POLICY

TITLE: PSIRP Plan	
Version Information:	
Lead author name and role (contact for the POD)	Jillian Tozer Interim PSIRF Transformation Lead/Patient Safety Specialist (NHSE)
Co-author/s	Version 1 author Anil Garcia PSIRF Implementation Lead
Team / service	PSIRF Implementation Steering Group
Status - draft / final	FINAL
Version number	V4.0
Superseded documents	V3.0
Ratified by	Quality Committee
Ratified date	February 2024
Review / expiry date	February 2025
Record of Changes: Update the latest version from the POD – list changes made and delete previous changes	
Page / Section: whole document/each section.	**Brief description of changes made:** full rewrite to bring the PSIRP in line with PSIRF Standards for completeness in readiness for the Transition Phase
Impact Assessment:	
How does this affect staff?	Transition from SIF 2015 to PSIRF Standards published 16th Aug 2022
How does this affect working practices?	Transition from SIF methodologies to SEIPS (systems engineering initiative for patient safety) to ensure learning from patient safety data is aligned to KLOEs Responsive, Safe, Effective.

IMPORTANT NOTICE: Staff should always refer to the POD for the most up to date information.

If the review date of this policy or procedure has expired staff should seek advice from their clinical lead or manager regarding the appropriate action to be taken.

1. Foreword

The new Patient Safety Incident Response Framework (PSIRF) sets out the approach across NHS England to developing and maintaining effective systems and processes for responding to patient safety incidents. PSIRF is not simply an updated version of previous national frameworks but provides an opportunity to think differently to enable a Safety II approach to continuously developing systems based learning across the footprint of the organisation, allowing time to learn thematically from patient safety insights supplied to the organisation by qualitatively utilising the rich intelligence contained within its patient safety data.

Whilst the majority of the care delivered within Nottingham CityCare Partnership (NCCP) is delivered with staff working to meet high standards, it is very important that we review our interventions where avoidable harm has or might have occurred.

NCICP is keen to nurture an organisational wide safety culture where people feel psychologically safe and supported to speak up – this applies equally to our patients, their families, and our staff. Speaking to those involved and affected by safety events proactively enables NCICP in developing an understanding of the decisions made during the delivery of care provision for patients. Adopting this responsive approach in identifying immediate learning, validating decisions, and facilitating psychological closure for those involved in and impacted by patient safety events/incidents are all core objectives of NCCP in demonstrating compliance with PSIRF Standards.

PSIRF offers a Phased approach to implementation and transition and provides the opportunity to focus more on learning responses and immediate safety improvement as we continue to foster a sound safety culture. In doing so, we will support our core ambition of working in partnership to improve quality and safety. Having psychologically safe conversations with people who have been involved in and impacted by a patient safety incident is an important part of ensuring we are an organisation which promotes good governance and fosters a culture of physiological safety aligned to the FTSU national agenda.

A known risk to the successful implementation and transition to PSIRF methodologies is to continue to investigate and review incidents as per the approach NCCP adopted previously under the SIF (Serious Investigation Framework 2015). It is therefore important that NCIC embrace the changes and develop new ways of working aligned to PSIRF Standards.

This is the second iteration of the Version 1 Patient Safety Incident Response Plan NCCP signed off with internal and external stakeholders in November 2023. It is the organisations expectation that the way NCICP respond to incidents will evolve over the transition phase and into the establishment phase as the journey through transition to the new arrangements outlined within this Plan are tested and evaluated (PDSA).

2. Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how (NCCP) proposes to implement PSIRF, as part of the workplan to continually improve the quality and safety of the care NCCP offer and to be proactively responsive to patient safety incidents with a standardised and sustainable approach.
This Patient Safety Incident Response Plan (PSIRP) describes how the learning from incident responses will be translated into measurable, systemic recommendations and SMART actions which enable continual safety improvement. The PSIRP is not intended to prescribe a rigid or permanently fixed approach that cannot be changed, aligned to PSIRF Standards the PSIRP is a movement that focuses on engagement and empowerment and is not focused on a traditional command-and-control approach:

- Sets out a new approach to achieving effective learning and improvement following patient safety incidents.

- Embeds patient safety incident response within a wider system of improvement.

- Supports a significant shift in safety culture (Safety I to Safety II).

- Prompts a move away from a reactive and bureaucratic approach to safety to a more proactive approach.

- When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their PSII systems “in a way that allows organisations to demonstrate improvement, rather than compliance with prescriptive, centrally mandated measures”.

NCCP will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected. The key will be to engage effectively with those involved in a transparent and compassionate way.

The PSIRP is underpinned by the quality priorities and organisational values.

Policies on incident reporting and investigation are available to all staff via the organisation’s intranet.

Nottingham CityCare Partnership CIC

NCCP is registered with the Care Quality Commission (CQC) to provide community based physical health services.

NCCP is a community health services provider, rated overall outstanding by CQC during its last inspection in November 2016, Report published: 8th of March 2017.

NCCP provide long-term health and wellbeing to the local community. Providing a broad range of health services in the community, ranging from health visiting and education for young families to community nursing and home-based rehabilitation services for older people. In addition, NCCP operationalise the city’s NHS Urgent Treatment Centre (UTC) at Seaton House.

NCCPs services are delivered across the city in a variety of community settings, such as health centres, children’s centres, GP practices, nursing homes, and primary care settings, as well as within people’s homes.

In one year the organisations care providers/services and staff came into face-to-face contact with 457,900 patients, and our community nurses visited 148,300 patients. CityCare employs 1,200 clinical and non-clinical staff.
At the time of writing Version 1 of this PSIRP in November 2023, the Quality Priorities for 2023/2024:

	Priority Title
Priority One	Attend three community user groups to discuss Nottingham CityCare services, how people access healthcare and potential barriers to our services
Priority Two	Increase engagement in the response to patient safety incidents by all staff.
Priority Three	Compassionate treatment of staff following a patient safety incident as part of quality improvement, to share examples of excellent care delivery.
Priority Four	Develop Patient Safety Champions in teams to lead patient safety huddles and/or following action reviews.
Priority Five	Roll out of the skin tone tool to all services.
Priority Six	Have skin tone recorded on patient electronic record.
Priority Seven	Discuss skin tone identification and pressure ulcer as issues in patient safety investigations when assessing patient incidents.

3. Scope

There are many ways to respond to an incident where harm has occurred or where it might have occurred (Near Miss incident data). This PSIRP details responses for the purposes of individual, organisational and system learning and improvement and how NCCP intend to maximise these opportunities.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare[1].

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

This PSIRP explains the scope for a system- based approach to learning from patient safety incidents. NCCP will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Learning Responses covered in this PSIRP include:

- How NCCP undertake Patient Safety Incident Rapid Learning Reviews (RLRs)
- When and how NCCP will undertake Patient Safety Incident Investigations (PSIIs)

Other related types of review and responses also exist to address specific issues or concerns.

Examples of such responses include:

- Complaints management
- Litigation claims handling
- Human Resources investigations into employment concerns
- Professional standards investigations
- Inquests undertaken by HM Coroner

[1] NHS England » Report a patient safety incident

- Safeguarding enquiries and statutory reviews (Working Together to Safeguard Children 2022 & Care Act 2014)
- Other statutory reviews and investigations such as Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004)
- Criminal investigations and Civil investigations.

The principle aims of each of these responses differ from the aims of a patient safety response and although may be taking place in parallel, are outside the remit of this PSIRP. It should be noted that misconduct, gross misconduct, and professional conduct processes should only be triggered where there is evidence of malicious harm, deliberate negligence, or criminal activity .
Core patient safety activities undertaken at NCCP include:

- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Development of Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Supporting improvement programmes

The operational ‘work-as-done’ for these patient safety activities is predominantly owned by colleagues on the front-line. This is teamed with expert support from their Care Group based and Central Quality Governance colleagues who are supported through strategic, educational and subject matter expert support.

4. National Framework

Background to PSIRF

PSIRF replaces the Serious Incident Framework (SIF 2015) which has been in place since April 2013 and was revised in March 2015. It fundamentally changes the way in which incidents will be viewed and managed within the NHS. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. There is no distinction made between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it.

Principles

PSIRF sets out four broad principles:

1. Compassionate engagement and involvement of those affected by patient safety incidents – patients, their carers and staff.

2. Application of a range of system-based approaches to learning.

3. Considered and proportionate response to patient safety incidents.

4. Supportive oversight.

Objectives

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. Removal of the serious incident process does not mean do nothing. PSIRF requires that incident reviews will be proportionate to the learning opportunities available. It requires Organisations to identify the rationale for the process chosen and removes the blanket root cause analysis approach, allowing for more flexibility in the approach used. All patient safety incidents will continue to be reviewed. However, several different methodologies and tools will be available to ensure a proportionate response.

Between 1st January 2020 and December 31st 2022, 6333 patient safety incidents have been reported in NCC with 65 of these being investigated as a Serious Incident as per the Serious Incident Framework.

A large portion of the work Quality colleagues participate in is serious incident investigations. These can be a very time- consuming process which doesn't maximise the oppoertunity for identifying learning and introducing immediate safety improvement to prevent recurrence following patient safety incidents.

Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99.6% of patient safety incidents. In short, the burden of effort is placed on fewer than 0.4% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is organisations continuing to investigate as many things as possible within the guidelines set out within the Serious Incident Framework process but under the label of patient safety reviews or patient safety systems investigations. The goal of PSIRF is proportionate investigations based on the potential for immediate learning and prevention of recurrence to enable sustainable safety improvements be established.

A key part of developing the new national approach is to understand the amount of patient safety activity the Organisation, including the identification of emerging themes and trends by analysing investigation data which has been undertaken over the last few years. This enables NCCP to plan appropriately and ensure that we have the people, system and processes to support the methodologies and expectations as set out in the new approach within the PSIRF Standards.

Patient Safety Reviews/Rapid Learning Reviews (PSRs/RLRs) include several techniques to gain insight into incident data to inform sustainable improvement plans and identify immediate safety actions, and to respond to concerns raised by anyone impacted or affected by the incident.

These will make up most learning responses and will involve local, single incident events rather than indications of wider systemic issues.

PSRs/RLRs can be divided into four broad categories:

• Incident Recovery • Team Reviews • Systematic Reviews • Monitoring

Patient Safety Incident Investigations (PSIIs) are broader focused reviews that identify the circumstances surrounding incidents of a similar theme and the systems-focused, interconnected contributory factors. They are managed as mini projects and will make up the minority of activity undertaken. These are mobilised by utilising the PSIRF approved/HSIB approved SEIPS methodologies (systems engineering initiative for patient safety) templates for SEIPS investigations are contained within the National PSIRF toolkit.

There are three broad categories of PSIIs proposed, each with different resource implications for the organisation. These categories are:

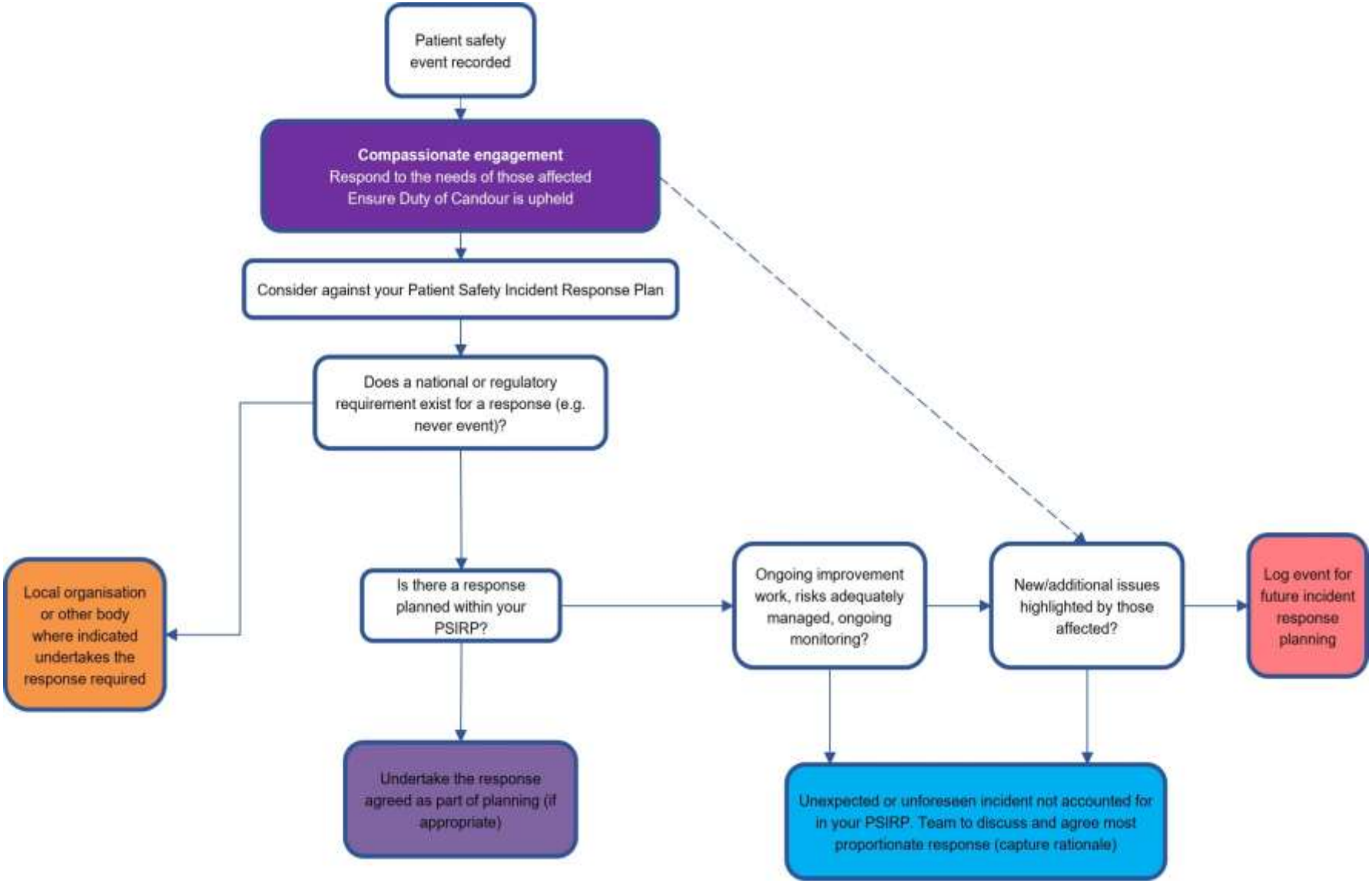
- Locally investigated PSIIs
- Externally investigated PSIIs funded by the Organisation.

- Independent PSIIs funded regionally/nationally.

Table 1: Strategic Aims and Objectives

Strategic aims	Strategic objectives
Improve the safety of the care we provide to our patients.	❖ Develop a climate that supports a just culture[2] and an effective learning response to patient safety incidents. ❖ Conduct Patient Safety Incident Investigations (PSIIs) purely from a patient safety perspective. ❖ Reduce the number of PSIIs into the same type of incident to enable more rigorous activity that identifies systemic contributory factors. ❖ Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of specifically similar repeat incidents. ❖ Consider the safety issues and contributory factors that are common to specifically similar types of incidents. ❖ Develop system improvement plans across aggregated PSIIs and, where appropriate, other incident response data to produce systems-based improvements. ❖ Better measurement of improvement initiatives based on learning from incident responses.
Improve the experience for patients, their families, and carers wherever a patient safety incident occurs or the need for a PSII is identified.	❖ Act on feedback from patients, families, carers, and staff about their concerns relating to patient safety incident responses in the NHS. ❖ Support and involve patients, families, and carers in PSIIs and PSRs, for better understanding of the issues and contributory factors.
Improve the use of valuable healthcare resources.	❖ Transfer the emphasis from quantity of investigations to a higher quality, more proportionate response to patient safety incidents, and the implementation of meaningful actions which lead to demonstrable change and improvement. ❖ Develop a local Organisation Board led, commissioner and integrated care system (ICS) assured architecture around response to patient safety incidents, which promotes ownership, rigor, expertise, and efficacy.
Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.	❖ Act on feedback from staff about their concerns with patient safety incident responses and PSIIs in the NHS. ❖ Support and involve staff in PSIIs and PSRs, for better understanding of the issues and contributory factors.

[2] A culture in which people are not punished for actions, omissions, or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.


Patient safety event recorded
Compassionate engagement
Respond to the needs of those affected
Ensure Duty of Candour is upheld
Consider against your Patient Safety Incident Response Plan
Does a national or regulatory requirement exist for a response (e.g. never event)?
Local organisation or other body where indicated undertakes the response required
Is there a response planned within your PSIRP?
Undertake the response agreed as part of planning (if appropriate)
Ongoing improvement work, risks adequately managed, ongoing monitoring?
New/additional issues highlighted by those affected?
Log event for future incident response planning
Unexpected or unforeseen incident not accounted for in your PSIRP. Team to discuss and agree most proportionate response (capture rationale)

5. Local Focus

Defining our Patient Safety Incident Profile in Nottingham CityCare Partnership

PSIRF requires each Organisation to identify their key organisational risk areas which are the areas of focus for PSII level projects.

The criteria for identification of these incident profiles are those incidents that are of the highest concern for the organisation in terms of occurrence frequency or the level of harm and impact for patients - often described as those incidents 'keeping staff awake at night' or those incidents where the opportunities for learning are greatest.

To define the NCCP patient safety incident profiles and priorities an analysis of all reported Organisation incidents, across all levels of harm that occurred within the last 2 years have been analysed. These were distilled down into a list of most frequently occurring incident types with further analysis to understand the presenting themes. The list of key themes was cross referenced with other sources of available data including:

- Key themes from Complaints/contacts with the Service Customer Care Team (PALS)/Claims//Inquests/Freedom to Speak Out data)
- Medicines Management Group review of frequently occurring medication incidents.
- Risk register entries.
- Incident types - recurrence and frequency were explored, together with consideration of safety improvement opportunities and knowledge and plans and interventions already in place (the PSIRF recommended tool AAR (after action review) underpins the sustainable and standardised approach to transacting this business)

The following stakeholders were involved in defining the patient safety incident profiles:

Staff – through the incidents reported on the Datix incident system and a review of the thematic contents of Complaints, PALS contacts, outcomes from inquests, claims and other sources of patient experience data.

Senior leaders across the organisation – through a series of awareness raising meetings.

Commissioners/Integrated Care Boards partner organisations – through partnership working with the wider health system patient safety and quality leads.

Patient Safety Collaborative leads through the delivery of staff awareness and feedback sessions enabling a current understanding of staff views and concerns about the implementation of PSIRF, then supported targeted communications.

In addition, regular contact with both early adopter and other Foundation Organisations has enabled NCC to share learning based on what is/has worked well and understand different approaches.

Theme	Key Theme	Key Risks from Activity
1	Pressure Injury	Pressure injuries are the top patient safety incidents Pressure injuries are a noted theme of SI's.
2	Medication - Insulin	Medication was indicated as a theme through the reported patient safety incident review. Medication is the second most reported patient safety incident In particular in relation to the management of insulin.
3	Falls	Patient falls were a patient safety incident category, with increasing potential for learning and greater understanding of causation and management across the community teams and care home work.

Organisation wide Top 3	
Pressure Ulcers	✓
Medication Errors – particularly in relation to Insulin	✓
Falls	✓

As a result of this work, the Organisation has identified the top incident profiles occurring to be:
The following have been agreed as the first pilot PSII Projects to be undertaken during the transition phase in NCCP:

1. Pressure Ulcers
2. Medication errors – especially in relation to insulin administration
3. Slips, Trips and Falls

Click for NHS England PSIRF Framework document

NHS England » Patient Safety Incident Response Framework website

Figure 2 details the NCCP PSIRF Process. All activity outlined will be supported by the central Quality Team and local Care Group Quality Governance infrastructure by using Local Risk Management System dashboards to inform resilient, locally led 'PSIRF ready' ways of working.

Figure 2: The NCCP PSIRF Process

6. Mortality Governance

Reviewing and learning from the mortality of patients known to the Organisation is integral to our patient safety approach.

Organisation Review Process

There are several processes used to review deaths.

Structured Judgement Review (SJR) – a review following an unexpected death in a service to determine whether a more in-depth review is required. More detailed reviews will occur where there are concerns about the care delivery. This may lead to a PSR or PSII review if there is a concern of a systemic nature.

Mortality Reviews are a systemic review of a series of case records using a structured or semi–structured methodology.

National Review Process

NHS organisations also need to adhere to the **Learning from Deaths** criteria in the event of a death being more likely than not due to problems in care. (See section xx for more details).

Multi-agency Statutory Review Processes

There are also several possible multi-agency reviews related to children and adults who have died and were known to the Organisation at the time.

	Review synopsis
Learning Disability Mortality Review (LeDeR)	Reviews funded by NHS England into the health and social care provided to people with learning disabilities and autism with the objective of reducing health inequalities.
Safeguarding Adult Reviews	Carried out by Adult Safeguarding Boards for the purposes of learning when an adult(s) with care and support needs dies and abuse and/or neglect is known or suspected to be a factor in the death.
Child Death Overview Panel (CDOP)	A multi-disciplinary Panel which considers information in relation to child deaths to establish and learning and prevent future deaths.
Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review	This review establishes whether multi-agency public protection arrangements were effectively applied in the event of a death caused by someone known to be a sexual or violent offender.

Expected Deaths - Expected Deaths and End of Life Care are reviewed by our **CityCare Holistic Incident Review Panel.**

Unexpected Deaths - Unexpected Deaths may be subject to internal reviews and/or statutory reviews as outlined above.

Reporting of Deaths

Unexpected deaths should initially be reported as catastrophic incidents.
Expected deaths should be reported as no harm, pending an After Death Analysis (ADA) Review.

Local Patient Safety Review (PSR) Responses

Case audit is recommended to act as an information gathering tool to determine the best approach to investigation and review.

Local PSR responses are conducted for incidents where an incident is specific and local to an area. Responses will be determined on an individual basis and the decision how a PSR will be conducted will be based upon the opportunity for:

- Recovery and minimising the impact of harm.
- New learning.
- Need to gather insight for future prioritisation work.
- Need to understand how and why an incident happened.
- Need to provide a description of the incident for the patient or for relatives of the patient involved in an incident.
- Practice improvement

PSRs/RLRs include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected patient, family, or carer.

The following details examples of Patient Safety Review/Rapid Learning Review methods that NCCP will use:

PSR/RLR Type	Methods	Purpose
Incident Recovery - Immediate measures taken to: • Address or minimise serious injury or threat to life. • Respond to concerns raised by the affected patient, family, or carer. • Determine the likelihood and severity of an identified risk	Immediate actions	To take urgent measures to address serious and imminent: • injury, discomfort, or threat to life • damage to the environment or any equipment
	Risk assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied.
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'.
Team Reviews - Post-incident review as a team to:	Debrief	An unstructured, moderated discussion. The simplest and most informal method to gain understanding and insight soon after an

PSR/RLR Type	Methods	Purpose
• Identify areas for improvement. • Celebrate success. • Understand the expectations and perspectives of all those involved. • Agree actions. • Enhance teamwork through communication and collaborative problem solving		incident (debriefs held immediately after an incident are known as 'hot' debriefs)
	Safety Huddle SWARM Huddle	**Proactive:** a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive:** triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions
	After Action Review (AAR)	A 'cold' structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What was expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?
Systematic Reviews - To determine: • The circumstances and care leading up to and surrounding the incident. • Whether there were any problems with the care provided to the patient	Case record review/notes review (such as Structured Judgement Review)	To determine whether there were any problems with the care provided to a patient by a service. To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.
	Mortality Review	A systematic review of a series of case records using structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care. This can be within a setting or for a specific patient group, particularly in relation to patients who have died.
	Individual Event Review	For example, where there is a need to answer queries in relation to the standard of care delivery and where learning is anticipated.
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both)

PSR/RLR Type	Methods	Purpose
	Survey	To understand if there is a more generalised issue
	Appreciative Inquiry	Action research approach

Local PSII Level Response

The process to identify the key Organisation risks is set out in section 3 of the Plan.

As stated, the following have been agreed as the first Pilot PSII Projects to be undertaken during the transition phase in NCC:

- Pressure Ulcers
- Medication errors
- Slips, Trips and Falls

This will allow for the methodology to be tested and outcomes reviewed, ahead of decisions being made for other key risk areas.

The Quality Team has been part of the PSIRF Implementation Steering Group since project inception, there is a need for quality improvement methodology to be embedded as part of the learning methodologies. There is a plan to scope the role of Quality Improvement Facilitators across the divisions. Each PSII project will have a Steering Group which will oversee the project design and delivery. Through this engagement each PSII Steering Group will be supported to engage with appropriate quality improvement methodological approaches in their area of practice; and their selected quality improvement tools taking a Plan Do Study Act (PDSA) cyclical approach. This will enable the Steering Group for each pilot PSII area to test, adapt and then adopt the proposed PSII approach.

National PSII Level

In addition to the locally agreed PSII categories, there are also three categories of national priorities requiring local PSII:

1. Incidents that meet the criteria set in the Never Events (2018) updated 23rd February 2021

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have not been implemented by healthcare providers.

2. Incidents that meet the 'Learning from Deaths' criteria

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care,

and conducted either as part of a local Learning from Deaths plan or following reported concerns about care or service delivery.

Examples include:

- Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- Deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- Deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

3. Death or long-term severe injury of a person in state care or detained under the Mental Health Act 1983 (as amended 2007)

Examples include suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act 1983 (as amended 2007).

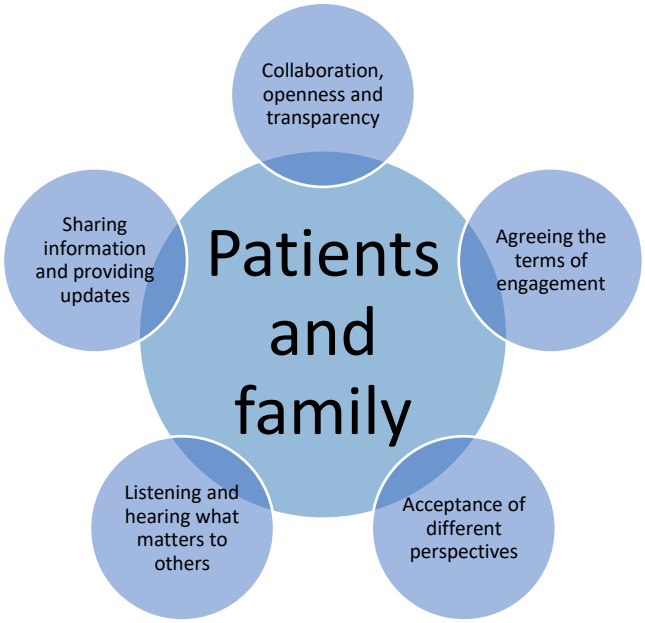
Approach to Local PSIIs

The Quality Team will support the initiation of the PSII Projects.

- ❖ PSII Teams will be led by staff who have undertaken the required accredited training.
- ❖ PSIIs are not usually appropriate for single item investigations. They are to be viewed as improvement projects where a critical mass of incidents following the same theme are reviewed and improvement plans developed.
- ❖ PSIIs will ordinarily be completed within one to three months of their commencement date and should take no longer than six months. A balance will 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 findings remain relevant. SEIPS methodologies will be utilised to facilitate immediate learning responses and measurable safety improvements.
- ❖ Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further analysis activity.
- ❖ Analysis is underway to identify the key lines of enquiry in relation to each NCCP PSII to understand what are the questions that need to be asked, learned from and understood.

Working with Patients and Families

Patients and families should be given every opportunity to be involved at every step and have the process explained to them. Involvement should be flexible and adapt to changing needs as each situation will be different. The Organisation will apply the following principles when working with patients and families:



The organisation recognise the significant impact patient safety incidents can have on patients, their families and carers and our colleagues.

Getting the involvement right first time with patients and families in relation to how the organisation responds to incidents is crucial, particularly to support improving the services we provide.

As part of the new policy framework, we are developing procedures and guidance to support staff in how to discuss incidents with patients and family to enable compliance with engaging and involving patients, families and staff following a patient safety incident. This guidance has been produced in partnership with the Healthcare Safety Investigation Branch and Learn Together.

The patient/family/carer voice is very much an integral part of work at NCCP and work is underway to develop the role of the Patient Safety Partners both within NCCP and within the wider Nottinghamshire regional system.

Resources for engaging and working with families are available at learn-together.org.uk – Serious Incident Investigation resources

Duty of Candour

Incidents that meet the Statutory Duty of Candour thresholds:

Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says Healthcare Providers must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.

5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.

6. Keep a secure written record of all meetings and communications.

Add link to Duty of Candour Policy and guidance (currently under review by Andrea Noble/Rory O'Reilly Quality Team)

Quality Improvement
Continuously improving safety is a central element of providing excellent patient care and underpins the successful delivery of PSIRF. Findings from PSIIs and PSRs/RLRs will be translated into safet improvement plans for implementation in a sustainable and measurable, auditable infrastructure..

Links to other processes
Where other processes are being followed in addition to PSRs/RLRs or PSIIs there will be co-ordination of processes to minimise any duplication and distress for patients, families, and staff. This includes where a safeguarding enquiry is happening alongside, a complaint has been received and where an inquest is taking place. **See Appendix 1 for more details.**

Supporting staff

NCCP have embarked upon an ambitious journey to ensure it is a safe and fair Organisation, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve by putting listening into action.

Reported patient safety incidents will be reviewed and managed by the PSIRF ready patient safety processes prior to any HR involvement unless criminal intent is suspected/evidenced.

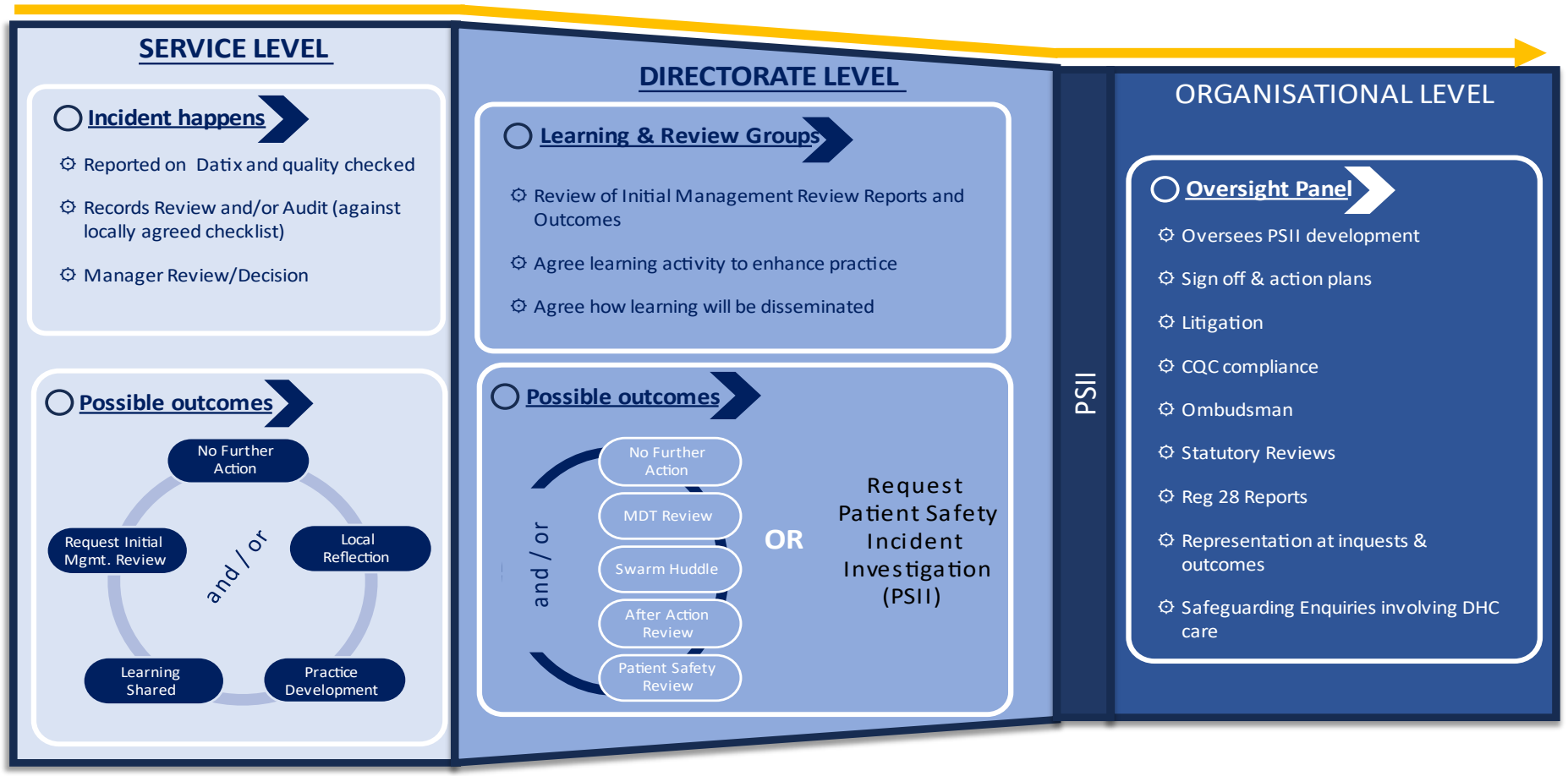
When a colleague reports an incident or is providing their insights into the care of a patient for an investigation NCCP will proactively encourage a psychologically safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new PSIRF ready policy, procedures and guidance will support this to be mobilised into practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff.

Staff can access support from HR or their trade union but also from our Employee Assistance Programme (HealthHero, formerly Validium) and Occupational Health).

7. Governance and Oversight

The following describes the way in which PSIRF will be managed within NCCP



A change to the current process is the proposed development of PSI Triage Panels which will serve as **Learning and Review Groups.** These groups will sit within operational services, supported, and administrated by the Learning and Response Lead. The role will be to oversee all PSR/RLR activity and lead on ensuring the quality improvement interventions central to the aims and objectives of PSIRF are delivered at a directorate level.

The PSI Triage Panels/Learning and Review Groups will:

- promote the Organisational culture of open and honest reporting of a situation or incident that may impact on the quality of patient care in accordance with Organisational policies on patient safety incident reporting and risk management.
- Oversee the data driven approach by monitoring and analysing PSR/RLR activity within operational directorates and support the operational directorates to meet the requirement of the PSIRF Standards..
- ensure that the principles of engaging with people affected by incidents are followed in line with the PSIRF standards.
- promote the use of the quality improvement methodologies in responding to and identifying learning from patient safety data.
- monitor recommendations arising from all PSR/RLR activity by utilising the AAR resource.
- share information, learning and examples of good practice via the Organisation wide SQRL (Safet Quality Risk and Learning) mechanism.

The Organisation will also establish an Oversight Panel to oversee PSII activity alongside a number of other areas. This Panel will have a lead assurance role.

The Oversight Panel will:

- monitor the implementation and progress of the PSIRF Response Plan
- establish procedures for monitoring and agreeing PSII reports in line with PSII standards and monitor outcomes and learning from PSIIs.
- discuss, approve, and sign off local PSII reports prior to Board ratification.
- receive reports on PSRs/RLRs to identify emerging themes and trends.
- review and discuss high level incident data identifying any new emerging themes and trends in triangulation with other organisational intelligence relating but not limited to PALs and complaints, freedom to speak up, patient experience, staff experience, mortality/coroner's inquests, claims.
- provide oversight and monitoring of Inquests where NCC is legally represented and oversee any Prevention of Future Deaths (Regulation 28) action plans.
- oversee the process for the management of Litigation Claims.
- receive reports related to any large-scale safeguarding enquiries directly related to NCC care.
- receive progress reports on any Safeguarding Adult Reviews, Partnership Reviews, Domestic Homicide Reviews, or other statutory reviews to ensure learning is disseminated and any actions are completed.

Transition arrangements

It will be important to continue to support staff through the current PSIRF ready organisation wide training and development programme.

This has included:

- ❖ National Level 1 & 2 training
- ❖ Commissioning of external training

Training requirements

Table 4 Details of training expectations

Topic	Minimum duration	All Staff	Clinical Staff	Learning Response Leads/Managers	PSIRF Lead Roles	Oversight Roles
National Patient Safety Level 1: Essentials for Patient Safety	eLearning	✓	✓	✓	✓	✓
National Patient Safety Level 2: Access to Practice	eLearning		✓	✓	✓	✓
Involving those affected by Patient Safety Incidents	1 day / 6 hours			✓	✓	
Approach to Patient Safety Reviews	1 day / 6 hours (blended approach)			✓	✓	
Systems approach to learning from Patient Safety Incidents	eLearning plus 2 days				✓	
Oversight of Learning from Patient Safety Incidents	eLearning 6 hours					✓

Directorate Support

To achieve the aims of PSIRF reorganisation of existing responsibilities within the Quality Team is taking place to meet the requirements and to facilitate support for Directorates. This will include the creation of a Learning and Review Lead role.

Resourcing

Table 5 provides an overview of estimated resource allocation for local PSIIs and PSRs/RLRs

Response Type	Category	Hours
Local priority PSII	Locally defined PSIIs	**Minimum 60 hours per Project for:** 1 Lead Reviewer 1 Support Reviewer **Up to 30 hours per Project for:** Subject Matter Expertise ***Plus*** **Up to 30 hours per Project for:** Oversight and Support Administration Support
	Unanticipated PSIIs	

		Interview and statement time of staff involved in the incident Organisation Board approval and sign off
Patient Safety reviews (PSRs) Rapid Learning Reviews (RLRs)	All types of PSR/RLR	Maximum eighteen hours per Learning Response

8. Appendices

Appendix 1 - Links to other processes

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. The table below sets out the local or national mandated responses relevant to NCC.

No.	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII by NCCP
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSR/PSII by NCCP
3	Child deaths	Refer for Child Death Overview Panel review Locally led PSR (or other response) may be required alongside the Panel Review
4	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSR (or other response) may be required alongside the Panel Review
5	Safeguarding incidents in which: Babies, children, and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) with care and support needs experiencing or at risk of abuse or neglect, unable to protect themselves The incident relates to Female Genital Mutilation, Prevent (Radicalisation to terrorism); Modern Slavery & Human Trafficking or Domestic Abuse / Violence	Refer to Local Authority Safeguarding Teams Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, Domestic Homicide Reviews, Safeguarding Adult Reviews, and any safeguarding enquiries as required to do so by the multi-agency Local Safeguarding Partnership (for children) and Local Safeguarding Adults Boards (for adults). The Care Act 2014 sets out the statutory obligations in relation to adult safeguarding.
6	Mental health related homicides	Refer to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent review Locally led PSII may be required with mental health provider as lead and NCC participation if required

No.	National priority	Response
7	Domestic Homicide	A Domestic Homicide is identified by the Police usually in partnership with the Community Safety Partnership (CSP). 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, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.
8	Criminal investigation	Refer to Police.

Appendix 2 - Glossary of Terms

AAR – After Action Review
A patient safety review tool that that is used to provide an opportunity for positive change by looking at the intended and actual outcomes of an event.

ADA – After Death Analysis
A reflective tool created by the Gold Standards Framework to review care for people at the end of their lives.

CDOP – Child Death Overview Panel
An independent and multi-disciplinary panel that reviews all child deaths.

CQC – Care Quality Commission
Regulator of Health & Social Care

CSP – Community Safety Partnership
A group made up that works together to protect local communities. Membership can include police, health services, local authorities, probation and fire and rescue services.

DHR – Domestic Homicide Review
A review to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse.

EPMA – Electronic Prescribing and Medicines Administration Programme
A system that allows health care professionals to prescribe, administer and review patients' medications electronically in a more efficient manner.

EPS – Electronic Prescription Service
A service that allows doctors to send electronic prescriptions to a dispenser, such as a pharmacy.

Expert by Experience
Someone with a patient/carer voice who supports in an advisory capacity.

ICB - Integrated Care Board
Members from GP practice, acute hospitals, community health services, mental health, social care and public health

ICS - Integrated Care System
Arrangements of managing health and social care

Inquest
Conducted by the Coroner into an unexpected death to establish the cause.

LeDeR – Learning Disability Mortality Review
Funded by NHS England into the health and social care provided to people with learning disabilities and autism with the objective of reducing health inequalities.

MAPPA - Multi-Agency Public Protection Arrangements
A process where various agencies such as the police, the prison service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders that are living in the community.

Never Events
Events that should never happen if guidance and safety protocols have been followed.

Palliative/End of Life Care

When healthcare to prolong life is no longer an option or has been agreed that it is not in the patient's best interest, care is provided to keep the patient comfortable and support their relatives.

PSII - Patient Safety Incident Investigation
A type of investigation that takes place under the new framework of PSIRF. This type of investigation will focus on wider systemic changes that are needed to improve patient safety.

PSIRF - Patient Safety Incident Response Framework
A new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This framework allows a more flexible and proportionate response to learning from patient safety incidents

PSIRP - Patient Safety Incident Response Plan
The plan that sets out the Organisation's improvement priorities

PSP - Patient Safety Partners
Experts by Experience or Organisation staff who put the experiences of patients and their family or carers, into patient safety settings.

PSR/RLR - Patient Safety Review/Rapid Learning Review
This includes a wide range of tools to allow a stepped and proportionate way in which to review and learn from incidents to improve patient safety.

QI - Quality Improvement
The use of tools and techniques to continuously improve the quality of care and outcomes for our patients.

SJR - Structured Judgement Review
A type of patient safety review that allows reviewers to identify and describe the quality of care that a patient has received.

Appendix 3 - Complaints and Appeals
Local and national arrangements for complaints and appeals relating to the Organisation response to patient safety incidents are available via Patient Liaison and Advice Service (PALS).

9. Equality & Diversity

THE EQUALITY STATEMENT SHOULD BE PERSONALISED USING INFORMATION GAINED FROM THE EQUALITY IMPACT ASSESSMENT FORM BELOW. SEE EXAMPLES:

CityCare is committed to embracing diversity and embedding inclusion in all aspects of our business, in relation to the communities that we serve and staff at all levels within the organisation. CityCare recognises and endorses responsibilities placed on us by equality and diversity legislation, and is fully committed to promoting equality, diversity and inclusion whilst achieving the elimination of unlawful discrimination. We recognise that in valuing and investing in our staff we will grow a positive, motivated workforce, working to build healthier communities and deliver the best possible outcomes for the people that we provide services to.

Less favourable treatment of anyone on the grounds of their age, disability, gender, marital status, being pregnant or on maternity leave, race/ethnicity, religion or belief, sexual orientation, gender reassignment, responsibility for dependents, trade union or political activities, or any other reason which cannot be shown to be justified will not be tolerated. Positive action may be taken to improve the diversity of our workforce to reflect the city's population and to encourage people from protected groups to participate where their level of participation is disproportionately low. (Equality and Diversity Policy 2021)

Change to job roles within a service:

All roles, service delivery and individual staff have been considered. No staff are disadvantaged. Some staff will gain advantage through the opportunity for promotion and pay increase which will not be influenced or disadvantaged by any protected characteristic including their age, disability, gender, marital status, being pregnant or on maternity leave, race/ethnicity, religion or belief, sexual orientation, responsibility for dependents, trade union or political activities, or any other reason which cannot be shown to be justified.

Children Young People, Families and Health Improvement:

This service has a positive impact for children and young people from the antenatal period through to 25 years of age, and their families only. Less favourable treatment of anyone on the grounds of their, disability, gender, marital status, being pregnant or on maternity leave, race/ethnicity, religion or belief, sexual orientation, responsibility for dependents, trade union or political activities, or any other reason which cannot be shown to be justified will not be tolerated. (Equality and Diversity Policy).

Equality Impact Assessment Form (Short)

(Please use your review from this assessment to tailor the Equality and Diversity Statement)

		YES/NO	COMMENT
1.	**Does the policy affect one group less or more favourably than another on the basis of:**		
	Age		
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems		
	Gender Reassignment		
	Marriage/Civil Partnership		
	Pregnancy/Maternity		
	Race		
	Religion or Belief		
	Sex		
	Sexual Orientation		
2.	**Is there any evidence that some groups are affected differently?**		
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the policy/guidance likely to be negative?**		
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy without the impact?**		
7.	**How can the impact be reduced by taking different action?**		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the sponsoring director; together with any suggestions as to the action required to avoid/reduce this impact

Further sections can be added or the order of sections can be changed to ensure that the content flows in a coherent way and makes sense to the person reading it.

Further Guidance

If you have any concerns or issues with the contents of this policy or have difficulty understanding how this policy relates to you and/or your role, please contact the author.