Sussex Community
NHS Foundation Trust

Patient Safety Incident Response Plan

2023/2024 V.1

Policy Author/ Reviewed by:	Patient Safety Manager and Patient Safety Team		
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Excellent care at the heart of the community

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1. Foreword

The patient safety movement has progressed since the early 1990's since the publication of the Institute of Medicine report "to Err is Human" and the establishment of the National Patient Safety Agency. As a relatively new discipline within the healthcare professions the focus has always been on improving patient safety as an important public health issue. Since then, substantial efforts have been made to identify sources of error, develop safety metrics and create impactful policy initiatives to improve safety in hospitals and other healthcare settings.

Although awareness has increased, improvements have occurred at a much slower rate than initially expected. Initiatives targeting specific harms, such as venous thromboembolism, have demonstrated improvements. However, safety policies, research and development have revealed that achieving sustainable improvements in patient safety aimed at broader spectrums of harm have been less successful. The issue is more complex than defining and measuring 'preventable harm'. The range of metrics to consider goes beyond mortality and includes things such as morbidity, decreased quality of life and loss of dignity. Solutions must be approached holistically and implemented at system level. Creating sustainable change relies on the leadership establishing a safety culture within healthcare, requiring accountability at organisational and individual levels. Key elements to achieving sustainable improvement in patient safety, across the entire care continuum, include meaningful support to the health care workforce, partnering with patients and families and ensuring technology is safe and optimised to improve patient safety.

The NHS National Patient Safety Strategy published in 2019 laid the foundation for meeting the requirement for a whole system change in how we think and respond when an incident happens. The NHS Serious Incident Framework told us when and how to investigate a patient safety incident. The strategy replaces this with the Patient Safety Incident Response Framework and focusses on enabling us to take responsibility for how we learn and improve. It replaces time scales and external scrutiny with a set of principles to work to. It means that we are responsible for the entire process, including what to investigate, how to investigate and the time and resources assigned to our investigations. Essentially, this enables us to own, prioritise and direct our efforts for learning and improvement to find and address the harms that are relevant to the healthcare services we provide to the population we serve.

Here at SCFT, we have been working within the principles of the strategy and PSIRF alongside the current framework for several years. Whilst the pandemic slowed down our ability to progress the entire ambitions of the strategy, as a patient safety team we focused our efforts on the importance of fostering a restorative, just culture in which people feel psychologically safe to speak. Enabled through the positive support and leadership provided by our Chief Nurse and Chief Medical Officer we have worked in more creative ways to reach out to our people. We promote our firm belief that staff wellbeing and patient safety are two sides of the same coin and interdependent. We strive to improve how we listen to and support all those involved in incidents and related processes, such as inquests or serious complaints. We have developed tools to support staff to consider the learning and development aspects that sit alongside these upsetting events, enabling growth and supporting registrant revalidation. We have balanced the sharing of findings from incidents with 'shout outs' and celebrations of the

amazing achievements and initiatives of individuals, teams and services across the organisation. We have aligned ourselves more closely with our Freedom to Speak Up Guardian and Patient Experience Team. We invite feedback to help us to learn and improve how we interact with individuals, teams, services and service users also continually. There is always more to do!

The implementation of Patient Safety Incident Response Framework means we will still review incidents and carry out investigations. However, we will foster a range of investigation and learning response tools and train people to use these within their teams and services. The aim is to ensure a proportionate response, focused on finding the gaps and errors in our systems and processes, depending on the type of incidents and associated factors. To remove elements that lead to seeking blame whilst supporting accountability. To enable this, we have gathered and analysed our patient safety data and engaged with specialist leads and stakeholders to develop our understanding of the patient safety incidents and challenges across our organisation. Using this insight, we created our SCFT incident profile. This led to the development of a plan of how we will respond to specific incidents and patient safety issues. This is our Patient Safety Incident Response Plan and it provides the headlines and description of how Patient Safety Incident Response Framework will be applied at SCFT.

It is important to note that this plan is a living document and will be kept under continual review as we try, test and adapt to new methodologies and tools, recognise emerging patient safety issues and shift our priorities. We have laid down our foundations, but we may not get it right first time and need to ensure that we learn and adapt how we respond to incidents to achieve optimal learning benefits.

This plan belongs to everyone, because everyone has a part to play in patient safety. It is everyone's business. For this reason, we don't have a network of champions, we recognise that every person in the organisation; from the board to the floor, clinical and non-clinical is here for the ultimate purpose of supporting the delivery of safe, effective care to our population of people who trust and depend on us to do so. You are all vitally important patient safety champions! To this end, its success relies on each and every one of us. So, I hope that you all embrace this plan, get involved with implementing the new learning responses and contribute to its continuing development.

Thank you for being part of this exciting new approach to all things patient safety!

Deborah Fron, Patient Safety Manager

Howard Pescott, Associate Director of Quality and Safety

2. Introduction

2.1 Background

The Patient Safety Incident Response Framework (PSIRF) promotes working in a way that focusses on learning and improvement, whilst being guided by a systems thinking approach. This Patient Safety Incident Response Plan (PSIRP) describes how SCFT intends to respond

to patient safety incidents from September 2023 to March 2025 and outlines key areas for improvement. Our PSIRP is a public document and will be published on our Trust website.

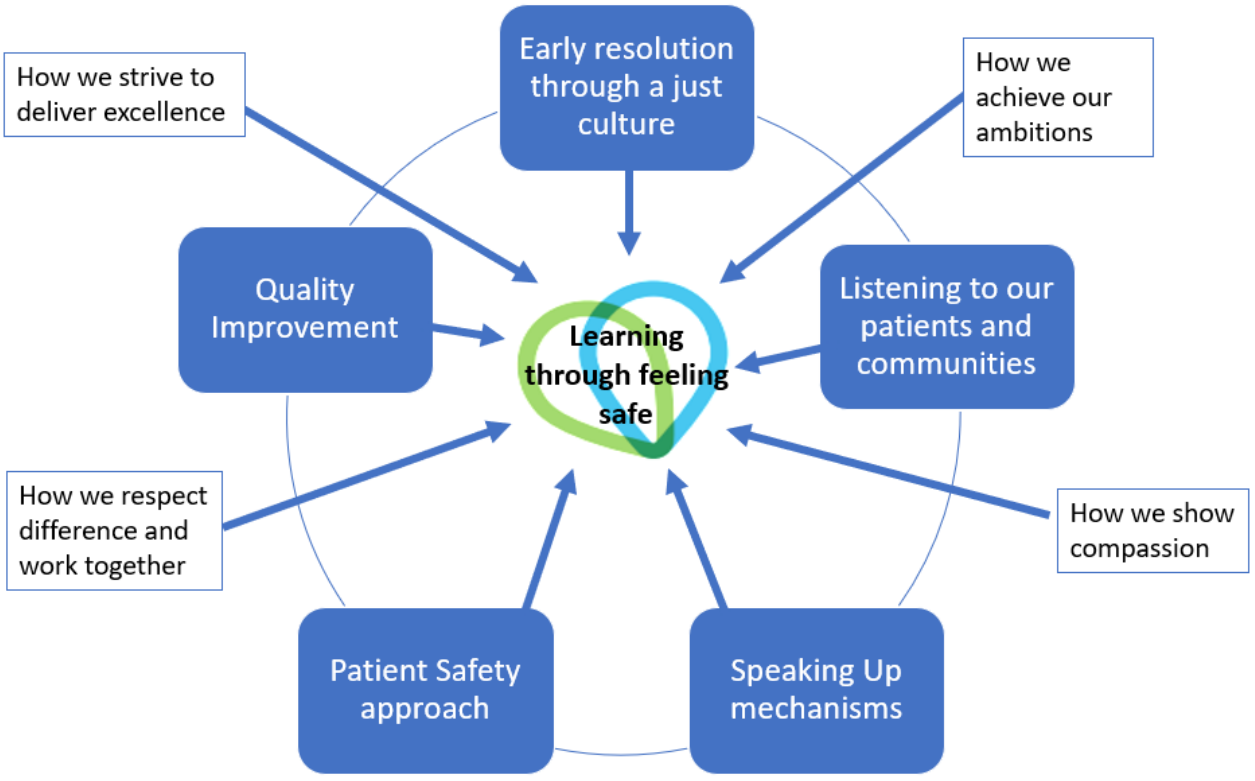
2.2 Aim of our PSIRP

At SCFT we see our PSIRP as a positive step forward for Patient Safety, and we have seven key aims:

- Ensuring patients/service users/clients and their families are informed and supported when a patient safety incident occurs, inviting and supporting their involvement and inclusion in our learning and improvements. This means being open and honest in a more meaningful way than merely seeking to comply with the legal Duty of Candour.
- Ensuring that staff and volunteers involved in or affected by patient safety incidents are fully supported and involved throughout the learning response. By ensuring we include our people as participants in the resolution and repair of harms, together we will create a sustainable just, restorative culture.
- Identifying our most common incidents and responding to them in the most proportionate and beneficial way for patients and staff, and listening to all viewpoints.
- Ensuring we learn from all incidents affecting patients/service users/clients to maximise learning across the full range of Trust services.
- Ensuring we take a Quality Improvement approach to improvement activities that come out of investigations, ensuring these are closely monitored, effective and fully embedded.
- Ensuring we use and triangulate data from a variety of sources to ensure that our plan takes a thorough and holistic approach.
- Ensuring that we work closely and collaboratively with our partner organisations to foster a system wide safety culture and work together on improving safety throughout each patient pathway.

At SCFT we recognise that our safety culture is the foundation stone upon which our success in achieving continuous improvements in patient safety rests. To ensure that this foundation is also continuously improving we will use a variety of tools to measure our success. These tools will include and is not limited to, gathering post learning response feedback, staff insights shared during learning responses and at staff drop in sessions, FTSU cases, the staff survey results and consideration of retention and vacancy rates.

These aims are visually represented in the below infographic:



2.3 Building our PSIRP

Our PSIRP has been created through collaboration with a range of stakeholders to ensure that it is as inclusive and wide reaching as possible, and benefits from the knowledge and insight from specialist expertise.

Our incident profile was built through reviewing a vast variety of SCFT patient safety data enabling us to identify our patient safety trends, themes and priorities with our internal stakeholders. The full list of the data we reviewed is listed in section 7.1 below. Once our priorities were established the learning responses to key patient safety incidents was agreed with subject matter experts for each incident in the incident profile.

A draft plan was shared with internal and external stakeholders for feedback, including a wide range of core internal stakeholders from different roles, disciplines and teams across the Trust, and our Patient Safety Partners (PSPs). The plan is being presented at our Patient Experience Group, which is attended by Healthwatch and other patient representatives. The plan was approved at SCFT Trust Wide Governance Group on 04/07/2023. Following this it was presented at the Quality Improvement Committee on 20/07/2023, which is chaired by the Non-Executive Directors. Final approval was received at the SCFT Executive Management Group

on 26/07/2023. It was then submitted to the Integrated Care Board Lead for approval. This process has ensured thorough stakeholder engagement and involvement across the organisation. The plan and policy will be publicly available on the SCFT website and the Trust will welcome any further external input in the plan's future iterations.

2.4 Keeping our PSIRP up to date

SCFT's PSIRP is a 'living document' outlining our learning responses to patient safety incidents according to our incident profile and emerging risk and themes. To ensure our focus remains current it will be reviewed at least every 12-18 months and will be responsive to changes and ongoing improvement work. The updated PSIRP will be published on our website and replace the previous versions. In order to support this, the Quality and Safety Department will hold quarterly triangulation meetings with key stakeholders to review patient safety data from a range of sources to identify any cross-cutting and emerging themes. Alongside this the Patient Safety Team will hold quarterly patient safety drop in sessions for all staff from any role or service to come and share their thoughts and insights on patient safety in the area they work. This will be a safe space for staff to share within and support our commitment to listening up and our wider patient safety culture. Both of these meetings will ensure that we not only focus on the data, but we ensure a rich picture of what is happening at SCFT and ensure that this is reflected in our plan.

In addition to the above a rigorous planning exercise will be undertaken in line with when the Trust strategy is updated, to ensure the two align. This more in-depth review will ensure efforts continue to be balanced between learning and improvement, and will include reviewing our patient safety data, including patient safety incident investigations, themes from other learning responses, improvement plans and projects, complaints, claims and inquests, Freedom to Speak up data, and staff survey results. It will also involve reviewing our response capacity to patient safety incidents, mapping our services and will include stakeholder engagement. This exercise will also take into account staff and patient feedback, including those who have been involved in incidents should they wish to share their feedback. Our Patient Safety Partners will also be a part of this review.

The SCFT PSIRP sits alongside the SCFT Patient Safety Incident Response Policy which provides guidance on the different processes for PSIRF and the governance around it.

3. Our Trust vision, values and goals

AT SCFT our vision is "Excellent care at the heart of the community", and our values are:

- Compassionate care
- Achieving ambitions
- Working together
- Delivering excellence

Our Trust has five strategic goals; a great place to work, reducing service inequities, continually improve, digital leader and sustainability.

Our PSIRP aligns closely with the Strategic Goal to continually improve, which states *"We will continuously improve. In the years ahead continuous quality improvement will be present in everything we do. Our people will be able to show how they have made a demonstrable difference to our patients through continually learning, accelerating improvement and sharing what works."*

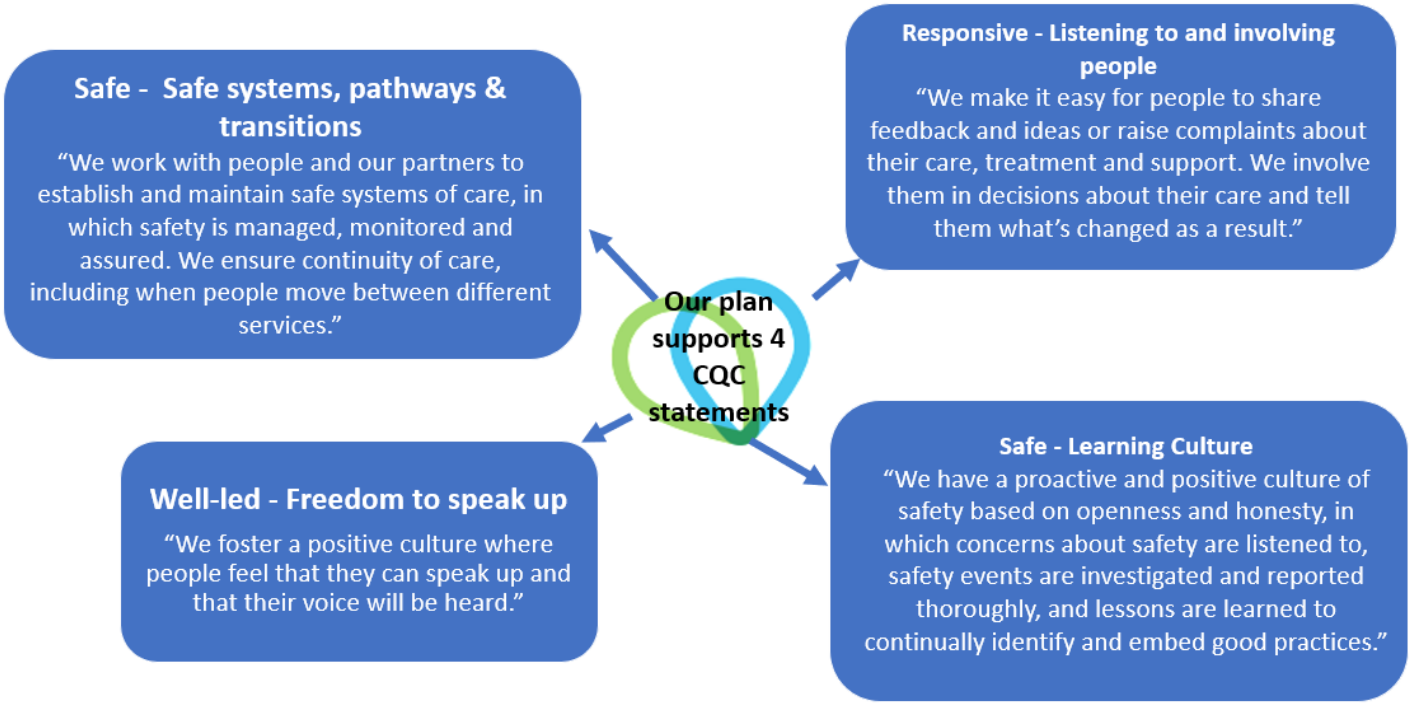
Our criteria for success of this goal includes:

- *"we will learn through an open approach when things go well and when things go wrong; we will drive safety through learning which will have, at its heart, the voice of our patients"*
- *"QI methodology and approaches will be embedded throughout the organisation enabled by access to learning, guidance and mentoring to improve care for the people who use our services"*

The above information has been taken from our SCFT website here. Further information about the Trust is available on this website.

The SCFT PSIRP will support this goal by ensuring that we respond to patient safety incidents, investigate in the most suitable way, identify key learning, and use Quality Improvement Methodology to carry out any improvement actions to ensure that they are fully embedded either locally or Trust Wide depending on the action itself. We will also support the sharing of good practice and when things have gone well for staff and patients, to ensure this positive practice can be learned from and shared. This will be done through our Patient Safety Newsletter, governance meetings, social media and other communications as agreed on a case by case basis.

Our PSIRP also aligns with the following CQC Quality Statements:



4. Our services

"We are the specialist provider of community health and care services to the people of Brighton & Hove, East Sussex and West Sussex. Every day our expert teams provide medical, nursing special care dentistry, specialist and therapeutic care to more than 9,000 people. Across the age range, we care for some of the most vulnerable people in our communities, from our health visitors caring for babies and young children through to our multi-disciplinary community teams caring for the elderly.

We provide a range of different services both out in the community and in dedicated clinical areas. In total we have nearly 6,000 members of staff working across Brighton & Hove, East Sussex, High Weald Lewes and Havens and West Sussex. Our staff work in multi-disciplinary teams combining a range of specialisms and backgrounds and linking closely with our health and social care partners to offer integrated, seamless services to our patients, some of what we do includes the following.

***Community Rehabilitation** - Supporting people with complex health needs and long-term conditions or people needing end of life care.*

***Community Rapid Response** - Assessing and caring for patients with urgent care needs, helping to keep them out of hospital.*

Intermediate Care - Short Term Recovery and Rehabilitation *- Keeping patients out of hospital where we can, or helping them to leave hospital when this is the right thing for them.*

Integrated Discharge *- Working with patients, carers and hospital staff, to help a patient return home from a hospital stay as soon as possible.*

Health Promotion *- Supporting people to improve health and well-being.*

Children and Families *- Coordinating flexible services for children and families through our health visitors and our child development centres."*

The above information has been taken from our SCFT website here. Further information about the Trust is available on this website.

5. Engagement and involvement

SCFT will take a trauma-informed approach when supporting both staff and patients/service users/clients involved in a patient safety incident, i.e. offering safety, choice, collaboration, trust and empowerment in our approach. When patients/service users/clients and staff are supported by the Patient Safety Team we will take into consideration the impact of past and current traumatic and adverse experiences on their ability to engage with the process, on understanding their reactions and possible barriers to engaging or speaking up, their levels of stress during interactions and the relevance of paying attention to this.

5.1 Involvement of patients/service users/clients and their relatives/carers/parents/representatives

Open and effective communication with patients/service users/clients begins at the start of their care and should continue throughout their time within the healthcare system. This should be no different when a patient safety incident occurs; when a patients/service users/client makes a complaint; or in the case of an inquest or claim.

The Trust is committed to a safe and just culture of fairness, openness and learning to enable staff to feel confident speaking up when things go wrong, rather than fearing blame. Supporting staff to be open when care does not go to plan, and harm was, or could have been, caused to the patient as a result, allows valuable lessons to be learnt that can guide improvements in the safety and quality of the care and treatment we provide to patients.

A professional duty to be honest with patients/service users/clients when things go wrong is incorporated into professional conduct by the General Medical Council (GMC), Nursing and Midwifery Council (NMC), the Health Care Professions Council (HCPC), and the General Dental Council (GDC). The requirement is to inform patients/service users/clients and/or their relatives/carers/parents/representatives about patient safety incidents that affect them; to provide an apology and to keep them informed about investigations and involve them in investigations should this be their wish. In addition the way a patient/service user/client or their relatives/carers/parents/representatives is communicated with throughout the investigation is

discussed with them and a method is agreed based on their preferences, for example a phone call, letter or face to face meeting.

Duty of Candour is a statutory requirement for when significant harm has resulted from an incident, and/or the patient/service user/client has prolonged pain and/or prolonged psychological harm. This legal duty is a defined process laid down in regulation 20 of The Health and Social Care Act 2008. SCFT will ensure that patients/service users/clients or their relatives/carers/parents/representatives will be fully involved and engaged with throughout an investigation process, and a trauma informed care approach will be taken. SCFT will liaise with people to ensure that they are supported and are able to share their experience and insight about what happened. They will be given the opportunity to ask questions and the investigator will incorporate these as part of the investigation. SCFT will ensure that their concerns and preferences are considered and documented in the investigation records, including noting where they have chosen not to contribute or be involved in the investigation process. In those circumstances, a discussion will be held to ensure that all options have been discussed for them, to explore their reasons for not wishing to be involved and ensuring that they have the option to change their mind at any time.

The patients/service users/clients or their relatives/carers/parents/representatives will be kept up to date throughout this process and they may request meetings at any stage during the investigation. A draft investigation report will be shared with the patients/service users/clients or their relatives/carers/parents/representatives if they wish to see it, to verify facts and agree any amendments to the final report whenever possible.

5.2 Patient Safety Partners

SCFT appointed Patient Safety Partners (PSPs) in April 2023 and they will work closely with the Patient Safety Team to provide the voice of patients in patient safety. This will include attending Quality Improvement Committee meetings, as well as reviewing policies and plans, and being involved in project work. This is a new role for the Trust, but one that we believe will offer great benefits for further ensuring that the voice of patients is heard in patient safety. The PSPs have also been consulted on during the creation of the SCFT PSIRP. This exciting new role is one that will develop as we work with the PSPs and explore the wealth of insight they bring to the organisation.

5.3 Involvement and support of staff

SCFT will ensure that staff who report a patient safety incident on the Trust's online reporting system, are fully supported as per their wishes. Initially following an incident, staff receive a feedback email signposting to support services including Professional Nurse Advocates. Professional Nurse Advocates can provide support and help create the opportunity for reflection, reduce stress and enable learning.

Further information and support can be provided, and SCFT offers a range of health and well-being resources including:

- The Connect service, which provides support and signposting with the in house team, as well as other resources in our local communities and nationally through online services.
- Health Assured employee assistance programme which offers confidential counselling support.
- The Staff in Mind Wellbeing Support Hub offers rapid mental wellbeing assessment and priority access to the right treatment services.
- Mental Health First Aiders, who are staff that are trained to provide support and can support staff with getting more help and supervision.
- Training on Trauma Informed Care should also be considered.

If at the point of triage the Patient Safety Lead feels that staff will likely have been affected by the incident, or it looks particularly intense or stressful, the Patient Safety Team will send a communication form via the Trust's online reporting system to the team lead, ward manager or appropriate senior member of staff to enquire about staff wellbeing, and check that support is being offered and available for the staff who have been involved. Further information and support from the Patient Safety Team about the above resources can also be provided at this point, should the staff involved ask for it or feel it is required. In addition, for incidents which involve a deteriorating patient or child, the Deteriorating Patient and Resuscitation Lead for the Trust can carry out a debrief with the staff as needed.

Patient Safety Leads will work with the staff and teams involved to ensure that they are supported in the early stages of an investigation. This can include setting up meetings, calling the staff involved and arranging a table top meeting to debrief and discuss the incident and provide further support to the staff involved. The Patient Safety Team take a sensitive approach with the above, and will tailor the support for the staff members involved. This may include meeting with particular staff on their own, for example, to ensure that staff are supported in the way that they would like to be. This promotes the trauma-informed approach the Patient Safety Team aim to take.

The Patient Safety Team have developed staff reflection tools to enable them to document a reflection on the incident and use this as part of their personal and professional development and revalidation, should they wish to. The tools are shared with senior staff following an incident, to provide to the staff involved to complete if they feel able to.

The Patient Safety Team are available to answer any questions or provide support to any staff member or team reporting a patient safety incident. There is a Patient Safety Team inbox for staff to use, as well as a page on the Trust's intranet with resources and contact details for the team.

At SCFT we understand the pressures that our staff our under, and we know that when staff feel under pressure, tired and frustrated that this can affect how we work and ultimately the quality and safety of the care and services we are providing to our patients. We understand that being involved in an incident is distressing for staff and that staff wellbeing and patient safety are two sides of the same coin. Therefore, we aim to ensure that staff are supported, listened to and are able to speak up about concerns, and we work closely with our Freedom to Speak Up Guardian to promote and enable this.

6. Freedom to Speak Up Guardian

SCFT has a Freedom to Speak Up Guardian who sits within the Quality and Safety Department. They work closely with the Patient Safety Team, Patient Experience Team, and all teams across the Quality and Safety Department.

Speaking up for staff can involve anything that gets in the way of doing a good job. Raising a concern at work can involve unsafe patient care, dangers to health and safety, unsafe work conditions, a bullying culture, suspicions of theft, fraud or bribery or something just doesn't look or feel right. Speak Up guardians offer a safe confidential space where staff can speak freely and be supported to decide the next best steps for them. The Freedom to Speak Up Guardian at SCFT works within the Trust to improve speaking up and to ensure that lessons are learnt, and things are improved when workers do speak up.

Freedom to Speak Up Ambassadors support the guardian by offering a confidential listening and signposting service, but they do not take on casework. Sometimes they will signpost to services or people within the organisation or to the guardian. SCFT currently has 18 Ambassadors across the trust who work in a variety of clinical and non-clinical roles (including Clinical Nurses, Health Visitors, Administrators, Accountants, Supervisors and IT). They are unpaid volunteers who take on the Ambassador role in addition to their day jobs.

7. Defining our patient safety incident profile

To create SCFT's patient safety incident profile we took a holistic approach when reviewing patient safety data from a wide range of sources. This process was led by the implementation team, supported by internal stakeholders, who were involved with the collating and reviewing of data from their area of work and expertise. This fully collaborative approach was key when establishing our incident profile and creating our PSIRP. The following sections describe the process in more detail.

7.1 Patient safety data review and development of incident profile

A range of patient safety data was reviewed from January 2021 to December 2022. The data reviewed was Trust Wide, as all services across the Trust will be covered in our PSIRP. This included the wide range of different services across our Children's and Specialist Services. The data was taken from the following sources and reviewed by the specialists in each area with the implementation team:

- Patient safety incident data reported on the Trust's online incident reporting system.
- Contributory factors from previous Serious Incidents and investigations.
- Complaints Patient Advice and Liaison Service (PALS) and the Friends and Family Test (FFT).
- Freedom to Speak Up themes reviewed by the Freedom to Speak Up Guardian.
- Claims and inquests data.
- Safeguarding Adults s42 Enquiries.
- A review of Information Governance data and themes.
- Health and Safety data.
- Clinical audit results.
- Staff Survey 2022 results were reviewed by the implementation team.
- Emerging themes from discussions and workshops with stakeholders were identified.

Once this data was reviewed the implementation team created the draft incident profile, and a list of emerging themes and issues. This draft incident profile was shared with the internal stakeholders ahead of a meeting in April 2023, and was subsequently discussed and agreed at this meeting.

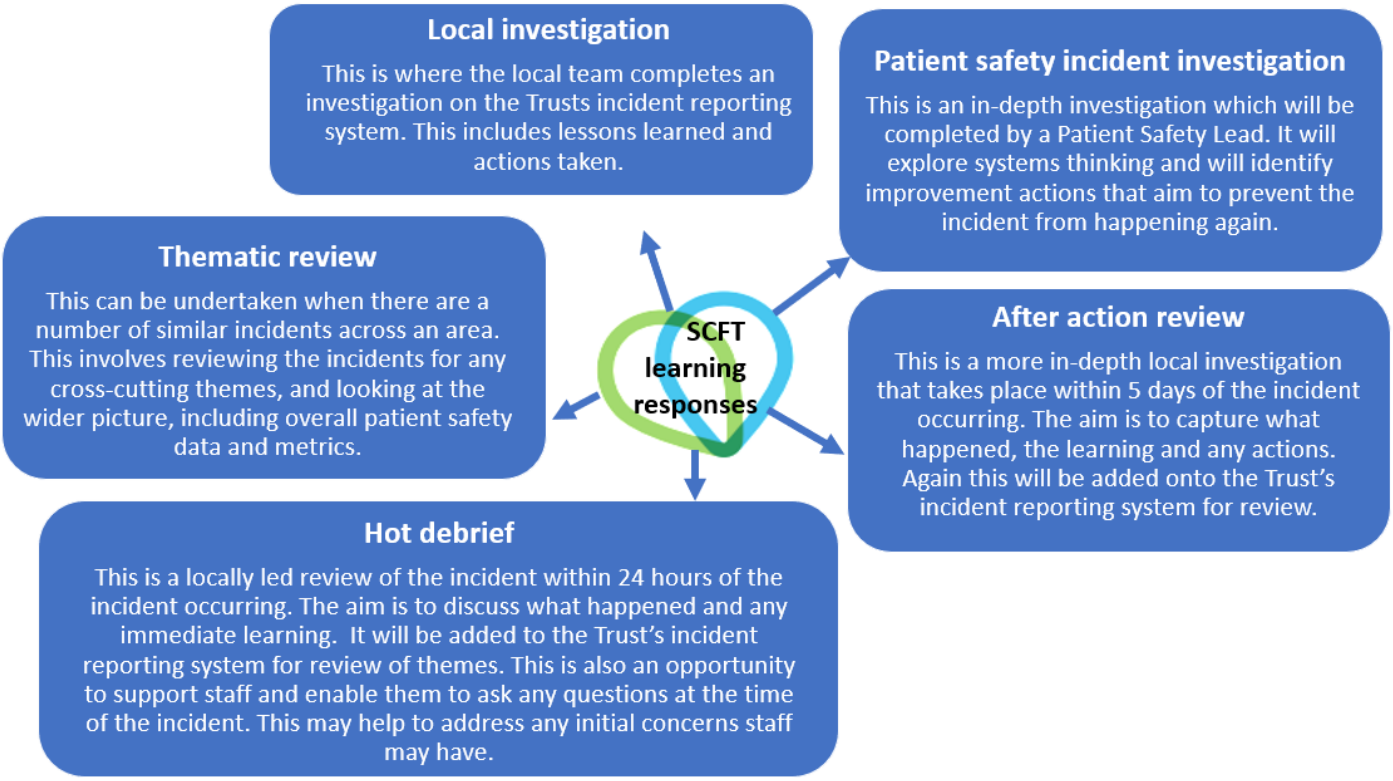
7.2 Our learning responses

Once the incident profile was agreed, the implementation team met with subject matter experts in between April and June 2023 to agree the most effective learning response for each type of incident, any known key themes, and areas for improvement. This included the Trust Wide Falls Lead, Tissue Viability Nurse Specialists, Area Clinical Director for Central and the Deteriorating Patient and Resuscitation Lead, and the Chief Pharmacist and Senior Clinical Pharmacist and Medication Safety Officer.

The proposed learning responses will include a range of different methods, including the following:

- A patient safety incident investigation (PSII)
- An after action review (AAR)
- A thematic review
- A hot debrief.

The diagram below provides further detail on each of the learning responses.



8. Defining our patient safety improvement profile

We have developed and agreed our patient safety improvement profile based on themes identified from the review of the patient safety data with stakeholders, as well as collaborating with a range of subject matter experts and specialist leads and across the Trust to establish areas for improvement within their services. This has ensured that our improvement projects will have an impact on the vast and diverse range of services and health care that SCFT, and the patients/service users/clients who access them.

Current improvement and service transformation work

Our PSIRP includes the following improvement projects and service transformation work, some of which will link in closely with our incident profile below.

Falls within the Intermediate Care Units
This aligns with the Quality Account Priorities for Improvement 2023/24 - we shall continue to improve the assessment and management of patients at risk of falls across all our ICUs.

Community Falls
We will improve:

- the completion of falls risk assessments.
- the completion of lying and standing blood pressure (BP).
- falls prevention planning.
- post falls management.

Pressure ulcers
We will improve:

- the application and completion of mental capacity assessments and working with patients with self-neglect.
- the use of patient choice agreements for patients.
- the completion and application of care plan for carers
- Multi-disciplinary team (MDT) working to support pressure ulcer care.
- wound photography on the Intermediate Care Units (ICUs).
- our reporting of deteriorating pressure ulcers across the Trust.

We will have a strong focus on the aSSKINg (assess risk; skin assessment and skin care; surface; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help). Care bundles in healthcare are a set of three to five evidence-based practices that when performed collectively aim to improve quality of care (Lavallée et al 2017). The use of a care bundle is seen as a potential solution to the underuse of evidence-based practice (Resar et al, 2017). The aSSKINg pressure ulcer prevention framework/ care bundle supports clinicians in the management of patients with or at risk of pressure ulcer/s.

Medication
We will review:
- our end of life medication prescribing.
- missed insulin visits in the community.
- our rheumatology service and the use of high risk drugs.

Deteriorating patient improvement work
- To continue to carry out cardiac arrest scenarios and mock arrests.
- Role allocation at safety huddles.
- To improve National Early Warning Score (NEWS2) recording and response Trust Wide.
- NEWS2 score recording for both Bank/locum nurses and doctors in the Intermediate Care Units.
- To explore the use of prompt cards for procedures or assessments.
- To continue to improve on the management of the deteriorating child.

Nutrition and hydration:
We will continue to develop tools with patients to support their nutritional and hydration status for wellbeing and rehabilitation.

Learning disability and autism:
We will:
- continue to improve the management of patients with a learning disability and/or autism who use our services.
- work more closely with Learning from Lives and Deaths - People with a Learning Disability and autistic people (LeDeR). These reviews look to identify areas of learning and improvement, as well as examples of good practice, in order to develop the services that people with learning disability and/or autism access.
- look to collaborate with the staff neurodiversity network in Sussex Partnership NHS Foundation Trust (SPFT).

Childrens and specialists:
- To aim to reduce the number of incidents relating to Information Governance across these services by continuous review of incidents and current processes.
- The Healthy Child Programme (HCP) to continue to work with our acute partners to work on a system that will reduce the number of missed antenatal visits.

The above improvement work links closely with the Quality Account Priorities for Improvement 2023/24, and we have therefore decided to include what these are within SCFT PSIRP.

The Quality Account Priorities for Improvement 2023/24 are:

- We shall continue to improve the assessment and management of patients at risk of falls across all our ICUs.
- We shall continue to enhance and improve the delivery of community rehabilitation services we offer across West Sussex and Brighton & Hove.
- We shall continue to increase our engagement for Children, young people and carers who access our services; enabling us to improve the delivery of children's services and improve the health and wellbeing of individuals and their families. We shall work with children and young people, with support from their families and carers where necessary, produce a self-management information.
- We will improve communication with people who experience delays or extended waiting times and develop a framework to support people to 'wait well'.
- Through a proactive approach of continuous learning and development staff will have opportunities to develop their skills and confidence in order to deliver improved care for those patients with learning disability and autism.

9. Listening to and responding to staff

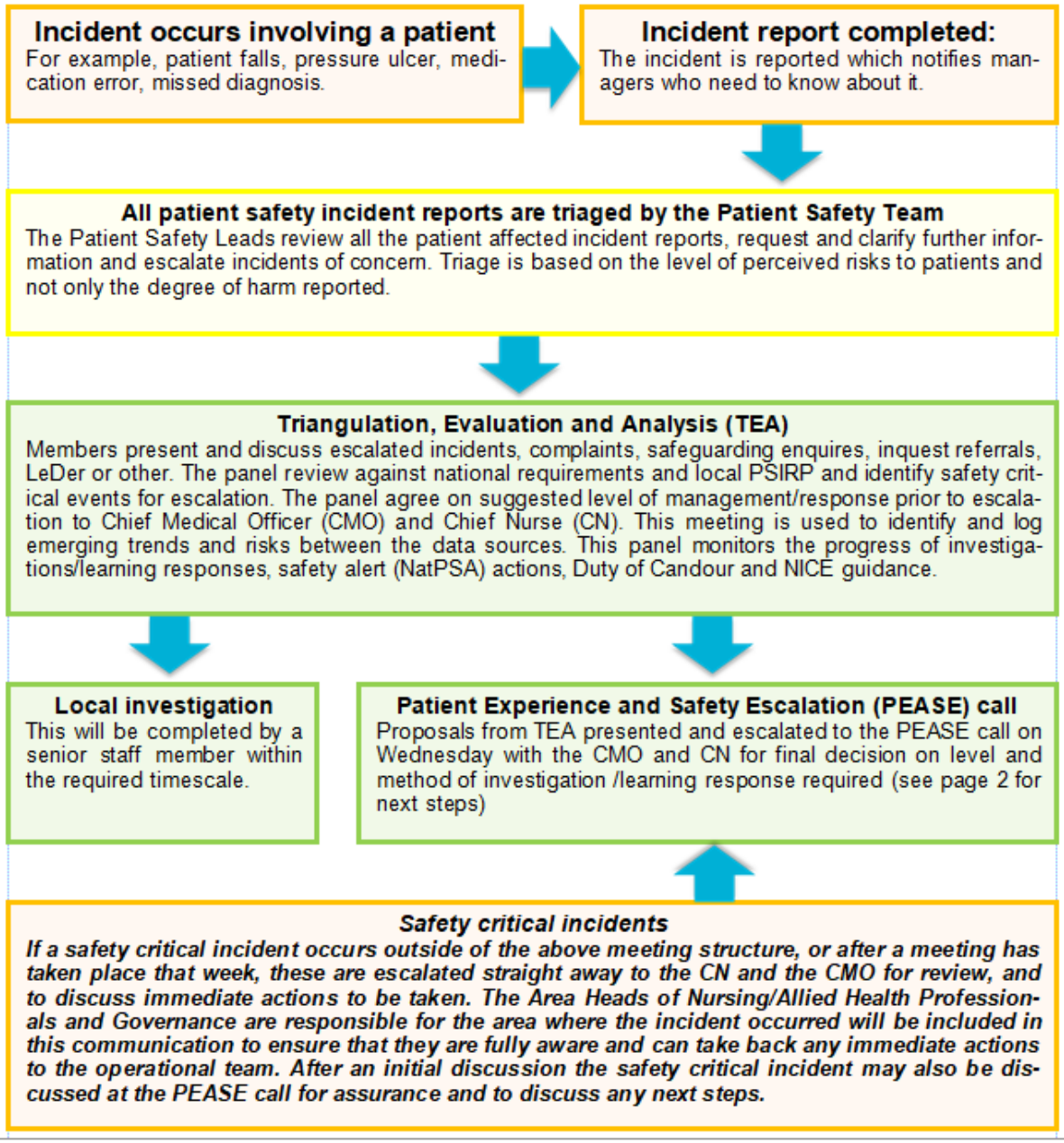
At SCFT it is important that we listen to and respond to staff in all roles, bands, services and teams across the Trust. Staff on the frontline will be most aware of what the work is like on a day to day basis, what works well, what concerns them, and what needs to be improved on. These issues may not have reached the threshold for incidents reporting, and therefore it is vital that we are made aware of them before they could potentially become an incident causing harm to patients or staff.

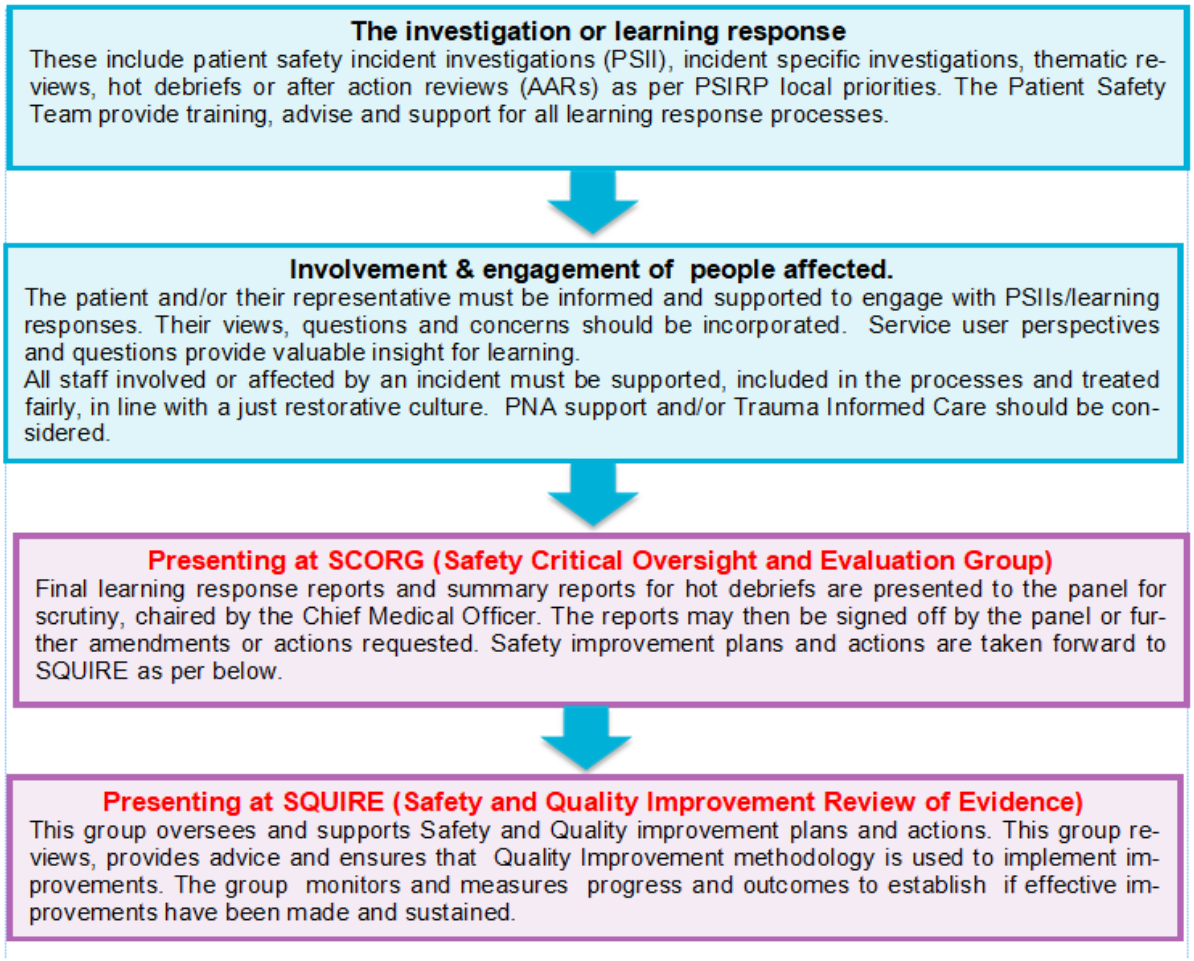
Listening to and responding to the voices of our staff is therefore a key element of our PSIRP, and it will enable us to take a proactive approach rather than a reactive approach. We will aim to achieve this through a number of ways, including a quarterly patient safety online drop in session, patient safety walk abouts, and liaison with the Freedom to Speak Up Guardian. Staff are also encouraged to contact the Patient Safety Team using the team inbox to raise any concerns or to discuss any issues, and we are always happy to listen to staff and take on board what they have to say.

We will acknowledge the issues that staff raise and will commit to responding to their concerns by including these into existing workstreams that can address them or escalating them to relevant senior managers. We will ensure that we monitor and feedback to them what we are doing to facilitate and monitor resolutions. We want to ensure that we hear about and identify emerging issues and manage them early, supporting our aim of a proactive approach.

10. Overview of our incident review process

SCFT has a robust process in place for the reporting, reviewing and escalation of incidents, which is demonstrated in the flow chart below and it is anticipated that on agreement with the ICB, that we will have ICB partner attendance at our Safety Critical Oversight and Review Group and also at our Safety and Quality Improvement Review and Evaluation Group:




The investigation or learning response
These include patient safety incident investigations (PSII), incident specific investigations, thematic reviews, hot debriefs or after action reviews (AARs) as per PSIRP local priorities. The Patient Safety Team provide training, advise and support for all learning response processes.
Involvement & engagement of people affected.
The patient and/or their representative must be informed and supported to engage with PSIIs/learning responses. Their views, questions and concerns should be incorporated. Service user perspectives and questions provide valuable insight for learning.
All staff involved or affected by an incident must be supported, included in the processes and treated fairly, in line with a just restorative culture. PNA support and/or Trauma Informed Care should be considered.
Presenting at SCORG (Safety Critical Oversight and Evaluation Group)
Final learning response reports and summary reports for hot debriefs are presented to the panel for scrutiny, chaired by the Chief Medical Officer. The reports may then be signed off by the panel or further amendments or actions requested. Safety improvement plans and actions are taken forward to SQUIRE as per below.
Presenting at SQUIRE (Safety and Quality Improvement Review of Evidence)
This group oversees and supports Safety and Quality improvement plans and actions. This group reviews, provides advice and ensures that Quality Improvement methodology is used to implement improvements. The group monitors and measures progress and outcomes to establish if effective improvements have been made and sustained.

11. Our patient safety incident response plan: national requirements

There are four patient safety incident types that will be responded to using a particular investigation according to national requirements. These, and their learning response, are outlined in the table below:

Patient safety incident type	Required response
Incidents meeting the Never Events criteria	Patient safety incident investigation
Incidents that result in death thought more likely than not to be due to problems in care	Patient safety incident investigation
Child deaths	Patient safety incident investigation These will also be referred to a Child death overview review panel.
Deaths of people with learning disabilities	Patient safety incident investigation These will also be referred for Learning Disability Mortality Review (LeDeR).

12. How we respond to local incidents

Our PSIRP also allows us to have a local focus for the most common incidents which occur to patients/service users/clients whilst they are under the care of SCFT. This has enabled us to outline how we are going to respond to these incidents to ensure that we carry out a learning response that will promote and support maximum learning through taking a systems approach. The following table lists the top 4 patient safety incidents affecting patients/service users/clients at SCFT, these are pressure ulcers, patient falls, deteriorating patient incidents and medication incidents. The table then outlines the type of learning response SCFT will use to review and investigate the incident.

It is important to note that in addition to the below responses SCFT will also carry out table top discussions/meetings, where the staff involved in the incident meet with the patient safety team, subject matter experts and any other key member of staff. The aim of this is to create a supportive safe space for those involved in the incident. The outcome from the table top

discussion/meeting will then be used to support the learning response chosen to ensure that staff's views and opinions are captured accurately.

Incident type	SCFT Learning response	Further details & improvement route.
Pressure Ulcers	To have a local investigation for all category 2 pressure ulcers reported at SCFT.	For all category 2 pressure ulcers to be managed with a local incident investigation that measures against best practice and policy. This will be completed by the local community team or ward team and recorded in the Trust's incident management system.
	To have an after action review for pressure ulcers developing in the Intermediate Care Units	To carry out an after action review for all pressure ulcers which develop on the Intermediate Care Units. This will be supported by the Tissue Viability Nurse Specialist Service and the Patient Safety Team.
	To carry out a hot debrief investigation for all deterioating pressure ulcers under SCFT.	To carry out a hot debrief into pressure ulcers which have deteriorated under SCFT care.
	Deep dive/thematic review for areas where there has been an upward trend in pressure ulcers (category 2, category 3, unstageable and deep tissue injuries)	When it has been identified that there has been an increase in pressure ulcers (category 2, category 3, unstageable and deep tissue injuries) over a 3 month period, a deep dive/thematic review will be completed by the Patient Safety Team and Tissue Viability Nurse Specialists will provide support for this.
	Pressure ulcer investigation for category 3 pressure ulcers	To carry out a pressure ulcer specific investigation for category 3 pressure ulcers (dependent on the site of the pressure ulcer). This discussion will include the Tissue Viability Nurses.
	Patient safety incident investigations for category 4 pressure ulcers in both community and Intermediate Care Units	For all category 4 pressure ulcers, in both community and Intermediate Care Units the Patient Safety Team will complete the full and in-depth Patient safety incident investigation with involvement and support from a Tissue Viability Nurse Specialist.

Medication	To investigate locally and record findings on the Trust's incident management system.	To record local investigations into insulins errors, anticoagulant errors and end of life care medication incidents on the Trust's incident management system. All these incidents are triaged by Patient Safety Leads, and any incidents of any concern will be escalated to establish whether a higher level of investigation is needed. For example a thematic review around a particular type of incidents in an area
Deteriorating patients	To locally manage and record incidents on the Trust's incident management system for all areas of the Trust.	All deteriorating patient events are reported as part of the Trust guidance. To review these through the triage process by the Patient Safety Team, and review by Deteriorating Patient and Resuscitation Lead and Area Heads of Nursing/AHPs and Governance. This is to identify good practice and any learning. If there are any concerns then these can be escalated for a more detailed review. This will then also be monitored through the Deteriorating Patient & Resuscitation Meeting.
	To share good practice across the Trust.	To share good practice from areas that are doing well in order for this to be shared widely across the Trust and with our regional partners.
	To complete a thematic review for where there are themes or areas that have raised a concern.	To carry out a deep dive/thematic review for any areas where we might want to look in more detail about the management of deteriorating patients. This will be completed by the Patient Safety Team with support from the Deteriorating Patient and Resuscitation Lead.
	Patient safety incident investigation	For incidents where it has been identified that there were gaps in care that contributed to a delay in escalation of the patient, to identify any learning. This will be completed by the Patient Safety Team with support from the Deteriorating Patient and Resuscitation Lead.
Falls	A hot debrief for all inpatient falls on the Intermediate Care Units	For all inpatient falls on the Intermediate Care Units, the ward team will carry out a hot debrief straight after the fall. The ward will complete this on a template within 24 hours and this can be incorporated into the Trust's incident management system. If the hot debrief information indicates emerging/repeating trends/themes these will be discussed with the Trust Wide Falls Lead for guided decision making for further learning response, for example a thematic review or clinical audit.
	After action reviews for falls on the	All repeat falls and those falls that have resulted in significant (moderate/severe/fatal) harm for the patient should have an after action review within 5 days of the

	Intermediate Care Units	fall, and be incorporated into the Trust's incident management system. All after action reviews will then be reviewed by the Trust Wide Falls Lead, Patient Safety Team and the Area Heads of Nursing and AHPs at Mondays TEA meeting and escalated to Wednesdays PEASE call if it is agreed that a Patient safety incident investigation is required.
	Hot debrief for community patient falls	To carry out a hot debrief for all community falls which result in a confirmed or suspected fracture, or a fall where the patient has been conveyed to hospital - whether or not the patient was with a member of staff at the time, or when the patient was not with a member of staff. To be completed within 72 hours of the fall occurring or being reported by the patient. To be completed with members of the team who know the patient well. To also be used to capture good practice as part of the hot debrief (what has been done for the patient). To be incorporated into the Trust's incident reporting system.

The adults or children who are involved in these incidents, may be frail, at the end of their life, have dementia or have complex needs. The Patient Safety Team will liaise with the subject matter experts to support the investigations and ensure that their expertise is included. This may include the Consultant Nurse for Children's Community Nursing & Complex Care, Nurse Consultant Palliative & End of Life Care, lead for Frailty and Nurse Consultant Dementia/Delirium & Teaching Fellow.

13. Health inequalities

At SCFT we will ensure that as part of our learning responses we will be asking the question about any discrimination or health inequality for both patients affected by the incident and the staff involved. We want to ensure that there were no adverse outcomes to either patients or staff due to their protected characteristics. When reporting an incident on the Trust's reporting system staff must enter the following details about a patient: Gender (and if this is different to the sex that they were assigned at birth), ethnicity, disabilities, religion and sexual orientation. We have also added an option to select whether the patient has a Learning Disability or Autism, and we are able to pull out and monitor data on this option to understand the number of incidents which occur for patients with a Learning Disability and/or Autism. We will also work closely with Learning Disability Mortality Review (LeDeR), when this arises, and can look to use the learning from the learning from the National LeDeR Audit.

14. Ensuring improvement

At SCFT there is a clear process in place for the review of learning responses, to ensure that investigations are robust and any learning and improvements are progressed and monitored.

The Safety Critical Oversight Review Group (SCORG) is a monthly meeting to review all Patient Safety Incident Investigations and Patient Safety Learning Responses, which will be chaired by the Chief Medical Officer (CMO). ICB partners and patient representation will be invited to this group. The aim of this meeting is to establish whether the investigation or learning response undertaken has been effective and proportionate and has identified improvement actions to address any patient safety or quality risks. It will ensure that there is a provisional agreement on how the improvements identified will be carried out using a QI methodology. Once agreed, the group will sign off the response and monitor improvement actions through the Safety and Quality Improvement Review of Evidence group.

The Safety and Quality Improvement Review of Evidence (SQUIRE) group sits alongside SCORG, and is chaired by the Associate Director of Quality and Safety and/or the Associate Director of Quality Improvement, with the Patient Safety Team supporting. ICB partners and patient representation will be invited to this group to provide their valuable insights and support. The aim of the meeting is to monitor the progress and effectiveness of improvement actions to ensure that the right processes are taken for the action and ensure that it follows QI methodology. This might for example include a clinical audit, or a Quality Improvement Project. Each meeting will first focus on any new actions and deciding on the right next steps, and following this will review existing actions and monitor the progress of any improvements. The group will also include subject matter experts for specialist advice and guidance.

In addition NHS Sussex will be involved in and review, from an improvement opportunities lens, a minimum of two learning responses per financial year. The learning response will be selected by the provider and can range from an After Action Review, thematic review or Patient Safety Incident Investigation. This will enable the ICB to fulfil its oversight and assurance function and support in reviewing the process and learning. This will also facilitate the sharing of learning across Sussex as well as regionally and nationally via NHS England.

The SCFT PSIRP will also be reviewed with NHS Sussex monthly for the first six months of implementation using a “plan, study, do, act (PDSA) approach” to understand any changes that may be required, learning identified and improvements to be realised. The SCFT PSIRP will be reviewed with the ICB quarterly thereafter.

15. Consultation and approval

The SCFT Patient Safety Incident Response Plan has been written in consultation with our stakeholders involved with the implementation of PSIRF. This includes the Area Heads of Nursing and Governance, the Area Head of Allied Health Professionals and Governance, the Patient Experience Team, the Quality Development Team, the Freedom to Speak up Guardian, the Claims and Inquests Senior Advisor, Head of Safeguarding, Named Nurse: Adult

Safeguarding, Named Nurse: Children's Safeguarding and the Associate Director of Quality Improvement.

This plan has been approved by Trust Wide Governance Group on 04/07/2023. Following this it was reviewed by the Quality Improvement Committee on 20/07/2023 and it was then approved at Executive Management Group 26/07/2023.

The plan will be reviewed at least every 12 to 18 months by Patient Safety Manager and the Patient Safety, and approved by The Trust Wide Governance Group.

16. Sharing the plan

The SCFT PSIRP will be published on the Trust's internal staff website on the service specific intranet page of Patient Safety. A quick guide will also be developed to be shared with staff.

A link to the PSIRP will also be shared via the external Trust website, alongside the SCFT Patient Safety Incident Response Policy. SCFT offers translations of all essential leaflets for patients in all major languages, plus Braille, easy read, large print, and audio formats.

17. Appendices

Appendix A - Definitions

Term (abbreviations included)	Definition/meaning
Category 2 pressure ulcer	A pressure ulcer where there is partial thickness skin loss.
Category 3 pressure ulcer	A pressure ulcer where there is full thickness skin loss.
Category 4 pressure ulcer	A pressure ulcer where there is full thickness tissue loss.
Deep tissue injury (DTI)	Where there is damage to underlying tissue, but the depth is unknown.
Duty of candour (DOC)	Duty of Candour is a requirement for when moderate, severe or fatal harm has occurred, following an incident, and or the patient/service user/client has prolonged pain and/or prolonged psychological harm. This is a legal duty and follows a defined process laid down in regulation 20 of The Health and Social Care Act 2008.
Friends and Family Test (FFT)	A quick and simple survey to complete about the care your family has received in a hospital, outpatient or healthcare setting.
Integrated Care Board (ICB)	An NHS organisation which oversees and is responsible for healthcare across a local area. They manage the budget and ensures a clear plan about how this healthcare is going to be delivered.
Intermediate Care Unit (ICU)	An inpatient rehabilitation unit run by SCFT.
Learning Disability Mortality Review(LeDeR).	*"Learning from Lives and Deaths - People with a Learning Disability and autistic people (LeDeR).* *Research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. We want to change this. LeDeR reviews deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability and autistic people"* Taken from NHS website here.

National Patient Safety Strategy 2019	*"The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems."* Taken from NHS website here.
Patient Advice and Liaison Service (PALs)	*"The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers."* Taken from NHS website here.
Patient Safety Incident Response Framework (PSIRF)	*"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."* Taken from NHS website here.
Quality improvement (QI)	A particular method of carrying out an improvement in a service or area.
Stakeholders	There are key people we have worked with in put together this PSIRP. They came from a range of different roles and areas across the Trust, and have enabled us to ensure engagement with a wide range of people.
Subject matter experts	These are people who are experts in a specific area, and so they have provided key expertise advise when putting together this PSIRP. Examples include the Trust Wide Falls Lead and Tissue Viability Specialist Nurses.
Trust Wide governance Group (TWGG)	A monthly governance meeting where several aspects of governance are reviewed, including reports and policies to gain assurance.
Unstageable pressure ulcer	A pressure ulcer where the category cannot be confirmed. This is usually because the wound is covered in a layer of dead tissue or slough.

Appendix B – Useful links

Care Quality Commission (2022) *Key questions and quality statements.* Available here: https://www.cqc.org.uk/about-us/how-we-will-regulate/five-key-questions-and-quality-statements

NHS England. 2017. *NHS England Patient and Public Voice Partners Policy.* Available here: https://www.england.nhs.uk/wp-content/uploads/2017/08/patient-and-public-voice-partners-policy-july-2017.pdf

NHS England and NHS Improvement. 2021. *Framework for involving patients in patient safety.* Available here: *https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-framework-for-involving-patients-in-patient-safety.pdf*

NHS England and NHS Improvement. 2021. Framework for involving patients in patient safety, Summary. Available here: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-summary-framework-for-involving-patients-in-patient-safety.pdf

NHS England and NHS Improvement. 2019. *The NHS Patient Safety Strategy.* Available here: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

SCFT. *Our vision, values and goals.* Available here: https://thepulse.intranet.scft.nhs.uk/our-trust/our-strategy-top/our-vision-values-and-goals

Appendix C – Equality and Human Rights Analysis (EHRA)

Title(s): SCFT Patient Safety Incident Response Plan

Aims: To provide clear guidance to staff on the Patient Safety Incident Response Framework, and how Trust processes will ensure that the standards within PSIRF are followed. It provides an overview of the process form incident reporting, to completing a learning response to monitoring the patient safety actions.

Evidence

Please summarise any evidence about how the work may impact people either positively or negatively specifically linked to their characteristics. E.g. performance or survey data; focus groups; PALS; incident reviews; NICE guidance; research; good practice; demographic data. Mark an 'X' in the columns for as many characteristics as are relevant.	Mark 'X' relevant characteristics								
	Age	Disability and Carers	Race	Religion or Belief	Sex	Pregnancy or Maternity	Gender Reassignment	Sexual Orientation	Other (e.g. Armed Forces)
Positive impacts:	X	X	X	X	X	X	X	X	
Negative impacts:									

Equality Analysis

Please evaluate how the work may impact people with protected characteristics to meet the three aims (A-C) below, referencing any evidence identified above. If an aim is not relevant to your work, please explain why.

Aim A. Eliminate discrimination – Please evidence if the work could unlawfully discriminate.

Include who is discriminated (e.g. disabled adults) and how. Include detailed reasons if it is lawful.

This plan aims to ensure that health inequalities are reviewed and considered as part of patient safety incident reporting and the completion of learning responses. The Trust's online reporting system currently asks for some patient demographics to be inputted at the time of the reporting, however not all protected characteristics. However this should be reviewed as part of the learning response.

Aim B. Advance equality of opportunity – Please evidence if the work:

Minimises disadvantage – Does the work address any poorer outcomes for particular protected groups?

Meets different needs – Does the work meet different protected groups' social, cultural or other needs?

Encourages participation – Does the work target under-represented groups to increase involvement?

SCFT will ask about any discrimination or health inequality for both patients affected by the incident and the staff involved when carrying out learning responses. This is to confirm there were no adverse outcomes to either patients or staff due to their protected characteristics, and if there were put plans in place to address this.

When working with patients and staff involved in patient safety incidents their protected characteristics will be taken into account.

Although SCFT will aim to ensure patient involvement in a learning response, it acknowledges that this may not always be straightforward if the patient themselves is unable to be involved in the investigation. In this case the effort will be made to contact their NOK or best representative.

Aim C. Foster good relations – Please evidence if the work:

Tackles prejudice – Does the work increase contact between groups to reduce negative attitudes?

Promotes understanding – Does the work educate people about groups to change negative attitudes?

Yes – this policy supports contact with both patients and staff as part of a patient safety incident learning response.

Human Rights Analysis

Mark 'X' against the relevant rights which are safeguarded (+), or breached (−) by the work:	+	−
Article 2. Right to life (e.g. The Deteriorating Patient policy, DNACPR or Clinical competencies)	X	
Article 3. Prohibition of torture, inhuman or degrading treatment (e.g. Consent or Safeguarding)	X	
Article 5. Right to liberty and security (e.g. Deprivation of Liberty or Restrictive Interventions)	X	
Article 8. Right to respect for private and family life, home and correspondence (e.g. Confidentiality, health records, carer involvement, correspondence or staff leave)	X	
Article 9. Freedom of thought, conscience and religion (e.g. End of Life Care or Prescribing)	X	
Article 10. Freedom of expression (e.g. Patient information or Raising Concerns policy)	X	
Article 12. Right to marry and found a family (e.g. Pregnancy testing procedure)	X	

Monitoring

Please describe how any impacts will be monitored: (e.g. annual policy review, audit, performance metric).

The plan will be reviewed every 12 to 18 months, by the Patient Safety Manager and the Trust Wide Governance Group.

Outcome

Choose the final outcome(s) a-d of the analysis with an 'X' and explain the reasons in the space below:

X	(a)	Continue the work	The work in this policy can be carried out.

☐	(b) Change the work	
☐	(c) Justify and continue the work	
☐	(d) Stop the work	

Please score any risks to equality or human rights below and update your risk register:

Consequence score:	1	x	Likelihood score:	1	=	Equality and Human Rights Risk Score:	1

Assurance Statement: I have reviewed the evidence with rigour and an open-mind and am satisfied there has been due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations, and there is compliance with Section 149 of the Equality Act 2010.

Analysis Lead(s) names: Charlotte Pearce and Deborah Johnson		Date: 03/08/2023
Ratifying committee / body: Executive Management Group		Date: 16/08/2023
Reviewer (office use):	Decision:	Date:

Improvement Plan

Description of actions	Date	Person	How will this be delivered?
Add more rows if necessary			

Send this form along with your main paperwork for consultation to sc-tr.equality@nhs.net