

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

**BOD 64/2022**

(Agenda item: 12)

# Board of Directors

**28th September 2022**

**Patient Safety Incidents reported July and August 2022**

**For: Assurance**

**Executive Summary**

It is crucial that we learn from every incident and near miss that happens to address concerns and continually improve the safety of care.

During July and August 2022 there were five Patient Safety Incidents meeting national criteria to be reported as serious incidents. These sadly included three suspected suicides for patients receiving treatment in the community and two unexpected deaths in the community from physical health conditions.

There were also 16 Patient Safety Incident Investigations completed in July and August 2022. The learning identified from these is captured in action plans to achieve improvement. These are implemented at service level and are monitored with executive oversight.

The key themes for learning were;

* Quality and completeness of initial assessments, risk assessments, safety plans and care plans
* Communication between teams, external organisations/services and with partnership providers
* Timeliness of raising safeguarding concerns
* Lack of physical health care plan
* Estates/building issues, enabling AWOL from ward
* Observations not being completed or documented as expected

The actions being taken are detailed in the report.

We have seen a decrease in Patient Safety Incidents in June, July and August 2022 compared to previous years, which we have explored and found no difference in incident reporting levels by harm or cause. We have also reviewed all decision making for moderate harm and above incidents and found no concerns. However, we have seen a reduction in the number of reported suspected suicides in May and August 2022, therefore we have strengthened our processes to ensure we do not miss any incident of suspected suicide.

The report shares the details of the new national Patient Safety Incident Response Framework (PSIRF) published in August 2022. The framework represents a significant shift in the way the NHS will approach and respond to Patient Safety Incidents with the sole purpose to learn and improve the safety of care. NHS providers have 12 months to implement the changes, with transition to be complete by autumn 2023. The Trust is in a good position as had started making some of the changes in our approach over the last year.

**Governance Route/Escalation Process**

Every Patient Safety Incident (PSI) is investigated which includes the involvement of patients/ families and those staff involved in the incident. A report is then scrutinised at an internal PSI panel by senior clinicians which is shared with clinical teams for learning and the patient/ family members involved. The report is then presented to the relevant commissioner (now the ICB) for review and closure. This process has executive director oversight via the CMO and the CNO.

PSIs are also reported and discussed:

* weekly at the Weekly Review Meeting,
* monthly at the Quality and Clinical Governance Sub-Committee

**Recommendation**

For the Board to be assured regarding the current management and learning from PSI’s.

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**Jane Kershaw, Head of Quality Governance**

**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/Priorities – this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust):*

*1) Quality - Deliver the best possible clinical care and health outcomes*

**1.0 Introduction**

It is crucial that we learn from every incident and near miss that happens to address concerns and continually improve the safety of care. The Trust reviews all incidents to take any immediate actions identified and consider safeguards for patients. Alongside this senior clinician’s review incidents on a weekly basis, and on a quarterly basis we identify learning and more thematic areas for improvement.

The Trust reports externally all unintended or unexpected incidents which could or did lead to harm via the NHS National Reporting and Learning Service.

In line with national guidance Patient Safety Incidents (PSI’s) are reported and an in-depth investigations completed to identify our learning and any actions. This report gives high level detail of PSIs that have been reported in July and August 2022 and the learning we have identified. It then gives an overview of the Patient Safety Incidents reported this year to date.

**2.0 Patient Safety Incident Reporting**

The outcome of all PSI Investigations are scrutinised at an internal panel before finalising a report, which has executive director attendance. These reports are shared with patient/family and also submitted to our commissioners (now the ICB) for review and closure.

Areas of learning and themes are presented at various forums including clinical team meetings, directorate governance meetings, learning events and the Trust’s Quality and Clinical Governance Sub-Committee. The areas of learning are acted upon with recommendations and action plans implemented. Progress against actions are monitored at the Trust’s Regulatory Action Monitoring Group.

**3.0 Patient Safety Incidents in the past year**

The Trust reported 91 PSIs in the past 12 months from September 2021 to August 2022. Of these 13 were downgraded by our commissioners after being investigated however we still used this opportunity to review what happened and to identify any learning. Below are the main concerns for PSI’s:

* Self-inflicted harm such as suicide for patients being supported in the community
* Unexpected deaths in the community
* Pressure ulcers
* Since the start of the pandemic, up to March 2022 we have reported all COVID-19 outbreaks on our wards and deaths of patients related to COVID-19 whereby COVID-19 was acquired on one of our wards

The effect when someone sadly takes their own life is unimaginable to families and loved ones. We review the care provided to patients so we can try to reduce the number of suicides through learning. From these reviews we are currently focusing on:

* Embedding safety plans co-produced with patients and their families,
* Development of suicide prevention champions within teams and
* Staff training co-produced with people with lived experiences to improve skills

The Trust’s Suicide Prevention Strategy is being co-produced with patients/ families and taking forward actions around four workstreams which is based on national evidence:

* Gender (risk to men, women with ASD and LGBTQ+)
* Substance misuse
* Access and inclusion
* Communication and research activity.

We held a workshop in August 2022 with senior clinicians and members of the Suicide Prevention Steering Group to have a deep dive into the trends and learning from reviews into suicides, which is being used to inform the actions of the four workstreams.

The below graphs show the number of PSIs each month for the last 12 months. The increase in January 2022 related mostly to COVID-19 ward outbreaks, which accounted for 11 out of the 18 Patient Safety Incidents. We have seen a decrease in PSIs in June, July and August 2022 compared to previous years, which we have explored and found no difference in incident reporting levels by harm or cause, we have also reviewed all decision making for moderate harm and above incidents and found no concerns. However, we have seen a reduction in the number of reported suspected suicides in May and August 2022, therefore we have strengthened our processes and introduced a weekly arrangement with the Real Time Surveillance System hosted by the Police to ensure we are being informed about all people who die from suspected suicide in Oxfordshire and Buckinghamshire.

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**4.0 Patient Safety Incidents reported in July and August 2022**

There were five PSI reported in July and August 2022. These included:

* Three suspected suicides, all were patients receiving treatment in the community
* Two unexpected deaths in the community from physical health conditions

**5.0 Themes and Learning**

The following is the learning we have identified from the 16 PSI investigations completed in July and August 2022:

* Quality and completeness of initial assessments, risk assessments, safety plans and care plans
* Communication between teams, external organisations/services and with partnership providers
* Timeliness of raising safeguarding concerns
* Lack of physical health care plan
* Estates/building issues, enabling AWOL from ward
* Observations not being completed or documented as expected

Below are the actions being taken to address the areas of learning identified:

* Quality Improvement projects have started to address the complex issues to improve risk assessment and formulation, working with families, and to improve access to physical healthcare for people with a severe and enduring mental illness. Tests of change are happening at team level to identify sustainable actions which make an impact.
* Oxon/BSW Head of Nursing is leading on improvement focused work around completion and documentation of observations on wards. This s also a national piece of work led by the Trust Chief Nurse.
* Estates have corrected immediate issues on ward following AWOL. With options of securing capital budget being reviewed to extend the height of the fence.

**6.0. National Patient Safety Strategy**

The Trust continues to implement the national NHS patient safety strategy, available [here](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/), focused on organisations being curious and actively looking at how to keep improving.

A major part of the strategy relates to the new national Patient Safety Incident Response Framework (PSIRF), this was published on 16th August 2022. The framework will replace the current Serious Incident Framework. The framework represents a significant shift in the way the NHS will approach and respond to Patient Safety Incidents with the sole purpose to learn and improve the safety of care. The following video provides a summary about the new framework, <https://youtu.be/TyYekgo_IN0>. Owing to the significant changes required to systems, processes and behaviors - NHS providers have 12 months to implement the changes, with transition to complete by autumn 2023.

The work the Trust has been doing over the last year around introducing post-incident learning huddles, increasing the central resource in the patient safety team, changing our approach to investigations to be more restorative focused on what we can learn as a system, as well as changing the language used, has been part of internally preparing for the new framework. A small working group is taking the first step to review and assess our current systems and processes against the PSIRF, the outcome will be an improvement plan that will be implemented over the next year.

The gap analysis and current progress will be reported via the Quality Committee