Blackpool Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

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Name	**Designation**	**Date Response Received**
Louise Cheung	Deputy Director of Quality Governance	02/11/2023
	Integrated Care Board Quality Committee	18/10/2023

Foreword

The Patient Safety Incident Response Framework (PSIRF (1)) 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. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different, instead it's a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence. This new approach:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the strategy, including the introduction of patient safety specialists, development of a national patient safety syllabus, development of the involving patients in patient safety framework and introduction of the Learn from Patient Safety Events service. The NHS Patient Safety Strategy (2) sits alongside and supports the NHS Long Term Plan.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that it will take time to fully embed this new approach, and so we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff.

Our implementation date for transition to the PSIRF is 1 November 2023. From this date, any new patient safety incident reported will be managed through the processes outlined within the Trust's new Patient Safety Incident Response Policy, meeting the PSIRF requirements. Ongoing Investigations not yet completed by this date, will progress to completion under the Trust's Management of Incidents, Incorporating Serious Incidents Policy, meeting the requirements of the previous Serious Incident Framework (2015).

CONTENTS

1 Introduction / Purpose

This patient safety incident response plan sets out how Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT) intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan will be underpinned by our new Trust Patient Safety Incident Response Policy, which replaces the previous Management of Incidents, Incorporating Serious Incidents Policy; and the Trust's Being Open and Duty of Candour Policy.

A glossary of terms used can be found below in Section 3.

2 General Principles / Target Audience

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

Responses under this plan follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There are processes which sit outside the scope of a Patient Safety Incident as the focus of the investigations are different in principle from that of a PSI response. It is not the purpose of a PSI response to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Processes that sit outside the scope of a PSI are as follows:

- Claims.
- Human Resources investigations into employment concerns.
- Professional standards investigations.
- Coronial inquests.
- Criminal investigations.

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this plan.

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 Definitions and Abbreviations

AIR – After Incident Review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

BTHFT Blackpool Teaching Hospitals NHS Foundation Trust

CQC Care Quality Commission

COAST – a ward-based accreditation scheme.

DNACPR Do Not Attempt Cardiopulmonary Resuscitation

FGM Female genital mutilation

GIRFT Get It Right First Time

ICB Integrated Care Board

IOPC Independent Office for Police Conduct

LeDeR – Learning from Deaths Review

LeDeR is a service improvement programme for people with a learning disability and autistic people, funded by NHS England. There are several different review processes for people who die, for example: child death review, safeguarding adults' review and review of deaths of people in hospital.

MDT Multi-disciplinary Team

Never Event Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers (3).
Error! Hyperlink reference not valid.NHS England » Revised Never Events policy and framework

PPO Prison and Probation Ombudsman

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned 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 including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors effectively and sustainably, and help deliver safer care for our patients.

PSA – Patient Safety audit
A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline).

PSR – Patient Safety Review

Patient Safety Reviews are rapid reviews undertaken as soon as possible after the reporting of a patient safety incident, and provide initial information around the incident, level of harm, immediate actions to be taken and initial learning. Patient Safety Reviews are used by the Trust to help determine the level investigation required.

QI Quality Improvement

RIIT Regional Independent Investigation Team

SIF Serious Incident Framework

SJR - Structured Judgement Review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SMART SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows:

S- Specific – a goal should not be too broad but target a specific area for improvement.

M- Measurable a goal should include some indicator of how progress can be shown to have been made.

A- Achievable a goal should be able to be achieved within the available resources including any potential development needed.

R- Relevant – a goal should be relevant to the nature of the issue for improvement.

T-Time-related a goal should specify when a result should be achieved, or targets might slip.

SQAS Screening Quality Assurance Service

SWARM Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

VTE – **Venous thromboembolism** – a term referring to blood clots in the veins.

4 Our Services

The Trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria, supporting a population of 1.6 million. The Trust is a provider of specialist tertiary care for Cardiac and Haematology services across this region.

The Trust provides a range of acute services to the 352,000 population of the Fylde coast health economy and the estimated 18 million visitors to the seaside town of Blackpool. Since April 1, 2012, the Trust also provides a wide range of community health services to the 445,000 residents of Blackpool, Fylde, Wyre and North Lancashire.

The Trust also hosts the National Artificial Eye Service, which provides services across England.

The Emergency Department (ED) at Blackpool Victoria Hospital is open 24 hours a day, seven days a week to treat emergency and life-threatening conditions. Work on our new Emergency Village and Critical Care scheme is progressing and is due to be completed by December 2023. The Trust's new Critical Care Unit has now opened, along with the new Same Day Emergency Care Unit (SDEC), which opened in September 2022. This is a new facility benefitting both patients and the healthcare system by reducing waiting times and hospital visits.

The Trust has taken a ground-breaking approach to Same Day Emergency Care by being the first hospital that has brought both Medical and Specialty teams together under one roof. This enables a collaborative multi-disciplinary focus to patient care and widens the range of conditions which might normally have ended up waiting long hours in an Emergency Department waiting room.

The Trust services are provided from the following main sites:

- Blackpool Victoria Hospital
- Clifton Hospital
- Fleetwood Hospital
- Whitegate Health Centre
- Lytham Road Primary Care Centre

- South Shore Primary Care Centre
- Fleetwood Primary Care Centre
- Moor Park Health and Leisure Centre
- National Artificial Eye Service

Our Community services are provided across the Blackpool, Fylde, Wyre and North Lancashire area, including sites in Blackpool, Ansdell, Cleveleys, Freckleton, Garstang, Kirkham, Lytham, Poulton, St Annes, South Shore, Thornton, Accrington, Burnley, Colne, Preston, Lancaster, Skelmersdale and Morecambe.

4.1 Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years. We have regular executive director-led safety forums and committees, divisional governance and safety meetings, safety huddles, a twice weekly Rapid Review Panel and our Serious Incident Safety Panels, which provide oversight of the Trust's serious incident investigation process. With the implementation of PSIRF, the Serious Incident Safety Panels will be adapted to incorporate the need to review and approve Patient Safety Incident Investigations.

Quality Improvement methods help us to deliver our mission, to deliver safe, effective, sustainable care for everyone, every day. We do this through a targeted portfolio of safety improvement programmes, which the Trust believes have a significant impact on unintentional patient harm and mortality. The aims of the initiatives are all strongly linked to the Care Quality Commission (CQC) fundamental standards.

In 2019 the Trust implemented a Quality Improvement (QI) strategy (2019-22). The Trust has now launched a new strategy and our priorities have been refreshed in line with our high level aims to reduce preventable deaths, reduce avoidable harm and to improve the last 1,000 days of life.

In 2022, following an important period of engagement with colleagues, partners and stakeholders, we were excited to launch our new Trust five-year strategy for 2022-2027 (4), which set out the critical themes and objectives we will achieve. From this, we developed our quality objectives for 2023/24 which continue the important work progressed the previous year.

The PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement, apart from the national requirements listed on pages 15-17.

To fully implement the Framework the Trust has completed a review of what types of patient safety incidents occur to understand what needs to be learned to improve care and services.

4.2 Stakeholder Engagement

The Trust has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on page 18.

We commenced planning for the implementation of PSIRF in accordance with national timeframes in September 2022. We have consulted extensively with local PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF and their assistance has been invaluable.

We are conscious that the PSIRF requires a very different approach to the oversight of patient safety incidents and that engagement with both our internal and external key stakeholders was an important priority. This was carried out with the understanding that early engagement due to the changing nature of responsibilities within the PSIRF was essential and that we needed to work collaboratively on this.

Internally, a series of resources were made available to staff to promote awareness of the main differences between the current SI framework and PSIRF. These were made available via the Trust's intranet and via the Executive Team Brief.

The Trust undertook a number of data review exercises in which the Trust's key quality governance and safety data was reviewed to determine a long list of potential local priorities for the Trust to adopt under PSIRF and investigated as Patient Safety Incident Investigations using the SEIPS model.

A series of engagement and project meetings have been held since September 2022 onwards with key stakeholders from various disciplines to outline the impact PSIRF might have and to begin to explore the nature of incidents reported, what processes are in place to currently manage and review these and what such reviews might look like under PSIRF.

We also undertook a resource analysis exercise using our own Patient Incident and Risk team data, which was used to support the identification and proposal of the Trust's Learning Response approach and was invaluable for understanding our current resource and capacity for responding to patient safety incidents. Further details of this are provided in the Patient Safety Incident Investigations policy document.

Once the data was collated, a series of engagement meetings were held with our key internal and external stakeholders to review this together to finalise our local focus and priorities for review by PSII. We also utilised the Trust's weekly PSIRF Project Management Meeting with key members of staff to identify our approach to other patient safety incidents requiring a response. The weekly PSIRF Project Management Meeting has included presentations and group work to enable co-working on the development of our safety profile and response planning.

Engagement meetings have also been held with our local Integrated Care Board (ICB) colleagues, to share our safety priorities prior to sign off. The sign off of these priorities

has been through our Clinical Governance and Quality Assurance Committees and our Trust Board.

The key stakeholders the Trust has consulted with are as follows:

- Executive and Non-Executive Directors
- Divisional Directors
- Divisional Matrons, Managers and Operational Staff
- Ward staff
- ICB
- Patient Safety Representatives – via the Trust's Influence Panel
- Healthwatch Lancashire
- Maternity Neonatal Voices Partnership

4.3 Data Sources

To define our patient safety response profile, data review exercises of the Trust's safety data were completed in early 2023 and included a quantitative analysis of the Trust's governance data over the last 5 years which included:

- Patient Safety Incidents
- Complaints
- Mortality Data
- Audits
- Claims
- Clinical pathway data

The review also incorporated a qualitative analysis of thematic information from:

- Serious Incidents
- Incidents
- Complaints
- National patient survey data
- Freedom to speak up concerns
- CQC action plan responses
- Trust risk profile

We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process.

Where possible, the Trust has considered what elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered new and emergent risks relating to future service changes and changes in demand that the historical data did not reveal.

5 Defining our patient safety improvement profile

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The Clinical Governance Committee, Quality Assurance Committee and Trust Board will oversee assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard.

Our clinical and corporate divisions are required to report through Divisional Board meetings in order to monitor and measure improvement activity across the organisation. This includes review of progress against our overarching priorities and goals as defined by our quality strategy. This group will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil SMART requirements and are sufficient to allow the Trust to improve patient safety in the future.

The Trust's new Quality Improvement Enabling Plan is being launched in 2023 and our high-level aim is to:

5.1 Deliver safe, effective, sustainable care for everyone, every day.

This will be delivered through the following goals:

- Building quality improvement capability, so that our staff have the skills to do their job and improve their job, without being afraid to fail.
- Working collaboratively with patients and local partners to improve services, reduce health inequalities, to keep people out of hospital and in the place they live for longer.
- Delivering the best possible safety, environment and financial outcomes through a targeted portfolio of improvement programmes.

Goal 1 – By 2027, the majority of our staff will have quality improvement awareness, ability or expertise, depending on the needs of the individual and their role.

Goal 2 – Reducing avoidable harm through our Improving Fundamentals of Care Improvement Programme:

- Eliminate avoidable harms.
- Improve our safety culture.
- Ensure our COAST framework has been delivered in every area of the Trust and improvements made to our baseline.

Goal 3 – Reducing preventable deaths through the Acutely Unwell Patient Collaborative:

Cardiac arrests and in-hospital medical emergencies are often preceded by a period of physiological deterioration during the previous 24-hour period, which is sometimes unrecognised. Early detection, escalation of deterioration and early interventions to prevent further deterioration and cardiac arrests are essential to ensure that effective, quality care is provided. To achieve this, the project will focus on three primary areas:

- Accurate assessment and monitoring
- Reliable recognition, response and escalation
- Culture of safety and continuous improvement

Goal 4 – Improving the Last 1000 Days of Life

Working in partnership with care homes, their residents and other system partners, the Trust is taking a collaborative approach to help keep more residents safe from harm and out of hospital. Our vision is to spread the learning across our whole system, working with our system partners and population to ensure people can stay in the place they love for longer.

Since 2020, the Quality Improvement (QI) journey at the Trust has been substantial. In a short space of time, large-scale change programmes that have already shown sustained reductions in harm. There have been training programmes that provide our staff with the education they need to “do the job and improve the job.” As a Trust, we are devoted to the continual improvement of the health of our people, to support them when they need us.

We believe it is the duty of everyone who works in the Trust to be involved in QI and make changes that will lead to better patient outcomes, better system performance, better patient experience and better professional development for our staff. We will pay careful attention to the different data sources, our incidents, complaints and local data to make sure we focus our improvement efforts in the right place to improve quality and safety.

This QI plan takes recommendations from the new NHS England Delivery and Continuous Improvement Review which helps us to think about how we can learn and embed an improvement approach, build clinical leadership and address unwarranted variation in care.

In our new QI strategy, currently in development, the Trust agreed an objective to reduce avoidable harm events and improve patient experience and therefore, in terms of the

specific priorities for Quality Improvement we have decided to continue our ongoing programmes of work and will continue to work on the Quality Improvement objectives previously agreed, which are:

- Reduction in pressure ulcers
- Improving the identification and management of the deteriorating patient
- Reducing fractured neck of femurs (in partnership with local care homes)

We will oversee the work on these QI priorities through our Quality Assurance Committee and will report regularly to our Board of Directors and our Council of Governors on our progress.

In addition to the above objectives, we will also continue with the following QI programmes:

- implementing all actions aligned to Better Births, the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust and the continuity of care model for maternity services.
- putting quality accreditations in place across all wards and services, with key action plans to address any concerns.
- ensuring Getting It Right First Time (GIRFT (5)) plans are in place for all identified specialties and included in regular performance reporting.

We plan to focus our efforts on the development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

6 Our patient safety incident response plan: national requirements

The Trust does not have infinite resources for patient safety incident responses, so we intend to use those resources to maximise improvement. The PSIRF allows us to do this rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths, thought more likely than not to be due to problems in care, will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below.

6.1 National Requirements for PSII

Patient safety incident type	Required response	Anticipated improvement route
Incidents that meet the criteria set in the Never Events list 2018 (3)	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Maternity and neonatal incidents meeting HSIB criteria.	Refer to Healthcare Safety Investigation Branch (HSIB) for independent PSII	Respond to recommendations as required and feed actions into the quality improvement strategy.
Child deaths	Refer for Child Death Overview Panel review (6). Locally led PSII (or other response may be required alongside the Panel review.	Respond to recommendations as required and feed actions into the quality improvement strategy.

Patient safety incident type	Required response	Anticipated improvement route
Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or victim of wilful neglect or domestic abuse / violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority, The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery and human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent enquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy.
Incidents in screening programmes	Refer to local Screening Quality Assurance Service (SQAS) for consideration of locally led learning response.	Respond to recommendations as required and feed actions into the quality improvement strategy.
Deaths in custody (e.g., police custody, in prison etc.) where health provision is delivered by the NHS.	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC). Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy.
Deaths of patients detained under the Mental Health Act (1983 (7)), or where the Mental Capacity Act (2005 (8)) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria).	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy

Patient safety incident type	Required response	Anticipated improvement route
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII may be required.	Respond to recommendations as required and feed actions into the quality improvement strategy.
Deaths of patients detained under the Mental Health Act (1983 (7)) or where the Mental Capacity Act (2005 (8)) applies, where there is reason to think that the death may be linked to problems in care.	Locally led PSII	Create locally led recommendations and actions as required and feed actions into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) May require locally led PSII (or other response) alongside the Panel review.	Respond to recommendations as required and feed actions into the quality improvement strategy

7 Our patient safety incident response plan: local focus

The PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and engagement meetings and workshops we have determined that the Trust requires 3 patient safety priorities as local focus. We have selected this number due to the breadth of services that the Trust provides and the shared learning from early adopters of PSIRF.

We will use the outcomes of PSII to inform our patient safety improvement planning and quality improvement work.

This was agreed at the Quality Assurance Committee meeting in August 2023 and was approved by the Trust Board in September 2023.

No.	Patient safety incident type or issue	Description	Response type
1.	Deteriorating Patient	Serious harm occurs to a patient as a result of a failure to recognise or act when a patient deteriorates.	PSII
2.	Cancer pathways	Serious harm occurs as a result of diagnostic delays, delays in MDT action, lack of pathway navigation within a cancer pathway.	PSII
3.	Delays in Treatment	Serious harm occurs due to delays in referral, diagnosis, treatment or follow up	PSII

8 Other Considerations

It was also identified through our data review exercise, that there were a number of themes that required further focus in terms of improvement work; however, it was felt that a PSII would be the wrong approach to identify learning and improvement.

These were as follows:

No.	Patient safety incident type or issue	Description	Response type
1	Pressure Ulcers	Pressure ulcers developed in our care – category 2 – 4..	PSR (Cat 2 and 3) AIR (Cat 4)
2	Falls	Inpatient falls resulting in a bone fracture or haemorrhage.	PSR Debrief and AIR
3	DNACPR	Poor communication with families around DNACPR decision making.	PSR PSA
4	Medication errors	Medication errors involving opioids management, gentamycin / vancomycin, medication patches, Diabetes medicines management, thromboprophylaxis etc.	PSR / AIR PSA / Thematic review

No.	Patient safety incident type or issue	Description	Response type
5	Documentation	Documentation errors leading to harm or the potential for harm.	PSR PSA / Thematic review
6	Advanced Care Planning	Failed opportunities for advanced care planning leading to harm or the potential for harm.	PSR PSA / AIR
7	Acute Pathways	Failure to follow in-patient clinical pathways leading to harm or the potential for harm.	PSA / AIR

Where an incident does not fall into any of the categories for a PSII, an investigation and/or review method described above may be used by the local team **except** PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

Local methods and investigation tools such as Patient Safety Reviews (PSRs), SWARM approach, After Incident Reviews (AIRs), Patient Safety Audit (PSA) or Thematic / cluster reviews, the national PMRT and SJR tools and/or structured local proformas may be used.

The completion of a narrative response on the Ulysses Safeguard incident module is also appropriate.

9 References and Associated Documents

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7. **Crown.** Mental Health Act 1983. [Online] 1983. [Cited: 15 09 2023.] http://www.legislation.gov.uk/ukpga/1983/20/contents.

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9. **HSIB.** Healthcare Safety Investigation Branch. [Online] [Cited: 15 09 2023.] https://www.hsib.org.uk/.

Appendix 1: Equality Impact Assessment Form

Department	Quality Governance	Service or Policy	CORP/PLAN/047	Date Completed:	02/11/2023

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	RESPONSE		IMPACT	
	Issue	Action	Positive	Negative
What is the service, leaflet or plan development? What are its aims, who are the target audience?	This plan details the Trust's process for the reporting of and investigation of all untoward incidents and serious incidents occurring within the Trust, under the new PSIRF Framework.		Yes – compliance with this plan will ensure the reporting and investigation of all untoward incidents and the sharing of learning from these safety events.	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	The plan is relevant to the safety of all in-patients, community patients and staff.		Yes	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No, this plan should ensure a positive impact across all groups of staff and patients.		Yes	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No		Yes	
How does the service, leaflet or policy/ development promote equality and diversity?	The plan defines the standardised process and approach to be followed in the event of an untoward incident.		Yes	
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The plan includes a completed EA which provides the opportunity to highlight any potential for a negative/adverse impact.		Yes	
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.		Yes	
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	No	N/A	N/A	
Does the service, leaflet or policy/ development promote equity of lifelong learning?	No	N.A	N/A	
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	The procedure identifies the process in relation to reporting, investigating and learning from incidents which occur within the Trust which will result in improving the safety of our patients and staff.	Persons working within the Trust are provided with adequate training in order to ensure understanding of the process to be followed.	Yes	
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	No	N/A	N/A	

Appendix 1: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	This plan will have an impact on all members of staff working in the Trust and patients in their care.		Yes	
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	The plan promotes access to information for all members of staff in the Trust.	N/A	Yes	
Does the policy/development promote access to services and facilities for any group in particular?	No	N/A	N/A	
Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis		**No**	**(Please delete as appropriate)**
Name of Author: **Signature of Author:**	**Helena Lee, Quality Governance Manager**	**Date Signed:**	**02/11/2023**
Name of Lead Person: **Signature of Lead Person:**	Stuart Logan, Head of Quality Governance	**Date Signed:**	02/11/2023
Name of Manager: **Signature of Manager**	Louise Cheung, Deputy Director of Quality Governance	**Date Signed:**	02/11/2023