Wirral Community Health and Care NHS Foundation Trust

Patient Safety Incident Response Policy GP60 Version 1

TRUST-WIDE POLICY DOCUMENT

Document detail	
Policy Number	GP60
Version	1
Approved by	Clinical Assurance Group 08/2023 NHS Cheshire and Merseyside Integrated Care Board, Wirral Place 08/2023
Effective from	08/2023
Date of last review	08/2023
Date of next review	02/2025
Lead Director	Chief Nurse
Responsible Lead	Patient Safety Lead
Superseded documents	N/A
Document summary	Supports effective implementation of PSIRF (Patient Safety Incident Response Framework) across WCHC

Document History		
Version number	Comments	Approved by
1	New policy shared with quality and safety committee September 2023.	Quality and Safety Committee

Policy on a page

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Wirral Community Health and Care NHS Foundation Trust will approach the development and maintenance of effective safety systems and processes for responding to patient safety incidents, and related issues for the purpose of learning and improving patient safety.

As a Trust we have worked over the last year to transition from Safety I to Safety II. A Safety System II approach is aligned to a proactive, restorative and learning culture which recognises a complex adaptive system in which humans make things work by problem solving and adapting to the pressures in their environment. This approach has a key focus on understanding what works well, and how that can be fostered to support spread of good practice, continual learning and quality improvement.

The Trust has already implemented the NHS England Health Education England Patient Safety Training Syllabus. PSIRF will enhance these principles by creating stronger links between a patient safety incident learning and continuous improvement. The Trust is committed to working in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to support psychological safety, and share change ideas, regardless of hierarchy, to enhance the Trust patient safety learning culture in which everyone has a voice.

The Trust will work in partnership with our patient safety partners to learn from recurring incidents, complaints and feedback from patients and families to feed into the learning cycle of quality improvement. This process will continue to increase transparency and openness amongst our staff to report incidents and engagement to frame the learning and improvements that follow. The Trust will embrace an appreciative inquiry model to include insight from the many things that have gone well and where things have not gone as planned.

The Trust will continue to analyse findings from the annual NHS staff survey metrics based on specific patient (and staff) safety questions to monitor staff perspectives on how well the patient safety culture is making positive changes on a day-to-day basis for staff to deliver safe patient care.

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way. The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the nine protected characteristics. The Trust has a five-year strategy which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Wirral Community Health & Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/adult concern';
- ensuring appropriate advice and support is accessed either from managers, S*afeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role; ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Wirral Community Health & Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

EQUALITY AND HUMAN RIGHTS

Wirral Community Health & Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act also requires public authorities to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership. The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Wirral Community Health & Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act. Wirral Community Health & Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity and **A**utonomy.

Contents

1. PURPOSE AND RATIONALE

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Wirral Community Health and Care NHS Foundation Trust will approach the development and maintenance of effective safety systems and processes for responding to patient safety incidents, and related issues for the purpose of learning and improving patient safety. This policy is linked to the Raising Concerns policy which promotes open and honest reporting of concerns and compassionate and supportive response to any Freedom To Speak Up concerns reported.

The PSIRF advocates a co-ordinated, proportionate and data-driven response to patient safety incidents and Freedom To Speak Up concerns. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management and learning

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

This policy supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF which is aligned to Trust values: Compassion, Open and Trust. This is further supported by five key Trust strategies:

- Organisational Strategy
- Quality Strategy
- Inclusion and health inequalities Strategy
- The People Strategy
- Digital Strategy

These strategies will be delivered over a five-year period and align to key components of the PSIRF:

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

The Trust is committed to the implementation of the nationally led PSIRF and has aligned strategies to provide transparency to all employees of the Trust. This policy should be read in conjunction with the Patient Safety Incident Response plan and Incident Management Policy GP08.

3. SCOPE

This policy relates to patient safety incident responses conducted for the purpose of learning and improvement across the Trust.

The Trust is aligned to utilising a systems-based approach. This recognises that patient safety is a priority of our healthcare system: that is, safety is multifaceted and as a Trust we do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

It is important to note that when applicable other governance processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope of this policy. Please refer to individual policies and where appropriate report via the Datix incident reporting platform.

- Human resources investigations into employment concerns, professional standards investigations such as Nursing and Midwifery Council (NMC) or General Medical Council (GMC)
- Information governance concerns
- Financial investigations and audits
- Safeguarding concerns
- Coroners' inquests
- Claims handling
- Complaints (the exception is if patient safety concern is noted).

4. DEFINITIONS

Glossary of Terms	Definition
PSIRF	Patient Safety Incident Response Framework
NMC	Nursing and Midwifery Council
GMC	General Medical Council
PSP	Patient Safety Partners
ICS	Integrated Care System
ICB	Integrated Care Board
DOC	Duty of Candour
Safety (SEIPS Model)	Systems Engineering Initiative for Patient safety
PSII	Patient Safety Incident Investigation
HSIB	Health and Safety Investigation Branch
AAR	After Action Review
CRMG	Clinical Risk Management Group
CAG	Clinical Assurance Group
MDT review	Multi-disciplinary Team - Group of members review incident
Thematic review	Number of similar incidents are reviewed for themes and trends
SAFE	Standards Assurance Framework for Excellence
OPG	Operational Performance Group
JUSS	Joint Union Staff Side
Work as done	How you work in practice
Work as prescribed	Work as directed by policies and procedures within the system
Work as imagined	The potential discrepancy between work as done and work as prescribed
Work as disclosed	Is the way people work and feel safe to disclose this aligns to psychological safety

5.RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

5.1 The Chief Executive is the designated officer accountable for ensuring compliance with the arrangements under the statutory regulations. In their absence the role is designated to a nominated Executive Director.

5.2 The Non-Executive Director is the responsible chair for the Quality and Safety Committee. This meeting is reported to the board of directors

5.3 The Medical Director is responsible for clinical governance including patient safety, reporting to the Chief Executive and is responsible for the strategic development of systems and processes.

5.4 Chief Nurse and Deputy Chief Nurse for escalating concerns relating to incidents to the Medical Director.

5.5 The Board of Directors has responsibility for the implementation of this policy and the monitoring of compliance.

5.6 Quality and Safety Committee is responsible for the monitoring of compliance with this policy. Through the committee reviewing reports they are assured that the policy is being followed.

5.7 CRMG is responsible for the management of the incident reports, ensuring that all incidents are managed in accordance with the principles of openness, transparency and candour.

5.8 Service Directors/Team Managers and Senior Managers are responsible for ensuring incidents and improvement plans relating to their service are investigated thoroughly and action plans are monitored through SAFE/OPG meetings to reduce the likelihood of reoccurrence.

5.9 All staff members should be aware and adhere to the Incident management process as described in this document and other policies aligning to this policy.

Joint Union Staff Side (Trade Unions)

5.10 JUSS representatives have an important part to play in providing advice, support and if required, representation to their members as well as working in partnership with managers and the Human Resources team to ensure the Patient Safety Incident Response Policy is applied fairly and consistently across the Trust.

5.1.1 PROCESS

Our patient safety culture

As a Trust we have worked over the last year to transition from Safety I to Safety II:

- A Safety System I approach, uses processes which are reactive and focused on investigations, root cause analysis and direct causal factors, without full consideration of the complex adaptive systems needed within the NHS. This approach traditionally apportions responsibility to individuals rather than systems. A safety ll approach appreciates that clinical problems can arise from safety systems that had not been designed to minimise incidents occurring to support staff and promote patient safety

- A Safety System II approach is aligned to a proactive, restorative and learning culture which recognises a complex adaptive system in which humans make things work by problem solving and adapting to the pressures in their environment. This approach has a key focus on understanding what works well, and how that can be fostered to support spread of good practice, continual learning and quality improvement.

- The Trust Clinical Risk Management Group and the Quality and Governance Team have embraced the transition from the previous serious investigation process, moving towards appreciative inquiry and learning based on openness and trust, using the new PSIRF toolkit.

- The Trust has already implemented the NHS England Health Education England Patient Safety Training Syllabus. The main aims of restoration when an incident has happened have been outlined as follows:
    - Moral engagement
    - Emotional healing
    - Organisational learning
    - Prevention

- PSIRF will enhance these principles by creating stronger links between a patient safety incident learning and continuous improvement. The Trust is committed to working in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to support psychological safety, and share change ideas, regardless of hierarchy, to enhance the Trust patient safety learning culture in which everyone has a voice.
- The Trust will work in partnership with our patient safety partners to learn from recurring incidents, complaints and feedback from patients and families to feed into the learning cycle of quality improvement. This process will continue to increase transparency and openness amongst our staff to report incidents and engagement to frame the learning and improvements that follow. The Trust will embrace an appreciative inquiry model to include insight from the many things that have gone well and where things have not gone as planned.
- The Trust will continue to analyse findings from the annual NHS staff survey metrics based on specific patient (and staff) safety questions to monitor staff perspectives on how well the patient safety culture is making positive changes on a day-to-day basis for staff to deliver safe patient care.

Patient Safety Partners

- The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK. In February 2023 we welcomed two PSPs to the Trust, and the role is evolving within services to support staff, patients, families/carers to influence and improve safety across our range of services. They also participate in key governance safety meetings within the Trust which has been invaluable.

- PSPs can be patients, carers, family members or other people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

- The PSPs will be supported in their honorary role by the Patient Safety Lead for the Trust who will provide expectations and guidance for the role. PSPs will have regular scheduled reviews and regular one-to-one sessions with the Patient Safety Lead and training needs will be agreed based on the experience and knowledge of each PSP. The PSP placements are on an honorary basis and will be reviewed after one year to keep the role aligned to the patient safety agenda as this develops.

Addressing Health Inequalities

- The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way. The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the nine protected characteristics. The Trust has a five-year strategy which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.

- The strategy recognises the vital role we play as a population-health focused organisation specialising in supporting people to live independent and healthy lives. It acknowledges the importance of collaborative working across places and systems with partners and stakeholders from all sectors. It takes account of national, regional and local strategies and addresses Cheshire and Merseyside ICS's priority areas.

- Engagement of patient, families and staff following a patient safety incident is critical to review patient safety incidents and learn from their responses and change ideas. We will use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

6. CONSULTATION

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

6.1. 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.

6.2. We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected for our patients, their families, or carers to prevent recurrence.

6.3. We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when delivery of care has not been provided as expected.

6.4. As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident, as recognised with our existing Duty of Candour Policy (GP43). This approach will be underpinned within our divisions and the 'your experience' team who are able to guide patients, families and carers through any investigation or learning review. In addition, at WCHC we have the Your Experience team to support with concerns and complaints wcnt.yourexperience@nhs.net.

6.5. We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers and advocates to signpost to their preferred source for this.

Patient safety incident response planning

6.6. PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. This will enable the Trust to explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

6.7. The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement, this will continue to be monitored to clarify improvements are having the desired effects. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams and align these. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

6.8. Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

7. TRAINING AND SUPPORT

Resources and training to support patient safety incident response

7.1. The Trust has committed to embed PSIRF and meet its requirements. The NHS England patient safety response standards (2022) has been adopted to frame the resources and training required to allow for this to happen. The Trust aims to have

learning responses led by staff who were not directly involved in the patient safety incident itself or by those who directly manage those staff.

7.2 We have agreed responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division. A learning response lead will be nominated by the Division and the individual will have an appropriate level of seniority, knowledge, skills and influence within the Trust – this may depend on the nature and complexity of the incident and response required, but learning responses are led by a senior member of staff.

7.3 The Quality and Governance team will provide governance oversight and assurance of processes to enhance responses and can provide advice and guidance on cross-system and cross- locality working where this is required.

7.4 For staff affected by patient safety incidents we will provide the necessary managerial support and be given time to participate in the learning responses to help inform 'work as done' rather than 'work as prescribed' in policies and standard operating procedures, which at times are too prescriptive and inflexible for a dynamic working culture to promote patient safety. All Trust managers and senior directors will work within our just and restorative culture principles. The responses in the annual NHS Trust survey will help identify areas for potential improvement.

7.5 The Trust will utilise both internal subject experts and our patient safety partners throughout the learning response process to provide expertise in line with the PSIRF Systems Engineering Initiative for Patient Safety (SEIPS Model) for clinical governance, advice and proof reading.

Training

7.6 The Trust has implemented the NHS England Health Education England Patient Safety Training Syllabus as follows:

- Level 1 - essentials for patient safety is an e-learning session designed to raise awareness of patient safety, focusing on risk, communication and raising concerns, and our collective responsibility for preventing harm to patients

- There is a separate Level 1 targeted at senior leaders and Board members, implemented in April 2023, whose ability and responsibility for creating safety is especially significant within an effective patient safety culture

- Access to Practice comprises two e-learning sessions setting out key concepts in safety science: systems thinking, risk management, human factors, and safety culture. This sets out a common understanding and shared safety vocabulary for all staff

- In August 2022 we implemented mandatory Level One and Two for all our front-line staff as this aligns to the standards of our previously delivered in house training for patient safety. The level one element to this training has been further rolled out to other eligible staff within the Trust since April 2023.

Learning response leads training and competencies – for Patient Safety Incident Investigations (PSII)

7.7. The Trust procured a three-year contract with an NHS England approved trainer to deliver PSII path 2 training which includes: -

- A system approach to patient safety investigations
- Creating a just and learning culture
- Patient, family and staff involvement in learning from Patient Safety Incidents

7.8. Trust learning responses will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. This level of training is also provided online by the Health and Safety Investigation Branch (HSIB), which follows the NHS England

Health Education England Patient Safety Training Syllabus, a resource available to all Trusts via a booking process. Online training provides a wider opportunity for developing the skills and knowledge for staff involved in leading incident reviews and investigations.

7.9. Records of internal training for senior clinicians who are regularly involved with incident reviews and investigations will be maintained by the Learning and Development Team as part of their general education governance processes. Senior Clinicians who have completed the HSIB training equivalent to the trust approved training will send the certification to the learning and development team for their records.

7.10. Learning response leads must also have completed Level one and two of the national patient safety syllabus. Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge by engaging in incident reviews and providing peer support to learning response leads. Learning response leads will aim to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Quality and Governance Team.

7.11. As a Trust we expect that those staff leading learning responses are able to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources
- Summarise and present complex information in a clear and logical manner and in Patient Safety Incident Investigation (PSII) report format as required within the new PSIRF
- Manage the conflicting information that can arise from different internal and external sources
- Communicate highly complex matters in difficult situations, with care, civility and compassion
- Support for those new to this PSII role will be offered from the Quality and Governance Team.
- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way
- Listen and support the distress of others in a measured and supportive way
- Maintain clear records of information gathered and contact those affected
- Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services
- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement)
- Apply human factors and systems thinking principles
- Obtain both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences)
- Summarise and present complex information in a clear and logical manner in report format.

Oversight roles training and competencies

7.12 All patient safety response oversight will be led/conducted by those who have had the Trust's procured training approved by NHS England or HSIB's online systems-based approach (6 months training). Records of such training will be maintained by

the Learning and Development team as part of their general education governance processes.

7.13 Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

7.14 All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Patient Safety Champion Training and Role

7.15. The role of the patient safety champions will be to introduce the concept of Systems Thinking and Models of Safety to our key services with agreed leads (see Appendix 1).

Senior PSII leads for the trust

7.16 PSII leads must have completed Level one and two of the national patient safety syllabus.

7.17 PSII leads will undertake appropriate continuous professional development on incident response skills and knowledge.

7.18 To maintain expertise the Trust will undertake an annual networking event for all PSII leads

7.19 PSII leads will need to aim contribute to a minimum of two learning responses per year, this may include reviewing reports and providing feedback via CRMG.

8. Our patient safety incident response plan

8.1 Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is dynamic and will be updated as required to ensure responsiveness to emerging trends. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. The plan can be accessed on staff zone by staff and our website

Patient safety incident response plan and policy review

8.2. Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. The plan will be reviewed every 12-18 months to ensure the focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12-18 months. Updated plans will be published on our website, replacing the previous version.

8.3 A planning exercise will be undertaken as agreed with the Integrated Care Board (ICB) to continue to maintain a proportional balance between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data and wider stakeholder engagement.

9. MONITORING

Safety incident reporting arrangements

9.1. All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system Datix and will record the level of harm they know has been experienced by the person affected.

9.2 Localities will have review mechanisms in place so patient safety incidents can be responded to proportionately and in a timely fashion. Key incidents will be discussed at CRMG, and considerations will be made if these meet Duty of Candour threshold (See GP43 Duty of Candour Policy). Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these will be escalated within the locality at SAFE/OPG and discussed at CRMG.

9.3 The Quality and Governance team will highlight to CRMG any incident which appears to meet the requirement for reporting externally. This will allow the Trust to work in a transparent and collaborative way with the ICB or regional NHS teams if an incident meets the national criteria for PSII (which are mainly for acute, maternity and secure services) or if supportive co-ordination of a cross system learning response is required.

9.4 The Quality and Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Patient safety incident response decision-making

9.5. The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, and in specific circumstances a PSII may require review or referral to another body depending on the event. These are set out in our PSIRF plan.

9.5. PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

9.6. We have established a process for our response to incidents which allows for a clear 'Ward to Board' set of mechanisms allowing for oversight of incident management and our PSIRF response. Localities will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents and reporting on Datix which appear to meet the need for further exploration. Quality and Governance review all moderate harms and above and the cases are shared with the Clinical Risk Management Group which makes recommendations when indicated for Duty of Candour or further review as required to highlight unexpected levels of risk, potential for learning or new emerging themes. This methodology is guided by the PSIRF toolkit, which can be an After-Action Review, MDT review or thematic review and a range of other methodologies to promote the potential for learning and improvement. By using a proportional approach, capacity will be released to focus

on implementing the change ideas for making continuous quality improvements. Staff engagement is key to this process to understand 'work as done 'rather than 'work as prescribed' in procedures or 'work as imagined' by those not working in the clinical teams. This will enable us to build on psychological safety within teams to support work as disclosed.

9.7. CRMG group members decision making will be founded on a systems-based approach and safety actions are validated to strengthen existing safety improvement plans or the establishment of such plans where they are required. Patient safety learning will be underpinned by a knowledge management framework and shared on the Learning Hub as one of the mechanisms for sharing learning across the Trust. CRMG will define terms of reference for a PSII to be undertaken by an appropriate PSII lead. CRMG will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared. The Quality and Governance team will monitor safety actions arising from any PSII or review which is tracked at CRMG.

9.8. The Quality and Governance Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, Quality and Governance team will work with the Divisions to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

9.9. The Clinical Risk Management Group have designated authority for final sign off processes for PSII Reports. The Group is chaired by a Director and Senior Clinicians on behalf of the board. CRMG are expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

Responding to cross-system incidents/issues

9.10. The Quality and Governance team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's Quality and Governance team. Where required, summary reporting can be used to share insight with another provider about their patient safety profile. The Trust incident reporting system facilitates this sharing of information across the system.

9.11. The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Quality and Governance team will act as the liaison point for such working and will have supportive guidance for effective clinical governance.

9.12. The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses/Timescales for patient safety PSII

9.13. Where a PSII for learning is indicated by the Trust Clinical Risk Management Group (CRMG), the investigation must be started as soon as is reasonably possible with a named lead identified within 5 working days after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. Progress updates will be tracked via CRMG. No local PSII should take longer than six months. Early implementors have shared that processes underpinning PSII's can be longer than one

month as time is needed for patient and family engagement and to gather staff views to support effective learning.

9.14. The time frame for completion of a PSII will be agreed in partnership by those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, 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.

9.15. In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Clinical Risk Management Group. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected and documented on the Trust incident reporting system and monitored via CRMG.

Timescales for other forms of learning response

9.16. The Trust aims to complete an After-Action Review within three weeks and a thematic review within six to eight weeks and to be started as soon as possible, following recommendation from CRMG, when level of harm is verified for the patient safety incident. PSII's will be usually completed within three months occasionally this may take longer. It is important to work with patients and families and have discussions with them regarding timeframes. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

9.17. The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better partnership working with teams and understanding 'work as perceived', 'Work as prescribed' 'work as done' and 'work as disclosed' will inform more robust safety actions.

9.18. The Trust has systems and processes in place to implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm, these will be shared at CRMG. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. The Trust will implement quality improvement methodology to identify priority aims, change ideas and measurements for improvements. This will be complimented by the trust audit programme to monitor, and evidence sustained improvements.

9.19. Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from localities and the support of the Quality and Governance Team and Quality Leads with their improvement expertise.

Safety Action development

9.20. The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
- Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

9.21. Safety actions must continue to be monitored within the Localities to ensure that actions put in place remain impactful and sustainable. Locality reporting on the progress with safety actions including the outcomes of any measurements is tracked at SAFE/OPG meetings and at CRMG.

Safety improvement plans

9.22. Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has Quality Improvement plans in place that focus on key risks across the organisation, these are monitored at CRMG at agreed intervals to demonstrate progress on our improvement journey and to discuss any emerging themes. Other improvement plans such as CQUINs follow the same pathway.

9.23. The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where opportunities to strengthen current improvement plans have been identified.

9.24. The Trust will use the outcomes from existing patient safety incident reviews (SI's and 72-hour reviews reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Quality and Governance team will work collaboratively with locality leads and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

10. Oversight roles and responsibilities

Principles of oversight

10.1 Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

Responsibilities

10.2. Alongside our NHS regional and local ICB structures and our regulator the 'Care Quality Commission', we have specific organisational responsibilities within the Framework. In order to meet these responsibilities, the Trust has designated the Deputy Chief Nurse to support PSIRF as the executive lead.

Ensuring that the organisation meets the national patient safety standards

10.3. The Executive Chief Nurse will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the Trust has implemented over a number of years.

10.4. To achieve the development of the plan and policy the Trust will be supported by internal resources within the Quality and Governance Team, this will initially be reviewed at Clinical Assurance Group which is led at Director level/Deputy Chief Nurse, prior to sign off at committee, once approved this will be reviewed by Cheshire and Mersey Regional ICB.

Ensuring that PSIRF is central to overarching safety governance arrangements

10.5. The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Committee meeting on a quarterly basis. This will enable the committee to ask further questions for assurance and support a continuous understanding of organisational safety.

10.6. The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its clinicians in supporting an effective organisational response to incidents.

10.7. Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development alongside a review of all safety actions.

11. Quality assuring learning response outputs –

11.1 The Trust reviews all investigations at CRMG which will provide assurance that all investigations and PSIIs are conducted to the highest standards and to support the executive sign off process. This governance structure will enable learning to be shared and safety improvement work is adequately

Complaints and appeals

11.2. At Wirral Community Health and Care NHS Foundation Trust we recognise that there will be occasions when patients, or carers are dissatisfied with aspects of the care and services provided by the Trust.

11.3. The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the National Health Service Complaints (England) Regulations 2009. See Trusts Concerns and Complaints policy GP01.

11.4. The Trust has developed an improvement plan to align our handling of complaint and concerns to PSIRF. This includes training for all staff who manage complaints within their role and also offering face to face contacts with patients at an early point in the process. We will continue to focus on the collection of the 9 protected characteristic to promote an equitable service.

12. EQUALITY AND HUMAN RIGHTS ANALYSIS

12.1 Refer to Appendix 2.

13. LINKS TO OTHER POLICIES

13.1 Incident Management Policy – StaffZone (wirralct.nhs.uk)
13.2 Duty of Candour Policy – StaffZone (wirralct.nhs.uk)
13.3 Concerns-and-Complaints-Policy-Staff Zone (wirralct.nhs.uk)

14. References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities
core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Appendix 1

Patient Safety Champions Role: understanding of patient safety, key risks for clinical areas, supporting a positive learning culture and psychological safety for their team. This includes an appreciative inquiry model, by reflecting on the key factors when something has gone wrong and comparing to a good day when everything went well, alongside providing excellence in both clinical and professional practice.

Our Organisational Goal is to create an open environment where safe care and support is guaranteed, highly skilled staff are empowered and trusted, and safety incidents are managed with compassion with service users', their families and our staff Our vision is based on 3 principles of safe care and support every time.

This role will enable us to further build on the 3 principles:

- Safety and wellbeing at the core: - We will understand and act on our highest areas of clinical risk and take a preventative approach to minimising harm by supporting people to keep active and independent
- System wide learning: -We will enhance opportunities to learn together across care pathways and involve people in creating improvement ideas
- Positive safety culture: - We will nurture our positive safety culture by promoting psychological safety and further embedding a Just Culture approach aligned to organisational values and appreciative inquiry.

We want to build further on a Just and Learning culture, supporting staff and service users to share their stories. Understanding how we can better prevent harm from a system level to the service users, families and stakeholders. Furthermore, how we better form partnership working throughout the system. Our Patient Safety Champions will play a vital role in improving safety of care, support and psychological safety with staff by embedding further a learning culture which includes promoting a culture of compassion, respect, dignity, and safety towards the people we work with and care for and one another. Our champions will support a culture of continuous improvement in relation to quality and safety that is centred around our service users, focused on health and wellbeing which provides the best experience for the service user.

Part of this role includes working closely with our quality improvement champions as these roles go hand in hand. Our champions will be empowered and valued so they are liberated to support our staff, service users and families.

Values and attributes for the role: As a Patient Safety Champion, you need to have a passion and energy for safety and continual improvement. This includes the people we serve and our staff. You will promote a learning culture and support psychological safety whilst demonstrating professional curiosity. Champions will have a strong commitment to ensuring that people in our community are considered as equal partners in their care and value the importance of closing the gaps around health inequalities, ensuring everyone has a voice.
The role will include:

- Support with the role out and embedding of the Patient Safety Incident Response Framework
- Training to provide you with the safety skills required – 3 days 18 CPD points
- Support your service in safety thinking and driving a learning psychological safe culture.

- Be an advocate for using an appreciative inquiry model.
- Share with other services how you have tackled safety issues which have led to improvements.
- Working in partnership with the Quality Improvement lead
- Attending bi-monthly patient safety meetings with guest speakers' presentations, sharing key safety changes and work currently underway, demonstrate an appreciative inquiry model of when things have gone well and when things haven't to provoke discussions within the group.
- Share learning for the Learning Hub
- Continue to promote a culture that places excellence at the heart of everything we do, with people being treated as equal partners in their care and support.
- Promote the vision and strategy to deliver services that are safe, fair, equitable, inclusive, and accessible for all members of the community.
- Ensure services celebrate best practice and positive experiences of care
- Work with services to monitor trends and themes around incidents, near misses and complaints.
- Support services with undertaking Journeys of Care with patients/service users, to be shared at Board and the Learning Hub

Wirral Community Health and Care NHS Foundation Trust

Appendix 2

Stage 1 Quality and Equality Impact Assessment (QEIA) template

Policy Title					
Department/service	Trust Board		**Lead Name & Job Title**	Chief Nurse	
Rationale for completion	A new policy ✓	Change to an existing strategy or policy	Change to a service or function	A new service or function	Other
Initiative/Project/Change Description *Describe current status followed by any changes that stakeholders would experience*.					
Who is likely to be impacted?	Patients/service users/carers ✓	Workforce✓	Organisation✓	Partners✓	Other

Quality Impact

This looks at the policy as a whole and asks how it will impact patients/service users, staff and the organisations involved and how any identified risks or negative impacts could be mitigated.

If the risk score is greater than 10 in any area, this will require a more detailed impact assessment to be carried out and shared for Executive approval
Standard Operating Procedure - template (wirralct.nhs.uk)

	Positive/ Neutral/Negative impact	Negative Risk Score (L x C)	Mitigations for impacts
Patient/Staff Safety – will the scheme have a positive/negative or neutral effect on the aim to treat and care for people in a safe environment and protect them from avoidable harm?	Positive National PSIRF principles initiate the use safety system engineering models to promote patient safety and implementation of learning from incidents, complaints & other feedback processes		
Clinical Effectiveness – will the scheme have a positive/negative or neutral effect on the aim to apply knowledge that is based on research, clinical experience, and patient preferences, to achieve optimum processes and outcomes of care for patients/service users?	Positive This policy supports clinical effectiveness as learning is implemented following reviews and investigations, using best practice		
Patient/Staff/Organisation Experience – will the scheme have a positive/negative or neutral effect on patients' experience of care, based on all interactions, before, during and after delivery of the care? How will it affect staff experience and the portrayal of the organisation as a whole?	Positive Improved patient and carer experience anticipated Strengthens a restorative safety culture		

Equality Impact - Who may be affected by this activity?

	Positive/Negative/ Neutral impact description	Negative risk score (L x C)	Mitigations
Protected characteristics (Equality Act 2010)			
• Age • Disability • Race • Gender reassignment • Marriage & civil partnership • Pregnancy & maternity • Religion & beliefs (including no belief) • Sex • Sexual orientation	Positive PSIRF principles aim to address and reduce the impact of inequalities		
In addition, consider the following vulnerable groups:			
• Armed forces/veterans/reservists • Carers • Digital exclusion • Domestic abuse • Education (literacy) • Gypsy Roma Travellers • Homeless • Looked after children • Rural/urban areas • Socioeconomic disadvantage • People with addiction or substance misuse problems • People on probation • Prison population • Undocumented migrant, refugees, asylum seekers • Sex workers • **Neurodiversity** • **Other (please describe)**	Positive PSIRF principles aim to address and reduce the impact of inequalities		

If the risk score is greater than 10 in any area, this will require a more detailed impact assessment to be carried out and shared for Executive approval

Standard Operating Procedure - template (wirralct.nhs.uk)

Approval activity

Approval Group Name	Quality and Safety Committee		
Group Chair		**Date**	**10/2023**
Decision/outcome	**Approved**	**x**	
	Not Approved		
	Full QEIA required		

On-going monitoring

Where will the project/initiative be tracked?	**Clinical Assurance Group**
Project Leads	**Chief Nurse, Deputy Chief Nurse and Patient Safety Lead**

Please ensure the QIA/EA is added to the SAFE quality tracker

Appendix 3

Minimum requirement to be monitored	Process for monitoring (e.g. audit)	Responsible individual / group/ committee	Frequency of monitoring	Evidence	Responsible individual for development of action plan	Responsible committee for monitoring of action plan and Implementation
Review of the Policy	Review of Policy	Patient Safety Lead	3 years	Amendments to the policy	Patient Safety Lead	Quality and Safety Committee
Timescales for Duty of Candour process	CRMG	SAFE /OPG/CRMG	Weekly	SAFE /OPG/CRMG	Quality and Governance	Quality and Safety committee

Patient safety incident response plan

Effective date: 1 August 2023

Estimated refresh date: 1 August 2025

	NAME	TITLE	SIGNATURE	DATE
Author (s)	Patient Safety Lead			
Reviewer	**Clinical Assurance Group**			
Authoriser	**Quality Committee**			

Foreword

The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. “

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to and although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage meaningfully with our patients, families, and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Contents Pages

Introduction

This patient safety incident response plan sets out how Wirral Community Health and Care Foundation Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent rule that cannot be changed, we will continue to monitor all incidents for themes, trends and when necessary, these will be escalated to the Clinical Risk Management Group where decisions will be made for appropriate steps to undertake to maximise patient safety. This will enable us to remain flexible in our approach and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Plan is underpinned by our Trust 'Incident Management policy GP08' available to all staff via Staff Zone. WCHC is developing a PSIRF policy in 2023, this incident management policy will be updated and aligned to avoid duplication but to provide further clarity for staff on pathways for escalation, methods of review, safety action development, safety improvement plans and monitoring improvement.

A glossary of terms used can be found at Appendix A

Our services

Our expert teams provide a diverse range of community health care services, seeing and treating people right through their lives both at home and close to home, ensuring essential care continues to be delivered, and preventing a visit to hospital.

We employ over 1,500 members of staff, nearly 90% of whom are directly supporting our patients. Our services are local and community-based, provided from over 50 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead, and Victoria Central Health Centre in Wallasey.

We also provide the Community Integrated Care Centre on the Clatterbridge site providing 71 beds across 3 wards offering reablement care and support to the local community.

We provide integrated 0-19 services in Cheshire East comprising health visiting, school nursing, family nurse partnership and breastfeeding support services from a number of bases including medical centres and children's centres. In September 2021 we started delivering the 0-19 health and wellbeing service in St Helens and in February 2022 we launched a new 0-25 service in Knowsley. It is important to note that due to changes within the commissioned contract for social care from July 2023, we have excluded them from this profile and data sets,

although we will continue with our strong working relationship to provide the safest and high-quality care working cross organisationally.

We have over 1500 members of staff, and nearly 90% of which are patient facing.

We have seven operational localities:

Birkenhead Locality

South Wirral Locality

West Wirral Locality

Wallasey Locality

Wirral System 1

Wirral System 2

Wirral and Regional System

This structure will help us to sustain and grow our services in line with our strategic and transformation plans. It will also allow us to respond to local and national priorities including Patient Safety Incident Response Framework. We will also align our work with key trust strategies such as

- Organisational Strategy
- Quality Strategy
- Inclusion and Health Inequalities Strategy
- The People Strategy
- Digital Strategy

This will enable us to embed the Patient Safety Incident Response Framework by utilising all these resources to further embed a psychological safe culture for our staff and working in partnership with Patients and Families

Defining our patient safety incident profile

Defining our patient safety profile at Wirral Community Health and Care Foundation Trust we reviewed the following data sets taking into consideration the national profile of applicable areas for the trust.

The Trust incident reporting platform Datix system including date ranges reported by all staff employed at the trust 2020-2021, 2021-2022, 2022-2023, this enabled us to identify the top ten incidents reported by the trust, further analysis enables themes and trends to be reviewed. Due to the pandemic and the impact following on from this, we believe the 2022-2023 data provides a more accurate picture for the next few years. Furthermore, due to changes within our profile for newly commissioned services, expansion of existing services and also changes relating the ceasing of the social care contract so further analysis was applied to this date range.

The following other data sets were reviewed for themes and trends alongside our top 10 incidents

StEIS reportable incidents including, never events
Mortality reviews
Staff Surveys
Staff suspensions
Patient Safety reports
72-hour reviews- key themes identified in our Quality Improvement Plans
Claims and complaints data
Safeguarding data
Freedom to speak up

These key areas where triangulated to understand common themes in line with the patient safety strategy 2019 and Patient Safety Incident Response Framework 2022
Internal key stakeholders were involved with the process including, Patient Safety Specialists, Patient Safety Partners, Patient Safety Manager, Quality improvement lead. The reports and findings were initial shared with the key stakeholders for comment. The Clinical Assurance Group also reviewed the key themes identified within the presentation, the plan and policy for approval.

The second part of the sign off process is to seek committee's approval prior to the Patient Safety Incident Plan being agreed and signed off by the ICB
Defining our patient safety incident profile. The patient safety risk process is a collaborative process. To define the WCHC patient safety risks and responses for 2022/23 the following stakeholders were involved.

- Staff – through the incidents reported on the WCHC Datix incident system
- Senior leaders across the divisions Via, CAG and PSIRF stake holder group
- Patient groups – through a review of the thematic contents of complaints and Concerns
- Analysis of three years' of Datix incident data 2020-2023
- Detailed thematic analysis of Datix incident data 2022-2023
  Key themes from other data sets as mentioned above
- Themes from the Learning from deaths reviews were undertaken, but it was noted as learning for the trust and not the cause of death 2020-2023
- Themes and trends have been reviewed from complaints/concerns and claims these have been cross referenced to incidents
- Themes from steis reported incidents where cross referenced with themes of incidents of all incidents reported

- HR are leading on the work stream for culture and psychological safety and have reviewed themes and trends from staff survey, reports from freedom to speak up and other processes related to staff conduct. These have been cross referenced and will flow through the People Plan

- Safeguarding S42 reports have been reviewed from 2022-2023 whilst there has been a theme around falls, further analysis will occur over the following year

- 72-hour reviews and SI reports are reviewed for themes and trends and feed into the Quality improvement driver diagrams for our key organisational risks

- incidents Local patient safety risks related to national priorities have been defined as the list of risks covered by national priorities that WCHC anticipates will require a response in the next 12-18 months.

- The top local patient safety risks have been defined as the list of risks identified through the risk stakeholder approach and the data analysis described above. These local identified risks represent opportunities for learning and improvement in the WCHC health system.

Table 2 lists these top local patient safety risks. Potential for harm for patients these have been triangulated with other data sets named above to better understand the level of risk.The criteria WCHC have used for defining the top local patient safety risks is as follows

Category	Descriptor
Pressure Ulcer	All pressure ulcers that have occurred under the trusts care
Slips, trips, falls and collisions	All patients Slips trips falls that have occurred whilst under our care
Delayed delivery of care	All incidents that included where care had been delayed
Communication	All communication incidents including with patient and staff
Moisture Lesion	All Moisture lesions that have occurred whilst under trust care
Medication: Administration or supply of a medicine from a clinical area	All incidents across the elements of the medication process
Information Governance non treatment related	All incidents of breach of IG or relating to issues with recording and storage or management of patient and staff information
KPI breach	All incidents where a KPI breach had occurred
Medical device/equipment	All incidents with equipment including failure or difficulties with supply or use
Access / Admission / Appointment	All incidents relating to the stated stages in the patient journey
Diagnostic Incident	All diagnostic incidents for patients in receipt of care
Treatment, procedure	All care and treatment provided
Implementation of care or ongoing monitoring/review	All patients under the care of WCHC
Clinical assessment	All clinical assessments on patients undertaken within the trust

Discharge	All discharge related incident managed by Discharge Team or from Community Integrated Care Centre (CICC) to other care in the community
Quality of care concern - another provider	Relates to either patients under our care and in receipt of other services or patients referred in from another provider
Information Technology	Relates to all IT incidents
Unexpected Death	All unexpected deaths of patients who are under the trusts care at time of death
Environmental matters	Relating to trust buildings
Infection control	All Trust infection control incidents
Catheter related incident	All catheter related incidents
Consent	All consent incidents that related to patient care
Moving and handling	All moving and handling incidents related to patient care
Incident relating to package of care	All incidents relating to supply and receipt of a package of care
Security Incident	All security related incidents reported within the trust
Abuse - other	All incidents where violence and aggression has been witnessed or experienced by patients, staff, and others
Safeguarding Adult and Children	All incidents where it has been reported or noted that a patient has required to be safeguarded
Exposure/Contact electricity, hazardous substance, object	All hazardous incidents
Information Governance	All IG related incidents
Property Incident	All community trust property incidents and those that relate to incidents occurring within patient property
Resuscitation Incident	All incidents related to resuscitation
Acute Life -Threatening Episode (ALTE) in Children	All children related incidents related to this area
Fire Incident	All fire incidents with trust premises or patient who are under our care
Abuse etc of patient by another patient	All reports of abuse between patients
Vehicle Incident	Any vehicle incident reported by staff or on trust premises

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years and transitioned away from a Root Cause Analysis (RCA) framework and started using a system-based approach (Serious Incident). We have a weekly safety huddle which reviews incidents for levels of harm moderate and above , these are then presented at CRMG which is chaired by an Executive-led and has Quality and Governance and key divisional leads in attendance. Key themes and trends are shared with the group, following analysis of the Safety Risk and Learning Review Panel. CRMG reviews After Action Reviews, Thematic Analysis and PSI reports, these are cross referenced with Safety Quality Improvement Plans to ensure we are continually improving patient safety.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on page 11. To fully implement the Framework the Trust has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve.

A small group from the PSIRF key stake holder group including the Patient Safety Partners have reviewed data sets and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on page 13.

Defining our patient safety improvement profile

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

CRMG will provide assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard. The Quality and Governance Team will be responsible for the oversight of this quality improvement work including the effective use of quality improvement methodology.

Our clinical and corporate divisions are required to report via SAFE and OPG in order to monitor and measure improvement activity across their divisions. This includes review of progress against key divisional improvement plans. These divisions will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil SMART Goals requirements and are sufficient to allow the Trust to improve patient safety in future.

We have current improvement plans underway within the Trust these are listed within the local priorities table page 13

We plan to focus our efforts on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required when a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

National Priority	Trust Response
Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII at WCHC, if applicable work in collaboration with other trusts involved in care
Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII at WCHC, if applicable work in collaboration with other trusts involved in care
Maternity and neonatal incidents meeting HSIB criteria	Not applicable to WCHC as relates to maternity services
Child deaths	Locally led PSII, as appropriate and SUIDIC process

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Mortality Review Group
Safeguarding incidents in which: Babies, child and 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 by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
Incidents in 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 Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	WCHC as Trust not currently commissioned to provide services to these areas
Mental health related homicides	Locally led PSII by the provider in which the event occurred with WCHC participation if required
Domestic Homicide	The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews. Locally led PSII by the provider in which the event occurred with WCHC participation if required

In order to utilise trust resources effectively for patient safety incident responses, we intend to take a measured approach which we have indicated within the plan to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 5 PSII reviews where national requirements have been met per annum.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their services and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and sharing the themes and trends analysis we have determined that the Trust requires 10 patient safety priorities as a local focus. We have selected this number due to the breadth of services that the Trust provides. We will undertake a minimum of 1 index case PSII for 5 of the local priorities in each of the types of incidents proposed, the other 5 will have either an AAR or a thematic analysis. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work.

			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	Trust Priorities	Medication - priority • Error in administration of critical medications resulting in moderate harm or above	Patient Safety Incident Investigation / AAR	QI Plan in place further learning identified will feed into this
			Delayed Delivery in care - priority • Delay in patient care, treatment, or across care systems resulting in harm or distress, focusing on EOLC patients	Patient Safety Incident Investigation / AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Slips Trips and falls - priority • Any patient who has been reviewed on the MIFPAT deemed at risk of falling and has a risk factor within bone health/following falls from bed or within the bathroom resulting in moderate harm and above	Patient Safety Incident Investigation / AAR / Thematic Review	QI Plan for Falls Prevention in place further learning identified will feed into this
			Pressure ulcers - priority • Any patients who have developed a category 2 pressure ulcer within the community who are assessed as Low	• Category 2 pressure ulcers thematic review • Category 4 Patient Safety	QI Plan for Wound Care Steering group in place further learning identified will feed into this

			risk • Category 4	Incident Investigation / AAR	
			Discharge incidents -priority • Discharge incidents where patients are discharged with no referral, or equipment to meet their needs	Patient Safety Incident Investigation if a moderate harm and above or AAR / Thematic review	Create local organisational recommendations and actions and feed these into the quality improvement
			Patient Records • Wrong information that has led to harm or near miss where significant harm could have been caused	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Medical device incidents • Unable to provide safe care due to delay / broken equipment	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Moisture Lesions • Any moisture lesion that has developed in the community for patients with continence products	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Access admission and appointments • Delay in patient's appointments that have led to moderate harm or themes in delay per service	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Communication • Monitor themes around communication failure within services • Monitor themes around patients within services • Monitor themes around information giving	Thematic Analysis/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
	Patient safety Review	Local	Incident resulting in moderate or severe harm to patient	Statutory duty of candour agreed at CRMG	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new

	Incident response		No/Low/Near miss Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	improvement plan or inform ongoing improvement efforts

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix A

Glossary of terms

CRMG- Clinical Risk Management Group

CAG-Clinical Assurance Group

Safety Huddle- Safety huddles (or safety briefs) are short meetings used for sharing information about potential or existing safety problems. They increase safety awareness among front-line staff, allow for teams to address identified safety issues, and foster a culture of safety

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan
Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients.

AAR – After action review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

SMART

SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved, or targets might slip