L

NHS
Leicestershire Partnership
NHS Trust

Trust Board - Patient Safety Incident and Incident Learning Assurance Report – January 2025

Purpose of the report

The overall aim of this report is to provide assurance that the Trust is meeting its responsibilities in terms of patient and staff safety. This report covers November and December 2024 and provides assurance on the management of incidents within LPT (Leicestershire Partnership Trust). It focuses on reviewing the systems of control in place to ensure they remain robust, effective, and reliable, reinforcing the organisation's commitment to continuous improvement in safeguarding both patients and staff through incident management and harm reduction practices.

Analysis of the issue

Patient Safety Improvement Programme

The **Patient Safety Improvement Programme (PSIP)**, has evolved from the previously implemented Rapid Improvement Programme, is now at the forefront of LPT's efforts to ensure that the safety measures put in place are not only maintained but continually improved to further enhance patient safety and the organisation's learning culture.

The workstreams are: -

- Directorate Governance
- Assurance
- Incident review/investigation
- Learning and Improving
- Embedding and Auditing
- Patient, Family, Carer Engagement
- Safeguarding
- External Learning and Learning Culture

The programme is structured to allow the Trust to fully transition from focused improvement actions to having these practices embedded and integrated into daily work, ensuring long-term benefits for patient safety and the overall quality of care provided.

Patient Safety Incident Response Framework (PSIRF)

The Trust is now one year on from the transition to the new Patient Safety Improvement Plan (PSIP). Key recent highlights:

Patient Safety Incident Response Lead Posts:

To strengthen oversight of local investigations, three Patient Safety Incident Response Leads have been recruited, one in each directorate on a fixed term 12-month contract. These roles will support the ongoing management and monitoring of local investigations, ensuring

consistency in the approach to incident reviews and response actions. The impact of these roles will be reviewed and evaluated.

Patient and Family Liaison officer (PFLO)

We have successfully recruited to this newly created post. The post holder will come into post in early February. This will complement the work already in place to support and engage with families, throughout the process from incident investigation and external review.

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.

It is important to recognise that while incident reporting is a valuable tool for tracking patient safety, it should not be viewed as a sole indicator of safety within clinical environments. Incident reports can, however, serve as an early warning system, highlighting trends or emerging issues within specific specialties or even across the broader Trust or healthcare system.

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 SPCs, this has been reviewed in the appropriate governance group and the reasons considered and analysis included under the groups section later in this report. 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.

Violence and Assault

Slide 9b in the Appendix shows a statistically significant increase in violence and assault incidents within DMH in November and December 2024. These incidents are reviewed at the Least Restrictive Practice Group for themes and to identify any learning. The group has already highlighted the increase to Quality Forum and explored the patient issues on Griffin Ward and the Beacon Unit and the assaults on staff leading to an increase in incidents requiring reporting under RIDDOR (there have been 17 RIDDOR incidents reported by Quarter 3 24-25, this compares with 17 for the whole of 23-24).

The five incidents reported in November/December all happened on Griffin ward and involved two patients with one member of staff involved in two of these incidents. These incidents all resulted in sickness absence. The staff affected have all been supported and all staff on the ward offered opportunity for psychological de brief or a period of alternative duties to reduce the risk of burn out.

In December, the incidents on Griffin reduced as patients progressed through treatment plans and on the Beacon Unit self-harm episodes requiring staff holding intervention has reduced slightly. There has also been an increase in safety interventions used at lower levels to hold patients for personal care at Mill Lodge due to the patient's clinical condition resulting in challenging behaviour; the trust is exploring care holding training from our existing safety intervention provider to support patients and staff going forward.

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

SPC Charts: Show normal variation for Category 2 and 3 pressure ulcers developed or deteriorated in our care indicating that there has been no statistically significant improvement. The data also shows special cause concern identified for the number of Category 4 pressure ulcers; further analysis identifies that this increase is all attributable to patients under the care of community Nursing.

- **NHS Community Nursing Benchmarking**: The mean number of pressure ulcers acquired per 100 unique service users is 4.3 for NHS Community Nursing and 4.5 for CHS Community Nursing. Meaning LPT are slightly (0.2) above the mean.
- **Category 4 Pressure Ulcers:** Analysing the increase this is attributable to patients under the care of CHS, in community nursing care. There were four historical cases in community hospitals however no new 'in patient' category 4 pressure Ulcers have been reported for inpatients since March 2024. No Category 4 pressure ulcers have developed or deteriorated in DMH or FYPC/LDA.
- **Validation Process**: The Deputy Head of Nursing and matrons for Community Hospitals conduct weekly pressure ulcer validation meetings to confirm, challenge, and share learning.
- **Outlier Hubs**: A review of community nursing hub data identified three outlier hubs for patients who have developed Category 4 pressure ulcers in our care based on case numbers; City West; East Central and Hinckley. Additionally, Charnwood hub, with the largest caseload (1,035 patients), was identified as an outlier, with 0.1% of patients having a new ulcer and 1.0% with active Category 4 care plans.
- **Care Review Process**: Each patient who has developed a Category 4 pressure ulcer whilst in our care is reported as an incident, verified by a Tissue Viability Nurse (in person), and reviewed through a Multi-disciplinary Team (MDT) process using a standardised template designed to elicit the key areas for learning. From mid-November 2024, Category 4 pressure ulcers have been reviewed using a pilot Initial Service Managers Review (ISMR) template.
- **Themes identified with the opportunity for learning**: Including complex patient factors (e.g., multiple comorbidities, end-of-life care), an increase in heel ulcers, challenges in patient/carer understanding and adherence to prevention plans, issues with staff monitoring, incorrect categorisation leading to inappropriate prevention plans/equipment, and delays in necessary equipment provision.

Actions Being Taken in response to the above:

These actions have been shared with Quality Forum and Quality and Safety and progress will be monitored at these groups for their impact.

- **Category 2 Pressure Ulcers Review**: Starting from December 2024, 8 patients who have developed Category 2 pressure ulcers whilst in our care (1 per hub) are being reviewed monthly through the MDT care review process, focusing on prevention, early learning, and actions to prevent deterioration. This will be evaluated after three and six months for impact.
- **Complex Care and Tissue Viability Collaboration**: Senior nurses for complex care in City West, East Central, and Hinckley are working with Tissue Viability teams to review care reviews and provide focused staff education using various delivery methods and resources.
- **Incorrect Categorisation**: a programme of additional training has been implemented as well as peer review to oversee and address any incorrect categorisation early as well as to assess the impact of the additional training.
- **Quality Improvement Sharing**: Learning from the Group Pressure Ulcer Prevention (PUP) quality improvement project was shared through the CHS delivery group in December 2024, with a focus on "Keep Moving" and nutrition & hydration. The project is now being spread and will inform a system-wide project focussing on information for patients, families and carers that relates to prevention, nutrition & hydration and keep moving.
- **Quality Account Priority (2024/25)**: The Pressure Ulcer Prevention through Repositioning quality improvement project, launched in April 2024, will run through to March 2025. Quality reporting will be provided to the Quality Forum and the Strategic Pressure Ulcer Group.
- **Applying Safeguarding thresholds in relation to reporting pressure ulcers to local authority:** Currently reviewing the ability to link these standards to Ulysses and reassess the categories as well to ensure that all Pressure Ulcers are assessed and reported appropriately to Local Authority.

Falls Incidents.

Gwendolen Ward (November):

- There was a reduction in patients who fell in November 2024, this is however partly attributed to a lower level of occupancy.
- DMH has identified a theme of falls related to physical health issues. They continue working on improving the falls huddle process and ensuring timely post-fall learning, especially for wards with fewer incidents.
- Ongoing audits are taking place in DMH and CHS are looking to do the same soon to ensure adherence to fall prevention processes.

CHS (December Deep Dive):

CHS undertook a ‘deep dive’ review into those patients who have fallen in our inpatient wards.

- Patient falls were found to occur more frequently around mealtimes and medication rounds.
- CHS is reviewing the use of enhanced care, conducting spot checks of falls risk assessments, and reviewing care plans.
- Weekly validation meetings to review patients who have fallen is considered to have contributed to a reduction in repeat falls and a decrease in patients suffering from moderate harm because of falling.
- There is a focus on improving practices for monitoring lying and standing blood pressure of patients, with an updated SystmOne template anticipated to support this.

- Stable staffing on the wards has been reported to be a positive factor in reducing falls.
- Flat lifting equipment use to lift patients off the floor (as reported in the November 2024 Trust Board report) following a fall is being used appropriately, with no inappropriate hoist usage reported.

A meeting is planned for January 2025 to review falls incidents from December 2024.

Deteriorating Patients.

Progress on the Deteriorating Patient and Resuscitation Group (DPRG) work plan has continued, with the Lead Nurse for Patient Safety who is assisting in the oversight of the actions from investigations that are being managed to completion by DPRG.

The focus remains on embedding non-contact observations training into practice, with ongoing discussions regarding which staff are required to complete the training and how compliance will be tracked for the Trust.

The new Sepsis policy (that was previously part of the Deteriorating Patient policy) has been finalised to both raise the profile of the management of Sepsis and for ease of access by staff. This has been circulated to relevant stakeholders for feedback.

Mental Health Safe and Therapeutic Observations Task and finish group

The group has paused meetings since autumn 2024 as phase one improvements in the policy, guidance for staff and training was updated. During this period there has been 3 workstreams still meeting and progressing improvements:

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. The App monitoring tool has been redesigned to make it clearer and quicker for staff to log during an observation. The group are currently waiting for Snowmed code descriptors to be finalised for each element they may see during observation. Large screens have been purchased for wards to support at a glance reviewing of patients on observations and will enable alerting when they are due or late. A pilot was due to commence at the end of September 2024 but been deferred until Quarter 4 24/25.

- Reviewing the current training provision for substantive and agency staff and offering training to agency staff has commenced.
- LPT and NHFT have formed an Improvement Collaborative and are taking forward 2 areas as quality improvement projects, the 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; this has maintained representation from the trust and the Agnes Unit is part of the pilot.
- The training and competences workstream paused whilst some national work within the Mental Health and Learning Disability Directors of Nursing Forum took place and a set of workforce and training principles are due to be published in quarter 4. The Deputy Director of Nursing and Quality has been leading one of the workstreams within the national work.

The work programme of the main group is due to recommence in February 2025 and will also involve CHS to consider a revised special observation tool.

Medication incidents and Medication Safety

There continues to be a statistically significant increase in the reporting of medication incidents and as described in the November 2024 Trust Board Report, this is in direct response to teams working together to improve the number of omitted medicines for our patients.

The work has involved raising awareness/knowledge of the impact of late or omitted high risk medicines. These are particularly relevant for patients taking medicines to manage Parkinson disease symptoms where effects can impact quickly. In addition, some of which can lead to increased risk of falls.

Key features of this work are:

- A link has been included within Wellsky prescribing system to prompt incident reporting when patients' medication is not available or is delayed. This is being reviewed and evaluated to ensure it is supportive for staff.
- Pharmacy and CPST are reviewing/expanding the medicines management training in relation to recent learning described above around omitted and delayed medication administration. This is in the final stages of review and overseen by Medicines Management Committee (MMC). Strengthened information related to medication management has been included and the updated information. Up to date resource links have been included in relation to the National medication safety work. Organisation Development will update on U Learn when this review is complete.
- To continue to monitor the effectiveness of the circulated omission/delay reports shared with senior clinicians/leaders in the workplace for the continued ownership /support with staff responsible for medicines administration.

Learning from National reports.

A 'Prevention of future deaths' report (Ref: 2024-0635) issued by HM coroner to another NHS trust was reviewed by CPST and medicines management for cross learning. This described the risk of Olanzapine depot medication (long-acting anti-psychotic) this had been considered to have caused a patient's death due to the depot being administered in an inpatient setting that was not usual and the post injection monitoring was not undertaken.

We are reviewing system wide to establish if there are any learning/actions for LLR by reviewing the pharmacy/prescriber findings described to ensure that our systems/processes are clear and are supportive of effective prescribing/administration.

The compliance team are also using the learning to inform our mock inspection programme of CMHT's and doing these in partnership with Pharmacy colleagues.

Trust self-harm and suicide prevention group

Incident Data Related to Patients/Individuals Self-Harm:

Central Access Point Incidents:

Observation: The highest reporting incidents are still originating from the Central Access Point, which has seen an increase due to the introduction of the 111 option

2 service. This change has caused an uptake in persons reporting self-harm, particularly involving individuals who are not under the care of LPT or awaiting any of our services input, however, still trigger incident reporting.

Impact: These reported incidents reflect individuals who may not yet be under formal care, which could skew data regarding self-harm occurrences within LPT wards. This is acknowledged when analysing trends to avoid misinterpretation of the data. An agreement is in place to not report incidents for patients who are not under LPT care. However, this is being phased in to ensure staff understand the need to continue to report safeguarding incidents.

Beacon Ward:

Observation: There's been a significant reduction in self-harm incidents on Beacon Ward. This change is attributed to the recovery and discharge of two patients, along with the implementation of a self-harm reduction quality improvement (QI) project on the ward.

Impact: The reduction could be a direct result of both the discharge of individuals and the focused efforts of the QI project. Continuing to monitor the impact of the QI project is important to ensure that the reduction is sustainable.

Heather Ward:

Observation: A QI project has commenced on Heather Ward which includes focusing on staff care/therapeutic interventions being implemented at times of the day that have been analysed as peak reporting times for self-harm incidents

Impact: like Beacon Ward, whilst it is still too early to report a statistically significant improvement, the success of the QI project on Heather Ward could be key in creating long-term reductions in self-harm incidents, highlighting the value of targeted staff care/therapeutic interventions.

Beaumont and Watermead Wards:

Observation: The highest number of inpatient self-harm incidents are occurring on Beaumont and Watermead Wards. Since transition to an all-male ward, Watermead incidents have significantly reduced in a short space of time. Analysis has identified Incidents are linked to a small cohort of patients on each ward during the acute phase of their illness. Staff are also reporting incidents where they have been alerted to a possible self-harm event, and as a result, they have been able to intervene at a low level to prevent harm. This reporting provides the opportunity for patient's risk assessments to be reviewed and updated.

Training Initiatives:

Suicide Prevention Training (STORM):

- **Observation**: Over the past two years, LPT had a gap in specific suicide prevention training, but the STORM Training has been reintroduced. Six PDNs

were trained in November 2024, and further training will commence in small groups, with an aim to train 12 staff members over two days. a

- **Impact:** The reintroduction of targeted training like STORM is crucial to building skills for managing self-harm and suicide risk.

Postvention Initiatives: (extending to staff in LPT and families in Primary Care)

LPT Postvention Strategy:

- **Observation**: Postvention is designed to support anyone affected by suicide to reduce their own risk of harm by suicide. A draft SOP has been created, and the next meeting of the task and finish group is scheduled for early February 2025. This work aims to integrate postvention into the broader Post Incident Pathway for Staff Support (PIPS) pathway.
- **Impact**: The development of a clear postvention strategy is critical for providing ongoing support to those affected by suicide. If successfully rolled out, it could reduce future risks and enhance recovery efforts within the community.

Toolkit for Primary Care:

- **Observation**: A postvention toolkit for primary care services, developed by a GP in Derbyshire ICB, is in the process of being rolled out in LPT by the suicide prevention lead and overseen by the suicide prevention group. This toolkit provides guidance on offering support to those bereaved by suicide.
- **Impact**: The toolkit could serve as a vital resource for primary care providers and help LPT better address postvention across its services. Support from local GPs for adoption will be important to ensure its successful implementation.

Medicines Amnesty:

Planning and Execution:

- **Observation**: A medicines amnesty is scheduled to commence March 2025, this has been developed in response to findings from incident reviews and is a joint project by the suicide prevention group, medicines management group and the LLR interface pharmacist. The aim of this is to reduce the risk of suicide by medication overdose. This initiative will support the removal of unused medications from homes and therefore availability.
- **Impact:** Medication overdose is a common method of suicide, so this initiative could be significant in reducing suicides in LLR. Ensuring engagement from the public and coordination across relevant services will be crucial for success.

Conclusion:

LPT has made progress in addressing self-harm and suicide prevention, with several key initiatives in place, including the development of postvention strategies, targeted suicide prevention training, and the medicines amnesty.

Culture/Duty of Candour

We are reviewing and updating our culture of candour policy and will update this in line with the outcome from the National consultation published at the end of 2024.

There have been no statutory breaches of Duty of Candour in the reporting period and compliance is monitored through the trust incident oversight group (IOG). We continue to ensure we have a culture of openness and transparency.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC

The Trust has a process in place to inform Commissioners and the CQC of any significant incidents. This proactive communication helps ensure that these stakeholders are aware of important developments and can provide guidance or support as needed.

This practice reflects the Trust's commitment to transparency and accountability, ensuring that external bodies have the information necessary to provide oversight and assess the effectiveness of the Trust's incident management systems.

As part of the ICB Enhanced Quality Assurance and Improvement Review, LPT presented a deep dive session on patient safety learning events on 23 December. The ICB and partners took full assurance from the deep dive.

Learning from Deaths (LfD)

In January 2025, the Learning from Deaths Clinical Lead post will be advertised, and the recruitment process will commence. This important role will be pivotal in building on and strengthening the work already undertaken by the Trust in relation to the Learning from Deaths (LFD) process. The primary focus of this role will be to identify key learning from patient deaths by thoroughly analysing themes**,** gaps in service provision**,** and potential health inequalities that may contribute to reducing life expectancy. The group are assured in relation to the identification in relation to the data of those deaths that are in scope for LPT. There is still further work to improve the availability of accurate and complete demographic data on SystmOne to support in depth analysis of any possible health inequalities. Our links with the Medical Examiner office continue to strengthen with a flow of feedback being received, the majority of this is for CHS community patients in relation to End of Life Care.

The group have also strengthened links with the LeDeR process and have received reports on thematic learning and associated actions commenced. The Chair is now supporting work to replicate this learning with the Child Death Overview Panel (CDOP)

Decision Required

Briefing – no decision required	
Discussion – no decision required	**x**
Decision required – detail below	

Governance Table

For Board and Board Committees: Paper sponsored by:	Trust Board James Mullins, Interim Director of Nursing, AHP's & Quality	
Paper authored by: Date submitted: 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): If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured: 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	Tracy Ward, Head of Patient Safety January 2025 N/A N/A	
LPT strategic alignment:	Great Health Outcomes Great Care Great Place to Work Part of the Community	✓ ✓ ✓ ✓
CRR/BAF considerations *(list risk number and title of risk):* Is the decision required consistent with LPT's risk appetite: False and misleading information (FOMI) considerations: Positive confirmation that the content does not risk the safety of patients or the public		