East Sussex Healthcare NHS Trust

Patient safety incident response plan

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Approved at Quality and Safety Committee 21/09/2023, Trust Board approval received 10/10/2023 and ICB approval 13/11/2023.

Contents

1. Introduction

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as a 'foundation for change' therefore it challenges us to think and respond differently when a patient safety incident occurs. This new framework replaces the Serious Incident Framework (SIF). This document is East Sussex Healthcare Trust (ESHT) Patient Safety Incident Response Plan (PSIRP). It describes how ESHT has prepared for the 'go live' with the PSIRF.

The PSIRF Policy and Plan are in this first iteration transitional in approach to enable ESHT to be compliant for a 'go live' date. We fully anticipate and expect that eventually this new framework once it has started will become transformational for patient safety with the learning from incidents/events embedded in ESHT services and organisation culture and behaviour.

This PSIRP sets out how ESHT intends to respond to patient safety incidents over a period of 12 to 18 months. The Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This Plan is underpinned by our Trust policies on incident reporting and investigation available via our organisation's intranet (available to staff only) and ESHT as part of the PSIRF national plan will be developing a specific PSIRF policy ready for the **go live launch 20th November 2023**.

Expected schedule to go-live:

Divisional review of the PSIRF Plan and Policy	August 2023 – The Patient Safety Specialist/Lead and Patient Safety Team discussing the draft plan and policy with the Divisional senior managers.
Trust Board review via presentation by the Assistant Director of Clinical Governance.	September 2023 - Trust Board members seminar to receive a presentation and have an opportunity for questions and answers on the draft Plan and Policy.
Trust Board approval	October 2023 – Seen and approved by the Quality and Safety Committee 21/09/2023 and Trust Board approval received 10/10/2023.
Transition period from the Serious	October 2023 – The Trust will enable the transition to the new framework via the decision-making group on level of clinical harm for

Incident framework to the PSIRF	patient safety incidents/events on a weekly basis at the Weekly Patient Safety Summit (WPSS).
ICB approval Trust go-live	November 2023 – The ICB will receive the Trust approved PSIRF Plan and Policy for review. These documents will be shared with the LMNS by the Trust/ICB. Formal approval by the ICB will be at the Quality Reporting Monitoring Group on the 17th November. **The Trust will go live with PSIRF 20th November** and ensure the documents are available for all staff and the public on our Trust intra and internet pages via the Trust Communication Team.
Moving forward: the ICB to have continued oversight and improvement responsibilities in relation to Safety.	NHS Sussex to be involved in and review, from an improvement opportunities lens, a minimum of two learning responses per financial year. The learning response to be selected by the provider and can range from for example, an AAR, thematic review or PSII. This will enable the ICB to fulfil its oversight and assurance function and support in reviewing the process and learning. This will also facilitate the sharing of learning across Sussex as well as regionally and nationally via NHSE. The PSIRP to be reviewed with NHS Sussex monthly for the first six months of implementation to use a "plan, study, do, act (PDSA) approach" to understand any changes that may be required, learning identified and improvements to be realised. To be reviewed with the ICB quarterly thereafter.

It will provide further clarity for staff on the various incidents and appropriate templates for review or investigation to achieve the best systems and organisational learning. Additionally, the policy will enable the staffs' understanding on pathways for escalation safety action development plans and monitoring improvement.

PSIRF is ***very different,*** and it is very exciting.
Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement. With PSIRF, we, the Trust, are responsible for the entire process, including what to investigate and how. There are no set timescales except for the completion of a Patient Serious Incident Investigation (PSII) or submitting reports for external agency to approval. There are a set of principles that the Trust will work within but outside of that, it is up to us in the Trust. This will undoubtably feel a 'bit scary' but together we will move this new agenda forward.

The initial phases and timelines to get all of the elements drafted, shared, and discussed with internal services/Divisions and external parties has been slow due to lack of capacity in the Trust Patient Safety Team. The team have had to still monitor and report appropriate incidents and investigate SI's as per the SIF 2015 framework. There are and remain many challenges.

The immediate work on PSIRF has commenced by the Patient Safety Team, Patient Safety Specialist/Lead and overseen by the Assistant Director of Clinical Governance. Monthly updates progress reports are provided to the Trust Patient Safety Quality Group.

One of the underpinning principles of PSIRF is to do fewer 'investigations' but to do them better. Better means taking time to conduct systems-based investigations by people who have been trained to do them. This Plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy 2019 challenges the NHS to think differently about learning and what this means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean 'do nothing', it means respond in the right way depending on the type of incidents and associated factors. It means we respond in a timely way, working even more closely with the patient/families and staff to achieve effective sustainable learning and change, where appropriate.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety incidents and the insights this will provide the organisation in terms of learning and any recommendations for quality improvement.

PSIRF recognises the need to ensure we have support structures for staff and patients and families involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, our Trust-wide strategy, and our reporting systems.

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement. 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. It is outside of the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resources (HR) matters, legal claims, and inquests.

This Plan explains the scope for a systems-based approach to learning from a patient safety incidents perspective. ESHT will identify incidents to review through nationally and locally defined patient safety priorities, an analysis of which is explained within this document, see Tables 1, 2 and 3.

There are four strategic aims of PSIRF upon which this Plan is based:

- 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 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.

ESHT aims to incorporate a patient perspective into future Patient Safety Incident Reporting (PSIR) planning through the introduction of Patient Safety Partners (PSPs) in 2024.

- Further information on the national PSP programme can be found on the NHS England website: https.//www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

2. Our services

ESHT has made significant improvements for patients and local residents in recent years. The Trust is rated ‘good’ by the Care Quality Commission (CQC), with several ‘outstanding’ services and has ambitious plans for the future, enabling residents to access the best care in the most appropriate place: at home; in the community; or when they need to come into hospital.

As an integrated acute and community provider, an important part of the Trust’s five-year strategy to be the best to meet the healthcare needs of our population is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the Trust to focus our hospitals to build on our strengths while improving how services work together across the whole health and care system.

The Trust has two acute hospital sites, Conquest Hospital, Hastings, and Eastbourne District General Hospital. Both sites provide urgent and emergency services, along with specialist acute medical and intensive care units. The Trust is focused on driving innovation and best practice. This will improve services across East Sussex and is particularly suited to the population the hospital serves. A number of services are located solely or primarily at one or other of our acute sites, Conquest Hospital and Eastbourne District General Hospital. The Conquest Hospital is home to the Trust’s main theatres and therefore looks after most specialist surgical services, like general, vascular, and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. This includes:

Main Theatres, Majority of Surgical Specialties, such as: General Surgery, Vascular Surgery, Orthopaedic Surgery, Designated Trauma Centre, Specialist Maternity Services, including consultant led services and specialist Obstetrics and Gynaecology Services. More anaesthetic and Intensive Care Unit (ICU) provision to support the theatres and surgical services, Specialist Inpatient Paediatrics, Sleep Studies (Respiratory Physiology).

Eastbourne District General Hospital looks after the most serious stroke cases, patients needing inpatient diabetes care, day case eye surgery, and a diabetic foot service. There are also inpatient endocrinology beds and the Trust’s urology service, which includes recent investment in a dedicated investigation suite, robotic surgery, and non-invasive treatment for kidney stones, Ophthalmology Jubilee Eye Suite, a day case theatre. Note: Other day cases for Ophthalmology are undertaken at Bexhill Hospital. Urology, including a Urology Investigation Suite, Robotic Surgery, and Lithotripsy, Specialist Medicine Services including specialist endocrine and diabetic inpatient beds. Cardiology Electrophysiology, Endobronchial ultrasound for respiratory and Diabetic Foot service.

The community services are also extensive with Crisis Response Team, District Nursing teams, therapist and dietetic services, paediatric care teams. Inpatient rehabilitation beds are sited at the Irvine Unit at Bexhill Community Hospital and Rye Memorial Community Hospital.

Sussex Premier Health (SPH private care) are covered and work within ESHT governance arrangements.

Further information can be found on the ESHT website pages.

3. Defining our patient safety improvement profile

The patient safety risk process is a collaborative process. To define the ESHT patient safety risks and responses for 2023/24 the following list of groups and work was undertaken:

Stakeholders involved:

- Staff – through the incidents reported on the ESHT Datix incident reporting and management system.
- Ongoing discussions received from the Divisional Governance and Risk meetings.
- Discussion with stakeholders for the Trust 2023/24 Quality Account.
- Discussions at Trust Patient Safety Quality Group and Quality and Safety Committee meetings.
- Discussions at the Trusts Medication, Falls, Tissue Viability groups.
- Review of data from the Patient Advice and Liaison Services (PALS) contacts.
- Review of data/key themes provided by the Complaints team and the Healthcare Litigation Clinical Claim and Inquest Team.
- Review of data/key themes provided by the bereavement team for learning from deaths principles.
- Discussions with the Integrated Care Board (ICB) at the local and national Patient Safety Specialist forums and the national discussion on the Futures Platform for Patient Safety Specialists.

ESHT Gap analysis:

- The ESHT Patient Safety Team undertook a gap analysis reviewing the last 4 years of Datix and Serious Incidents data – 2018 to 2021, we then dropped 2018 as we found there was very little difference between 2018 and 2019. Therefore the 4 years of data that has informed ESHT PSIRF Plan are 2019 to April 2023.
- The areas in Tables 2 and 3 in this plan are the incidents/events that have been significant for ESHT. At the time of completing the gap analysis consideration was taken on the data on Complaints/PALS, learning from deaths and inquests/claim's themes. The Patient Safety Team in this first incidence found the themes from SI's 'mirrored' these issues.

The key areas highlighted are reflected in Tables 2 and 3 in this Plan:

- Slips /Trips/Falls – the numbers of incidents are mainly severity 1 and 2's (no harm to minimal harm) and since 2022 all severity 3, 4 incidents and as appropriate severity 5 falls incidents have had SWARM Falls template completed. These are further presented and discussed at the Trust Falls Steering Group to share the learning and recommendations / actions both relevant for the service and Divisions.
- Surgical invasive – this is a broad category that encapsulates all aspects of surgical and post-surgical issues across all specialities who undertake a surgical intervention.
- Treatment delays - this is a broad category that encapsulates all aspects of treatments and care pathways where issues have arisen across all specialities.
- Healthcare Associated Infections (HCAI – thematic review may need to be considered depending on the outcome of the National Infection Control Team's response for Trusts on PSIRF. The ESHT Director of Infection Prevention and Control may consider a repeat

of the thematic review on outbreaks experienced during COVID-19 pandemic 2020/21 report.

- Suboptimal care/delay in diagnosis - this is a broad category that encapsulates all aspects of treatments and care pathways where issues have arisen across all specialities.
- Pressure Ulcers – Tissue Viability Nurses have already adapted appropriate processes for reviewing and investigating. The Team is awaiting the National Tissue Viability Services response to PSIRF, and the Trust is awaiting the outcome of this publication. The Trust in the meantime is considering undertaking a thematic review to highlight the breadth and depth of learning so far in the organisation especially with the National Wound Care Strategy.
- Maternity - this is a broad category that encapsulates all aspects of treatments and care pathways in obstetrics both the care of the mother (parents) and baby. The Trust has included its first iteration of the internal processes to be utilised in the event of an obstetric incident in this plan and in the Trust PSIRF Policy, see Table 4 on page 16.

The ESHT patient safety risks were identified through the data sources mentioned above and the various reports prepared and presented to the groups.

Local patient safety risks have been developed and will be further defined as the list of risks identified through the various groups/stakeholder involvement and data mining as completed for the Trust patient safety plan gap analysis. ESHT anticipates that the list of risks will further be refined over the coming 12 months from the launch date in August 2023.

- Table 1 sets out the full list of national priorities that will require a response.
- Table 2 sets out the local patient safety risks which when identified represent opportunities for learning and improvement in the ESHT healthcare system.
- Table 3 details local additional methods and tools.

ESHT has utilised the following criteria to define the top local patient safety risks:

- Potential for harm: People – physical, psychological, loss of trust (patients, family, care givers); Service delivery – impact on quality and delivery of healthcare services, impact on capacity; Public confidence – including political attention and media coverage; Likelihood of occurrence – persistence of the risk, frequency, and potential to escalate.

4. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses may include review by or referral to another organisation/team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths identified more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) will require a locally led PSII by an ESHT Patient Safety Team investigator (see Appendix 1 process flowchart of an incident/event to review).

Table 1 below sets out the local or national mandated responses. As ESHT does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types 6 to 11 in the table.

Table 1 National priorities and expected response by ESHT.

	Patient safety incident type	**Required response by ESHT**	**Anticipated improvement route**
1.	Incidents that meet the criteria set in the Never Events list 2018.	PSII	Create local organisational learning and actions. Feed these into the quality improvement strategy for that service.
2.	Learning from Deaths (LfD) due to for example care and service issues when reviewed rated between 1-3 using the LfD Framework and rating criteria.	PSII	Create local organisational actions and feed these into the Trust/service quality improvement strategy.
3.	Obstetrics, for example, incidents that meet Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.

4.	Child deaths	Refer for Child Death Overview Panel decision via the Trust's Safeguarding Team. Locally led – could be a PSII or another response, for example After Action Review (AAR) alongside the Panel review. The Trust Director of Midwifery is reviewing this process in accordance with national guidance.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
5.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review using the Learning from Lives and Deaths framework. (LeDeR). Locally led – could be an PSII or another response, for example After Action Review (AAR) alongside the Panel review.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
6.	Safeguarding incidents in which: Baby, child or young person is on a child protection plan; looked after plan or is a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) who are in receipt of care and support needs by their Local Authority. The incident relates to female genital mutilation (FGM), Prevent (radicalisation to terrorism); modern day slavery and human trafficking or domestic abuse/violence.	Refer to Trust Safeguarding Lead, 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.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

7.	Incidents relating to screening programmes.	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. Reference: *Guidance for managing incidents in NHS screening programmes, NHS England, published 01/03/2015 and last updated 16/07/2021.*	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
8.	Deaths in custody (e.g., police custody, in prison, etc,) where health provision is delivered by the NHS.	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
9.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria).	Locally led PSII by the provider in which the event occurred.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
10.	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
11.	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

		whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, set out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	

5. Our patient safety incident response plan: local focus

ESHT considers that all of the 10 incident types set out in Table 2, below, have relevance for all of our inpatient and community services (including maternity) and all except two (items 2 and 7) have relevance for all our inpatient and community services. To this end this is an organisation wide PSIRP and there are no separate patient safety incident response plans for individual services.

Local focus incidents are based on incidents on Datix of severity 3, 4 or 5 these cases will be discussed at the Weekly Patient Safety Summit (WPSS) to confirm the level of harm and investigation/review template the service will utilise. Where an incident remains at a severity 3 or above the services must undertake and complete verbal and written Duty of Candour as part of the Trust legal responsibility.

Table 2: Trust local response

	Patient safety incident type or issue	**Description**	**Planned response**	**Anticipated improvement route**
1.	Transfer of care	Potential for patient harm as a result of missed communication with one or more stakeholders for on-going safe patient care.	After Action Review (AAR), or Hot Debrief, or Multi-Disciplinary Team (MDT) discussion.	E.g., create local safety actions and discuss at Divisional Governance/Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.
2.	Discharge	'Failed discharge' where a delay has led to adverse outcome within the length of stay and after the patient was medically optimised for discharge.	AAR, or Hot Debrief, Chronology or MDT.	E.g., create local safety actions and discuss at Divisional Governance/Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.
3.	Never Events – medication, surgical, mental health and general (Reference: Never Events List 2018 (updated Feb. 2021)	Any clinical incident that meets the Never Event List	PSII (a chronology must be completed prior to an PSII being started)	Actions developed will be in the report and will be recorded on Datix through to completion.

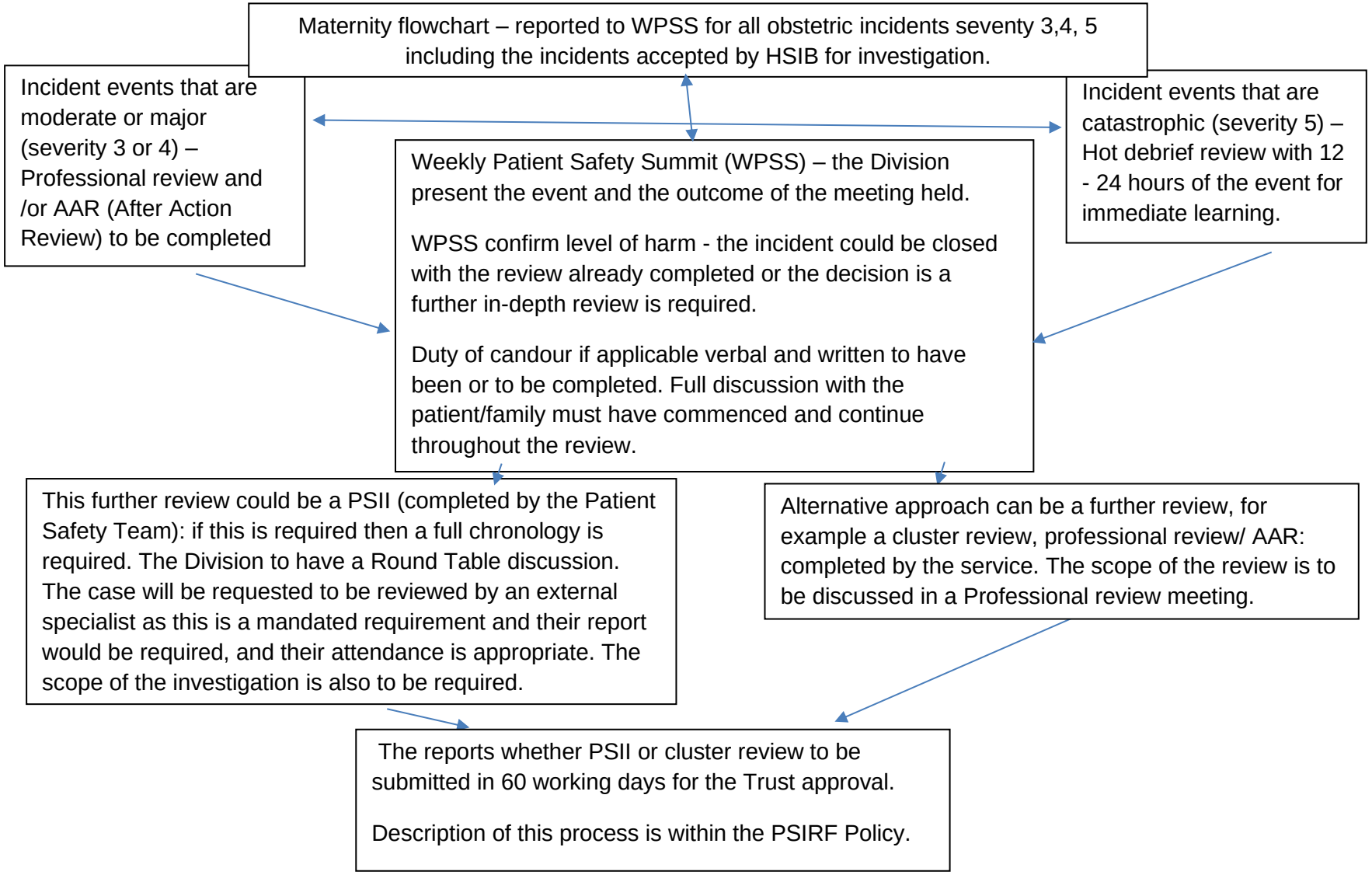
4.	Validation of results	Potential for patient harm as a consequence of missed/delayed/non-communication or action of diagnostic results.	MDT or service review with outsourced companies. Depending on the level of harm this could be considered for PSII.	Actions developed will be in the report and will be recorded on Datix through to completion.
5.	Digital systems	Emerging risks identified as a result of the use of the Trust Digital Systems.	Thematic review/ Cluster review.	Actions developed will be in the report and will be recorded on Datix through to completion.
6.	Clinical care and treatment	Covers all service across the acute and community service and inpatient services.	AAR, Chronology, Hot Debrief.	Actions developed will be in the report and will be recorded on Datix through to completion.
7.	Falls	Inpatient falls resulting in a bone fracture or haemorrhage.	SWARM fall template.	Actions developed will be in the report and will be recorded on Datix through to completion. The Swarm template once completed will be reviewed at the Trust Falls Steering Group.
8.	Tissue Viability – pressure ulcers, surgical wounds, leg ulcers	Tissue Viability (TV) Team discusses cases at the appropriate group meeting and according to the level of harm TV templates are completed.	TV templates / AAR/ Cluster reviews/ TV service templates	Actions developed will be in the report and will be recorded on Datix through to completion.
9.	Medication	Opioids management, Gentamycin, Vancomycin, medication patches, extravasation, Diabetes Mellitus medication management, thromboprophylaxis	AAR, Chronology, for DVT/PE non-fatal hospital associated thrombosis (HAT) or fatal HAT	Actions developed will be in the report and will be recorded on Datix through to completion.

		(pulmonary embolism (PE)/deep vein thrombosis (DVT).	templates are available.	
10.	Multiple cases similar and recorded at various levels of severity	These cases can be clustered and considered for further review/investigation.	Thematic review / cluster review or the use of PSII.	Actions developed will be in the report and will be recorded on Datix through to completion.
11.	Other	Patient safety incidents which meet a criterion for harm or potential harm not included in the areas highlighted above.	Where an incident does not fall into any of the categories 1-10 above then an investigation and / or review method as described in Table 3 below may be used by the local services except PSII (which must be undertaken by the Trust Patient Safety Team who have undertaken and completed additional investigation training). The local methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/ or structured local proformas maybe used. The Trust Infection Control Team in collaboration with the Trust Patient Safety Team will ensure robust PSIRF compliant templates are available for the service fir infection control issues, events/incidents, as highlighted in a letter received 16/08/2023 Alignment of Infection Prevention and Control (IPC) with the Patient Safety Incident Response Framework (PSIRF). The completion of a narrative response on the Trust Datix incident reporting management system incident module will also be updated.	

Table 3 Local additional methods and tools

1.	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 PSII's and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those systems factors and help deliver safer care for our patients effectively and sustainably.
2.	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.
3.	PSA – Patient Safety Audit	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guidelines).
4.	PMRT – Perinatal Mortality Review Tool	Developed through a collaboration led by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK) with user and parent involvement, the PMRT ensures systematic, multi-disciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care; refer to: Perinatal Mortality Review Tool/National Perinatal Epidemiology Unit (NPEU).
5a. 5b. 5c.	SJR – Structured Judgement Review Learning from Deaths Cluster review or Thematic Reviews	Developed by the Royal College of Physicians as part of the national Quality Board guidance on Learning from Death; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. Refer to National Guidance Learning from Deaths Framework (NHS England). These types of reviews are useful to see the trends and be able to offer analysis for the Trust services to take forward learning and embed as appropriate.

Table 4 Maternity process flowchart



Glossary

PSIRP – Patient Safety Incident Response Plan – ESHT local plan sets out how the Trust will carry out the national PSIRF by adhering to national requirement and introduction of local processes. This framework and the Plan cover all the Trust Divisions and supported by the Trust Patient Safety Team and analysis of local data.

PSIRF – Patient Safety Incident Response Framework – 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.

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.

List the patient safety incident types that must be responded to according to national requirements (see Appendix A: National event response requirements in the Guide to responding proportionately to patient safety incidents).

PSII – Patient Safety Incident Investigation – this process will be a flexible approach, informed by local and national priorities. ESHT will be utilising the Weekly Patient Safety Summit (WPSS) to discuss the incident and decide on the level of severity. If the incident remains at a severity 3 or above on Datix then other modes of review/investigation will be considered before a PSII is considered.

Patient safety incidents are events where a patient experienced or could have experienced harm during an encounter with healthcare. An incident is the system showing us symptoms that something is wrong with it.

Duty of Candour (statutory requirement where the incident is a level of harm severity 3 or above). There is no legal duty to investigate a patient safety incident. Once an incident that meets the statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, ‘We are very sorry that this happened.’
- Provide a true account of what happened, explaining whatever we know at that point.
- Explain what else we are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

Appendix 1 Process Flowchart – incident/event to review.