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Leicestershire Partnership NHS Trust

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

Purpose of the report

This report for July and August 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 are exploring opportunities both internally and externally to develop safety dashboards and ways to improve this data and provide more meaningful data that is available closer to clinical 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 (PSIG) we are ensuring that we are also reviewing learning identified nationally across the NHS and implementing learning in LPT. Most recently the Section 48 review into Nottingham Healthcare NHS Trusts care of Valdo Calocane (separate paper)

Rapid Improvement Programme

Since receiving three preventing future deaths reports from HM Coroner (Regulation 28). Following a thematic review of the learning from these, a series of improvement actions have been implemented via a rapid improvement programme.

The preventing future deaths reports have highlighted there are some potential gaps in processes and assurance oversight. The risk profile for the organisation has subsequently increased and a rapid plan is required to ensure appropriate actions are taken to share and embed learning from incidents along with plans for improving visibility and oversight of risk.

We are responding by connecting our learning and a thematic analysis of these has identified the below themes:

- MDT function
- Embedding learning identified through our patient safety reviews.
- Robust discharge process
- Evidence of risk assessment
- Communication
- Family involvement
- Continuity of care

To address the key elements of work required to make the necessary improvements the following workstreams are in place:

- Directorate Governance
- Accountability
- Incident investigation
- Safety Oversight
- Inquest Preparation
- Regulation 28 Process
- Risk Assessment, Control and Management Plans
- Safeguarding
- Crisis Pathway

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. The aim is that these reviews will really identify the system issues and associated actions.

Feedback from staff has been positive and they appreciate the collaborative nature of the new investigation style and shared that they feel part of the process rather than being investigated (as per previous serious incident framework); we are starting to gather formal feedback from our staff involved through electronic anonymised feedback.

There is a challenge due to capacity both within the investigation team and directorate to investigate in a timely way all of the areas we described in our plan. We are reviewing a designing a capacity management plan to ensure that learning is identified and appropriate action taken.

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.

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. The 'Reporting and Managing incidents; leading safely', training that is led by CPST is very well attended, popular and oversubscribed. We have responded to the demand by providing additional sessions on Ulearn. A review of the training requirements and

the available capacity of the patient safety team to deliver is in progress. There will be consideration and prioritisation of the training offer to balance with the other competing priorities.

Review of Patient Safety Related Incidents.

The overall numbers of all reported incidents continue to be above the mean and can be seen in our accompanying appendices. There is no particular theme and is seen as a positive that staff are recognising and reporting incidents.

Learning from Regulation 28's

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. We are monitoring actions arising from the 3 Regulation 28' we have received through the Patient Safety Improvement Group (PSIG) and doing this in alignment with our compliance team.

An example of the learning from the Reg 28' is the monthly quality summits that are now in place for the Crisis pathway. The summits are led by the Interim CNO and Medical Director and focus on the key themes from the Reg 28' in order to bring support and improvement to the services within the Crisis Pathway. The themes are also being discussed as a deep dive session at Quality Forum to ensure that learning is discussed and shared trustwide.
PSIG are also developing a process to horizon scan and learn from relevant Regulation 28's issued to other organisations. These will be gathered by the patient safety team and shared with the appropriate service for review and to assess themselves against the learning and respond with any actions required

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

We have continued to see normal variation of the number of pressure ulcers developed or deteriorated in our care, with some improvement noted for category 3 pressure ulcers and some special cause concern peaks noted for category 4 pressure ulcers in December 2023 and January, April, June and August 2024.

NHS Benchmarking Network District Nursing report (2023) identified a mean number (4.3) of pressure ulcers (grade 2, 3 & 4) acquired whilst under the care of the service per 100 unique service users. LPT community nursing is not an outlier at 4.5, which provides reassurance in terms of standards and practices in comparison to peers, however, the key aim remains to reduce pressure ulcer harm and prevent development and or deterioration.

We have seen improvement in outcome measures for several quality standards including pressure ulcer risk assessments and the provision of information on preventing pressure ulcers to patients' families and carers.

The focus of the current community nursing workplan is prevention, a revised process has been agreed via the quality and safety DMT to review category 2 pressure ulcers as a focus, whilst continuing oversight and review of the category 4 pressure ulcers by the Matrons. Inconsistency and poor wound photography have been a theme from incident reviews and following a successful trial with the Isla application, this is now in the process of being rolled out to all community nursing hubs. Repositioning is a quality account priority, and a quality improvement project is commencing to strengthen the education and information for patients and families/carers. Review of Health Care Support Workers (HCSWs) Pressure Ulcer

Prevention visits, including review of the criteria, with a trial planned in NorthWest Leicester (NWL) starting Sept 2024. The equipment workstream group are currently working with the equipment provider to gain a better understanding of rejected referrals and are supporting the introduction of super users into the community nursing hubs.

There are weekly pressure ulcer validation and monitoring meetings in place within community hospitals, led by the Deputy Head of Nursing, to confirm, challenge and share best practice. Other key actions include:

- Roll out of replacement chairs, to improve patient positioning and reduce pressure.
- Additional pressure ulcer training day planned for link nurse staff in quarter 3.
- Repositioning paperwork has been updated and piloted for 6 weeks ending early August 2024. Weekly AMAT audits in relation to repositioning have been undertaken.
- Deputy Head of Nursing (DHoN) reviewing alternative Medstrom products and operational process relating to the use of Dolphin Mattresses
- Dedicated in-patient Tissue Viability specialist nurse input.

There remains a key focus and commitment to reducing pressure ulcer harm and reducing the numbers of pressure ulcers developed and or deteriorated in our care. Both the Strategic group and CHS delivery group members are committed to actions and improvement programmes of work in response to factors that influence this, including care delivery approaches, exploring barriers to care and opportunities to look at this across the system through collaborative working.

Falls Incidents.

There was a rise in total number of falls in August, mainly as a result of a rise in falls on Gwendolen Ward. The ward report that this was due to a small number of male patients whose presentation and behaviours make them prone to placing themselves on the floor. The ward reported 26 falls incidents with 5 first falls and 20 repeat falls, all were reported as either no harm or minor harm. One patient was recorded as falling 7 times, another patient 3 times. Patients placing themselves on the floor are recorded as falls events. Falls Awareness training is being updated in several areas around MCA, huddles, flat lifting. Further work is progressing on developing a standard operating process on the review of equipment including bed rails and bed levers in patient's homes. This is on the back of the MHRA/National Patient Safety alert on bed rails last year and creation of specific risk assessments for reviewing bed rails and bed levers.
Falls incidents resulting in harm are reviewed using a Nationally developed After Action Review (AAR) designed specifically for identifying learning from falls. The themes from these reviews are considered by the falls group to consider systemic actions required to support staff to reduce the risk of falls.

Deteriorating Patients.

The DPRG Policy is now completed and approved. In completing this, the deteriorating patients group have also address several of the workplan objectives for the group.
The group have now moved their focus to ensuring they are clear on communicating training needs for the different staff groups with regards to the deteriorating patient and then be in a position to seek assurance around this training and staff confidence and knowledge in this area.

In addition, they are looking at how to co-ordinate and communicate the needs of all staff to look at the non-contact observations training which will allow any member of staff then to raise a concern even if they are not medically trained, hopefully enhancing early recognition of a deteriorating patient and ultimately better outcome for that patient.

Furthermore, there is work continuing around NEWS2 and identification of Sepsis. There is still a national focus on improving recognition and treatment of Sepsis. The group have recognised that there is currently not a clear lead in the Trust for either of these work streams, any work is being done by individuals who are passionate about this work but do not have dedicated time in their job plans to undertake, which does inevitably delay progress. Further discussions about how this can be improved have been requested so that we can look for a solution to this.

The group is also working to develop a process for the review of any VTE incidents and identifying the themes. The group will develop this and a process to assure that work is progressing in this area as well.

The DPRG have been asked to contribute to an options appraisal around resus trolley equipment for DMH and to look to assure ourselves we are sufficiently aligned to national guidelines and policies for mental health Trusts as well as in keeping with our service level agreement with our UHL colleagues who support us with 2222 calls. We have fed our opinions back to both PSIG, TED and the DMH groups and this will be further discussed by those teams.

Collaborative work continues with NHFT on the NEWS2 project, and the Trust continues to explore how to pilot the Martha's rule work.

Groups related to self-harm and suicide prevention.

Trust self-harm and suicide prevention group

LPT have a Suicide prevention lead working on key areas and along with the national suicide prevention strategy. Coordinating multiple projects across LPT with a focus on

- Training
- Standards– NCISH – safer services
- Quality improvement
- Self-harm policy and drivers
- Joined up working across our communities – high risk locations
- Postvention
- LPT suicide prevention plan.

The group have agreed training for staff within the trust and what this will look like, funding has partly been agreed and we have identified staff to carry out train the trainer roles. We have asked for an additional 80 places for direct to participant training, funding dependant. There is work to do to further ensure our staff are equipped with appropriate training. In addition LPT have signed up to the ZSA organisation and we

are using the ZSA training which can be accessed via their forum, this has the additional bonus of being specific to certain groups, i.e., veterans, students.

LPT postvention offer is in the process of being developed, we have engagement form key individuals, our next step is writing and agreeing the pathway. Initially for staff and then to expand the offer with patients. We are using the postvention toolkit developed by the Samaritans and NHSE.

The NCISH self-assessment is moving forward though has had significant delays due to workload and engagement, we have now completed the safer services toolkit and will be completing the self-harm prevention toolkit. The result so far is looking positive however there are areas we will need to focus on, this is an expected outcome of the self-assessment with an expected completion date November 2024

The suicide prevention plan for LPT is moving forward, has been presented to DMH, FYPCLDA, and will be going to CHS for comment. The plan reflects the national strategy and the above NCISH work on safer services. Expected date for completion December 2024

Ongoing work and a process is being developed on how staff can choose to access mental health support. A SOP has been drafted and a group being pulled together to develop the offer.

MH Safe and Therapeutic Observations Task and finish group

The group is working on the following:

- Developing a new template for mental observation on the Brigid App to support using electronic observation recording directly on the patient electronic records with DMH and FYPC/LDA Directorates. A pilot is due to commence at the end of September 2024.
- Reviewing the current training provision for substantive and agency staff.

LPT and NHFT have formed an Improvement Collaborative, and are taking forward 2 areas as quality improvement projects:

- Nighttime observation – safety vs therapeutic relationship and sleep hygiene
- Training and competences

The groups are commencing change ideas during quarters 2 and 3.

Medication incidents and Medication Safety

Work is ongoing to align the model with the NHS England patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates.

There is work ongoing to review the number of omitted doses for medicines. This includes electronic system changes as well as other parts of the system issues that may be contributing, i.e., by reviewing stock drugs in relation to the current context and common unavailable drugs

for patients transferred from acute providers, i.e., eye drops for treating glaucoma. Additional training and policy review is also being undertaken to support staff to engage and deliver the changes required for sustained improvement along with shared learning from UHL of family feedback via a video involving delay in Parkinson's drugs and the impact it had on their family member.

This work above is resulting in an increase in incident reporting as drug unavailability is now more readily being recognised as an incident. The current process of reviewing and investigating medication errors is being reviewed to bring this into line with modern system safety thinking rather than focussing on individual actions. The increased reporting is across the organisation and is not currently highlighting any particular areas as outliers. The medicines safety groups are requesting directorates report in on their themes and actions taken in relation to medication safety.

There has been no progress in the recruitment to the role of Medicines Safety Officer (MSO) due to competing priorities for funding.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC

We continue to update Commissioners and CQC with any significant incidents that have occurred even though 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 our commissioners will receive assurance from the process

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 and continue to work through their plan.

The Medical Examiner process is now being extended to Primary Care as of early September, 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, the extension to community deaths does mean that the ME's office are talking to patients families of patients who have died in the community. This has resulted in an increase in feedback from families in relation to some areas that need to be reviewed as well as thanks for excellent care. This is impacting on CHS particularly and they are strengthening a process to ensure that the feedback is appropriately considered.

Patient Stories/Sharing Learning

Patient stories are used to share learning from patient safety reviews. 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.

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.

For Board and Board Committees:	Trust Board	
Paper sponsored by:	James Mullins, Interim Director of Nursing, AHP's & Quality	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	16 September 2024	
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):	NA	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
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	NA	
DIGB Q strategic alignment*:	**D**evelop	
	Innovate	
	Grow	
	Build	
	Quality	√
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite?		
False and misleading information (FOMI) considerations:	NA	
Equality considerations:		

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	James Mullins, Interim Chief Nurse	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	September 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 July-August 2024.

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

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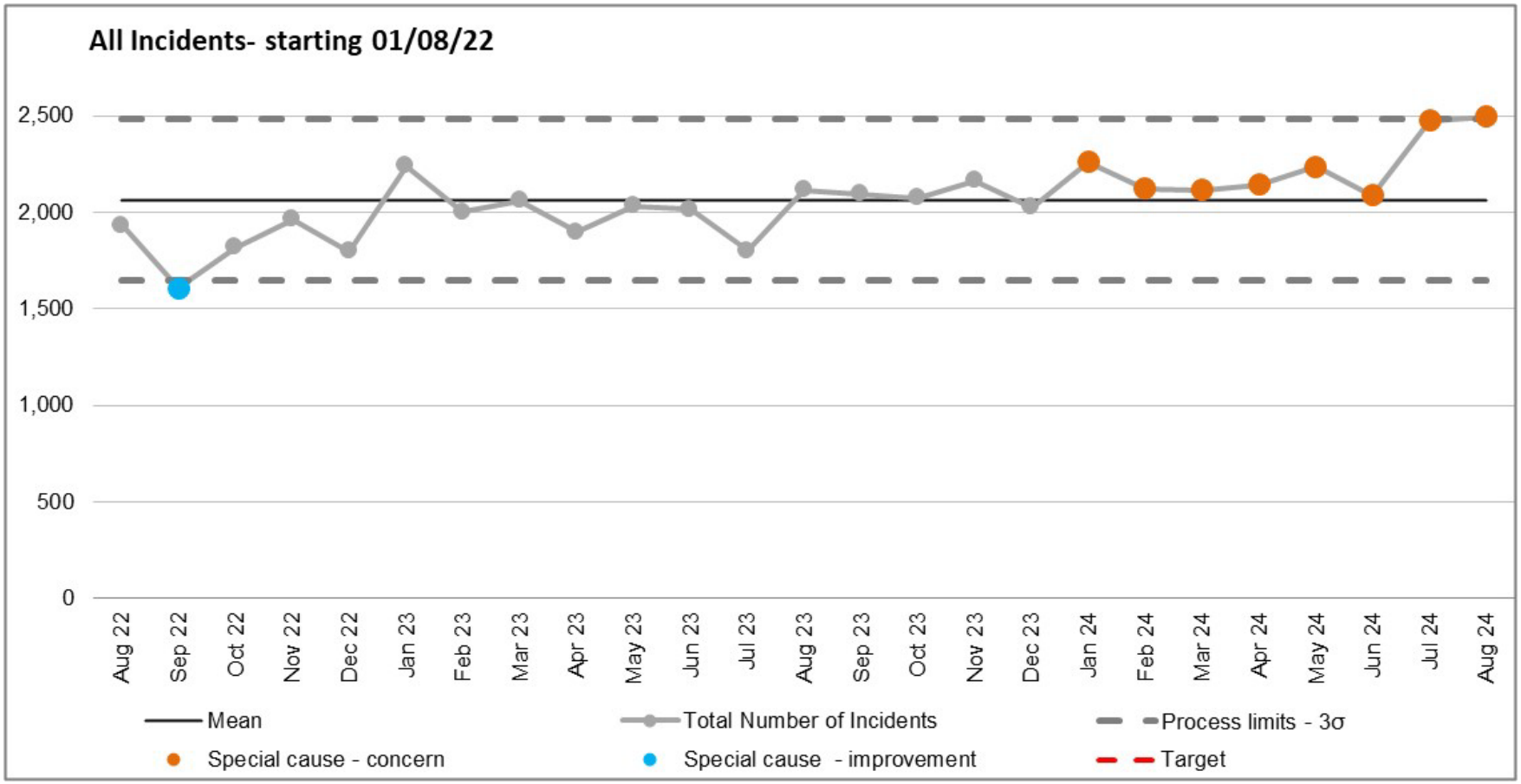
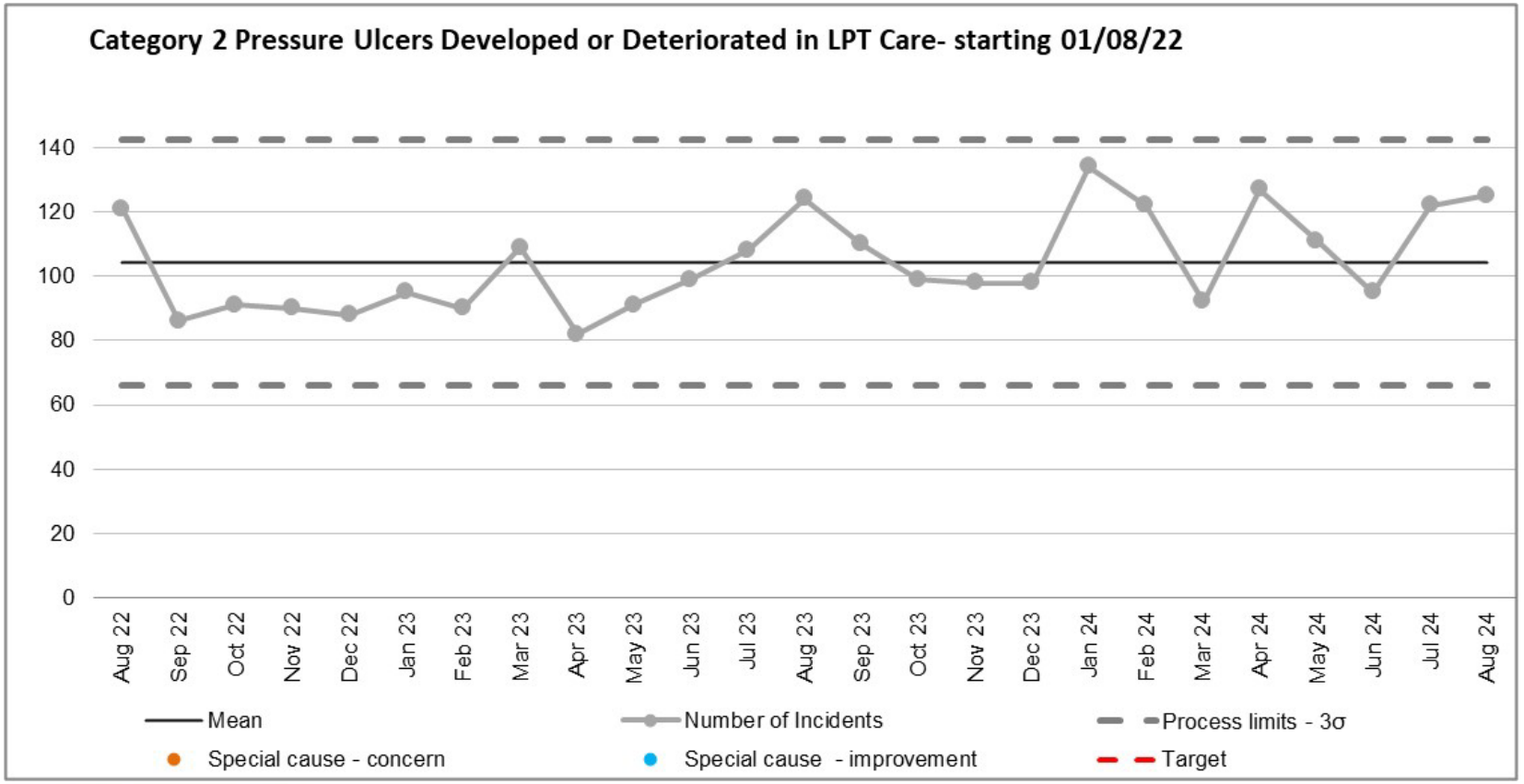
compassion respect
integrity trust

1. All incidents



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



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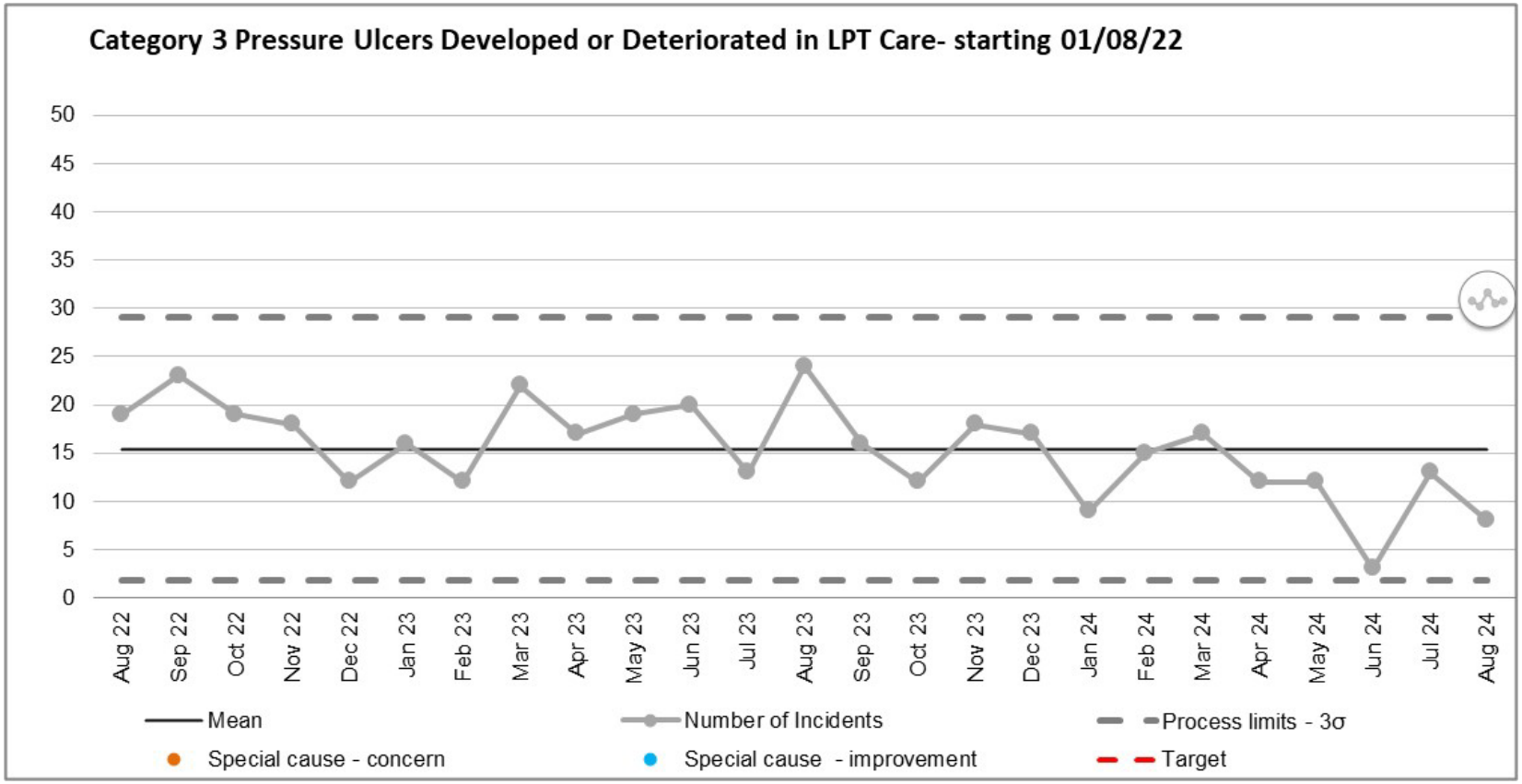
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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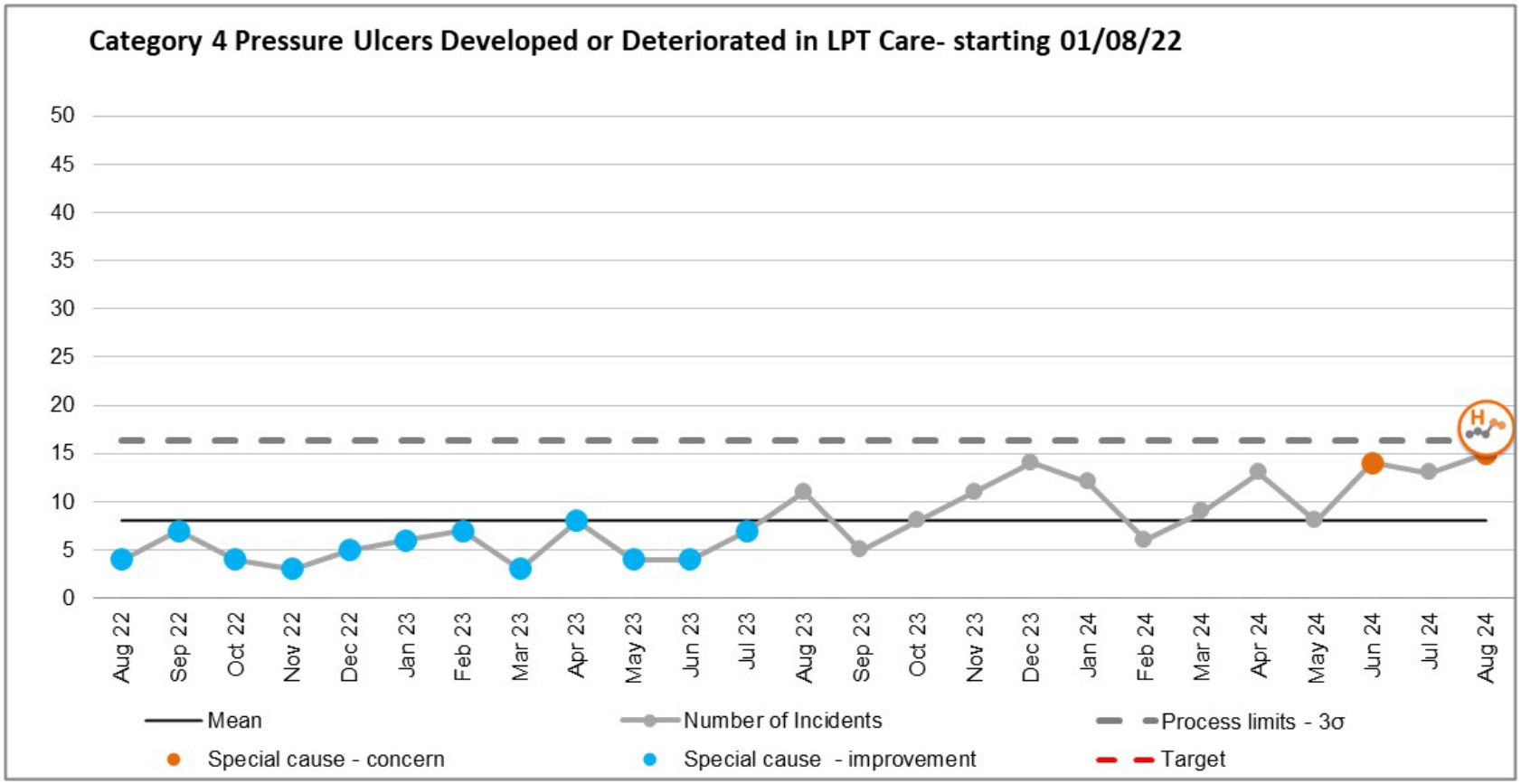
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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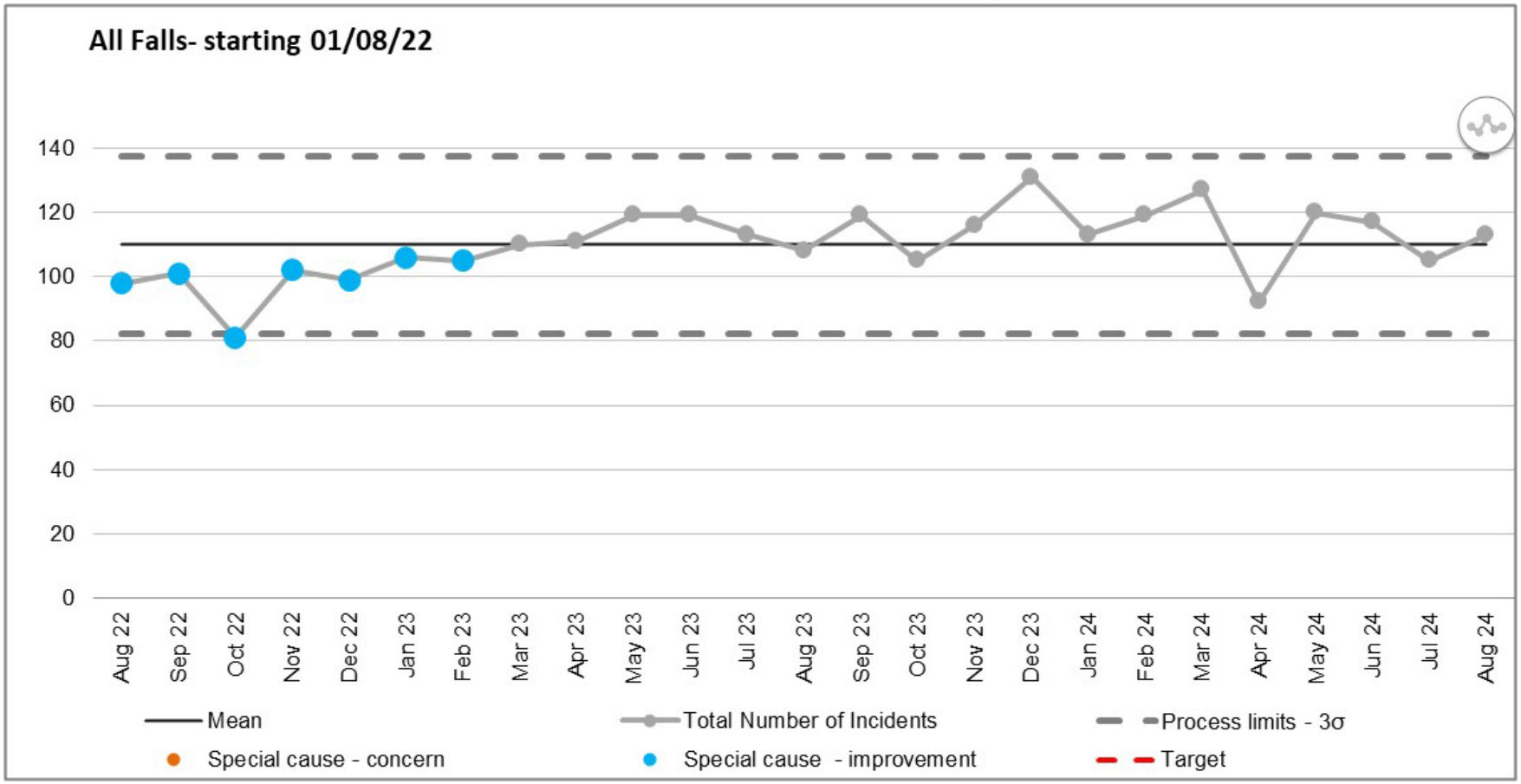
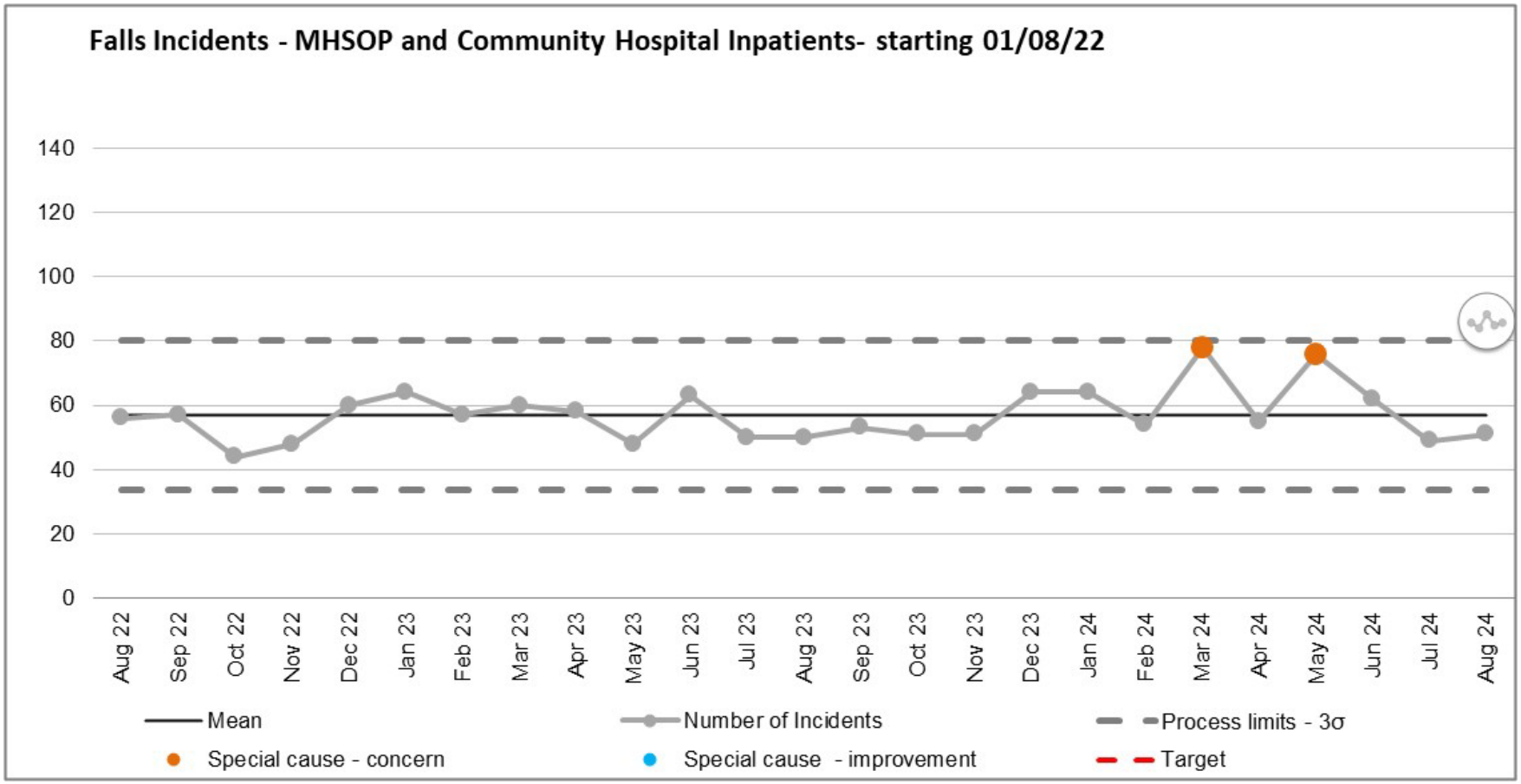
integrity trust

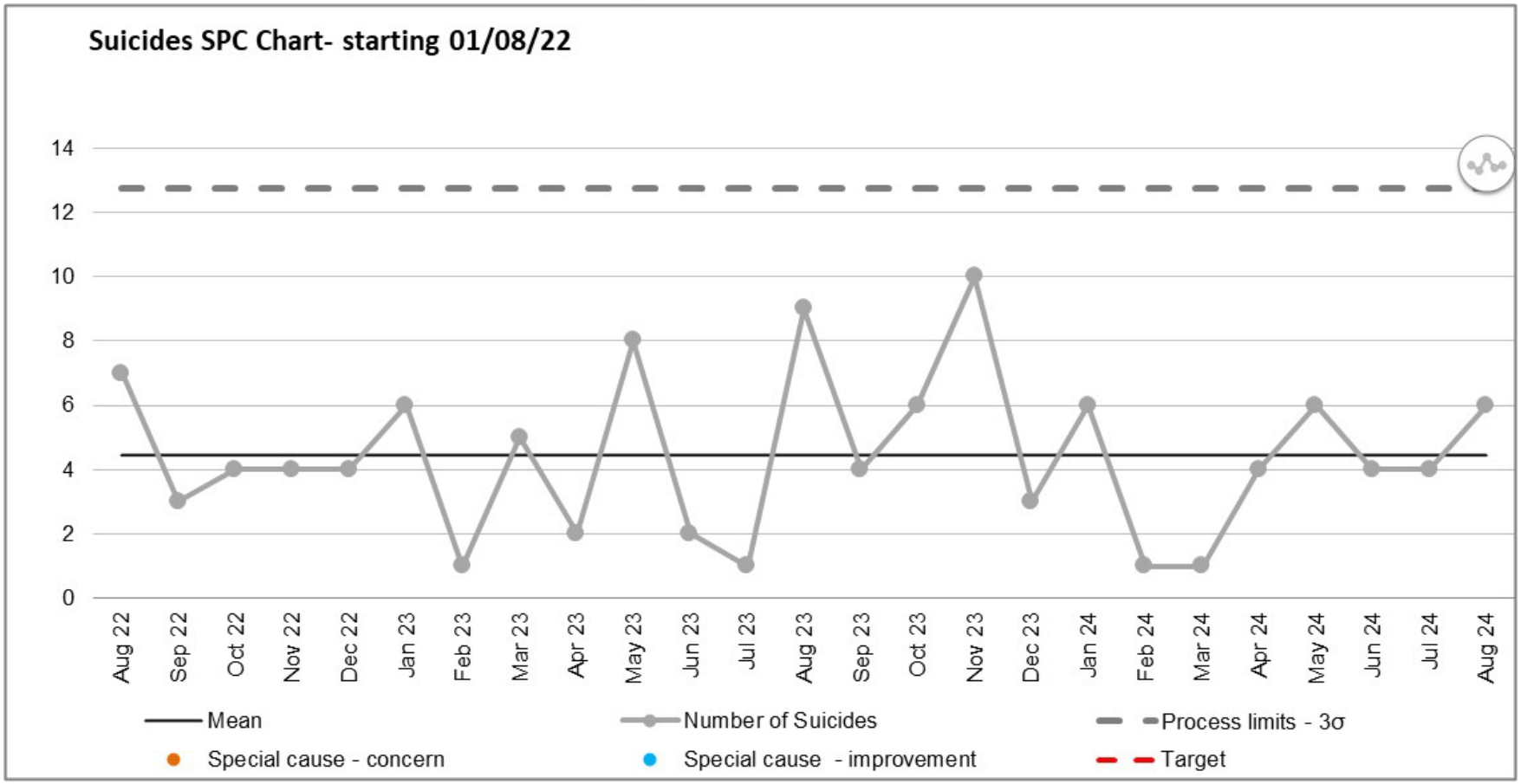
5. All falls incidents reported



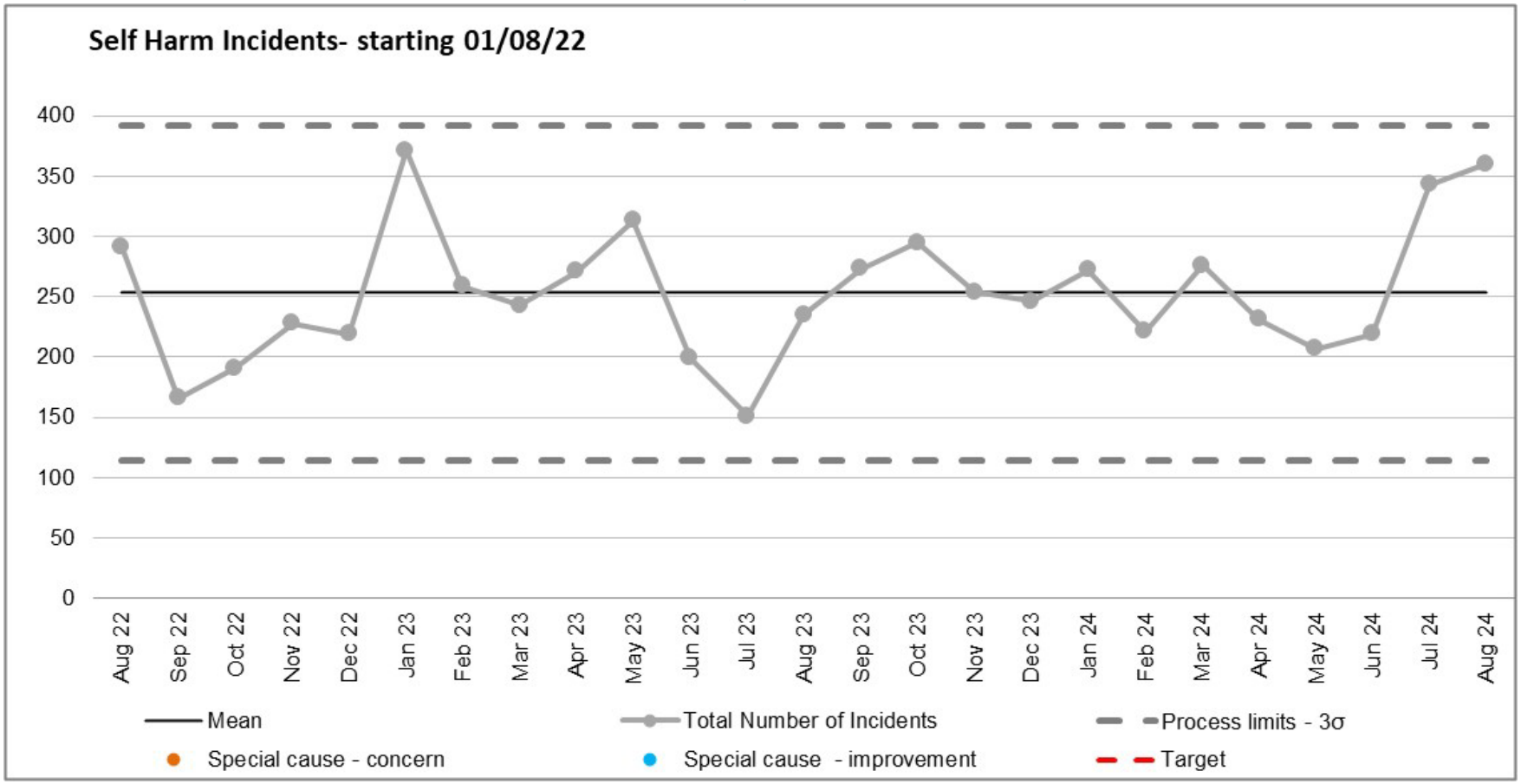
6. Falls incidents reported – MHSOP and Community Inpatients



7. All reported Suicides



8. Self Harm reported Incidents



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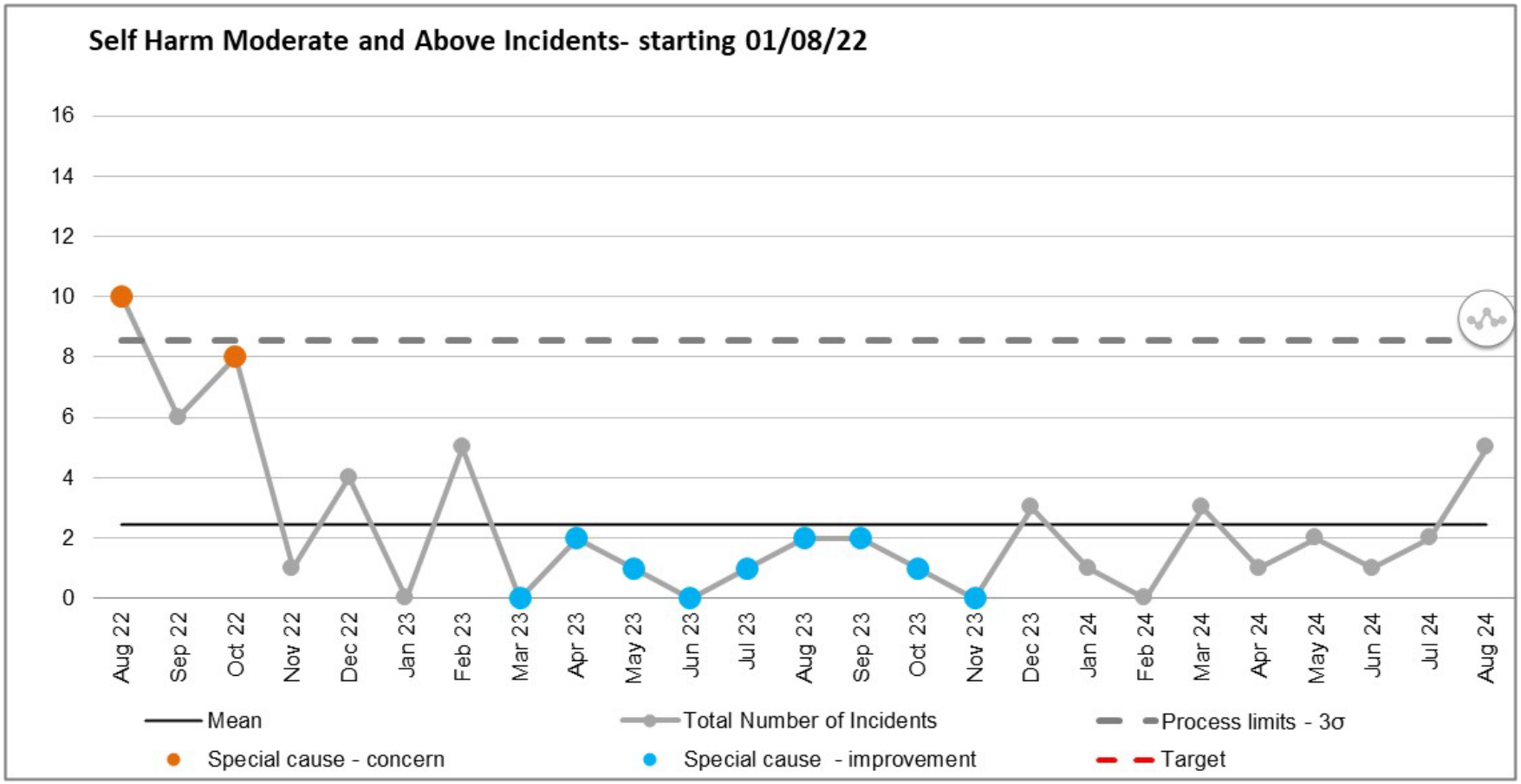
8a. Self Harm reported Incidents – moderate & above harm



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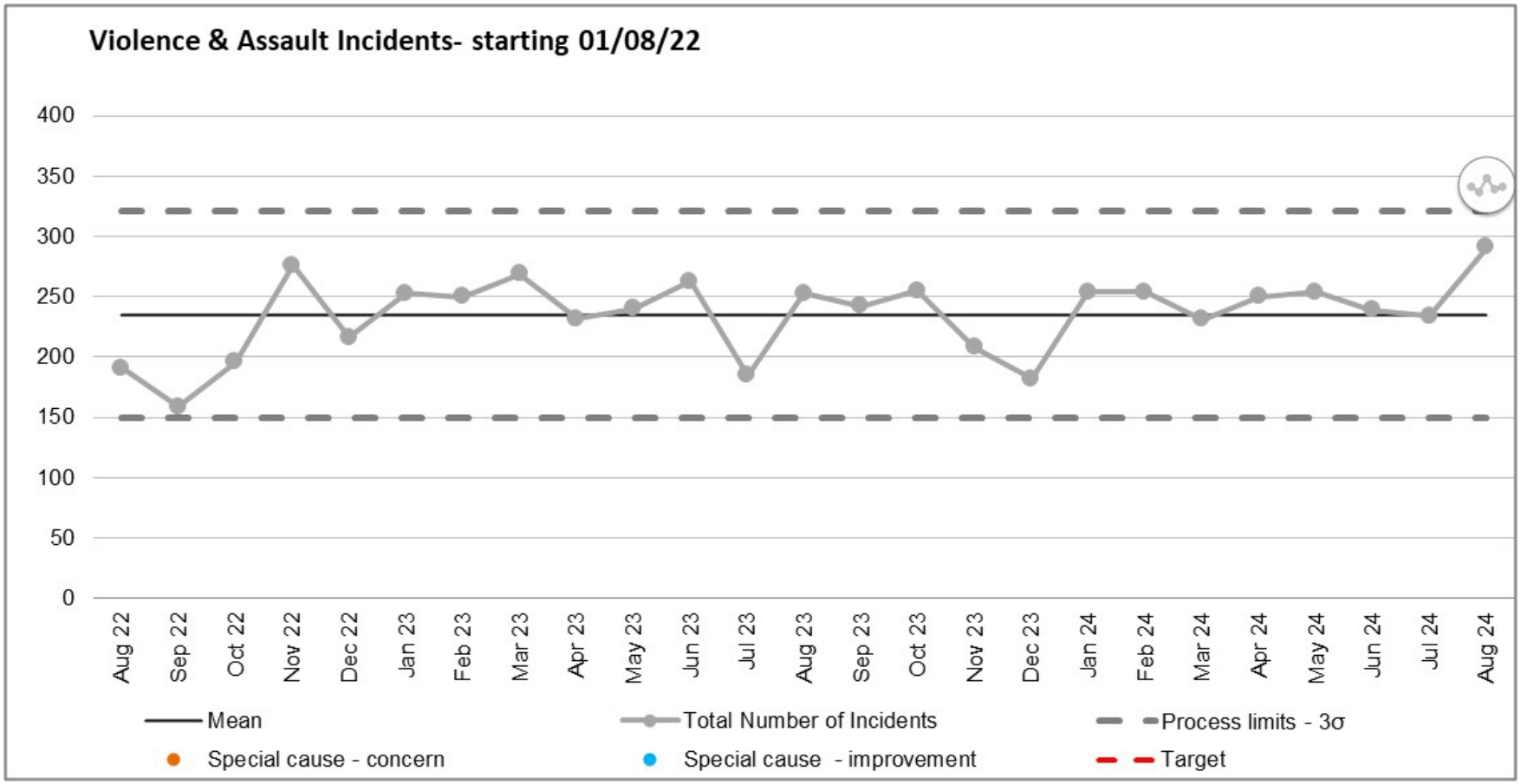
9. All Violence & Assaults reported Incidents



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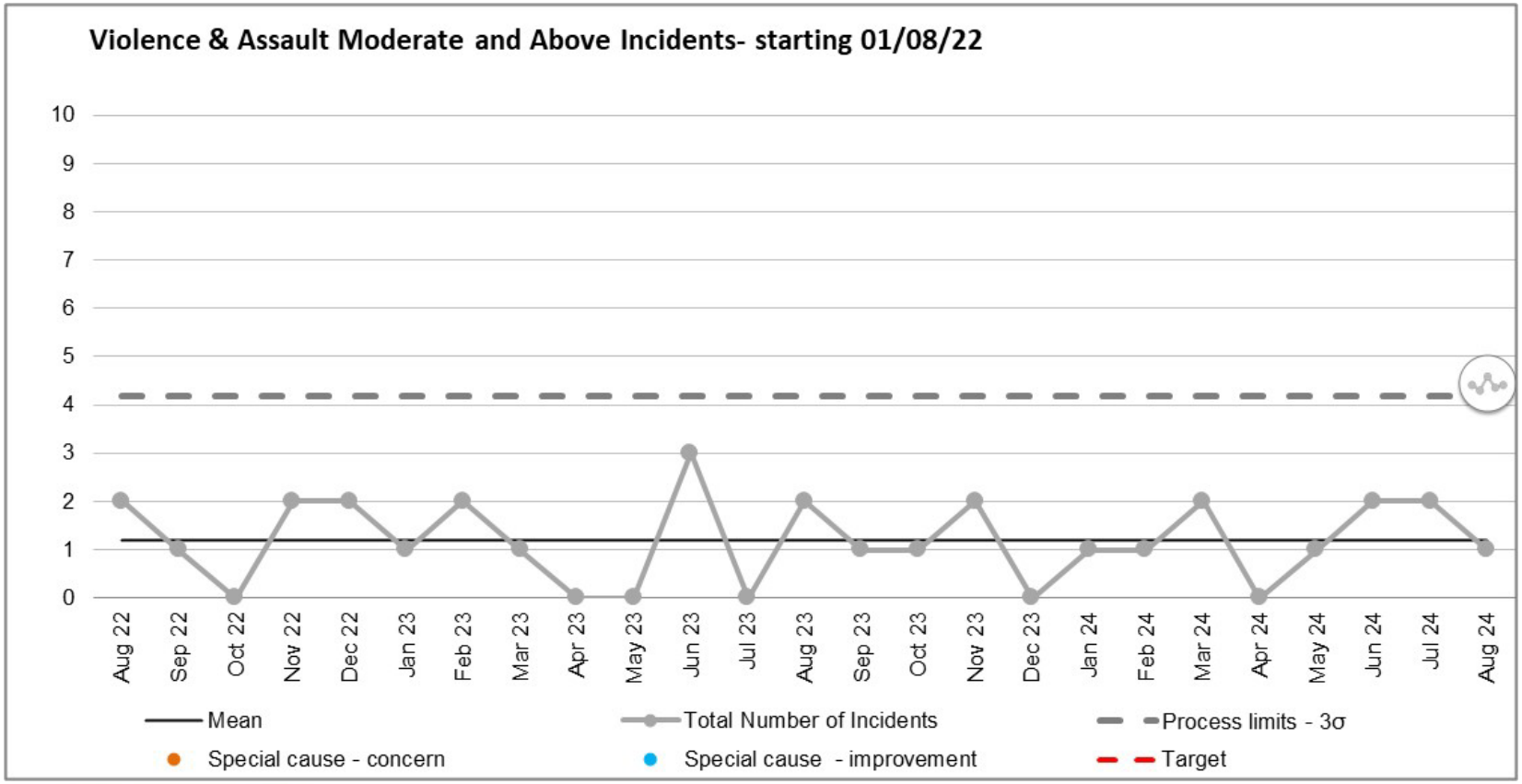
9a. Violence & Assaults moderate harm & above reported Incidents



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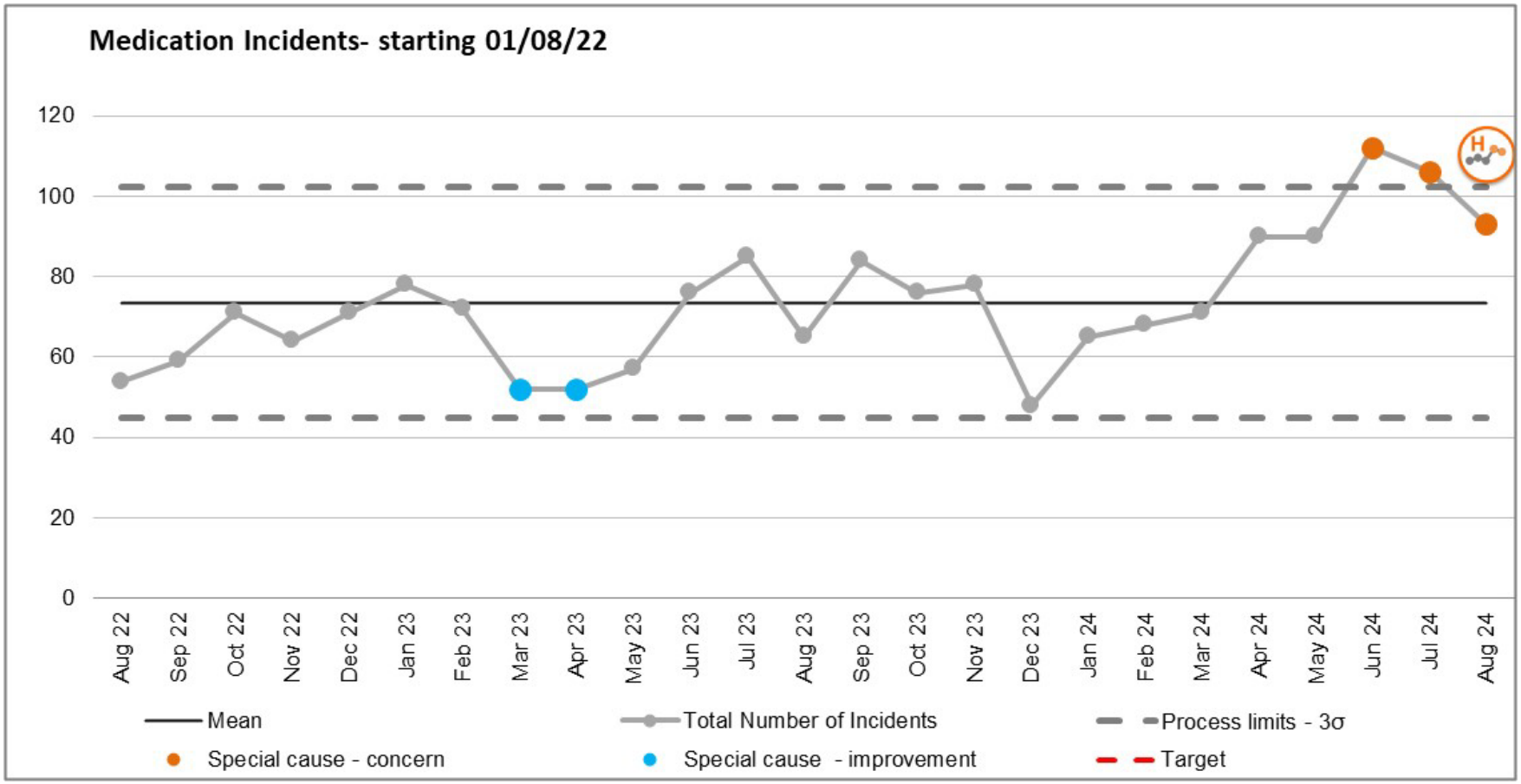
10. All Medication Incidents reported



13. Learning from our learning response process

The CPST have worked with the IPC team to share with them the system thinking approach to reviewing care and together they are amending their processes to gather system learning

System Actions

The CPST are working with the corporate governance groups to ensure the process around the robust system actions is understood and working.

There has been great progress made in relation to learning from PSIRF reviews particularly in relation to The work undertaken by the nutrition and hydration group and the newly formed Clinical systems improvement group who have both included the themes and recommendations as an integral part of their work plan

Leicestershire Partnership NHS Trust

Patient Story – Learning from Incident

329736 Anna and Kate

About Anna:

Anna is a 25-year-old woman with mild learning disability, autism, epilepsy, and emotionally unstable personality disorder. Anna was admitted to the Agnes Unit on 5th October 2021 under section 3 of the Mental Health Act (MHA) due to presenting with suicidal ideation, self-harm, intense agitation, ingestion of foreign objects, and with verbal and physical aggression towards others. Anna also presents with features of pathological demand avoidance and it is formulated that this can have an impact on her ability to maintain positive relationships with others.

About Kate:

Kate is a 39-year-old lady, who has a mild learning disability, emotionally unstable personality disorder, moderate depressive episode, and post-traumatic stress disorder. Kate was assessed and detained under Section 3 Mental Health Act in November 2021 at the Agnes Unit. Kate's mental state fluctuates regularly. Reassurance can have limited success' despite this Kate has built some trusting, therapeutic relationships with a number of staff at the Agnes Unit.

At the time of the incident Anna was being cared for on Pod 1 and Kate on Pod 4. They had both presented with levels of anxiety and experienced potential triggers over the 24 hours leading up to the incident.

What Happened:

Anna and Kate were both accessing the therapy suite on the Agnes Unit. Earlier in the day Anna had a tonic clonic seizure and one of Kate's allocated staff members left to respond leaving her with an unfamiliar member of staff. This is one of her documented triggers as well as loud noises (alarm sounding).

At the time of the incident, Anna was refusing her allocated staff asking them to observe her from outside the therapy room. Kate was standing nearby getting her art and craft items ready to go back to the next room. Anna threw a craft item at her allocated staff resulting in Kate becoming agitated and shouting that Anna should not hit staff, and also that she should not choose which staff work with her. Kate then tried to hit Anna. Staff quickly intervened. Then Kate threw some water towards Anna.

Staff were with both patients and verbal de-escalation was used with some effect and Anna was escorted from the room. Staff working with Kate stayed with her verbally de-escalating and allowing her to vent which helped; however she then turned on one of her allocated staff and accused him of being with Anna instead of her and she did not want to work with him again. The staff member disengaged leaving two allocated staff and the Shift Leader to verbally de-escalate which was effective. Kate then returned to the Pod and engaged positively.

At the time of the incident, copies of the individual care plans and positive behaviours support (PBS) plans were available on the electronic patient record and physical copies on each Pod, however there was no process in place to provide assurance that staff supporting patients had read them.

Following the incident, it was identified that there were gaps in recording accurate information on what happened and when therapeutic observations were undertaken in the electronic patient record in the incident notification forms. Records also did not contain enough detail, for example the use of safety interventions.

Good Practice:

There was evidence of daily review of Kate and Anna's mental and physical wellbeing by a daily board round or a weekly ward round.

A debrief was held with both Anna and Kate by the Matron and Charge Nurse following the incident to support them.

Staff were supportive and flexible to engaging both patients in meaningful activities.

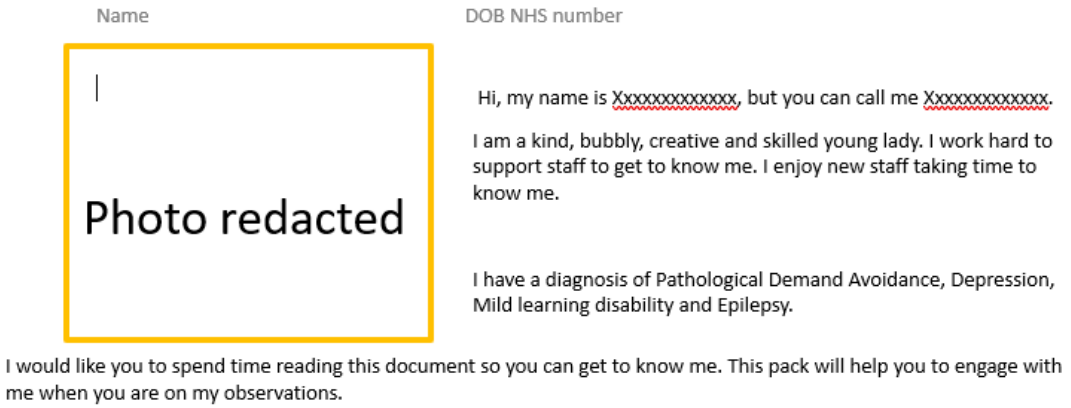
There is evidence of collaborative working and MDT discussions.

The Shift Leader de-escalated the situation well and followed the PBS guidance to positive effect for both Anna and Kate.

A short-term plan was put in place to allocate time slots for the therapy suite out of hours (evenings).

Learning:

Patient profiles (see below) are now available on each Pod to provide staff with a snapshot of essential information need to support each patient. Checking of this has been added to the Shift Leader Checklist which is done daily.



Name

DOB NHS number

Photo redacted

Hi, my name is Xxxxxxxxxxxx, but you can call me Xxxxxxxxxxxx.

I am a kind, bubbly, creative and skilled young lady. I work hard to support staff to get to know me. I enjoy new staff taking time to know me.

I have a diagnosis of Pathological Demand Avoidance, Depression, Mild learning disability and Epilepsy.

I would like you to spend time reading this document so you can get to know me. This pack will help you to engage with me when you are on my observations.

To support improvements of staff record keeping, development day training sessions were delivered over a 6-week period to ensure maximum staff could attend which included training on record keeping and completion of incident forms. An induction pack has been developed for new starters which includes information on incident reporting and the use of electronic systems used such as Brigid (for therapeutic observations), SystmOne (the electronic patient record).

Learning from the incident around the timetabling of patient access and use of the therapy suite in evenings and weekends has been taken on board and a clear timetable which reflects evenings and weekends is now in place. All patients now have a care plan that incorporates access to the therapy suite on weekends and evenings which identifies risk management of sharing the space with other patients.

NHS
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NHS Trust

Patient safety – learning from incidents.

Introducing Paul (not real name and some personal details changed to ensure anonymity).

A fifty-two-year-old gentleman who had a long history of alcohol dependence, records suggest that he disclosed he started drinking after sexual assault by 5 men in the past when he was twenty-five years old. (He had not discussed this with LPT staff, he wanted to discuss with a consultant) He was open to Turning Point and was due to be assessed by the crisis service on the day he died. His alcohol intake had increased over recent months and was reported to be drinking 2 litres of vodka a day and taking non-prescribed drugs obtained from street dealers, he was prescribed methadone and diazepam. Paul had been referred to Charnwood CMHT Outpatients for assessment in June 2024 but had not been seen by the time of his death (except a telephone call with team duty worker in June 24), his appointments were either cancelled by the service or the patient did not attend. He did have some contact with LPT Central Access Point (CAP) and was previously assessed by Crisis Resolution Team in October 2024 but was not in crisis and was discharged back to his GP. He was re-referred just before his death via LPT CAP but unfortunately was deceased when staff visited to assess further.

Physical Health: Liver cirrhosis. Diabetes Type 2 Gall stones High cholesterol.

What happened.

16.6.24- Paul rang LPT Central Access Point (CAP - Turning Point), reporting to low mood, suicidal thoughts, and self-harm by cutting. Internal Triage Questionnaire completed and referred for clinical triage which was completed later that day where Paul reported to be experiencing anxiety and depression and self-diagnosed Post Traumatic Stress Disorder following 2 traumatic events in the past (didn't disclose exact content).

Paul had moved in with his mother since his father had died to help look after her.

Paul hadn't worked since 2005 due to substance use (under Turning Point for substance dependency).

At the time of the assessment – Paul did not disclose his current alcohol use despite being asked the question directly, he admitted to self-harming, (cutting, and burning with kettle water). Plan: Refer to Community Mental Health Team (CMHT) for potential diagnosis and treatment. Prescribed by GP. Methadone 30mg Daily Diazepam 10mg BD Nitrazepam 10mg BD Zopiclone 7.5mg Nocte No note of current alcohol use or signs of intoxication. The assessment completed on 16.6.24 included a risk assessment which highlighted past alcohol & substances, however at the time of the assessment – Paul did not disclose his current use despite being asked the question directly.

20.6.24-Reviewed at Charnwood CMHT Referral Meeting Plan: To offer Outpatient clinic Assessment. At this point Paul had reported not to be using alcohol. The referral is a brief summary of the reason for referral it is not a full core mental health assessment, full documentation is on systmone for everyone working in DMH to see. The referral states Paul is taking methadone and not used heroin for 10years. There is no mention of alcohol use, however the assessment gives a history of alcohol use for approx. 10 years with periods of relapse when he consumed up to 3 litres of vodka.

24.6.24- Outpatient appointment sent for telephone consultation 8.9.24.

Outpatient appointment review booked for made for review for September but had to be rearranged for October due to unforeseen circumstances, during this time Paul contacted CAP for emotional support x 4 occasions with thoughts of suicide but denied wanted to end his life, discussed carer pressures and increased isolation.

Advised to contact GP for medication review whilst waiting for CMHT assessment and to engage with services such as mental health neighbourhood cafes, Cruse bereavement and victim first.

Discharge letter sent to CMHT, GP and Paul after each CAP contact and CAP reported to CMHT that Paul was struggling and needed support.

Paul was contacted by the CMHT duty staff member. Presented as anxious and spoke about his difficulties as a carer as well as previous alcohol and illicit substance use. Duty worker provided anxiety management and offered to make a referral to social care for carer support and GP to review medication, but both were declined.

Between July and October Paul was seen by his GP several times as well as in urgent care for injuries to his leg and hand and later presented with further injuries which he stated was caused by a self-injury due to carer stressors and had been drinking alcohol to cope.

A week later Paul DNA his outpatient appointment, not answering on 3 occasions. Letter sent with new appointment which was bought forward due to concerns raised. Paul also contacted the CMHT, there is no documentation to show what was discussed on this call.

Following this GP made a referral to CAP due to concerns raised by Pauls partner that he was isolating himself, had been obsessed by knifes and had been buying them on the internet and had caused self-injury with them. Paul was assessed by CAP following a number of failed attempts to call and referred to CRT due to guarded behaviour around risk to self.

During CRT assessment Paul initially wanted to speak to a consultant as he wanted to disclose a historical trauma event but would not disclose to CRT staff. Paul did speak of suicidal thoughts, no active plans although stated that he wanted to ensure when he attempts that he is successful. Paul also spoke of alcohol use and reported alcohol intake had recently increased, Paul asked that CRT to not tell turning point or GP of alcohol use as they may reduce his medication. It was mutually agreed that Paul was not suffering from any acute mental health illness which requires hospital admission or any support from the Crisis Team, Paul was referred to his GP. GP asked to refer Paul to some counselling for bereavement and historical trauma.

The following week GP was contacted by Paul's neighbour although Paul would not speak, it was reported he had been drinking a lot and had self-harmed with a knife. GP referred to CAP who contacted Paul and he requested an admission to hospital, staff were concerned at Pauls presentation as he was slurring his voice but declined alcohol intake, Paul was advised to attend A&E due to concerns for his physical health, ambulance called by CAP, the ambulance came the following day after being chased by CAP staff, police called due to Paul having a number of knifes and stating that he had a gun and was going to use on himself. Paul refused to attend A&E and over the following two days both police and ambulance crews attended the house on a number of occasions, eventually Paul attended A&E but self-discharged.

The following week Paul received a text message cancelling his appointment with the CMHT.

The following week Paul attended A&E after consuming large amounts of alcohol and taking an overdose of unprescribed medication. Paul was discharged when he was medically fit, no evidence of assessment by Liaison psychiatry team during admission possibly due to intoxication. Patient referred to CRT due to increased risk to self. CRT found it difficult to assess due to intoxication several attempts made over a couple of days, on home visit staff attended and mum reported he was passed out in his bedroom, when staff went to check him Paul was round to be unresponsive and appeared deceased, 999 called and death confirmed by paramedics.

Learning from the Incident.

1) No evidence of Liaison with Turning Point re Methadone Prescription & alcohol use when eventually disclosed to staff that use had increased.

2) On disclosure of weapons in possession, this needs to be added to the home page on EPR as a risk / notification

3) Referral for social care assessment & carers support should be considered where patients who are unwell have carer responsibilities

4) The communication channels between LPT & Turning Point need to be strengthened so that all professionals dealing with the patient have access to all the information

5) Review of the guidance for consultant cover to supervise junior doctors where the supervising consultant is on planned or urgent leave / sickness.

6) Next of Kin details to be reviewed throughout patients contact with the service and regularly updated to include consent to share.

7. Review of communication pathways between CAP, CRT & CMHT and escalation & expedition of requests for more urgent CMHT assessments or Crisis input in light of increased crisis episodes and contact with CAP

How We Improved.

1. Report shared with staff within a team meeting.
2. Have some communications surrounding the use of risk notification on Systmone within the Trusts Newsletter.
3. Learning Board to be developed around the role of a carer and the need for this to be reviewed when the carer is known to be struggling with their own mental health needs.
4. Feed into the QI work underway around Dual Diagnosis.
5. Review of the guidance for consultant cover to supervise junior doctors where the supervising consultant is on planned or urgent leave / sickness.
6. Next of Kin details to be reviewed throughout patients contact with the service and regularly updated to include consent to share.
7. Review of current pathway for escalations to CMHT's when patient is in frequent contact with urgent care