North Staffordshire Combined Healthcare NHS Trust

Patient safety incident response plan 2023/24

Effective date: 01/10/2023

Estimated refresh date: 01/04/2024

	NAME	TITLE	SIGNATURE	DATE
Author	Craig Stone	Head of Patient and Organisational Safety		20/04/2023
Reviewer	Clinical Effectiveness Group			28/04/2024
Authoriser	Quality Committee			02/05/2024

Contents

Introduction

This patient safety incident response plan sets out how **North Staffordshire Combined Healthcare NHS Trust** intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Patient Safety Incident Response Framework (PSIRF) 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 incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead it:

• advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents

• embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Our services

North Staffordshire Combined Healthcare NHS Trust was established in 1994 and provides mental health, substance misuse and learning disability care to people living in the city of Stoke-on-Trent and in North Staffordshire. We employ an average of 1,414 permanently employed (WTE) during 2021/22. These staff work from both hospital and community-based premises, operating from over 30 sites. Our main site is Harplands Hospital, which opened in 2001, and provides the setting for most of our inpatient units.

Our staff are committed to providing high standards of quality, and safe services. We service a population of approximately 464,000 people from a variety of diverse communities across Northern Staffordshire, providing services to people of all ages with a wide range of mental health and learning disability needs.

Sometimes our service users need to spend time in hospital, but more often, we can provide care in outpatient, community resource settings, and in people's own homes. We also provide specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), Neuropsychiatry and Psychological Therapies, plus a range of clinical and non-clinical services to support the University Hospital of North Midlands NHS Trust (UHNM) and Midlands Partnership NHS Foundation Trust (MPFT). We have grown our primary care offer and successfully integrated a further primary care practice this year.

Our main commissioners are North Staffordshire (33%) and Stoke-on-Trent (49%) Clinical Commissioning Groups (CCGs). We also work very closely with the Local Authorities in these areas, in addition to our other NHS partners.

We have close partnerships with agencies supporting people with mental health, substance misuse, and learning disability problems, such as Approach, We are With You, BAC O'Connor Gateway, ASIST, Brighter Futures, Changes, EngAGE, North Staffordshire Huntington's Disease Association, Mind, PeGIS (Parent Engagement Group in Stoke), North Staffs Carers Association, Reach and the Beth Johnson Association.

Defining our patient safety incident profile

Our approach was to convene a PSIRF implementation group that would look at all areas of our response plan as well as close liaison with our local ICB and system partners to forge a sustainable approach. The local implementation group was designed to run alongside the implementation period and oversee all facets of clinical and operation care delivery, the membership included:

- Senior Responsible Officer (Chair)
- Project Manager (Deputy Chair)
- QI Lead Nurse
- Finance
- Performance
- Conracts
- H.R.
- Pharmacy
- Digital Lead
- Nursing Lead
- PMO Lead
- Expert Area (Risk)
- Expert Area (Patient safety)
- Governance Lead
- Patient Experience Lead
- Communication Lead

The oversight group would co-ordinate the activity of the task and finish groups that would then meet to review actions and these would be clinical and operational staff to support delivery of key objectives of the group such as:

- Digital
- Governance
- Templates
- Policy
- Communications

This local meeting would then support updates with other key stakeholders, those to be consulted during this process where as follows:

- ICB
- Local health partners (UHNM, MPFT, Stoke on Trent Council, Birmingham Womens and Childrens NHS Foundation Trust)
- CQC
- Medical Examiner
- Coroner
- Patient Safety Partners (PSPs)

At North Staffordshire Combined Healthcare Trust, we use the system Ulysses as our incident management system which accounts for patient safety incidents, safeguarding and risk to name a few modules. From this system we warehouse all the data that is collected form incidents reported by our employed staff, from this data we can us this intelligently to support raising our awareness of our own safety profile and take steps to rectify and drive improvement for these areas of known deficit and share this learning wider across the organisation.

Category	2021/22	2022/23
Access, Admission, Xfer, Discharge	60	88

Clinical Assessment -Diag's/Risk Ass'ts/Scans/Tests	14	24
Consent, Communication, Confidentiality	36	65
Discrimination	1	2
Documentation (Records, Identification)	44	71
Estates/Building Issues	32	38
Fire	12	18
Illicit Substances	9	11
Inappropriate Sexual Behaviour	51	35
Infection Control	39	29
Information Technology	12	35
Loss Of Confidential Information - Non-Clinical	15	22
Manual Handling	6	8
Medical Device	8	5
Medication	199	257
Mental Capacity Act Issues	0	1
Mental Health Act Issues	140	90
Missing Person	206	209
Other Accident (Patient)	27	46
Other Incident (Staff)	21	21
Physical Health - Patient	81	101
Safeguarding	404	428
Security	98	242
Self-Harm	1324	1023
Sharps/Needlestick/Bite/Scratch - Patient	1	1
Sharps/Needlestick/Bite/Scratch - Staff	12	11
Slip, Trip And Falls - Visitor	0	2
Slips, Trips And Falls - Patient	221	319
Slips, Trips And Falls - Staff	15	15
Smoking	48	39
Staffing Issues	128	84
Substance And Alcohol Use - Clinical Incident	20	32
Sudden/Expected Death	57	77
Tissue Viability	10	9
Treatment / Procedure	532	230
Vehicle Incident	7	8
Violence/Assault	1777	1959
Grand Total	**5667**	**5655**

As the table above depicts our highest areas of concern are as follows as a top 5:

1. Violence/Assault
2. Self-harm
3. Safeguarding
4. Slips, trips and falls – patient
5. Medication

On a weekly basis we review all incident submitted to ensure that they are factually correct, offer good levels of insight into the incident and that the lessons learnt are shared across the attendee list for this which is not exhaustive of but includes inpatient ward managers, quality improvement lead nurses (QILNS) as well as matrons. In addition to this we also hold learning lessons events monthly that targets and highlights examples of good practice as well as those incidents of deficient care and exploration of issues around this as well as celebrating the good aspects of care delivered.

The table below reports the impact of incidents reported for the period 2021/22 - 2022/23 as a reference point to the level of harm reported form the incident data collated.

Impact	**2021/22**	**2022/23**
1 - No Harm	4324	4348
2 - Minor	1130	1113
3 - Moderate	96	57
4 - Major/Severe	11	9
5 - Catastrophic/Death	60	79
6 - Near Miss	46	48
(blank)	0	1
Grand Total	**5667**	**5655**

Of all the incidents reported in 2022/23, 76% are recorded as no harm events with no harm caused to the patient, however there is 24% that have caused an element of harm or had an impact upon someone's well-being that would have required some level of response to understand the concern, these have been completed via our local investigation route or formal serious incident investigation. In comparison with data from 2021/22, interestingly it reports the same score as 2022/23, but there has only been a reduction of 12 incident between the reporting periods.

From this data we are then able to cross reference this with patient safety investigations that have been completed following the serious incident profile for the preceding reporting period and for the future reporting will be in line with the organisation's patient safety incident reporting framework. The below table report on the serious investigation activity for the years 2021/22 to 2022/23.

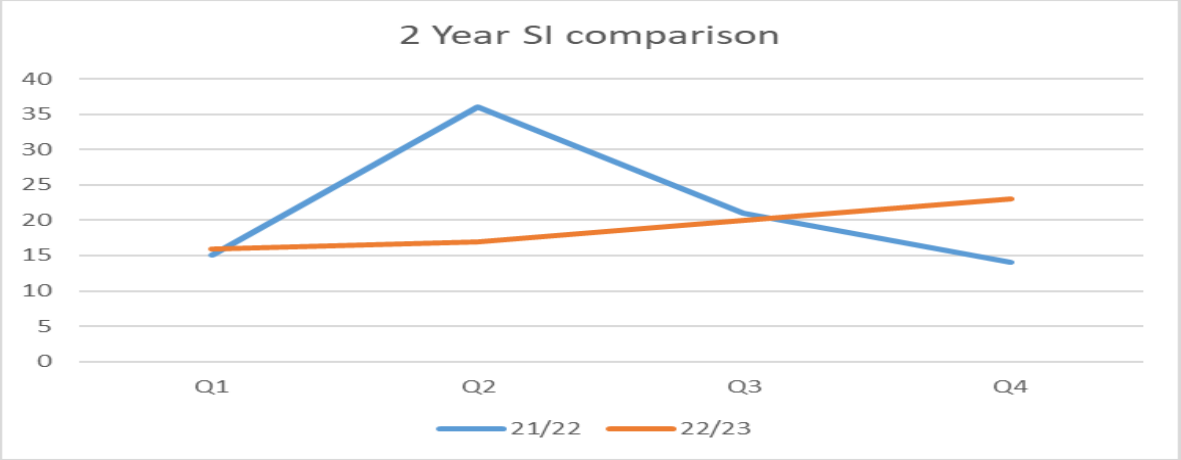
StEIS Incident category	Q1	Q2	Q3	Q4	Total 2021/22	Q1	Q2	Q3	Q4	Total 2022/23
Apparent/actual abuse	1	1	0	1	3	0	2	0	0	2
^ Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare (new Q4 2021/22)				2	2	0	0	0	0	0
^ Incident demonstrating existing risk that is likely to result in harm (new Q4 2021/22)				1	1	0	0	0	0	0
Unexpected potentially avoidable injury causing serious harm: This is subdivided as shown below										

Apparent/actual/suspected self-harm criteria meeting SI criteria	2	3	2	3	10	4	1	3	0	8
Slip, trip, fall	1	2	1	1	5	0	3	4	1	8
Disruptive, aggressive behaviour meeting SI criteria	0	1	0	0	1	1	0	0	0	1
Unexpected/Potentially avoidable serious assault (inc Suspected Homicide)	0	0	0	0	0	0	0	0	0	0
Unexpected/potentially avoidable injury causing serious harm (New Q3 2021/22)			1	0	1	0	0	0	0	0
Unexpected, potentially avoidable death: This is subdivided as shown below										
Pending review	9	8	6	8*	31	7	13	5*	5	30
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	3	1	10	6	20	3	15	8	8	34
Hospital Acquired infection	0	1**	0	1	2	0	2	1	0	3
Total	16	17	20	23*	76	15	36	21	14	86

From these categories the areas of concern in relation to serious incidents are as a top 3:

1. Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)
2. Apparent/actual/suspected self-harm criteria meeting SI criteria
3. Slip, trip, fall

You will notice that there is 31/30 pending reviews for unexpected, potentially avoidable death and these are awaiting further review from the coroner to enable us to determine the cause of death from toxicology and they are related to drug related deaths but not exclusive.



The below data represents PALS contacts with our trust and what the primary reason for contact with us to raise a concern/complaint, there is a comparison with the last two reporting year periods. It is worthy of note that there has been a reduction in 2022/23 of 82 against the previous year 2021/22

Patient safety incident response plan

Category	2021/22	2022/23
Appointment - Cancellation(OP)	3	2
Appointment - Delay (OP)	11	8
Appointment - Time	2	1
Attitude Of Staff - Admin	1	1
Attitude Of Staff - Medical	2	2
Attitude Of Staff - Nursing	20	6
Care Plan	1	0
Car Park - Charges /fines	0	1
Communication Error	5	5
Concerns About Medication	9	13
Concerns About Patient Safety	2	1
Consent to treatment	0	1
Delay In Medication	4	6
Diagnosis Problems	4	3
Disagree With Discharge Decision	23	21
Discharge Arrangements	2	0
Environment	6	1
Feedback	0	1
Incident	5	0
Lack Of Communication	18	9
Lack Of Support	123	91
Loss Of Property	2	0
Medication Error	3	0
Not Informed Patient Has Been	1	0
Nursing care	0	1
Patient's Privacy & Dignity	2	3
Personal Property	1	0
Personal Records (complaint)	1	0
Personal Records (Medical)	2	1
Policy & Commercial Decisions	2	0
Sectioning Procedure	1	1
Transfer Arrangements	1	0
Treatment On Admission	2	1
Unable To Make Contact	4	4
(blank)	20	17
Grand Total	**283**	**201**

From these categories the areas of concern in relation to complaints/concerns are as a top 3 (excluding the data set that has provided a Blank return {no category group recorded against PALS concern}):

1. Lack of support
2. Disagree with discharge decision
3. Lack of communication

Patient safety incident response plan

Defining our patient safety improvement profile

At North Staffordshire Combined Healthcare Trust, we use Quality Improvement (QI) to support a systematic evidence-based approach, using tools and techniques to improve the experience and outcomes for patients, service users, and carers.

It is often used to improve staff experience and enjoyment of our work by focusing on “what matters to you?”

Quality Improvement is about giving those closest to the issues affecting care the time, permission, skills, and resources to solve them. It involves a logical and coordinated approach to solving a problem to bring about a measurable improvement.

In addition, this is our commitment to this process of quality improvement:

- Support individuals, teams and directorates with their QI plans – “What matters to you?”
- Focus improvement work on the Model for Improvement with all QI tools supporting this
- Support the use of Life QI
- Provide QI learning opportunities
- Develop improvement leaders and mentors
- Considering readiness and take a bespoke approach
- Measure impact
- Celebrate our success and sharing our learning

Utilising this methodology and approach it provides a framework to enable us to look at what we do and see if we can do it better. These elements are captured within Life QI platform (Login – Life QI (lifeqisystem.com)) where all quality improvement projects are housed and managed with the support of our QI team. However, this is not an exhaustive approach and other tools can be used as a barometer to observe successes or challenges such as local audits, external audits as well as regulatory bodies.

The vision is that all patients’ safety reviews and any actions coming from these can be cross reference with any QI projects that can be used to support sustainable changes to ensure that there is embedded learning from incidents and help to reduce the likelihood of re-occurrence of reduce impact severity.

Each area would have its individual challenges and unique challenges so not all actions can be taken as directed above however the emphasis on learning and sharing this wider and linking to sustainable changes that support the ethos/principles of patient safety are what should be strived towards.

To meet the requirements of the new NHS National Standards for Patient Safety Investigation we will be committed towards:

- Assign an appropriately trained member in each directorate to oversee delivery of the PSII standards and support the sign off all PSIIs, these will be of a senior member of staff as a band 8a grade as a minimum.
- Provide access to update training for current staff who provide patient safety review oversight function on use of updated analytical tools, use of improvement science

approaches and utilization of the national report template. This includes access to level 1 and 2 of the patient safety syllabus and this is available via LMS training, this is a pre-requisite for the completion of the PSII oversight learning lead training.

- Provide access to update training for existing investigators or investigation teams/staff in specific areas. This will include:
    - Application of updated analytical tools to support PSII Training in identifying and addressing unconscious bias
    - Using Quality Improvement (QI) methodology and improvement science approaches
    - Report writing and use of the national PSII report template
- Identify an appropriate training provider for training new investigators of PSII's in the Trust to the standard required by PSIRF (e.g., minimum of two days). We will use a targeted approach to identify several investigators from a range of professional backgrounds i.e., medical, nursing, AHP, psychology.
- Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our website
- Work with senior nursing staff to review the existing tools for Patient Safety Incident Reviews to ensure they reflect current practice and analytical tools for the identification of all causal factors.
- Negotiate time in job plans for a core group of senior clinical staff to undertake PSII investigations every year.
- Modify existing internal training courses for staff who are required to undertake Patient Safety Reviews to include:
    - Application of updated analytical tools
    - Principles of PSIRF
    - Using QI methodology and improvement science approaches

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. It is the role of the patient safety incident investigation (PSII) oversight and learning lead to be the lead point of contact for patients, families and staff.

With this key role of engagement, there will be time and resources made available to support the meaningful of engagement with all of those affected by the patient safety incidents, in addition where it is indicated through discussion the effective signposting to clinical services to support any psychological support that may be required.

At the onset of all patient safety reviews, the patients, families and staff will be invited to take part of the process of reviewing the incident. This will be via letter in the first instance offering details of the reviewer and invite to contact them to agree or not to participate within the patient safety review. If there is a request to be accompanied during this process (at any stage) then this will be supported and facilitated to meet the needs of the individual, unless it is evident that this would cause further distress due to information available at the time of request. If this was to occur then a conversation with PSII oversight and learning lead as well as Head of patient and organisational safety would be required to review reason for this refusal. This reason would then be cascaded as agreed during this discussion.

Where there is acceptance to this every effort will be made to meet the identified person/s in a manner that is agreeable and safe for them which can be in person, by virtual platforms or via telephone contact.

At this point of engagement the terms of reference for the review will be discussed to see if there are any additional areas required for review based upon the patients, families and staff perspective.

The contact will be ongoing and completed as agreed at the outset introductory meeting however there is an expectation of frequency during the patient safety review process as directed below.

Patient Safety Incident Response	**Contact at which point**
Rapid review / Swarm Huddle / MDT review / After action Review (AAR)	Upon initiation of review to offer an understanding of the incident their family member had been involved in. Mid-point review to offer an update on progress. 10 working days post completion to offer feedback on review
Patient Safety Review (PSR) / Comprehensive Safety Review (CSR) / Falls PSR	When review is commissioned the identified family member will be written to inviting them to be a part of the review process Mid-point review to offer an update on progress. 10 working days post completion to offer feedback on review
Patient Safety Incident Investigation (PSII) / Thematic review / Independent review	When review is commissioned the identified family member will be written to inviting them to be a part of the review process Mid-point review to offer an update on progress. 10 working days post completion to offer feedback on review

At the mid-point review stage communication with those patient and identified family members or significant others are contacted to discuss the progress and report any interim findings from the report and for feedback to be received.

It is envisaged that upon completion and sign off of the proportionate review the outcomes would be discussed with the patients, families and staff affected within 10 working days of the review being signed off by the approving person, if at this point there will be opportunity for them to be involved in the construction of safety action planning to help gain a service user perspective and appreciate the learning form a recipients perspective..

If there is any delay with the process this should be communicated to with the patients, families and staff involved as soon as known, so they are kept informed and up to date. If possible a timescale where this will resolved and a subsequent discussion to review the outcomes offered.

It is also important to note that we do have an advocacy service within our trust for patients that they can be signposted to if they would require independent support through any identified issue, similarly if a family member wanted some additional support then they can be referred to our patient experience team who will be able to facilitate the support required.

At all points the staff involved will continue to review the incident in relation to the being open policy and where the threshold is met for Duty of Candour (DoC) (moderate level of harm or higher) then the reviewing person / governance group will review the information available with lessons learnt and findings to see if there has been a deficit in care and as a consequence moderate or higher harm was caused either physically or psychologically. If duty of candour applies, then the policy will be followed in relation to how we respond to patients and family members in offering that compassionate and meaningful apology for the deficit received in their care. It is important to recognise that patients, relatives and/or carers can be adversely affected by a serious incident. They may have questions about what has happened and should have access to appropriate support and information, such as discussion/explanation and should be supported by the most appropriate senior person.

It is important that the following policy is reviewed should the duty of candour be identified as applicable, and the policy followed as directed.

4.40-Being-Open-Policy-Inc-Duty-of-Candour.pdf (combined.nhs.uk)

In addition, we have a Patient advice and liaison service (PALS) (patientexperienceteam@combined.nhs.uk). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff,

managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions

PALS can help and support with the following:

• Advice and information

• Comments and suggestions

• Compliments and thanks

• Informal complaints

• Advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of how to obtain the response that the person raising the concern/complaint is seeking.

Our patient safety incident response plan: national requirements

Event	Action required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Locally-led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally-led PSII	The organisation in which the Never Event occurred

Event	Action required	Lead body for the response
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII See also Appendix B	HSIB (or SpHA)
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme
Safeguarding incidents in which: • • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding

Event	Action required	Lead body for the response
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	The organisation in which the event occurred
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

Our patient safety incident response plan: local focus

Activity / Learning Response	**Description**	**Impact score threshold for activity**	**Examples** However not an exhaustive list, please contact POST / PSII oversight lead for support if required
Ulysses incident form completion	Standard response to all identified patient safety incidents	Identification of patient safety incident	Any patient safety incident regardless of impact
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care. This would be completed as a precursor to any death of patient in receipt of service (last 6 months) to determine further patient review response. To be completed if request is received from an external reviewer in relation to a current PSII, if further learning response is required then this can be agreed upon to illicit the correct response.	Patient safety incident that meets threshold of minor impact	Medication errors, self-harm, violence and aggression, post notification of a death to be completed for initial review and findings (within 72 hours)
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care. These reviews are to be completed alongside CSIM or formal debriefs if there has been psychological trauma identified from the incident as to not adversely affect staffs wellbeing. If concern please review appropriateness with PSII oversight lead	Patient safety incident that meets the threshold of minor / moderate impact	MDT review / AAR - Falls, medication error leading to harm caused, self-harm leading to treatment required, patient on patient incidents
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery in care that require a detailed review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of minor / moderate impact and there is a potential deficit in care identified	Falls leading to a fracture of a minor bone, harm caused direct from episode of care, harm caused requiring external acute hospital treatment, breach of mental health act framework
Comprehensive Safety Review (CSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that	Patient safety incident that meets the threshold of moderate / severe /	Injury requiring hospitalisation / complex treatment, death, falls leading to a fracture of a major bone, safeguarding concern as a result of care received

	require an in depth review to understand the circumstances that lead to the event	catastrophic impact and there is a potential deficit in care identified	
Patient Safety Incident Investigation (PSII	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning	Patient safety incident that meets the threshold of severe / catastrophic impact and there is an identified deficit in care identified	Deaths related to care delivery received, death of an inpatient detained upon the mental health act, never events
Thematic Review	This is to be completed when there is a concern raised by a pattern in incidents, concerns or patient reviews which requires further collective review to see if there is any correlation or wider learning to be ascertained	A collection of patient safety incidents that require further review due to the correlation within these	All of the above

Activity / Learning Response	**Description**	**Timescales for completion** (*medical director sign off required)							
		24 hours	**3 days**	**7 days**	**14 days**	**30 days**	**60 days**	**90 days**	**180 days**
Ulysses incident form entered	Standard response to all identified patient safety incidents	✓							
Ulysses incident form signed off	Incident form to be signed off by designated manager for ward/team area			✓					
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care		✓ For deaths		✓				
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care					✓			
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where a detailed review to understand the circumstances that lead to the event.					First draft	✓*		
Comprehensive Safety Review (CSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where an in-depth review to understand the circumstances that lead to the event.					First draft	✓*		
Thematic review	This is completed on a collection of patient safety reviews where there is a concern raised over a particular element.						First draft	✓*	
Patient Safety Incident Investigation (PSII)	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning							First draft	✓*

When the proportionate review response has been decided upon, they are reviewing officer will work within dedicated timescales as directed within the Patient safety policy to support the review and learning into the incident, at each point there are lessons learnt and safety action sections within the above-mentioned forms so that these can be captured and cascaded as per agreed governance approach.

The reviewing officer will be supported and guided by the PSII oversight and learning lead to help shape and navigate the review to highlight learning opportunities as well as effective action plans, they will be supported by the PSI review process. A midpoint review meeting will be held to support the review process and this group would be inclusive of:

- Care reviewer
- Ward/team manager
- QILN
- Associate director (or authorised deputy)
- Head of patient safety (or authorised deputy)
- Service manager

During this review the report will be reviewed through the new PSRIF lens to help note the contributory factors and the learning opportunities that are evident, if there is further appreciative enquiry required then this can be discussed at this point to help further the outcomes of the report.

The reviewing officer will be external to the service line where the incident has occurred so that an external review can be completed to help remove any aspect of bias. Impartiality is required to help establish the learning opportunities available.

If during the review process it is felt that reaching out to potential subject matter experts i.e neuropsychiatrist to help understand the incident or learning point further then this would be encouraged to support wider learning as well as improving care to meet or exceed the standards that are governed by oversight bodies.

Where there is identified learning this is made clear in the proportionate review this will also include method for cascade locally, the patient safety team will also collate learning lessons and will add these to the current learning lessons platform for cascade. Additional learning lesson events can be held to support wider cascade learning and exploration of learning identified.

It is important to note that where there is identified psychological trauma for staff and/or patients then prior to any proportionate review that e debrief or CISM intervention is completed to support a compassionate approach to learning is achieved without further harm to those involved.

Within this there will be a mechanism in feeding back information to the patients and/or relatives / identified others for that patient. This can be done formally or informally dependent upon the severity of the incident impact of harm experienced. All staff will continue to be open and honest in their approach and where the impact of harm is moderate or higher than the consideration of duty of candour is also to be determined.

The review process for safety action plans is that they will continue to be reviewed within directorate board meetings at 6 and 12 month periods to ensure that there has been embedded change and learning established.

Oversight roles and responsibilities

At North Staffordshire Combined Healthcare Trust the role of oversight and learning leads will be the same person but to have these across all directorates to help enhance the clinical awareness of the challenges and successes for those specific directorates and service lines as well as spreading the resource so that there can be resilience put into our oversight structure and allow the potential for challenge cross directorates to help enhance the learning from our incidents.

The identified staff member for this oversight role and learning lead are from the senior staffing group (band 8a and above) and have the ability to have their time protected to complete the required elements of oversight of safety incident reviews as well as completing PSII, the designation or role is not specific across the organisation and the senior leadership in the directorates have nominated the key people within their areas to appropriately support this requirement within our PSIRF plan.

The staff identified will lead on the governance and collation of patient safety response reports and lead on the approval process and escalation to relevant authority for approval, in addition they will lead on trust response PSII reviews when clinically indicated that this is the required proportionate review. They will also ensure that all reviews are completed within the required timeframes and that the learning from these are reported and co-ordinated across the directorate and wider trust. Once this is achieved then the QILN would provide first level approval for the review to be submitted as per governance process.

The Trust Board has overall responsibility for governance, including safe clinical and non-clinical practice. The Board will ensure that effective management systems are in place to achieve high standards, the provision of mandatory reports to the Board including minutes of sub-committee meetings.

The Chief Executive Officer (CEO) has overall responsibility for patient safety and risk management within the Trust. The CEO will be responsible for ensuring that the Board, Chairman and Non-Executive Directors are kept informed as appropriate. The CEO will liaise with the Communications Department should media involvement arise following a Serious Incident.

The Chief Medical Officer will be responsible for final approval and ensuring that the report is comprehensive in highlighting the factors for occurrence as well as awareness of safety challenges and subsequent learning opportunities are followed. The viewpoint will be strategic and the review could support wider action across the organisation to support a reduction in likelihood of reoccurrence.

Where there is an external interest then we should actively liaise with these organisations and support them as directed through due process of the PSII process, the PSII process clearly explains to what these are for and who is the lead person for this. Local trust guidance would be to complete a rapid review and decide on next steps in relation to proportionate patient safety review.

When we are reviewing the deaths of our patients we liaise directly with the coroner's office and there is minimal contact with a medical examiner, in addition as any death of our patients under our care would result in a comprehensive safety review (CSR) then we would have minimal involvement with a medical examiner, however if there was a need to liaise with a medical examiner this would be done via the head of patient and organisational safety as well as the medical lead for mortality to review the concerns and decide the proportionate patient review response.

Where it is required, they will also provide support for other areas if this is required to as a result of leave (planned or unexpected).

The mind-set of the oversight function is to:

1. Have improvement as the focus
2. Focus on system factors rather than individuals to blame
3. Use learning from patient safety incidents as a proactive step towards improvement
4. Collaboration – with individuals and organisations
5. Psychological safety allows learning to occur
6. Being professionally curious

The directorate clinical director will be responsible for the second level approval of incidents and they would be checking the clinical impact of the information obtained in the report and to validate and review the evidence provided in the report whilst ensuring that the learning opportunities are highlighted and appropriate recommendations in place to improve safety.

The PSII oversight lead will regularly meet with a member of the POST team to review current progress of all patient reviews, and this will be completed on a weekly basis. Where there are concerns then these will be escalated to the head of patient and organisational safety for further support and resolution. In addition the PSSI oversight lead will report progress and status of action plans at the Clinical Safety Improvement Group ensuring that a programme of audit is implemented to ensure implementation of action plans and record measurable outcomes.

This role will also be the lead named contact who would support with learning responses as well as any ongoing support that may be required above and beyond already offered during this review process.

Furthermore, it will be required that the appointed care reviewer is in receipt of the terms of reference set out for the investigation care review level and the timescales and milestones for completion.

Ensure that the appointed care reviewer is in receipt of all relevant information relating to the incident including completed incident form.

Ensure that each completed care review, (including an action plan, where required) is submitted within the identified timescale. Where reviews are forecast to exceed the agreed timescale; Service Managers will inform the Patient and Organisation Safety Team (POST) at the earliest opportunity, in order that possible extensions to the investigation time scales may be negotiated.

Where there is learning identified that there is a completed action plan to support safety and that the details of these are cascaded for learning purposes, these will be monitored within the patient safety team and added to learning lessons platform and disseminated as required via the learning lessons platform.

The care reviewer will have received the required training to help support the completion of the required patient safety proportionate review, as well as utilising a system learning approach and in accordance with the agreed Terms of Reference, levels and scope of the investigation and within the timescales set out by the Directorate Service Manager. There will be close liaison with POST as well as the PSII oversight and learning lead to ensure that the review is on timescales identified.

The service manager will ensure that any recommendations, learning points and actions are articulated to the teams that they oversee to ensure effective cascade of pertinent information to the ward/team managers that they oversee, as well as actively collaborating with the completion of these items to ensure learning is completed and evidenced. This is also to be an agenda item to the service line meetings to allow oversight within the governance structure of the directorate.

The Ward/Team Manager will ensure that the recommendations, learning points and actions are articulated to their team, as well as actively collaborating with the completion of these items to ensure learning is completed and evidenced. This is also to be an agenda item to the service line meetings to allow oversight within the governance structure of the directorate.

All staff have a responsibility for risk management and for reporting incidents. All patient safety incidents must be reported via the electronic Trust incident reporting system Ulysses within 24 hours of the incident occurring or the identification that an incident has occurred and recorded within the electronic patient care record.

The complaints manager will liaise with the Patient and Organisational Safety Team regarding any complaint indicating requirement for a proportionate review in accordance with NPSA guidance and ensure cohesive communication to monitor trends arising from complaints and serious incidents.

Safety action development and monitoring improvement

All our patient safety incident reviews include the ability to record learning opportunities and outcomes of the reviews that then directly translate to meaningful actions to enhance the patient safety profile.

While safety action development may be led by one individual (e.g., a learning response lead) or team, a wider team must be engaged during development, including the local team, the quality improvement team and those with broader knowledge of ongoing improvement work related to the defined areas of improvement, or whose work may be informed by the findings from the learning response under consideration.

These safety actions can also be supported by the effective engagement and feedback with those affected by the incident and at the 10 day follow up post closure of review those affected would be able to help shape the safety actions by providing a different perspective on the incident and one of insight.

Quality improvement colleagues are a valuable resource for tools to develop safety actions and associated measures. Where possible, those affected by the patient safety incident should also be involved

Action plans arising from patient care reviews will be agreed and written by the Directorate Service Manager and the relevant team leader/ward manager and agreed at Directorate level prior to submission with the patient care review. Each action plan will have an identified person who is responsible for delivering the action. Directorate Service Manager will be responsible for tracking progress implementation and impact upon practice of action plans and will provide a monthly update on action plan progress to CSIG as a standing agenda item.

Once completed the Service Manager is responsible for forwarding the completed action plan to the Patient and Organisational Safety Team for uploading onto the Trust patient safety incident database.

The Directorate Service manager will be responsible for updating CSIG on the progress of completed action plans at intervals of 6 months and 12 months. This update will detail changes in practice and provide assurance as to the changes being embedded into practice.

The directorate feedback can be done via a delegated/authorised person if this person is not the service manager i.e., quality improvement lead nurse (QILN).

By early review of patient safety incidents, we can start the early understanding of incident profile and make meaningful change to patient care / treatment pathways. By utilising this approach fits alongside the trusts wider vision of utilising quality improvement to help sustain meaningful change that increases the delivery of services, this then can be made available to across the trust via the Life QI platform to allow transference of projects across teams / service lines.

The key points of safety actions are as follows:

1. Identify the measures - Consider what can be measured to increase confidence that the safety action is influencing what it was intended to
2. Prioritise and select safety measures - To prioritise your safety measures, consider the practicalities and data available to provide assurance to the action being achieved.
3. Define the measure - Once a measure has been selected, it must be clearly defined so that it is consistently recorded, reported, and understood across the organisation.
4. Safety actions should be SMART (specific, measurable, achievable, relevant, time bound).

The Clinical Safety Improvement Group (CSIG) will provide oversight of these and contribute to sharing of these learning lessons across all service lines within the trust, any areas of concern would be able to be challenged and assurance requested on reoccurring themes/trends and to understand the barriers/challenges in reducing the likelihood of occurrence.

Safety improvement plans

The Clinical Safety Improvement Group will review all open patient safety reviews monthly ensuring that any concerns or actions to be taken arising from patient's safety reviews are recorded in the group minutes and an action monitoring schedule maintained for progress and completion of actions.

Safety action plans for each safety review will be reviewed at 6 monthly and 12 monthly intervals to ensure that there is embedded learning, and these will take place during the directorate governance meetings or within service line meetings

Aggregation of numbers, themes, trends and links with complaints, PALS, claims and safeguarding reports will be monitored and analysed via the Trust quarterly Learning from Experience report which will reflect qualitative and quantitative data presented in a standard template.

The report will be facilitated by the Performance Team and be made available to the Quality Committee and Trust Board prior to submission to Commissioners. In addition, the report will be presented at the Directorate Management meetings and cascaded through directorate structures.

The Trust will ensure that there is a system in place to ensure that “lessons learned” from incidents and investigations are shared and disseminate throughout the organisation. The process will support the Trust’s efforts to reduce adverse incidents of a similar nature occurring in other areas of the organisation and externally where appropriate.

Learning following patient safety incidents is essential, not only for the ward/team that has been directly affected by the incident, but relevance to other teams and services across the Trust must be considered and shared

The Trust philosophy is to view feedback from patient care reviews and recommend actions arising out of review reports and associated actions as valuable information about the quality of the service we deliver and how we can strive to improve.

Learning from serious incidents to ensure that positive change occurs will be facilitated in the following ways:

- Operational debriefing following a patient safety incident to reflect on the incident will serve as an opportunity to consider the wellbeing of the team affected and provide an opportunity to consider current systems and ensure safe systems are completed to avoid further re-occurrence of an incident. Operational debrief should occur as soon as is practicable following the incident, ideally prior to the end of that shift. The team/service manager will be responsible for ensuring this is completed.

- Care reviewer to offer feedback to the ward/service area team to inform on the findings of the investigation, reflecting on notable practice, lessons learned, identified causative factors and any recommendations following executive

director agreement for submission to commissioners.

- Ward/service area will complete an action plan in conjunction with the directorate Service Manager in response to investigation recommendations to ensure initial local ownership and improvement to ensure safe practice.

- Bi-Monthly learning lessons events where an anonymised single case study/investigate or a collection of investigations with common themes are presented to a multidisciplinary audience. This can include GPs, commissioner, UHNM and any other external parties as appropriate.

Complaints and appeals

The Trust is committed to providing any service user, families or member of the public with the opportunity to make a compliment, seek advice, raise concerns or make a complaint about any of the services it provides. The Trust views all feedback, as valuable information about how its services and facilities are received and perceived.

The Trust aims to develop a culture that sees feedback and the learning from complaints as opportunities to improve and develop services. In addition, it sees the giving of accurate information about its services and other health- related matters as means of empowering service users and promoting health.

Emphasis is placed on responding to enquiries, feedback and concerns as quickly as possible through an immediate response by front-line members of staff in an open and non-defensive way. However, other processes are also available when desirable or appropriate, through PALS or the Complaints Department.

We are therefore very committed to ensuring that the complaint process is fair to all parties i.e., both complainants and staff. When dealing with complaints we aim to adhere to NHS England's organisation principles and follow the 'Good Practice Standards for NHS Complaints Handling' (Sept 2013)15 outlined by the Patients Association:

• Openness and Transparency - well publicised, accessible information and processes, and understood by all those involved in a complaint.

• Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints.

• Logical and rational in our approach.

• Sympathetically respond to complaints and concerns in appropriate timeframes.

• Provide opportunities for people to offer feedback on the quality of service provided.

• Provide complainants with support and guidance throughout the complaints process.

• Provide a level of detail appropriate to the seriousness of the complaint. • Identify the causes of complaints and to take action to prevent recurrences.

• Effective and implemented learning - use 'lessons learnt' as a driver for change and improvement.

• Ensure that the care of complainants is not adversely affected as a result of making a complaint.

For full details on how to support someone through this process please use the following policy,

Patient safety incident response plan

4.26-Listening-and-Responding-PALS-and-Complaints-Policy.pdf (combined.nhs.uk)