Leeds Community Healthcare NHS Trust

Patient Safety Incident Response Policy	
Author (s)	**Claire Gray-Sharpe** Head of Clinical Governance
Corporate Lead	**Leeds Community Healthcare NHS Trust** Executive Director of Nursing and Allied Health Professionals
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Executive summary

The NHS Patient Safety Strategy sets out how the NHS will support staff and providers to share patient safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. Getting this right could save almost 1,000 extra lives and £100 million in care costs each year.

The strategy is evolving over time to ensure it is supporting the NHS to meet its current challenges and priorities, remains relevant and can impact on the areas where need is greatest.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

NHS Providers are required to assess their patient safety incidents and develop a local Patient Safety Incident Response Plan (PSIRP) that details how patient safety incidents will be managed to maximise learning, improvement and outcomes for patients.

This policy supports our approach to implementation of the Patient Safety Strategy, the accompanying PSIRF and our local PSIRP.

Changes made to this version:

Section	Detail of each change made
Section	• 'we' substituted where possible
Section	• Safety changed to patient safety where possible
Section	• Comments addressed

Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to the Equality Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy.

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1 Introduction

The 2019 NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. The strategy sets out how the NHS will support staff and providers to share patient safety insight and empower people, patients and staff, with the skills, confidence and mechanisms to improve patient safety.

The strategy introduced the new Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022) that replaces the Serious Incident Framework (NHSE, 2015). The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a patient safety management system across the NHS.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

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

All NHS Trusts are required to develop their own Patient Safety Incident Response Plan with an accompanying Patient Safety Incident Response Policy.

2 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Leeds Community Healthcare NHS Trust (LCH).

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, patient 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.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment

concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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.

3 Aims and Objectives

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out our approach to developing and maintaining 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 detailed above.

4 Definitions

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

PSIRP - Patient Safety Incident Response Plan
Our local plan sets out how we will carry out the PSIRF locally (i.e. in our Trust) including our list of priorities. These have been developed by analysis of local data, consideration of other patient safety priorities and consultation with stakeholders (Appendix One).

PSIRF Implementation Plan
The PSIRF Implementation Plan sets out all the work streams and tasks for all ongoing work in relation to the implementation of PSIRF.

The PSIRF standards stipulate that where standards are not met at the time of publication, an achievable roadmap should be produced. LCH's implementation plan serves this purpose.

Learning Responses
The system-based learning response methods available for us to respond to a patient safety incident or cluster of incidents (Appendix Two).

Never Events
Never Events are defined as patient safety incidents that are wholly preventable because guidance or patient safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

PSII - Patient Safety Incident Investigation
A PSII is an in-depth investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. A PSII investigation uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework (Holden et al, 2013 and Holden and Carayon, 2021) to understand outcomes within complex systems.

Systems Engineering Initiative for Patient Safety (SEIPS)
SEIPS provides a framework to guide how we will learn from patient safety incidents from a systems perspective, and to inform how we can design and implement system targeted improvements. See Appendix Two for a diagrammatic representation of the SEIPS framework.

5 Responsibilities

All staff employed by LCH must work in concordance with the Leeds Safeguarding Multi-Agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and the public with whom they are in contact.

The roles and responsibilities for ensuring LCH implements the national patient safety incident response standards and that PSIRF is central to overarching patient safety governance arrangements are as follows:

Chief Executive
The Chief Executive is ultimately responsible for the implementation and central focus on the national requirements.

Non Executive Board Sponsor
The Board Sponsor will provide independent oversight of the implementation of the policy and associated PSIRP at Board.

Executive Director of Nursing and Allied Health Professionals/PSIRF Executive Lead

The accountable Executive Lead will ensure the organisation meets national patient safety incident response standards, ensure the PSIRF is central to overarching patient safety governance arrangements and will quality assure learning response outputs. They may be supported in this by relevant colleagues as appropriate.

The Executive Director is also responsible for ensuring this policy is implemented and accountable for ensuring the requirements of the national strategy are implemented.

Business Unit Clinical Leads and General Managers

Business Unit Clinical Leads and General Managers have responsibility to ensure all aspects of the national standards are implemented within each portfolio. They are responsible for ensuring identified learning is implemented and embedded within their Services.

Head of Clinical Governance

The Head of Clinical Governance will quality assure patient safety incident investigations. The final report must be produced by the identified Learning Response Lead for all individual PSIIs, and this reviewed and approved as complete.

Management Responsibilities

Each Head of Service is responsible for ensuring their teams have received and understood this policy and that they comply by having the necessary operational process in place to enable compliance with the standards. Heads of Service will be accountable to the Business Unit Clinical Lead and General Manager for implementation and continued concordance with the national standards and accompanying policy. Management teams will foster an environment in which staff are encouraged to report incidents and discuss them constructively and openly.

Patient Safety Team

The Patient Safety Team are responsible for the oversight and management of the patient safety incident response process. They should ensure the learning has been identified and that a plan for sharing and disseminating the learning is in place.

Patient Experience and Engagement Team

The Patient Experience and Engagement Team are responsible for overseeing the engagement planning for the Patient Safety Incident Response Plan implementation and review.

Learning Response Leads

Learning Response Leads are staff who are leading any kind of learning response to a patient safety incident using system-based approaches to capture learning to inform patient safety actions for improvement. They are responsible for identifying where learning should be shared and disseminated as part of the learning responses. They are

responsible for ensuring Datix is fully updated with learning from incidents. They have the following responsibilities:

- to have undertaken at least two days' training and skills development in learning from patient safety incidents and experience of patient safety incident response
- to have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the Patient Safety Syllabus which is a tiered education programme for those involved in patient safety.
- to undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise. Planning to support the Learning Response Leads achieve this requirement is underway by the Patient Safety Team.
- to contribute to a minimum of two learning responses per year or be supported by a colleague who has contributed to two learning responses per year.

Learning response leads in each Business Unit have been identified as part of the preparation for PSIRF implementation across the Trust and this information is held within the Trust patient safety team.

Staff in patient safety oversight roles (mandated in the Patient Safety Strategy) have the following responsibilities:

- have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development
- be appropriately trained to support the practical application of PSIRF oversight principles and standards.

Patient Safety Specialists have the following responsibilities to:

- be active members of the patient safety strategy steering/improvement groups
- actively contribute to the trusts Patient Safety Incident Response Policy and Plan on an ongoing basis
- communicate developments and progress with PSIRF, including any consultation exercise to their respective business units and corporate teams.
- play a lead role in other aspects of patient safety.
- keep up to date with PSIRF developments and participate in local and national network meetings.
- participate in Trust wide PSIRF learning and development events as a presenter / facilitator / attendee.
- be a point of contact and source of information about PSIRF and patient safety.

Critical Incident Practitioners

Critical Incident Practitioners are staff specifically trained to offer emotional support to colleagues and teams following potentially traumatic or critical incidents in the workplace, including patient safety incidents.

Staff Responsibilities

All staff are responsible for being concordant with the instructions within this policy. All staff are responsible for being concordant with the instructions within this policy. All staff must report patient safety incidents when identified and must adhere to and engage in the patient safety incident response processes.

6 Patient Safety Incident Response

6.1 Our patient safety culture

As a Trust we are embracing the NHSE's 2018 Just Culture Framework and its approach to learning across the organisation. A focus on systems thinking and systems approaches to investigations has been integrated into our serious incident training as work under the Serious Incident Framework 2015 continued but with a PSIRF lens, and in preparation to transition to the PSIRF. This has included a strong focus on human factors. This foundation will be used to support the culture change to fully adopt the principles of the PSIRF and Patient Safety Strategy (NHSE, 2019).

The new Patient Safety Strategy provides guidelines for investigatory and restorative conversations when concerns are raised and when untoward events occur. To support teams with the restorative and just culture approach LCH will develop training and supporting materials for the intranet. Individuals can also be supported by the Critical Incident Practitioners.

Staff members are confident about reporting incidents and near misses through the Trust's commitment to creating an open, honest and fair culture and utilisation of the Just Culture Guide (NHSE, 2018). Evidence suggests that by creating a 'reporting culture', organisations can improve their ability to learn when things go wrong and improve patient safety. An open and transparent reporting culture must be supported in the Trust. Guidance for incident reporting is available on the intranet. Additional fields have been included in our reporting system to encourage patient safety ideas in response to incidents by those reporting and reviewing incidents.

Supporting guides for the incident management process have been created and are available on the Trust Intranet. A dedicated guide of what to expect is attached to the Rapid Review meeting invite where incidents are discussed (Appendix Five). Staff must read the guide prior to joining the meetings to ensure they understand the restorative and just culture approach of the meetings.

In addition, our Freedom to Speak Up Guardian, Trade Union representatives and HR business partners work closely with teams and staff to encourage staff to feel safe to raise concerns.

6.2 Patient Safety Partners

In line with the NHS Framework for involving patients in patient safety the commitment to the involvement of Patient Safety Partners (PSPs) to support improvements in patient safety across the trust must be upheld. They are core members of our Quality Committee. Our partners provided feedback on our initial PSIRP and are involved in the engagement to improve our incident responses and drive our learning culture forward.

6.3 Addressing health inequities

There is a recognition of the importance of reducing the health inequity of the surrounding population that we serve by ensuring services are designed around the needs of our local population ensuring our services are accessible to all.

Health equity is a priority for LCH. Health equity data is routinely analysed. This currently includes cross referencing of our patient safety incidents against the equity domains for those incidents. A partial dataset that includes falls, pressure ulcer, medication and access incident categories against deprivation, ethnicity, age, learning difficulty, Autism Spectrum Disorder and communication requirements is currently in use. The Trust is working towards a complete dataset.

Trust Improvement Plans will be in place for our areas of frequent patient harm to ensure LCH's response to these incidents is co-ordinated and overarching of all teams. The Improvement Plan will also ensure LCH is using resources effectively for improvement as opposed to investigating similar patient safety incidents repetitively.

Each of our Trust Improvement Plans will have dedicated actions to ensure equity is considered and assessed within the context of the improvements required to inform the most effective learning and actions. Additional governance reporting will include equity review and the priorities will be reviewed with an equity lens at the annual review of the PSIRP where the datasets are available.

There is a commitment to supporting effective communication with our patients, and their representatives and carers, by working towards compliance with the Accessible Information Standard (NHSE, 2016). This includes use of supportive tools such as easy read, translation and interpretation services. This will ensure that the ability and potential for patients and staff to be involved in the patient safety incident response is maximised.

6.4 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, their representatives, families and staff). In the first instance our Patient Safety Partners have been part of our patient engagement activity in relation to the development of the PSIRP. This has been in addition to feedback from Healthwatch Leeds, Forum Central and Third sector partners.

Those affected by patient safety incidents and / or their representatives must be involved or an offer of involvement be made, to understand and answer any questions they have in relation to any patient safety incident. They must be supported and/or signposted to support as required. Wherever possible patients and/or their representatives as partners will be involved in our learning responses to ensure their voice is heard and our investigations keep our patient's central to those investigations. Involvement will be led by the investigation and learning response leads. Work is underway, with our Patient Safety Partners, to benchmark and improve Trust processes. Patient's and representatives will be supported by our Learning Response Leads, Patient Safety Team and where required our Patient Experience Team should they want to move forward with a complaint or to share their experiences wider within our Trust. Details of the independent advocacy services will also be provided when needed.

The Trust complies with the 2009 CQC Regulation 20 Duty of Candour . Duty of Candour is embedded within our services and captured within our reporting systems to ensure assurance of compliance can be provided. Staff must follow and be concordant with PL245 – Being Open and Duty of Candour Policy and Procedure.

In addition to complying with the regulation for our legal Duty of Candour requirements LCH has a strong approach to professional Duty of Candour. LCH is open and honest with patients when things go wrong but do not meet the legal or regulatory threshold.

6.5 Patient safety incident response planning

PSIRF supports organisations to respond to incidents and patient 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.

6.5.1 Resources and training to support patient safety incident response

The Patient Safety Incident Response Standards (Appendix Three) describe how patient safety incident responses should be resourced, including the required training and competencies for those undertaking these responses. The Trust will adhere to the defined standards set out within the Patient Safety Strategy and PSIRF to ensure staff

have the required competencies to lead and be involved in the implementation of the PSIRF.

The Trust have mandated the national syllabus Level 1 and Level 2 Patient Safety training for all staff, with compliance monitored through performance panels. The Trust Patient Safety Specialists are undertaking the Level 3 and 4 national syllabus training.

A review of the resource and activity associated with the Serious Incident Framework (2015) for the aforementioned four year period has been undertaken. From this data, it is estimated that approximately ten Patient Safety Incident Investigations (PSIIs) will be completed within a 12 month period. Based on this forecasting and cross reference with the incident response standards, the necessary resource is in place, through the identified learning response leads, to complete more learning responses as required (additional detail is held in Appendix Two and Four).

In addition, the current level of resource for rapid reviews and other learning methods e.g. After Action Reviews, walkthroughs etc. where PSIIs are not indicated has been assessed.

Our learning response leads and patient safety incident investigators will have received the training outlined in the Roles and Responsibilities section and will be supported by our Patient Safety Specialists in undertaking investigations.

In order to meet the requirements of the NHS national standards for Patient Safety Investigations we will:

- Assign appropriately trained member of the Executive Team to oversee delivery of PSIRF and sign off all of the PSIIs.
- Mandate level 1 and 2 patient safety training for all staff.
- Support Patient Safety Specialists to complete level 3 and 4 training.
- Provide access to update training for all identified Learning Response Leads and ensure they are facilitated to undertake at least two learning responses per year or be supported by a critical friend who has supported at least two responses per year.
- Identify an appropriate training provider for all new investigators of PSIIs to meet the national requirements (i.e. minimum of 2 days).
- Publish plan and policy on our Trust website.
- Produce new documentation for patients and staff involved in patient safety incidents.

6.5.2 Our Patient Safety Incident Response Plan

Available data over a three to four year period from 2019 to 2023 was analysed to inform our plan and the priorities within it. This included patient safety incidents, complaints, concerns, claims, inquests, Freedom to Speak Up reports, mortality reports and a review

of our risk register. Four years of data was analysed where possible to capture information prior to the COVID-19 pandemic.

Once the data had been reviewed, consultation with stakeholders was completed to ensure our quantitative information aligned with the softer intelligence within our Trust from staff and for those representing our communities.

Our finalised priorities were cross referenced to improvement work already being undertaken in the organisation, both centrally and locally and that information was used to define our responses.

Our plan (Appendix One) sets out how LCH intends to respond to patient safety incidents over a period of 12 to 18 months and started in January 2024. The plan is not a permanent set of rules that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected and will update the plan when required. The draft plan has been commented on by Quality Committee and Board as part of the stakeholder engagement. The final draft was approved Quality Committee, Board and the ICB in Quarter Four of 2023/24.

An operational plan has been developed for the management and closure of legacy rapid reviews and Serious Incidents. This will include a dual system throughout Q4 2023/24 with a view to move fully to PSIRP from Q1 2024/25.

6.5.3 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 to respond to patient safety incidents. The plan will be reviewed every 12 to 18 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 12 to 18 months. This will be completed by the Patient Experience and Engagement Team.

Updated Patient Safety Incident Response Plans will be published on our website, replacing the previous version.

A rigorous planning exercise 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 data (for example, Patient Safety Incident Investigation (PSII) reports, improvement plans, complaints, claims, equity data, and reporting data) and wider stakeholder engagement.

6.6 Responding to patient safety incidents

6.6.1 Patient safety incident reporting arrangements

There are clear processes in place to ensure all staff can report patient safety incidents and near misses. There is Trust wide training available and a clear direction that patient safety incident reporting is everyone's responsibility.

The Just Culture Framework (NHSE, 2018) will be followed. In addition, a systems and human factors approach to understanding our incidents through local and central investigations and involve our staff in those reviews has been adopted.

Systems are in place to liaise with partner Trusts when incidents are identified that require a cross system approach from multiple partner organisations.

6.6.2 Patient safety incident response decision-making

PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. As a Trust there are systems in place for patient safety incidents to be assessed in line with our PSIRP and our locally defined priorities. There are some pre-determined events in healthcare that require a specific type of response as set out in policies or regulations.

These responses include mandatory Patient Safety Incident Investigations (PSII) in some circumstances or review by, or referral to, another body or team, depending on the nature of the event. These are detailed within our PSIRP (Appendix One) and include incidents like Never Events that will require a PSII.

There are no further national rules or thresholds to determine what method of response should be used to support learning and improvement within the PSIRF. LCH is now able to balance effort between learning through responding to incidents or exploring issues and improvement work and responding proportionately.

Any incidents that fall outside of our Trust improvement plans will be assessed centrally if they relate to moderate harm or above or are of high risk of recurrence where moderate harm could occur. The LCH Patient Safety Team will arrange panel reviews for these incidents to determine the most appropriate learning response.

6.6.3 Responding to cross-system incidents/issues

The Patient Safety Team will identify cross system incidents and issues in collaboration with the Teams, Services and Business Units. The Patient Safety Team will then arrange an initial multi organisational panel to assess the most appropriate learning response and to understand who the main provider of care was, and who should naturally lead the response.

For any incident where the response is assessed to be too complex for one provider to lead, a discussion will be escalated to the ICB for their coordination. The ICB will support identification of a reviewer, agree the learning response required, and advise how patient safety actions will be monitored.

6.6.4 Timeframes for learning responses

A response must start as soon as possible after an incident is identified, and usually completed within one to three months and no longer than six months. The timeframe for completing a PSII should be agreed with those affected by the incident, as part of setting the terms of reference for the PSII, provided they are willing and able to be involved in that decision.

In exceptional circumstances, a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer (paid and unpaid), representatives and staff). The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve patient safety or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

6.6.5 Patient safety action development and monitoring improvement

Learning from responses will be translated into patient safety actions in conjunction with those involved and those who can make the appropriate changes in practice. Subject matter experts must support appropriate and meaningful patient safety actions to be developed that will result in harm reduction and safer systems. LCH will utilise existing systems and processes to develop, implement, embed, and monitor patient safety actions. Patient safety actions will be monitored by the Clinical Governance Team where they identify system or organisational learning originating from any learning response. Actions from local learning responses will be monitored locally by teams and services.

Learning will be shared via the most appropriate route available, including the LCH Learns intranet site, direct team communication and governance reporting. Patient safety actions will be assessed against the Trust’s Improvement Plans and the annual audit programme to ensure a robust approach to embedding learning and continuous improvement.

Trust reporting for patient safety follows three routes:

- Reports to a quarterly Quality Assurance and Improvement Group that is a sub-group of Quality Committee and chaired by the Executive Director of Nursing and Allied Health Professionals and the Executive Medical Director.
- Reports to Performance Panel, which is chaired by the Executive Director for Operations.
- Direct reports to Quality Committee and Board.

Each of our Improvement Group leads will complete a six monthly assurance report for Quality Assurance and Improvement Group, with any escalations to Quality Committee and Board.

A monthly report is completed by the Clinical Governance Team for the clinical business units that analyses the incidents (this is quarterly in children's due to lower reporting numbers but any significant incidents are escalated monthly). The monthly report is shared with the Business Unit Clinical Lead and is included in the Performance Report that is shared at service Performance Panels with escalations to the Trust Performance Panel. A quarterly report is shared with Quality Assurance and Improvement Group and includes any escalations or highlights from the monthly reports.

There is a bi monthly report completed for Quality Committee that reviews the Key Performance Indicators attributed to Patient Safety with a focus on trends and themes. There is also a six monthly patient safety report that is shared with Quality Committee that includes a review of any Trust wide trends, themes and learning.

6.6.6 Patient Safety improvement plans

Patient Safety Trust Improvement Plans bring together findings from various responses to patient safety incidents and issues. They can take different forms such as an organisation-wide patient safety improvement plan summarising improvement work, individual patient safety improvement plans that focus on a specific service, pathway, or location.

LCH will utilise organisation wide the improvement plans and individual service improvement plans. The plans will be revised in response to new learning and emerging themes. The plans will also be revised if they do not result in the required impact of the anticipated reduction in patient harm in those targeted areas. This will be assessed within the improvement groups and the audit programme.

6.7 Complaints and appeals

LCH recognises that there will be occasions when patients, families, carers or their representative might be unhappy with some aspects of a learning response that they might have been involved in. In the first instance patients, families, carers or representatives should raise their concerns directly with their Learning Response Lead to see if their concerns can be resolved. If they are still not satisfied they must be referred to the Trust's Patient Experience and Engagement Team. Staff feedback and

any concerns will be addressed by engaging and involving them in the learning response.

7 Risk Assessments

Risks identified with the implementation of this policy (and procedure) have been assessed and mitigated as far as possible, in line with the Trust's risk appetite. The Trust patient safety priorities and improvement activity will be recorded and updated within the Trust risk register.

Should any further risks be identified following implementation, these will be assessed and consideration will be given to an urgent review/revision of the policy (and procedure).

8 Mental Capacity Act (MCA 2005 Code of Practice)

This Act applies to all persons over the age of 16 who are assessed to lack capacity to consent or withhold consent to treatment or care. Under the MCA there are occasions when an individual lacking capacity may require the provision of an Independent Mental Capacity Advocate, specifically when treatment or residence decisions have a significant impact on that individual's life and rights.

For further information see LCH's Intranet.

9 Deprivation of Liberty Safeguards (DoLS)

In the ruling of Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16, known as the 'acid test', it was determined that a person without capacity is deprived of their liberty if they are both subject to continuous supervision and control, and not free to leave.

Any deprivation of liberty of a person who lacks capacity has to be carried out in accordance with law. If a LCH staff member is aware of anyone they believe is, or is likely to be, deprived of their liberty, they must act in accordance with the MCA policy and DoLS guidance or they must discuss their concerns with a member of the Adult Safeguarding Team.

For further information on the MCA 2005 or on Deprivation of Liberty see the LCH Intranet or speak to the Named Nurse for MCA/DoLS, Dementia or one of the MCA Champions.

10 Safeguarding

This policy describes the roles and responsibilities for the Trust in relation to the safeguarding of children and young people. All provider organisations commissioned by the ICB have a responsibility to ensure they meet the agreed standards for Section 11 of the Children Act 2004, and statutory guidance outlined in Working Together to Safeguard Children 2018.

They are expected to follow the multi-agency procedures, comply with this policy and assist in taking the necessary action to safeguard children experiencing or at risk of abuse.

The ICB has a duty to take reasonable care to ensure the quality of the services commissioned. It is an expectation that all provider organisations, including LCH, demonstrate robust safeguarding systems and safe practice within agreed local multi-agency procedures.

The Children Acts of 1989 and 2004, and the statutory guidance Working Together to Safeguard Children (2018) set out the safeguarding principles for and promoting the welfare of children and young people.

Working Together to Safeguard Children (2018, page 7) defines safeguarding children and young people as:

- Protecting from maltreatment
- Preventing impairment of health and development
- Ensuring that children and young people are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes

The Children Act 2004 emphasises that we all share a responsibility to safeguard children and young people. For further information see the LCH Intranet.

11. Training Needs

Refer to the Statutory and Mandatory Training Policy including Training Needs Analysis. Up to date information is available on the Intranet for course details.

There is an accompanying Patient Safety Syllabus of training. Level one and two are mandated in LCH, levels three and four are delivered to the Patient Safety Specialists by the NHS training provider and level five is being developed nationally but will not apply to all colleagues. Training delivered by LCH will be mapped to the national requirements in addition to the training delivered by the national team (Appendix Three).

12. Monitoring Compliance

Minimum requirement to be monitored / audited	Process for monitoring / audit	Lead for the monitoring/audit process	Frequency of monitoring / auditing	Lead for reviewing results	Lead for developing / reviewing action plan	Lead for monitoring action plan
Compliance with roles and responsibilities	Exception reports to Quality and Assurance Improvement Group	Clinical Leads ABU CBU SBU	By exception	Head of Clinical Governance	Head of Clinical Governance	Clinical Leads
Annual review of the PSIRP	Patient Safety Strategy compliance	Head of Clinical Governance	Annually	Head of Clinical Governance and the Quality Leads	Head of Clinical Governance and the Quality Leads	Head of Clinical Governance and the Quality Leads

13. Approval and Ratification process

The policy has been approved by the appropriate body and ratified by the Trust Leadership Team on behalf of the Board.

14. Dissemination and Implementation

The Clinical Audit & Effectiveness Team will support the dissemination of this policy by ensuring it is sent to the Quality Leads via email, uploaded to the LCH Intranet and shared via the Trust's weekly newsletter or the Trust's approved briefing.

Implementation will require:

- Operational Directors/ Heads of Service/General Managers to ensure staff have access to this policy and understand their responsibilities for implementing it into practice.

- The Quality and Professional Development and Workforce Department will provide appropriate support and advice to staff on the implementation of this policy.

15. Review arrangements

This policy will be reviewed in three years following ratification by the author or sooner if there is a local or national requirement.

16. References

Care Quality Commission (2022) Duty of candour

Holden, R.J. et al (2013) SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients *Ergonomics* 56(11) pp1669-1686

Holden, R.J. & Carayon, P. (2021) SEIPS 101 and seven simple SEIPS tools *BMJ Quality & Safety* 30(11) pp 901-910

NHS England (2016) Accessible information standard

NHS England (2019) The NHS Patient Safety Strategy

NHS England (2020) Learning From Patient Safety Events

NHS England (2022) Patient Safety Incident Response Framework

NHS England (2018) A Just Culture Guide

Associated documents

- PL245 Being Open and Duty of Candour Policy and Procedure

Appendix One – Patient Safety Incident Response Plan

Effective date: 1 January 2024

Estimated refresh date: 1 April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	Claire Gray-Sharpe	Head of Clinical Governance		
Reviewer	Sheila Sorby	Deputy Director of Nursing and Quality		
Authoriser	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals		

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1. Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (2015).

The PSIRF challenges us to think and respond differently when a patient safety incident occurs. PSIRF is best considered as a learning and improvement framework with emphasis placed on the system and culture that support continuous improvement. One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better with a focus on improving quality and patient safety.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. A key part of this is fostering a psychologically safe culture, a ‘Just culture’ where our staff and patients feel confident to speak up when things don’t go as planned.

This document is the Patient Safety Incident Response Plan (PSIRP) for Leeds Community Healthcare (LCH). This provides the blueprint of how we intend to respond to patient safety incidents over a period of 15 months. The plan will then be reviewed and refreshed in line with future fiscal years. This plan details our approach to reviewing incidents in line with nationally defined patient safety priorities and our locally defined patient safety priorities. The plan will remain a live document and will remain flexible to consider new and emerging patient safety issues.

There is no remit within this PSIRP, or indeed within PSIRF, to apportion blame or determine liability, preventability or cause of death. The responses we will conduct to patient safety incidents are for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resource matters, legal claims and inquests.

2. Our services

Leeds Community Healthcare NHS Trust is proud to provide great care to our communities. The Trust provides and/or sub-contracts NHS services that include services from pre-conception to the end of life across many different specialities and professional disciplines. This includes services to promote and maintain health, and to provide care and treatment to manage existing conditions or ill health.

The Trust primarily serves the population of Leeds, in addition to some regional services. Services are delivered within the patient's home or from a range of sites including health centres, GP practices, hospital sites, schools, police custody suites and HM Prison and secure estate sites.

LCH is commissioned and registered with the Care Quality Commission to provide the following Services:

Table One – Services within our Clinical Business Units

Adult Business Unit	Childrens Business Unit	Specialist Business Unit
• Neighbourhood Teams (Community Nursing) • Community Cancer Support Unit • Community Discharge Team • Colorectal and Urinary Continence Service • End of Life Team • Falls Team • Health Case Management • Neighbourhood Night Service • Recovery Hubs • Tissue Viability • Transfer of Care • Wharfdale Recovery Hub	• Children and Adolescent Mental Health Service (CAMHS) • ICAN • 0-19 Public Health Inclusion Nursing Service (PHINS) • Childrens Nursing • Childrens Speech and Language	• Dental • Musculoskeletal • Adult Speech & Swallowing • Podiatry • Wetherby Young Offenders Institute • Adel Beck • Leeds Sexual Health Service • Homeless & Health Inclusion Team • Long COVID Rehab • Gynaecology • Police Custody Suites • Leeds Mental Wellbeing Service • Tuberculosis • Community Stroke Rehabilitation • Community Neurological Rehabilitation • Community Intravenous Antibiotic Service • Diabetes • Liaison and Diversion • Respiratory • Dietetics

		• Tier 3 Weight Management • Cardiac • Leeds Community Pain Service

3. Defining the LCH patient safety incident profile

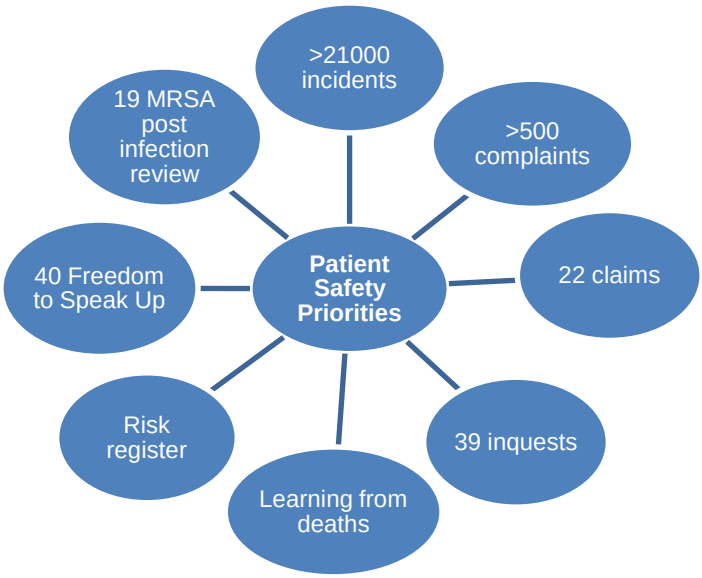
To identify our priorities a review was conducted of the data outlined below within the data section. As part of this we identified incident categories, and then reviewed other data sources against this list. Once all the data had been reviewed, the information was then cross referenced to inform the priorities.

In accordance with NHS England guidance on developing a PSIRP, we also identified and compared the on-going quality improvement work and quality improvement priorities currently in place for the Trust to inform our decision making on the Trust's local patient safety priorities.

4. Patient Safety Priorities Profile

To inform the Trust priorities we have assessed a breadth of data from the LCH Incident Management system (Datix ®) and other Trust information systems, which included incidents, complaints, inquests, claims and mortality data (see Table two). We also considered our learning from incidents, causal and contributory factors from incident reviews, post infection reviews and safeguarding reviews. The soft intelligence gained through our engagement phase has also been used to inform our priorities.

A period of four years was used to inform our priorities to include one-year pre COVID-19 pandemic in this first Patient Safety Incident Response Plan. The diagram below depicts the data reviewed.



The detail of this data analysis is described below.

Incidents: There were 21,353 incidents recorded during the four-year period. This is broken down by annual incidence within the table below. As expected, the data shows an increase in incidents for the 2020/21 period which coincides with the onset and first lockdown of the COVID-19 pandemic.

Year	No. of incidents
2019/20	4779
2020/21	6139
2021/22	5065
2022/23	5370

The highest reported category of incidents, annually and in total, in order, was:

- Skin damage
- Patient falls
- Medication
- Access/ admission/ appointment/ transfer/ discharge
- Self-harm
- Implementation of care.

On further analysis, although medication was the third most frequently reported incident, quarterly analysis by the medicines management team shows these generally occurred because of a preceding incident, for example, a missed visit. These incidents were predominantly no or low harm incidents (99.5%) with the remaining 0.5% of medication incidents resulting in moderate or major harm. During the period analysed only one incident (0.02%) was identified to meet the Serious Incident Framework (2015) criteria. As these incidents are already subject to a quarterly specialist review, they will not be included as a specific priority.

A detailed review was completed of the access/ admission/ appointment/ transfer/ discharge category. Given the breadth of this reporting category the sub-categories were reviewed and individually these were small numbers of incidents with low / no harm. The category will therefore not be included within specific priorities.

Self-harm was the fourth highest category during the total period. Most of these incidents were related to a Tier Three Inpatient CAMHS provision and incidence reduced when that service was transferred to another care provider in April 2021. However, the Trust continues to support children and young people within our Secure Estate provisions of Adel Beck Secure Children's Home and HMP Wetherby Youth Offending Institute. Whilst most self-harm incidents are low harm, there can be a cumulative psychological effect on these children that results in moderate or major harm. Therefore, self-harm will be captured as a local Trust priority.

Although the majority of these incidents relate specifically to the Secure Estate, the Trust do provide Community CAMHS and Leeds Mental Wellbeing Service. We will therefore consider self-harm within these services over the initial term of the plan and consider this within our PSIRP review to consider whether the priority should be broadened to these services. There is no data to indicate this is required within this plan.

To ensure learning continues to be captured from incidents resulting in moderate or major harm a local priority will be captured to review all moderate or major incidents for consideration of a Patient Safety Investigation and against the legal Duty or Candour regulation.

Serious Incidents: There were 261 serious incidents reported for the four-year period, and when cross referenced with the above data 112 (42.9%) related to pressure ulcers, 54 (20.6%) to falls, and 20 (7.6%) for self-harm.

Complaints: There were 542 complaints during the period that have been reviewed

Claims: On review of the claims profile over the period, 36% (8/22) of claims related to wound care including pressure damage and 9% (2/22) related to self-harm, the remaining 55% varied.

Inquests: There were 39 inquests registered with the Trust during the period reviewed and have also confirmed the local priority around pressure ulcers and informed a priority for deteriorating patients.

Learning from Deaths: From the Trust learning from death reports, the key themes from mortality review are early identification of the end of life phase for palliative patients, obtaining end of life anticipatory medication, and ensuring people's wishes are know for their end of life through advanced care planning.

Risk Register: A review was completed of the Trust wide clinical and operational risks. There were 117 risks that were reviewed to understand our wider risk profile. Our patient safety priorities will be added as risks to the register.

Freedom To Speak Up: The Freedom to Speak Up Guardian annual report was reviewed. The Freedom to Speak Up Guardian reviewed concerns from the previous four years. Of 374 concerns, 40 were patient safety related. Information held within the overview provided was assessed to be considered within the identified priorities.

Infection Prevention and Control (IPC) Post Infection Reviews:

MRSA Bacteraemia:

Three years of Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia data was reviewed. Of the 19 reviews for the 2020-2023 period the identified learning was cross system. Although there were no major specific themes for the Trust, there was some learning around deteriorating patient.

The Post Infection Reviews (PIR) will now fall under the PSIRP and are captured within the local priorities below.

MSSA Bacteraemia:

As an emerging trend Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia will be reviewed in LCH in line with discussions across Leeds during the term of this initial PSIRP. Individual learning will be identified, managed and this intelligence will then inform the 2025 PSIRP.

Escherichia coli (E. coli)*

All E.coli bacteraemia infections are currently reviewed and a PIR is completed if they occur in an LCH inpatient, where the bacteraemia is cited in Part One of a death certificate or where the Infection Prevention Control (IPC) team identify a specific trend in review findings. This approach will continue and the approach is captured within the local priorities below.

Clostridium Difficile

Reviews for Clostridium Difficile (C. Diff)* over the three year time period has found both an increasing trend (consistent with national trends) and similar learning to the national learning and therefore they will not inform a PSIRP priority at this stage. Reviews will continue within the IPC team as part of the Trust's contractual requirements.

*Due to changing processes during the time period reviewed, the dataset cannot be reliably quantified and therefore qualitative data has been used to inform this version of the PSIRP.

5. Health Equity

Health equity is a priority for the Trust and we currently consider patient safety incidents against the equity domains for those incidents. At present we have a partial dataset that includes falls, pressure ulcer, medication and access incidents and these are considered in relation to deprivation, ethnicity, age, learning difficulty, Autism Spectrum Disorder and communication requirements. We are working towards a complete dataset.

In addition, each of the Trust wide improvement plans detailed in the tables below will include dedicated actions to ensure equity is considered within the context of the quality improvements.

6. Stakeholder Engagement

The identification and agreement of our patient safety profile / priorities was a collaborative process that involved the people described in Appendix 1.

The proposed priorities were shared with our stakeholders for their feedback. Our patient safety specialists sought feedback from their respective areas in teams and with individuals including clinical and non-clinical staff. Colleagues were asked whether the patient safety priorities felt appropriate and were specifically asked, "do you agree with these priorities and what else would you add?".

7. Patient safety incident response plan: national requirements

The national requirements and how we will respond to these are detailed in Appendix 2.

8. Patient safety incident response plan: local focus

This part of the plan outlines our local priorities for the period 1 January 2023 to 31 March 2025. These priorities are detailed within Appendix 3 and are based on the review of local data as described above.

In relation to the local patient safety priorities, the Trust will apply one of three principles in the way we will respond to incidents:

1. Where patient safety issues are well understood and/or improvement plans are well developed, we will ensure the details of the patient safety incident is added to the

improvement project and consider no further investigation, with time and people resource focussing on the improvement activity.

2. Where contributory factors are not well understood and/or where local improvement work is still being developed, we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.
3. Where it is not clear if there is further learning in relation to an improvement plan OR where the incident highlights an area for future learning / improvement we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.

For incidents that are not related to local patient safety priorities but warrant further review we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning, on a case-by-case basis.

For each local patient safety priority underpinned by a Trust wide improvement plan, we will assess the quality of the improvement plan ensuring it is systems based e.g. ensuring that all known contributory factors have been addressed and using appropriate data to measure progress. The plans will be signed off by the relevant committees and executive lead.

Ongoing progress against the plans and tracking of subsequent incident trends will be monitored by the relevant improvement group and overseen by the relevant Trust committee.

The table below defines the criteria the Trust will use to decide which incidents require a PSII to be undertaken.

Table Five – SII criteria

Criteria for PSII response	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Appendix 1: Stakeholders

Stakeholder	Involvement
Trust board	The proposed patient safety incident profile (within the PSIRP) was presented to the Trust board for comment and ratification
Quality Committee	The proposed patient safety incident profile (within the PSIRP) was presented to the Quality Committee for comment and approval
Patient Safety Strategy Implementation Group (PSSIG)	The proposed patient safety incident profile (within the PSIRP) was presented to the PSSIG for feedback and discussion
Clinical Business Unit Senior Leadership Teams	The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment
Front line staff	The patient safety specialists shared the patient safety incident profile with front line staff for comment
Patient safety partners	Patient safety partners were involved via their membership of The Patient Safety Strategy Implementation Group. They were also specifically asked to comment on the patient safety incident profile and the draft Patient Safety Incident Response Policy and plan.
Third Sector Partners	Our proposed local and national patient safety priorities were shared for comment through our Third Sector Partner Groups and through the LCH engagement champions forum.
Integrated commissioning board	The proposed patient safety incident profiles (within the PSIRP) were presented to the ICB for comment and final approval.

Appendix 2: National patient safety requirements

Patient safety incident type	Response	Improvement approach
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Local organisational actions and feed these into the quality improvement activity
Death thought more likely than not to be due to problems in care. This can be identified through an incident and / or the learning from deaths process.	PSII	Local organisational actions and feed these into the quality improvement activity
Deaths of person who has lived with a learning disability or autism	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death LeDeR programme.	Respond to recommendations from LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria undertake a PSII.	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Deaths in custody (e.g. police custody, prison) where health provision is delivered by the NHS	Any death in prison or police custody 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	Respond to recommendations from PPO or IOPC
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	Refer to local authority safeguarding lead via LCH designated professionals for child and adult safeguarding. LCH will contribute towards domestic	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.

2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	
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 CSP Patient safety incident response plan v1.1 Approved by UHBW Board and ICB. Page 17 of 23 met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for	Respond to recommendations from external programme and feed these into the

	consideration for an independent PSII, with consideration of any local learning response	safeguarding strategy as required.
Incidents that meet the statutory Duty of Candour threshold (Regulation 20)	Will be reviewed on individual incident basis to determine most appropriate response to undertake to meet regulation 20	

Appendix 3: Local patient safety priorities

Priority	Patient safety incident type or issue	Planned response / Sampling technique	Improvement approach
1.	Pressure damage with lapses in care causing moderate or major harm	Any incident with themes corresponding to the Trust Pressure Ulcer Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority Six.	Trust improvement plan actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee
2.	Patient falls with lapses in care and resulting in moderate or major harm	Any incident with themes corresponding to the Trust Falls Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority Six.	Trust improvement plan actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee
3.	Implementing care / deteriorating patient resulting in delayed	Thematic review of failure to recognise the deteriorating patient (review of 20 incidents) to inform a new Trust Improvement Plan which will be managed via the associated	Trust improvement plan actions, monitored through Quality & Improvement Group (QAIG) and

	admission to hospital	Deteriorating Patient Improvement Group. Once established, new incidents will follow the approach of Priority 1 and 2.	escalations to Quality Committee
4.	Successive minimal harm, self-harm incidents in children and young people within the Trusts secure estate	After ten consecutive low harm incidents related to the same young person in a secure estate, a moderate harm incident will be reported for the same young person to assess the longer-term impact on their psychological harm. This will follow the existing rapid review process to determine if further investigation is required.	Appropriate learning response will be determined at rapid review meeting
5.	MRSA bacteraemia with LCH involvement.	A PSII will be completed where a PIR would have been completed	
Additional incident management processes:			
6.	Moderate and major harm incident relating to the clinical triage process in Neighbourhood Teams.	Service led improvement plan. This is expected to be a short-term local plan. If recurrent themes and trends continue this will be considered for future iterations of the PSIRP.	
7.	Moderate and major harm incidents will be reviewed for Patient Safety Incident Investigation consideration.	Initial service level review / learning to be cross referenced against the Trust Improvement Plans and managed in line with principles described in the PSIRP. A review of the legal requirement for Duty of Candour will be completed for all.	
8.	On review of all E.coli bacteraemia, where circumstance is: LCH inpatient, E. coli is specified on Part One of a	Initial IPC review against the relevant Trust Improvement Plan Where new learning is identified, further review will be through a Rapid Review. A review of legal Duty of Candour will be completed for all.	

	death certificate or an identified trend by the IPC Team.		
9.	Near miss or no / low harm incidents identified to be high risk by the team or via the Business Unit Quality Lead monthly report	Reviewed for learning through a Rapid Review	
10.	Near miss, no and low harm incidents	Service level review and response.	

Appendix Two – Learning Responses

Method	Purpose	When we will use this
Patient Safety Incident Investigation	A patient safety incident investigation (PSII) is an in-depth investigation.	It will be undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning
After Action Review	An after-action review method of evaluation usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved and it captures learning, which can then be shared more widely	It will be used where additional learning can be identified to inform patient safety improvements. This could be from a local response or a central review (eg priority seven). Additional information: After Action Review Learning Handbook
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.	A swarm is designed to start as soon as possible after a patient safety incident occurs and will be a locally led learning response.
Multidisciplinary Team Review	The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a patient safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.	MDT reviews are most useful when a wide range of stakeholders share their perspective on 'work as done' in the health or social care system being analysed and will be used as an outcome from Priority Seven or within a PSII. Work As Done Model
Supporting Methodologies	There are specific methodologies that will be used to inform the Learning Responses.	Link Analysis Observations SEIPS - System Engineering Initiative for Patient Safety Walkthrough Analysis Work As Done Model

Appendix Three - Patient Safety Incident Response Standards for Training

PSIRF training requirements

Topic	Minimum duration	Content	All colleagues	Learning response leads/ investigators	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and afteraction reviews • Patient safety action development, measurement, and monitoring • **Required when available**		✓	✓
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓

Investigative interviewing	3.5 hours	• Course offers an overview of the principles that underpin a professional safety investigation interview with either a member of staff, a patient or a family. • The course aligns to the PSIRF guidance on a systems approach to interviews • **Recommended unless prior experience**		✓	
Writing reports following investigations and other learning responses	4 hours	• Aimed at those who write and/or oversee reports following investigations and other learning responses. • **Optional initially**		✓	
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses	✓	✓	✓

Appendix Four – Learning Response Resource

On review of our Business Units the following Learning Response Leads have been identified:

Business Unit	**Learning Response Leads**
Adult Business Unit	A dedicated role of Care Quality Manager (CQM) has been developed. There are four CQMs with resource for the four whole time equivalent posts.
Childrens Business Unit	Service/Team Managers review locally led responses. Clinical Heads of Service will lead the PSII.
Specialist Business Unit	Service/Team Managers review locally led responses. Clinical Heads of Service will lead the PSII.
Specialist Corporate Teams will support the learning responses as required with specialist knowledge.	

Appendix Five - What to expect when attending Rapid Review Meetings

The following guide has been created by the Patient Safety Team to help you prepare and know what to expect when attending a Rapid Review Meeting.

When are Rapid Reviews?

Rapid Review meetings are held every Monday and Wednesday afternoon.

Day	Time	Meeting chair	Support to chair
Monday	2-4pm	Sarah Hemsley (Quality Lead for the Childrens Business Unit)	Sheila Sorby (Deputy Director of Nursing and Quality).
Wednesday	1-3pm	Frankie Skirrow (Quality Lead for the Specialist Business Unit)	Claire Gray Sharpe (Head of Clinical Governance)

What is a Rapid Review Meeting and why do we have these?

Rapid Reviews are part of our clinical governance process, held to discuss patient safety incidents of moderate harm, major harm and near miss/ minimal harm incidents where the risk to safety is high.

The purpose of the meeting is to gather evidence and assurance of effective pathways of care and good practice, as well as identifying where we need to improve systems and processes in relation to care delivery.

Where the group feel there is further understanding required and therefore learning opportunities a further investigation may be requested. This may be a formal patient safety incident investigation (previously referred to as an RCA), but it may be a walkthrough, a service intervention or a reflective conversation following an incident.

The meetings intend to support our ‘Just Culture’, an open and honest conversation focussed on learning and improvement. These meetings are not about blame. If this is not your experience, we request you provide that feedback to the Patient Safety Team so we can review this in order to improve future experiences.

Who will be at the Rapid Review?

Alongside the chair and support the meeting will include:

- a member of the safeguarding team
- a member of the patient safety team
- The author of the investigation
- The case load holder or team member who knows the patient best
- Specialist reviewers dependent on the incident type (for example: Tissue Viability nurse for pressure ulcers; CUCS for meatal tears; community falls team for falls incidents)

What happens in a Rapid Review Meeting?

All CBU and SBU incidents are allocated a 30-minute time slot.

All ABU incidents are allocated a 20-minute time slot.

There are two types of reviews VRR (Virtual Rapid Review) and RR (Rapid Review).

- VRR is an investigation that is completed on the investigation section in Datix. This type of review is currently only for ABU Neighbourhood Team incidents (meatal tear, Moderate harm pressure ulcers and falls)

- RR is an investigation report which is completed for all remaining incidents for ABU and all incidents for CBU/SBU. The Rapid Review template can be accessed via Datix.

In the meeting the investigator presents an overview of the incident and initial review findings. Those in the meeting may need to ask questions for clarity about the existing systems and processes, or a specific detail within the timeline. The good practice and learning is discussed. Input from the clinicians that know the patient is vital during the conversation as it provides essential context in relation to the patient, the incident and the circumstances in which care was delivered.

The meeting will conclude with a collective decision as to the requirement for any further investigation, actions required and whether statutory Duty of Candour applies.

We understand attending Rapid Review can be a daunting experience. If you have never been before and would like to attend for your understanding and development, please contact the Patient Safety Team at lchsafety@nhs.net and we would be happy to help.

We can arrange shadowing, provide support with the completion of Rapid Reviews and would welcome all feedback as this helps us to continuously improve. Thank you 😊

LCH Psychological Support is also available if you or your team have experienced an incident at work which has had an emotional and/or potentially traumatic impact and you think support may be helpful, LCH now have a team of staff able to offer 1:1 or group post incident support. Please email: Jen Gardner, Clinical lead for the Critical Incident Staff Support Pathway (CrISSP) on lcht.crissp@nhs.net

Helpful resources can also be found here:

Critical Incident Staff Support Pathway (CrISSP) (lch.oak.com)

Resources for me - critical incident support (lch.oak.com)

What is CrISSP and Post Incident Debriefs? (lch.oak.com)

Critical Incident Training Offer (lch.oak.com)