East Sussex Healthcare NHS Trust

Patient safety incident response policy

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Associated Documents:	Incident Reporting and Management Policy Being Open & Duty of Candour Policy Policy for Supporting Staff Involved in Incidents, Complaints or Claims Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C Model) Legal Policy (Management of Claims, Inquests and Access to Legal Assistance)

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1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out how East Sussex Healthcare Trust (ESHT) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can also align to our current Trust values:

- compassionate engagement and involvement of those affected by patient safety incidents (Respect and Compassion)
- application of a range of system-based approaches to learning from patient safety incidents (Improvement and Development)
- considered and proportionate responses to patient safety incidents and safety issues (Working Together)
- supportive oversight focused on strengthening response system functioning and improvement. (Engagement and Involvement)

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across ESHT.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses 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.

Where other 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 are therefore outside of the scope of this policy:

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance,
- estates and facilities concern,
- financial investigations and audits,
- safeguarding concerns,
- coronial inquests, and criminal investigations,
- complaints (except where a significant patient safety concern is highlighted).

For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

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3. Our patient safety culture

ESHT has continued to work over a number of years to move from a retribution approach to various types of incidents, such as patient safety and workforce, to establishing a restorative just culture within the organisation.

The main goals of restoration when an incident has happened which have been outlined as follows in the literature are moral engagement; emotional healing; reintegration of the practitioner; organisational learning and prevention.

PSIRF will enhance these by creating much stronger links between a patient safety incident, learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we endeavour to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

ESHT is clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define voidability or cause of death.

ESHT safety culture continues to improve and progress in a positive way with the reporting of patient safety incidents. To enhance the Trust safety culture, we have introduced safety huddles in clinical services across all Divisions at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning. This learning is then taken forward by the clinical services go the Divisional Governance and Risk meetings.

The organisation also utilises findings from the staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

4. Patient Safety Partners

The Patient Safety Partners (PSPs) are new and evolving roles developed by NHS England and Improvement to help improve patient safety across the NHS in the UK.

PSPs will be expected to communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved. This may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role is expected to evolve the PSP could be asked to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources. This will be underpinned by training and support specific to this new role in collaboration with the Patient Safety Team to ensure PSPs have the essential tools.

PSPs will be supported in their honorary role by the Patient Safety Specialist for the Trust who will provide expectations and guidance for the role, but this will be further discussed once recruitment commences in 2024.

Further updates on this role will be added in 2024.

5. Addressing health inequalities

ESHT 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 as a public authority 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 range of protected characteristics. The new DCIQ (Datix) electronic incident database/ system is expected once all the work is complete, to integrate with the PAS database whereby staff will be able to look up the patient by their NHS or X number and the information will automatically populate the necessary fields or they can manually input it if necessary. We will have whatever information is available in the PAS electronic patient database e.g., fields for date of birth, gender, ethnicity, nationality. At this time the Trust Datix Team are unsure, if we can have the religion section completed but this is expected to be confirmed following further testing, but the field is there, so it can be completed manually.

Staff information will eventually integrate with ESR (an electronic staff database) in the same way, but this will be introduced at a later date. When it has been introduced it will enable the Trust to have more protected characteristic information available

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be built into our documentation and governance processes.

ESHT will also address apparent health inequalities as part of safety improvement work. Our services provide care to significant numbers in the Core10PLUS5 population cohort identified by NHS England and Improvement (2021) see Appendix 1. ESHT does contribute to this national data requirement. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. This needs to be considered as an integral part of the future development process.

Engagement of patient, families and staff following a patient safety incident is critical in the review of patient safety incidents and their responses. The Trust will ensure that we 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.

The Trust's commitment to transforming organisation culture to that of restorative justice has already been outlined. Further to this, the Trust has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients / service users, carers, and families. System based approach to patient safety

responses is at the heart of PSIRF best practice and will be incorporated in any patient safety training for staff delivered in-house.

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

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

ESHT 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 by our patients, families, carers to prevent recurrence.

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 a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures for patient families and staff by the introduction of handbooks and leaflets that support patients, families and carers and staff – based on our existing Duty of Candour Policy.

ESHT has a Patient Advice and Liaisons Service (PALS):

esh-tr.PatientExperience@nhs.net 0300 131 4784 or 0300 131 5309. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS team will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

Appendix 2 relates to other forms of support that can help those affected by a patient safety incident and we will work with patients, families, and carers to signpost to their preferred source for this assistance.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. 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.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national, local focus for patient safety incident responses and on page 24 the Trust Maternity/Obstetric process flowchart.

See Appendices 3, 4 and 5 – the tables used in the PSIRF Plan.

7.1 Resources and training to support patient safety incident responses.

The Trust remains committed to ensuring that we fully embed PSIRF and meet its requirements. This policy therefore has used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

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 within the Division should be the *Divisional Governance Manager or appropriately nominated other* by the Division and the individual should have an appropriate level of seniority 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 staff at Band 8a and above.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The *Divisional Governance Managers including the designated member of the senior leadership team will manage the selection of an appropriate learning responses to ensure the rigour of* the approach for the review and will maintain records to ensure an equitable allocation. The Patient Safety Team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proof reading.

7.1.1 Staff Training

The Trust has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows.

- Level one

National and Internal - This comprises a local incident eLearning module setting out the Trust's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour. This has been aligned to the national patient safety syllabus.

National – Health Education England patient safety syllabus module (Essentials for patient safety)

All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years.

These modules are available as eLearning via MyLearn access.

National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams

This module can be accessed directly from the Health Education England eLearning for healthcare platform or Mylearn.

- Level two

National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff at Agenda for Change (AFC) Band 7 or above, with potential to support or lead patient safety incident management in their area.

This module is available as eLearning via MyLearn access.

7.1.2 Learning response leads training and competencies.

- Training

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents or the equivalent in dealing with patient safety response both in the current and or former NHS roles. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Learning response leads must have completed as minimum the national Level one and two patient safety syllabuses on the Trust MyLearn.

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

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional Governance teams and the Patient Safety Team will support this.

- Competencies

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

a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.

b. Summarise and present complex information in a clear and logical manner and in report form.
c. Manage conflicting information from different internal and external sources.
d. Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Divisional senior managers, Divisional Risk and Governance teams and the Patient Safety Team.

7.1.3 Engagement and involvement training and competencies

- Training

Engagement and involvement with those affected by a patient safety incident/event will be undertaken by those staff who have undergone a minimum of six hours training or equivalent in experience in patient safety incidents/events in the current or past roles in the NHS, such as the Duty of Candour training provided via the Patient Safety Team from 2021 and since this date the training has been delivered via eLearning.

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Engagement leads must have complete Level one and two of the national patient safety syllabuses.

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

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety Team and supported by Divisional Risk and Governance leads.

- Competencies

As a Trust we expect that those staff who are engagement leads to be able to

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.
c. Maintain clear records of information gathered and contact those affected.
d. 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.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

7.1.4 Oversight roles training and competencies

- Training

All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and or experience/knowledge either in their current or previous NHS roles the development in learning from patient safety incidents and understanding the need for the oversight of learning from patient safety incidents. Records of any local training will be maintained by the Learning and Development team as part of their general education governance processes.

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 Trust Boards and senior leadership teams.

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.

- Competency

As a Trust we expect staff with oversight roles to be able to

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. 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).
f. Summarise and present complex information in a clear and logical manner and in report form.

7.1.5 Training associated for Patient Safety Incident Investigators (PSII) – currently (as of 2022) only the Patient Safety Team, have all been trained and are qualified via HSIB level 2 (Gold and Silver standards). Other Trust staff can and are encouraged to do part or all of the training to understand systems thinking, learning from incidents, and setting appropriate recommendations / action plans for a PSII report with the investigator and the patient/family/carer and staff involved.

What are systems thinking: Systems Engineering Initiative for Patient Safety (SEIPS) it is a systems-based framework endorsed by PSIRF. It is a framework for understanding outcomes within complex systems which can be applied to support the analysis of incidents and safety issues more broadly. A SEIPS quick reference guide and work system explorer is provided in the patient safety incident response toolkit. All the national PSIRF tools are based on SEIPS.

The SEIPS model draws on three core human factors principles:

- Systems-orientation,
- Person-centredness and
- Design - driver improvements.

Systems approach for patient safety is based on rather than focusing on corrective efforts on punishment or remediation. The systems approach seeks to identify situations or factors likely to give rise to human error and change the underlying systems of care in order to reduce the occurrence of errors or minimize their impact on patients.

7.1.6 Our Patient Safety Incident Response Plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. 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.

A copy of the Trust current PSIRF plan can be found on the Trust internet page.

The Guide to responding proportionately to Patient Safety Incidents PSIRF 2022, page 7 figure 1 and the table 1 that goes on to add further narrative for each aspect, describes a cyclical diagram called the patient safety incident response planning process:

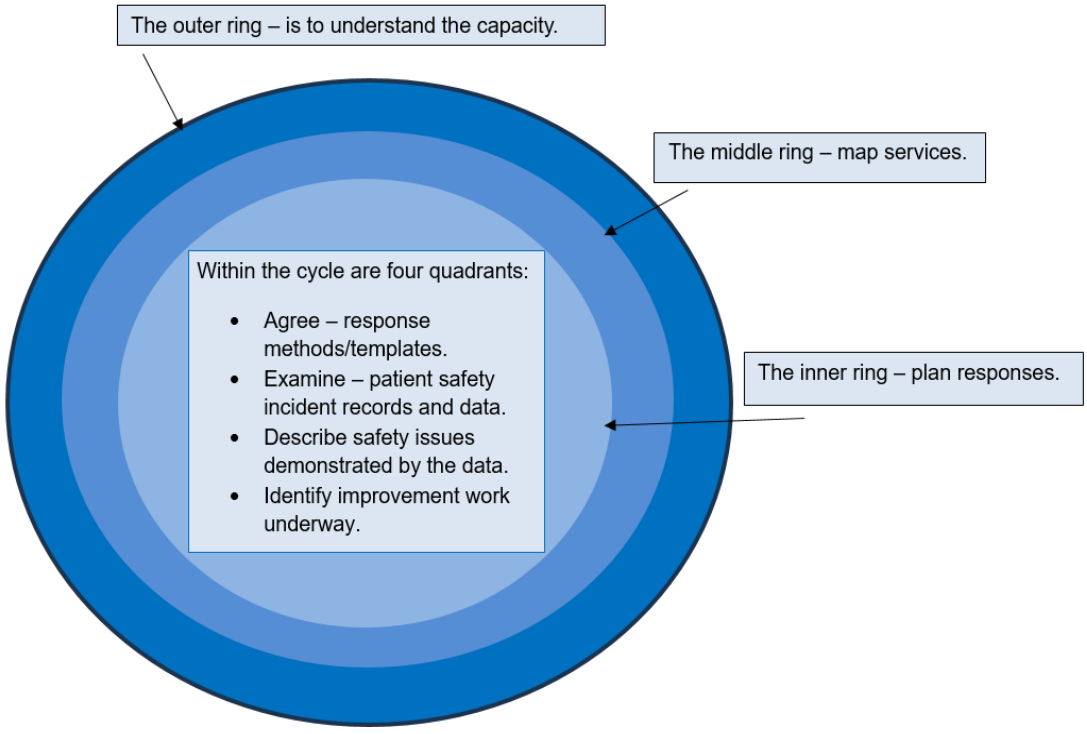
1. the outer ring – is to understand the capacity

2. the middle ring – map services

3. the inner ring – plan responses

Within the cycle are four quadrants:

- Agree – response methods/templates.
- Examine – patient safety incident records and data.
- Describe safety issues demonstrated by the data.
- Identify improvement work underway.



7.1.7 Reviewing our Patient Safety Incident Response Policy and Plan

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. We will review the plan every 12 to 24 months to ensure our 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 24 months.

Updated plans will be published on our website, replacing the previous version.

ESHT is proposing that moving forward with PSIRF it will initiate a rigorous planning exercise that will be undertaken every four years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational reporting data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, learning from deaths data) and sharing our findings with a wider stakeholder engagement.

8. Responding to patient safety incidents

All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system currently Datix (DCIQ) and will record the level of harm they know has been experienced by the person affected (see Appendix 6 for the complaints and appeals process used by the Trust).

Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour (DoC) applies (See ESHT Policy Being Open 2022). Most incidents will only require local review within the service, however, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Division (see Patient Safety incident response decision-making section). This will be via the Weekly Patient Safety Summit (WPSS).

Divisions will highlight to the Patient Safety Team any incident which appears to meet the requirement for reporting externally. This may be to allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

8.1 Patient safety incident response decision-making

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, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan and in Appendices 3, 4 and 5 in this policy.

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.

We are currently establishing 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.

Divisions will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a rapid review, for example completion of a detailed Chronology has shown that the incident/incidents could possibly meet the criteria as PSII or patient safety review (Patient Safety Review (PSR) using one of the appropriate agreed Trust PSIRF templates) due to the potential for learning and improvement or an unexpected level of risk. The Trust Weekly Patient Safety Summit (WPSS) will consider the incident, the additional information from the Division/Service and discuss, determine the level of harm and the scope of potential learning, and determine the level of review/investigation required for incidents presented.

The Trust WPSS will have delegated responsibility for the consideration of incidents for PSII or PSR. This group and the Patient Safety Team will keep an oversight/monitoring of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Trust Patient Safety & Quality group (PSQG) and Quality & Safety Committee will have overall oversight of such processes and will challenge decision making of the WPSS to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.

Any incident highlighted will follow the process outlined below which can be seen in diagram form in Appendix 4.

Divisional Governance & Risk groups may commission thematic reviews of such incidents to consider and understand potential emerging risks in discussion and agreement with the Trust Patient Safety Team.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as

soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety Team as soon as practicable so that the incident can be shared to executive level staff and discussed at WPSS. A chronology needs to be completed prior to a PSII being undertaken by the clinical service or the Patient Safety Investigator so that the scope of the investigation can be understood, and the patient/family can be informed and be part of the process.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety Team. Decision making with regard to escalation to the Trust WPSS can be considered at the next weekly meeting. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Trust WPSS meet weekly to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The investigator with the service and the patient/family will define the terms of reference for a PSII to be undertaken by an appropriate investigator in the Patient Safety team. The WPSS will also designate subject matter expert input as required /appropriate for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the Trust WPSS may request a patient safety review (PSR templates) and closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the WPSS discretion in such circumstances to specify a particular tool is used to complete a PSR. The Trust PSIRF Response Group will also indicate and discuss with the Division how immediate learning is to be shared.

Incidents requiring possible (patient safety response (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review utilising one of the reporting Templates to enable a response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. A rapid review will be undertaken by the Division/Service to inform immediate actions taken so that this information can be shared at WPSS.

The Divisional Governance Manager will discuss with the clinical service/s at the earliest time and opportunity to discuss the nature of the incident/event, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met and the Division update WPSS accordingly.

The Trust WPSS will make the final decision on whether an incident meets a PSII criteria or other means of PSR. The PSR tool (template) to be utilised for the review will be specified and a suitable member of the Divisional team to undertake the review will be allocated. Where it is deemed the incident meets the criteria for a PSII this level of investigation will be undertaken by

the Patient Safety Team. This will not be any staff involved in the incident or by those who directly manage the staff. The Division will also specify any subject matter expert input required. A detailed chronology by the service will be required prior to the investigator undertakes the PSII. There will be clear records maintained regarding this decision-making process and held by the Patient Safety Team.

Divisional Governance teams are to keep the Trust Patient Safety Team updated so that a 'master log' of reviews / actions and improvements for PSIIs and PSRs are maintained, and that reports/data is generated for reports to patient safety groups and committees to offer ongoing assurance on adherence to the PSIRF and future updates to the PSIRP.

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

Process for the Trust Approval of PSII reports and PSR templates:

- PSII reports will be reviewed by the Trust 'old' RCA group, Divisional senior manager and then the report will be submitted for final approval to the Trust Executive lead/s.
- Or The Trust Board will ?? either receive reports for final approval,
- or this will be delegated to Q&S Committee or delegated to the Executive – a decision is required.
- PSR templates are reviewed by the Trust 'old' RCA group (need a new name), Divisional approval.

The Trust Patient Safety Team will monitor the process through to completion and maintain a monitoring master log.

Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

The terms of reference will reflect the decision making by WPSS see appendix 9.

Responding to cross-system (external organisations) incidents/issues

The Patient Safety Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

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 Patient Safety Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the commissioners Integrated Care Board (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.

8.2 Timeframes for learning responses

Timescales for Patient Safety - PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with 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.

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 Trust WPSS panel.

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.

Timescales for other forms of learning response (this list will be further developed as the Trust implements and reviews the processes)

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete. Examples of expected time scales are:

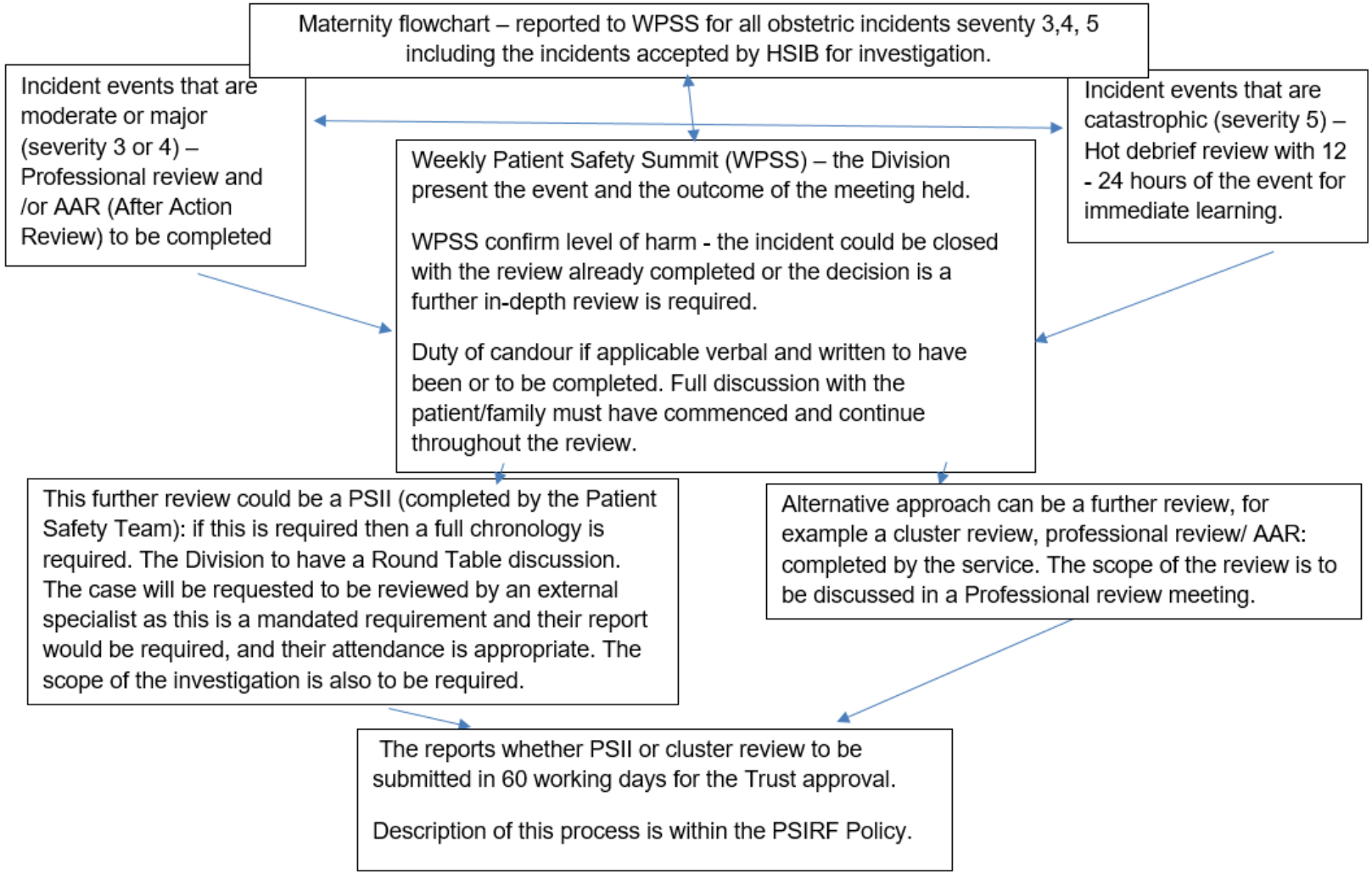
- SWARM falls template – this should be completed within two weeks from the incident date.
- Timeline/chronology should be completed within 2- 4weeks from the date of the incident and before a PSII will be started.

- Hot Debrief (rapid review) should be completed within 2 - 72 hours from the time of the incident.
- Debriefing session – 4-6weeks since the incident. Other reviews of the incident may have been completed and the learning/recommendations and actions already completed and in place and or being considered.
- After Action review (AAR) should be completed within 2-4 weeks from the date of the incident.
- Multi-Disciplinary Team – approach to be completed within 4-6 weeks of the incident.
- Cluster review – approach should take no longer than 1-3 months to complete.

8.3 ESHT Maternity/Obstetric process flowchart

The flowchart (in this report page 24) highlights the service process for incidents and patient safety events. This has been agreed by the service and will be reviewed and updated as indicated in the PSIRF Plan.

Table 4 Maternity process flowchart



8.4 Safety action development and monitoring improvement

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 safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. 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.

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 Divisions.

Safety Action development

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:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

Safety actions must continue to be monitored within the Divisions governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Trust Patient Safety Quality Group reports completed by the Divisions.

For some safety actions with wider significance, this may require oversight by the ESHT Quality & Safety Committee, and this would be presented in the Assistant Director of Clinical Governance report.

The Patient Safety Team will maintain an oversight and monitor actions until completion and maintain a 'master log' with the information data to be utilised for patient safety reports.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvements plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

The Trust PSIRP 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 improvement efforts have not been accompanied by reduction in apparent risk or harm (these Tables 1, 2, and 3 are Appendices 3,4,5 and have been included in this Policy).

The Trust will use the outcomes from existing patient safety incident reviews (Serious Incident Root Cause Analysis 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 Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed by the service and overseen by the Deputy Chief Nurse for Quality and Policies. These will be identified through Divisional governance processes and reports to the Trust Patient Safety & Quality Group by the Trust Patient Safety Team and by exception by the Assistant Director for Clinical Governance to the Trust Q&S Committee who may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of the plans and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reports received from the Divisional Governance Manager to the Patient Safety Quality Group.

9. Oversight roles and responsibilities

Principles of oversight

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

The Trust followed the 'mindset'/principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission (CQC), we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, the Trust has designated the Executive Chief Nurse and Chief Medical Officers to support PSIRF as the Executive leads.

1. Ensuring that the organisation meets the national patient safety standards

The named Executives 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 aspires to.

To achieve the development of the plan and policy the Trust will be supported by internal resources within the Patient Safety Team led by the Assistant Director for Clinical Governance and supported by the Deputy Chief Nurse, Patient Safety Specialist /Lead and the Trust named Executives.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders. This will be undertaken by the Trust Patient Safety Specialist /Lead and overseen by the Assistant Director of Clinical Governance.

2. Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality & Safety Committee via assurance reports. This will be provided by the Assistant Director of Clinical Governance.

The PSQG will provide assurance to the Quality & Safety Committee that PSIRF is in place and reporting appropriately managed via the Patient Safety Team and WPSS. Divisions will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the PSIRP and delivery of safety actions and improvement.

Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

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

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 or sooner as necessary to comply with Trust guidance on policy development, alongside a review of all safety actions.

3. Quality assuring learning response outputs

The Trust will implement a PSIRF Response Group to ensure that PSIIs are conducted to the highest standards and to support the trust Executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

10. Complaints and Appeals

ESHT recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the Patient Advice and Liaison Service (PALS) who will support the resolution of any concerns raised ESHT PALS details are esh-tr.PatientExperience@nhs.net Telephone contact: 0300 1314784 or 0300 1315309.

It is important to address any issue/s raised at the earliest opportunity as this may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner so long as this is with the agreement of the person raising the concern.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted directly. ESHT complaints team, contact details are esh-tr.complaints@nhs.net

See Appendix 6 for the Trust Complaints factsheets sent to complainants.

Appendix 1 CORE20PLUS5

Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.
The information below outlines the Core20PLUS5 approach for adults.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

PLUS, population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

1. Maternity

- Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. Severe mental illness (SMI)

- Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. Chronic respiratory disease

- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis

- 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management

- To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Appendix 2 Other sources mentioned in the section on PALS in this policy.

National guidance for NHS Trusts engaging with bereaved families – https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – information for families – https://www.england.nhs.uk/publication/learning-from deaths-information-for-families/ it explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide – https://www.nhs.uk/Livewell/Suicide/Documents/Help - this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support – https://www.england.nhs.uk/London/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of Duty of Candour are extended beyond the family and carers of the person who died, to family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support – https://www.childbereavementuk.org/grieving-for-a-child-of-any-age and https://www.lullabytrust.org.uk/bereavement-support/ Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy - https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

Healthwatch - https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman - https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

Appendix 3 (PSIRF Plan Table 2)

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.

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 (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 and 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.	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.

	The incident relates to female genital mutilation (FGM), Prevent 9radicalisation to terrorism); modern day slavery and human trafficking or domestic abuse/violence.		
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	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.

	meeting the Learning from Deaths criteria).		
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 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.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

Appendix 4 (PSIRF Plan Table 2)

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 out 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	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.

		medically optimised for discharge.		
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 in-patient 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 until completed. 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	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 (pulmonary embolism (PE)/deep vein thrombosis (DVT).	AAR, Chronology, for DVT/PE non-fatal hospital associated thrombosis (HAT) or fatal HAT templates are available.	Actions developed will be in the report and will be recorded on Datix through to completion.
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 until completed.
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 for 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 system incident and management module will also be updated.

Appendix 5 (PSIRF plan 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) (ox.ac.uk)
5a. 5b.	SJR – Structured Judgement Review Learning from Deaths	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).

5c.	Cluster review or Thematic Reviews	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.

Appendix 6 Complaints fact sheets

Number 1. **Complaints Factsheet**

This factsheet explains what we will do with the complaint you have raised about your experience, or that of a relative, friend or loved one, in respect of the care, treatment, services or amenities provided by the Trust. We treat all complaints seriously and aim to resolve them within the timescales set out in the acknowledgement letter that accompanies this factsheet. You can also be assured that making a complaint will never affect ongoing or future care or treatment at the Trust, and complaints are never filed in a patient's medical records.

What can I expect from raising a complaint?

We acknowledge all complaints received within three working days and after reviewing your complaint (in conjunction with your medical records if necessary), we will undertake a full investigation. If you have given us your telephone number or email address, we will also try to contact you to discuss your complaint.

We will then ask appropriate members of staff to provide a response to the complaint issues you have raised, and we may ask for a review of clinical care to be undertaken where appropriate. We will also endeavour to provide you with an update on the progress of your complaint and if we experience any delays in completing the complaint investigation, we will contact you to advise of this.

Once the investigation has been finished, the Patient Experience Team will prepare a written response. The Chief Executive will read your complaint, the investigation records and then the written response that has been prepared and if the response is satisfactory, it will be signed and sent to you. If the Chief Executive has questions about the investigation or the response, it will be returned to the Patient Experience Team to address these and ensure that the final response meets our quality standards.

What will you learn from my complaint?

You will be assured to know that we find complaints to be a very helpful source of feedback and any actions and/or learning identified as a result of your complaint will be shared with the relevant staff, wards or units. We have internal processes to ensure these actions and/or learning are logged, tracked, and implemented to prevent similar issues from happening in the future, as it is important that no-one else has the same experience you have had cause to complain about. **What can I do if I am not happy with your response?**

If you are not happy with our response to your complaint, please contact the Patient Experience Team in the first instance to let us know.

We can, in discussion with you, re-open your complaint and look again at any issues you feel we have not dealt with to your satisfaction or that require further clarification. We can also arrange for you to speak with relevant managers or clinical staff (subject to any restrictions), as this may provide further explanations or clarifications you need to help answer your questions.

It is important to us that we make every effort to resolve your complaint locally and, as far as it is possible, to your satisfaction. However, there may be occasions when we are unable to achieve this and, in these cases, you have the right to ask the Health Service Ombudsman to review your complaint. The contact details for the Parliamentary and Health Service Ombudsman are set out below.

Write To: Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP
Telephone: 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk

Website: www.ombudsman.org.uk

Other formats

If you require this leaflet in a different format, such as large print or an alternative language, please contact the Patient Experience Team:
Dial 0300 13 14 500 and select extension 770358.

Complaints Team fact sheet number 2 -

Independent Health
Complaints Advocacy (IHCA)

Support in raising a complaint when NHS care and treatment hasn't been at the standard you expect.

How we can help

Sometimes things don't go as well as we would expect when we receive care and treatment from the NHS.
When this happens, we have lots of questions: why did this happen? how can it be put right? will it happen to someone else?
The Advocacy People can support you to make a complaint and get answers to your questions. We offer different levels of support. Our self-help Factsheets can guide you through making your own complaint. Or one of our Independent Health Complaints Advocates can work with you from the beginning or at any stage.
For more information and to make a referral:
Call: 0330 440 9000
Web: www.theadvocacypeople.org.uk
Email: info@theadvocacypeople.org.uk
Write: PO Box 375, Hastings, East Sussex, TN34 9HU
Text: 80800 start messages with PEOPLE

Appendix 7 Level of harm explained.

Level of Harm

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety incidents.

In summary harm is defined as follows and recorded on ESHT DCIQ electronic risk management system (Datix).

No harm - Severity 1

This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.

No harm (impact not prevented) - Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the

Low harm – Severity 2

Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm – Severity 3

Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Severity 4

Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death/ catastrophic life changing Severity 5– Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix 8 Process followed by ESHT Datix Team in notification from Datix to Divisions, managers etc and action expected.

The ESHT Datix Team overseeing the clod based DCIQ risk management electronic database do not have a flowchart only narrative to explain the process followed.

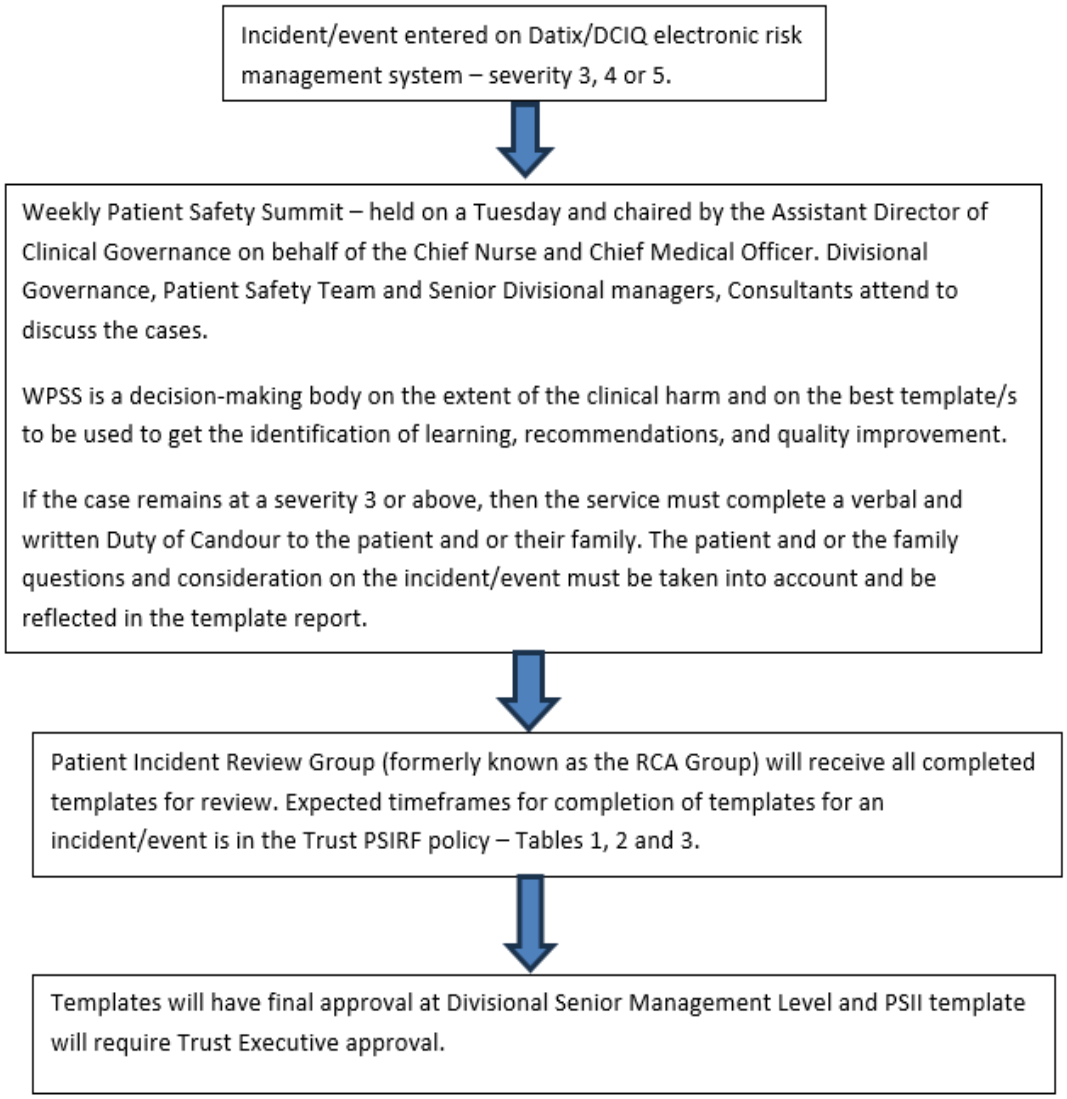
Notifications from DCIQ are determined by the profiles or on request of the Users themselves. Although the Trust Datix team have written the new profiles already for DCIQ we have not added notifications to any of these yet, so we will be discussing this with the project lead prior to Go Live. In general, though, the Trust Datix team try to minimise the email notifications as much as possible. They currently send out the following generic notifications and expect the new system will be much the same: -

- Managers receive an email notification when incidents are reported at severity 3,4 or 5 for their dept/service.
- Handlers or Investigators when any staff are assigned as Handlers or requests to investigate.
- Specialist staff also receive notifications when particular types of incidents have been reported e.g., Pressure Ulcers are sent directly to the Tissue Viability Nurses (TVN) team email inbox.
- When incidents are updated, the system notifies staff who have already received any of the above notifications again to inform them that the form has been updated.
- Reporters receive an email notification with feedback when the form is closed.

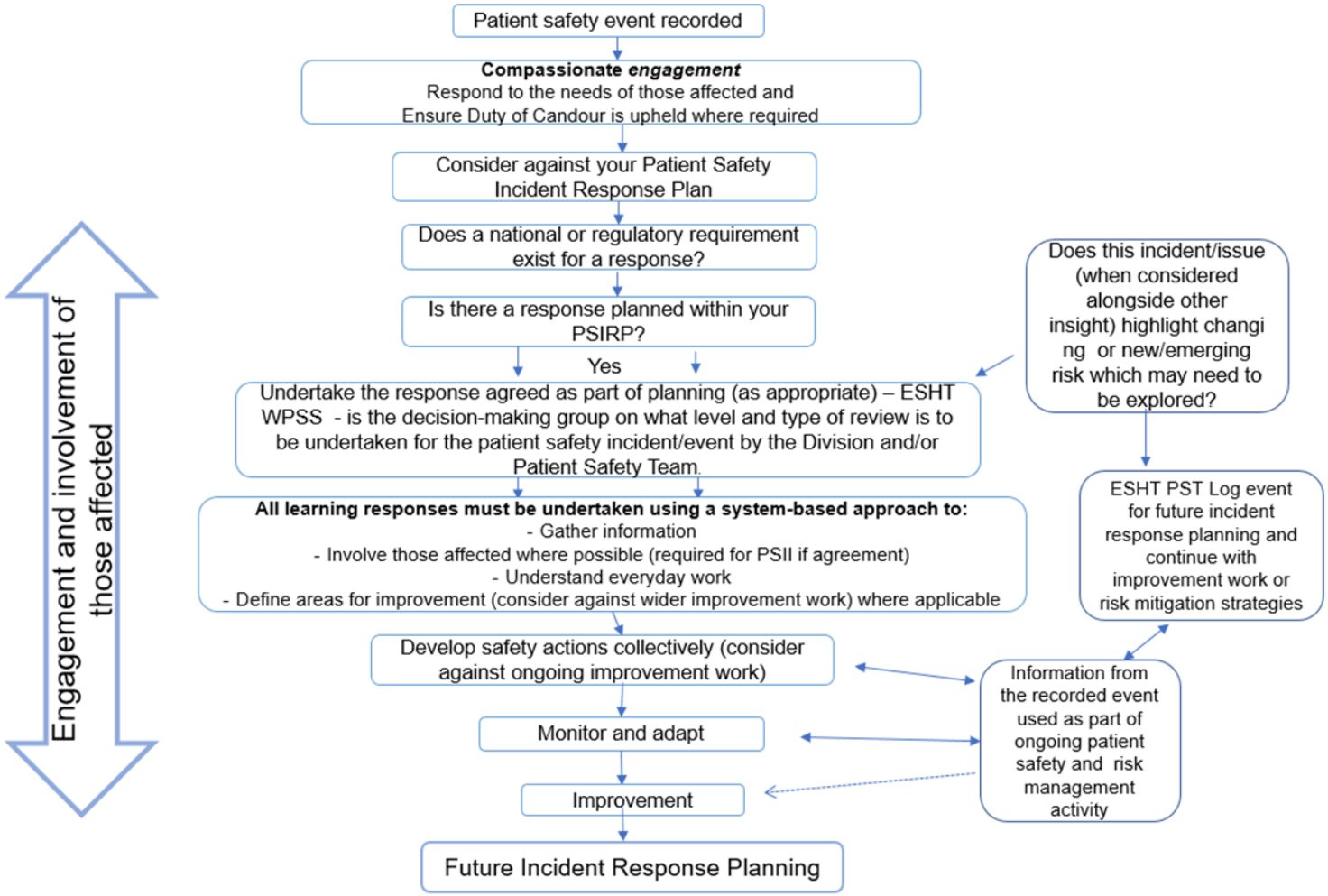
All other notifications are on the request of staff themselves and we set these up individually, but we again try to keep the email traffic from Datix as light as possible so that staff do not become bogged down by a large volume of emails and ignore the important emails.

Appendix 9

WPSS decision making process.



Appendix 10 Process Flowchart from incident/event to review.



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

Note that the policy is based on NHS England's Patient Safety Incident Response Framework (PSIRF) 2022.

Our patient safety culture based on PSIRF preparation guide 2022 to complete this section

Patient safety partners (PSPs) for further information see Framework for involving patients in patient safety guidance 2022

Engaging and involving patients, families and staff following a patient safety incident refer to the Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide 2022 to complete this section

Patient safety incident response planning refer to the Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide 2022 to complete this section

Resources and training to support patient safety incident response refer to the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

Our patient safety incident response plan refer to page 7 and page 9 see Figure 1 and Table 1 in the Guide to responding proportionately to patient safety incidents 2022 used to inform this section.

Reviewing our patient safety incident policy and plan refer to Patient safety incident response standards and roles and responsibilities 2022 documents.

Responding to patient safety incident section refer to NHS England » Report a patient safety incident 2022 used to inform this section.

Patient safety incident response planning refer to the Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide 2022 used to complete this section.

Responding to cross-system incidents / issues refer to the Oversight roles and responsibilities specification 2022 used to complete this section.

Safety action development and monitoring improvement refer to the learning from incident responses to inform improvements, see the Safety action development guide 2022.

Oversight roles and responsibilities refer to the Oversight roles and responsibilities specification and Patient safety incident response standards 2022 for further information and Patient safety incident response standards 2022 used to complete this section.