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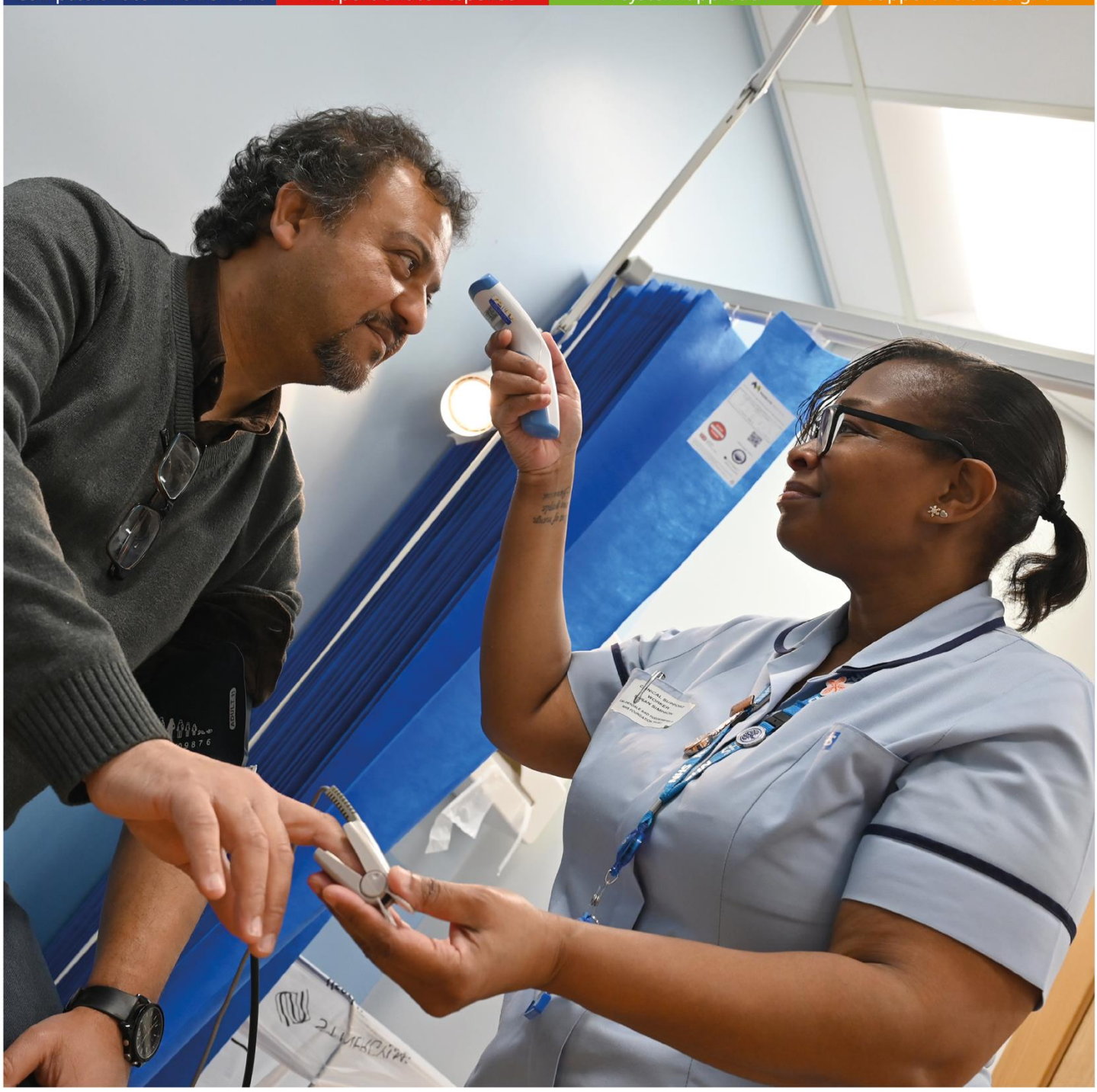
Patient Safety Incident Response Plan (PSIRP) 2024

Compassionate involvement | Proportionate response | A system approach | Supportive oversight



one culture of care

Calderdale and Huddersfield NHS Foundation Trust

Draft

Patient Safety Incident Response Plan

Effective date: 01 April 2024

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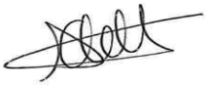
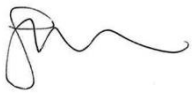
Author	**Sharon Cundy**	**Head of Quality & Patient Safety**		**01.03.2024**
Reviewer	**Joanne Middleton**	**Deputy Chief Nurse**		**21.03.2024**
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Foreword

Continual learning generates knowledge to inform practice from both what goes right and what does not. There is no distinction made between 'patient safety incidents' and 'serious incidents' and this is what makes the Patient Safety Incident Response Framework (PSIRF) so exciting to Calderdale and Huddersfield NHS Foundation Trust (CHFT).

Fostering a patient safety culture in which our staff, patients and their families feel safe to talk is pivotal for this new way of working to be a success. Having conversations with patients and their families can be difficult at times, but by continuing to foster a patient safety culture we can equip and support our colleagues to be the best they can be.

PSIRF fundamentally shifts how CHFT will respond to patient safety incidents for learning and improvement. CHFT will decide how it will respond to different incidents efficiently and proportionately.

Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the PSIRF, a replacement for the NHS Serious Incident Framework. The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them.

The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

These four strategic aims are the basis of how our plan has been developed. The strategic aims are aligned with our own four behaviour pillars that support 'one culture of care' and the implementation of PSIRF will see both the strategic aims and our Trust behaviours embodied in our work.

CHFT aims to create an environment and culture of openness, trust, and honesty. We encourage and celebrate diversity because broader perspectives, skills, experience, and knowledge will enrich and enhance the value we bring to each other, our patients/clients, and other stakeholders.

This document is the Patient Safety Incident Response Plan (PSIRP) which should be read in conjunction with the Patient Safety Incident Response Policy . It sets out CHFTs approach to developing and maintaining effective systems and processes for responding to patient safety events. The PSIRP describes the activities that we have undertaken to prepare to transition over to PSIRF. .

Calderdale & Huddersfield NHS Foundation Trust Vision and Values

NHS
Calderdale and Huddersfield
NHS Foundation Trust

One Culture of Care
Our values and behaviours

One culture of care is at the heart of everything we do

one culture of care

Purpose, scope, aims and objectives:

Purpose:

The PSIRP sets out how CHFT will respond to patient safety incidents reported by service-to-service referrals, our staff, patients, their families, and carers as part of the work to continually improve the quality and safety of the care we provide. The plan will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020 (NHS England » Patient Safety Incident Response Framework), which sets out the requirement for this plan to be developed.

Scope:

This plan explains the scope for a systems-based approach to learning from patient safety incidents. There are many ways to respond to an incident. This document covers responses completed solely for the purpose of system learning and improvement.

Patient safety incidents relate to any unintended or unexpected incident which could have or did lead to harm for one or more patient's receiving healthcare. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response completed for the purpose of learning and improvement.

Complaints, HR matters, legal claims, and inquests have their own processes and are outside the scope of PSIRF .

We have identified incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

We have developed the planning aspects of this PSIRP with the assistance and approval of the Trust's integrated care board. The aim of this approach is to continually improve. As such this document will be reviewed annually.

Strategic Aims:

There are four strategic aims of PSIRF, and these are aligned with the Trust's four pillars.

Strategic Objectives:

CHFT will develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. The Trust will make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:

- make patient safety incident investigations more rigorous and, with this, identify causal factors and system-based improvements.
- engage patients, families, carers, and staff in investigations and other responses to incidents, for better understanding of the issues and causal factors.
- develop and implement improvements more effectively.
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

[1] *A culture in which people are not punished for actions, omissions, or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.*

Situation Analysis (National):

Background:

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will, and do, go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment, and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

Historically, the NHS has set out plans to investigate each incident report that meets a certain outcome threshold or has features on a specific trigger list. When these plans were set it was clear that:

a. Investigation of incidents with a severe outcome may not always be the most productive for 'organisational learning' that informs risk management activity,[1] since luck often determines whether an undesirable circumstance translates into a near miss or an incident.[2]
b. Each incident report does not need to be investigated to identify the common causes and improvement actions required to reduce the severity and/or likelihood of repeat incidents, because in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.

In addition to the above, an increased openness to report incidents has placed greater demands on the limited patient safety services which are struggling to meet the task of investigating a high number of repeat investigations with the level of rigour and quality required. Available investigation resources are swamped by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to identify.[3,4,5,6,7.]

The remit for patient safety investigation has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (e.g., professional conduct or fitness to practise; establishing liability or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to investigation (e.g., the Rail Accident Investigation Branch, Air Transport Safety Board), others list the parameters that help their decision-making processes (the Police, Parliamentary and Health Service Ombudsman and Healthcare Safety Investigation Branch).

We need to remove the barriers in healthcare that have frustrated the success of patient safety investigation, learning and improvement (e.g., mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future patient safety learning responses.
b. conducting investigations purely from a patient safety perspective.
c. reducing the number of repeat investigations.
d. aggregating and confirming the validity of learning and improvements by basing PSIs on a small number of similar repeat incidents.

This approach will allow NHS organisations to consider the safety issues that are common to similar types of incidents and, based on the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or
b. the subject of current improvement work that can be shown to result in progress.
c. listed for PSII work to be scheduled in the future.

In some cases where a PSII for system learning is not indicated, another response may be required. This will depend on the intended aim and required outcome and might include case note review, thematic review, learning review meeting or sharing of an anonymised incident report. All information relating to PSIs, and the insight generated from all responses must be recorded within our Trust incident reporting system and shared with the National Reporting and Learning System (NRLS) or its successor LFPSE (Learning From Patient Safety Events. The LFPSE service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare which will improve the learning both locally and nationally.

There may be occasions where our patients may want to express concerns formally and these will be manged under the already existing pathways outlined in the Trust's complaints policy.

[1] Vincent C, Adams S (1999) A protocol for the investigation and analysis of clinical incidents. Available at: http://www.patientsafety.ucl.ac.uk/CRU-ALARMprotocol.pdf

[2] Health and Safety Executive (2014). Investigating accidents and incidents. Available at: http://www.hse.gov.uk/pubns/hsg245.pdf

[3] Public Administration Select Committee (2015) Investigating clinical incidents in the NHS. Sixth report of session 2014–15. Available at: https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf

[4] Parliamentary and Health Service Ombudsman (2015) A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. Available at: www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

[5] Care Quality Commission (2016) Learning from harm: Briefing paper. Available at: www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf

[6] NHS Improvement (2018) The future of NHS patient safety investigation. Available at: https://improvement.nhs.uk/documents/2525/The_future_of_NHS_patient_safety_investigations_for_publicatio n_proofed_5.pdf

[7] NHS Improvement (2018) The future of NHS patient safety investigation – engagement feedback. Available at: https://improvement.nhs.uk/documents/3519/Future_of_NHS_patient_safety_investigations_engagement_feedb ack_FINAL.pdf

Situation Analysis (Local):

Results of a review of activity and resources:

To support the assessment of risk and to agree patient safety incident priorities we undertook an in-depth thematic analysis over a five-year period, 2018 to 2022 using organisational data from patient safety incident reports, complaints, compliments, claims, inquests, structured judgement reviews, staff surveys, friends and family tests, Journey 2 Outstanding reviews, Observe & Act reviews, case note reviews, risk registers and audit. The review has been undertaken alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

Following the collation of our data, we held discussions on the themes identified within our PSIRF Task and Finish Group and these were presented to the Executive Board to agree local priorities for investigation.

This review has been undertaken by the Trust's Quality and Safety Team with support and involvement from the Divisional Leadership Teams, the Safeguarding Team, Mental Health Team, Workforce and Organisational Development and other stakeholders.

To improve our ability to deliver against PSIIs, the Trust plans to:

- Assign a team of appropriately trained PSII investigators who have received systems-based training on incident investigation methodologies.
- Assign an appropriately trained board member to oversee delivery of PSIIs and support the sign off of all PSIIs.
- Develop an incident investigation toolkit to support other Trust staff so they can review Patient Safety Incidents where a PSII is not indicated but learning can still be identified.

Top 10 local priorities collated from the local patient safety incident review:

Incident Type:	Description:	Response Type (see Appendix B for templates) :	Governance:
Infection	All instances of Healthcare Associated Infections	SWARM (Rapid Incident Review) if required. Checklist incorporating Yorkshire Contributory Factors Framework Quarterly Thematic Reviews	Infection, Prevention and Control Board. PSIRF Board. Divisional Patient Safety Quality Board (PSQB) Quality Committee
Pressure Ulcers and Tissue Damage	All categories of pressure ulcers and tissue damage resulting from hospital stay or attributed to CHFT community services	SWARM (Rapid Incident Review) if required. Checklist incorporating Yorkshire Contributory Factors Framework Observation to inform understanding of contextual factors influencing compliance. Continued monitoring of patient safety incident records to determine any emerging risks/issues. Quarterly Thematic Reviews	Pressure Ulcer and Tissue Viability Collaborative. PSIRF Board. Divisional PSQB Quality Committee
Slips, Trips and Falls	Patient falls resulting in injury	SWARM (Rapid Incident Review) if required. Checklist incorporating Yorkshire Contributory Factors Framework Continued monitoring of patient safety incident records to determine any emerging risks/issues. Quarterly Thematic Reviews	Falls Collaborative. PSIRF Board. Divisional PSQB Quality Committee
Delayed Treatment	Particularly Issues on Movement of Patients/Lost to Follow-up	SWARM (Rapid Incident Review) if required. After Action Review (AAR) +/- Thematic Review	Divisional PSQB PSIRF Board Quality Committee
Diagnostic Services	Test Results/Sharing Results	SWARM (Rapid Incident Review) if required. AAR +/- Thematic Review	Divisional PSQB PSIRF Board Quality Committee
Deteriorating Patient	Deterioration in patients leading to unplanned admission to level 2 or 3 care	SWARM (Rapid Incident Review) if required. AAR +/- Patient Safety Incident Investigation (PSII) Continued monitoring of patient safety incident records to determine any emerging risks/issues.	Care of the Acutely Ill Patient Group. PSIRF Board. Divisional PSQB Clinical Outcomes Group Quality Committee

Communication	Record Keeping /Documentation /Discharge Planning	SWARM (Rapid Incident Review) if required. AAR +/- Thematic Review	Divisional Patient Safety Quality Board PSIRF Board Quality Committee
Medication	Incorrect Medications for inpatients/outpatients and discharged (including prescribing, monitoring, administration, supply, and patient information)	SWARM (Rapid Incident Review) if required. AAR +/- Patient Safety Incident Investigation (PSII)	Medicine Safety Steering Group Divisional PSQB Quality Committee
Obstetrics	Post partum Haemorrhage in excess of 1.5L	SWARM (Rapid Incident Review) if required. AAR +/- Thematic Review	Maternity Forum Divisional PSQB Quality Committee
Health Records – Consent/Capacity	Records Consent / Capacity	SWARM (Rapid Incident Review) if required. AAR +/- Thematic Review	Clinical Records Group Divisional Patient Safety Quality Board PSIRF Board Audit and Risk Committee

Through our analysis of our patient safety insights, based on the review of the data, we have determined that the Trust requires two patient safety priorities as local focus. This will allow us the capacity to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

The priority areas identified, and incident types are set out in the table below and are relevant for all our patient services, including maternity services. Whilst these priorities have been agreed they are not fixed and are open to review. We have also established capacity for an additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Patient safety incident type or issue	**Planned response**
Deteriorating Patient: Deterioration in patients leading to unplanned admission to level 2 or 3 care (See Appendix C for criteria on Levels of Care)	Locally led PSII
Medication Errors: Delayed Medicines/Delayed Medicine Discharges/Unclear Explanations	Locally led PSII
New emerging risks or where learning and improvement can be gained from a particular incident or theme	Locally led PSII

All investigators will be supported by an investigation team which will include a supporting investigator, dedicated patient/family point of contact, administrative and management support. Executive support will be made available from the Chief Nurse and the Medical Director as required. Lead and supporting investigators will not be expected to manage more than 2 PSIIs at any one time.

Timescales for patient safety investigation

Where a patient safety investigation for learning is indicated, the investigation must be started as soon as possible after the incident has been identified.

Patient safety investigations should ordinarily be completed within one to three months of the start date.

Where a longer timeframe is required for completion of the patient safety investigation, this can be agreed by the CHFT PSIRF board members in consultation with the patient/family.

No local patient safety investigation should take longer than six months. A balance must be drawn between conducting a thorough investigation, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed local safety investigation can be reviewed to determine whether new information indicates the need for further investigative activity.

Nationally defined priorities requiring referral for investigation advice.

National priorities for the reporting and referral of patient safety incidents to other bodies for investigation are described in the table below:

Incident Type:	Response Type:
Incident in screening programmes	PSII Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional 15 Screening Quality Assurance Service (SQAS) and commissioners of the service)
Child Death	PSII (if indicated by the PSIRF panel) Incidents must be referred to child death panels for investigation
Safeguarding incident:	PSII (if indicated by the PSIRF panel) Incidents must be reported to the local organisation's named professional/safeguarding lead manager and the Chief Nurse for review/multi-professional investigation.
Death in custody where healthcare was provided by the NHS	PSII (if the death occurred at CHFT) Incidents must be reported to the Independent Office for Police Conduct (IOPC). Organisations should contribute to IOPC investigations when approached.
Notification of infectious diseases:	PSII (if indicated by the PSIRF panel) Incidents must be reported to the local organisation's DIPC and Chief Nurse for review/multi-professional investigation. Incidents will be managed locally through local review of the incident and through process audit.
Information Governance	PSII (if indicated by the PSIRF panel) Incidents previously reported under the Serious Incident Framework 2015 must be responded to according to Data Security and Protection guidance. This includes reporting via the data security and protection toolkit as required

Nationally defined incidents requiring local investigation:

National priorities for patient safety investigation are set by the PSIRF and other national initiatives. These are:

a. incidents that meet the criteria set in the Never Events list 2018.
b. incidents that meet the 'Learning from Deaths' criteria; that is, deaths which – following a case note review – are considered more likely than not due to problems in care.

Roles and responsibilities

CHFT describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

Chief Executive and Board of Directors:

The principal accountability of all providers of care is to patients and their families/carers. In their fulfilment of the Trust's duty in this regard, the Board must ensure that an appropriate incident management system is in place for the reporting of incidents and monitoring of incident trends, including PSIIs and the recording of all Never Events in the annual reporting arrangements. The Board must ensure that the patient safety incident response framework is implemented from ward to board. Provider organisations are also accountable for effective governance and learning through assurance of their PSIRP, and it is the duty of the Board to ensure appropriate arrangements are in place throughout the Trust to meet this expectation.

The Board takes responsibility for creating a just, open and learning culture within the organisation and for role modelling the behaviours required to achieve this.

The Chief Executive is accountable and responsible to the Board for ensuring that resources, policies, and procedures are in place to ensure the effective reporting, recording, investigation and treatment of incidents.

The Chief Executive has:

- Overall responsibility for ensuring the organisation has processes that support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or patient safety incident investigations (PSIIs) where required).
- Overall responsibility for ensuring the development of a patient safety reporting, learning and improvement system.
- Ensures that systems and processes are adequately resourced: funding, management time, equipment, and training.
- Appoints executive lead for supporting and overseeing implementation of the PSIRF.
- Approves publication and ongoing review of the organisation's patient safety incident response plan (PSIRP).
- Ensures that the PSIRF, patient safety incident reporting data, patient safety incident investigation data, findings, improvement plans, and progress are discussed at the board's quality subcommittee.
- Ensures that the organisation complies with internal and external reporting/ notification requirements.
- Acts as spokesperson in complex/high profile cases where the media/public is engaged.

Chief Nurse:

The Chief Nurse is the nominated Director responsible for ensuring the Trust has appropriate arrangements in place for the management of incident reporting and associated investigation. The responsibility for defining and verifying an adverse event as a PSII rests with either the Chief Nurse or the Medical Director (or the Chief Executive in their absence) as part of the Patient Safety Incident Response Plan. Once verified, the Associate Director of Quality & Safety or his/her deputy will ensure the appropriate internal and external reporting is carried out and the investigation commences in accordance with this policy and procedure.

Medical Director:

The responsibility for defining and verifying an adverse event as a PSII rests with either the Chief Nurse or the Medical Director (or the Chief Executive in their absence) as part of the Patient Safety Incident Response Plan. The Executive Medical Director is the Trust's lead in the formation and implementation of clinical strategy, taking a lead on clinical standards in relation to the quality and safety of patient care, and providing clinical advice to the Board.

Directors/Executive Team:

All Directors are responsible for ensuring incident reporting arrangements as described in this policy are implemented throughout their service areas. The Executive Team ensures accountability from divisions regarding the implementation of actions and dissemination of learning following serious incidents, or other incident trends highlighting emerging issues. It receives assurance that the Trust's Being Open and Duty of Candour policy is adhered to in terms of informing patients and/or relatives of incidents and the subsequent sharing of reports.

Associate Director of Quality and Safety:

The Associate Director of Quality and Safety is responsible (on behalf of the Chief Nurse and the Medical Director) for ensuring the following systems are in place and operate effectively:

- Ensures that the organisation has processes that support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Ensures that processes for preparing for and responding to patient safety incidents are reviewed as part of the overarching governance arrangements.
- Ensures that the executive and non-executive team can access relevant safety incidents, including the impact of changes following incidents.
- Oversees development and review of the organisation's PSIRP.
- Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families, and carers where required.
- Ensures that the Duty of Candour is upheld.
- Ensures that the organisation complies with the national PSII standards.
- Establishes procedures for agreeing patient safety investigation reports in line with the national PSII standards.

- Develops professional development plans to ensure that staff have the training, skills, and experience relevant to their roles in patient safety incident management.
- Provides leadership, advice, and support in complex/high profile cases.
- Liaises with external bodies/supports the Chief Executive as a spokesperson for the organisation as required.

The Associate Director of Quality and Safety will meet these duties through delegated responsibility to the Head of Quality and Patient Safety and the Patient Quality and Safety Team.

Patient Safety Specialists:

CHFT currently have five Patient Safety Specialists (PSS). The Chief Nurse, Deputy Chief Nurse, Director of Corporate Affairs, Associate Medical Director, and the Head of Quality and Patient Safety are the nominated PSSs. The designated PSSs within CHFT provide dynamic senior patient safety leadership. Each PSS plays a key role in the development of a patient safety culture, safety systems and improvement activity. Each PSS also facilitates the escalation of patient safety issues or concerns and has direct access to the Executive Team. The PSSs will coordinate and support CHFT's local patient safety priorities that are outlined in this document. All the PSSs have close links with the NHS England and NHS Improvement National Patient Safety Team who host a national network for Patient Safety Specialists, including regular meetings and information sharing through a dedicated national forum.

Patient Safety and Quality Team:

The Patient Safety and Quality Team has delegated day-to-day management responsibility for the Trust's electronic incident management system together with all other systems related to the recording, analysis and tracking of incidents and associated action plans. The team must also:

- Ensures that PSIIs are undertaken for all incident that require this level of response (as directed by the organisation's PSIRP)
- Develop and maintain local risk management systems and relevant incident reporting systems, including the National Reporting and Learning System (NRLS), the Strategic Executive Information System (StEIS) and its replacement, Learning From Patient Safety Events (LFPSE) once introduced, to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Support the development and review of the organisation's PSIRP.
- Ensure the organisation has procedures that support the management of patient safety incidents in line with the organisation's PSIRP (including convening review and PSII teams as required and appointing trained named contacts to support those affected).
- Establish procedures to monitor/review PSII progress and the delivery of improvements.
- Work with the executive lead to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents, including gaps in resource including skills/training.
- The Quality Governance Leads will help to support and advise staff involved in the patient safety incident response.

Patient safety incident investigators:

Patient safety incident investigators must have been trained in systems based thinking and human factors. They must also:

- Ensure that they undertake PSIIs in line with the national PSII standards.
- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.
- Identify those affected by patient safety incidents and their support needs.
- Provide them with timely and accessible information and advice.

Department leads/managers:

All department leads and managers must:

- Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information.
- Ensure that incidents are reported and managed in line with internal and external requirements.
- Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in reviews/PSIIs as required.
- Work with the patient safety team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).
- Lead the local learning response as indicated in the PSIRP for example : After action reviews, SWARMS.
- Develop communication strategies that ensure learning is disseminated effectively supported by a robust process of escalation when needed.

All staff:

All staff Trust wide must:

- Understand their responsibilities in relation to the organisation's PSIRP and act accordingly.
- Know how to access help and support in relation to the patient safety incident response process.

Commissioners and commissioning organisations (including ICBs, CQC, NHS England):

All our stakeholders must:

- Ensure that they are familiar with this introductory framework as they begin to consider how their roles and responsibilities will evolve to meet its requirements.
- Assess effectiveness of systems and processes to respond to patient safety incidents in NHS-funded provider services as demonstrated by the behaviours of openness and transparency; the existence of a just culture; evidence of continuous learning and improvement.
- Support/enable co-ordination of cross-system review/investigation where activity cannot be managed at the provider level because the incident is unusually complex/difficult or costly to manage due to multiple providers and/or services being involved across a care pathway.
- Provide improvement support where weaknesses are identified in a provider's systems and processes for responding to patient safety incidents.
- Share insights and information between organisations/services that have demonstrably improved care and or reduced risk.
- Annually review provider organisations' progress against investigation/review plans.

Specific roles/responsibilities - Patient safety incident response plans (PSIRPs):

The Head of Quality and Patient Safety along with the nominated Patient Safety Specialists must:

- Work with providers to agree PSIRPs before their publication on providers' websites. The designated lead commissioner for the provider should lead for this work and involve associate commissioners proportionate to their level of interest in the provider.
- With local system leaders, assure effective application of local PSIRPs and national patient safety investigation standards.
- Monitoring and annual review of the PSIRP must form part of the overarching quality governance arrangements and be supported by clear financial planning to ensure that appropriate resources are allocated to review, investigation and improvement activities.
- In line with recommendations from the Kirkup Review of Liverpool Community Hospital Trust, where a regulator or oversight organisation has concerns regarding the safety of NHS-commissioned services, additional information and assurance will be sought from the provider. If this involves the commissioning of an independent investigation or review, this will be additional to those in the provider's PSIRP.

Supporting cross-system patient safety investigations:

All commissioning systems must develop their capacity and capability, where these are insufficient, for co-ordinating cross-system investigation and have systems to recognise incidents that extend beyond local boundaries and may require co-ordination at a regional level.

Information sharing to support patient safety investigations:

Records will need to be shared when commissioning and undertaking patient safety investigations, in line with information governance structures and relevant guidance, regulation and legislation. Commissioners should assist in this process.

Incident reporting arrangements

Full details of incident reporting arrangements are detailed in the CHFT Incident Reporting, Management and Investigation Policy and the Patient Safety Incident Response Policy. This will include internal and external notification requirements for the reporting of patient safety-related incidents. All staff are required to:

- Report all incidents and near misses via the Trust's electronic incident management system.
- Ensure the details of any incident are contemporaneously and objectively reported in the patient's clinical record.
- Raise any concerns about situations that led to, or could lead to, an incident or a near miss with their line manager or the Patient Safety and Quality Team.
- Actively participate in any subsequent incident investigation such as: providing a written account of the incident; attending multidisciplinary fact-finding and feedback meetings.
- Attend a Coroner's inquest on behalf of the Trust if called to do so.
- Undertake mandatory training in the reporting of incidents.
- Undertake additional training, as required, to ensure competence in relation to the Datix (Safeguard) system.

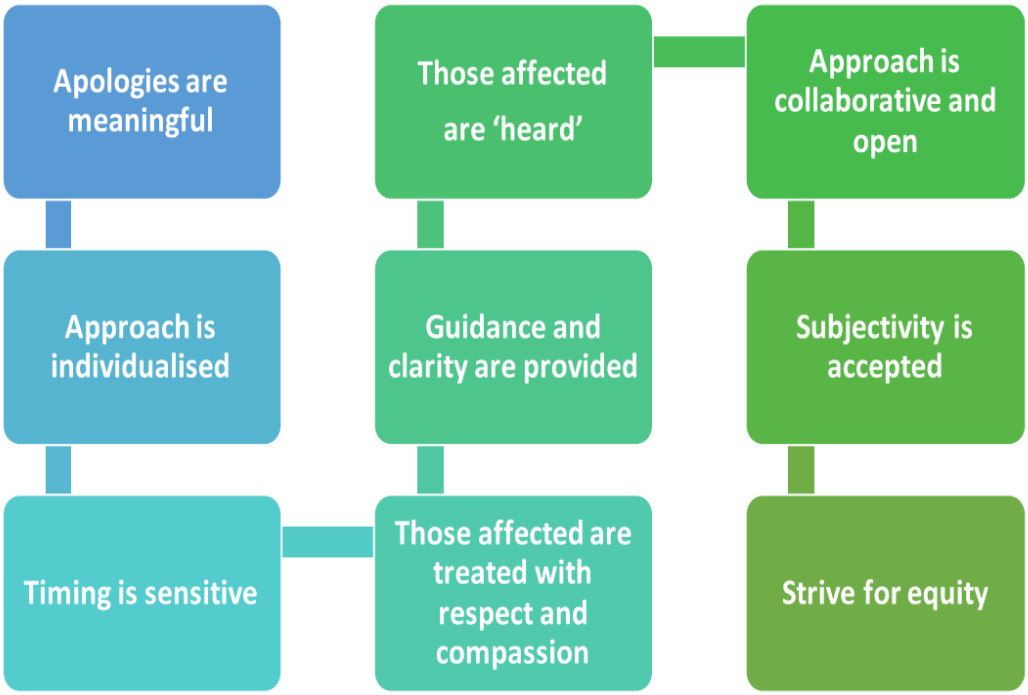
The Trust will make available appropriate support to those staff involved in an incident, where this is required.

There are specific incidents which may require reporting externally under specific criteria, these are detailed within the Trusts incident management policy, for the reporting and management of incidents.

Procedures to support patients, families and carers affected by patient safety incidents:

Engagement is pivotal within any review and those affected include staff and families in the broadest sense. The family includes the person or patient (the individual) to whom the incident occurred, their family and close relations. Staff includes those directly involved, their colleagues and those working in the same clinical area.

Principles for engagement



Four stages of engagement

The national and local arrangements for supporting patients, families and carers are:

Named contacts for patients, families, and carers:

- Each patient/carer will have a named contact identified to facilitate their access to relevant support services.
- The named contact will have experience of and been trained in 'being open' and Duty of Candour.
- The named contact will have sufficient time to undertake this role.
- Will support staff training in openness and transparency.
- Be able to establish a relationship with those affected (and become known to and trusted by the patient, their family, and carers).
- Be able to offer a meaningful apology, reassurance and feedback to patients, their families, and carers.
- Have a good grasp of the facts relevant to the incident but be sufficiently removed from the incident itself.
- Be senior enough or have sufficient experience of and expertise in the type of patient safety incident to be credible to the patient, their family and carers, and colleagues.
- Have excellent interpersonal skills, including being able to communicate with the patient, their family, and carers in a way they can understand, without excessive use of medical jargon.
- Have a good understanding of how the incident will be responded to and ensure realistic expectations are set.
- Be able to liaise with several different individuals and be prepared to help those affected navigate complex systems/processes.
- Actively listen to patient, family and carer queries/concerns and engage with other staff to ensure these are responded to openly and honestly.
- Be knowledgeable about and provide access to different types of support (including independent advocacy services as required).
- Be able to maintain a medium to long-term relationship with the patient, their family, and carers where possible, and to provide continued support and information during the investigation/review process.
- Be culturally aware and informed about the specific needs of the patient, their family, and carers.

For continuity and consistency of communication, a co-contact will be assigned to support the lead contact and to act as lead contact during times when the first named contact is absent.

Junior staff or those in training must not be appointed as lead named contacts unless accompanied to all meetings with patients, families and carers and supported by a senior team member.

Procedures to support staff affected by patient safety incidents:

CHFT is committed to supporting our staff and are proud to have been awarded a range of accreditation in recognition of our positive employment practice. Alongside being a Disability Confident Employer, CHFT has also signed the Armed Forces Covenant and our People Strategy sets out our plan for delivering One Culture of Care for all our colleagues.

The Trust provides all staff with an Occupational Health Service which focuses on the physical and mental wellbeing of employees in the workplace. Managers can refer a member of staff for support or alternatively, staff members can self-refer.

The Trust has a Spiritual Care and Chaplaincy Team who are available 24/7 on site or via switchboard for support for staff or patient/carer support following incidents. The Chaplaincy Team are trained to offer diffusing and debrief sessions, as well as offering guidance and signposting for further support.

Free counselling, support and advice is available via the Well-being online website which is available through the Trust's intranet.

The Trust has an identified Freedom to Speak Up Guardian (FTSU) available via a designated email address. The FTSU will provide support to colleagues if they have raised any concerns to them.

The Trust has an identified Nurse Consultant in Mental Health available via a designated email address.

Named contacts for staff:

- Facilitate private and confidential conversations with staff affected by a patient safety incident.
- Work with line managers to provide advice and support to these staff.
- Facilitate their access to additional support services as required.
- Liaise between these staff and review/PSII teams as required.
- Support staff training in recognising the signs of stress and post-traumatic stress disorder in themselves and others and how to access help and support.
- Work with the patient safety team and other services to prepare/inform the development of different support services.

Mechanisms to develop and support improvements following patient safety investigations:

The national and local mechanisms to develop and support improvements are:

- Measurement is fundamental to any improvement programme. Without it, organisations may invest time and effort implementing changes that have little or no impact or, in the worst case, increase the risk of further harm. From the start those responsible for

implementing improvements/solutions must establish procedures to monitor actions and determine whether they are having the desired effect. Both outcome and process measures should be used to interpret the impact of actions and to inform how actions should be adapted if they fail to have the desired effect.

- Maintaining an action log throughout the PSII to ensure identified improvements are actioned in a timely manner as identified.
- Completion of an Incident Evaluation Form following review of all incidents identified as Incidents for Review (IFR). The Incident Evaluation Forms will be reviewed through the Divisional Governance structure and weekly at the Trust Patient Safety Event Review meeting.
- Monthly reporting of improvements identified, and actions being taken to complete.
- Identification of Quality Improvement projects requiring a lead and registration and support through the Quality and Safety Team
- Identification of potential trust-wide transformation projects and proposals for transformation team support

Evaluating and monitoring outcomes following patient safety investigations and reviews

11.1 Robust findings from investigations and reviews provide key insights and learning opportunities, but they are not the end of the story.

11.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and investigations. The Quality & Safety Team along with the Workstream Leads for our collaboratives will support improvement design.

11.3 Reports to the board will be quarterly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from patient safety incidents
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view.
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents

In addition to the above, the Trust 'Information Performance Report' will provide the board with oversight of key quality and safety metrics.

PALS & Complaints

CHFT will ensure that effective engagement is maintained with all our patients, families, carers, and staff at the outset of any patient safety event reported. It is hoped that by involving our patients and their families from the outset will avoid having use the complaints route of engagement.

Local arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are:

- The Trust's Complaints Handling Policy is for patients, their carers, relatives, or friends to raise concerns regarding the care and treatment of a patient. Concerns are raised via Patient Advice and Liaison Services (PALS) or through a formal complaint. The Complaints Team, the Legal Team and Patient Safety Team work closely to ensure aligned and effective approaches in response to patient safety incidents.
- PALS offers patients, families and carers confidential advice, support, and information on health-related matters. As well as informally helping to resolve issues, PALS can guide people on filing a formal complaint and advise on accessing advocacy services.
- Everyone has the right to make a complaint about any aspect of NHS care, treatment, or service. The NHS website gives guidance on how to do this and details of local advocacy providers. The independent NHS Complaints Advocacy Service will provide someone to help navigate the NHS complaints system, attend meetings, and review information given during the complaints process. Local Healthwatch also provides information about making a complaint, including sample letters.
- Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

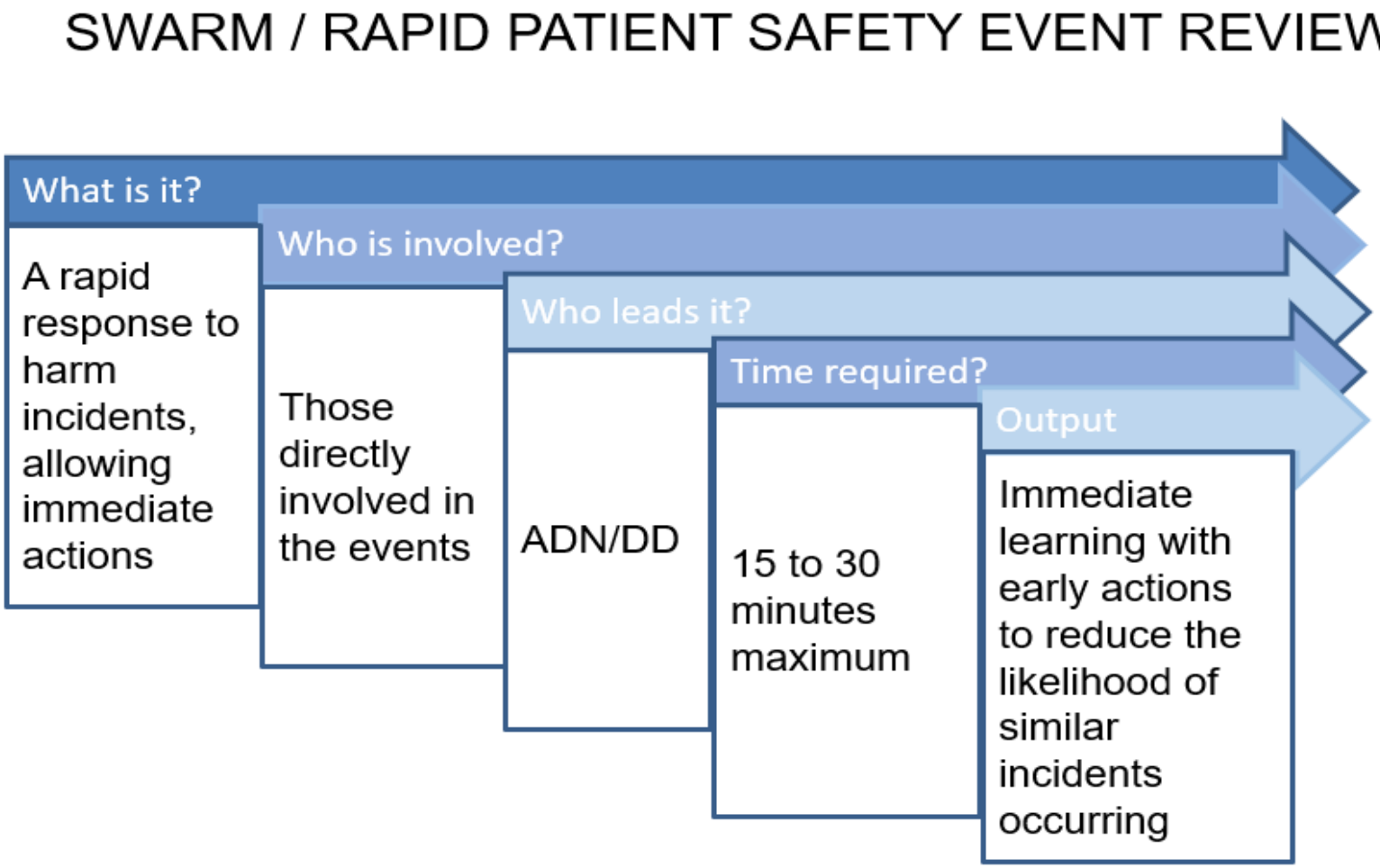
Appendix A:

Glossary of Terms

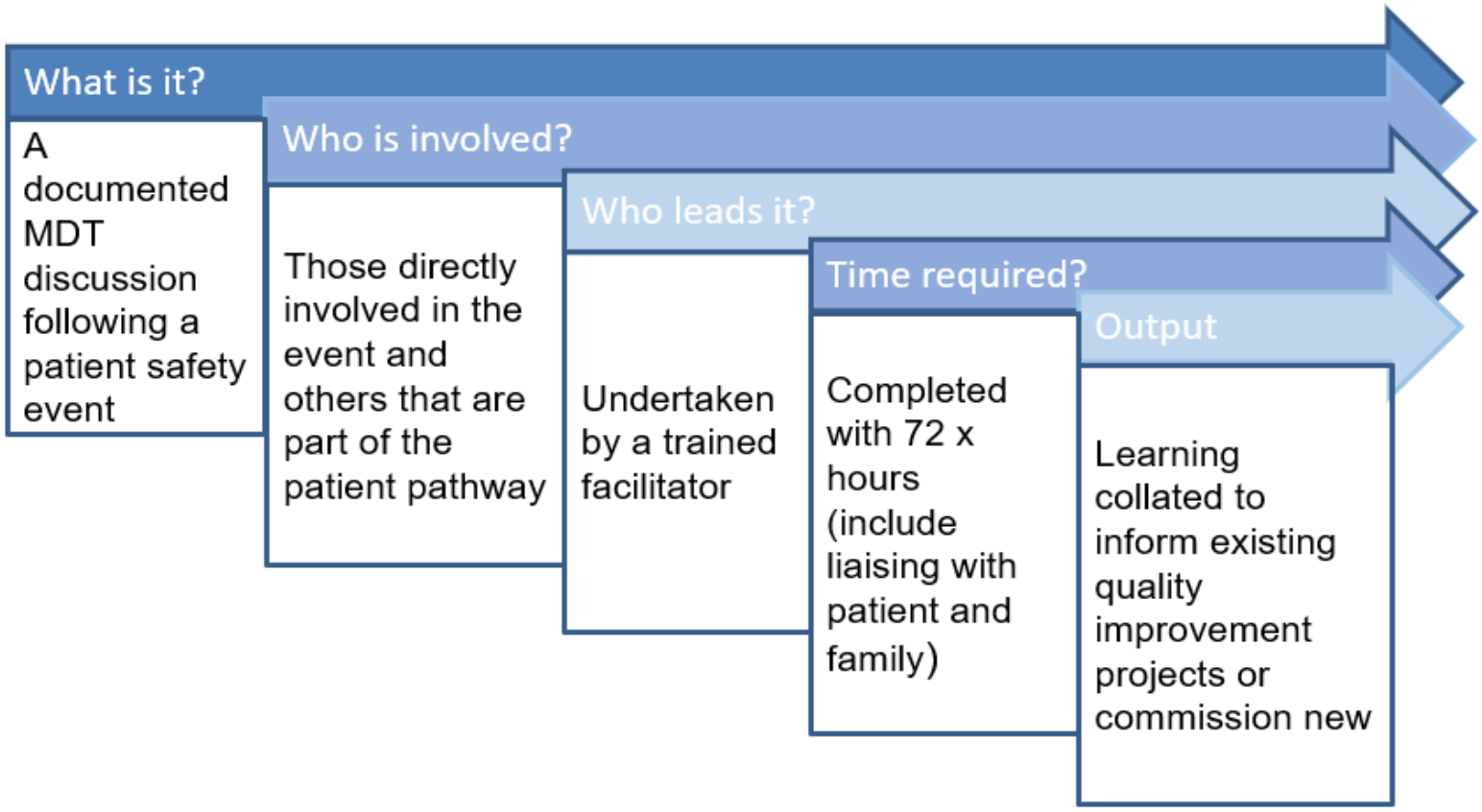
Term and abbreviation	Definition/description
Patient Safety Incident Response Framework (PSIRF)	A new NHS framework, published in August 2022 which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient Safety Incident Response Plan (PSIRP)	Describes the approach an organisation will take to address national safety priorities and its specific local safety priorities, to meet the requirements of the PSIRF.
Patient Safety Incident Investigation (PSII)	An in-depth review of a single patient safety incident (or cluster of events) undertaken by a Lead Investigator, trained in the systems approach to learning from patient safety incidents
After Action Review (AAR)	A structured and facilitated discussion of an event which includes the individuals involved in understanding why the actual outcome differed from the expected, what can be learned and improved upon.
Multi-disciplinary Team (MDT) Review	An in-depth process of review, with input from different disciplines, including those involved, to identify learning from multiple patient safety incidents, explore themes, systems, and processes.
SWARM (Rapid Patient Safety Event Review)	An immediate review of an event for the purpose of addressing immediate patient safety and staff well-being needs.
Thematic Review	A deep dive into identified themes and issues for a particular group of patients or events, to inform further analysis and/or align with improvement work.
Systems Engineering Initiative for Patient Safety (SEIPS)	A problem-solving tool which prompts the examination of the interactions between the component parts of a complex healthcare work system.

Appendix B:

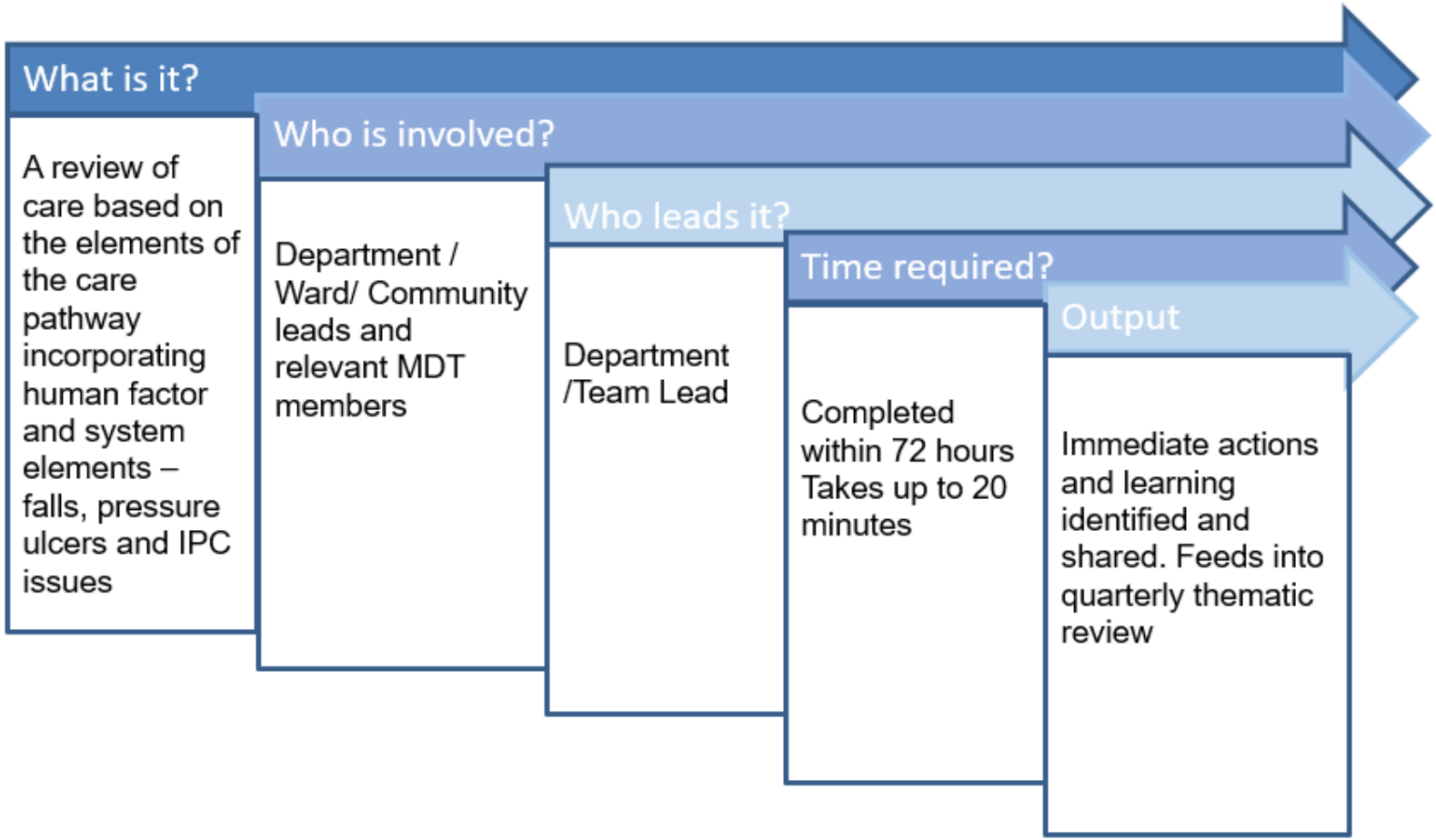
Learning Responses:



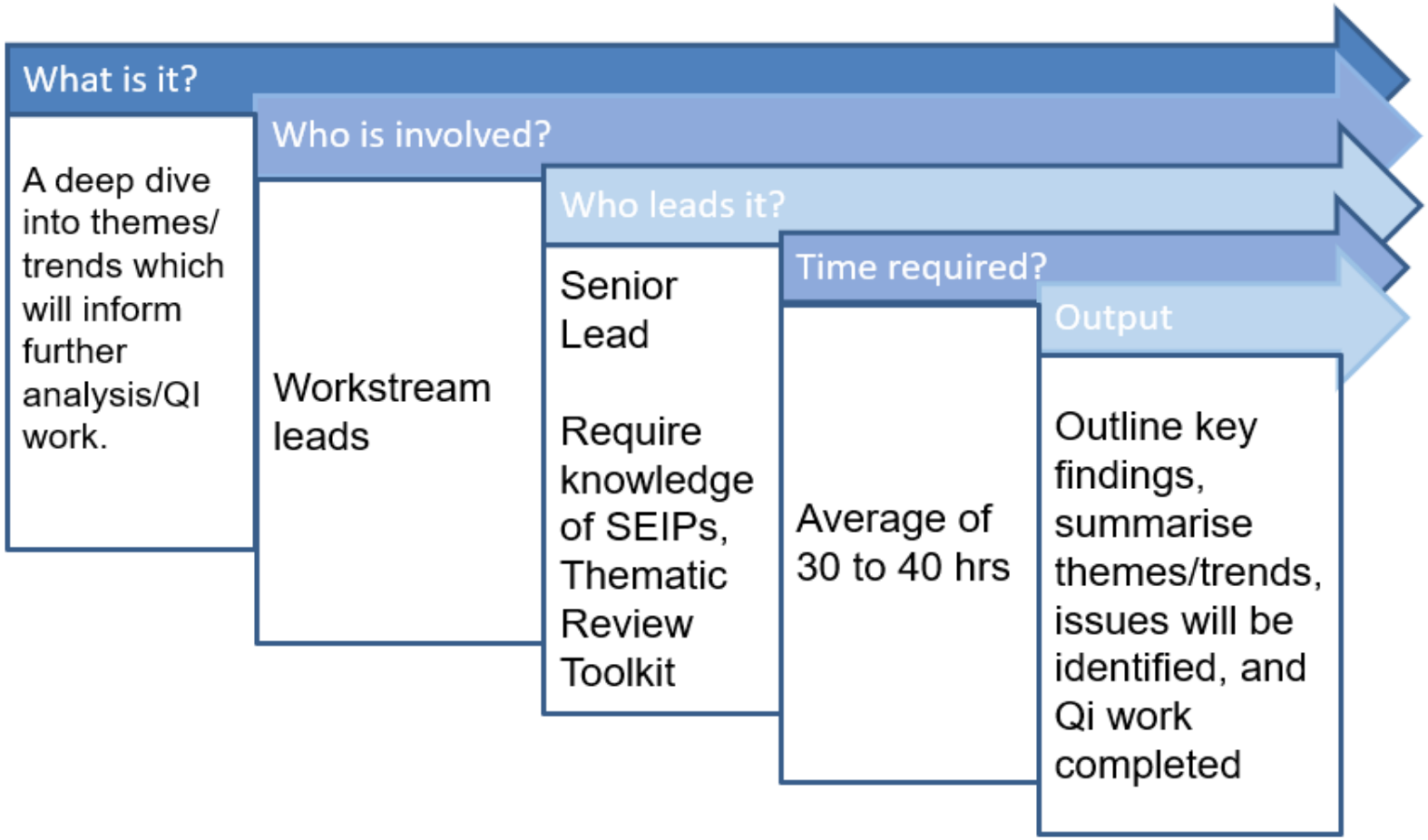
AFTER ACTION REVIEW (AAR)



Contributory Factors Checklist

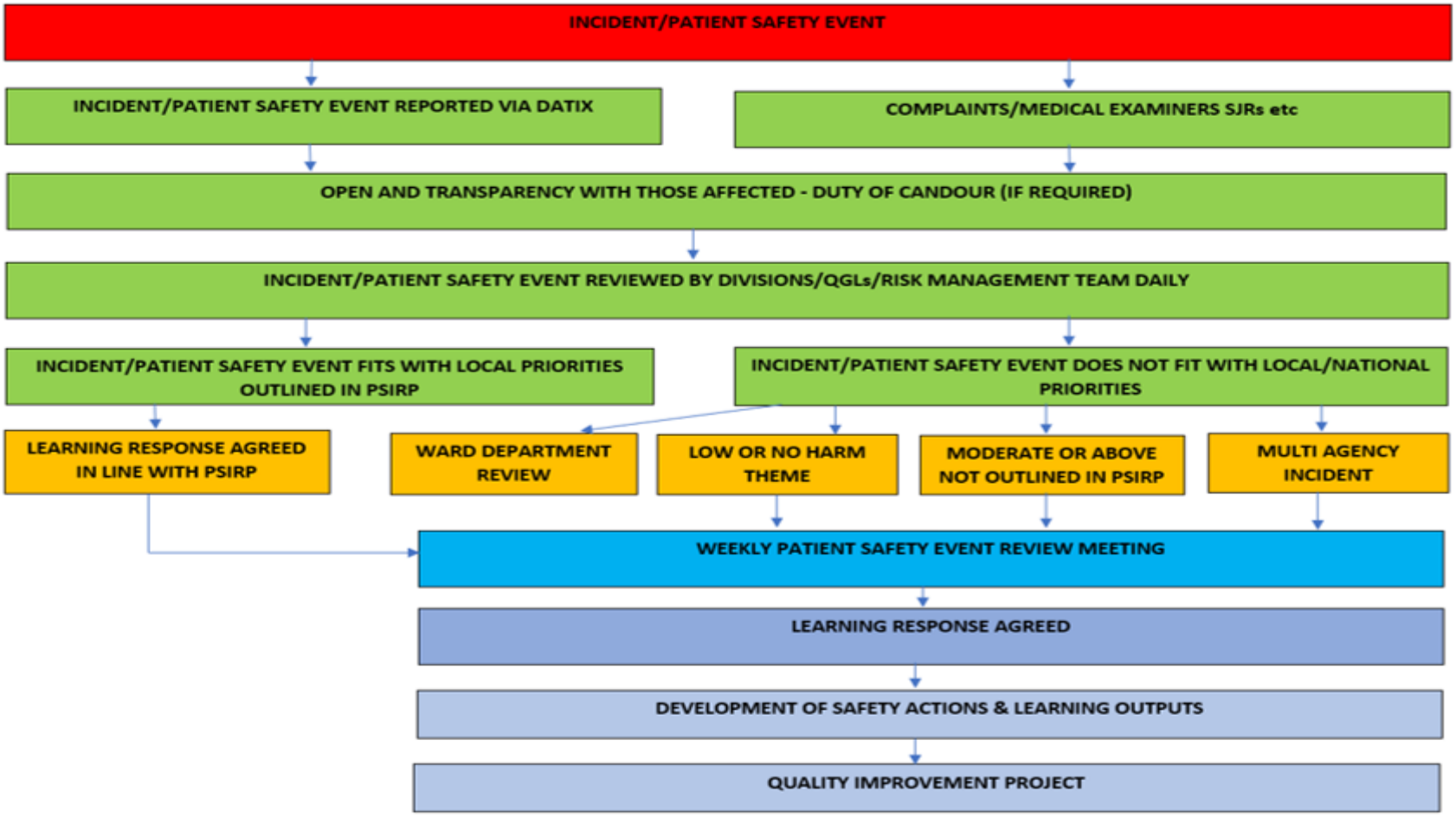


THEMATIC REVIEWS

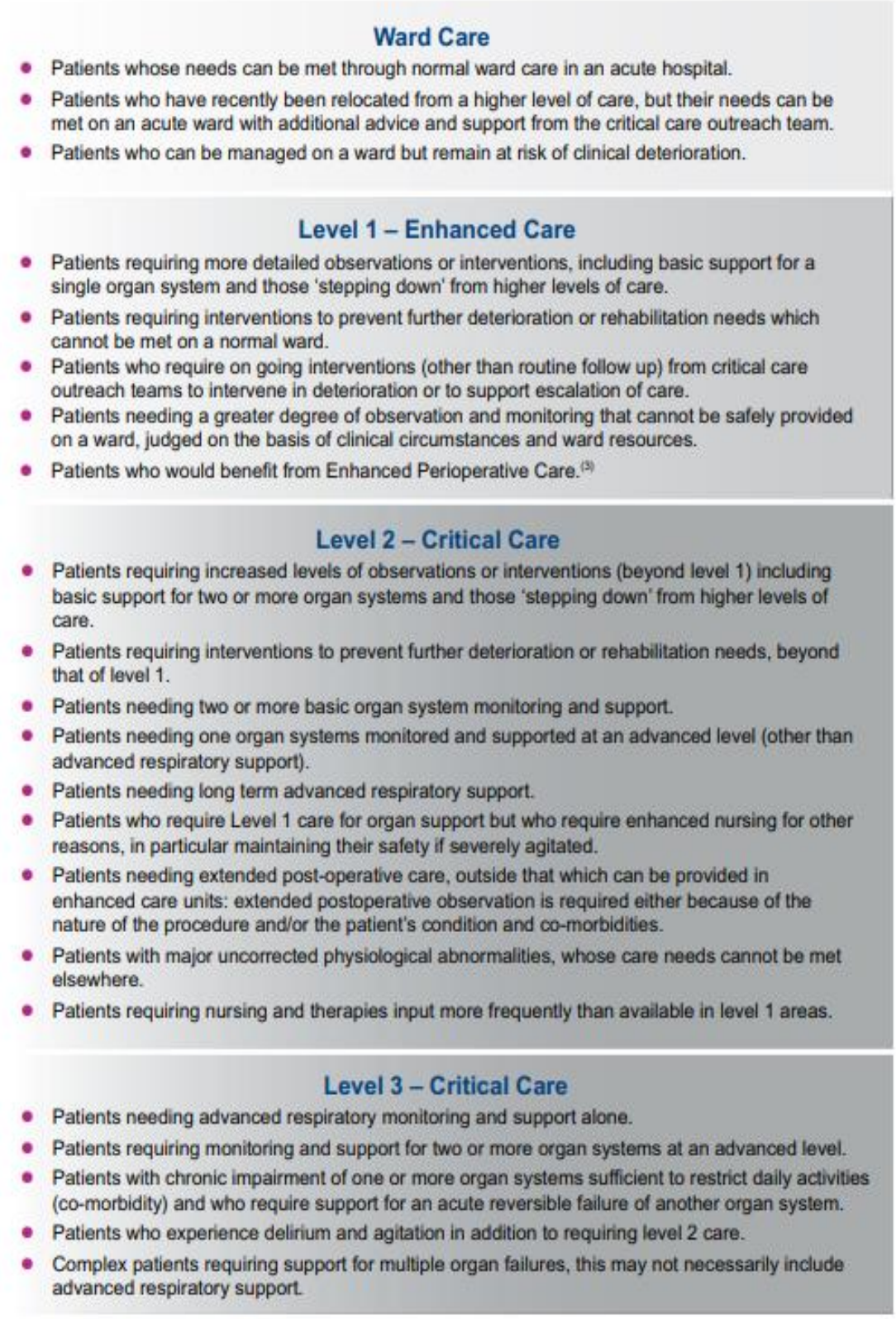


Appendix C:

Flowchart outlining incident review process.



Appendix D:



Ward Care

- Patients whose needs can be met through normal ward care in an acute hospital.
- Patients who have recently been relocated from a higher level of care, but their needs can be met on an acute ward with additional advice and support from the critical care outreach team.
- Patients who can be managed on a ward but remain at risk of clinical deterioration.

Level 1 – Enhanced Care

- Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward.
- Patients who require on going interventions (other than routine follow up) from critical care outreach teams to intervene in deterioration or to support escalation of care.
- Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged on the basis of clinical circumstances and ward resources.
- Patients who would benefit from Enhanced Perioperative Care.[3]

Level 2 – Critical Care

- Patients requiring increased levels of observations or interventions (beyond level 1) including basic support for two or more organ systems and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs, beyond that of level 1.
- Patients needing two or more basic organ system monitoring and support.
- Patients needing one organ systems monitored and supported at an advanced level (other than advanced respiratory support).
- Patients needing long term advanced respiratory support.
- Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining their safety if severely agitated.
- Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and co-morbidities.
- Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere.
- Patients requiring nursing and therapies input more frequently than available in level 1 areas.

Level 3 – Critical Care

- Patients needing advanced respiratory monitoring and support alone.
- Patients requiring monitoring and support for two or more organ systems at an advanced level.
- Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (co-morbidity) and who require support for an acute reversible failure of another organ system.
- Patients who experience delirium and agitation in addition to requiring level 2 care.
- Complex patients requiring support for multiple organ failures, this may not necessarily include advanced respiratory support.

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Together we can help improve the quality and safety of the care we provide.

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