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Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Incident Learning Assurance Report - November 2024

Purpose of the report

This report for September and October 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. As Part of phase two of our improvement work, we have two work streams that are developing the skill and capability of teams to identify learning and design system based improvement actions as well as another stream who are developing a model to ensure that we have appropriate processes to horizon scan national learning and assess ourselves against this and where there are gaps or areas for improvement appropriate plans are put in place through our governance groups.

Rapid Improvement Programme

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

This phase of the rapid improvement has now concluded, and we have moved into a second phase designed to provide strength and resilience to the safety improvements with the aim of becoming clinical governance business as usual.

The workstreams included are: -

- **Directorate Governance**
- **Assurance**
- **Safety Investigation Processes**
- **Embedding and Auditing**
- **Patient, Family, Carer engagement**
- **Learning and Improving**
- **Safeguarding**
- **External Learning and Learning Culture**

Patient Safety Incident Response Framework (PSIRF)

LPT transitioned to PSIRF 1st November 2023 and continue to build on 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; LPT 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.

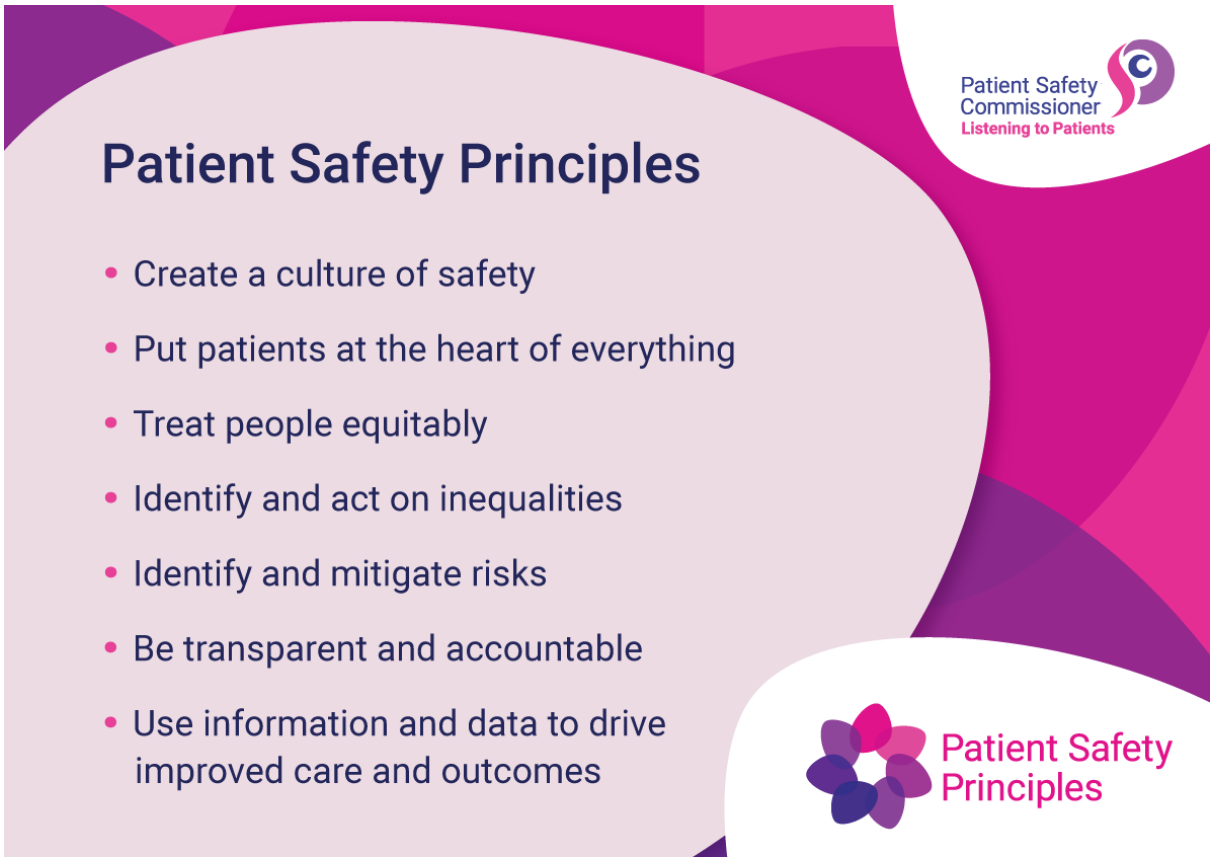
Feedback from staff has been positive and they appreciate the collaborative nature of the new investigation style and shared that they feel part of the process rather than being investigated (as per previous serious incident framework); we are starting to gather formal feedback from our staff involved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

There is a challenge due to capacity both within the investigation team and directorates to investigate in a timely way the areas described in our plan. The capacity management plan put in place and its associated focus has resulted in an improving position in relation to some significantly delayed reports. We have put in place an incident tracker meeting chaired by the CNO and have a trajectory to clear the backlog of overdue reports by end of November. In addition, we are increasing capacity to the investigators in the short term to ensure we continue to meet our deadlines.

This month we have seen the publication of the Patient Safety Principles

The Patient Safety Principles have been developed by the Patient Safety Commissioner in consultation with patients and act as a guide for leaders at all levels on how to design and deliver safer care for patients and reduce avoidable harm in a just and learning culture. These principles align with the NHS constitution.

The principles also support LPTs aim to ensure patients are equal partners in their care and in system-wide decision-making.



Safety Incident Response Accreditation Network (SIRAN)

LPT have undergone our interim review, and we are pleased to have retained our accreditation.
The standards are currently under review to ensure that they are aligned to PSIRF. As soon as they are published, we will assess ourselves against the new standards in preparation for re accreditation.

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.
SPC is used to provide data over time. This allows us to monitor the changes we are making are resulting in improvement.

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.
A review of the training requirements and the available capacity of the patient safety team to deliver training in relation to incident reporting and investigating particularly in relation to SEIPS 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. Where there is an increase in reporting seen on the individual SPC's this has been reviewed in the appropriate governance group and the reasons considered. We continue to encourage the reporting of incidents via patient safety governance groups and in directorate meetings. High reporting is considered as positive indication that staff are recognising and reporting incidents.

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

We continue to see normal variation (no statistically significant improvement) of the number of Category 2 and 3 pressure ulcers developed or deteriorated in our care, and some special cause concern peaks noted for category 4 pressure ulcers in the last three months. CHS Deputy Head of Nursing is undertaking a detailed review of the special cause concern incidents which have mainly occurred in patients in their homes, with outcomes and actions to be fed back through the strategic pressure ulcer group, patient safety improvement group and accountability framework meetings.

There has been a deep dive into the patients in the community and three of the district nursing hubs have shown as outliers for their number of pressure ulcers. There will be further work to now drill down into this data in order to understand what is contributing to this. For example, case load size, staffing skill mix and training and will be triangulated via the PU delivery group.

The CHS Pressure Ulcer Delivery group continue to implement and focus on the agreed actions including roll out of the Isla app to improve wound photography and response. They have now commenced a quality improvement project to enhance Registered Nurse oversight of Category 2 pressure ulcers and a pilot with LHIS testing Airmid to send pressure ulcer prevention leaflets to all new patients admitted to caseload due to start with East North hub in November 2024. They are also working with care agencies who are now using electronic record keeping for repositioning records. This means that our community nursing teams cannot have oversight of this and therefore work with carers to address any shortfalls in repositioning when they note deterioration.

It is national 'Stop the Pressure' day on 21 November 2024 with several activities planned to include:

- Stop the Pressure board competition.
- An education stand at Charnwood Mill
- Tissue Viability team have created a 'reel' video about repositioning for release to the public via social media with some 'top tips' about prevention pressure ulcers and repositioning regularly.
- E-blast with focus on repositioning and communication including signposting staff to all pressure ulcer prevention resources.

Falls Incidents.

- The rise in total number of falls seen in August continued in September (162) but October saw a drop (120). However, the number of moderate harm falls reported significantly decreased in Q2 (Q1 = 9, Q2 = 2)
- October saw a significant drop in falls on Gwendolen Ward, which is usually the highest reporter of falls incidents (Aug - 27, Sept - 28, Oct – 12) The ward looks after older males with organic mental health problems exhibiting behavioural and psychological symptoms of dementia of which aggression can often be a factor. The ward team presented to the falls group a deep dive and described recent actions which included timely MDT response to falls, mobility and toileting needs being included in daily handovers, optimising patient environment, improved seating reducing slips out of the chair and increased vigilance for patient with poor sleep.
- CHS have continued their weekly falls validation meetings and in October reported 0 repeat falls.
- Use of flat lifting continues to be embedded in post falls practice. For second month in a row there has been no hoist used post fall and training compliance continues to improve (CHS - 94.2 %, DMH -85.6%, Bank Staff - 76.5%).
- The Interim Executive Director of Nursing, AHP' & Quality has commissioned a 6-month review of falls data, themes, and trends to understand opportunities for further learning and improvement. This will be undertaken as part of safe staffing review and reported in the January Trust Board paper.

National Patient Safety Alert: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls (NatPSA/2023/010/MHRA).

- This alert is being led by our falls lead AHP Lead and Clinical Lead – this remains open past its closure date.
- Inpatient wards fully compliant with alert actions

LPT able to demonstrate compliance with MHRA actions apart from action 6 and 7.

> *6. Review all patients who are currently provided with bed rails or bed grab handles to ensure there is a documented up-to-date risk assessment. Complete risk assessments for patients where this has not already been done and for each patient who is provided with bed rails or bed grab handles.*
>
> *7. Implement systems to update risk assessments where the equipment or the patient's clinical condition has changed (for example, reduction/improvement in weight or mobility), and also at regular intervals.*

- This has been discussed as an LLR system and the situation raised *at the Regional Patient Safety Specialist meeting on the 26th of June 2024, NHSE regional team recognise that all systems are struggling to respond to the point – 'to ensure all patients have been reviewed regardless of whether they are active or inactive.' The Regional team have taken this point up with the National team and*

they will broach the subject with MHRA directly. The advice is to ensure a risk is recorded and covers pre–August 2023 as well as post August 2023 (the dates of the alert).

There is a Directorate risk on risk register for CHS (5734) as 98% of prescriptions attributable to CHS clinicians.

Deteriorating Patients.

The workplan for the Deteriorating Patient and Resuscitation Group (DPRG) has now been developed in response to the theming and recommendations from incidents that have been reviewed from across the Trust. At the last meeting, the group spent time going through these systematically and assessing progress and plans against them. Some are nearing completion and others following group discussion and assessment we have recommended to PSIG sit within other more appropriate governance groups. There is a small subgroup that have been meeting to determine next steps and progress with all of the actions outside of the main meeting as well.

There is work in CHS to consider the use of NEWS escalation and the response that staff receive in the out of hours period particularly. CHS are also considering as part of their PSIRF local priority; patients who are readmitted to the Acute trust within seven days of admission to CHS wards. This work is considering the suitability of patients to have been transferred and the nursing escalation of NEWS scoring and the response to this escalation.

The sepsis working group have completed their baseline data sets and again are working with the practice development nurses to disseminate training and knowledge skills across the directorates about recognition and management of sepsis. We have re-connected with representatives from the medical devices teams whose attendance at the meeting provided useful updates with regards to their no longer being a defibrillator battery supply shortage. The work towards Martha's rule has faced some barriers as this was initially designed for use in acute trusts, however the team have discussed potential options to overcome these and are planning to begin a pilot and monitor and refine and share as appropriate.

Medication incidents and Medication Safety

There has been an increase in the reporting of medication incidents. This is in direct response to a piece of work identified through reviewing the reporting from Wellsky where it was recognised that omissions in medicines administration on ‘in patient’ wards were often caused by not having the individual medication in stock or patients being transferred without the discharge medication. This included some high-risk (critical) and time sensitive drugs such as those prescribed for treatment of Parkinsons Disease symptoms, anticoagulants, antibiotics, and certain eye drops.

Medicines Risk Reduction Group has developed and supported Directorates to introduce:

- Standard Operating Procedure (SOP) and Local information/support to describe ‘How to manage out of stock at ward level’.
- The above SOP is now available on Staffnet.
- ‘High risk medicines’ list was added as appendix.
- ‘High risk medicines’ were also highlighted on Wellsky along with information and a link to reporting on Ulysses.
- CHS have been asked to add the SOPs to their highly valuable ‘what if’ resource folder found in their inpatient areas.
- A review and refresh of the medication incident categories on Ulysses was undertaken to support staff to report and make the system as easy as possible for them to do the right thing.
- Pharmacy and CPST are working together to update the medicines management training.
- High risk medication information along with video resources are available on the CPST intranet page for staff. This was also part of system wide initiative and work following information from UHL

Medical Examiner and family feedback.

We have seen an increase in medication incident category reporting as a direct result of information sharing/prompting the reporting of medication related to concerns. The 'tips' in the SOP has improved staff knowledge as to how to manage 'unavailable drugs' instead of just accepting they were not available on the wards. As a result, we have seen a drop in 'drug omissions. Our ongoing improvement is final completion of review and additional information to medication management training.

NPSA Alert - Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.

This alert is being led by the ICB and LPT are part of this working group, progress is reported through Weekly Alerts Review group through to PSIG.

All required measures implemented in LPT including full range of documentation live in SystmOne. No new patients under 55 can be initiated on Valproate without sign-off by a second consultant or pharmacist and the patient.

Groups related to self-harm and suicide prevention.

Trust self-harm and suicide prevention group

Review and analysis of the incident data in relation to self-harm has shown that the increase is in Community patients and correlates with the change made in July 2024 where 111 calls where option 2 Mental Health was chosen, and these calls were directed to LPT. Where a patient reports self-harm, the team are currently reporting this as an incident. 50% of these reports were patients not previously known to LPT and were reporting self-harm prior to accessing LPT services. This has been reviewed and as of November we will only be reporting incidents of patients who are open to LPT services.

In relation to in patient self-harm incidents, the highest reporting areas are Beaumont and Watermead. These wards have cohorts of patients at increased likelihood of multiple self-harm attempts. These patients are being managed through observation, environment, and psychological support.

Training dates are now in place for STORM suicide prevention train the trainers training – 25th November 2024. In addition, to pump prime the numbers trained funding has initially been agreed for 40 places for direct participant training this financial year. With additional place being considered in the next financial year.

LPT postvention offer (an offer to support those that have been affected by suicide to reduce their risk of harm) is in progress and will continue into 2025. There is an initial framework document for our staff postvention offer and this requires wider consultation with our staff.

The suicide prevention lead attended a suicide bereavement conference and has brought learning back to LLR in relation to a postvention offer for primary care services – contacts made with ICB safeguarding to progress.

National Confidential Inquiry into Suicide and safety in Mental Health (NCISH)
Our self-assessment is now complete, and this is now being written up to reflect both the good practice and areas for improving, this will be shared with the suicide prevention group in November 2024 for comment.

Our suicide prevention plan is out for directorate consultation. The plan reflects the national strategy and the above NCISH work on safer services. Expected date for completion will be moved to Feb 2025- (once complete will run for the next 3 years). The Trust Self-harm policy has been completed.

Staff access to mental health support –This is a piece of work being led by the suicide prevention lead and is currently out for consultation with staff to understand how they would best like to be supported. This will

be progressed with the aim of having a finished product by June 2025

Medicines amnesty – this is a project to reduce the risk of medicines that are no longer required or are being hoarded out of people's homes and returned to pharmacy, this is to help address the risk of suicide by overdose in our communities. This work originated from a local incident review. The practicalities of this are being developed and there is a plan to roll this out in March 2025.

There is currently no self-harm prevention training, and the suicide prevention lead has identified and reviewed training from Nottingham as part of our community of practice work and sharing good practice. This will be added to ULearn and available for staff to access by January 2025

MH Safe and Therapeutic Observations Task and finish group

The group is working on the following:

- 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 was due to commence at the end of September 2024 but there have been some delays in the coding requirements for the templates on SystmOne and the pilot has been deferred until Quarter 4 24/25.
- Reviewing the current training provision for substantive and agency staff – the training for substantive staff has been updated in line with learning from incidents and policy changes. Working with LPT's agency staff provider agency workers will be able to access LPT training via an external training site (learn LPT) and staff will be required to complete all 4 components required to be competent. Compliance will be reported to the agency provider and for part of contract monitoring. This process will be launched on 1st December 2024 offering 20 places per month.

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 – different bedding is being explored to promote comfort on some wards and individual patient risk assessment for not disturbing sleep.
- Training and competences –Workstream members are completing observations on engagement with patients during observations to inform training changes informed by patients and carers.

Medical Devices Oversight

Deteriorating Patient Group has oversight of key patient physical health observations equipment. As part of learning from near miss incidents, staff feedback and with the recommendations of the Medical Device and Resuscitation Teams best practice, we have reviewed key features of the Lifepak 1000 portable Defibrillators (defibs).

This equipment is trust wide and require the changing of the batteries to ensure its function when required, which, fortunately is very rare here at LPT. Currently Lifepak 1000 Defibs batteries are changed when they reach 1 bar, and a spare is kept on the emergency trolley. Unfortunately, although not significant, the risk was recognised incident reporting that the spare battery has expired. This was reviewed and identified that due to both batteries being purchased at the same time and this purchase date not being checked against the spare/stock appropriately rotated where we can. Staff are tasked with undertaking routine checks on the defibs, including checking the expiry date of the main and spare batteries to ensure they are replaced in time. Medical devices currently hold a number of spare batteries which can be provide should batteries be approaching their expiry date.

There is a proposal being developed which suggests that we change batteries in the Lifepak 1000 Defibs when they reach two bars (or reach their expiry date), and spare batteries will be held and managed centrally. This will ensure better stock rotation, save on battery wastage, and ensure a full in date battery is always available as required. We are starting to review the replacement of the Lifepak 1000's Defibs as the 'fleet' is ageing and part of this will be to review products with similar or better efficiency, reduce battery wastage adding to our carbon footprint/waste costs and engage staff in the choices of this from a training and competency/ease of use.

Gaining and revisiting assurance around Nasogastric Tube (NGT) safety for our patients

There have been recent incidents reported from one ward that were near misses where the process for testing placement of the NG tube was not followed. These incidents were reviewed at IRLM, and a series of immediate actions have been implemented by directorate around ensuring that staff are aware of and adhering to the correct process. There will be a full review of process and culture undertaken using Human Factors Methodology – this will include observation of process by our Human Factors specialist and a round table learning review using SEIPS. The timescales for this have been expedited and aim to have initial findings in four weeks.

An NGT improvement plan has been developed with actions linked to the outcomes of this self-assessment. A task and finish group has been set up and has been meeting since May 2024 to take this forward and is being monitored through Nutrition and Hydration Steering group that reports to Quality forum with updates given to Weekly Alert review meeting (WAR) and Patient Safety Improvement Group (PSIG). The work is supported by the quality improvement team to ensure we have robust safety improvement actions that demonstrate overall improvement once our initial 'groundwork' is completed.

This will be overseen by the Interim CNO and Medical Director and feed into a wider review and quality summit.

Culture/Duty of Candour

We are reviewing and updating our culture of candour policy and will update this in line with the National update expected to be published during November.
There have been no statutory breaches of Duty of Candour and compliance is monitored through the trust incident oversight group.

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 and progress 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 has now been 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.

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:	November 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:		