O

Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Incident Learning Assurance Report May 2024

Purpose of the report

This report for March and April 2024 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 incident investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incident and associated learning.

Analysis of the issue

Teams are working collaboratively to continuously improve our ability to review and triangulate incidents with other sources of quality data with the incident data we have available.
The quality of our data and ability to triangulate this information is essential to the culture of continuous improvement. We consider exploring opportunities internally and externally to consider ways to improve this data and provide more meaningful data that is closer to teams.

The NHS continues to be challenged with resources and priorities and to offer assurance we are working to improve the safety data and intelligence within the organisation, along with the Patient Safety Improvement Group reviewing learning nationally across the NHS.

We continue to review to ensure that we learn from the recent publicised Norfolk and Suffolk foundation Trust in relation to their learning from deaths process and an action plan has been developed based on their learning.

There is a review of the learning that has been undertaken from the recently published report into th review of Greater Manchester Mental Health Trust. The national review took place after Panorama broadcast undercover filming exposing abuse on the organisation's inpatient wards. The focus of the review was to seek to understand how the conditions were created in which this behaviour could happen and could go unchecked and unnoticed. The findings and recommendations from this review are being cross referenced for local context and if there is learning identified and developed.
The detail of the national review is being considered within our Trust with findings and recommendations cross referenced for our local context and learning identified.

The work with our change leaders to progress our 'psychological safety' for our staff continues; this is an important for our continuing progress with our implementation of Patient Safety Incident Response Framework (PSIRF) and the importance of staff engagement.

Patient Safety Incident Response Framework (PSIRF)

We transitioned to PSIRF 1st November 2023; we continue to build on our processes as we learn and develop these collaboratively. PSIRF allows organisations to design and learn from their incidents in line with their local context for patients, families and staff whilst considering local and national safety learning requirements. This is the largest scale national and organisational change in patient safety in the last twenty years and therefore there is not an expectation that these changes will happen rapidly. This change in 'thinking' requires a level of safety maturity, both in culture and expertise; we are continuing to build capability by providing awareness of the human factors models used to consider complex situations and

identify wider system changes to support our staff to do their best work.

Investigation compliance with timescales set out in the current serious incident framework.

This is an improving picture (see graphs in slides) as we complete the backlog of incidents and transition to our new processes.

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. Our numbers reported remain around 2000 per month.

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.

We continue to see 'normal' variation in the number of Category 2 and 3 pressure ulcers developed or deteriorated in our care. The special cause concern noted in December 2023 and January 2024 has now improved, reducing by approximately 50% in February and March 2024. Pressure ulcer prevention training continues to be prioritised across CHS. Pressure ulcer boards have been implemented across all community teams with all patients with a pressure ulcer identified and discussed at each board round. CHS Community Hospitals Deputy Head of Nursing is leading weekly reviews of all hospital acquired pressure ulcers and a new Tissue Viability nurse with a hospital focus has commenced in post to support learning and improvement.

Falls Incidents.

The total numbers of falls incidents have remained static in March andreduced in April. CHS – March 41, April 23, DMH - March 66, April 39. There is no clear reason for the reduction in falls incidents across directorates and may be a temporary variance which will be monitored; although it is hoped that this is as a result of the improvement work . Deep dives on Falls incidents for FYPCLDA and CHS directorates in the past 2 months presented the following. FYPC/LD actions include a re-focus on requirements for the FYPC/LD group with development of service guidance, documentation, and training. CHS described the establishment of weekly falls validation meetings, small improvement projects around use of sensor technology, continence care, using decaffeinated drinks to reduce urinary urgency, training around lying and standing blood pressure education and falls care planning.

A procedure for moving patients who have fallen outside (within LPT estate) has been developed as flat lifting not appropriate for moving patients outside ward environment.

Deteriorating Patients.

The group continues to provide oversight and trust clinical steer in relation to caring for and recognising patients who become unwell and deteriorate whilst in our care including the monitoring and compliance across all staff groups in relation to mandatory resuscitation training. The Trust-wide policy having been written and shared and awaiting final sign off at the May Clinical Effectiveness Group .

Groups related to self-harm and suicide prevention.

Trust self-harm and suicide prevention group

The group have considered the key priorities and developed a matrix to assess areas of further work by self-assessment against the recently published NHSE Suicide Prevention Strategy and NCISH self-harm toolkit. The Trust suicide and self-harm prevention lead has made good progress and requires further support to continue with progress so far getting back on track the Suicide and Self- Harm Prevention Plan/ strategy and implementing a training needs analysis to help mitigate the staff training risk. Our NCISH self-assessment is making progress and will further support our service and training needs going forward.

Support is required to influence the nationally recognised STORM training, which, is the preferred and agreed model of training in the trust to improve knowledge and skills of our staff at directorate level as to how to get training organised and delivered.

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 October 2023, the Recording Incidents and Creating Best Practice group agreed a revised handover guidance including the role of the nurse in charge in assessing the skill mix of staff on duty to carry out observations competently. The Engagement workstream presented the finding from the staff, patient and carer surveys/ focus groups which will feed into other workstreams. The group is closely linked to the NHFT/LPT MH Observation Improvement Collaborative, and 3 areas have been identified for quality improvement projects:

- Inpatient pathway review – acute care
- Nighttime observation – safety vs therapeutic relationship and sleep hygiene
- Training and competences/use of technology

The projects will be developed throughout the year.

Medication incidents and Medication Safety

Work is ongoing to align the model with the patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates. Electronic prescribing system is currently be updated to demonstrate that certain drugs meet the 'critical drug' criteria and to highlight to nursing staff the importance of avoiding delays and avoiding omissions. This work continues to explore the system issues that may be contributing, i.e., by reviewing stock drugs in relation to the current context. Additional training and policy review is also being undertaken to support staff to engage and deliver the changes required for sustained improvement.
The role of Medicines Safety Officer (MSO) continues to be progressed which is essential to build on medicines safety improvement work.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC

Continue to update Commissioners and CQC with any significant incidents that have occurred although they will not be formally reported as an SI and ongoing work with all commissioners to appropriately update on our transition to PSIRF. This includes understanding how trust will algin assurances, as we move away from relying on the review of Serious Incidents.

Learning from Deaths (LfD)

The group are continuing to review the learning from the review of the Norfolk and Suffolk learning from deaths process and strengthening our processes. A workshop took place in April with LPT stakeholders to consolidate and progress the plan.
The Medical Examiner process is now being extended to Primary Care, this extension of the process will both provide improved access to the data for our patients cause of death and therefore greater opportunity for learning. As well as greater opportunities to work with ICB colleagues where potential learning across and between the ICS is identified.

Patient Stories/Sharing Learning

Patient stories are used to share learning and it is important that we learn from both when things go well and not so well 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 we are working to ensure our stories are based on system thinking and human factors. The appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning, based on human factors and therefore transferrable.

Key Learning from the attached story is:

FYPC/LDA:
There were missed opportunities to monitor and offer interventions to support Mary with her disordered eating under CAMHS Outpatients – her family reported that what had been good care had fizzled out. A formal pathway is being developed when transitioning a patient from CAMHS EDT to CAMHS Outpatient to support monitoring and interventions.

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:	May 2024	
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	
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		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	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 March and April 2024.

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

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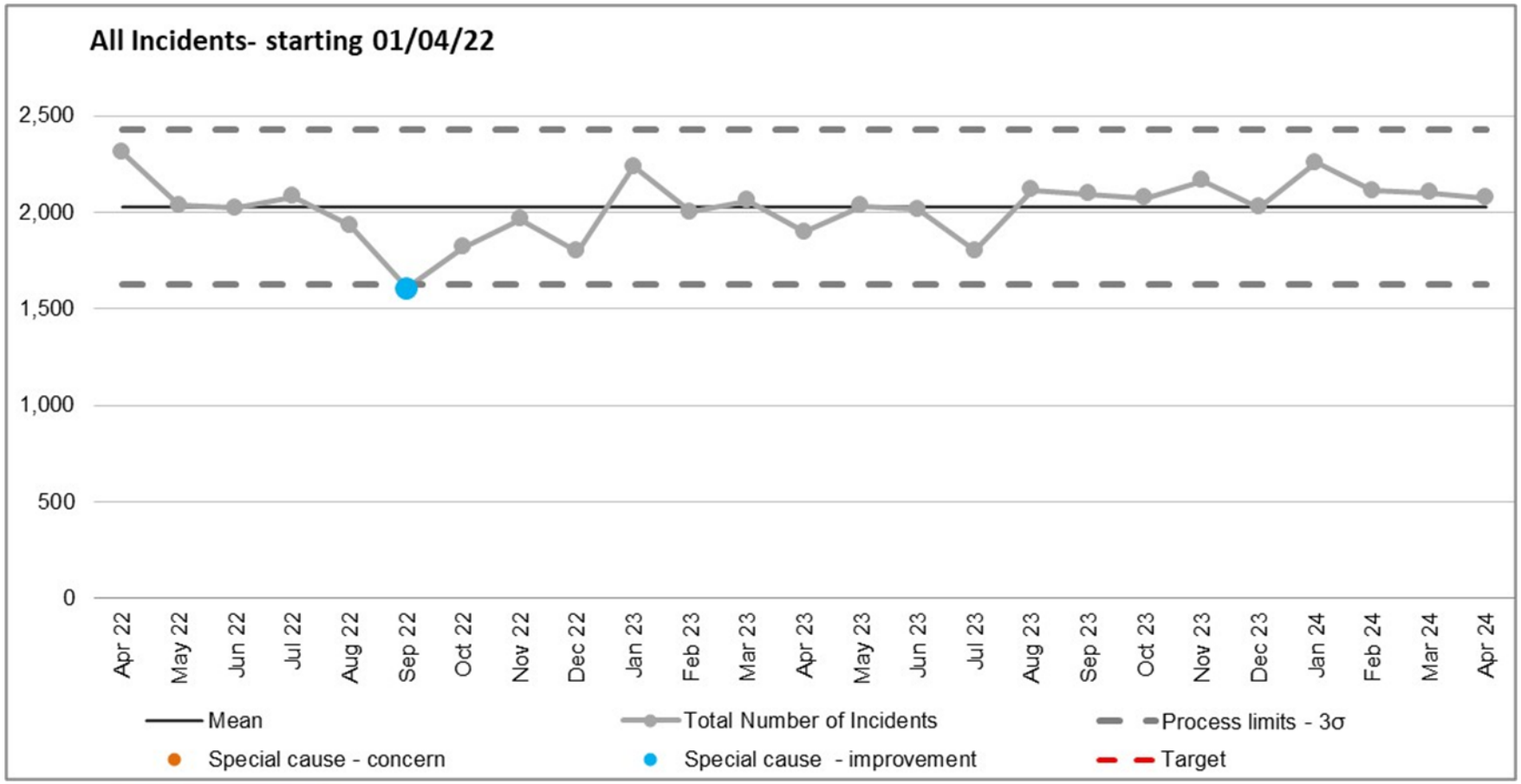
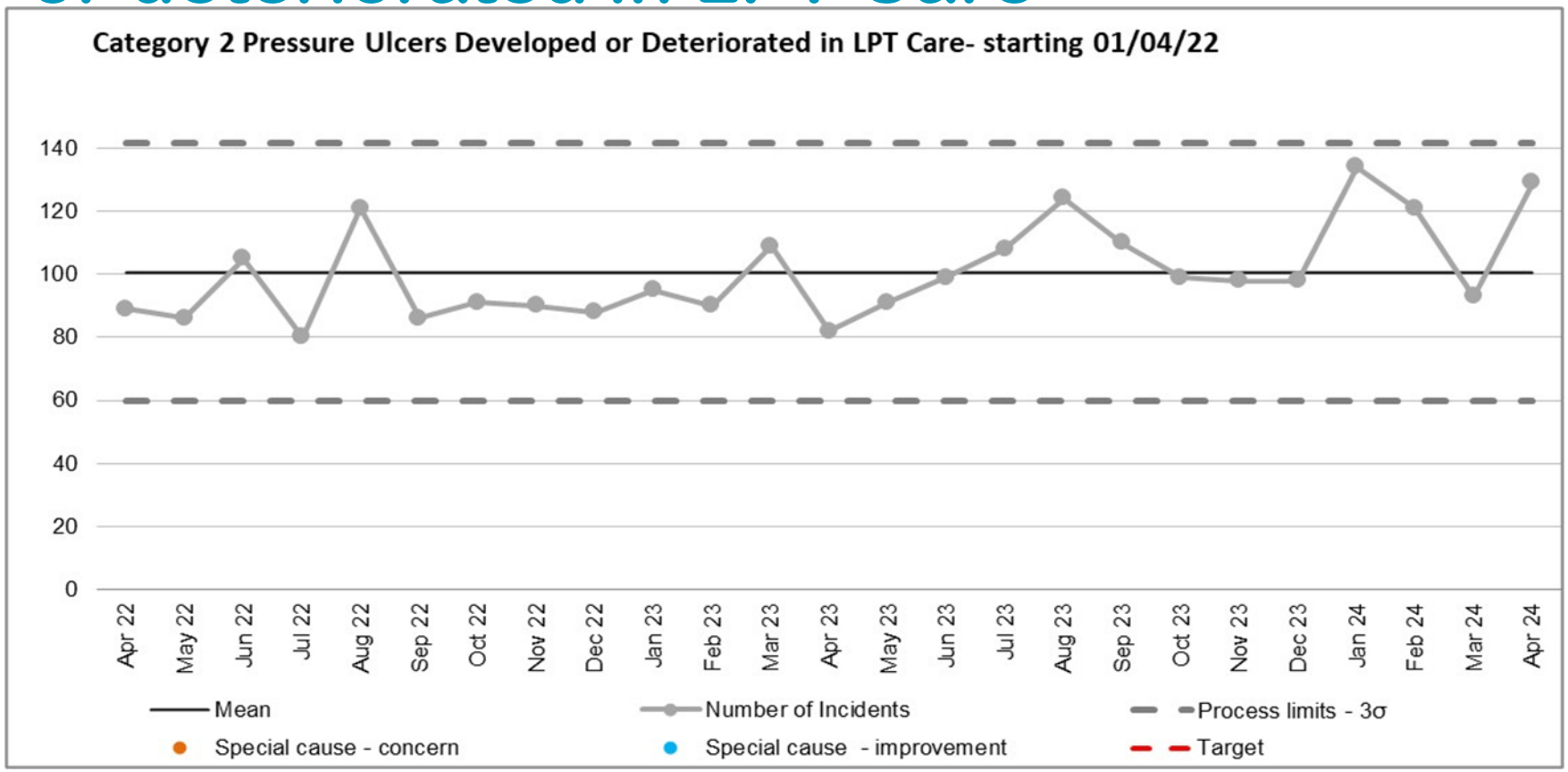
1. All incidents



2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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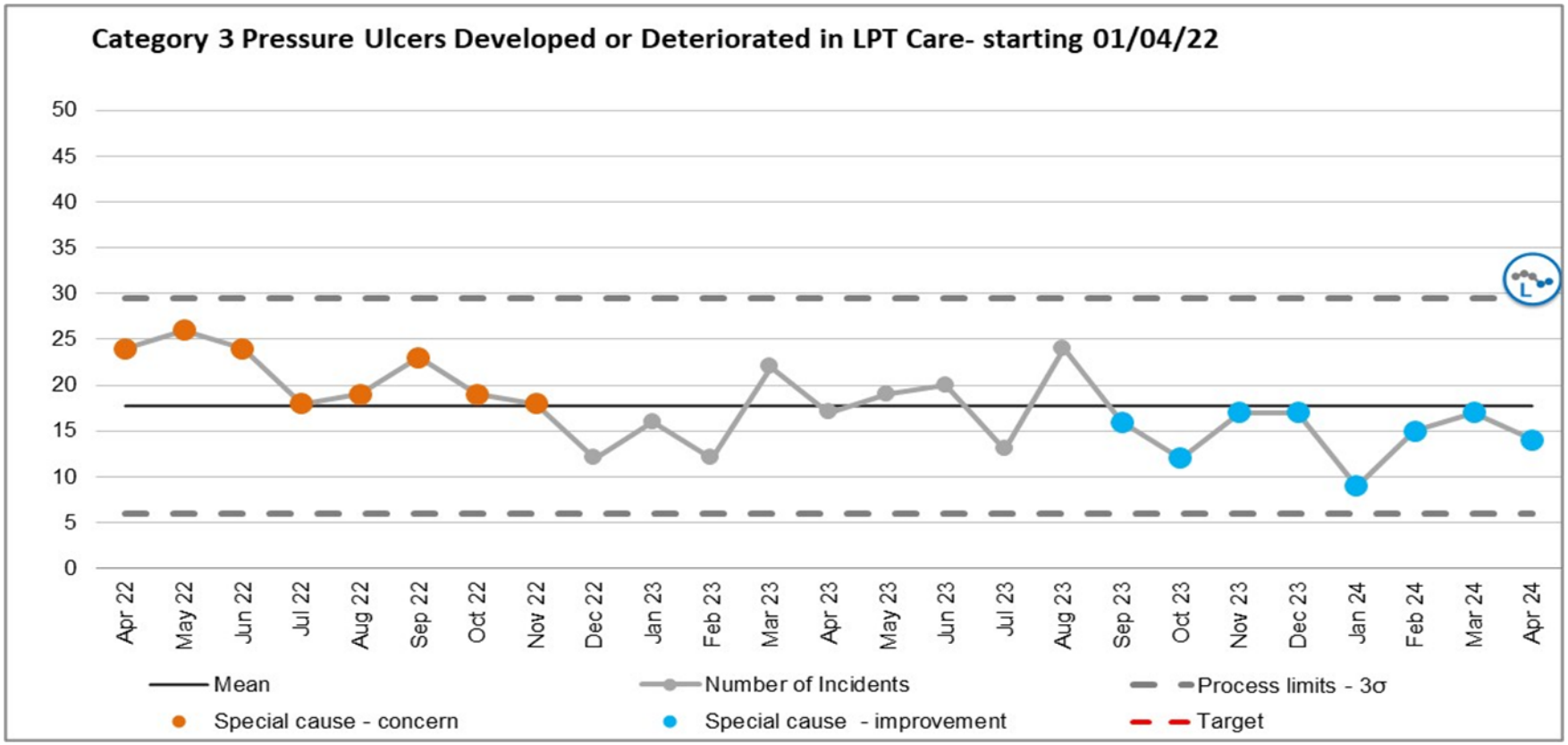
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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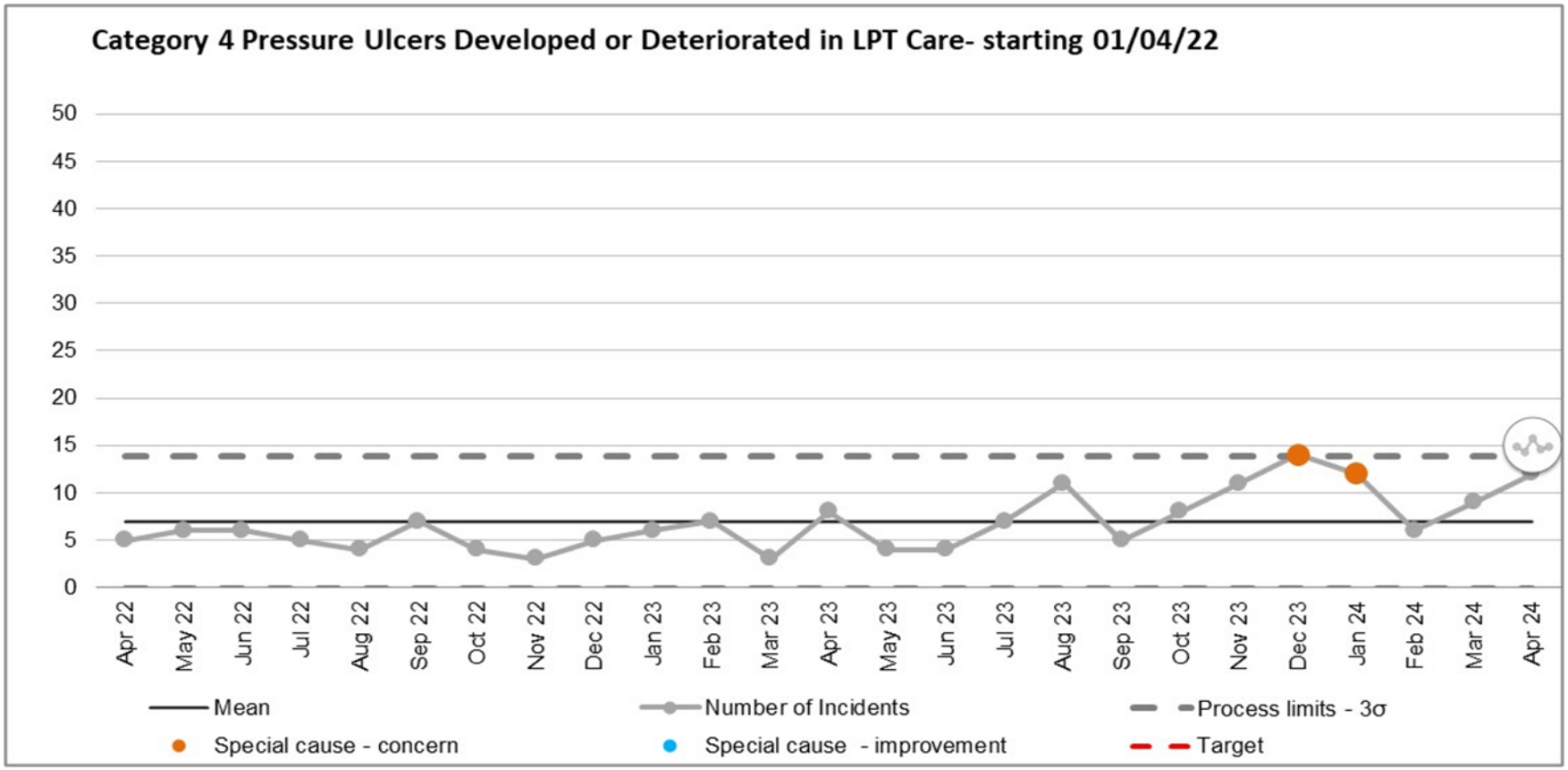
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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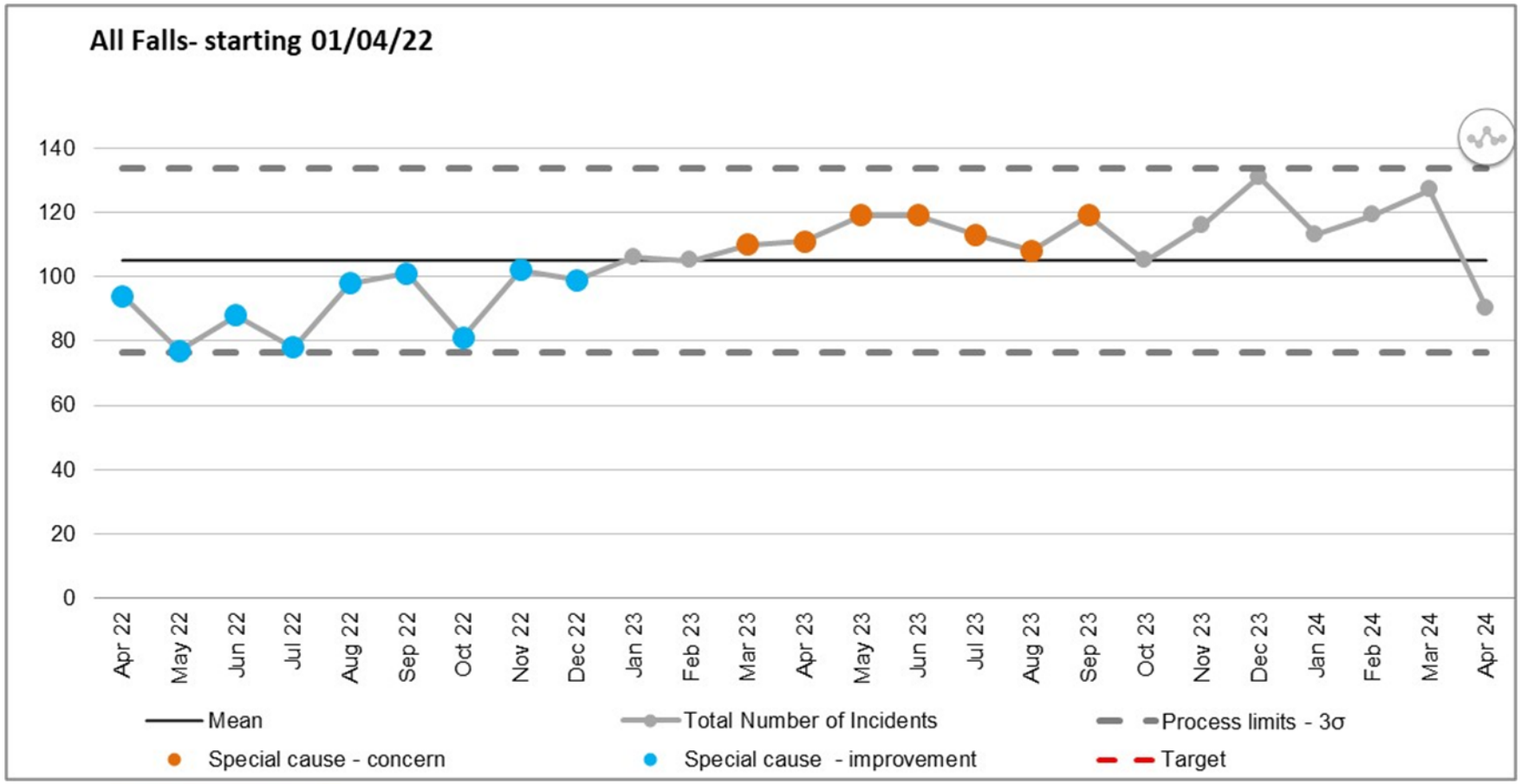
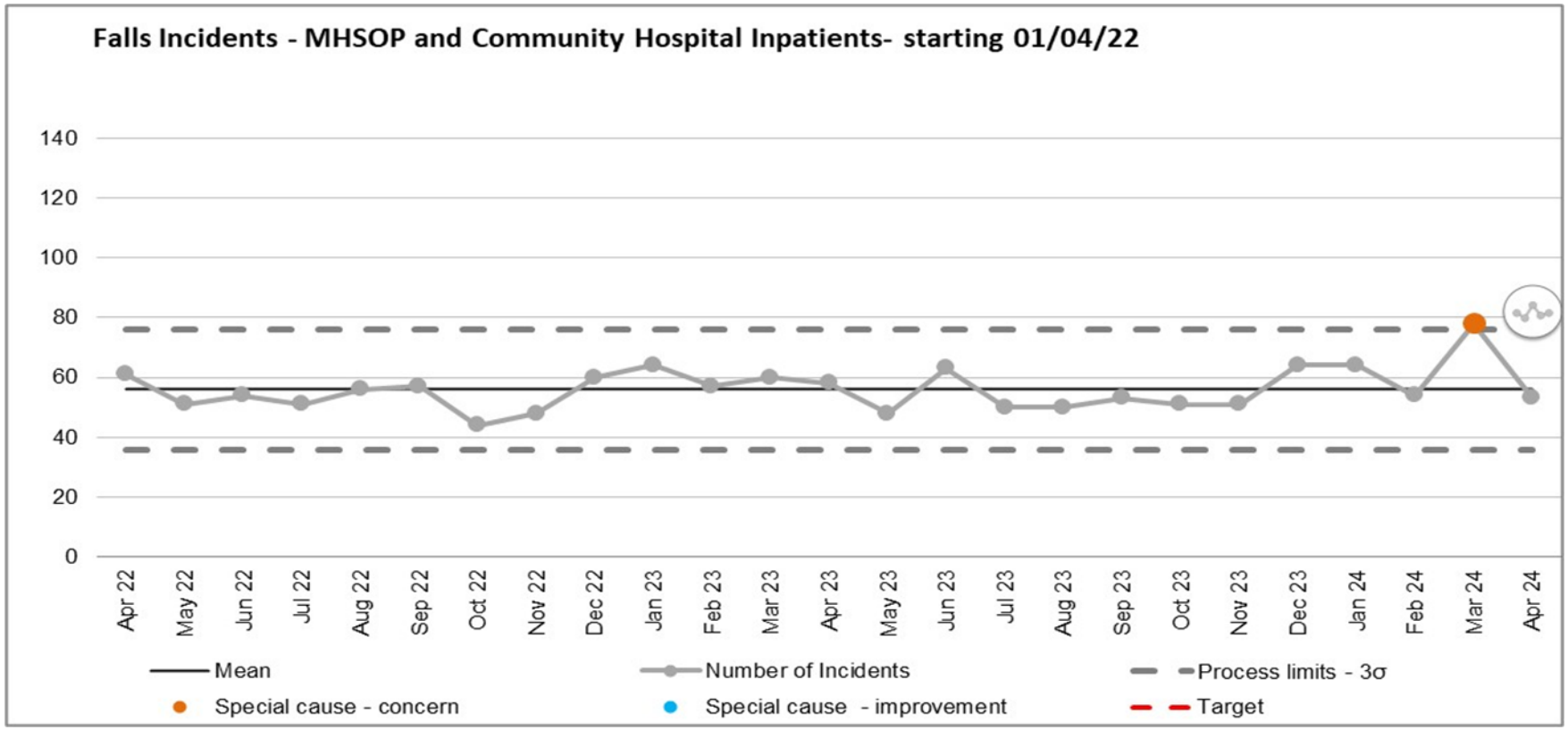
5. All falls incidents reported



6. Falls incidents reported – MHSOP and Community Inpatients



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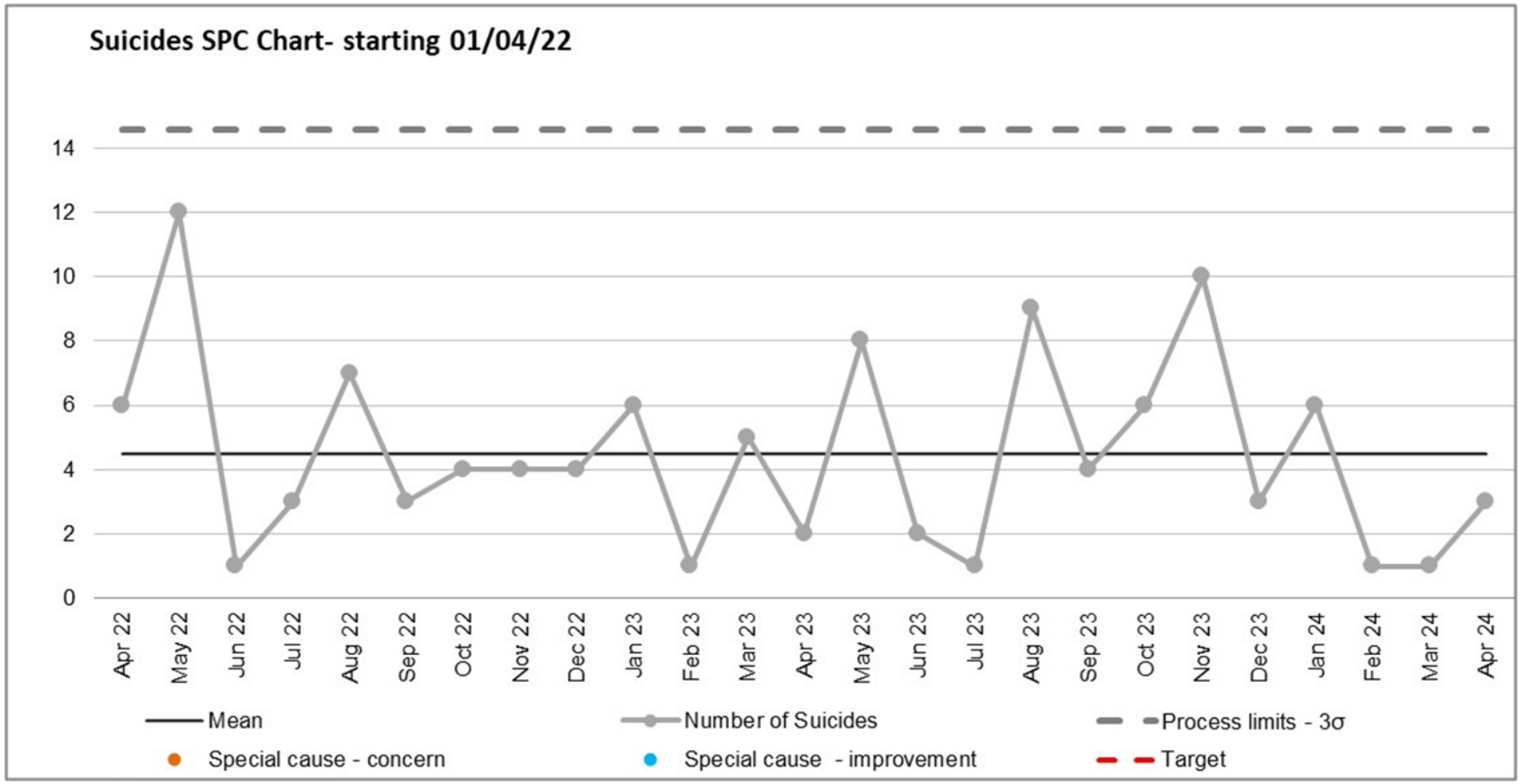
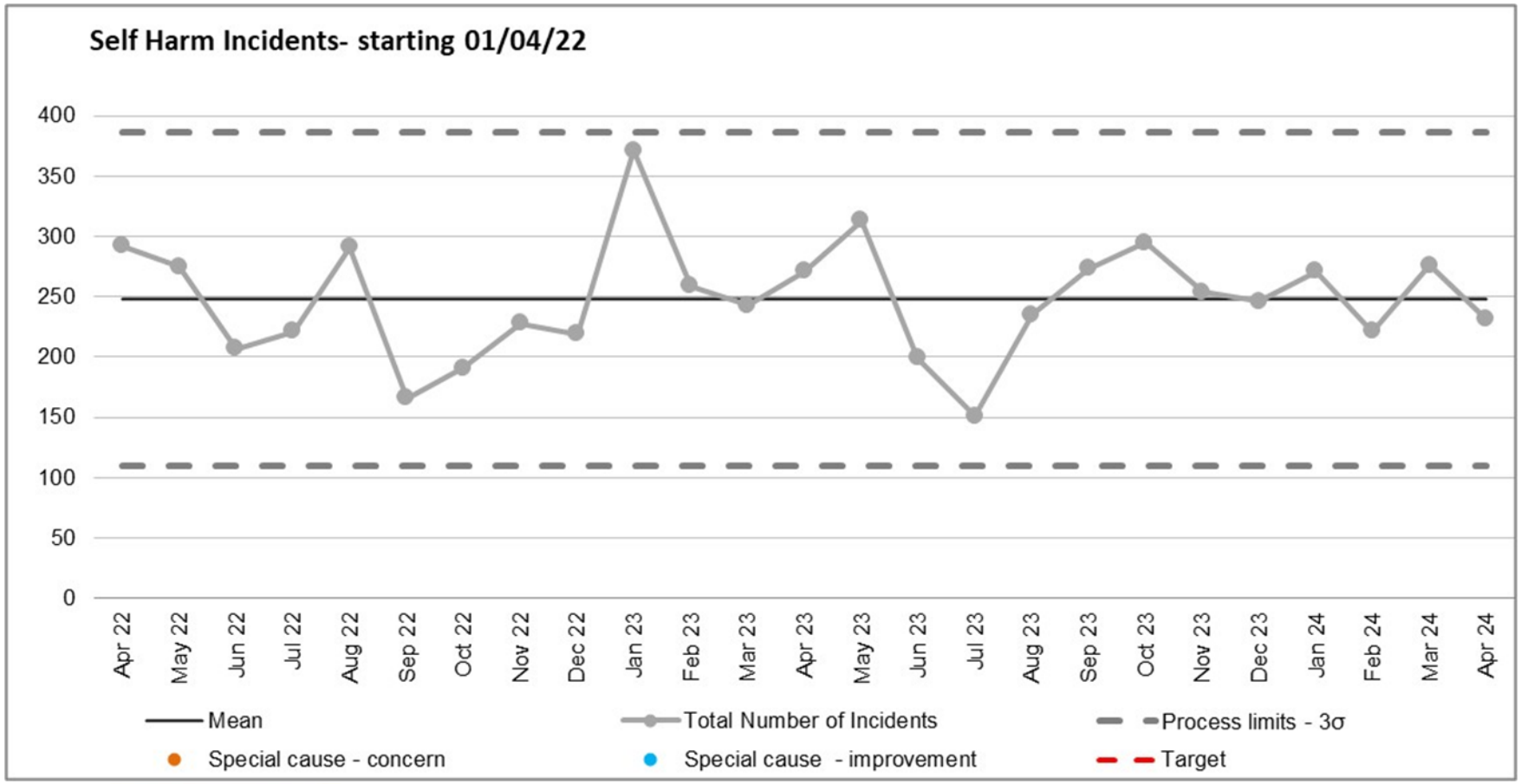
7. All reported Suicides



8. Self Harm reported Incidents



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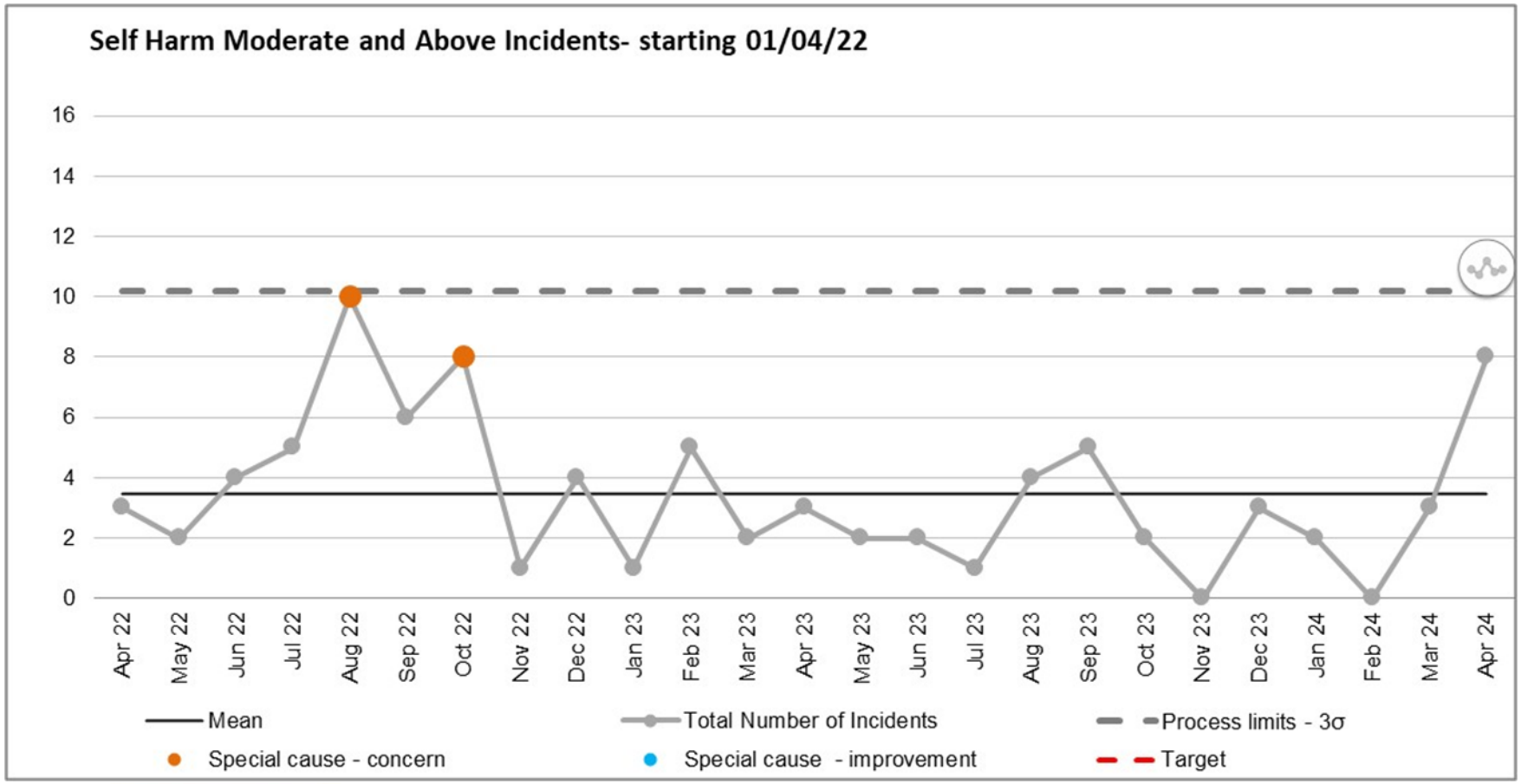
8a. Self Harm reported Incidents – moderate & above harm



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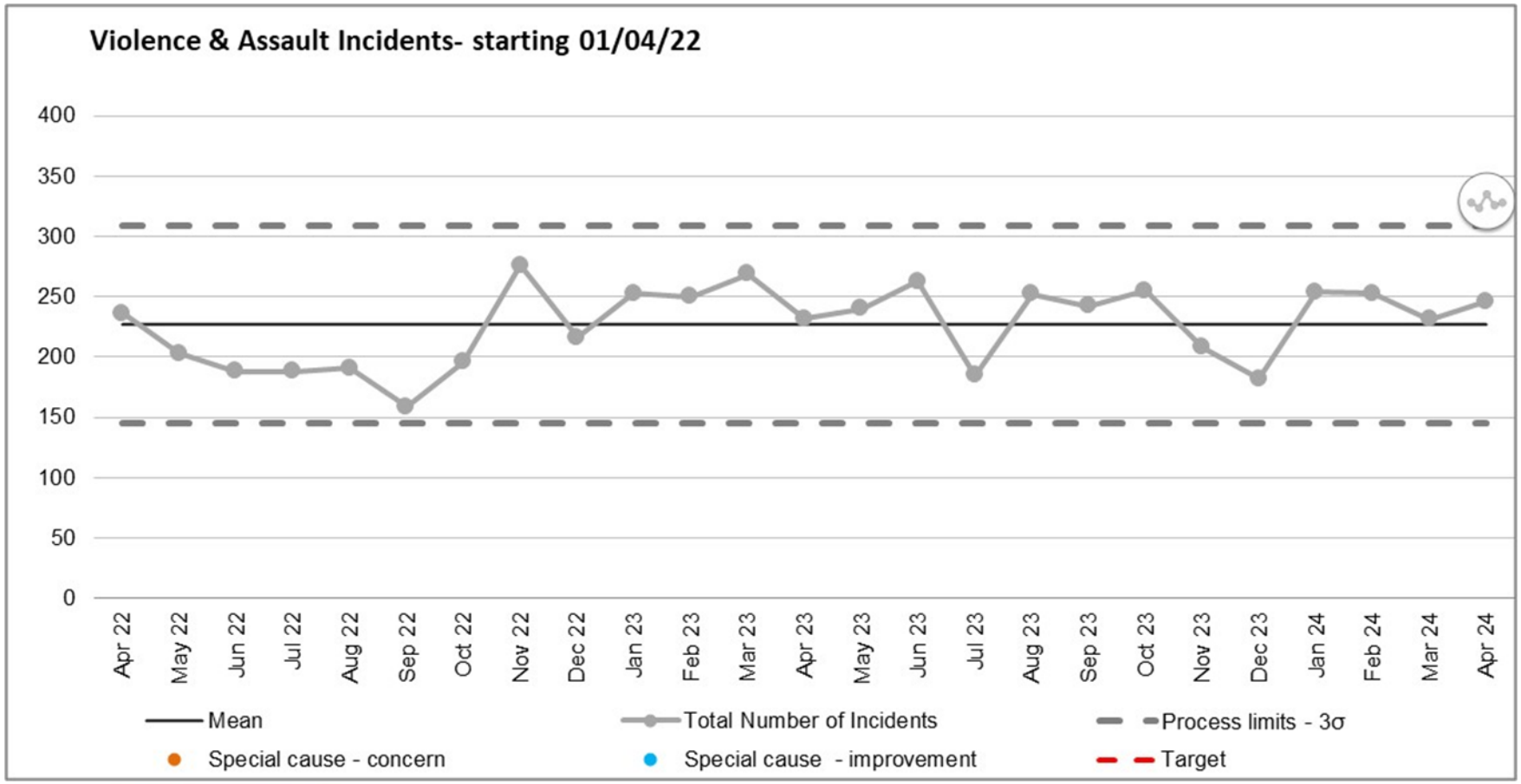
9. All Violence & Assaults reported Incidents



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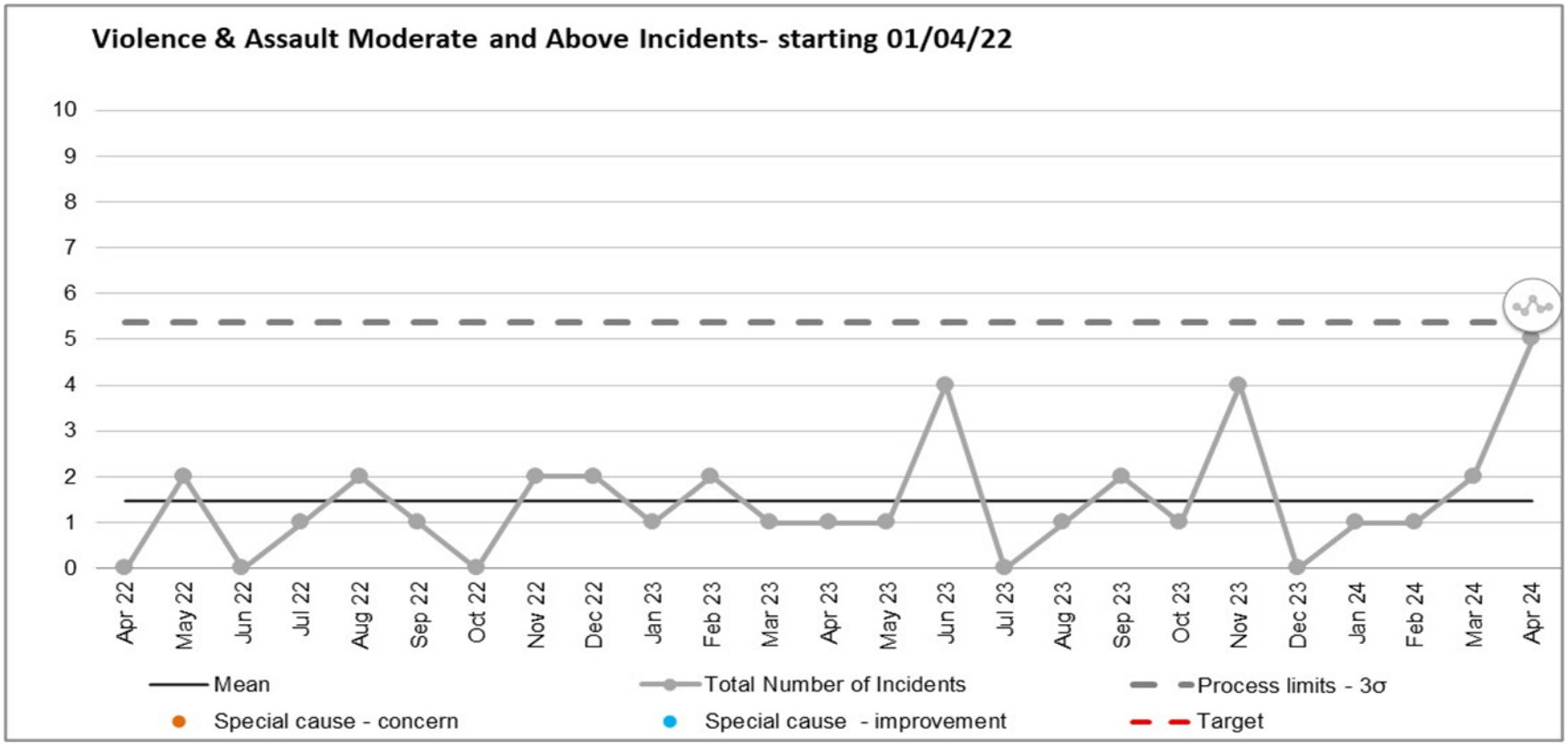
9a. Violence & Assaults moderate harm & above reported Incidents



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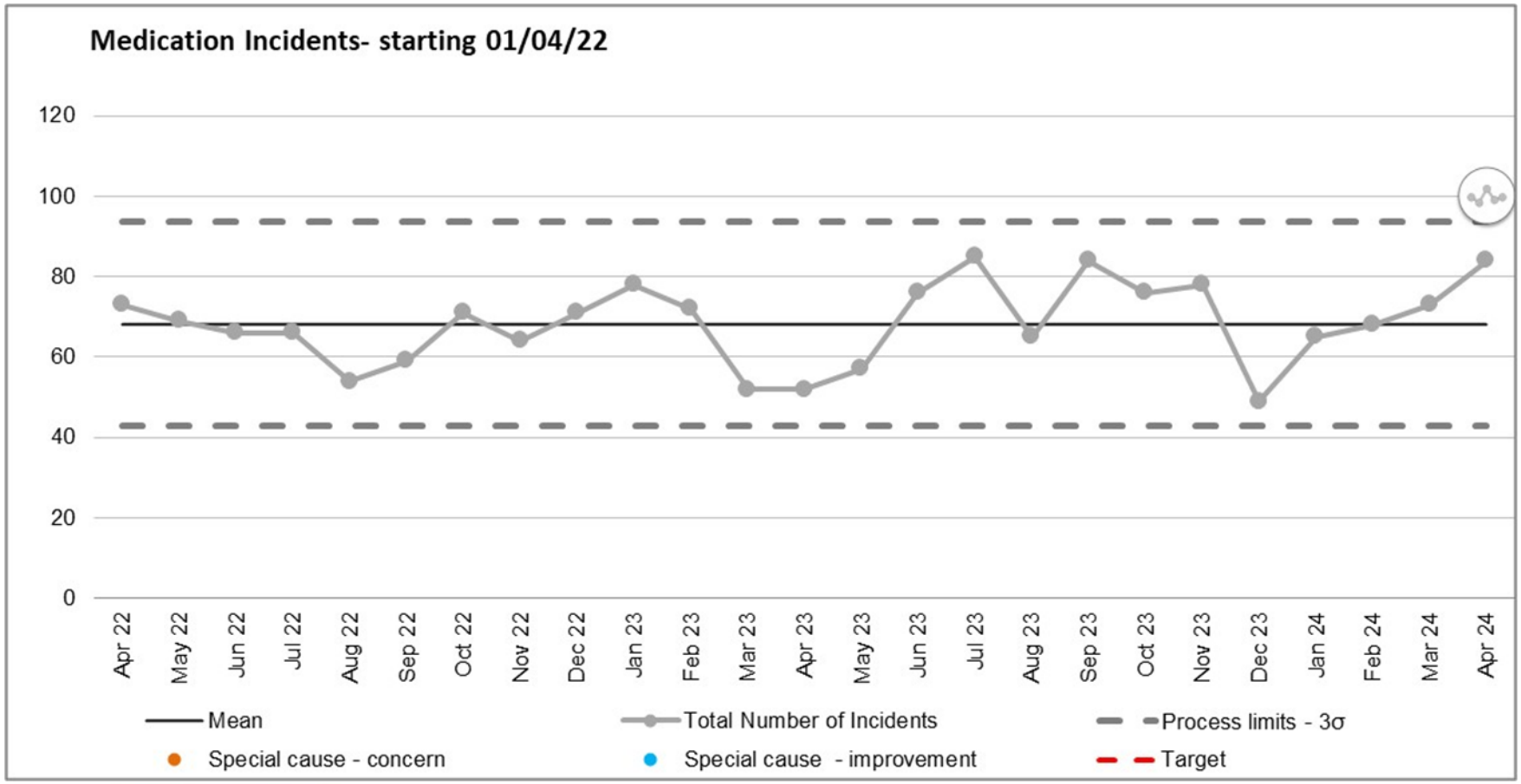
10. All Medication Incidents reported



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11. Ongoing - StEIS Notifications for Serious Incidents & PSII reviews

2022-2024 StEIS Notifications and SEIPS Investigations												
	SI INVESTIGATIONS				PSII MEETING NATIONAL CRITERIA				Internal/SEIPS/PSII Meeting local criteria Investigations		
	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Closed in month	PSII declared DMH	PSII declared FYPC/LDA	PSII declared CHS	Closed in month	DMH	FYPC/LD	CHS
2022-	Not Applicable due to PSIRF				N/A	N/A	N/A	N/A			
April	2	0	2	10	N/A	N/A	N/A	N/A	3	3	3
May	3	0	0	12	N/A	N/A	N/A	N/A	5	0	4
June	4	1	2	7	N/A	N/A	N/A	N/A	2	1	3
July	4	1	4	8	N/A	N/A	N/A	N/A	4	1	6
August	7	1	1	7	N/A	N/A	N/A	N/A	5	2	2
September	3	1	3	10	N/A	N/A	N/A	N/A	8	2	9
October	4	0	3	4	N/A	N/A	N/A	N/A	4	4	11
November	6	0	1	4	N/A	N/A	N/A	N/A	6	0	8
December	7	1	2	4	N/A	N/A	N/A	N/A	6	2	10
January	2	0	1	9	N/A	N/A	N/A	N/A	3	0	10
February	4	1	1	9	N/A	N/A	N/A	N/A	7	2	6
March	1	0	0	11	N/A	N/A	N/A	N/A	9	1	5
2023-2024											
April	3	1	1	4	N/A	N/A	N/A	N/A	8	2	2
May	4	0	2	4	N/A	N/A	N/A	N/A	7	2	3
June	2	1	1	9	N/A	N/A	N/A	N/A	2	4	6
July	1	0	0	10	N/A	N/A	N/A	N/A	3	1	5
August	1	0	0	4	N/A	N/A	N/A	N/A	6	4	13
September	2	0	0	6	0	0	0	N/A	3	1	9
October	1	0	0	4	0	0	0	N/A	5	2	10
November	0	0	0	5	0	0	0	N/A	2	2	1
December	N/A	N/A	N/A	7	0	0	0	N/A	8	3	5
January	N/A	N/A	N/A	3	2	0	0	N/A	7	3	1
February	N/A	N/A	N/A	1	1	0	0	N/A	3	2	7
March	N/A	N/A	N/A	1	0	0	2	N/A	6	1	4
April	N/A	N/A	N/A	1	1	0	0	N/A	3	1	0
	61	8	24	154	4	0	2	0	125	46	143

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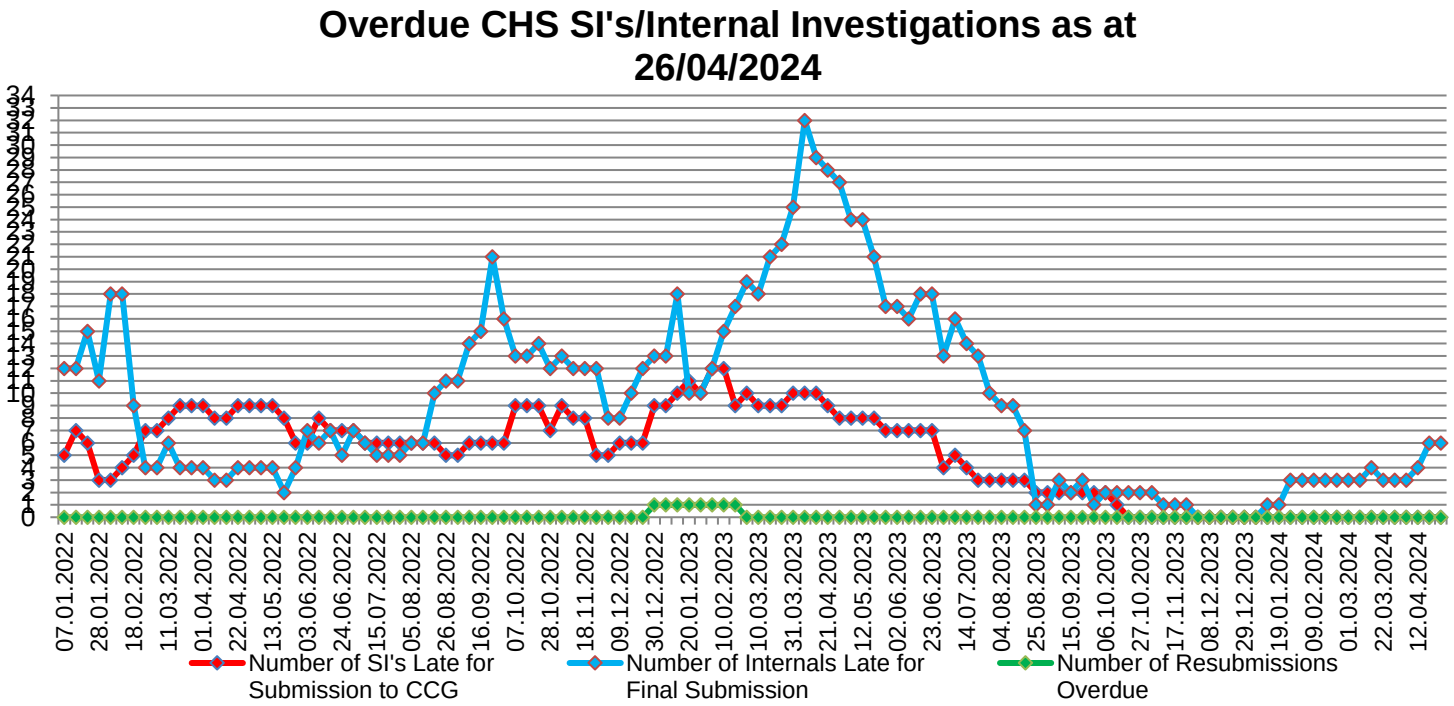
12. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) – CHS as at 26/04/2024



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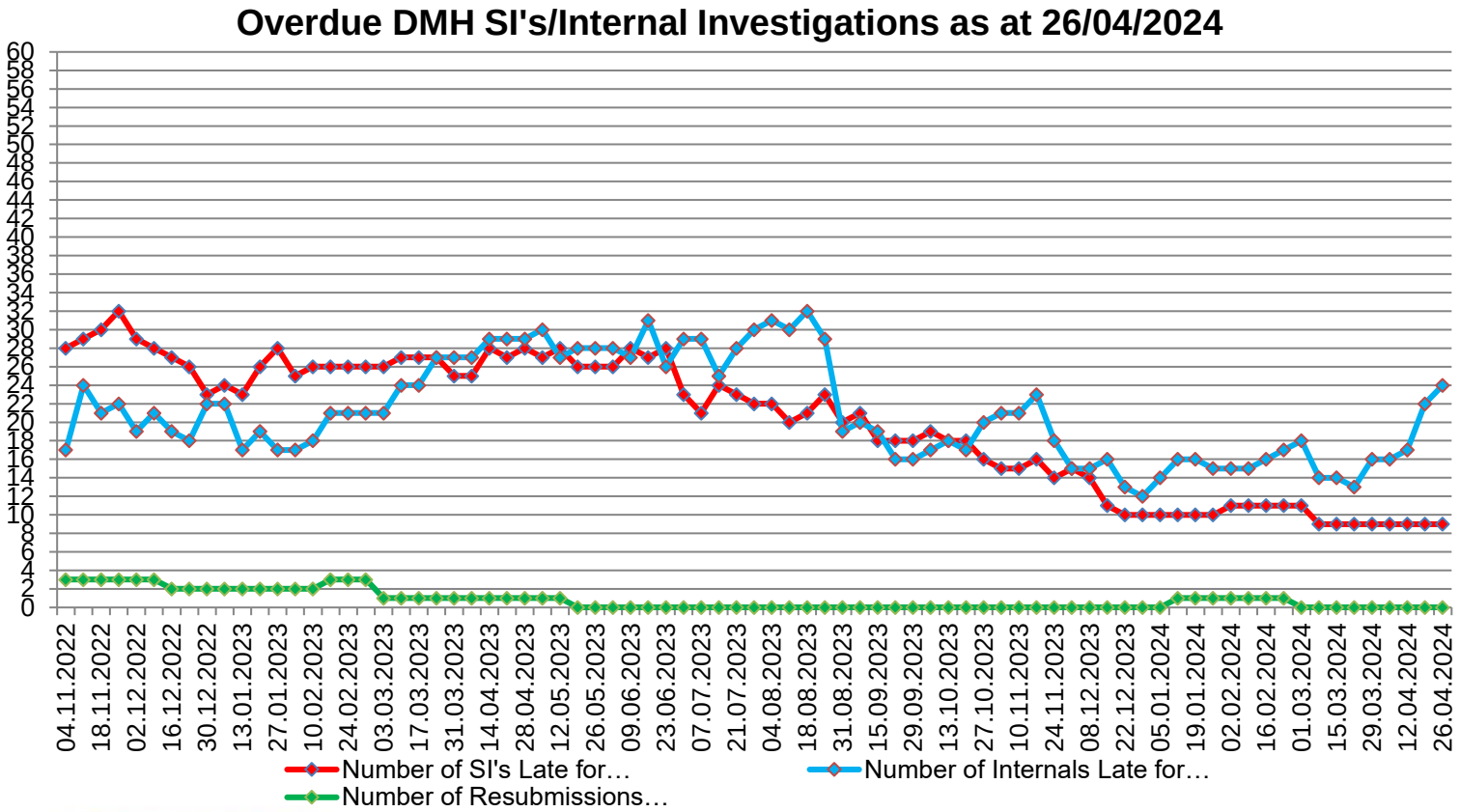
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH as at 26/04/2024



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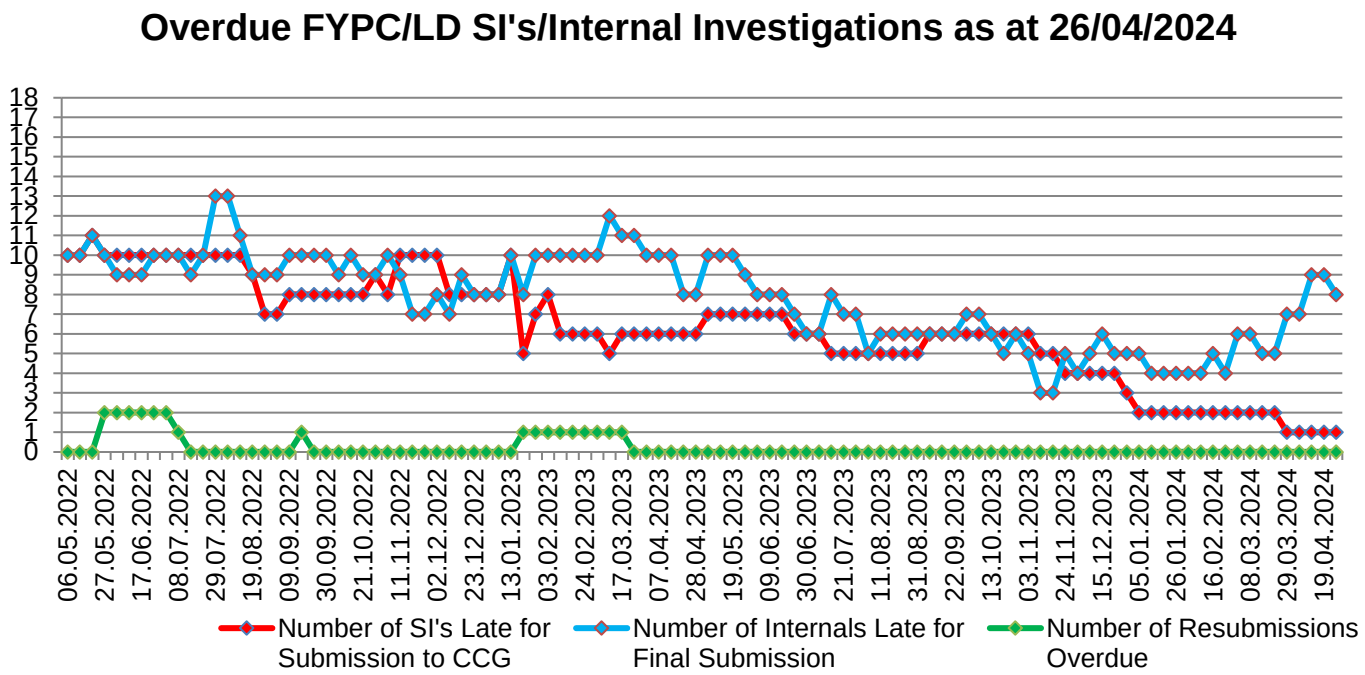
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) – FYPCLD as at 26/04/2024



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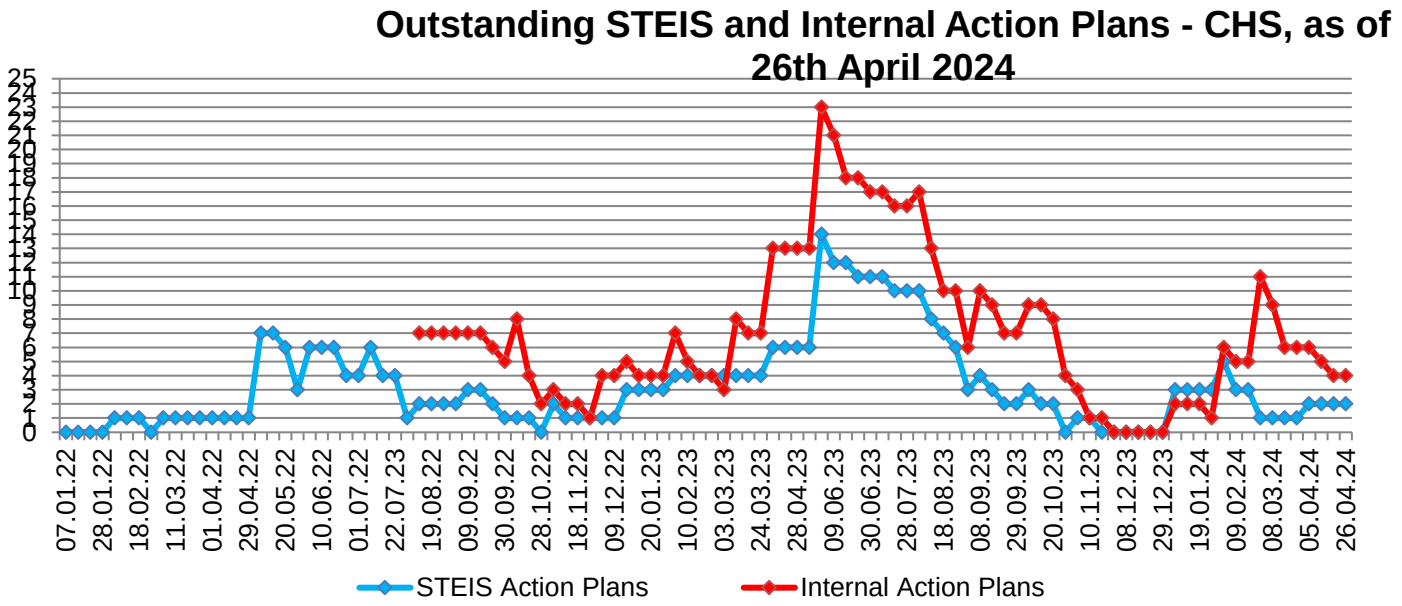
12b. Directorate Action Plan Compliance CHS Status 2021/24 as at 26/04/2024



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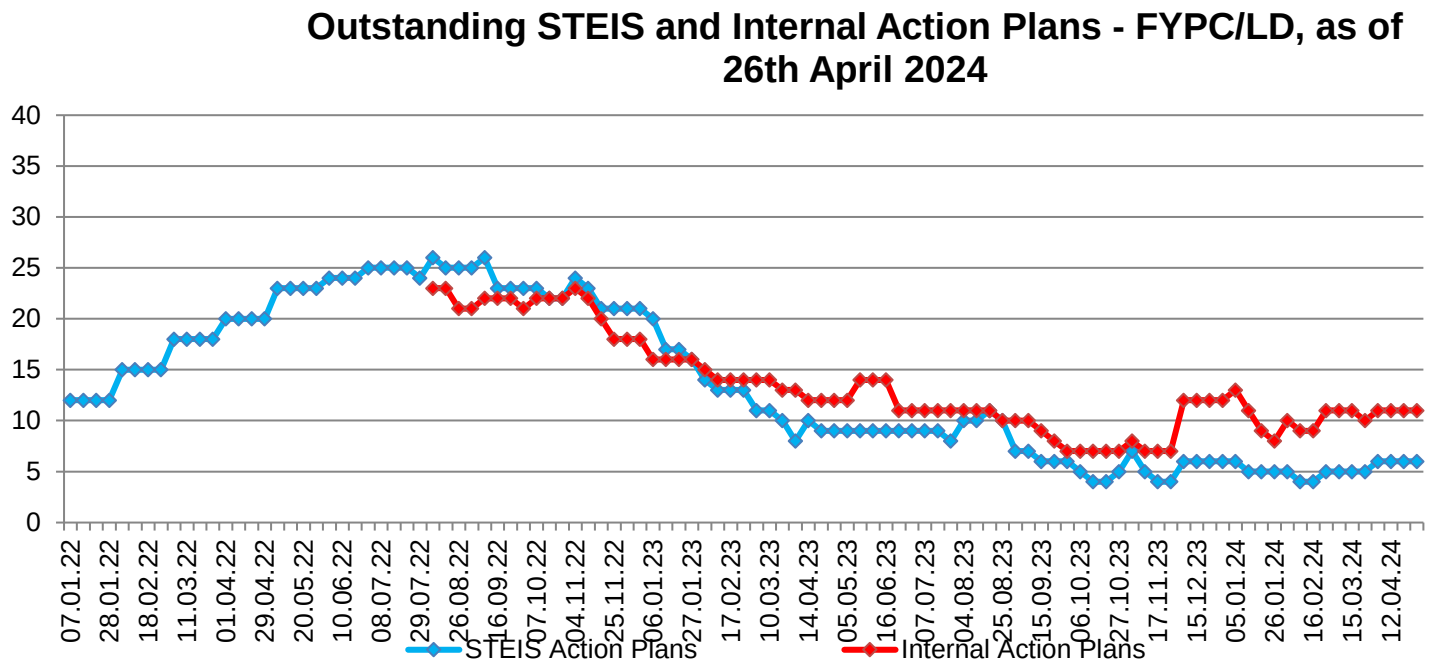
12b. Directorate Action Plan Compliance FYPC/LD Status 2021/24 as at 26/04/2024



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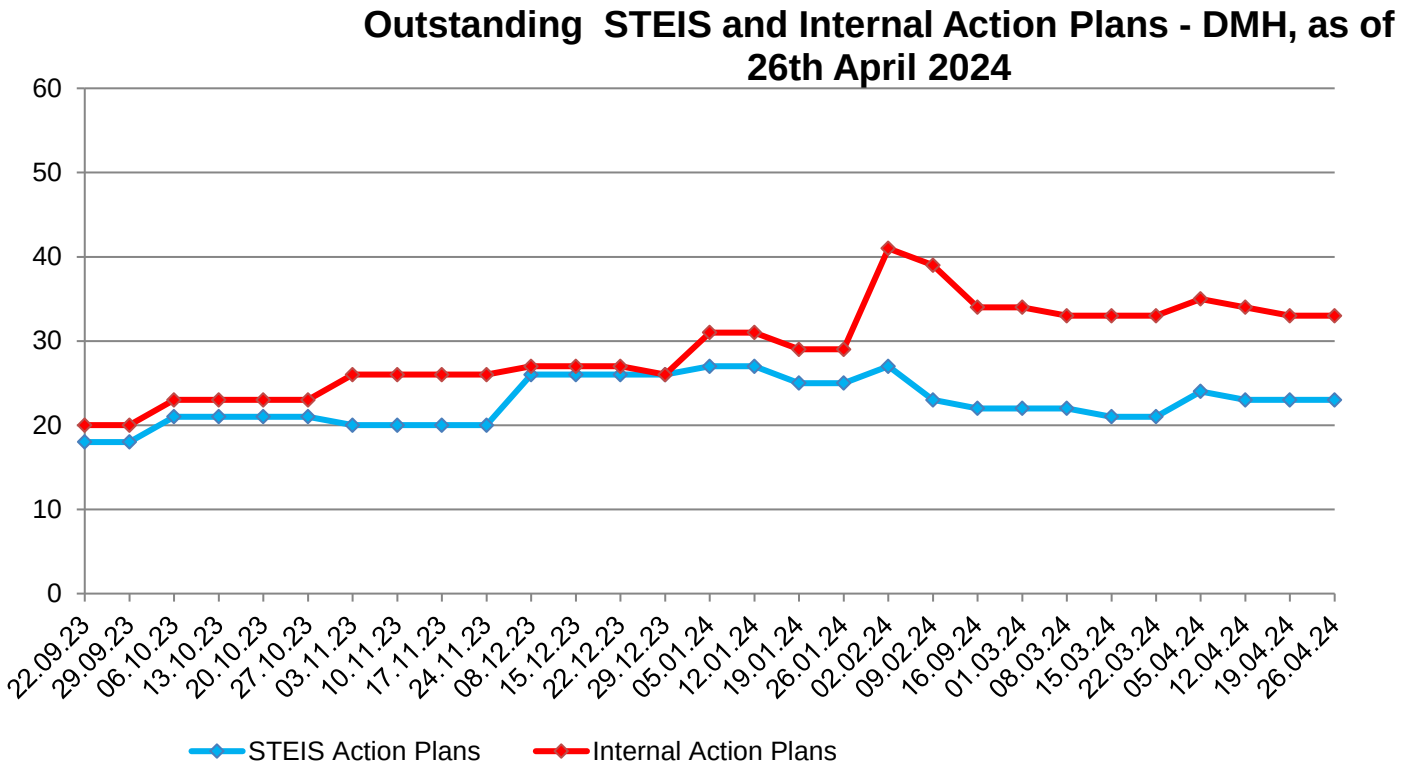
12b. Directorate Action Plan Compliance DMH Status 2021/24 as at 26/04/2024



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13. Learning from our learning response process

We have now transitioned to PSIRF (November 2023) we are working to skill wider groups of staff to use system thinking to consider incidents.

- Teaching methodology for System Engineering Initiative for Patient Safety (SEIPS)

- Encouraging confidence to talk together about system learning and less focus on writing reports

- Patient Safety investigators are spending time out with teams to work with them to think about robust actions

14. Learning March/April 2024

Incidents/Complaints Emerging & Recurring Themes

- There has been a theme around the timely availability of equipment to prevent pressure ulcer deterioration.
- **Action;** T+F group working together with the equipment supplier to understand this and to identify the areas of challenge and adress

- There has been a theme around the different places in patients notes were detail around their nutrition and hydration is documented resulting in it being difficult for staff to see clearly the patients status and risks
- **Action;** T+F group to streamline in collaboration with staff to simplify and standardise this process

Leicestershire Partnership NHS Trust

Patient Story – learning from incident 323235

Mary

About Mary:

Mary is a 16 year old young person with Autism who had been open to Outpatient CAMHS Services since July 2021, with a lead professional assigned. Within the previous 12 months Mary had also been known to CAMHS Groupwork and the CAMHS Crisis Home Treatment Team with a history of overdoses and self-harm within the same timeframe – this included incidents where Mary was admitted to the Leicester Royal Infirmary for treatment for overdoses. Mary's risk factors included her Autism, family dynamics and impulsiveness.

Previously Mary had commenced sessions with the CAMHS Eating Disorders Team (EDT) between February and May 2021. The transition from the CAMHS EDT to CAMHS Outpatient involved discussions between the teams and it was confirmed that Mary did not have a formal diagnosis of an eating disorder. However, disordered eating was identified as an ongoing feature. Mary also suffered with intermittent heart palpitations due to a Bicuspid Aortic Valve.

During Mary's care under CAMHS EDT, her and her family received treatment and support including with adopting and sustaining a feeding regime and food intake. Mary's eating patterns improved and her weight was restored. Mary also received support with monitoring her mental health, risks and disordered eating alongside attending the Emotional Skills Group under CAMHS Outpatients.

Mary had not been seen by CAMHS since June 2022 where she attended her 8th session of the Emotional Skills Group.

What happened:

CAMHS EDT received a re-referral for Mary after she had been admitted to Ward 14 at the Leicester Royal Infirmary (LRI) in April 2023 due to significant weight loss and hypoglycaemia (low blood glucose levels).

It became apparent at this time that Mary did not appear to have been reviewed in CAMHS Outpatients beyond March 2022 with no further appointments scheduled to review and assess her current difficulties and needs at the time. Mary also did not attend a CAMHS Outpatient appointment in May 2022. There was no evidence of the Was Not Brought Policy being followed or flagged.

Mary was discharged from LRI and continued to receive home support from the CAMHS EDT Home Intervention Team (HIT). Care, Education and Treatment Reviews (CETR) formed part of her care package as she was at risk of readmission into hospital.

Mary's physical and mental health sadly appeared to deteriorate and she was readmitted to Ward 14 in June 2023 with hypotension (low blood pressure), sinus bradycardia (cardiac rhythm lower than 60bpm) and weight loss (900g in 2 days). Later that month she was discharged and travelled to France to be with her mother and to access care there.

Duty of Candour:

Mary's father was contacted and informed of the investigation. When asked if he had any questions or concerns he would like to raise, Mary's father said he believed that was a lack of general oversight and joined up thinking following 'discharge' from CAMHS EDT.

It was agreed with the CAMHS Outpatient Family Service Manager that Mary should be informed as she was 16 years old, however as she was still an inpatient at the LRI, it was not considered appropriate at that point in time to speak to Mary due to her physical and mental health. On discharge, Mary went to stay with her mother in France.

A plan was agreed to liaise with Mary's mother and possibly the Consultant Psychiatrist in France to establish if Mary's condition was stable and consider a supportive approach to enable her to contribute to the review, and Mary's father was informed of this. On speaking to Mary's mother, she felt CAMHS EDT did provide a good service however the input then appeared to 'fizzle out'.

Mary was at home during this conversation and advised she would like to see a copy of the report and was agreeable for both her mother and father to receive a copy.

Learning:

A process for oversight across all CAMHS teams is being developed to monitor and review any child open on an active caseload who has not been seen within an agreed time period – this includes cases for medication reviews.

The investigation found that the group work care plan lacked current information and clarity on ongoing support for Mary and could have had appropriate oversight to ensure it meet the expected standard. CAMHS Group Work has reviewed their documentation as part of work on a new care plan and have developed new guidance – this includes a strengthened communication process for the Lead Professional to complete a review when group work is completed via the electronic patient record task function.

The investigation highlighted that there was limited support offered to Mary following her diagnosis of Autism. Mary's parents also identified the ongoing support for her Autism as lacking; and this was also acknowledged by professionals. The Autism Spectrum Disorder CAMHS pathway has recently been reviewed and strengthened, and the 'gold standard' pathway includes a definitive timeline in relation to completion of all aspects of the process. There has been a focus on sharing this widely to ensure that all services across CAMHS adopt the pathway – and for CAMHS EDT, this includes anyone who receives a formal diagnosis following a Neuro Developmental assessment to have access to a Guidance Psychoeducational Group.

There were missed opportunities to monitor and offer interventions to support Mary with her disordered eating under CAMHS Outpatients. A formal pathway is being developed when transitioning a patient from CAMHS EDT to CAMHS Outpatient to support monitoring and interventions.