

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

**BOD 21/2020**

(Agenda item: 10)

# Board of Directors

**30 April 2020**

**Incident, Mortality and Patient Safety Quality Report**

**For: Information and Assurance**

**Executive Summary**

This is a quarterly report which summaries the;

* Themes of incident reporting with detail by service, team and categories
* Themes being raised with the Freedom to Speak Up Guardian
* Our response to national patient safety alerts
* Learning from deaths
* Serious incidents and never events
* National developments and quality improvement collaboratives.
* Reducing restrictive practice – creating a positive and safe environment

The format of the report has changed from past reports to be more concise and to focus on sharing the actions and quality improvements being made.

**Governance Route/Escalation Process**

The Trust-wide Mortality Review Group met in February 2020 to review the trends, themes and learning from deaths. A more detailed version of this report was discussed at the last Safety Quality Sub-Committee in January 2020 and a highlight report presented to the Quality Committee in February 2020.

**Recommendation**

The Board is asked to note the report.

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**Lead Executive Director:** Marie Crofts, Chief Nurse

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. ***Strategic Objectives*** *– this report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust:*

*1) Driving Quality Improvement*

**Incident, Mortality and Patient Safety Quality Report**

Incident trends

* Trust-wide 3916 incidents were reported in Q3 (similar to Q2). Of the 3916 incidents, 1914 (49%) were flagged as patient safety incidents and reported nationally via NRLS. Of the patient safety incidents 61% resulted in no harm, 32% resulted in minor harm and 4% resulted in moderate/ severe harm.
* The Trust-wide Ulysses User Group established a year ago is an open forum for all staff to help improve the design/ configuration of the system to improve the ease of reporting an incident. A number of changes have been led by this group to improve incident reporting levels.
* The service lines that report the highest number of incidents are; District Nursing, Community Hospital Wards, Adult Acute Mental Health Wards, CAMHS Wards and Forensic Wards.
* In Q3, 29 patient safety incidents resulted in severe harm (4%) of these 27 were in the category of skin integrity, all of which were new grade 4 pressure ulcers. The skin integrity incidents occurred in 11 different departments and none are being investigated as serious incidents as there were no lapses in care provided. The other two incidents related to a self-harm cutting incident by a patient under the care of an AMHT and a fall on a community hospital ward resulting in a fractured hip.
* Overall violence and aggression incidents remain the most reported type of incident (15%). These relate mostly to violence from patients to staff and occur most often in our inpatient mental health wards. 97% of the incidents are reported as causing no harm or minor harm. However, in Q3 three incidents resulted in significant injuries to staff whereby they needed to take more than seven days off work (1 on VT ward, 1 on Wintle ward and 1 on Wenric ward). In the last 6 months there has been an increase of incidents in the evening, mostly occurring between 15:00-21:00. The Chief Nurse has asked for this to be discussed within the Mental Health and Forensic services to determine what could be put in place to support staff and patients at this time. Most violence and aggression incidents have been reported by CAMHS Highfield, Kennet or Evenlode and these relate to a small number of patients (circa four patients).
* The Trust is focusing on how to reduce violence and aggression from patients to staff and better support staff from injury at work, a series of QI initiatives both local and national have been started and new workstreams are also being identified. The work includes reducing violence and aggression on the adult acute mental health wards, learning from the national collaborative focused on forensic wards, and implementing the new policy on zero tolerance of violence and aggression towards staff - to better support staff who face abuse.
* The top categories for mental health incidents are violence and aggression, self-harm and security i.e. AWOLs, and for physical health services the main causes for incidents are skin integrity, communication/ confidentiality and medication.

Freedom to Speak Up Guardian

* Between Nov 2018 to Nov 2019 43 members of staff raised concerns. The number of concerns raised has varied each quarter. Most concerns were resolved locally.
* There have been no serious patient safety concerns raised.
* Patient safety concerns related to the level of complexity of cases and workload of the staff which is seen to result in less than best care for patients and ‘burn out’ for staff. In one case lack of medical cover in a team was raised- this was already well known and being addressed by senior management.
* The content of raised concerns demonstrates that incivility, lack of respect and bullying behaviour are the most often raised concerns this is supported by the staff survey results.

National safety alerts

There is a robust process of identifying, disseminating and monitoring the implementation of national patient safety alerts. In Q3 of 19/20, 49 CAS alerts were issued, 23 of these were applicable to the Trust and were cascaded appropriately. To date all alerts have been actioned and closed within deadline. New alerts and actions to escalate are discussed at the weekly clinical review meeting.

Three internal Trust risk notes have been issued/ available on intranet since Oct 2019;

* Risk Note 13 (2019) - Integral Valve Oxygen Cylinders 2020 Update – issued Nov 2019
* Risk Note 14 (2019) - Registered Nursing Associates & Medicines Administration – issued Dec 2019
* Risk Note 1 (2020) - Risk of death and severe harm from ingesting superabsorbent polymer gel granules – issued Jan 2020
* Risk Note 2 (2020) - Convex two-piece skin barriers for use with ostomy bags – issued Jan 2020
* Risk Note 3 (2020) - Fentanyl patches issued Feb 2020
* Risk Note 4 (2020) - Storage of batteries – fire risk – issued Feb 2020
* Risk Note 5 (2020) - Tresiba (insulin degludec) dosage – issued March 2020

Learning from Deaths

* The trust has a weekly process to review deaths which feeds learning into the Trust-wide Mortality Review Group held quarterly. The majority of deaths for open and recently discharged patients relate to people aged over 75 who last received treatment from the district nursing service, this includes people on an end of life pathway. There has been no change in trend over time or variance in trend when compared to the national picture by month.
* The next national development will be in relation to introducing a medical examiner role to provide additional independent medical review of all inpatient deaths, the suggested national approach is to ask for support from local acute Trusts who have been required to set up medical examiner services. This is expected to be in place by April 2021.
* We have had three tragic inpatient deaths in the last 9 months; a female patient on Allen ward who died in August 2019 - no concerns about care were identified, a male patient on Sandford ward who died in December 2019- no immediate actions were identified from the initial review and the SI investigation is still underway. The third death was a male patient on S17 leave from Opal ward who died in the community in February 2020. This was due to a suspected illicit drug overdose and an SI investigation has been commissioned. The families of each person have been contacted, immediate learning has been actioned and an SI investigation commenced (now completed in relation to the death on Allen ward).
* We have had two suspected suicides of young people in Swindon in December 2019 and January 2020, both known to the CAMH service. Immediate work around possible contagion was completed, as was close working with the school. An initial review has been completed and a serious incident investigation has started.
* The Trust has received 3 preventing future death notices from the coroner so far in 2019/20 relating to deaths in 2012, 2017 and 2018. We have responded to the coroner in each case. All actions resulting from PFDs are monitored through Ulysses until completed. The rulings in 2019/20 were:
* A mental health homicide relating to a patient who killed her mother in 2012. The inquest concluded in September 2019. The Trust received the preventing future death notice on 24th September 2019 and has responded to the five concerns raised.
* Suicide of a female on Ruby ward in 2017 who was on unescorted leave from the ward. An external investigation was commissioned by the Trust into the death which was shared with the coroner. The Trust received the preventing future death notice on 12th April 2019 and has responded to the concerns about; access to cutlery on the ward used for self-harm, access to means for self-harm outside the ward, timeliness of hourly observations, access to an immediate response from ward staff to telephone calls and planning for discharge.
* Suicide of a male known to Oxon City and NE AMHT who died in 2018. The Trust received the preventing future death notice on 11th November 2019 which raised a concern around the lack of clear discharge planning and communication of the plan to community teams following a short period of inpatient stay.
* The Trust is participating in a national research study about how NHS Trusts have implemented the national learning from deaths guidance issued by NHS Improvement in 2017 and 2018. Due to report in the summer 2020.
* A key area for improvement identified from reviews into deaths has been how we can better and more consistently involve families in patient’s care. A task and finish group has been set up to lead work in this area.

Serious Incidents

* The new draft national framework for the management of serious incidents was published in March 2020 this will lead to significant changes. The final framework will be published in spring 2021 with implementation expected by autumn 2021. This is part of the developments within the national 5-year patient safety strategy published in July 2019. A summary of the implications of the national strategy were presented to the Quality Committee in Feb 2020.
* Locally in 2020/21 we are seeking to develop and implement a family liaison service (FLO) to provide more support to bereaved families during the SI process. We are working with national charities in relation to this and what would be the most appropriate provision
* In Q3 of 19/20, 10 SIs[[1]](#footnote-1) were identified, 2 of these were subsequently downgraded. Four of the SIs relate to apparent/actual/suspected self-inflicted harm, all of which involved the death of the patient involved and 2 of which were in the Forensic community team. Three of the SIs related to treatment delays meeting SI criteria. In 2019/20 the Trust has reported 52 SIs with 11 being subsequently downgraded after investigation. The majority of SIs fall into the category of ‘apparent/actual/suspected self-Inflicted harm’ and occur in the community mental health teams (adult and older people).
* Overall from November 2016 there has been a reduction in the number of confirmed SIs in the Trust, from an average of 10 per month prior to November 2016 to an average of 4 per month subsequently.
* In 2019/20 the Trust has had one ‘never event’ which occurred in September 2019 in the community dental service related to the extraction of a wrong tooth of an adult with severe learning disabilities whilst under a general anaesthetic. Her mother was informed same day about the incident and the patient was discharged as planned from the ward the same day as treatment. Several follow appointments have been carried out by a senior dentist and the patient has recovered well. The investigation has been carried out by an external reviewer from Somerset Partnership NHS trust. The report has been submitted to commissioners for review.
* Trust-wide the overall themes and learning from serious incidents are:
* Challenges with numerous teams experiencing a continued high level of vacancy with the resulting use of temporary/ agency staff. This may lead to a lack of continuity of care and with variable completeness of clinical notes
* The transfer of patients between several care co-ordinators where staff turnover is high. This continues to have a negative impact on the quality and continuity of care for patients and the morale of permanent staff
* Lapses in clinical documentation for example- quality and completeness of risk assessments, safety planning, consent to share with family members, pressure ulcer risk assessments, MEWS, care plans
* Accessibility for staff of both historic and current risk assessments in CareNotes which can hinder staff when clinically assessing patients at a point of crisis.
* The actions for every SI investigation are captured in an electronic system (Ulysses) managed centrally with automatic updates to action leads and monitoring at the weekly clinical review meeting. The Service Manager for Patient Safety follows up the leads for all outstanding actions on a monthly basis in addition to the automated reminders.
* In relation to managing the serious incident process the Trust has had two breaches in timescale in 2019/20; 1 was 2 days delayed and 1 was 6 days delayed both due to staff capacity.
* The Trust participates in a range of multi-agency external reviews including mental health homicides, domestic homicide, safeguarding adult and child serious case reviews. The actions from these are monitored centrally. A detailed analysis of learning from all these different types of external agency reviews is provided 6 monthly. The Trust is currently participating in 12 domestic homicide reviews and zero mental health homicide reviews.

The above themes identified following SI’s are part of the Trust overall Quality Improvement programmes developed following the CQC inspection. These themes include:

* Consistent high-quality documentation particularly in relation to care planning
* Ensuring access to regular supervision
* Training and knowledge in relation to the Mental health Act (MHA) and the Mental Capacity Act (MCA)

Quality Improvement initiatives

The Trust is engaged in a series of local and national QI initiatives to improve patient safety. The national NHS Improvement collaboratives we have/ are involved in around patient safety include;

* Reducing time spent on enhanced observations in PICI and acute wards
* Reducing restrictive practices in acute, LD and forensic wards
* Closing the Gap in AMHTs
* Reducing length of stay for people with autism
* Improving Sexual Safety in mental health inpatient settings
* Tissue viability

The areas of focus on patient safety in the quality account for 2019/20 have been; suicide prevention, training in relation to carrying out restrictive practice, reducing violence and aggression by patients on wards and reducing patient falls with harm.

The Trust received one regulatory breach from the 2019 CQC inspection relating to seclusion practice. Work is being led by the Chief Nurse to ensure standardised practice across the organisation and learning from Trusts with low or no seclusion and reduced restrictive interventions.

The 2020/21 quality improvement objectives to be published in the quality account are currently under development, the objectives to improve patient safety are likely to be around; creating positive and safe environments to reduce the use of seclusion and long-term segregation (mentioned above), developing psychological safety for teams alongside a restorative and learning culture, to implement the national 5 year patient safety strategy locally, and to implement the changes around the Mental Capacity Act/ new Deprivation of Liberty Safeguards.

Positive and Safe (Reducing Restrictive interventions)

* The CQC inspection in 2019 rated Evenlode as inadequate in the safety domain which related solely to seclusion practice. Overall the rating for the service was Good.
* A new ‘Positive and Safe’ committee chaired by the Chief Nurse is being established to raise the profile of the importance of this work, and to develop/ lead on a strategy to reduce the use of restrictive practice.
* The CQC is currently undertaking a thematic review on restrictive interventions in settings that provide inpatient and residential care for people with mental health problems, a learning disability and/or autism. This work is undertaken in 3 phases with the aim to publish a final report with recommendations in March 2020. OHFT has been involved in the different phases of the work initially providing data followed by visits to Evenlode, Highfield and Kestrel wards in 2019. The Trust will not be named in the national report. We were also informed in November 2019 that the CQC will carry out a review in the next 12 months of the care provided to a young person on Highfield ward who was in segregation.
* NHS Improvement launched a quality improvement collaborative as part of 3 workstreams relating to data, quality improvement and training standards. The aim is for organisations to reduce the use of restrictive interventions by 25%. Kestrel Ward is participating in the collaborative and the process will be replicated concurrently with Kennet, Evenlode and Phoenix Ward supported by the Oxford Centre for Healthcare Improvement.
* Kestrel ward have reduced restrictions by increased activities, opening access to a water point and engagement with staff in kitchen and meal preparation. The ward is collaborating with their service users for other change ideas.
* Kennet ward have implemented ‘Know Each Other’ as part of the Safewards bundle and have had good feedback from patients. They are using the folder to introduce the staff for new admissions to both families and service users. They will be using ‘Soft Words’ as their next test of change.
* Phoenix ward were keen to look at areas of low-level violence and aggression which may not be recorded upon Ulysses by using a safety cross to record these. The recording of this was not consistent and the ward are re-examining Ulysses incident data during the diagnostic phase.
* Evenlode ward commenced their project and had begun to look at restrictive practices such as garden use and access to drinks. However, the ward have had to suspend QI work at the moment due to staff pressures and patient acuity.
* All training with a restrictive intervention component will be required to meet specific quality standards developed by the Restraint Reduction Network which were published in August 2019. The Trust is undertaking a full training needs analysis and review of training resources. The Trust’s training certification application has been successful and the PEACE training department will be submitting evidence over the next 6 months to become a commissioner and provider of training. Some of the changes to PEACE training were implemented from January 2020 which include an increased emphasis on preventative approaches.
* Restrictive practice continues to be reported to the weekly clinical review meeting. Above average incidents involving prone restraint were reported in 7 of the 9 months from Jan-Sept 2019. The most common reason for prone restraint was to administer IM medication (56%). This will form part of the Positive and Safe programme of work. Oxon Eating Disorder inpatient service has seen high levels of restrictive practice, this has been reviewed and relates to a small number of patients and naso-gastric tube feeding. Although a lower number of incidents of Long-Term Segregation (LTS) commenced in Q3 there were more days spend in LTS. During Q3 131 seclusions were reported as incidents with 78 patients being secluded.
* Highfield was the highest reporter of physical restraints in Q3. The service are undertaking a piece of work to explore their incident rates in relation to national data with other similar adolescent units. Being a specialist service, all restrictive practice is reviewed monthly with NHS England the commissioner.
* We have seen a decline in the number of violence and aggression incidents that led to the use of restrictive practice on inpatient wards. A staff safety task and finish group has been established with involvement of TVP to progress some of the themes coming from the Partnerships in Practice groups with TVP and SCAS and to support the implementation of the new policy on zero tolerance of violence and aggression towards staff.

1. Serious Incidents are nationally defined as incidents where there were acts or omissions identified in care that resulted in death, lead to abuse or serious harm requiring further treatment [↑](#footnote-ref-1)