York and Scarborough Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

2023-25

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Introduction and scope

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It provides the detail of how we will implement the requirements of the PSIRF as set out in our associated Patient Safety Incident Response Policy.

PSIRF offers a very different way of reviewing and learning from incidents.

The Serious Incident Framework (SIF) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a ***learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement*** in patient safety through how we respond to patient safety incidents.

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

In addition, PSIRF introduces other 'learning responses', such as After-Action Reviews and hot debriefs, where an investigation is not required.

The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. Removal of the serious incident process does not mean "do nothing". It means doing things differently.

Under the old SIF too much time and resource were spent investigating incidents based on a predefined threshold, such as a subjective level of harm. PSIRF provides the framework to shift the focus to provide a better balance between investigating and learning and improvement to improve patient safety.

PSIRF aims to be more efficient by:

- Taking a proportionate response to incidents
- Linking with quality improvement projects where there are common themes; thereby reducing local action planning and supporting organisation-wide learning
- Focusing efforts on learning and improvement rather than investigating
- Conducting fewer Patient Safety Incident Investigations (PSIIs)
- Sharing learning across other patient safety insights, such as mortality reviews
- Minimising multiple reviews of the same incident.

PSIRF uses systems-based methodologies to establish the causes of incidents. This approach aims to move away from person-centred causes and supports a 'just culture'. Staff training is necessary to build skills in systems-thinking.

Compassionate engagement sits at the heart of PSIRF – ensuring support structures are in place for staff and for patients / families involved in patient safety incidents. Fostering a psychologically safe culture must be evident in staff behaviour throughout our organisation.

This document covers responses conducted solely for the purpose of systems-based learning and improvement.

It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, human resource matters, legal claims and inquests.

There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

This plan sets out how PSIRF will be implemented at the Trust over the next 12-18 months.

The process is new, and initially there will a period of 'double running' with the old framework as serious incident investigations in progress are completed. The PSIRP describes our intentions with the detail underpinned by an updated Incident Management Policy, a series of supporting guidance documents and developments on the incident reporting system (Datix) to facilitate the flow and sharing of information.

The Trust's strategic aims underpin this Patient Safety Incident Response Plan (PSIRP).

- ***Deliver safe, quality services in partnership with our communities***
- ***Live our values***
- ***Deliver excellent integrated care through the transformation of services***
- ***Lead the way in education, research and innovation to continuously improve care***
- ***Provide a rewarding place to work***

Our Trust values: Kindness, Openness and Excellence, will also be integral to implementation and adoption of the PSIRF.

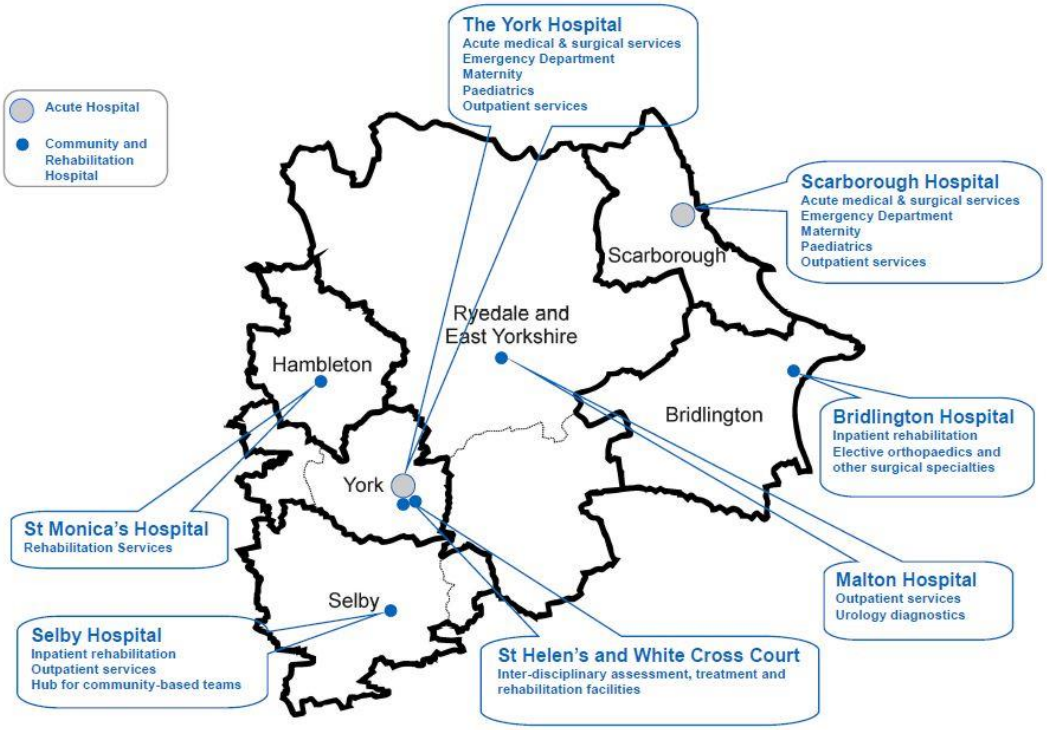
Trust values

PSIRF strategic aims

Improve the safety of the care we provide to our patients	Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified	Improve the use of valuable healthcare resources	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations

Our services

Chart 1: Hospital and community services offered by the Trust



York and Scarborough Teaching Hospitals NHS Foundation Trust (Y&STHFT) provides a comprehensive range of acute hospital and specialist healthcare across eight sites and community services for people living in and around York, North Yorkshire and East Riding.

The Trust has a Corporate Directorate. The central Patient Safety Team works closely with other Corporate Teams, particularly the Patient Experience, Quality Improvement, Clinical Effectiveness and Legal Services teams.

There are 4 clinical Care Groups:

Medicine Care Group:	Acute, Emergency, Frailty & Internal Medicine
	Community Services
Surgery Care Group:	Surgery, Theatres, Anaesthetics & Critical Care
Family Care Group:	Obstetrics & Gynaecology, Sexual Health, Paediatrics
Cancer, Specialist and Clinical Support Services Care Group:	
	Cancer, Specialised Medicine, Ophthalmology & Outpatients
	Radiology, Diagnostics, Pathology & Pharmacy

Supporting services, eg. estates and facilities, are not listed but do form part of the wider system in the PSIRF.

Defining our patient safety incident profile

We reviewed our local system to understand the people who are involved in patient safety activities across the Trust, as well as the systems and mechanisms that support them.

Our local care system is complex with many interrelated components that are crucial to ensuring everything works. We have reviewed all patient safety activities and engaged closely with our network of key stakeholders and partner agencies who are integral to the Patient Safety agenda.

Core patient safety activities undertaken at Y&STHFT include:

- NHS Patient Safety Strategy
- Trust Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Partners involvement
- Risk Management
- Central Alert System
- Supporting improvement programmes

Other activities within the Trust that provide insights to patient safety include Structured Judgement Casenote Reviews (learning from deaths), complaints and feedback and inquest outcomes.

The operational 'work-as-done' for these patient safety activities is predominantly owned by colleagues within the clinical Care Groups.

Each Care Group has a small governance team who provide local expertise and advice on patient safety matters with support from the Corporate Teams and the Patient Safety Specialist.

The Care Groups could not function without other support services such as estates and facilities or information technology. These services form part of the wider Trust system and their role is integral to the implementation of PSIRF. Their importance can be seen when applying systems methodologies to analyse and understand incidents.

In combination all these teams are integral in facilitating our patient safety system and patient safety culture, on our road to implementing PSIRF.

We have developed our understanding and insights of our safety incident profile covering the past three years. Achieving this has involved:

- Discussions and engagement with our committees and groups
- Detailed analysis of themes and trends arising from a range of information reviews and data sources
- Learning from previous serious incident investigations and existing improvement programmes.

Situational analysis

In the last three years Trust staff reported more than 24,000 patient safety incidents. 2.5% of these were investigated as a Serious Incident (SI) as per the Serious Incident Framework (NHS England 2015).

A significant amount of time and resource is consumed in completing all stages of SI investigations, including action planning, and providing assurances of learning. Arguably, there is a disproportionate amount of time and effort spent in carrying out SI investigations, significantly limiting time to learn thematically from the other 97.5% of patient safety incidents. In short, the burden of effort is placed on fewer than 2.5% of all patient safety incidents. PSIRF aims to redress this imbalance.

A key part of developing the new national approach is to understand the amount of patient safety activity the Trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, systems, and processes to support the new approach.

Analysis of PSIRF related activity in the last three years is shown in Chart 2.

Chart 2: Patient safety activity over the last three years (2019-2022)

Patient Safety Activities	Activity	Definition	Av. of prev. 3 calendar years	Last calendar year
National Priorities	Incident resulting in death	A serious incident requiring investigation which met the standard investigation timeframe and resulted in a patient's death	12	4
	Never Event	Incident meeting national criteria for never events	3	3
Local Patient Safety Activities	Serious Incident (SI) Investigations	A serious incident requiring investigation which met the standard investigation timeframe.	174	177
	Patient Safety Incident reviews (PSIRs)	Including moderate harm incidents meeting the requirement for statutory Duty of candour, or other incidents of concern.	N/A	431
	Patient Safety Incident Validation	Patient safety incidents of low / no harm requiring validation at department / ward level.	17577	19521

Thematic analysis

To identify our key improvement priorities we analysed 3 years of data up to 31 December 2022 relating to the following activities:

- Reported incidents (including low and no-harm incidents)
- Learning points from mortality casenote reviews (SJCR's - Structured Judgement Case-note Reviews)
- Complaints, Concerns and Patient feedback
- Risks and Risk Registers
- Legal Claims and Inquests
- Serious Incident investigations

The data and analysis present a complex picture with significant variation between Care Groups as would be expected given the diverse nature of services provided. From analysis of the incident data it was clear that falls, pressure ulcers, medication safety, harm related to clinical assessment and delayed treatment were the most significant categories of incidents.

Falls and pressure ulcers in particular had occurred frequently in the last 12 months (calendar year 2022). This has some correlation with incidents relating to nursing staffing levels. Also noteworthy is variance between sites with a higher proportion of falls incidents at York, whereas Scarborough has a higher proportion of pressure damage on admission and admission /transfer /discharge incidents.

Clinical incidents resulting in moderate or above harm levels presented a slightly different picture with infection control incidents being the most common, particularly in the last 12 months.

There is considerable variation between Care Groups and Specialties in terms of incident reporting profiles and numbers of incidents reported. The highest numbers reported relate to Emergency Medicine, Elderly Medicine, Obstetrics and Theatres /Anaesthetics /Critical Care.

Claims and inquests

Legal claims and inquests provide a similar picture though interpretation of radiological investigations and failure to treat /diagnose were more common. Lack of follow up advice on discharge and 'safety netting' was also a theme.

Serious incidents

Themes from Serious Incident investigations related more to causal factors including delayed diagnosis /treatment, communication /documentation, escalation /deterioration and reduced adherence to pathways /processes.

Mortality review

Mortality reviews mirror the serious incident findings to some extent, though management of nutrition / hydration, senior review / post take review and operational pressures also featured strongly.

Complaints and concerns

Data and information from complaints /concerns presented a more nuanced picture based on perceptions of patients or relatives, such as communication issues, care needs not being met and inadequate discharge arrangements. Again, these concerns were more prevalent in the specialties seeing the largest number of patients such as Emergency Medicine, Elderly Medicine, Acute Medicine, Trauma and Orthopedics, Obstetrics and Ophthalmology.

Risk registers

Analysis of risk registers highlighted the key operational challenges that impact upon quality and safety of patient care. These relate primarily to system capacity to deliver services such as:

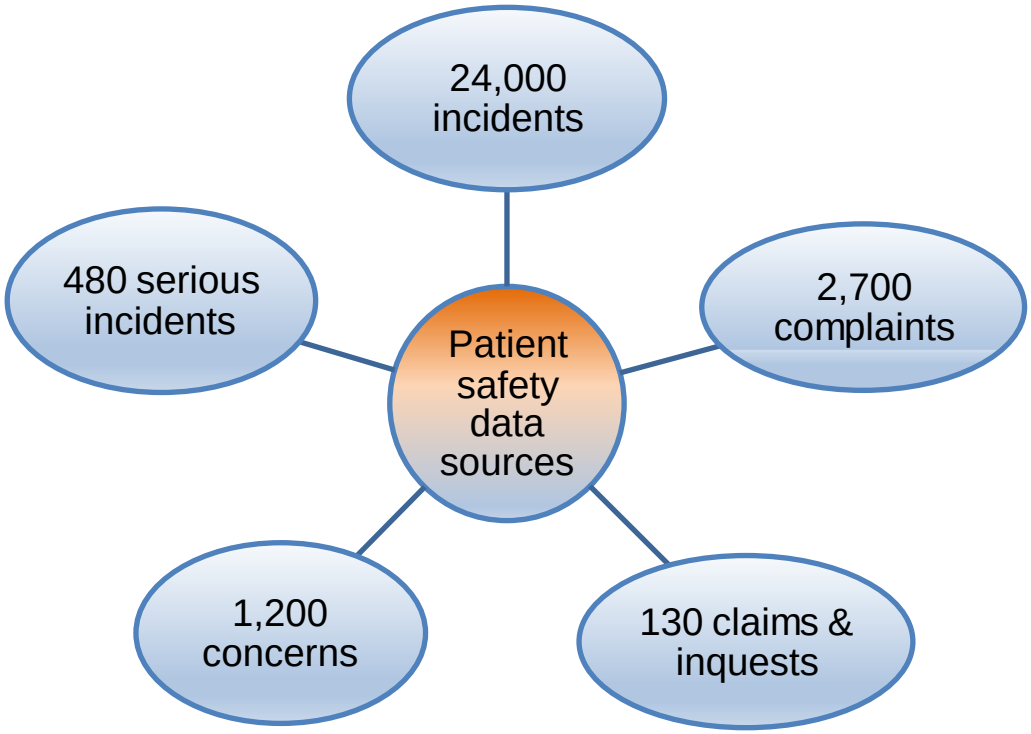
- Operational performance targets (referral to treatment, cancer and Emergency Department waiting times)
- Staffing shortages / vacancies and recruitment
- Estates / refurbishment
- Medical equipment.

Content of the risk register belongs to the Trust System. Understanding this alongside other data sources provide a more holistic assessment of patient safety as required within the PSIRF.

The governance of the risk framework will be more closely aligned with patient safety at the strategic and operational level in future. Improvement plans and risk mitigation should be co-terminus with patient safety priorities to maximize efficiency and improvement outcomes.

The summary of the review of data over three years to 31 December 2022 which has influenced the selection of patient safety priorities is given in Chart 3 below.

Chart 3: Summary of the data analysis over the last three years (2019-2022)



Defining our patient safety improvement profile

Through analysis of our patient safety insights, we have determined 7 patient safety priorities we will focus on for the next two years. These were agreed at the Quality and Patient Safety Group in February 2023 and are shown in Chart 4.

Focusing on these priorities means that we are maximising effort in addressing the matters that are causing most concern.

When the PSIRP is revised in the future the priorities may change. Emerging safety priorities may be incorporated into the PSIRP at any point.

Chart 4: Agreed patient safety priorities

Theme	Key Theme	Rationale
1	Inpatient fall	Patient falls, especially unwitnessed falls, have consistently been the most frequent category of incident. Nearly 200 falls resulted in moderate or severe harm for the 3 years of data analysed.
2	Medication	Medication errors, particularly in relation to administration and prescribing errors, are a frequent and persistent issue. Several serious incidents and concerns have been raised in relation to critical medications such as insulin, methotrexate, opioids and Parkinson's medications.
3	Responding to a deteriorating patient	This has been a consistent theme across various reviews where delayed treatment or escalation has resulted in missed opportunities resulting in serious harm and in some cases death.
4	Pressure related skin damage	Pressure injuries are the second most commonly reported incident category and account for a quarter of all incidents reported.
5	Discharge & onward referral	This is a consistent theme, especially in analysis of mortality reviews and complaints. Communication, planning and discharge medications are sub-themes within this.
6	Nutrition & hydration	Serious concerns regarding this were identified by the Care Quality Commission (CQC) in 2021/22 and several serious incidents and inquests since then have further identified this as an area for improvement.
7	Post-Partum Haemorrhage (PPH)	Management of PPH has been flagged by recent CQC visits and is a consistent theme in incident reviews as well as in national reports such as the Ockenden review.

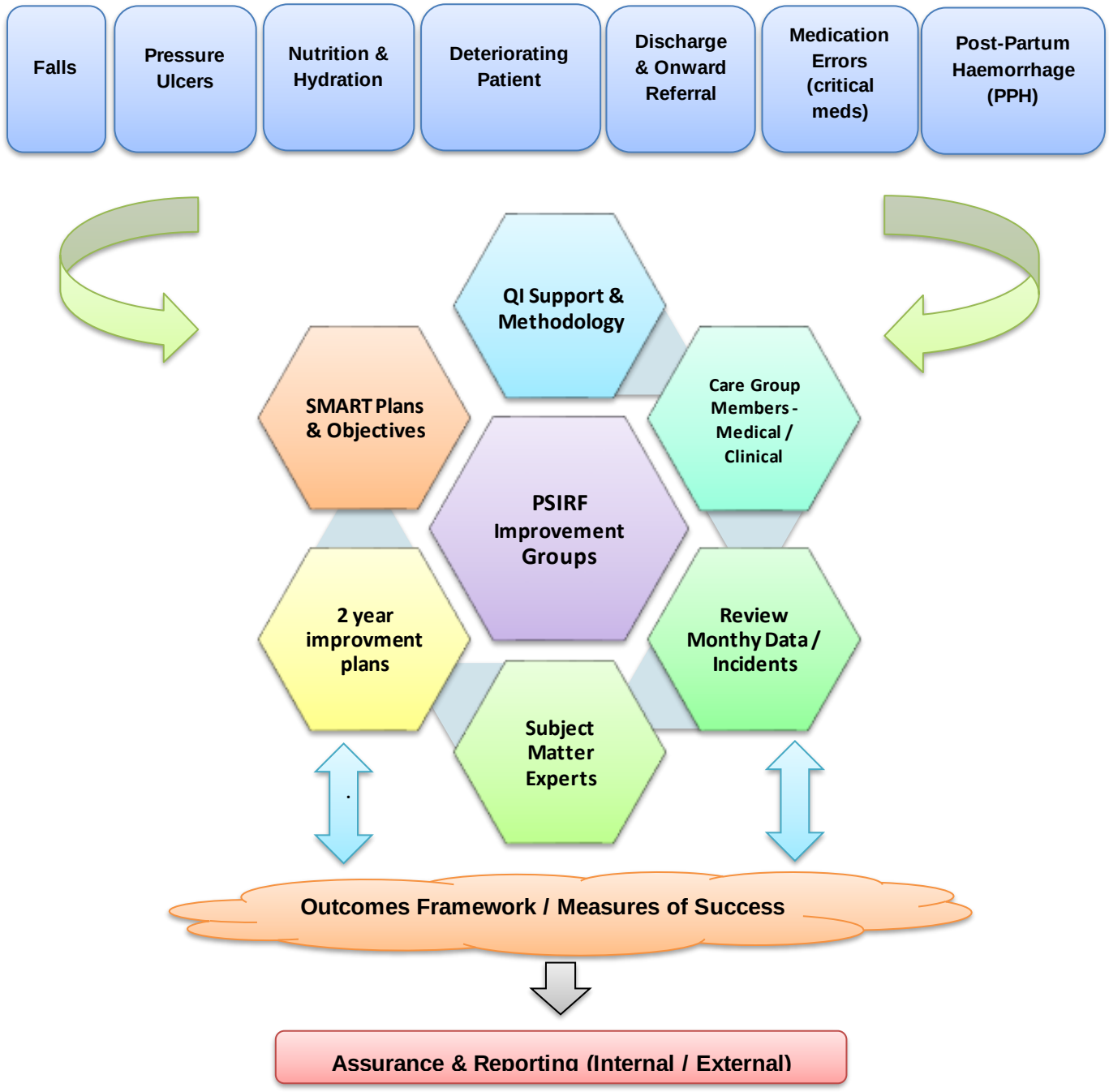
Improvement Groups associated with the PSIRF patient safety priorities are already established. These groups are responsible for coordinating and overseeing improvement work; and for monitoring outcomes via a series of data collections. With membership comprising multi-disciplinary team members from across all Care Groups together with subject matter experts the Improvement Groups are well-placed to oversee Trust-wide improvement. The improvement system can be seen in Chart 5.

Incident responses may also link with one of the many other improvement workstreams.

These include:

- End of life care
- Gastro-intestinal bleed
- Safety standards for invasive procedures
- Fractured neck of femur
- Handover
- Diabetes

Chart 5: Patient safety priorities within the improvement system



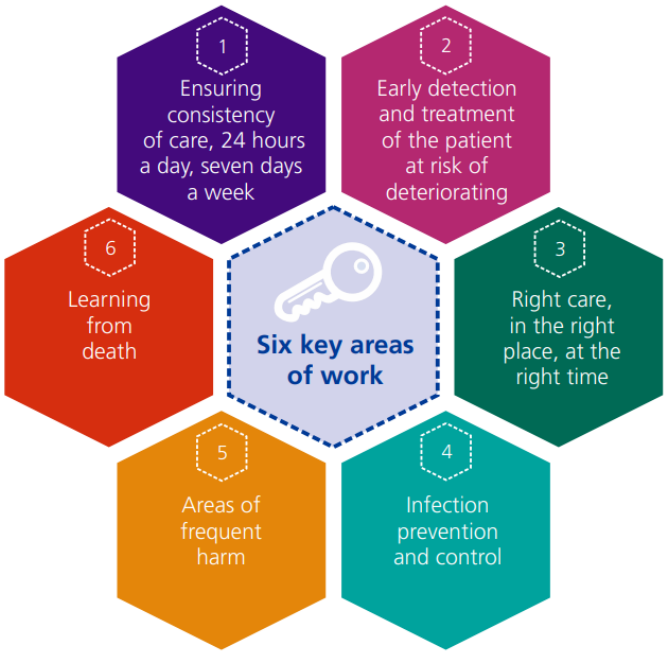
Alignment with our Patient Safety Strategy

The Trust's Patient Safety Strategy 2019-24 describes four key principles underpinned by openness and transparency. These can be seen in Chart 6. Alignment with PSIRF is clear and implementation of PSIRF will significantly contribute to the vision and intention set out within the Strategy.

Chart 6: Key principles of the Trust Patient Safety Strategy (2019-24)

The Strategy goes on further to describe six areas of work, shown in Chart 7. One of these – 'areas of frequent harm' (Area 5) is central to the PSIRF programme; and further alignment is seen relating to work on managing the deteriorating patient (Area 2) and to learning from death (Area 6).

Chart 7: Key areas of work identified within the Trust Patient Safety Strategy (2019-24)



Our patient safety incident response plan – national requirements

Decision for a patient safety incident investigation

Under PSIRF there are only two national criteria which will trigger a patient safety incident investigation:

- Incidents meeting the Never Event criteria
- Incidents resulting in death, where the death is believed to be directly attributable to the incident. This may be immediately obvious or identified via the Learning from Death process.

Any new national priorities will be added if /when they are published.

The situational analysis resulting in the data shown in Chart 2 has identified that 7 such investigations were completed in the last year of analysis. **This PSIRP is therefore assuming that 7 nationally mandated patient safety incident investigations (PSII's) are likely to be commissioned each year within the Trust**.

External investigation / review

Some incidents are subject to review by external bodies. Examples include:

- Incidents referred to the Maternity and Newborn Safety Investigations Programme (previously Healthcare Safety Investigations Branch)
- Child Death Overview Process
- Perinatal Mortality Review Team process
- Learning Disabilities Mortality Review.

Under PSIRF any incident which meets the criteria for external review will continue to be reviewed in the same way as is currently conducted.

There is no mandated requirement to undertake a local patient safety incident investigation where an external investigation or review is performed.

Our patient safety incident response plan – local focus

Local governance structures and groups will remain in place where possible to minimise the impact of change; and clinical teams will continue to report and complete the initial review of incidents on Datix as occurred previously. It is how we respond to the incidents that is changing.

PSIRF provides freedom to choose how we will respond to patient safety incidents. Whilst released from the constraints of the Serious Incident Framework the PSIRF places greater responsibility at the Care Group level for both commissioning and signing off learning responses.

A series of flow charts and diagrams will guide the decision-making process.

Documentation will be entirely different with the majority in electronic form directly accessible via Datix.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before. The challenge is to embed a wide response to patient safety incidents whilst allowing time to learn thematically and to focus on improvement.

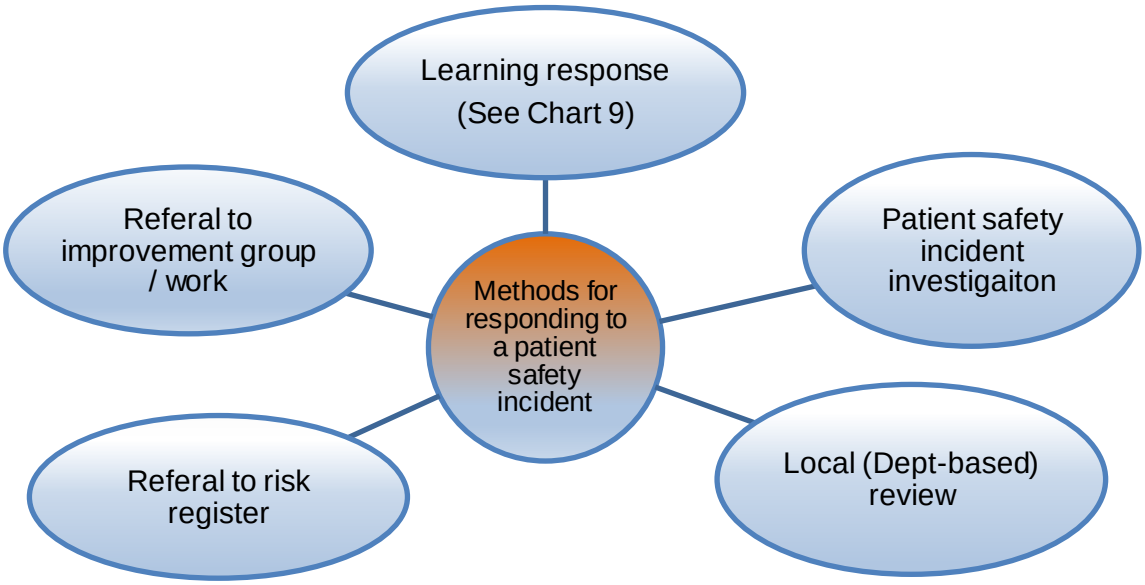
We will use existing structures to support the implementation of PSIRF.

- Daily review of reported incidents will continue within the Care Groups
- Decisions around the need for further review will continue to be made at the Care Group level by existing staff at existing meetings, but with new PSIRF response options. A guide and flowchart will support the decision-making process
- Care Groups will commission the learning response and will notify the weekly Quality & Safety Group of the decision
- There will be no requirement to complete a Patient Safety Incident Report (PSIR)
- The Quality & Safety Group will be a sounding-board to support decisions and to ensure the Patient Safety team is fully engaged when investigations are commissioned
- There will be no pre-defined timeframe for completion of a patient safety incident investigation. This will be agreed between the Care Group in conjunction with the patient /family and the Quality & safety Group.

As we transition into PSIRF, the Patient Safety team will continue to work closely with the Care Group Governance teams to review and identify incidents that may require a patient safety incident investigation. The processes will be described in detail in the updated Incident Management Policy and in supporting flowcharts and tools accessible via the intranet.

Response options available to the Care Groups are given in Chart 8 below.

Chart 8: Options for responding to an incident



Decision for a patient safety incident investigation (PSII)

Under PSIRF the decision to investigate is not based around the level of harm. A **patient safety incident investigation** will be commissioned when the following apply:

- The incident meets the national thresholds as described above
- The incident is linked to one of the Trust's PSIRF Patient Safety Priorities. An investigation comprising a thematic review relating to a cluster of 3-6 incidents, or of a single index incident, will be completed three times each year.
- The incident is an emergent area of concern such as a cluster of 'new' patient safety incidents of a similar type or theme. In this situation, a proactive investigation can be commenced, using a single index case or group of incidents, upon agreement by an Executive Director.
- A maternity incident that meets the criteria for investigation as defined within the Local Maternity & Neonatal System procedure.

Using these criteria at least 28 PSIIs will be commissioned each year in total (21 related to priorities; 7 linked with national requirements).

Decision for an alternative 'learning response'

All reported patient safety incidents will require some level of response, even if that is a considered decision to not review any further. Where this is the case then closure of the incident may refer to the risk register for a known problem; or to an existing improvement group or workstream already dealing with the concern.

Most incidents result in no harm or low harm and require local review and closure on Datix as has been the practice for many years.

Where an incident is one of the 7 Trust priorities or results in moderate harm or severe harm one of the PSIRF system-based responses must be used to understand how an incident came about. Three learning response methods for use within the Trust are shown in Chart 9.

Chart 9: Learning responses

Method	Description
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved an understanding of why the outcome differed from that expected; and the learning to assist improvement. AAR generates insight from the various perspectives of the team and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/ what was expected to happen? • What was the actual outcome/ what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?
Hot debrief (Swarm huddle)	To be known as a hot debrief - this is designed to be initiated as soon as possible after an event and involves a team discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
Pathway (Multidisciplinary team (MDT)) review	An MDT review is more complex and supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/ or where it is more difficult to recollect events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

Templates and matching electronic fields on Datix will be available for all responses.

There are a range of tools that may assist with undertaking a learning response. Guidance will be available to staff on the intranet and details included within training.

Such tools include:

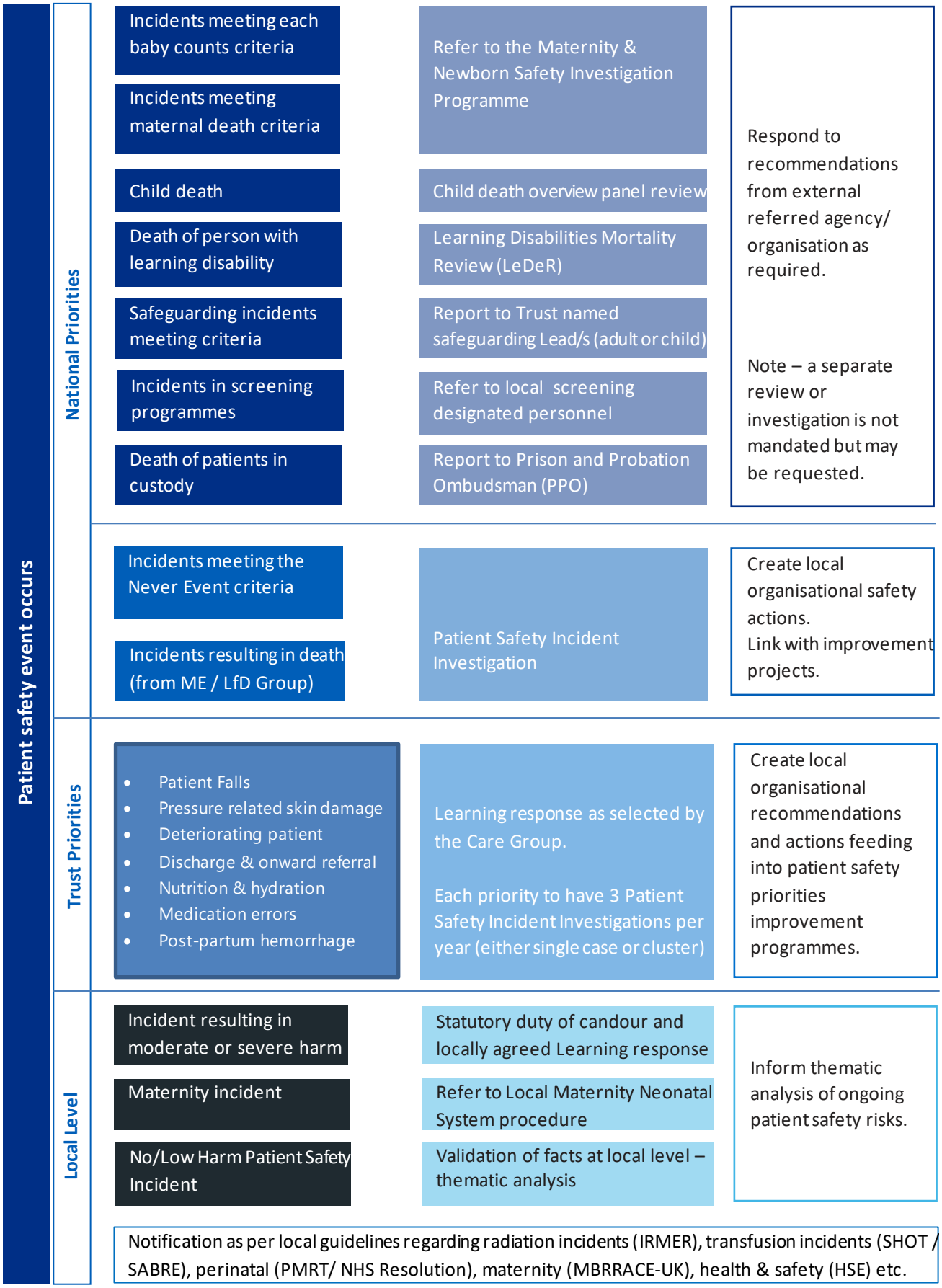
- SEIPS on a page (default)
- Observation guides
- Timelines
- Walkthrough guides

The Yorkshire Contributory Factors Framework (YCFF) is a systems-based tool and can be used as an aide-memoire to assist with carrying out these responses.

What to do when

At first the options may seem daunting but to help a summary of the approaches is given in Chart 10.

Chart 10: Guide to required responses



Training

As we move to the PSIRF framework there will be a requirement for additional training and education. PSIRF introduces new theory which takes account of the latest research in safety science.

Current research has recognised that a more systems-based approach to identify causal and contributory factors, and how these interact with 'work systems' and human factors, is more beneficial if we are to prevent reoccurrence of safety incidents. Root Cause Analysis (RCA) is no longer a recognised tool to investigate incidents. Instead, learning responses using systems-based methodologies are required to review incidents. The Systems Engineering Initiative for Patient Safety (SEIPS) model will become the central framework for our investigations and other learning responses. The Yorkshire Contributory Factors Framework is a systems-based tool and can act as an aide-memoire.

PSIRF training

NHS England has mandated the completion of up to three training courses by key staff to be able to successfully implement PSIRF. These are:

- Systems approach to learning from patient safety incidents
- Engaging with patients, families and staff following a patient safety incident
- Systems approach to learning from patient safety incidents - oversight

Under PSIRF there are three specific roles:

- Response Lead
- Engagement Lead
- Oversight Lead

The Trust recommends that all staff who undertake patient safety incident investigations also complete the engagement training alongside the nationally mandated systems training.

The Trust has developed a training plan which identifies which staff require training in the first two cohorts. This training will be delivered by an external company; the first cohort prior to PSIRF implementation. Subsequent cohorts will receive training by a variety of means – externally procured training, in-house or on-line training where possible. The requirements for the PSIRF training are shown in Chart 11.

Chart 11: PSIRF training requirements

	Systems	Engagement	Oversight
	2 days	**1 day**	**1 day**
Learning Response Leads	✓	Recommended	-
Engagement Leads	-	✓	-
Oversight Leads	✓	✓	✓

National patient safety syllabus training

The national Patient Safety Strategy has identified the need for patient safety awareness training amongst all NHS staff. National online training has been developed and these are accessible via the Learning Hub:

- Level 1 (essentials for patient safety) for all staff / for boards and senior leadership teams
- Level 2 (access to practice) providing more advanced training

The Trust requires all staff to undertake Level 1 training.

The Trust recommends all staff at Band 6 and above as well as non-Foundation Year doctors to complete Level 2 training.

The national patient safety syllabus training is mandated for all those with a PSIRF-related role as per Chart 12.

Chart 12: National syllabus training applied to those with a PSIRF role

	Level 1	Level 2
Learning Response Leads	✓	✓
Engagement Leads	✓	✓
Oversight Leads	✓	✓

Additional training and support

This plan recognises that so much is new, and that time is required to embed the new knowledge and skills into the organisation. A training 'plan on a page' has been developed to provide an overview of training provision. This can be seen in Chart 13.

The plan describes the intentions for training of staff in cohorts 1 and 2 for the PSIRF training; the requirements for national safety syllabus training and the options for training staff in the future.

The plan will be updated as new national courses are released and as in-house capacity / shared training with other Trusts is established.

A full range of guidance, templates and support materials can be found on the Trust intranet:

Patient Safety Incident Response Framework — York NHS Staff Room (yha.com)

Use of Datix

Once a learning response is selected on Datix then relevant electronic fields will appear to enable staff carrying out the review to capture all necessary information. This will ensure records are maintained which support subsequent analysis and learning.

Chart 13: Training plan on a page

PSIRF training					National Patient Safety Syllabus training
	Initial training Cohort 1	**Initial training Cohort 2**	**Alternative approaches for training (initial & subsequent)**	**Hot debrief** (SWARM Huddle) **After Action Review** **Multi-Disciplinary Team Review**	Access via the Learning Hub Time: 20 mins / course **Level 1** - Required learning for all staff. *Essentials for Patient Safety* Or *Essentials for Patient Safety for Boards & Senior Leadership teams* **Level 2** – Recommended for ≥ Band 6 and clinical staff Required for PSIRF leads *Access to Practice*
Systems • Oversight leads • Investigators	Primarily for oversight leads & subject matter experts	Primarily for senior clinical staff & investigators	HSSIB Level 2 *A systems approach to learning from patient safety incidents* Self-paced online (30 hours) Cranfield University Healthcare Investigation Course *Baby Lifeline* 5 days for maternity staff	For: staff conducting non-investigation learning responses In-house: Access via Patient Safety Team HSSIB *After Action Review* Online – live event (3.5 hours)	
Involvement • Oversight leads • Investigators • Engagement leads	Via external nationally validated training company over 3 days	Via external nationally validated training company over 3 days	HSSIB *Involving those affected by patient safety incidents in the learning process* Online – live event (1 day) In-house: Access via Patient Safety Team		
Oversight • Oversight leads			HSSIB *Patient Safety Incident Response Framework Oversight* Online – live event (1 day)		

Supporting education		
Healthcare Services Safety Investigations Body (HSSIB)	www.hssib.org.uk/education/nhs-courses	Range of course inc. report writing, thematic analysis, investigative interviewing
eLearning for Health	www.e-lfh.org.uk	Range of courses inc. L1 and L2 national patient safety syllabus courses; Human factors / ergonomics for patient safety
Future Learn	www.futurelearn.com	Range of healthcare courses inc. Understanding systems thinking in healthcare; Human Factors in the healthcare environment; Airway matters (case study)

Patients, families and staff

We recognise the significant impact patient safety incidents can have on patients, their families, and staff. PSIRF promotes effective engagement and involvement with those involved in incidents and builds upon the duty of candour and just culture approaches already in place.

The 'Engaging with patients, families and staff following a patient safety incident' training covers how we can best engage with, involve, and support those affected to minimise compounded harm and maximise learning opportunity.

Supporting and involving patients and families

Getting involvement right with patients and families in how we respond to incidents is crucial. This means delivering the duty of candour where applicable but is more about having open discussions about what has happened and what action will be taken to review the incident.

It is important that patients and families have opportunities to share their views in an open and supported way so that their views are heard. It is equally important that the expectations of patients and families as to what type of review may be undertaken is carefully managed ie. it would be inappropriate to promise an investigation if one will not be undertaken. Training and guidance will help with these discussions.

Duty of Candour

Once an incident that meets the Duty of Candour threshold (ie. a notifiable patient safety incident – an unintended/unexpected incident that has caused at least moderate harm) is identified the Trust must discharge its statutory duty as described in the Duty of Candour Policy. The PSIRF makes no changes to the Duty of Candour but provides greater flexibility in the choice of learning response.

Supporting and involving staff

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience.

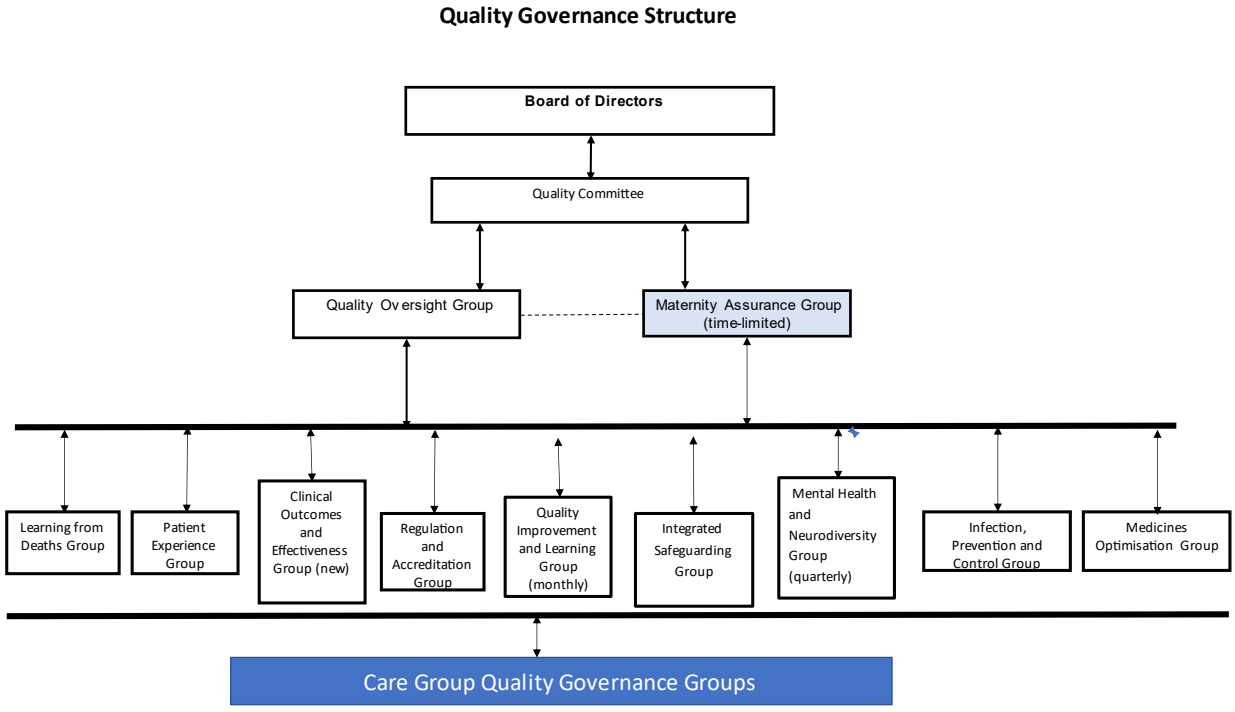
Staff must be treated with compassion.

When a colleague reports an incident or is providing their insights into the care of a patient as part of a learning response, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

Oversight

The Trust's committee structures which support the implementation of the PSIRF are shown in Charts 14 and 15. [Note – committee structure has not been finalised at the time of approval of this plan and may change.]

Chart 14: Committee / Group structure supporting PSIRF



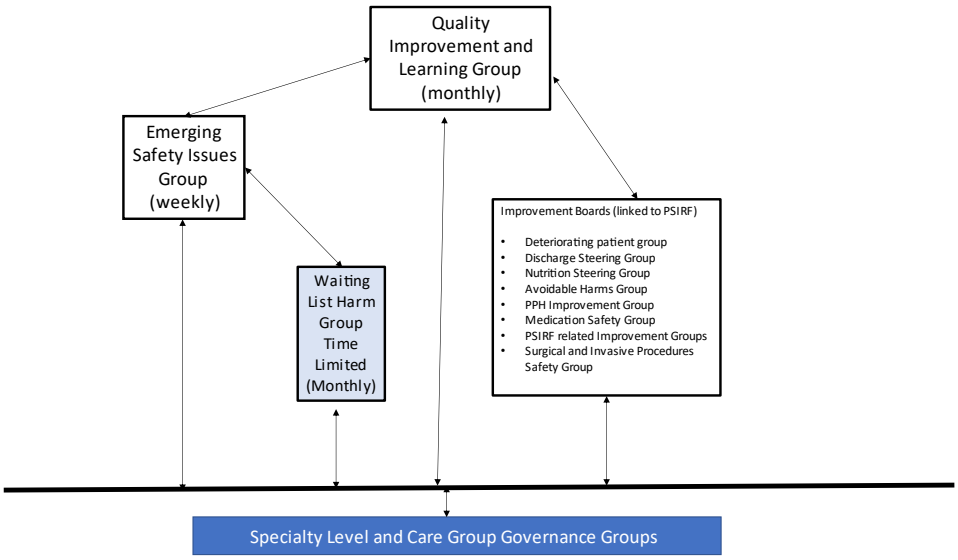
The Quality Oversight Group is responsible for monitoring quality within the organisation. It undertakes this duty through the receipt of scheduled reports:

- Patient Safety (including PSIRF and Duty of Candour) will report on a monthly basis
- PSIRF thematic analysis and improvement priorities progress will report quarterly

This structure enables outcomes across various services and teams to be considered in a holistic way; enabling themes and emerging concerns to be identified.

The Quality Improvement and Learning Group has been established and is significant in supporting the PSIRF. This focuses on learning and is informed by improvement groups and any emerging themes. The Emerging Safety Issues Group will meet weekly to support Care Groups in their management of incidents. This structure is shown in Chart 15.

Chart 15: Groups with specific PSIRF roles



Integrated Care Board

Under PSIRF Integrated Care Boards (ICB) do not have responsibility for signing off patient safety incident investigations. However, a level of assurance and involvement regarding the quality of care will continue to be provided through the attendance of ICB staff on some Trust Groups.

The Trust will continue to use the Strategic Executive Information System (StEIS) for investigation reporting and monitoring. When the national replacement for StEIS is introduced reporting and monitoring will change according to the new requirements.

Maternity

The maternity team will transition fully to PSIRF once the national position is agreed, and the processes defined by the Local Maternity and Neonatal System. Prior to their transition the maternity team will follow the PSIRF ethos, and use the PSIRF tools, where possible. Patient Safety Incident Review forms will continue to be used but learning responses will be determined locally.