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Leicestershire Partnership NHS Trust

Public Trust Board - March 2025

Patient Safety & Learning Assurance Report for January and February 2025

Purpose of the Report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed and refreshed to assure that systems of control continue to be robust, effective, and reliable thus underlining our commitment to the continuous improvement of incident and harm minimisation.

The report will also provide assurance around Being Open, numbers of investigations and the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the Issue

The 'top 5' reported patient safety incidents are considered and reported on in this paper; however, it should be noted that in addition all incident types for the reporting period are reviewed, to establish changes within all categories that may present emerging themes for wider consideration.

Review of Top 5 reported patient safety incidents

During January and February 2025 there were 3041 patient incidents reported that were classified as "incidents attributable to LPT" and "Incidents affecting patients". The top five reported incidents account for 60% of all patient incidents reported during this period and are explored in order and in more detail below. This equates to an average of 1520 incidents per month during January and February 2025.

Top 5 reported patient safety incidents January and February 2025

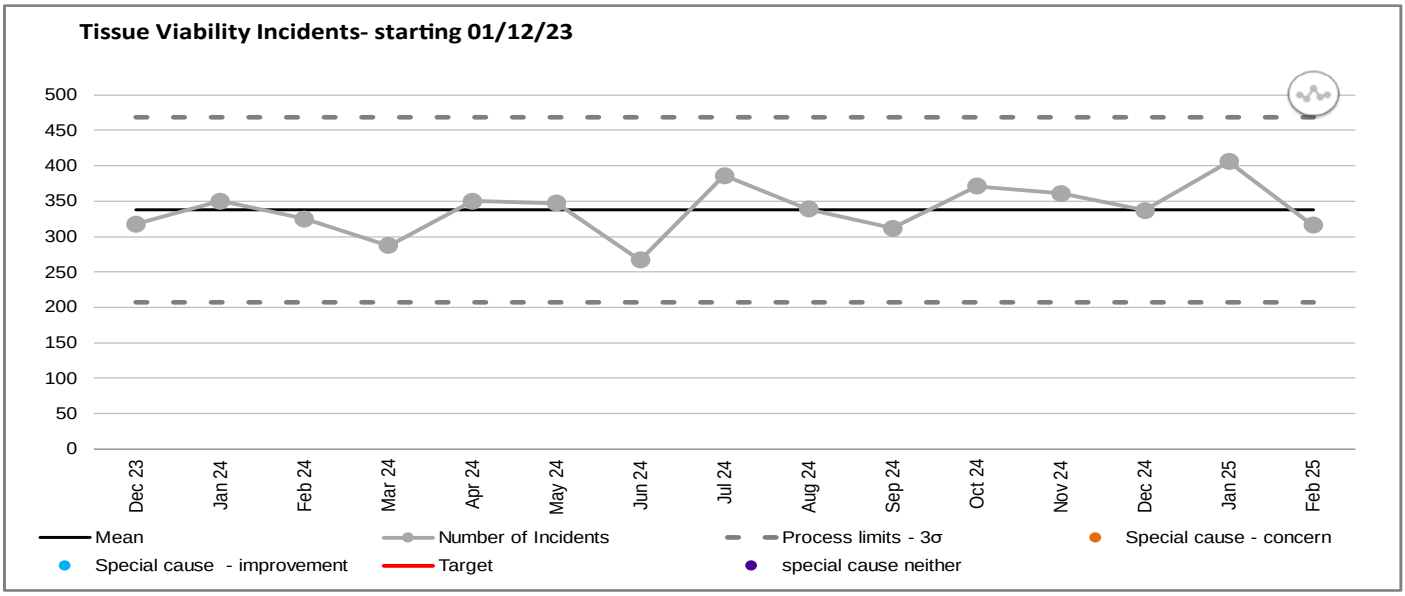
Category	Number of incidents	Directorate with highest % of the total reported
Tissue Viability	720	CHS 98.2%
Self-Harm	413	DMH 66.34%
Falls	254	DMH 51.57% CHS 42.13%
Violence and Assault	237	DMH 73.42%
Clinical Condition	208	DMH 47.6% CHS 41.83%

Degree of harm recorded for all patient safety incidents for January and February 2025

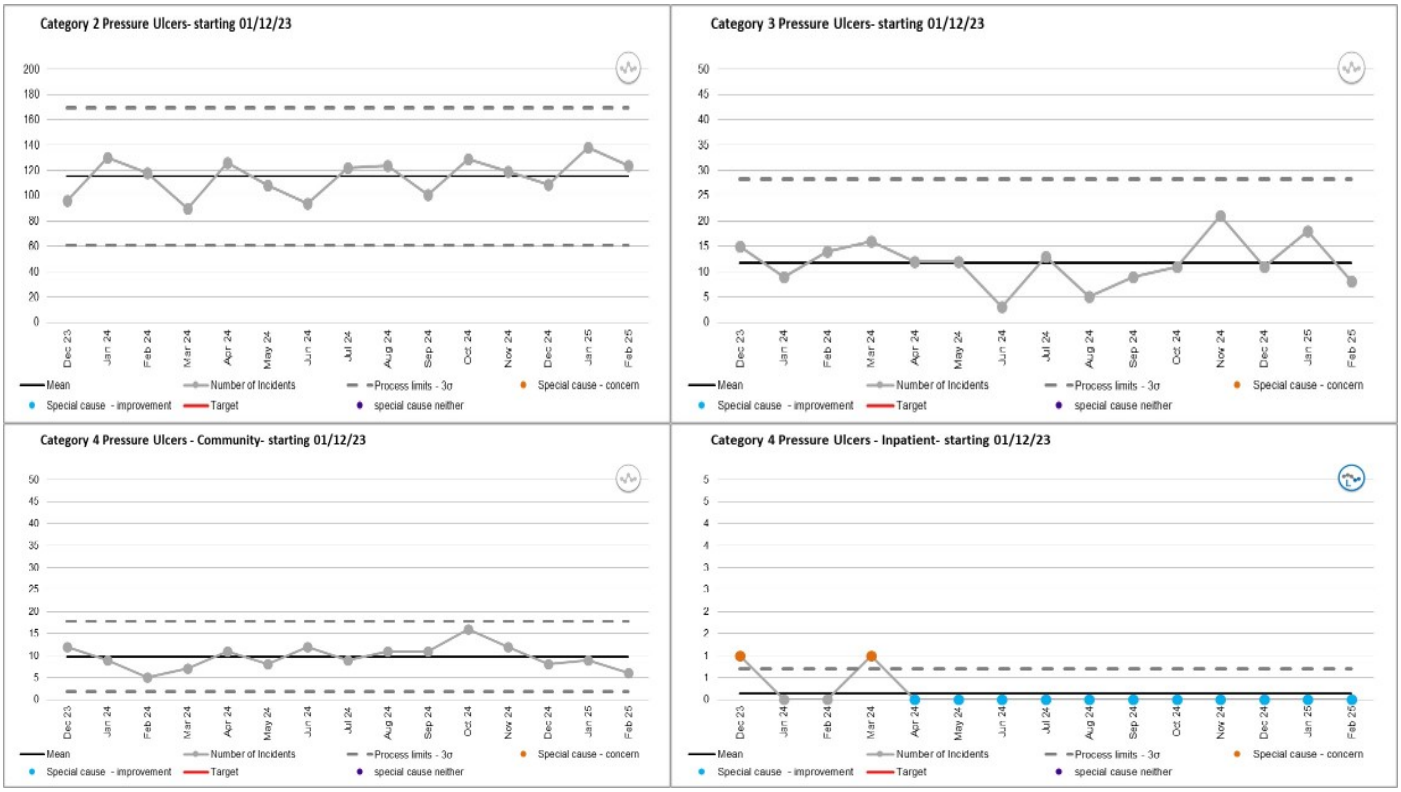
Reported degree of harm	Number	% of total incidents reported
No Harm	1640	53.9%
Minor/Low Harm	1332	43.8%
Moderate Harm	27	0.89%
Severe Harm	2	0.07%
Death	40	1.32%

NB these incidents were reported in January and February 2025 and will be being reviewed through local and corporate governance structures and degree of harm may change. Since moving to the LFPSE there is a requirement to report incidents by harm to the patient even if not as a result of your organisations care. This will account for the increase in number of deaths reported compared to the reporting period last year.

1. Tissue Viability this includes Burns/Scalds/Moisture Lesions/Medical Device Injury/Podiatry Pressure Ulcer



23.68% of all patient safety incidents reported relate to 'Tissue Viability' during January and February 2025; this equates to 720 incidents. This category includes pressure ulcers on admission, developed or deteriorated in our care, skin tears, scalds, wounds, and moisture associated skin damage. As Pressure ulcers (category 1,2,3,4 and unstageable) represent 71.94% of these, we will focus on this aspect of patient harm. Of all tissue viability incidents, 82.78% were logged as a cause of 'minor/low' harm to our patients in CHS.



There were 279 Category 2,3,4 pressure ulcer incidents reported as developed or deteriorated during patient care in CHS, of which 90% were reported in community nursing services and 10% reported in community hospitals. Review of Trust wide SPC has identified normal variation for Category 2 and 3 pressure ulcers developed or deteriorated in our care and special cause concern noted for Category 4 pressure ulcers.

In community nursing services it is noted that there has been a 2% reduction in category 2 pressure ulcers; a 3 % increase in category 3 pressure ulcers and a 23% reduction in category 4 pressure ulcers developed or deteriorated in our care in the last 2 months compared to the previous 2 months. The following hubs have been identified as outliers above the mean number of incidents; Charnwood, Northwest, Hinckley, and City West overall. A review of the outlier hubs is to be presented to the CHS pressure ulcer delivery group on 21 March 2025 which will take into consideration wider interdependencies such as caseload size and patient factors.

A number of quality improvement projects are in place including HCSW pressure ulcer prevention education visits in Northwest Leicestershire hub for patients at high risk, RN oversight and review of patients with a category 2 pressure ulcer in Northwest. Senior Nurse for complex care in Hinckley delivering bespoke staff training, reflective practice/ supervision sessions and events to promote staff learning in response to incidents. Repositioning project being trialled in Rutland to send electronic patient information using AIRMID on admission to caseload.

In community hospitals, it is noted that there has been a 16% increase in category 2 pressure ulcers developed or deteriorated in our care in the last two months compared to the previous 2 months. There were no Category 3 or category 4 pressure ulcers developed or deteriorated in our care. Special cause improvement noted that there have been no category 4 pressure ulcer incidents developed or deteriorated in community hospital care for 12 months. The Deputy Head of Nursing has led weekly pressure ulcer safety huddles, introduction and support of Tissue Viability nurses

working across the service to support clinical teams, learning, sharing, and embedding actions to improve assessment, pressure ulcer prevention strategies and continuation of the 2024/25 quality account priority focusing on repositioning.

Pressure ulcer harm is a nurse sensitive indicator linked to safe staffing. There has been no evidence through the monthly safe staffing reviews that staffing was a contributory factor. The MDT care review process of Category 2 and Category 4 pressure ulcers has highlighted there are opportunities to improve categorisation of pressure ulcers, repositioning, escalation of concerns and senior nurse oversight.

During January and February 2025, the CHS directorate, together with the patient safety team, reviewed and strengthened the process for review of these Pressure Ulcers by designing a tool for theming as they are reviewed.

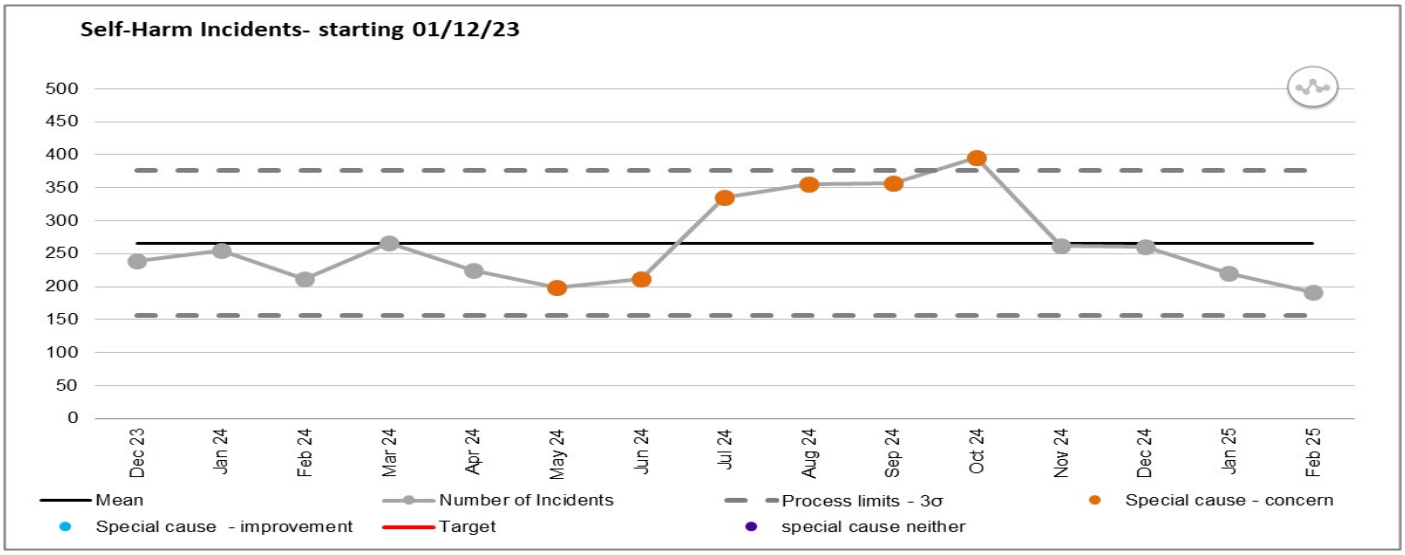
In early January 2025, 3 PU incidents (from December 2024) came to IRLM with the outcome of no further review needed and actions to be progressed. Two were CHS and one was DMH. Early learning and actions were confirmed as appropriate and to be progressed.

11 Category 4 pressure ulcers were reviewed in January February 2025 through a bespoke ISMR and IRLM. The themes were collated and reported to the PU Improvement Delivery group. The process for review has been strengthened to allow specialist focus at an MDT Review of care, this commences in March 2025.

20 Category 2 pressure ulcers are reviewed through a monthly MDT review of care by DHON, Matrons & Tissue Viability Nurse with Head of Service (one CAT 2 PU per hub identified monthly for this review). Themes are identified and reported to the PU Improvement Delivery group for review.

The quality account priority for 2025/26 is currently being scoped with a focus on reducing Moisture Associated Skin Damage (MASD) and category 2 pressure ulcers developed in our care. NHFT have shared learning from a quality improvement project as part of the initial scoping.

2. Self-Harm



There were 413 self-harm incidents reported during January and February 2025, this equates to 13.58% of all reported incidents during this period.

During the previous reporting period there were 523 self-harm incidents reported, this shows a decrease of 21.03% during the current reporting period. This reduction is as a result of previously reported work with the CAP team who are stopping reporting incidents relating to patients that are not open to LPT since November 2024.

The number of incidents has been analysed and over the reporting period there are 3 areas with a significant number of self-harm incidents reported relative to the total number (413) of such incidents reported; CAMHS Beacon Unit - 69 incidents (16.71%), Central Access Point - 57 incidents (13.8%) and Heather ward with - 40 incidents (9.69%). Heather ward have consistently reduced incidents prior to the last report and 17 of the 24 incidents were related to 4 patients on the ward. Heather ward has consistently reported less incidents month on month since the self-harm reduction QI work started and this has been recognised by the regional Community of practice work group. As such, the process the ward are using is doing more of what works rather than restricting and removing items. Heather ward being nominated for an award for the innovative approach we are taking with East midlands Alliance.

Overall, of the 413 total reported self-harm incidents, 236 (57.14%) have been reported as minor/low harm, a further 172 (41.64%) have been recorded as no harm, 4 (0.97%) have been reported as moderate harm, with the remaining 1 (0.24%) incident being reported as severe harm.

Of the 3 areas (CAMHS Beacon, Heather Ward and CAP) discussed above; there have been no incidents reported as moderate or severe harm. Of the 69 incidents reported by CAMHS Beacon, 44 (63.77%) were recorded as minor/low harm with the remaining 25 (36.23%) as no harm; of the 57 incidents reported by CAP, 28 (49.12%) have recorded as minor/low harm with the remaining 29 (50.88%) being recorded as no harm; and Heather ward have recorded 32 (80%) as being minor/low harm with the remaining 8 (20%), being recorded as no harm.

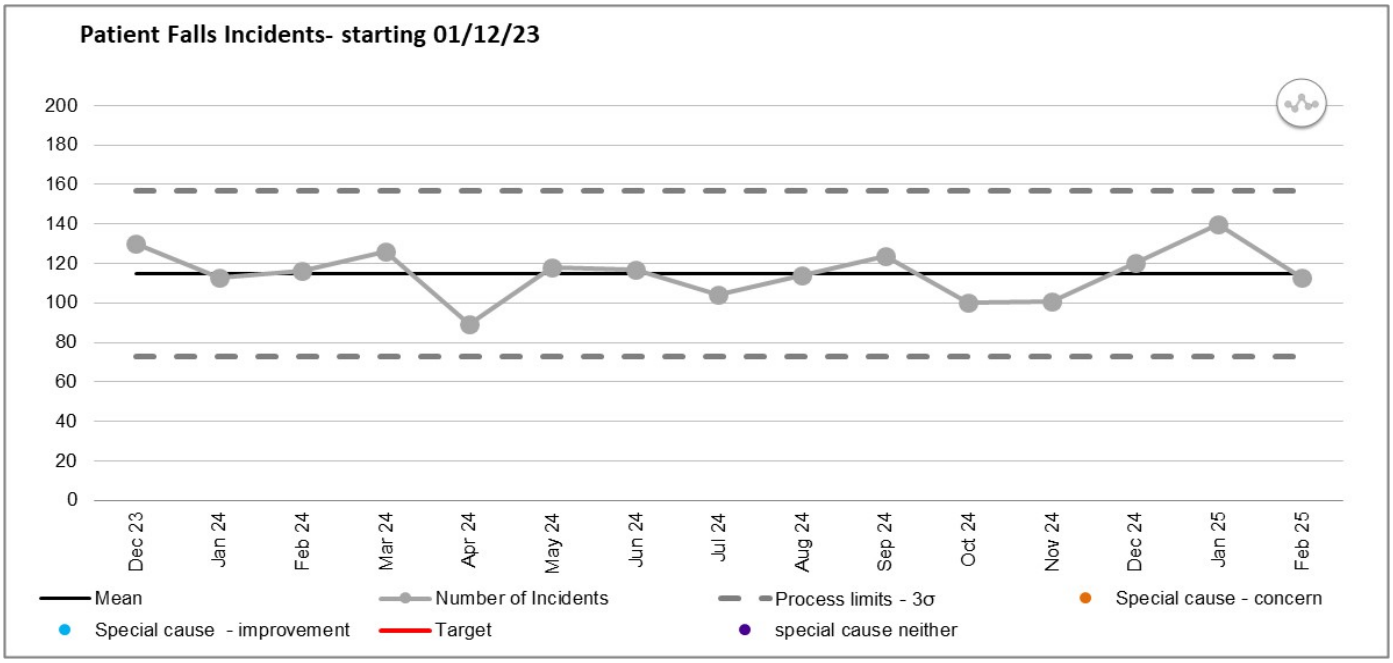
Self-harm incidents are reviewed in directorate and actions taken. Three incidents were escalated for review at IRLM, on review it was confirmed that appropriate actions were in place including continued support for the patients.

Quality Improvement

The suicide and self-harm prevention lead has been reviewing National learning and assessed LPT against this. Evidence identifies that self-harm features in over 60% of those that have died by suicide. This review has identified that there is currently no additional training for staff (over and above their professional qualification) in relation to self-harm and together with the Self Harm and suicide reduction Group have articulated a risk in relation to this with a series of actions and management plan. A training package has been obtained and reviewed. We are working to get this available on our Ulearn platform. In addition to this, improvements to **Safety planning** are part of the strategy to support patients and this is being progressed. The Trust have developed a safety plan template available on SystemOne and in line with QI methodology, this is being trialled initially with one Community Mental Health Team, the Crisis Resolution Team, and Mental Health

Facilitators. Feedback will be reviewed and supporting guidance on safety planning is being drafted by the suicide prevention lead, the final version will be available to all services.

3. Patient Falls, Slips and Trips



There were 254 falls during January and February 2025 representing 8.35% of all reported incidents. During the previous reporting period there were 221 Falls incidents reported, this shows an increase of 14.93% during the current reporting period.

Numbers of falls have been analysed and over the reporting period Coleman Ward at the Evington Centre reported 27 out of a total of 254 which equates to 10.63%, with Langley ward reporting 24 falls which equates to 9.45%. However, using the last 6-month trend analysis, Gwendolen Ward at the Evington Centre were the highest reporter of Falls over this time.

This data together with the 6-month trend analysis does not identify a change in reporting.
During this period, 3 falls were reviewed at IRLM; 2 resulted in no further action for the group and 1 was identified for local directorate review to allow conversation with staff to understand the challenge. There have not been any identified interdependencies with safe staffing.

CHS
The significant reduction in repeat falls reported over the autumn has not been sustained with a rise in numbers since December. January showed 12 patients having 1 x repeat fall and one patient having 2 repeat falls. Data also shows a slight rise in unwitnessed falls in this period across 10 hospital wards.

MHSOP
It was reported that the significant reduction in falls on Gwendolen in Dec /Jan was related in part to the reduced number of patients on the ward. However, there had been a general rise in number of repeats falls in MHSOP due to a small number of individuals falling repeatedly.

FYPLDA

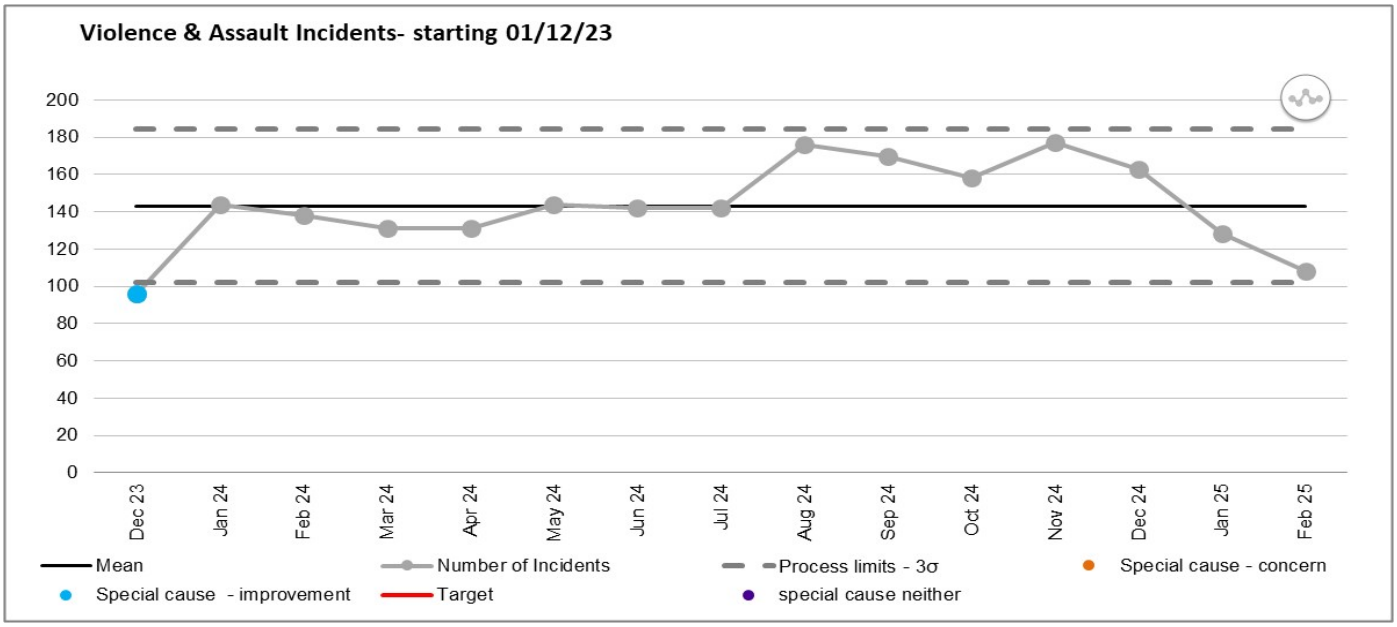
Directorate normally report quarterly due to low number of falls; however, it was noted that in January there was significant rise in number of falls in the Agnes Unit; data showed there were 24 falls during the reporting period. Prior to this date there had been no falls for the previous 6 months on either area. The directorate reported that this was related to one patient who repeatedly placed themselves on the floor and they had moved between the two Pods.

QI Initiative

Medications and falls.

- A senior pharmacist has undertaken a piece of work exploring the relationship between Anticholinergic burden (ACB) and falls. The Audit on MHSOP and CHS wards demonstrated clear causal link with a high ACB score and falls. Recommendations have been made to monitor ACB levels and identify trigger to have medication reviewed and falls care plan that both consider reducing ACB where possible.

4. Violence/Assault



There were 237 incidents of violence and assault reported during January and February 2025. This represents 7.79% of all reported incidents. During the previous reporting period, there were 340 violence and assault incidents reported, this shows a decrease of 30.29% during the current reporting period. We have explored data differently for this reporting period, but the general decrease has been related to patients responding to treatment and care changes.

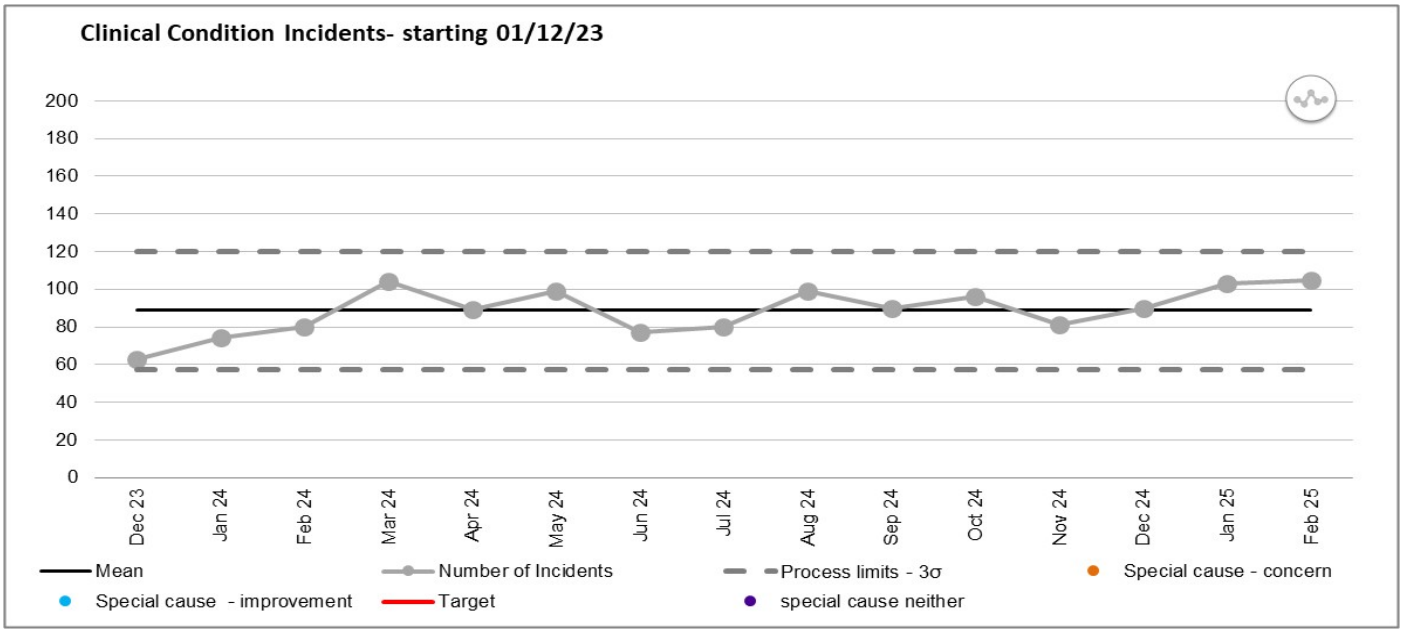
These incidents represent patient violence towards other patients, people not employed by the trust and incidents of staff incidents towards patients and incidents of disruptive behaviour towards others. The numbers of violence and assault incidents has been analysed and over the reporting period there are 4 areas with a significant number of incidents reported relative to the total number (237) of violence and assault incidents, those being Griffin ward with 21 incidents (8.86%), Agnes Unit with 19 incidents (8.02%), Langley ward with 17 incidents (7.17%) and Watermead ward with 16 (6.75%). The incidents on the Agnes Unit were related to a patient whose mental health and physical health is being stabilised before commencing positive behaviour support planning. On Langley Ward, the incidents were related to 2 patients who were verbally aggressive to staff and others related to care plan restrictions for smoking and access outside of leave arrangements. On

Griffin Ward, during this time period, there were 6 admissions of acutely unwell patients and there were several issues of verbal and physical aggression between patients. Staff discussed treatment approaches with the doctor, activities, group work and use of de-escalation.

Of these 237 incidents, 170 (71.73%) were recorded as disruptive behaviour. Agnes unit recorded 18 of these (10.59%) and Langley ward reported 12 (7.06%) such incidents.

There were no incidents of violence and assault reviewed at IRLM during this reporting period.

5. Clinical Condition



208 Incidents have been reported during January and February 2025 under the category Clinical Condition which equates 6.85% of the total number of incidents reported. Of the 208 clinical condition incidents 151 related to deterioration in physical health condition which equates to 72.6% which is analysed further below

East ward has reported 13 incidents of physical health deterioration out of the 151 such incidents overall which equates to 8.61% and both Coleman and Dalgleish wards are higher reporters with 9 incidents of physical health deterioration which equates to 5.96% each. The data is showing common cause variation only. Deterioration in physical health is not always recognised as an incident so high reporting is welcomed as it gives us the opportunity to review if there is any learning.

Through the Transferring care safely process CHS have reported that some patients transferred from the acute trust have been too unwell and required re admission to the Acute. This is being reviewed to understand how this can be reduced.

Analysis and learning from incident reporting and learning from reviews has driven the focus and work plan of the trust Deteriorating Patient Group (DPRG) and the key areas of work/improvement are as follows. Work continues to provide assurance that the Venous Thromboembolism(VTE) policy is being followed across the Trust. There needs to be further audit work undertaken to provide

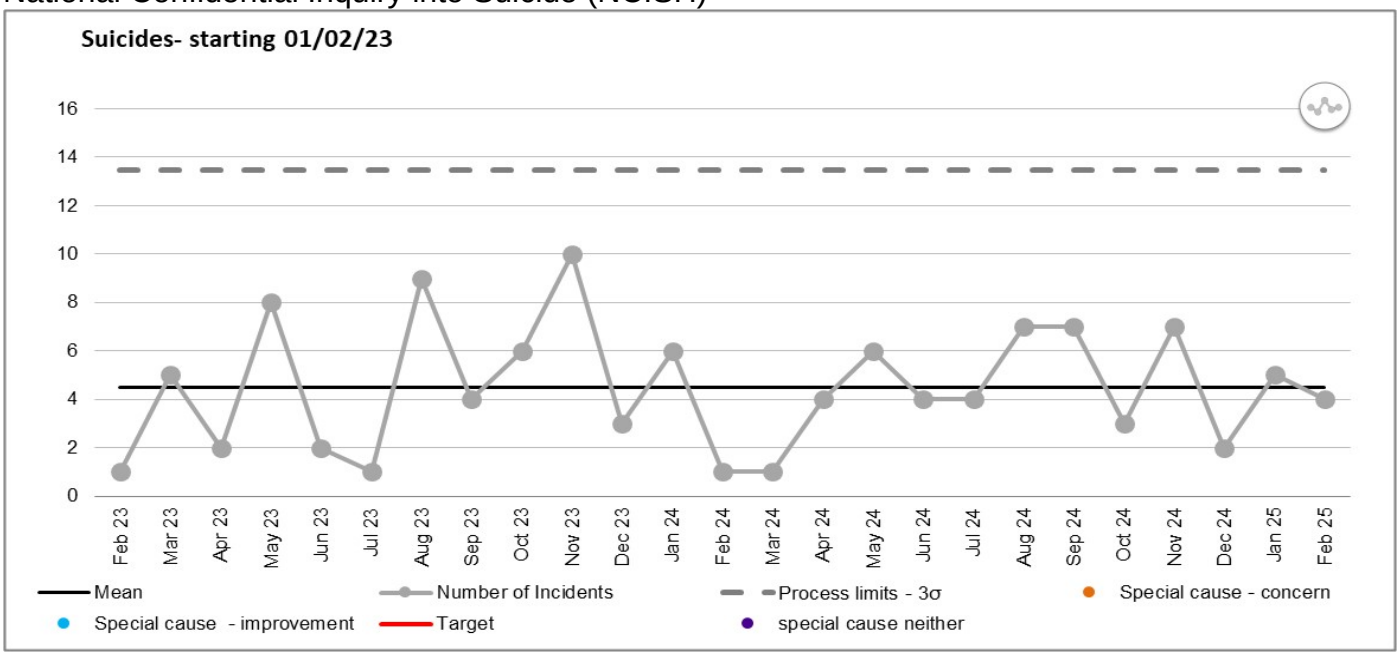
assurance of the effectiveness of this. There is a working group looking at how we can best review any incidents related to hospital acquired VTE to support this.

Incidents related to deterioration in physical condition are reviewed to understand if the NEWS2 process has been followed and patient's deterioration recognised and managed. There is a collaborative project with NHFT and this has now commenced training sessions with the two pilot wards. The group is meeting regularly to assess progress.

The Sepsis working group have now completed and had the new Sepsis policy ratified and in place.. This will then allow the roll out of meropenem (antibiotic) in the sepsis boxes. There has been a focus on training to support staff with this.

Suicide Prevention

While suicide does not feature in the top five reported incidents, we review every suicide for learning, themes, and trends. We also assess our services and actions against National Learning from National Confidential Inquiry into Suicide (NCISH)



It is important to consider suicide over time. The data above currently does not identify any statistically significant reduction.

The Self Harm and Suicide Prevention Lead has been in post for 12 months and in that time has progressed a series of interventions based on our self-assessment against NCISH recommendations and the national suicide prevention strategy.

Our initial self-assessment is now complete, and this is being compiled to reflect both the good practice and areas for improving and will be shared with the suicide prevention group once the summary and findings are completed. Once agreed, the report findings will go to DMH and FYPCLD quality and safety DMT for agreement on actions to achieve best practice along with a date for re-audit.

Previous reports have identified STORM training as one of the areas for development and we now have six Practice Development Nurses trained to be 'train the trainers' and they are now able to deliver STORM training across the services.

Future work to look at debrief for patients after an incident of self-harm and what these could look like will be proposed as part of the suicide prevention LPT plan, in line with the national suicide prevention strategy.

Learning from Deaths

The National Quality Board (NQB) Guidance on Learning from Deaths (LfD), published in March 2017, sets out the expectation for NHS Trusts to collect and publish specified information on deaths on a quarterly basis. This quarterly report is presented separately to Q&S Committee for assurance.

LeDeR

- Monthly panel meetings continue as per the revised LeDeR processes and Governance arrangements.
- There have been 2 referrals made by LPT to LeDeR: 2 for January 2025 and 0 for February 2025.
- For city and countywide reviews there were 5 notifications in January 2025 and 4 notifications and February 2025.
- None have undergone a focused review; none currently allocated, all currently initial but they might change to focused when allocated.
- LeDer colleagues report that they describe deaths as 'graded 1' for quality of care and 'graded' 1 for right support; as part of the response following full review. Demographic Data:

Table 1: Age and gender

Age Bands	0-18	19-24	25-44	45-64	65-79	80+	**Total**
Female	13	2	3	18	43	130	**209**
Male	9	1	6	16	51	83	**166**
Total	**22**	**3**	**9**	**34**	**94**	**213**	**375**

Table 2: Disability

Disability Status	**%**
Disability Stated	119
No stated Disability	35
Asked but declined to respond	4
Not known / not recorded	217

Table 3: Religion

Religion	**%**
Buddhist	>1%
Christian	1%
Declined to disclose	1%
Hindu	3%
Muslim	2%
None	12%
Other	3%
Sikh	>1%
Unknown	77%

Table 4: Ethnicity

Ethnicity	**%**
Asian or Asian British - Indian	7%

Asian or Asian British - Pakistani	>1%
Asian or Asian British - Any other Asian background	1%
Black or Black British - African	>1%
Black or Black British - Caribbean	1%
Any other ethnic group	>1%
Mixed - White and Asian	1%
Mixed - White and Black African	>1%
Mixed – any other mixed background	1%
Unknown / Not stated	8%
Any other white background	4%
White British	76%
White Irish	1%

Table 5: Sexual Orientation

Sexual Orientation	%
Heterosexual or straight	34%
Bisexual	>1%
Person asked and does not know or is not sure	6%
Not known / not recorded	59%
Person asked but declined to provide a response	1%

Of the 8 patient deaths in January and February 2025 that met the NQB scope as defined within LPT 'Learning from Deaths Policy' (2019) and an initial screening was applied, none went on to full review using the modified Structured Judgement Reviews (mSJR's) in DMH/MHSOP.

22 child deaths were reported for this period; none of these have been identified through the initial Child Death Overview Process (CDOP) as having been attributed to the care provided by LPT.

Learning and themes identified.
This has been identified from the review or investigation of patient deaths concluded in Q3 2024/25 are set out below.

Community health services (CHS) were:

- Communication with relatives and carers in relation to approaching end of life and deterioration in care of their loved ones.
- Documentation of management plans for those nearing end of life in relation to communication with relatives and carers.
- Transfer of patients to LPT and their care requirements did not always match the information shared by our colleagues which necessitated review of medication, care intervention and re-enforced communication with relatives and carers in relation to end of life.

Directorate of mental health (DMH & MHSOP) (include older persons):

- Review of antipsychotic medications and documentation.
- Drugs and alcohol use and the assessment and influence in people's life and the impact on being accepted into services.

Families, young people, children, learning disability and autism (FYPC-LDA):

- Record keeping and communication to enable understanding of risks and needs.

Good practice/ family feedback identified and shared via Q3:

CHS

In Q3 families some the feedback shared was that they were happy with the care provided in our Community Hospitals and felt it was ‘very good’, ‘amazing’ or ‘excellent’. Families felt that they ‘couldn’t fault the care provided’ and in particular, ‘that every member of staff went out of their way to help and to make the family’s experience as good as could be’.

DMH/MHSOP - Assessment and management plan

72hour follow up post discharge, was recognised in MHSOP that the CPN used the opportunity appropriately to complete the risk assessment care plan. This good practice has been fed back to the CPN involved.

FYPC/LDA - Listening to patient’s wishes.

A patient had a terminal diagnosis of cancer at the point of referral into the LD service. She had lived at the care home for 20+ years and LPT staff worked with care staff and especially Occupational Therapy (OT) to enable her to stay at home. OT had the idea of having a small area of things upstairs so she could still “go to the shop”, which greatly reduced the risk of her using the stairs and probably enabled her to stay at her ‘home’. The care home staff and management were identified as being ‘brilliant in actioning all recommendations. Care home staff were very fearful as they had not had anyone who was going to die and was approaching ‘end of life’ before. However, they quickly developed skills noticing when help from the MDT was needed and making contact, rather than LPT staff going in regularly and potentially distressing the patient. They adapted well to keeping her at home, surrounded by people who cared for her right up until she died.

MDT working

MDT working was described as ‘fantastic’ and considered to be influenced by the skills of, LB, Seconded Physical Health Matron, having a background of infection control and district nursing, which was instrumental in supporting the team with developing a plan of care and giving confidence to those involved in the patients care. In conjunction with her colleagues, LB has almost completed physical health pathway for LD patients that includes reference and support available for end-of-life care.

Emerging Theme / Risk

Reviewing audit data in relation to positive patient identification and reported incidents has identified that not all patients are being positively identified prior to the delivery of care. The reported incidents have been related to medication administration, taking of blood samples and delivery of care. Research shows that such incidents are generally underreported as they are not always recognised. This has been discussed at Patient Safety Improvement Group as well as within Medicines Risk Reduction. Collaboratively with clinical teams, a series of actions has been agreed. These include the sharing of information at each team’s safety huddles, exploring the practicality of the patient and their prescription being in the same location (i.e. mobile technology), patient education re their safety and the wearing of an ID band. An electronic solution is being explored which will further close the loop on these interventions.

Outstanding patient safety reviews

Directorate	Number of reports late	Still being drafted	In sign off process
Corporate Investigators	10	0	10
CHS	7	2	5
DMH	32	18	14
FYPC/LDA	11	3	8
TOTAL	60	23	37

We continue to be challenged in relation to incidents that we have identified for further review. As of the end of February, there were 60 reports that were not yet completed within timescales. Of these 23 (38.3%), were in draft stages however this means that the other 37 (which equates to 61.7%) of the reports are already going through the sign off process indicating that although late, they are close to completion. Of these, 3 are SIs from under the previous framework all due for completion by end of March 2025.

We are working hard to understand how we can improve this. Some of these late repots are allocated to staff who also have clinical commitments and trying to balance these priorities. We are exploring options to support by asking the corporate investigators to work differently and also identifying if there are any other teams, for example within the enabling directorates, who may be able to support. The PSIRF is very clear that our reviews are to be proportionate to identify learning. We know that talking to staff is the way to identify this and we are exploring methodologies that allow this while not resulting in a length report to write which is particularly challenging for staff with clinical commitments.

Duty of Candour

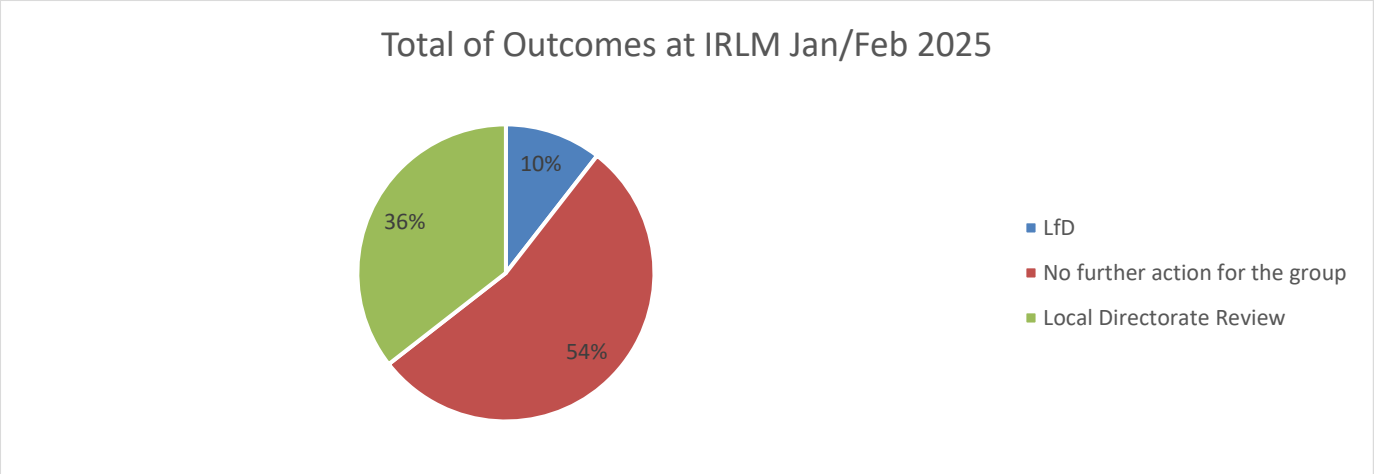
There was no statutory duty of candour breaches during this period we continue to follow being open principles.

Never Events

There were no Never Events reported during this period.

Incident Review & Learning Meeting (IRLM)

75 cases were reviewed at IRLM during January and February 2025. No PSIIs were declared during this reporting period. 41 (54.7%) were identified as having already identified any learning and actions put in place. There were 27(36%) Local Directorate reviews requested to explore appropriate actions, 7 (9.3 %) ISMR's were shared with LfD for theming.



Proportionality review of IRLM

As part of our improvement work it has been agreed to assure ourselves that the decisions made at IRLM are appropriate in relation to proportionality i.e. reviews are undertaken appropriately and proportionately and for the purpose of learning. It has been agreed that the Executive Medical Director and Executive Director of Nursing will attend a meeting each per quarter for assurance.
In addition there will be a review undertaken of a random selection of Incidents that were reviewed both in directorate or at IRLM to confirm and challenge the decisions made.
The outcome of this will provide both assurance of the process and the opportunity to make any changes to improve the process and support the culture of psychological safety when discussing incidents.

LFPSE

The number of incidents raised in LFPSE is 3037 matching the total number of patient safety incidents above.

Queries Raised by Commissioners / Coroner / CQC on reports submitted shared.

The ICB patient safety team are members of the IRLM and have fed back how assured they find the conversations and appreciate the focus on system learning. Whilst there is no requirement under PSIRF to share reviews with the ICB, we continue to share as assurance of our learning.

Patient Safety Strategy

Training

SEIPS training
During 2024, 120 members of staff from across all directorates undertook the SEIPS training provided by the corporate patient safety team. So far in 2025, 35 members of staff have undertaken the training and there are further dates available throughout the year.

This training is evaluating well with staff feeding back that it feels a really supportive way to learn:

Directorate	Numbers trained in SEIPS 2025	Numbers trained in SEIPS. 2024
DMH	26	71
CHS	4	27
FYPC/LDA	5	22
TOTAL	**35**	**120**

Level one and level two National patient safety training.
This is national training delivered as E learning to support the patient safety strategy and the implementation of PSIRF. The training has been available for staff to access and is required as pre learning for the SEIPS training. The below figures are the staff who have attended so far and as part of our improvement work, we have agreed that all staff will access level 1 and are finalising the staff groups who will benefit from level 2:

- Level 1 = 424 staff
- Level 2 = 296 staff

Patient Safety Improvement Programme

The **Patient Safety Improvement Programme (PSIP)** continues to drive progress towards further strengthening LPTs patient safety and learning culture supported by systems, processes and resources that are visible and helpful to frontline staff, patients, and families.

The medical director and director of nursing AHPs and quality launched communications on 7 March with a summary of the work achieved so far. The piece '2025 - Our year of Patient Safety Improvement' paves the way for regular features on progress we are making:

Since the Trust Board meeting in January 2025, update the workstream groups have continued to deliver their assigned actions:

Patient Safety Incident Response Workstream

The Patient Safety Incident Response Policy was approved at the Quality Forum in February and presents the exciting and different approach to how we are now responding to patient safety incidents, replacing the Serious Incidents (SI) policy. This policy supports the requirements of the NHS Patient Safety Incident Response Framework (PSIRF) and sets out LPTs approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues, for the purpose of learning and improving patient safety. It provides guidance on roles and responsibilities throughout the processes of managing patient safety incidents under PSIRF as well as our response methodologies using a 'Human Factors' and 'just culture' approach.

Work is underway to review the Initial Service Management Review process and templates. Robust and consistent approaches to capturing and tracking immediate actions and learning through the ISMR process are in place in clinical directorates.

Assure Workstream

A review of the coverage, content, and documentation of directorate processes, including safety huddles, to capture and escalate patient safety concerns has been completed. This resulted in

guidance and conversation prompts being developed to ensure a common understanding across LPT of the theory, purpose, and expectations of safety huddles.

The initial stages of establishing a Quality and Safety Dashboard have been completed with an initial set of quality and safety indicators being agreed for all inpatient areas with directorates. The next stage is to create a minimal viable product to test out in one directorate.

Patient, Family and Carers Engagement

The programme places significant importance on meaningful engagement with patients, families, and carers. Their input and feedback are critical in shaping safety practices and ensuring that improvements meet the needs and expectations of those directly affected by the care provided.

A successful event took place in 30.01.25 with over 40 attendees. The group focused on three key CQC statements in relation to carer and family voice and collaborative care, with the top three priorities identified and agreed.

Carers Awareness Training is in place as part of the Triangle of Care implementation - training co-delivered with carers. Training has been identified as a key priority from the Carer, Family and Staff Summit.

Proposal

The Trust Board of Directors are asked to:

- Review and confirm that the content and presentation of the report provides assurance around the processes we have to identify levels of harm.
- Be assured that data presented around learning from deaths is aligned to the '*learning from deaths'* guidance.
- Be assured on the quality of Patient Safety Incident reports, completion, and compliance with 'Being Open' and 'Duty of Candour'.

Decision Required

No decision is required of the Trust Board of Directors.

Governance Table

For Board and Board Committees:	Trust Board
Paper sponsored by:	James Mullins, Interim Executive Director of Nursing, AHP's & Quality
Paper authored by:	Patient Safety Team
Date submitted:	March 2025
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):	N/A – in this format however learning is reported from governance groups
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	N/A

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		
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		