L

Leicestershire Partnership NHS Trust

Public Trust Board – December 2021

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for Oct – Nov 2021

Purpose of the report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed to assure that systems of control 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 around 'Being Open', numbers of serious incident (SI) investigations, the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

The Corporate Patient Safety Team (CPST) continues to work to support the governance of patient safety improvement and early recognition of trending incidents across the trust to offer early insight for leaders and working closely with the Directorates.

The data presented in relation to incidents is considered in the specialist groups with the learning and actions required to improve patient care and staff engagement in the investigation process; the expectation is that they are owned and monitored through the directorate governance route.

The continued impact of Covid19 Pandemic and staffing resource challenges continues to impact on the compliance with NHS framework timescales of Serious Incident (SI) investigations. This has resulted with variables in compliance with the 60 working day deadline for submission to the CCG. We are also noting reallocations of investigations due to unplanned absence, increasing workloads and need to support staff due to lack of training/experience as part of the operational teams managing priorities.
AS we start to work towards the principles of the new patient safety investigation framework (PSIRF) we are working with the CCG to ensure processes are in place to enable their assurance from the process.

Timescale compliance of internal investigations remains extended to 50 working days, however many not completed before 60 days due to the increasing challenges as noted above. The timely closure and enactment of SI and internal action plans to close the investigation process also continues to be challenging. However all Directorates have embraced ownership of this and are working hard on improvements.
The risk described is well detailed within the Trust's risk register and continues with robust local monitoring processes and oversight within governance routes into the Quality Forum. The November Quality Forum agreed to further analyse the challenges noted using Quality Summit methodology which is planned early new year.

The Corporate incident investigator posts have now all been recruited to with 8 investigators coming into post during October/November and December. with a variety of skills and backgrounds. All of the investigators are leading investigations or supporting on investigations with resulting investigation reports of a high standard. The investigators fresh eyes are already bringing a greater opportunity for learning and system change.
In addition the CPST are providing training for all investigators from directorate and the Corporate team which is being evaluated well and supporting staff to 'think differently'. The investigators from directorate that have undertaken this training will form a wider safety Faculty and be supported by the corporate team.

Analysis of Patient Safety Incidents reported

Appendix 1 contains all of the Statistical Process Control (SPC) charts utilising the NHSI Toolkit that are shared to support the narrative and analysis below and local speciality incident information. We have now included the overall position of all investigations and action plans previously unreported through the bi-monthly board report.

All incidents reported across LPT in October and November 2021

CPST continue to describe incident reporting is not 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. Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS). The NHS again is awaiting the transition to a database that is more robust and advanced system allowing for improved and quicker identification of national/regional trends in themes, earlier national escalation and eventually learning; this has been interrupted by the Covid19 pandemic. CPST upload trust wide incidents at least once a week to the current NRLS database; this is to avoid 'peaks and troughs' on our nationally reported incident profile with corporate monitoring of NRLS reports via NHSE/I website.

There are occasions when our incidents that are reported as 'moderate harm and above' are uploaded to NRLS before local review of harm/incident; these are then seen by NHSE/CQC and can be included on the national NRLS reported. We have the ability to flag incidents for re-upload to NRLS once we have reviewed the level of harm.

The CPST Lead Nurse and Incidents Officer continues to act as a 'safety net' regularly reviewing and additional monthly reviewing/escalating any outstanding incidents still flagging at 'moderate harm and above' and encourage this review through the incident review process, or by checking and challenging harm levels not reviewed in conjunction with incident review and/or closure of incidents at directorate level.

The importance of directorate and speciality ownership for timely review of incidents identifying action and the accurate application of harm level assigned to them is paramount;
The CPST are developing a business case for a Ulysses manager to support the most effective use of Ulysses as well as improved training programme for Ulysses super-users in directorates to be responsible for training locally on managing incidents from induction through to refresher and supporting newly promoted leadership roles.

Review of Patient Safety Related Incidents
The overall numbers of reported incidents remains within expected range based on previous reporting patterns and can be seen in our accompanying appendices.

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care

There continues to be inconsistent trend in the trajectory and the impact on patients with category 4 Pressure Ulcers that significantly increased in October 2021 prompting a Quality Summit.

This increase is also mirrored in Category 2 pressure ulcers that have showed special cause variation since February2021.

Following the Pressure Ulcer Quality Summit, 4 work streams have been developed reporting directly into CHS DMT. These are;

- Staffing and work force.
- Specific QI projects
- SI full investigation and QI plan
- Staff engagement and Communication

The SI investigation is reviewing the care of 3/4 patients who were thought may have been affected by the prioritisation plan and in particular deferred visits. Two of the Corporate investigators are undertaking this piece of work. On review of local investigations, further Category 4 pressure ulcers have been reported to StEIS for openness and transparency

The directorate have also arranged a series of listening events for staff which will include support from one of the corporate investigators with Human Factors expertise, consider the 'system learning' and identify any ways to support staff to make it easier for them to provide care.

All inpatient acquired category 4 pressure ulcers are reported as SI's, the Executive Director of Nursing notified and an additional sharing with the CQC; there was one reported to date for October/November 2021 which also coincided with escalation of care concerns by the patients family to the CQC.

Falls

The falls group continue to meet and monitor all falls and the CPST support this work offering additional scrutiny with increased focus on work promoting the importance of accuracy with falls risk assessment to inform and proactively manage the required nursing and therapy intervention in the clinical area.

Inpatient Falls with harm Incident Investigations continue to be shared with the Executive Nurse and her deputies for review and sign off before sharing with CCG. This enables greater information in understanding challenges of inpatient falls prevention and how the patients and families are affected.

'Flat lifting' equipment has been successfully rolled out in many inpatient areas to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury. 'Raizer chairs' are also being supplied to some wards e.g. Mill Lodge, as a less invasive way of lifting patients from the floor who has fallen and when no injury has occurred.

Post fall safety huddles are used to allow the team to rapidly identify and implement additional interventions to reduce the risk of repeat falls. Falls across the organisation are starting to show a positive downward trajectory include those with harm. This is positive and demonstrates the positive targeted work in areas such as MHSOP and Mill Lodge.

All Self-Harm including Patient Suicide & Progress

In October 2021 there was an increase in suicides with several patients sadly ending their own lives in public places including a local acute hospital. There is ongoing work and discussions for

'preventing suicide in public places' with British Transport Police. This includes fencing upgrades and engagement events planned in Loughborough and Sileby. In addition the CPST have identified some thematic similarities between several incidents over a period of time, for example patients with mental health challenges have all used a car park in Leicester City centre to either cause harm or make threats to the emergency services. This has been escalated through our system wide work in reducing suicide.

The LLR Suicide Prevention Group hasalsoidentified five incidents that have taken place over the last 12 months on one particular road near Loughborough with a system wide review of responses to this.

We continue to see variable numbers of self-harm incidents resulting in moderate harm and above with a significant increase in November from July 2021. The picture remains the same within the community mental health access services continuing to report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This is distressing for patients, their families and the staff trying to offer support and share coping strategies.

Inpatient self-harm reporting across both CAMHS and adult mental health continues to demonstrate that it can fluctuate depending on individual patients and their individual risk profile. CAMHS inpatients have seen increased incidents of inpatient self-harm, many linked to a few patients only. The incidents range from very low harm to multiple attempts by inpatients during individual shifts posing significant challenge to staff to keep them safe and supported; head-banging, ingestion and ligature attempts being common attempts by many distressed patients.

'STORM' a bespoke Training package for training Suicide Awareness, Prevention and Postvention to support our staff to deliver high quality interventions and support patients in distress by thoughts to end their lives is a priority for the trust with a options appraisal paper is being submitted for approval in adult mental health with a need to recognise this across directorates.

In November 2021 we were informed that NHSE has commissioned the Samaritans to develop 'NHS Postvention Guidance' which is due to be published in Spring 2022 to assist in staff well-being and suicide Prevention along with the National Suicide Prevention Alliance who undertook initial scoping of the challenges faced in the universities, colleges and schools with supporting students in suicide prevention and have identified possible work-streams/solutions.

The inpatient 'ligature' group have identified learning in equipment use, storage and quick availability from our EMAS colleagues with the purchase of matching equipment. This is a good example of shared learning across the disciplines for some of the most distressing incidents to affect emergency workers and inpatient NHS staff.

Violence, Assault and Aggression (VAA)

The concerning trend of high numbers of VAA across the Trust continues. In October and November 2021 incidents of moderate harm have remained consistent.

Unfortunately, this category of incident continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. However, the position is not unique as VAA has featured nationally across all aspects of the NHS in particular access services; however, this should not be accepted as the 'norm'. LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

A report on the new VAA standards and our approach has been presented to QAC from Health and Safety and clinical teams. . This was a self-assessment against the new VAA standards and to propose a twice yearly meeting to allow the different work streams to come together to assess progress and consider any joint pieces of work.

The LPT security specialist is also working with other key staff to run a live trial by March 2022 on body worn cameras similar to other NHS Trusts, Emergency departments and emergency workers as a deterrent and also to positively improve staff safety and training.

Medication incidents

There has been a drive to ensure that medicines management continues to be covered by the AMAT audit project; which is demonstrating encouraging involvement and results across the Trust that are regularly reviewed by directorates and by the medicines audit group. This work supports learning and why areas have variables that may not always demonstrated by incidents reported; medication error is often multifactorial. The pharmacy teams and senior nursing/medical staff are also focussing on medicines omissions. Working with Heads of Nursing, reports are being produced which allows visibility of the issues in their clinical areas to a sufficient depth to allow them to make improvements where necessary; again these omissions may not always be identified through incident reporting which is an area for improvement. The establishment of dedicated medication safety officer posts will help to allow the Trust to move to a more proactive footing on medicines safety and also provide medicines expertise to support incident follow-up to maximise learning from patient safety incidents.

Directorate Incident Information

Appendix 1

This details the top 5 reported Incidents for each Directorate speciality illustrating the level of diversity. Violence and Aggression has been reported in the top 5 reported incidents across Mental Health, CAMHS and Learning Disability specialities, which demonstrates some of the challenges that the clinical teams continue to face across the Trust as they interact and deliver care to our patients.

Self-harm across CAMHS and inpatient adult mental health remains a feature in the top 5 along with safeguarding adults. Worryingly, the tissue viability incidents reported across CHS account for a significant number of the incidents with 941 of the 1188 being reported related to these incidents affecting our patients.

Queries Raised by Commissioners / Coroner / CQC on SI Reports Submitted

The CQC continues to receive 72hr reports for newly notified SI's, completed SI reports and action plans along with embedded evidence.

The position with 'new' provider collaboratives remains unchanged with the lack of formalised processes meaning there is an inconsistent approach to feedback submitted in relation to patient safety incident investigation (PSII) reports. CPST are working to develop relationships and agree processes and ensuring that the focus remains on achieving learning and supporting families/patients and staff and towards the principles of the Patient Safety Strategy.

The coroner has been requesting overdue SI reports for inquests; this has placed additional pressure on the CPST and the clinical directorates with these reports having to be virtually signed off in haste.

Learning Lessons and Action Plan Themes

The learning lessons exchange group is working together as a community of practice to achieve true sharing of learning and extended the invitation to those in roles were patient safety improvement work takes place. Learning will often mean the need for a system change rather than individual change and these groups is learning together to spread and implement this thinking along with sharing what already exists at foundation of great care. System thinking and Human factors are naturally 'Just'. There was a session planned for October to consider 'features of an outstanding organisation' unfortunately this did not go ahead due to competing priorities of attendees. This will be re-scheduled for the new year now.

Key learning themes from SI's:-

Emerging and Recurring themes (some remain unchanged):

- Record keeping consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide and flow of knowledge **Action;** teams considering how audit can support the QI work in relation to this

- CMHT's have identified challenges with the MDT approach to updating and **Action;** this is being considered as part of the transformation work
- Mental Capacity and safeguarding knowledge of staff across the organisation **Action;** safeguarding team responding to the identified gaps in knowledge and understanding
- Medication quantity for regular prescriptions linked to risk taking behaviour of self-harm behaviour, knowledge **Action;** working group looking at a model for safe dispensing
- Lying and standing blood pressure and medication reviews in falls with harm **Action;** ANP's to action by asking staff for results as part of their review
- Feedback related to changes from face to face to virtual appointments has been identified by staff patients/families as a challenge for some patients and also makes assessment more difficult **Action;** reports to ensure we are clear 'patient seen on' to be specific on the methodology. Senior Nursing Team for DMH considering this emerging theme

Culture of Candour

There have been no statutory breaches identified. Any delays in best practice timescales are monitored and reported and reviewed for the purpose of learning and improvement and reported at Quality Forum. There is a continued improvement across all directorates in the timeliness (<10days of recognition of 'moderate harm' and above) and quality of letters/communication with our patients and families. Services continue to embrace the practice of the person who knows the patient/family should initiate the process of candour and openness. Final duty of candour communication to be undertaken by directors has seen a sustained and positive change for our patients, their families and our staff. We continue to see positive change with letters that are well written, demonstrating kindness, compassion, apology ('saying sorry') and need for learning from incidents for both final and initial culture of candour letters.

Incident Review & Investigation Process

The CPST continue to facilitate the weekly incident review meeting process that is shared with all three directorate governance teams and other key stakeholders which was extended to LLR CCG in June 2021 and does add a positive contribution to the group; there has been request by other provider collaboratives to attend with variable contribution. The Medical Director is identifying senior medical colleagues to also contribute to this process. The meeting has seen an increased attendance and presentation by key staff in directorates including those who are wanting to 'listen and learn' as part of their next step patient safety incident investigation training.

The CPST Lead Nurse continues to deliver a short training session for band 6 and above staff to promote the importance of initial incident reviews and the need for quality to better inform decision making for next steps investigation. This monthly training support continues to be well received with 112 staff attending over 4 sessions in October/November 2021 and has resulted with an increase in team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation.

In November 2021, a further 3 corporate PSSI investigators join the trust who are in the early phases of induction and inclusion in investigations according to their individual needs. Two are new to the NHS with backgrounds in the Legal and Network rail and one from East Anglia Ambulance service bringing variety to the CPST's knowledge and skills.

The CPST continues to deliver a PSII training programme which commenced in September 2021 for band 7 staff allocated by directorates to assist in the timely undertaking of investigations and supporting learning. There are planned programmes to continue well into 2022 along with refresher training for existing staff who have previously undertaken investigation training.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of PSSI investigation reports and action plans; there continues to be challenges faced by all directorates in relation to compliance and timely completion. There is a planned quality summit in the early new year to further explore the challenges around completion, quality and oversight.

In addition we are now monitoring on the timeliness and quality of initial service managers reports that inform next steps decision making for investigation.

Learning from Deaths (LfD)

The LfD process is now supported by a newly appointed Trust coordinator with expertise from the acute provider aspect of the NHS.. A process mapping exercise of the individual directorates is underway as part of working together to streamline processes from agendas to documents and in December 2021 will take over the role of administration of all LfD meetings across the organisation.

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 through incident reporting and patient safety improvements

Governance table

For Board and Board Committees:	Public Trust Board 21.12.21	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Jo Nicholls, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	13/12/2021	
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):	PSIG-Learning from deaths-Incident oversight-Incident Review Meeting	
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	
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	Bi Monthly	
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 Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	1 – There is a risk that the 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. 3-- There is a risk that the Trust does 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:		