M

Leicestershire Partnership NHS Trust

Public Trust Board - May 2025

Patient Safety Report for March and April 2025

Purpose of the Report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed and refreshed to assure that systems of control continue to be robust, effective, and reliable thus underlining our commitment to the continuous improvement of incident and harm minimisation.

The report will also provide assurance around 'Being Open' supporting compassionate and timely engagement with patients and families following a patient safety incident, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses patient safety incidents and associated lessons learned/opportunities for learning.

Analysis of the Issue

The 'top 5' reported patient safety incidents are considered and reported on in this paper; however, it should be noted that in addition all incident types for the reporting period are reviewed, to establish changes within all categories that may present emerging themes for wider consideration.

Review of Top 5 reported patient safety incidents

During March and April 2025, there were 3028 patient safety incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 59% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1514 incidents per month during March and April 2025.

Top 5 reported patient safety incidents March and April 2025

Category	Number of incidents	Directorate with highest % of the total reported

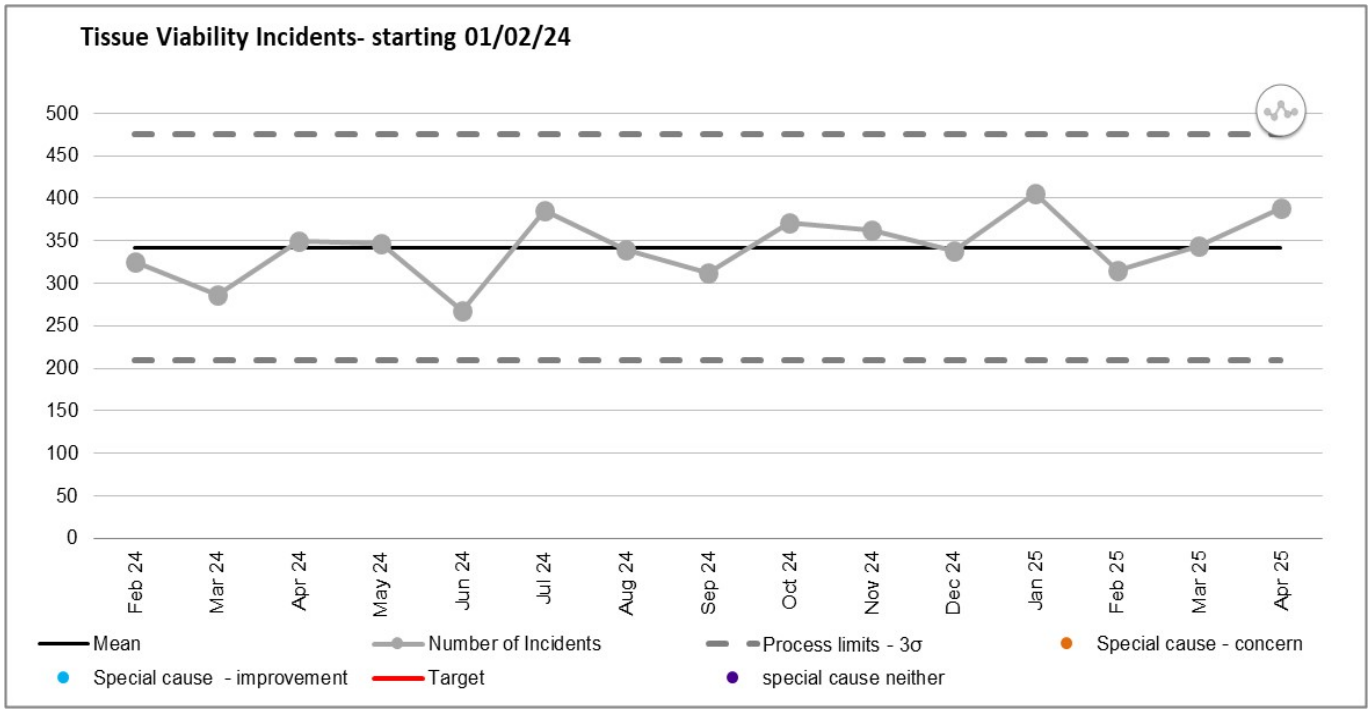
1. Tissue Viability	732	CHS 98.8% - community and inpatient
2. Self-Harm	342	DMH 67.5%
3. Falls	255	DMH 60.4%
4. Violence and Assault	250	DMH 80%
5. Medication	221	CHS 68.3% community and inpatient settings

Degree of harm recorded for all patient safety incidents for March and April 2025

Reported degree of harm	**Number**	**% of total incidents reported**
No Harm	1577	52.1%
Minor/Low Harm	1359	44.9%
Moderate Harm	38	1.25%
Severe Harm	9	0.3%
Death	45	1.49%

NB these incidents were reported in March and April 2025 and will be being reviewed through local and corporate governance structures and the degree of harm may change, dependent on further learning and review.

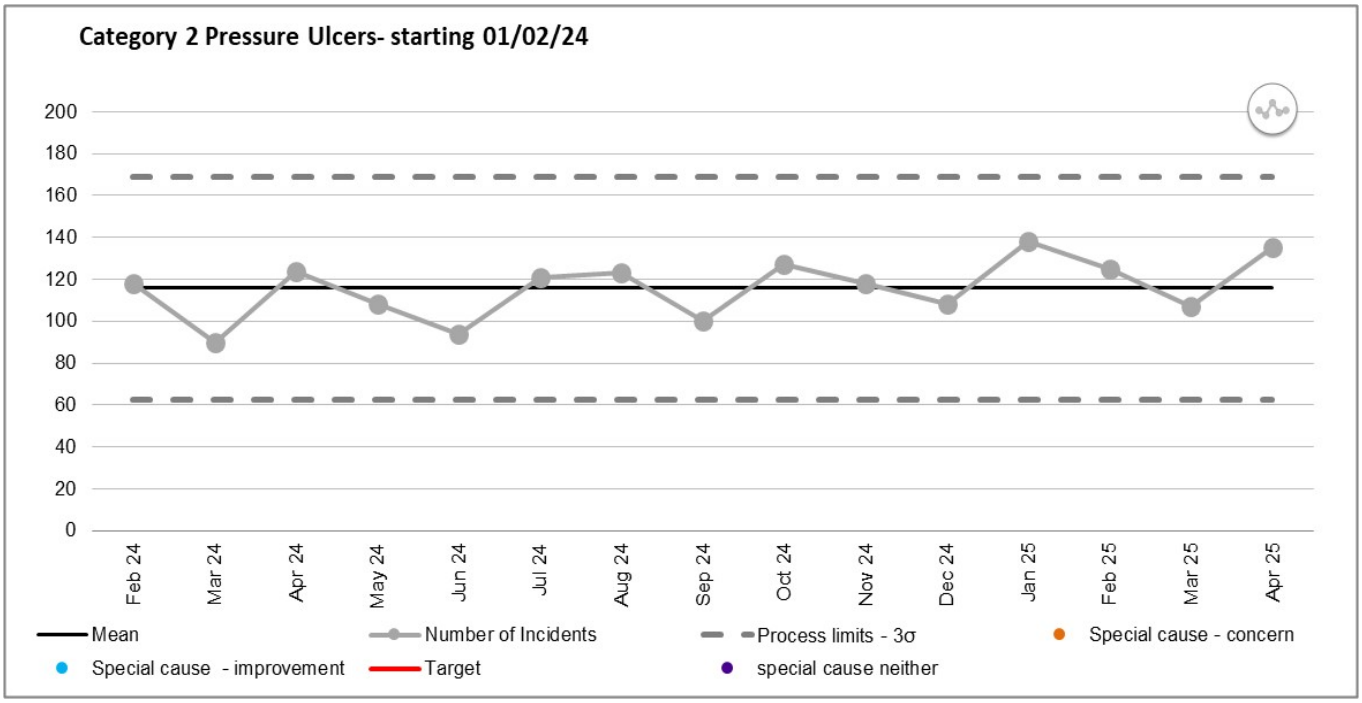
1. Tissue Viability this includes Burns/Scalds/Moisture Lesions/Medical Device Injury/Podiatry Pressure Ulcer – All incidents.



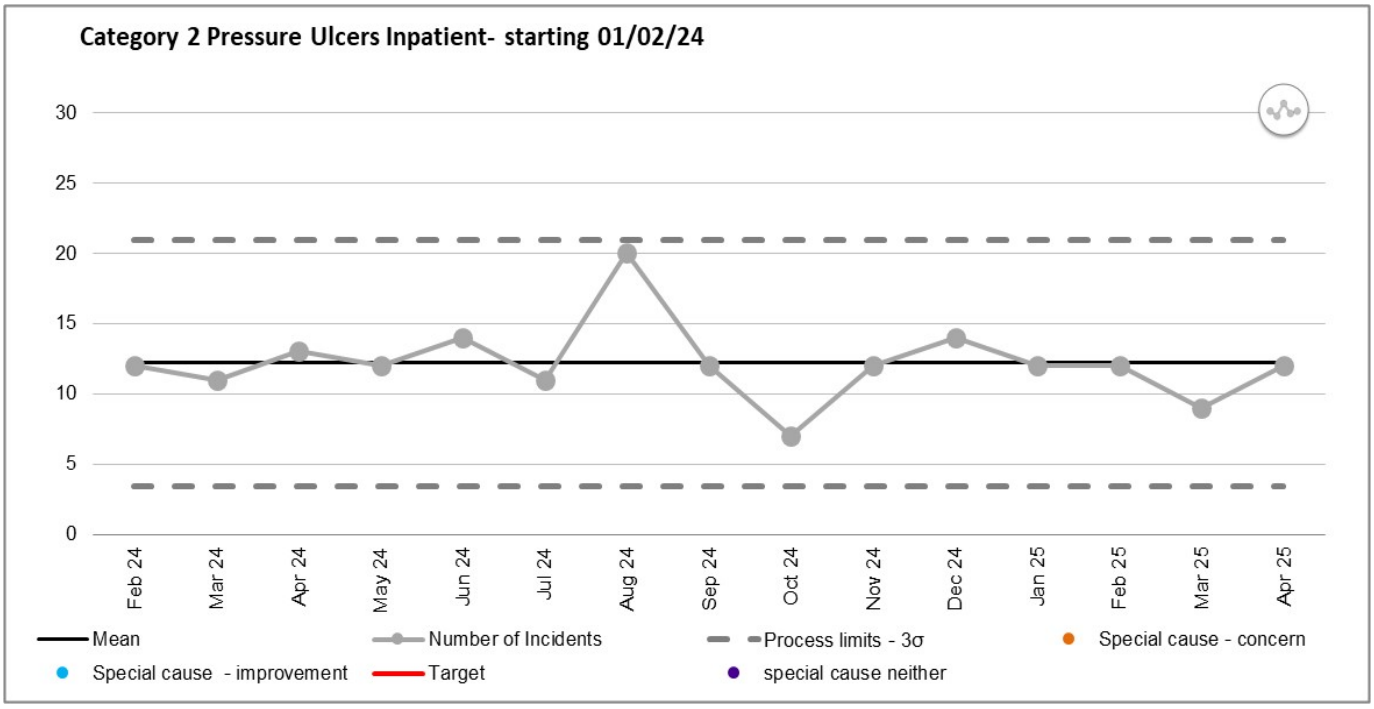
24.17% of all patient safety incidents reported relate to 'Tissue Viability' during March and April 2025; this equates to 732 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 1,2,3,4 and unstageable) represent 69.26% of these, we will focus on this aspect of patient harm.

In March and April 2025, there were 277 reported incidents whereby patients had been affected by category 2,3,4 pressure ulcers reported to have developed or deteriorated in LPT care which represents a 9% reduction in pressure ulcers reported in comparison to the previous 2 months reporting. During patient care in CHS, 253 (91.33%) were reported in the CHS community nursing services and 20 (7.22%) were reported in community hospitals (inpatients). The remaining 1.55% (4 incidents) that have affected patients were reported in DMH inpatients (2) and FYPC-LDA community Diana Service (2); both related to the development of category 2 pressure ulcers.

Category 2 pressure ulcers developed or deteriorated in LPT care – Trust Wide



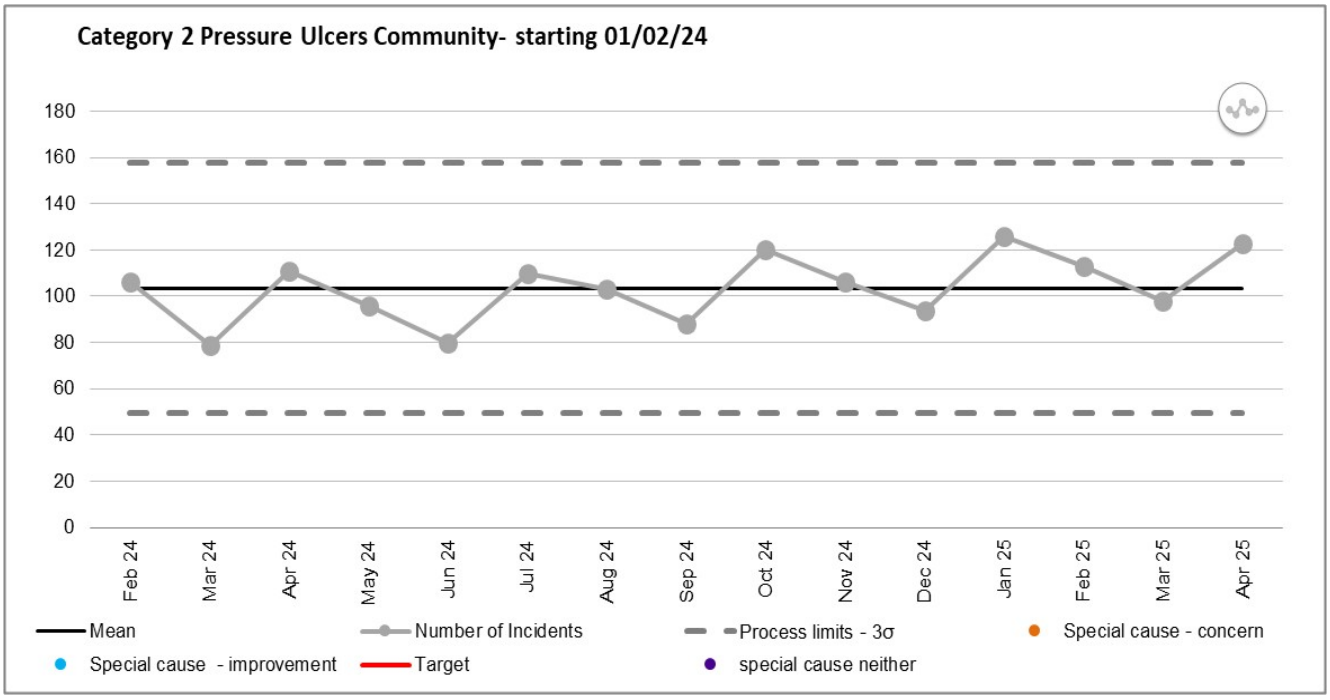
In-patient Category 2 pressure ulcers developed in our care – Trust Wide.



CHS Community Hospital pressure ulcer improvement work continues. The hospital tissue viability nurse continues to work and support ward staff through increased education and training and clinical support on the wards.

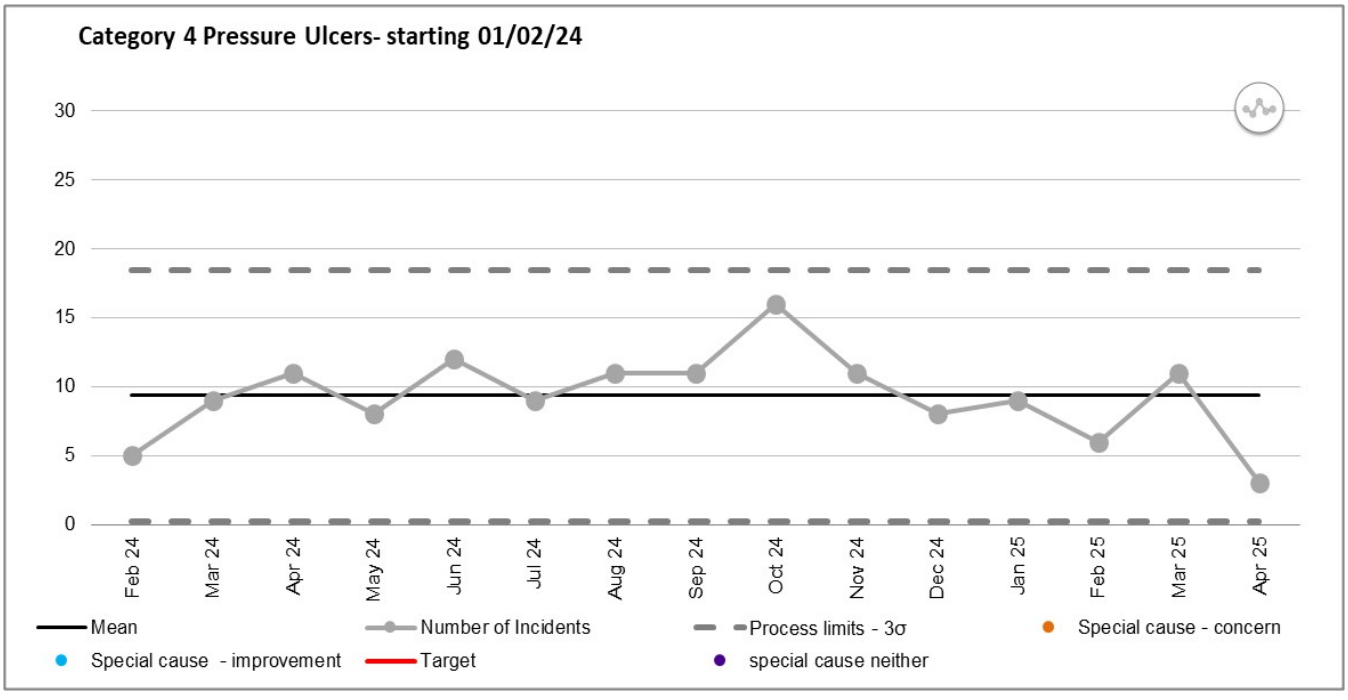
To note, there have been no patients who have developed a category 4 pressure ulcer whilst in LPT in-patient care since March 2024.

Community Category 2 pressure ulcers developed in our care – Trust Wide.



The chart above details the number of patients who have been affected by a Category 2 pressure ulcers that have been reported as developed in LPT CHS community nursing care. A review of these incidents by the community Hubs from 1st March 2024 – 31st March 2025 and their caseload data has identified that Charnwood, East South, and North-West Leicestershire are the highest reporting hubs. Several quality improvement interventions are in place linked to these hubs to support the teams and facilitate improvements.

Category 4 Pressure Ulcers developed or deteriorated in our care – Trust Wide.

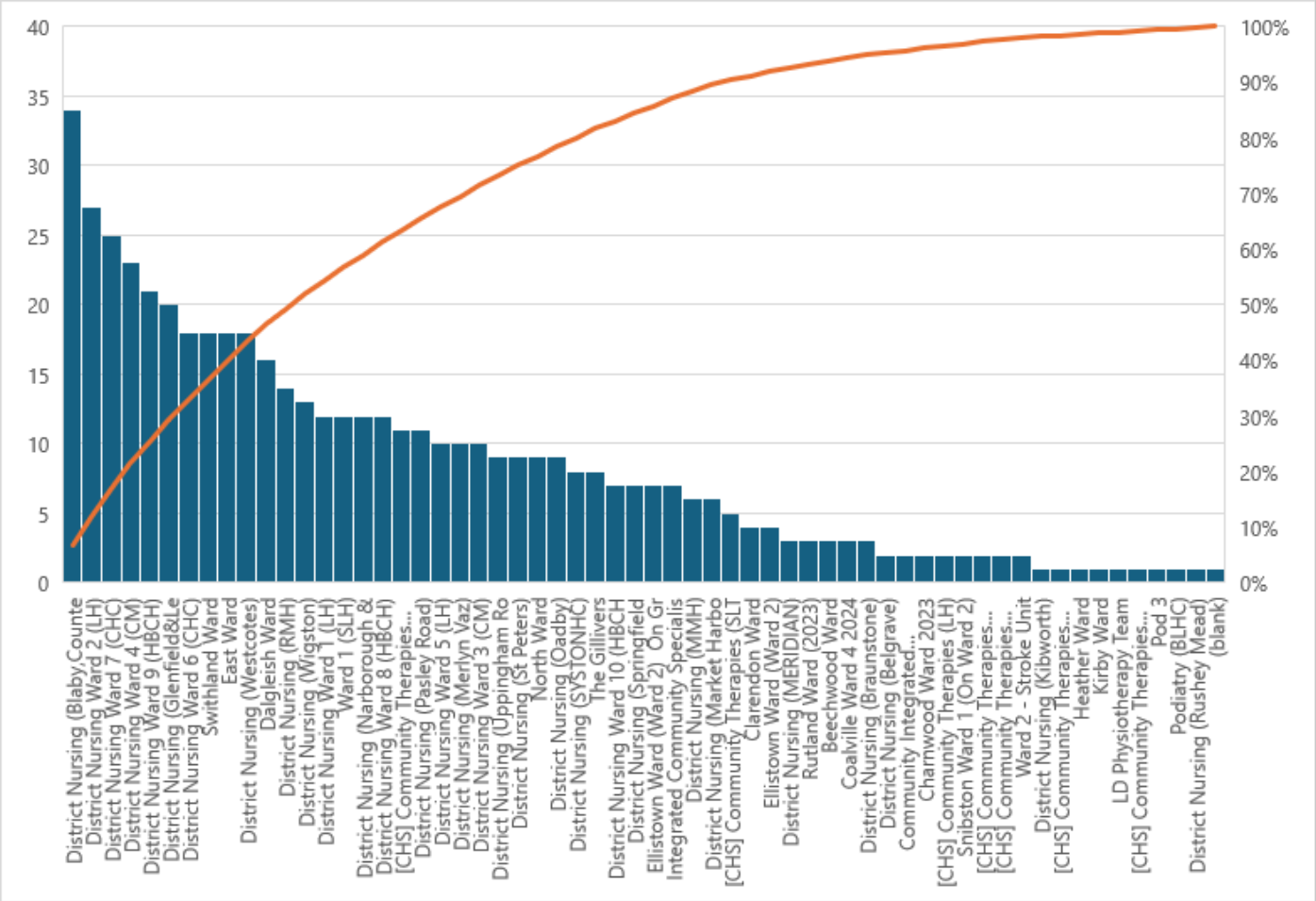


All patient incidents reported related to category 4 pressure ulcers either developed, or deteriorated in CHS community nursing care has identified a reduction in April 2025. It is too early to draw any conclusions from this as patient acre reviews of Aprils reported incidents are still being reviewed. Progress will be monitored over the next month. Overall review of Trust wide SPC is showing normal variation only and no statistically significant reduction in pressure ulcers.

Patients affected by pressure ulcer harm is a ‘nurse sensitive indicator’ linked to safe staffing. There has been no evidence through the monthly safe staffing reviews that staffing was a contributory factor. The MDT care review process of Category 2 and Category 4 pressure ulcers has highlighted there are opportunities to improve repositioning advice and the oversight of it when undertaken by care staff in patient’s homes and escalation of concerns and senior nurse oversight particularly for complex patients. Challenges remain particularly supporting patients with positioning difficulties, access to carers beyond packages of care in their own home or for those who prefer to remain seated for extended periods of time.

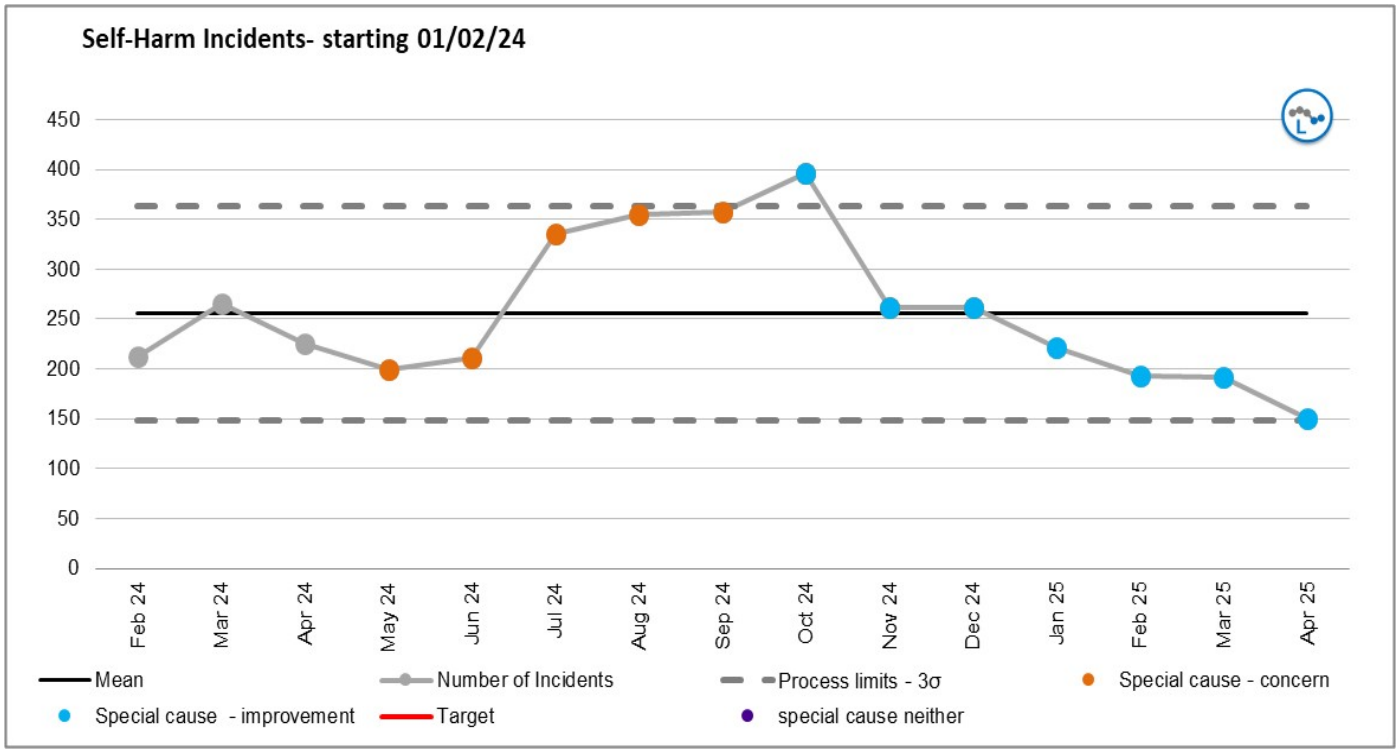
It is recognised by the Pressure Ulcer prevention group that there is ongoing work and staff education to be undertaken in relation to consistency of categorising of patient’s pressure ulcers. When reviewing incidents using System Engineering Initiative for Patient Safety (SEIPS), it has been identified that some patients in their own homes are in bed for extended periods overnight without being repositioned due to access to carers. This is a patient safety risk that the Pressure Ulcer prevention group is reviewing with system colleagues.

The related quality account priority for 2025/26 is developed with a focus on reducing Moisture Associated Skin Damage (MASD) and category 2 pressure ulcers developed in our in-patient care. the data has been analysed as per chart below and work will be piloted for our inpatient wards on East and Swithland Ward who are showing as ‘outliers’ for MASD and category 2 pressure ulcers that have developed in our care.



The Trust wide pressure ulcer reduction group are concentrating on standardising and simplifying the paperwork used to assess and plan care. The aim of this is to bring a consistent approach to assessment, planning of care and making it easier for our staff to assess patient's progress.

2. Self-Harm – Trust Wide



There were 342 patient self-harm incidents reported during March and April 2025, this equates to 11.29% of all reported patient safety incidents during this period. During the previous reporting period, there were 413 self-harm incidents reported across both inpatient and community settings; this shows a decrease of 17.19% during the current reporting period. This reduction is considered to previously reported ceasing by the central access team (CAP) who stopped reporting incidents in November 2024 relating to patients that are not open to LPT services. (i.e., members of the public calling in for support related to their mental health.

The number of incidents has been analysed and over the reporting period, there are 3 areas with a higher number of self-harm incidents reported relative to the total number (342) of such incidents reported; CAMHS Beacon Unit with 38 incidents (11.1%); Ashby Ward with 36 incidents (10.5%), Crisis Resolution Team (CRT) with 33 incidents (9.6%). Of these, here has been 1 incident reported as moderate or severe harm. Of the 38 incidents reported by CAMHS Beacon, 31 (81.58%) were recorded as minor/low harm with the remaining 7 (18.42%) as no harm. Of the 36 incidents reported by Ashby Ward, 25 (69.44%) have recorded as minor/low harm with the remaining 11 (30.56%) being recorded as no harm and Crisis Resolution Team have recorded 6 (18.18%) as being minor/low harm, 26 (78.79%) being recorded as no harm, and 1 (3.03%) being recorded as moderate harm.

Overall, of the 342 total reported self-harm incidents, 197 (57.6%) have been reported as minor/low harm, a further 136 (39.77%) have been recorded as no harm, 7 (2.05%) have been reported as

moderate harm, with the remaining 2 (0.58%) incident being reported as ‘severe harm’. Following a review of these 2 incidents (377574 & 379127, 1 reported by DMH and 1 reported from FYPC-LDA), there is no significant learning for LPT.

Self-harm incidents are reviewed in directorate and actions taken. Three incidents were escalated for review at Incident Review & Learning Meeting (IRLM). On review, it was confirmed that appropriate actions were in place including continued support for the patients.

Some key incident details:

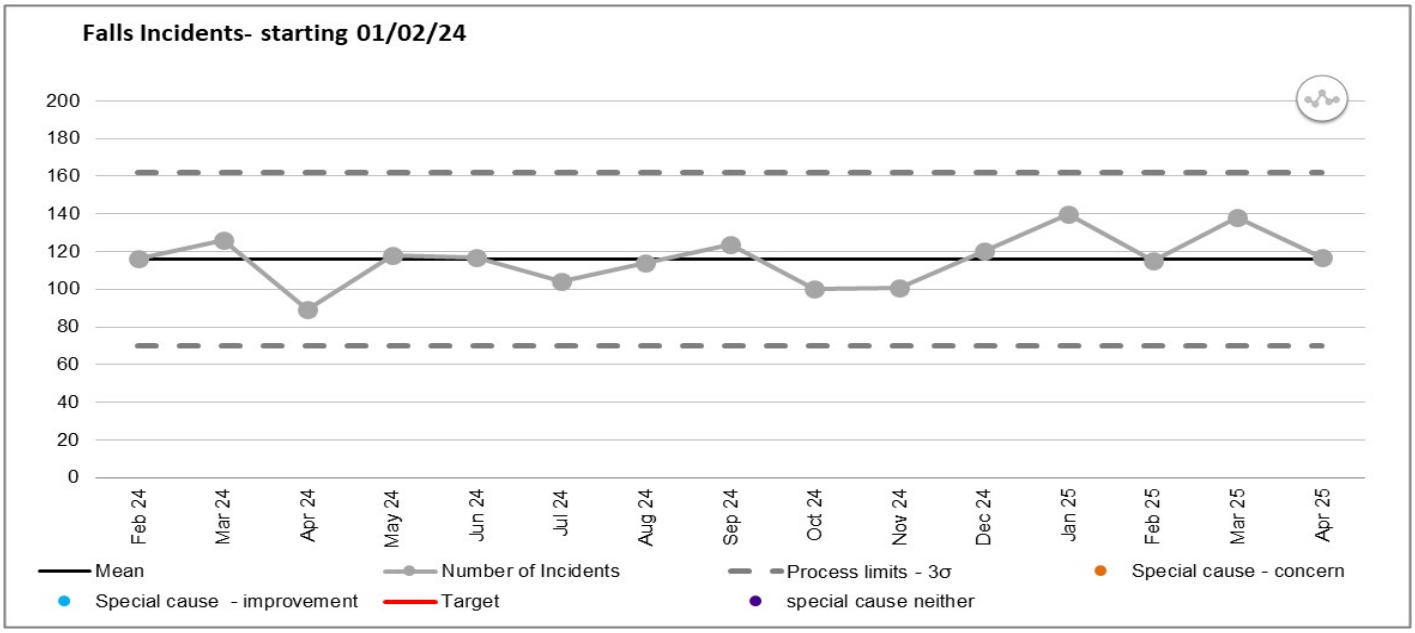
There were 170 patient self-harm incidents reported across LPT for April 2025; this is following a 2-month downward trend below the mean average of 260 reported patient self-harm incidents. Supporting data to understand this continues to be explored by the clinical teams.

The areas below have a reduction in reported self-harm incidents.

Heather inpatient ward – continues downward trend. The positive supporting staff and patients in reducing self-harm that has been undertaken over several months has led to ward team, QI link and previous suicide prevention lead being nominated for a HSJ award related to the project of reduction and alternative way of addressing incidents and restrictive practice.

Beacon Inpatient ward - has seen a reduction in self-harm incidents, significantly now with 4 reported in April 2025 which has decreased significantly in comparison for 30+ reported in the previous 2 months. This is likely due to change in patient group and the risks/clinical features of these young people. The ward currently does not have any targeted self-harm reduction programme in progress.

3. Patient Falls, Slips and Trips – Trust Wide



There were 255 falls during March and April 2025 representing 8.42% of all reported incidents. During the previous reporting period, there were 254 Falls incidents reported, this shows an increase of 0.39%.

DMH

Numbers of falls have been analysed and over the reporting period. Kirby Ward at the Bennion Centre reported 40 out of a total of 255 which equates to 15.69% of the total reported, with Coleman Ward and Gwendolen Ward at the Evington Centre both reporting 21 falls each which equates to 8.24% each. Kirby had an increase in March with 26 falls. The 26 falls involved 12 patients; on analysis there were no common themes and individual care plans were reviewed. However, using the last 6-month trend analysis, Gwendolen Ward at the Evington Centre were the highest reporter of 'patient falls' over this time. Gwendolen and Coleman are typically the highest reporters of falls due to the complexities and vulnerabilities of the patient cohort. There is ongoing work across the DMH wards to review falls data and reduce harm to patients.

CHS

The number of patients reported falls fell in March. The falls prevention group are reviewing the data for both good practice and any areas that may be an outlier to understand any actions required. Inpatient falls Validation meetings continue weekly to ensure all actions are addressed and to provide shared learning across wards.

FYPLDA

Directorate report reducing number of falls, this is after an increase in January due to one patient who repeatedly placed themselves on the floor. To demonstrate the fall there were:

Month	Number of falls in FYPC-LDA
January 2025	38
February 2025	18
March 2025	8

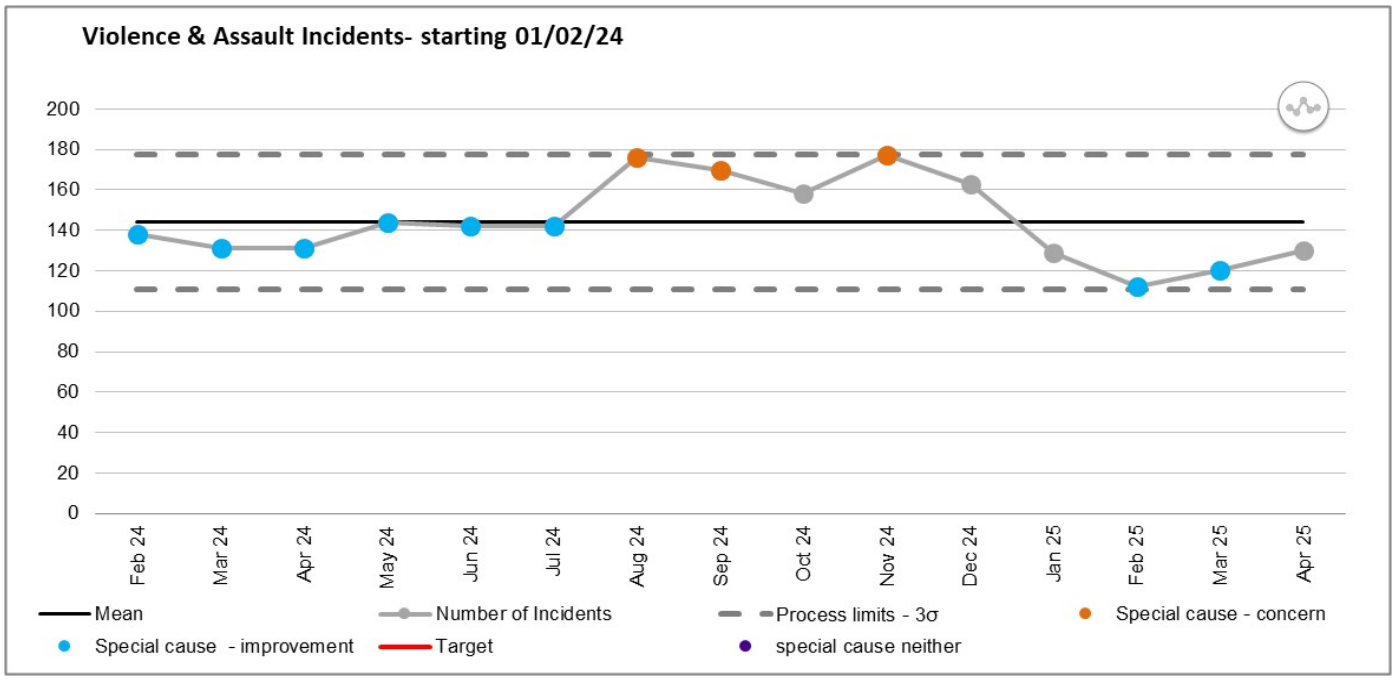
QI Initiative - Medications and falls.

As previously reported, a senior pharmacist undertook a piece of work exploring the relationship between Anticholinergic burden (ACB) and falls. The Audit on MHSOP and CHS wards demonstrated clear causal link with a high ACB score and falls. Recommendations have been made to monitor ACB levels and identify a trigger to have medication reviewed and falls care plan that both consider reducing ACB where possible. There is a working group between Pharmacy and Falls reduction group taking this forward in relation to consideration for prescribers and a QI project and plan to ensure a co-ordinated and evidenced based approach. This learning has also been shared with UHL pharmacy. There will be an update on progress in July's board report.

National guidance changes related to falls prevention.

Updated NICE guidance was issued at the end of April 2025; 'NG249 - Falls: Assessment and prevention in older people and in people 50 and over at higher risk' and 'QS86 - Falls: prevention of falls and assessment after a fall.' Both sets of guidance will be circulated and will be reviewed at the next Falls steering group.

4. Violence/Assault – Trust Wide



There were 250 incidents of violence and assault reported during March and April 2025. Incidents reported under this overarching category include patient violence towards other patients, people not employed by the trust and incidents of disruptive behaviour towards others. This represents 8.26% of all reported incidents. Of these 250 incidents, 163 (65.2%) were recorded as disruptive behaviour. Gwendolen Ward and Coleman Ward each recorded 13 (7.98%) and Griffin Ward and Heather Ward each reported 12 (7.36%) such incidents.

During the previous reporting period, there were 237 violence and assault incidents reported, this shows an increase of 5.49% during the current reporting period.

Violence and assault incidents have been analysed and over the reporting period there are 3 areas with a significant number of incidents reported relative to the total number (250) of violence and assault incidents, those being Griffin ward with 27 incidents (10.8%), Bosworth Ward with 22 incidents (8.8%), and Gwendolen Ward with 21 incidents (8.4%).

Of these reported incidents, 1 is reported as resulting in death (this is related to the Homicide described below). The remaining incidents are all reported as low/no harm.

Bosworth Ward: relate to several patients admitted presenting with disruptive and aggressive behaviour, several of who required a move to a male Psychiatric Intensive Care Unit (PICU).

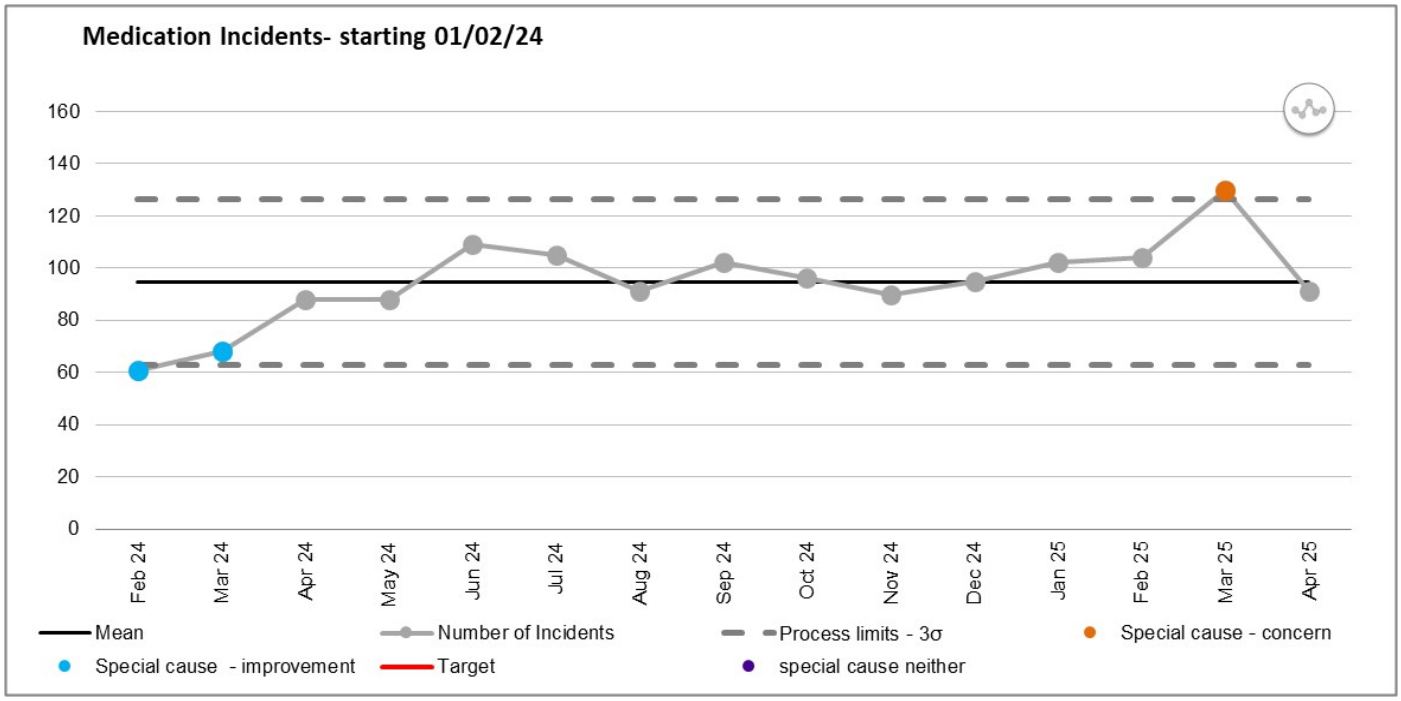
Griffin Ward: the number of incidents reflect a small number of patients who are acutely mentally unwell.

Gwendolen Ward: the incidents relate to a group of patients who are acutely mentally unwell and displaying aggressive behaviour.

There were 2 incidents reported that related to one community homicide - this involved two family members. There is currently no further action for LPT in relation to this homicide.

There were no incidents of violence and assault reviewed at IRLM during this reporting period.

5. Medication Incidents



221 Incidents have been reported during March and April 2025 under the category 'Medication' which equates to 7.3% of the total number of all patient safety incidents reported. 29 incidents (13.12%) were recorded as incorrect dose administered, 28 (12.67%) were recorded as failure to follow procedure/policy/guidance as 20 (9.05%) were recorded as prescribing – 'other'.

Of these 26.22% were reported as Low harm and the remaining as no harm

There continues to be oversight and scrutiny related to insulin incidents in CHS. There were reports of Extra Dose having been given (7%) as well as errors related to various parts of the administration process. this is being reviewed through the Insulin project group to understand the systems and processes and how these can be improved.

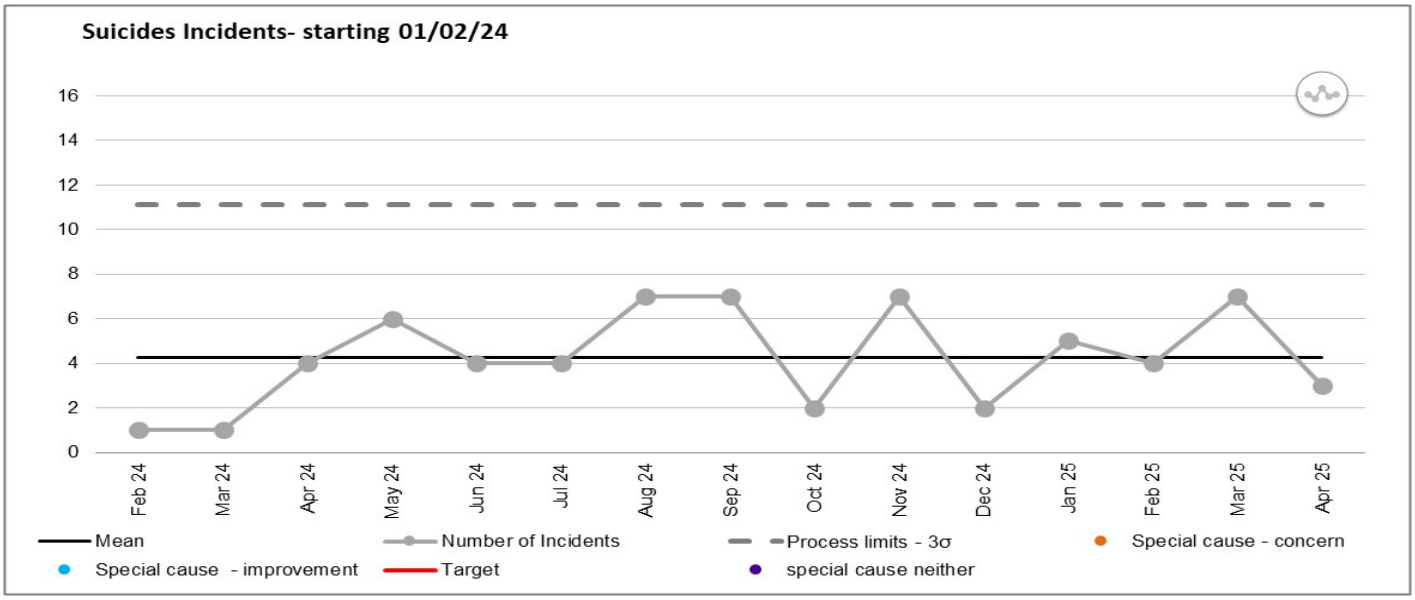
CD Register/ or drug count' issues make up 6.5% and these are reviewed by Pharmacy in relation to the management of controlled drugs.

Incidents reported under the category of 'Medication Omissions without medical guidance' also made up 6.5%. The directorate teams and medication safety group have been asked to review this to understand the circumstances and actions required.

There are no departments reporting a particularly significant number of medication incidents, with the top two teams (Pasley Road District Nursing team and Coalville Hospital Ward 1) each reporting 10 incidents (4.52%).

6. Suicide Prevention

While suicide does not feature in the top five reported incidents, we review every suicide for learning, themes, and trends. We also assess our services and actions against national learning from NCISH.



It is important to consider suicide over time. The data above currently does not identify any statistically significant reduction.

Skills Training on Risk Management (STORM) continues as an ongoing area of development and embedding these skills. There are six Practice Development Nurses trained to be 'train the trainers' and continue to support the delivery of STORM training to staff across the services.

The latest update from NCISH describes that self-harm is a major factor in people who die by suicide, across society and in all healthcare areas, not just those people who have been known to or in receipt of care in mental health services.

Sadly, we had 9 patient deaths by suspected suicides (for patients known to LPT) during March 2025 of these 7 were male and 2 were female. There were 3 patient deaths by suspected suicides, all were male during April 2025.

There is continued improvement work on completion of risk assessments across LPT regarding using a formative approach and summary.

The Self Harm and Suicide Prevention Lead was in post for 12 months and in that time had progressed a series of interventions based on our self-assessment against NCISH recommendations and the national suicide prevention strategy.

The post is now under review and the coordination of suicide prevention and self-harm is being shared between other mental health nurse leads.

Emerging Themes / Risks

Reviewing audit data and reported incidents has identified that not all patients are being positively identified prior to the delivery of care. The reported incidents have been related to medication administration, taking of blood samples and delivery of care. Research shows that such incidents are generally underreported as they are not always recognised. This has been discussed at Patient Safety Improvement Group as well as within Medicines Risk Reduction. Collaboratively with clinical teams, a series of actions has been agreed. These include the sharing of information at each team's safety huddles, exploring the practicality of the patient and their prescription being in the same location (i.e., mobile technology), patient education regards their safety and the wearing of an ID band. An electronic solution is being explored which will further close the loop on these interventions. The Patient Safety Improvement Group is working with both Comms and local teams to improve compliance and raise the importance of this key patient safety intervention.

Learning from Deaths

The National Quality Board (NQB) Guidance on Learning from Deaths (LfD), published in March 2017, sets out the expectation for NHS Trusts to collect and publish specified information on deaths on a quarterly basis. The quarter 4 report will be shared separately through the Quality and Safety Forums for assurance.

LeDeR

Monthly panel meetings continue as per the revised LeDeR processes and Governance arrangements. The panel have shared the following information:

- There have been no referrals made by LPT to LeDeR related to patients with a known learning disability and who have died for March 2025 and April 2025.
- For city and countywide reviews there were 8 notifications in March 2025 and 5 notifications in April 2025.
- None have undergone a focused review; none currently allocated, currently 10 initials, however, this may change to 'focused' after allocation, 3 are Focused, 1 due to ethnicity and 2 meet the local priority area (2025/26) for all deaths from cancer.
- LeDer colleagues report that they describe deaths as 'graded 1 -6' for quality of care and 'graded' 1-6 for right support; as part of the response following full review.

Outstanding patient safety reviews: As of 17 April 2025:

Directorate	Number of reports late Jan/Feb 2025	Number of reports late March/April 2025	Still being drafted March/April 2025	Right of reply process	In sign off process March/April 2025
Corporate Investigators	10	10	1	1	8
CHS	7	5	1	0	4
DMH	32	27	10	0	17
FYPC/LDA	11	13	2	1	10
TOTAL	60	55	14	2	39

We continue to be challenged in relation to incidents that we have identified for further review for the opportunity of learning. As 17 April 2025 in directorate, there were 55 reports that were not completed within timescales. Of these, 14 (25.45%), were in draft stages, however this means that the other 39 (which equates to 70.91%) of the reports are already going through the sign off process indicating that although late, they are close to completion.

Of these, 2 are ‘Serious Incident Investigations (SI’s)’ from under the previous framework. One is near completion post executive review and the other investigators are working with the family engagement which has been delayed due to factors outside of LPT control.

As local directorate learning responses are allocated to staff who also have clinical/operational commitments and are trying to balance completion within time frame, applying different thinking and approach to undertaking reviews along with work priorities it is considered that this trend is likely to continue. The Patient Safety Incident Response Framework (PSIRF) is clear that our reviews are to be proportionate to identify learning. We know that involving staff as part of reviews is a positive way to identify this; we continue to explore other incident review methodologies that allow this.

Duty of Candour

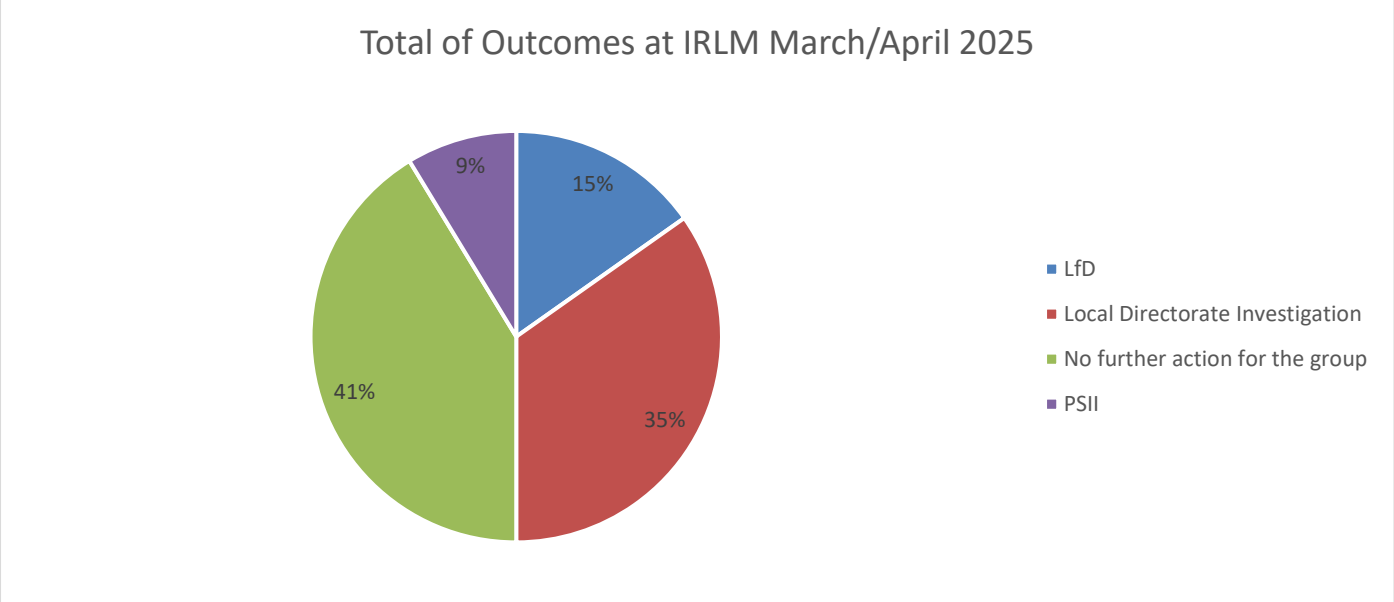
There was no statutory duty of candour breaches during this period we continue to follow ‘being open’ which is inbuilt in the PSIRF principles of compassionate and positive engagement with patients/families.

Never Events

No Never Events were reported during this period. We are awaiting NHSE outcome of the review of the 'Never Event' Framework.

Incident Review & Learning Meeting (IRLM)

46 cases were reviewed at IRLM during March and April 2025. Four (9%) Patient Safety Incident Investigations (PSIIs) were declared during this reporting period. Nineteen (41%) were identified as having already identified any learning and actions put in place. There were 16 (35%) Local Directorate reviews requested to explore appropriate actions, 7 (15 %) initial service managers reviews (ISMR's) were shared with Learning from Deaths (LfD) for theming.



Proportionality review of IRLM

As part of our improvement work it was agreed to assure ourselves that the decisions made at IRLM are appropriate in relation to proportionality i.e., reviews are undertaken appropriately and proportionately and for the purpose of learning. This was led by the Medical Director and Interim Director of Nursing & AHPS & Quality.

Methodology:

- 3 ISMR's for each directorate were randomly chosen.
- 2x had been at IRLM and 1 had not progressed from directorate.
- Only one person knew the outcomes.
- A special IRLM was set up with an agenda and papers shared the day before – senior nursing from all 3 directorates – DON team, corporate patient safety team (CPST), safeguarding and governance present.

- The reports were presented by senior nurse representative from appropriate directorate.
- The group asked questions and had a discussion as would happen at IRLM.
- The MD and DON decided on what they thought should have happened in relation to next steps.
- These decisions were compared with the original IRLM decision and reviewed the record of the meeting on Ulysses.

Outcome

It was considered that the methodology worked well and was as 'non-biased' as possible to replicate the original decision making. There was minimal difference in the decision making around 6 of the reports. There was one report that had not progressed from CHS to IRLM which were considered should have done. This ISMR and findings had, however, been shared with a task and finish group in CHS who are managing insulin related incidents. This is being reviewed to understand the actions taken by that group. This methodology has been reviewed by the Executive Management Board and agreed to continue in a quarterly basis with as we assure ourselves that we have appropriate governance and proportionality to ensure learning.

Learning from patient safety events (LFPSE)

The number of incidents reported to LFPSE is 3028 matching the total number of patient safety incidents above. This assures us that we have our mapping correct. The first NHSE release of Trust focussed data is expected in May 2025.

Queries Raised by Commissioners / Coroner / CQC on reports submitted shared.

LLR ICB patient safety team are members of the IRLM and continue to feedback how assured they find the conversations and appreciate the focus on system learning. Whilst there is no requirement under PSIRF to share completed reviews with the ICB, we continue to share as assurance of our learning and request that they use the National Learning and Response review tool which LPT CPST contributed to the testing and final development of the tool. Collaborative working with LLR ICB continues with information and supporting training places in autumn 2025 for the Systems Engineering Initiative for Patient Safety (SEIPs) approach to investigation have been allocated to 3 GP practice managers/governance leads who are engaged in the pilot for PSIRF in primary care.

Patient Safety Strategy

Training: SEIPS approach to investigation training.

During 2024, 120 members of staff from across all directorates undertook the SEIPS training provided by the CPST (this does not include refresher training and basic SEIPs for the governance

teams who were asked to roll out the changing way of approaching incident reviews locally). So far in 2025, 79 members of staff have undertaken the training and there are further dates available throughout the year.

This training is evaluating well with staff feeding back that it feels a supportive way to learn and undertake incident reviews:

Directorate	**Numbers trained in SEIPS 2025**	**Numbers trained in SEIPS. 2024**
DMH	57	71
CHS	12	27
FYPC/LDA	10	22
TOTAL	**79**	**120**

National: Level one and level two National patient safety training.

This is national training delivered as E learning to support the patient safety strategy and the implementation of PSIRF. The training has been available for staff to access and is required as pre learning for the SEIPS training. The below figures are the staff who have attended so far and as part of our improvement work, we have agreed that all staff will access level 1 and have finalised the staff groups who will benefit from level 2 as band 7 and above.

Months	Patient Safety Level 1	Patient Safety Level 2	Grand Total
Mar-25	10	13	23
Apr-25	1269	10	1279

Patient, Family, and staff engagement as part of PSIRF

The offer of training via Ulearn continues from the CPST supporting one of the key principles of PSIRF ‘compassionate engagement and involvement of those affected by patient safety incidents. The training has been attended by a wide range of staff not just for support for engagement post incident as part of a review and conversation and topical discussion has meant the training is now extended to hour & half.

Patient Safety Improvement Programme (PSIP)

PSIP continues to drive progress towards further strengthening LPTs patient safety and learning culture supported by systems, processes and resources that are visible and helpful to frontline staff, patients, and families.

The medical director and interim director of nursing, AHPs and quality launched communications on 7 March with a summary of the work achieved so far. The piece '2025 - Our year of Patient Safety Improvement' promotes regular features on progress we are making, and the importance of patient safety being built into our daily work and promoting an open and thriving culture in our workplaces.

Proposal

The Trust Board of Directors are asked to:

- Review and confirm that the content and presentation of the report provides assurance around the processes we have to identify levels of harm.
- Be assured that data presented around learning from deaths is aligned to the '*learning from deaths'* guidance.
- Be assured on the quality of Patient Safety Incident reports, completion, and compliance with 'Being Open' and 'Duty of Candour.'

Decision Required

Briefing – no decision required	✓
Discussion – no decision required	
Decision required – detail below	

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	James Mullins, Interim Executive Director of Nursing, AHP's & Quality
Paper authored by:	Corporate Patient Safety Team
Date submitted:	19 May 2025
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A

If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Bimonthly
LPT strategic alignment:	**T** - **T**echnology **H** – **H**ealthy Communities **R** - **R**esponsive **I** – **I**ncluding Everyone **V** – **V**aluing our People **E** – **E**fficient & Effective
CRR/BAF considerations *(list risk number and title of risk):*	• CRR 19 - Rapid improvement work programme to improve systems and process for reviewing patient safety incidents. • CRR 27 – processes for proportionate and timely review of incidents
Is the decision required consistent with LPT's risk appetite:	
False and misleading information (FOMI) considerations:	
Positive confirmation that the content does not risk the safety of patients or the public	
Equality considerations:	