients have a lying and standing blood pressure completed on admission.
- An EIRF was not completed until the day after Mrs E's fall, this did not allow accurate record keeping of the events, this has been shared with the team to highlight the importance of contemporaneous record keeping.
- Staff have Shared that they were monitoring Mrs E'S level of consciousness frequently following the fall until the paramedics arrived, however this is only recorded once on the records, the importance of all physical health observations being recorded to ensure that accurate information regarding can be shared between health care professionals has been shared with the nursing team.

NHS
Leicestershire Partnership
NHS Trust

Patient safety incident response plan (PSIRP)

2023-2024

Contents

Foreword

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."
Aidan Fowler, National Director of Patient Safety, NHS England

Leicestershire Partnership Trust (LPT) have welcomed and embraced the theories and principles of the Patient Safety Strategy of which the Patient Safety Incident Response Framework (PSIRF) is one area. This is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different. It is a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident learning responses that support learning and improvement to prevent recurrence.

Where previously we have had set timescales and shared with external organisations to approve what we do, PSIRF gives us a set of principles to which we will work. Although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents, with the aim of learning and improvement. We know that we investigate incidents to learn however, we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to keep our patients safe.

We need to engage meaningfully with our patients, their families and carers and our staff, to ensure that their voice is heard in patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

We will work towards a restorative and just culture to underpin how we approach our incident responses and continue to foster a culture in which people feel invited and supported to highlight incidents, knowing there is psychological safety. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult and continue to equip, support and hear the voices of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, and these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning. However, we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. This plan sets out a high level series of principles we will work to using a Quality Improvement approach.

In this, we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us opportunities to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff.

Dr Anne Scott
Executive Director of Nursing/AHP's & Quality

Dr Saquib Mohammed
Acting Medical Director

Introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the PSIRF, a replacement for the NHS Serious Incident (SI) Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at LPT to prepare for “go live” with PSIRF, and what comes next.

The NHS Serious Incident Framework: Supporting learning to prevent recurrence (2015 provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety, through how we respond to patient safety incidents.

PSIRF removes the requirement that all/only incidents meeting the criteria of a ‘serious incident’ are investigated. This enables resources to be focused more effectively on the identified areas with the greatest potential for patient safety improvement; and enable responses to look at incidents that would not have met the SI criteria, but where important learning can still be gained.

One of the underpinning principles of PSIRF is to do fewer “investigations” and to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associated policies and guidelines will describe how it will work. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for an NHS provider healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the SI process does not mean “do nothing” it means respond in the right way depending on the type of incidents and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff, patients and families/carers involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, trust-wide strategy, and reporting systems.

We have developed our understanding and insights over the past year, including regular discussions and engagement through our committees and groups. Most recently in June 2023, we held a PSIRP Planning Day which 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 trust's local patient safety priorities for PSIRF.

This plan provides the headlines and description of how PSIRF will be applied at LPT and sets out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed: we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred, significant opportunities for learning and the needs of those affected. This is a key feature of our approach to continuous learning and allows us to use a Quality Improvement (QI) approach to both the plan and our learning responses.

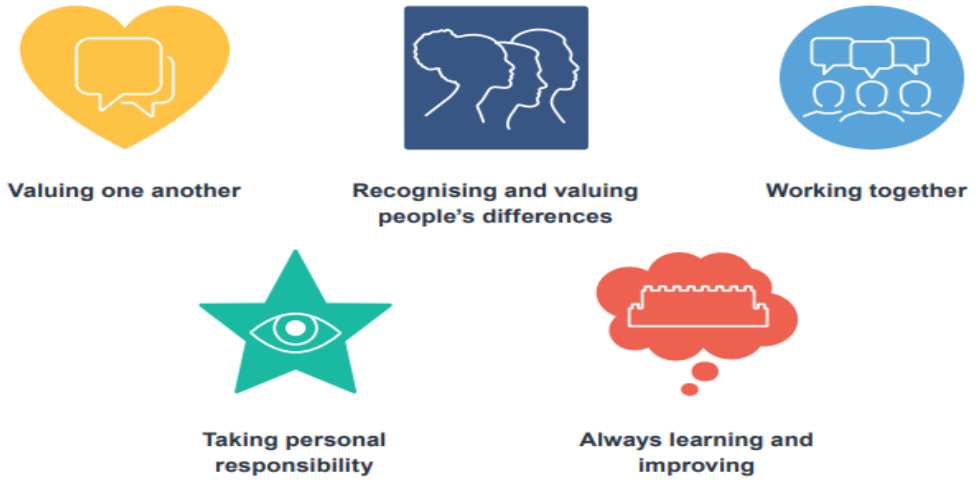
The scope of the PSIRP and our vision

It is recognised that there are many ways to respond to an incident. This plan covers responses conducted solely for the purpose of systems-based learning and improvement from patient safety incidents. There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resource matters, legal claims and coroner inquests.

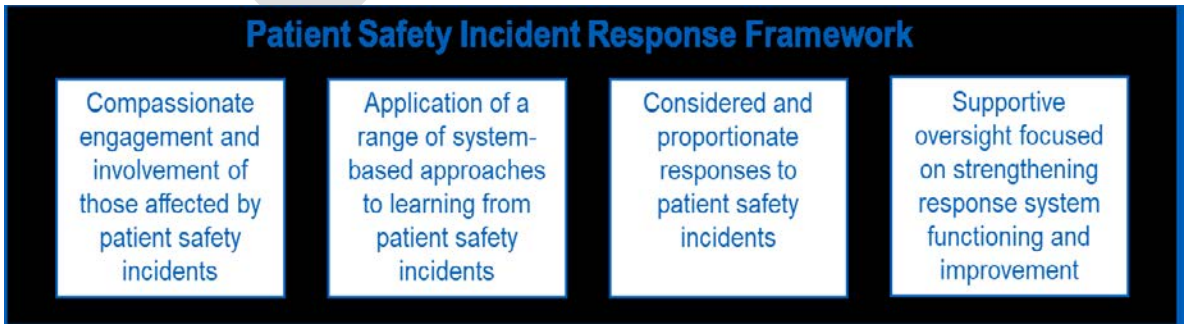
We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of this is explained later within this document.

The implementation of PSIRF will see our Trust vision of "**Creating high quality, compassionate care and wellbeing for all"** embodied in our work.

LPT Values



Our plan supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:



Overview of Leicestershire Partnership NHS Trust services

LPT is the only NHS mental health trust provider in Leicestershire. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a unique person. LPT is a complex system with many areas supporting each other. We have reviewed all patient safety activities and our network of key stakeholders across LPT who are integral to the Patient Safety agenda.

About Us and the community we serve
In April 2011, mental health and learning disability services in Leicester, Leicestershire and Rutland were brought together with local community services and families, children and young people's services to create Leicestershire Partnership NHS Trust as we know it today.

We provide community health and mental health support to over 1 million people living in Leicester, Leicestershire and Rutland. Our services touch the lives of all ages (from health visiting to end of life care), from head to foot (from mental health to podiatry) and everything in between. We have over 7000 staff (including bank staff) who provide this care through three clinical directorates:
• Mental health services
• Families, young people and children's services and learning disabilities and autism services
• Community health services

Their work would not be possible without our enabling and corporate services staff, alongside our hosted service providers and around 300 volunteers.

During 2022/23 we provided and/or subcontracted 129 relevant health services. Mental health and learning disabilities account for 72 services, and 57 were community health services.

It should be noted that in addition to the services above, LPT has been a key provider in relation to the delivery of the Covid 19 vaccination programme to the population of LLR and has been running the workforce bureau for staffing LLR vaccination sites. LPT also hosted the LLR staff mental health and wellbeing hub on behalf of the system up to 31 March 2023, at which point the funding was discontinued.

Our population
Our Trust provides a range of community and mental health services from many different locations across the Leicester, Leicestershire and Rutland (LLR) region, including hospitals, longer term recovery units, community and outpatient clinics, day services, GP surgeries, community centres, schools, health centres, people's own homes, and care homes.

A small number of specialist services are also provided to service users from wider geographical areas, primarily areas of the East Midlands adjacent to Leicestershire, this

includes our Adult Eating Disorders service, male Low Secure forensic mental health care and Huntington's Disease Services. The population of LLR is currently estimated at 1.1million and is expected to grow in the coming years. Just under two thirds of the population live in Leicestershire, just under one-third in Leicester city and approximately four per cent in Rutland. With a population of this scale, our Trust serves more people than the average community and NHS mental health Trust.

Situational Analysis of Patient Safety Activity

In the last three years, more than 38,800 patient safety incidents have been reported in LPT with <1.4% of these being investigated as a 'Serious Incident' as per the current Serious Incident Framework (2015).

A significant portion of the work of our Directorate colleagues has been carrying out SI investigations. These can be a very time-consuming process impacted by the NHS's ongoing staffing challenges and has resulted in some delayed investigations over recent years.

Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 98.6% of patient safety incidents. In short, the burden of effort to support patient safety improvement is placed on fewer than 1.4% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as within the current SI Framework (2015) and calling them something else. A key part of developing the new national approach is to understand the amount of patient safety activity the trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

The PSIRF related activity undertaken at LPT prior to PSIRF can be broken down as follows:

Patient Safety Activities	Activity	Definition	Average of 2020/21 and 2021/22	1 April 2022-31 March 2023
National Priority	Incident resulting in death	Serious Incident (SI) resulting in patient's death, reported to STEIS and requiring investigation within the standard investigation	129	27
National Priority	Never Events	Incident meeting criteria for never events framework, reported and investigated to STEIS as a SI	0	0
Local Patient Safety Activity	Serious Incident Requiring Investigation (SIRI)	Serious incident requiring investigation (SIRI) which met the standard investigation time limit.	301	77
Local Patient Safety Activity	Patient Safety Incident reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SIRI criteria	435	319
Local Patient Safety Activity	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring validation at department/ward level.	23635	13898

Defining our patient safety incident profile

The Trust has a commitment to continuously learn from patient safety incidents and has developed understanding and insights into patient safety activity over a period of years. We have committed to the recruitment of corporate patient safety investigators to ensure we have the resource, skill and expertise to undertake system reviews using investigation science. We have links from each of our directorates into the trust's Patient Safety Improvement Group (PSIG), where learning is shared and oversight and support is provided to their subgroups who are undertaking improvement work. This improvement work is designed based on national NHS and regulatory requirement or local learning. This learning activity was considered as part of our plan.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement, apart from the national requirements listed on p13 below.

To fully implement PSIRF and to understand what needs to be learned from in order to improve, the Trust has completed a review and triangulation of:

- What types of patient safety incidents occur
- Themes from complaints

- Themes from claims
- Patient and staff feedback
- Identified risk and audit results

The Corporate Patient Safety Team (CPST) has engaged with key internal and external stakeholders and directorates have undertaken a review of data from a variety of sources, to arrive at a safety profile. This process involved:

- Identification of what is working well.
- Where there is good progress with and improvements from quality improvement (QI). projects, as well as where QI projects have stalled or not produced effective improvement.
- Where there are gaps in our understanding of why improvements in certain areas are not happening was also important for us to know.

This has led to the development of the local focus for our incident responses described on p19.

Stakeholder engagement

The CPST commenced planning for PSIRF in advance of the release of NHSE supporting documents in August 2022. We have consulted with and learnt from PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF, and their assistance has been invaluable.

PSIRF requires a very different approach to the oversight of patient safety incidents, and we have worked closely with our lead (ICB) commissioners currently responsible for the majority oversight of our application of the current SI Framework. We are a core member of their system Patient Safety Network and PSIRF Operational Group.

Additionally, we have engaged with all our other commissioners who oversee care delivery and management of incidents within some of our services, as well as the Coroner to explore and agree how PSIRF will affect reporting and management for them.

A PSIRF Project Group was set up to progress preparations for implementation of PSIRF at LPT and met monthly. Core members were from the following teams: patient safety, directorate clinical and quality governance, QI, communications and senior nursing representation. The group has also worked closely with the Human Resources, Organisational Development and Communications teams in relation to a project “Our Future Our Way” (OFOW), working with over 80 Change Leaders who are supporting the trust on its culture change journey. It is with this group we will work to support the culture change required to be successful as a trust with PSIRF.

Internally, presentations were made to our Board development day, Directorate Management Team meetings, Change Leaders forums and other corporate team meetings.

The Group made an early decision that to identify our safety profile, each directorate would collate and review their patient safety data from several sources, followed by analysis and synthesis within their teams, to identify local priority areas and present their conclusions to a diverse audience of stakeholders at the trust wide PSIRP Planning day.

The process of preparing for the planning day has been a part of our continuing 'culture change' journey. Our change leader programme has patient safety, patient experience and quality improvement at its heart and ensures a shared understanding and appreciation for the role these play in our efforts to step up to great.

Compassionate engagement and involvement of those involved in patient safety incidents (patients, carers, families, and staff) is a key aim of PSIRF. Patients and carer representatives, staff from across the trust including bank staff, have been engaged and collaborated at the planning day. Our patient experience team are actively supporting this work and supported the recruitment of patient involvement partners to offer challenge where required and add the patient voice to the conversation to agree the trust's local priorities for the PSIRP.

The PSIRP Planning day took place on 19th June 2023, with attendees including patient/ carer partners, staff from each directorate, bank staff, representatives from corporate teams such as legal, human resources, health and safety, programme management office, pharmacy, patient safety, patient experience, executives, non-executives, communications, organisational development and commissioners.

Our data sources and how they were used to define our safety profile is detailed below.

Data sources
To define our patient safety response profile, we drew data from a variety of sources including the Ulysses incident reporting system. Data was collated on the incidents that had taken place over the period of April 2022 to March 2023. We decided to look at this year to minimise the possibility of any variation in data arising from the COVID-19 pandemic impact.

We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process. Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident investigation reports
- Complaints
- Freedom to Speak Up reports
- Safeguarding reviews
- Mortality reviews and Structured Judgement Reviews
- Staff survey results
- Claims
- Trust risk profile
- Anonymous CQC concerns
- Quality Improvement projects

Safety issues and gaps highlighted by the data

Once the data was collated and reviewed, the directorate clinical and quality governance teams carried out a series of engagement with their staff and management teams, to

confirm and agree the areas requiring further understanding to support improvement. These were then drilled down to four priorities from each directorate.

The PSIRP Planning day event was a collaborative approach to agreeing and finalising our local focus and priorities for review by patient safety incident investigations (PSII) based on in depth systems-based investigations.

Each directorate presented the process they had used for review and analysis of the data, a summary of the data reviewed and how they identified and prioritised the four priorities for review by PSII. Themes and subcategories were considered to agree the final profile. The audience were then asked to confirm if they were assured by the process and to say how they would order the priorities, to see if it matched the directorate's. The Slido polling platform was used at the event for audience engagement.

One of the aims of the day was to agree five local priorities for review by PSIIs, however, the conversations and some challenges from stakeholders means that six local focus priorities as detailed on page 19 were eventually identified for review by PSII.

Addressing health inequalities

As a large provider of mental health and community services, LPT has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system. For example, our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda. Impact from health inequalities or equality, diversity issues have now been included in the standard terms of reference for all PSIIs.

Our engagement with patients, families and carers following a patient safety investigation, must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

We will therefore be able to better demonstrate how our priorities for the PSIRP reflect our local population's demographics and diversity (EDI) and link to addressing health inequalities for the next review of the PSIRP.

The question of how we will evaluate whether the priorities chosen for focus have resulted in improvements in patient safety and care, was also asked. Guidance within the national patient safety strategy discourages aiming for "quick wins" as, invariably, they turn out not to address the factors within the system. Ongoing review of the data, trends and improvement work will take place regularly through oversight routes.

The process of preparing for the planning day has been a part of our culture change journey, as is the work of our Change Leaders, who have patient safety as integral to the work they are doing. The patient experience and the QI teams have also been key. This is a significant development from previous culture change work.

Whilst the final list of priorities has been agreed, this list is not fixed thereafter. Within our corporate patient safety team of investigators resource, we have also established capacity for a small number of additional ad-hoc PSIIs, where a new risk emerges or learning and improvement can be gained from investigation of a particular incident or theme; this may also include national patient safety steer.

Patient safety incidents not for PSII will be reviewed using other methodologies within PSIRF; these include initially:
Systems Engineering Initiative for Patient Safety (SEIPS)
After Action Reviews (AAR)

Other methodologies can be used where staff have the training and capability, for example:
SWARM
Multidisciplinary meetings (MDT)
Structured Judgement Reviews (SJR)
Thematic Reviews

The CPST are supporting the upskilling of staff to use human factors approach and system thinking to consider and review all incidents. This will require a long-term approach to develop and build on these skills and competencies across the organisation.

Defining our patient safety improvement profile

Over several years, the Trust has developed its governance processes to gain insight from patient safety incidents and this has fed into QI activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

There is QI work being undertaken across our quality governance groups with PSIG being a key group for the professional discussion/decision and oversight of progress of QI projects. These groups including PSIG report into the Trust level Quality Forum, which will continue to provide assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be timely and of high standard.

The Incident Oversight Group (IOG) will be responsible for oversight of the implementation of this plan and the PSIRF approach using a QI methodology to develop and refine the plan as we learn and move forward. This group will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF, to ensure they have followed robust processes during development, fulfil SMART

requirements and are sufficient to allow the Trust's continuous improvement and risk reduction/mitigation in future patient safety.

Our clinical directorates are required to report through our quality governance routes to monitor and measure improvement activity across the organisation.

Governance and oversight

Robust local governance routes have been clearly defined by our directorates which will then feed into the corporate oversight and assurance groups. These will include:

- Weekly clinical huddles to review reported incidents
- Clinical and quality governance team reviews
- Directorate sign off groups
- Directorate management team oversight
- Oversight at Directorate management team quality and safety meetings.

Under PSIRF, our commissioners the ICB, Public Health Local Authority (PHLA) and Provider Collaboratives, will be invited to attend oversight meetings; this is a shift, as currently the majority is LPT services being requested to meet with them, often linking in with 'contract monitoring.'

Identification of incidents

Methodologies for identification of incidents have also been agreed and will be reviewed as we learn. The weekly, trust wide Incident Review Meeting (IRM) will provide support and advice for directorate teams and a record of discussion and decision making to support a response to those involved in patient safety incidents.

Current patient safety related improvement

We have robust management and oversight of QI activity within the trust including Clinical Audit, Service Evaluation and PDSA improvement projects. Quality improvement methodology is fundamental to the delivery and continuous improvement of high quality care. Our QI approach empowers all staff to identify changes needed, develop the skills to make and lead the change. Additionally, we are able to use QI methodology when improvements are identified through our quality assurance and control processes. Working collaboratively as part of the Group model with Northamptonshire Healthcare Foundation Trust, three priority areas for patient safety have been identified for 2023/24. The priority areas are based upon patient safety/patient experience data and aligned to those areas that have or continue to be quality priorities in both organisations and provide the opportunity for collaborative working and improvement. The three priority areas are:

- Pressure ulcer prevention, care, and treatment
- Recognition and care of the deteriorating patient
- Mental health safe and therapeutic observations

Further examples of QI projects supporting patient safety are included in Appendix B. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated workstream noted.

During our development of this plan our directorates identified four areas each for consideration as the trust's local priorities and for review using PSIIs. As previously described, six areas were chosen. The remaining six non-psii priorities (detailed in appendix D), will be reviewed at directorate level by the clinical and governance teams, utilising other PSIRF methodologies. They will be developed into QI projects to initially scope the learning and identify improvement actions. These will be implemented over the next 12 months and overseen by the PSIG. The results will be considered in the next PSIRP review.

Our Patient Safety Priorities

Our patient safety incident response plan: national requirements

The Trust has finite resources for patient safety incident response and we intend to use those resources to maximise learning and improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care, will always require a PSII through which we can learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally and the Trust fully endorses this approach, as it fits with our aim to learn and improve within a just and restorative culture. As well as PSII, some incident types require specific reporting and/or review processes to be followed as shown below.

For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below.

From our incident and resource analysis we estimate due to the services we provide, that we will complete approximately 10 PSII reviews where national requirements have been met per annum.

National event response requirements: additional to local priorities

Patient safety incident type	Required response	Anticipated improvement route
Patient safety incidents meeting the Never Events 2018 criteria or its replacement	PSII	Create local organisational actions and feed these into quality improvement
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into quality improvement
Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care (including in patient suspected suicide)	PSII	Create local organisational actions and feed these into quality improvement
Section 42 and other mandated safeguarding enquiries	AAR or similar methodology	Create local organisational actions and feed these into quality improvement

Our patient safety incident response plan: local focus

The type of response to patient safety incidents will depend on:

- The views of those affected, including patients and their families
- Capacity available to undertake a learning response
- What is known about the factors that lead to the incident(s)
- If improvement work is underway to address the identified contributory factors
- If there is evidence that improvement work is having the intended effect/benefit
- If the Trust and its ICB are satisfied risks are being appropriately managed.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure Ulcers (PU) (category 4)	Using SEIPS methodology	Create local safety actions and feed these into the quality improvement plan overseen by the trust PU group
Falls resulting in Harm (where there is opportunity for learning)	After Action Review (AAR) trialling the template from the National Falls audit	Create local safety actions and feed these into the quality improvement plan overseen by the trust Falls group
Infection Prevention and Control (IPC) incidents	Using SEIPs methodology	Inform ongoing improvement projects
Information Governance incidents	After Action Review (AAR)	Identify processes to strengthen improvement
Deteriorating patients	Structured Judgement Review (SJR) type screening and thematic analysis	Reviewed thorough Mortality and Morbidity meetings and learning enacted

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents, engagement meetings and the planning day, we have determined that the Trust requires 6 patient safety priorities as local focus. We have selected this number based on the services that the Trust provides and outcome from the planning day with input from key stakeholders.

We will undertake 5 index case PSII in each of the types of incidents proposed (should they occur). This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors. We will use the outcomes of PSII to inform our patient safety quality improvement planning and work.

This was agreed at Executive Management Board (EMB) on 1st August 2023.

Trust Local Priority	Directorate	Patient safety incident type	Planned response	Anticipated improvement route
1	FYPC/LDA	Omissions in care due to communication or information sharing across services where child/ren under 4 years and 10 months old who are open to Healthy Together and there is one or more known significant adult within child/ren's core network open to adult mental health services	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
2	FYPC/LDA	Significant incident occurring due to lack of care coordination where there are multiple services (including external partners) involved in a patients care	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
3	CHS	Patients who deteriorate within 7 days of transfer to a community hospital and require readmission to an acute bed	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
4	CHS	Patients who have been on a community caseload for more than 6 months where deterioration is not recognised and actively managed	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
5	DMH	Suicide of an individual where substance misuse is also a risk factor	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
6	DMH	Serious patient safety incident where patients are awaiting treatment from community mental health services.	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight

Standard terms of reference have been agreed for all PSIIs. This will include the gaps that were identified during analysis of incidents for the planning day:

- To establish the impact of any workforce or skills deficit on the incident –this is not about apportioning blame but to review the impact of system issues on staff/staffing.
- To investigate if the patient was in the care of more than one LPT service and to identify any systemic issues or breakdowns in communication between the services.
- To consider if there was an impact on the care or patient experience from health inequalities or the patient's protected characteristics.
- To identify if any electronic system used, impacted on the patient's care and experience.

PSII is not the only tool we will use to respond to incidents. Our Responding to Incidents policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents. We have outlined several ways we can respond to individual incidents, including:

SEIPS model: System Engineering Initiative for Patient Safety -a human factors methodology
Safety Huddle: Triggered by an event to assess what can be learned
After Action Review (AAR): A structured facilitated debrief
Multi-disciplinary team (MDT) meetings: SJR (mortality/morbidity and learning from deaths)

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers. The statutory Duty of Candour process is still an obligation for the trust, requiring a meaningful verbal and written apology for the harm resulting from a patient safety incident. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

As part of our new policy framework, we are developing a family liaison and engagement guide to support staff in engaging compassionately with patients and their families, during responses to incidents. We are also developing a process for gathering feedback proactively to allow us to change and develop our response as we learn.

Involvement and support for staff following incidents

We are on an ambitious journey at LPT to ensure it is a safe and fair place, where everyone's voice is invited, valued and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. As part of our commitment to staff health and wellbeing, we have a suite of support for our staff which is always being reviewed and added to. Led by the Trust's lead psychologist, we are developing a debrief process to support staff in the immediate aftermath of an incident.

Teams are also implementing Schwartz rounds to allow a safe space for staff to come together to discuss how they are affected by the challenging nature of events in healthcare. This is a proven method of support used widely in healthcare across the world.

Further to this, the methodology for investigation has been developed to be very clearly focussed on learning and not in any way to apportion blame.

Roles and responsibilities in the new system

The Trust Executive Management Team oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Directorates and the Executive Team.

The Quality and Safety Committee is chaired by a Non-Executive Director and this bimonthly meeting will receive the assurance of both the process of implementation, the undertaking of learning responses and the associated QI work.

Progress of PSII, risk and other types of patient safety reviews will be overseen by the IOG. Safety recommendations from PSIIs will be reviewed through PSIG in support of the six patient safety priority improvement programmes.

Appendix A

Glossary of terms

AAR - After Action Review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase the occasions where success occurs.

Never Event
Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS organisations commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response Plan
Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the Directorates and specialist risk leads, supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients effectively and sustainably.

Schwartz Rounds (NHS)
Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

SEIPS - System Engineering Imitative for Patient Safety
A framework for understanding outcomes within complex socio-technical systems.

SJR - Structured Judgement Review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score

care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SMART
SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows:

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved or targets might slip

SWARM
Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

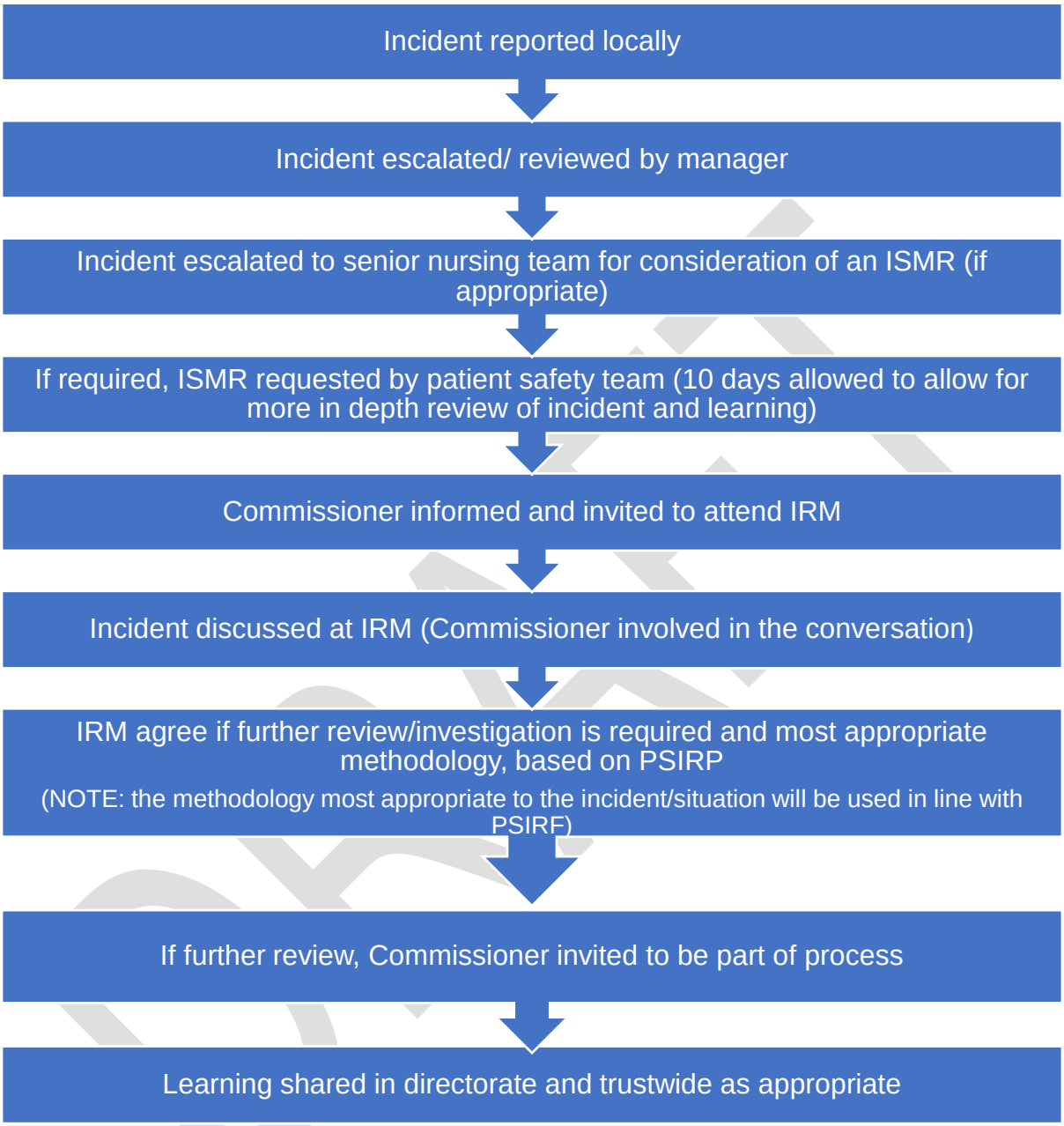
Appendix B

Improvement programmes

Checking and searching of patients in inpatient areas	PDSA
Reducing the dependency of therapeutic observations on MHSOP organic wards	PDSA
Charge Nurse's weekly Environmental Check	Monitoring audit
CHS community therapy clinical observations practice improvement.	PDSA
Improve the use of Sepsis tools and pathways on Community Hospital and Bradgate Mental Health Unit inpatient wards.	PDSA
Reducing the number of pressure ulcer incidents occurring in LPT care (CHS District Nursing)	PDSA
Reducing the number of category 2 pressure ulcers occurring in LPT care	PDSA
Introduction of Falls Huddles	PDSA
Improve identification and management of falls risks	PDSA
The impact of a medications alert tool on falls in a Mental Health for Older People inpatient setting	PDSA
Use of Flat Lifting equipment post fall	PDSA
Best Practice seating	PDSA

Appendix C

Process for local review of patient safety incidents



Appendix D

Non PSII priorities for review using other PSIRF methodologies

Directorate local priority	Non-PSII priorities
DMH	Where there is an incident of significant harm and there was evidence of poor multi-agency communication across directorates or within LPT or with gaining and sharing information with families.
	Patient safety incident where an inpatient come to significant harm whilst under therapeutic observations on the ward
CHS	Near misses and incidents where patients receive inappropriate care due to incorrect positive patient identification
	Patients who are in the care of more than one LPT service who deteriorate in our care
FYPC	Assaults on staff e.g. "Reportable incidents related to assaults on staff (verbal or physical) to ensure staff are supported and to enable the Trust to address issues related to reduced staff wellbeing"
	Record Keeping and Digital Competency e.g. "Serious omissions that occur directly related to documentation in the electronic patient record, including formatting, use of templates and staff competencies around use of electronic systems"