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Torbay and South Devon NHS Foundation Trust

Patient Safety Incident Response Plan

Contents

Foreword from our Interim Chief Nurse, Nicola McMinn

I am proud to introduce our plan for the management of patient safety investigations under the new Patient Safety Incident Response Framework (PSIRF). 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. It is a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again with a focus upon how we can best learn and improve to prevent recurrence.

As an organisation we are committed to engaging meaningfully with our patients, their families and carers and our staff, to ensure that their voice is heard in patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

We are working towards a restorative and just culture to underpin how we approach PSIRF and we continue to foster a culture in which people feel invited and supported to highlight incidents, knowing there is psychological safety. PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture where people are confident to about patient safety events and to simply express their opinion. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, and these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning. The implementation process will take time to progress and embed and will require regular review to ensure the Trust can demonstrate positive assurance in improvements to the quality and safety of our services with improved patient safety outcomes. 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.

PSIRF offers us opportunities to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers while also protecting the well-being of our staff. I thank you for being part of this journey.

1.0 Introduction

Patient safety has been recognised as a health priority and is seen as fundamental to the delivery of quality health services. The World Health Organisation highlights that clear policies, leadership capacity, appropriate data to drive safety improvements, skilled healthcare professionals and effective involvement of patients in their care are key in the realisation and implementation of patient safety strategies.

These requirements are reflected in actions taken by the NHS nationally, changing the way in which healthcare organisations and Torbay and South Devon NHS Foundation Trust thinks about safety.

The NHS Patient Safety Strategy (2019) builds on the two foundations of a patient safety culture and a patient safety system by defining the three following aims:

1. Improving an understanding of safety by drawing intelligence from multiple sources of patient safety information (insight)
2. Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (involvement)
3. Designing and supporting programmes that deliver effective and sustainable change in the most important areas (improvement).

1.1 The Patient Safety Incident Response Framework (PSIRF)

The NHS Patient Safety Incident Response Framework (2022) replaces the NHS Serious Incident Framework (2015). The Serious Incident Framework (SIF) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

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

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

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works in practice. The NHS Patient Safety Strategy

challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean “do nothing”, it means respond in the right way depending on the type of incident and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents, part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems.

1.2 Patient Safety Incident Response Plan (PSIRP) scope

This patient safety incident response plan (PSIRP) sets out how Torbay and South Devon NHS Foundation Trust intends to respond to patient safety incidents over the next 12 to 18 months. The PSIRP is a ‘living document’, meaning the PSIRP can be reviewed and refreshed as new safety intelligence is identified to inform the safety priorities for the Organisation. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This PSIRP explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities, our analysis of which is explained later within this document. There are many ways to respond to an incident. This plan will detail how different types of incidents will be responded to, based on the potential for learning and being mindful of existing improvement work.

This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues

b. focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents

c. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents

d. demonstrating the added value from the above approach.

This plan is underpinned by the national Patient Safety Incident Response Framework and should be read in conjunction with the **TSDFT Patient Safety Incident Response Policy (D2364)** and **TSDFT Incident Reporting and Management Policy 0848**.

1.3 PSIRF alignment to our Trust vision and purpose

The vision of Torbay and South Devon NHS Foundation Trust is better health and care for all, and our purpose is to support our people to live well. The PSIRF strategic aims will support the Trust to realise our vision and purpose and ensure closer alignment with our Trust values.

PSIRF strategic aims are to:

- Improve the safety of the care we provide to our patients
- Improve the experience for patients, their families and carers when the need for a patient safety review or investigation is identified
- Improve the use of valuable healthcare resources
- Improve the working environment for staff in relation to their experiences of patient safety incident investigations.

Our Trust values are:


Our Values
Respect and dignity
Commitment to quality of care
Compassion
Improving lives
Working together for people
Everyone counts

This PSIRP has been developed to complement the Torbay and South Devon vision to deliver outstanding care, ensuring excellence in experience and outcomes for our patients and the wider community we serve.

Our quality goals have also been considered to inform and shape this PSIRP:

1.4 Our Trust 'Regain and Renew' plan

This PSIRP recognises that Torbay and South Devon NHS Foundation Trust is in special measures (NOF4), both as an Organisation and as part of the Devon Health and Care system. We are the only Integrated Care System in England where every acute trust is in special measures – this means we are in the national spotlight and are the focus of intensive attention from the national and regional teams at NHS England and NHS Improvement (NHSEI).

The Trust is receiving external support, scrutiny and challenge to maximise delivery against key areas of improvement for the benefit of those who access our services and our staff; PSIRF will help us to achieve these improvements. By identifying and focusing on our key safety and quality priorities, PSIRF will also support the Trust to deliver against our 'Regain and Renew' plan maximising improvements across patient pathways and ensuring that staff are supported via a restorative just and learning culture.

Figure 1: Regain and Renew Plan

2.0 Our services

2.1 Our population

We serve our local people by providing community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites. We are the lead organisation in the alliance of Children and Family Health Devon (CFHD) which is one of our 5 care groups. Increasingly, we are providing more care as close to home as possible for our people, reducing their need to travel and helping to keep them safe and live well. Increasingly, we are delivering care directly into people's homes either through visits, online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

The Trust covers a wide geographical area, including parts of Dartmoor (Newton Abbot, Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes and Dartmouth. We employ over 6,700 staff across a variety of roles. We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in several community locations. We support around 500,000 face-to-face contacts with patients in their homes and communities each year and see over 78,000 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

Our maternity service at Torbay Hospital offers Midwifery-led and Consultant-led care for approximately 2,000 women and birthing people per annum, The service is provided by midwifery teams based in the community giving antenatal, intrapartum and postnatal care both at home, children's centres and in the hospital. We also have a Special Care Baby Unit with 10 cots and provide care for babies born from 30 weeks' gestation (depending on care needs).

The Torbay Recovery Initiatives (TRI) drug and alcohol service provides support and treatment interventions for people in Torbay who have issues related to substance use. TRI is part of an Alliance which includes the Torbay Domestic Abuse Service (TDAS) and the Homelessness Hostel – Leonard Stocks Centre. TRI provides a range of psychosocial and pharmacological interventions. Alongside these interventions TRI also provides Groupwork Programmes, Peer Support, Online Self-Management Support through SilverCloud and has a strong connection with our local Recovery Network. Mental Health services are provided by the Devon Partnership Trust. The TRI service has engaged in the development of this plan.

The Integrated Care Organisation (ICO) is responsible for the delivery and quality assurance of adult social care services via a s75 agreement with Torbay Council. All Trust staff including members of the adult social care (ASC) workforce adhere to the 'reporting and responding to incidents' requirements within the ICO's policies and procedures. As such, ASC staff will participate in safety reviews and investigations when requested and report incidents onto the DCIQ system. Further discussions are planned to explore how this transition will impact the frontline workforce going forward. It is the intention to adapt this plan as these conversations evolve.

2.2 The impact of health inequalities for our population

This PSIRP has considered and been informed by health inequality data for our local population. The Trust serves the coastal population of Torbay which is referenced in the Chief Medical Officer's Health in Coastal Communities report 2021. This report demonstrates that coastal communities have a higher burden of disease across a range of physical and mental health conditions (for example coronary heart disease). Life expectancy (LE), healthy life expectancy (HLE) and disability free life expectancy (DFLE) are all lower in coastal areas and the Standardised Mortality Ratios (SMRs) for a range of conditions, including preventable mortality, are significantly higher in coastal areas compared with non-coastal. Torbay is highlighted within this report to have worse admissions for alcohol related conditions than the average population. Factors which impact upon health outcomes such as housing quality, educational attainment, employment and crime are either comparable to, or significantly worse for the population of Torbay than the England average.

The Trust recognises that health inequalities and deprivation can shorten life expectancies and have a negative impact upon health and wellbeing. The Trust is taking steps to reduce the negative impact of inequalities in health outcomes for our population. We are currently working with local partners to finalise a waiting list equality action plan to ensure parity of access to elective treatment for members of our community with learning disability, a complex mental health illness or those living in areas of the highest social deprivation. We also note the impact that being an older aged carer can have upon an individual's own health. Torbay has higher than

average rates of children who are in care which impacts upon their health and wellbeing.

The Trust is also working closely with the ICB and local partners to deliver the Core20PLUS5 strategy which seeks to reduce health care inequalities for the 5 key areas of national focus. The Trust and local partners are also working to identify and agree our local population groups to be prioritised under the PLUS agenda.

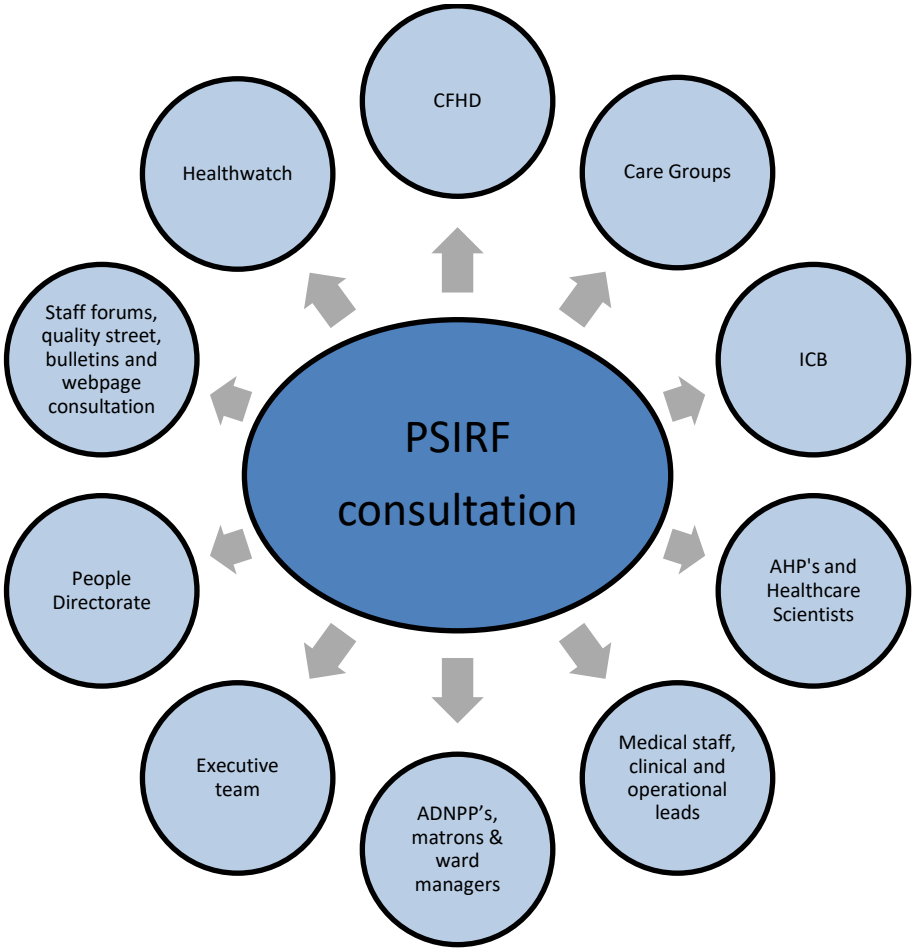
We will seek the support of our patient safety partners once in post to look to improve how we engage compassionately and equitably with patients from all back grounds and progress will be updated at the next revision of this plan.

3.0 Stakeholder engagement

The Patient Safety team commenced planning for PSIRF in November 2022 via the establishment of a PSIRF Expert Advisory Panel (PEAP) which was supported by a number of key pillar working groups. The voice of care groups has been represented at PEAP and PSIRF transition has been discussed in local forums including CFHD, Infection Prevention and Control, and with medicines leads. Our local Healthwatch member has been present at these meetings to collaborate and represent the voice of patients. Our Patient Safety Specialist has engaged with PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF; their assistance has been invaluable. We have also reached out to engage with different staff groups via their key meetings (see Figure 2) and supported Trustwide conversations via our Chief Executive Officer briefings, Trust Talk, Clinical Senates and Quality Street meetings. Patient safety data and intelligence was shared during these forums and staff views were sought to ascertain the priority focus via online surveys and focus groups. The proposed Patient Safety Incident Investigation (PSII) priorities were shared on the TSDFT webpage seeking staff feedback and informing the choice of our 3 priorities.

We recognise that the changing nature of oversight under PSIRF and the move to a systems-based investigation approach requires collaboration and we have engaged with Devon ICB, NHS England regional and national colleagues and the Southwest Academic Health Science Network to support, inform and enhance transition.

Figure 2: Stakeholder Engagement



4.0 Patient safety resource analysis

As part of preparation for PSIRF transition we have considered the resource we need to respond to incidents and how this can be organised to ensure a safe implementation of PSIRF across the Trust. Under PSIRF, our central Patient Safety and Quality team will continue to monitor all patient safety incidents and act as a core resource in supporting staff across the organisation with incident reporting and management. The coordination and review of all PSII's will be the responsibility of the central team; local level reviews (it is anticipated that the majority of safety reviews will be managed locally) will be supported by the central Patient Safety and Quality team. Under PSIRF, we will continue to maintain the high profile for patient safety across all services.

Given that the Trust has finite resources available for patient safety incident response, we intend to use this resource to maximise the impact on learning to improve patient safety and quality of care. 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.

A review of the resource associated with the current Serious Incident Framework for the 12 months leading up to October 2023 has been completed. We have also correlated and reviewed our patient safety data based on the national PSII criteria to

provide an indication of the PSII workload under PSIRF and to determine how many PSII's can be supported during a 12-month period. This review has been undertaken noting the Patient Safety Incident Response Standards to ensure that all future PSIIs are compliant with these standards. In addition, a review has been undertaken to determine our current level of resource for non-PSII related activity which will include Hot Debriefs, After Action Reviews (AAR), Case Note Reviews, Thematic Review, MDT meetings and 'Being Open' conversations, to name a few. This supports planning of appropriate responses and the application of different review techniques where PSII is not indicated.

The number of SI investigations undertaken over the previous five years has been reviewed (Table 1), along with the resource allocated to patient safety investigations, both within the central patient safety team and job plans for clinical staff in all care groups.

In summary, TSDFT has identified that it will undertake 20 PSII's per year. Each lead investigator will be supported by an investigator 'buddy' and the central patient safety team. Lead investigators will not be expected to lead any more than one full PSII at any one time to ensure the quality of the review is maintained; they will however be able to act as a buddy for other lead investigators. We recognise that the Organisation currently has a backlog of Serious Incidents and that these are and will continue to be the focus once the transition to PSIRF has occurred. This workload is likely to impact upon the ability of the Organisation to undertake PSII's within the stipulated timeframe, therefore a plan will be shared at the Incident Review Group (IRG) to agree a deadline for the completion of PSII's.

To improve our ability to deliver against PSII standards, we plan to:

- Assign an appropriately trained Board member, supported by the Associate Director of Patient Safety and Quality, to oversee delivery of the PSII standards and support the sign off of all PSIIs
- Provide a PSIRF oversight session for all Board members
- Train staff in system-based investigation training to support leading or reviewing an investigation – to date, 20 members of staff have been through this training
- Work with senior clinicians, nursing and AHP staff to review the existing tools for Patient Safety Reviews (PSRs) to ensure they fit the requirements of PSIRF and a system approach to patient safety
- Continue to deliver our internal patient safety curriculum which is designed to touch all colleagues in the organisation from Board to floor

Table 1: Patient safety incident investigation activity 2018 – 2023

Activity Type	2018/19	2019/20	2020/21	2021/22	2022/23	Average
Never Events	2	3	5	0	3	2.6
Serious Incident Investigations (i.e., StEIS reportable and including	3	10	69	90	62	46.8

IMRs submitted to DHR, SCR etc.)						
Patient/Family/Carer complaint-initiated patient safety investigations	1	2	0	0	0	0.6
Other PSIIs (currently classed as ward, department or directorate-level root cause analyses)	0	0	20	68	228	105
Child death overview panel (CDOP)			2	1		
Independent PSIIs sourced and funded directly by the local provider	0	0	0	3	0	0.6
Incidents referred (to HSIB/regional independent investigation team (RIITs)/PHE, etc.) for independent PSII	3	3	3	2	4	3
Independent PSIIs commissioned nationally or regionally on behalf of the local provider	0	0	0	0	0	0

4.1 Current patient safety resource

The current structure relies on Clinical Governance Coordinators (CGC's) to undertake reviews supported by senior clinicians, nurses and AHP's in their allotted management / administration. Currently the central governance team does not have any line management responsibilities for the CGC's with regards to investigations and thus limited influence over how investigators prioritise their time for investigations. It has been proposed that the CGC's line management responsibility move to the central governance team to support oversight and planning of patient safety work. These discussions are ongoing.

Torbay and South Devon NHS Foundation Trust has the following existing substantive resources dedicated to patient safety and quality:

- 1 WTE Associate Director of Patient Safety and Quality
- 1 WTE Patient Safety Specialist
- Medical Director of Patient Safety (2 sessions per week)

- 2 WTE Quality and Patient Safety Facilitators

In addition, the Trust has 6.4 WTE resource comprised of both Clinical Governance Coordinators and Governance Support Nurses/Radiographer who are in post to support patient safety at care group level, including incident investigation support and oversight. Each care group is also supported by a medical clinical governance lead at 1 session per week. All CGC'c have undergone 4-day PSII training, which was undertaken by over 20 members of staff. A further 20 staff members will undertake training in PSIRF alternative learning methodologies in January 2024.

The Trust will follow the recommendations detailed in the Patient safety incident response standards where possible. The Trust has not elected to have 'stand-alone' lead PSII investigator roles due to current financial constraints, therefore any PSII will be undertaken by staff as part of their existing role (it is anticipated that staff will have capacity to deliver the PSIRF requirements due to the mapping of existing safety workload detailed above). It is acknowledged that due to the recent implementation of the new care group structure, the level of clinical governance support for each care group is variable meaning that capacity and capability will need to be monitored and reviewed regularly as part of this plan.

The Trust notes that the PSIRF standards recommend that learning responses are led by staff who have an 'appropriate level of seniority and influence' within the organisation likely to be at grade 8a or above. We acknowledge that our investigators are not employed at this level and to mitigate this risk the investigator will work with a peer for support. In addition, the Trust will provide support and coaching for learning responses (such as PSII's) by the Patient Safety Specialist and Associate Director of Patient Safety and Quality. We will adopt a panel approach when agreeing terms of reference and at further touchpoints during the investigation to discuss findings and recommendations. The final report will have executive oversight at the Incident Review Group and at the soon-to-be-established Patient Safety Group.

The effectiveness of this approach will also need to be reviewed as part of the plan to ensure that high quality safety investigations are completed in a timely manner for patients, families and staff. The members of staff detailed above, and senior members of each care group have been trained in the PSII methodology.

5.0 Defining our patient safety incident profile

5.1 Analysis of Trust patient safety intelligence

PSIRF sets no rules or thresholds to determine which safety incident should be investigated to generate learning and improvement apart from the national requirements for external and local PSII (detailed further in this plan) A significant risk to the successful implementation of PSIRF is continuing to investigate all 'serious incidents' to the same level as previously under SIF but calling them something else.

A key focus of the Trust approach to transition to PSIRF is to understand our Trust safety profile. To support this, we have reviewed the patient safety activity within the Trust over the last 5 years (an extended time was selected to allow for a change in safety profile during the COVID-19 lockdowns). To support us to further define and understand our patient safety profile, we have analysed data from a variety of sources including the Datix incident reporting systems. Data has been collated and reviewed from the actual incidents that had occurred over the previous 5-year period from 2018 – September 2023. Data and information (both qualitative and quantitative) have been received and reviewed from the following sources:

- Incidents recorded on Datix related to patient safety
- Serious incidents and never events
- Complaints and concerns relating to clinical care and treatment
- Freedom to Speak Up themes
- Statutory Safeguarding reviews for Children & Adults
- Bi-monthly mortality scorecard data
- Staff survey results and focus groups
- Legal claims and inquests
- Trust-level risks relating to patient safety
- Intelligence and feedback from Quality Improvement programmes
- Mortality reviews, though further work will be needed here to address challenges in accessing non-electronic data
- CQC inspection findings, published November 2023

Where possible we have considered what elements of the data tells us about inequalities that may adversely affect outcomes or the health and wellbeing of our population. As part of our engagement, we have also considered any new and emergent risks relating to changes in demand that the historical data does not reveal. Feedback and information provided by internal stakeholders and subject matter experts has also been considered as part of the diagnostic and discovery planning phase of PSIRF implementation. We have also consulted our ICB colleagues for their perspective on patient safety themes to inform the plan.

Our approach has also considered the Quality Account annual report, the quality of services offered by Torbay and South Devon NHS Foundation Trust and our ability to demonstrate improvements in the services we deliver. The quality of services is measured by considering patient safety, the effectiveness of treatments that patients receive and patient feedback about their experience of the care provided.

We have also consulted with and sought the views of staff to obtain their views on our patient safety profile and priorities as detailed earlier. The PSIRP has also been informed by the Devon system being in NOF4 and the associated improvement priorities, in particular reducing elective waiting lists and delays across the urgent and emergency care pathway.

5.2 Our Trust Patient Safety Incidents

The Trust reported 52,971 patient safety incidents from July 2018 to June 2023 via the DatixCloudIQ (DCIQ) incident and risk management system. The majority of the reported incidents were no harm, low harm and near miss, however 4% of incidents led to more significant moderate harm to the those involved.

The highest recurring harm in incidents reported as moderate or above harm related to infection prevention and control, falls and pressure ulcer incidents; this correlates with the pandemic and COVID-19 cases reported through the Trust, and the national picture on pressure ulcer prevalence and falls where harm occurs which is linked to an ageing population. Existing quality improvement projects are underway for falls and specific learning and improvement tools are utilised when pressure ulcer incidents occur. Feedback from the falls and pressure ulcer groups, including number of incidents will be shared at the Incident Review Group to monitor trends and to seek assurance regarding improvements.

Serious Incident data for the past 5 years has been reviewed as part of our safety intelligence. The top 10 categories are detailed below.

Table 2: Highest reported Serious Incidents 2018 – 2023

Serious incident Category	Total
Accident/Injury (Including slips, trips and falls)	85
Pressure ulcer	34
Clinical assessment (including diagnosis, scans, tests, assessments)	26
Implementation of care and ongoing monitoring / review	16
Access, admission, transfer, discharge (including missing patient)	15
Obstetrics related issue	12
Treatment, procedure	12
Medication related issue	8
Never Events List	7
Cardiac / Respiratory Arrest	6

Table 3: All incidents 01/04/2020 - 31/03/2023

Criteria	Moderate	Death	No harm	Severe	Low harm	Near miss	Total
Pressure ulcer	1122	1	3441	8	3452	27	8051
Access, admission, transfer, discharge (including missing patient)	66	3	5006	9	246	460	5790
Accident/Injury (Including slips, trips and falls)	47	7	2182	41	1236	199	3712
Security / Crime related incident	18	0	1643	0	249	286	2196
Medication related issue	16	4	1570	0	228	275	2093
Blood Transfusion and Blood Sample incident	4	0	288	0	23	1228	1543
Implementation of care and ongoing monitoring / review	27	12	801	4	223	220	1287
Documentation (including electronic & paper records, identification and charts)	1	0	867	0	57	356	1281
Infection Control Incident	2	3	530	4	341	113	993
Clinical assessment (including diagnosis, scans, tests, assessments)	24	7	522	6	145	219	923
Total	1327	37	16850	72	6200	3383	27869

As part of our data analysis, a review of the top safety themes from our corporate risk register where considered. These related to patient flow pressures resulting in delays, non-compliance with waiting times, delayed follow-up across surgical care, incorrect labelling of samples and delays in intervention for stroke patients. Treatment delay and delayed diagnosis are our highest volume of claims. Wait times and access to pathways are also reflected in our top 3 complaints and concerns from patients for quarters 1 and 2 of 2023/24. Mortality data nationally indicates that delays across emergency care and for those waiting for elective care correlates to a rise in mortality. Mortality data for the Trust indicates a higher mortality rate associated with delays accessing emergency and elective care in particular for our older population; this data requires further analysis.

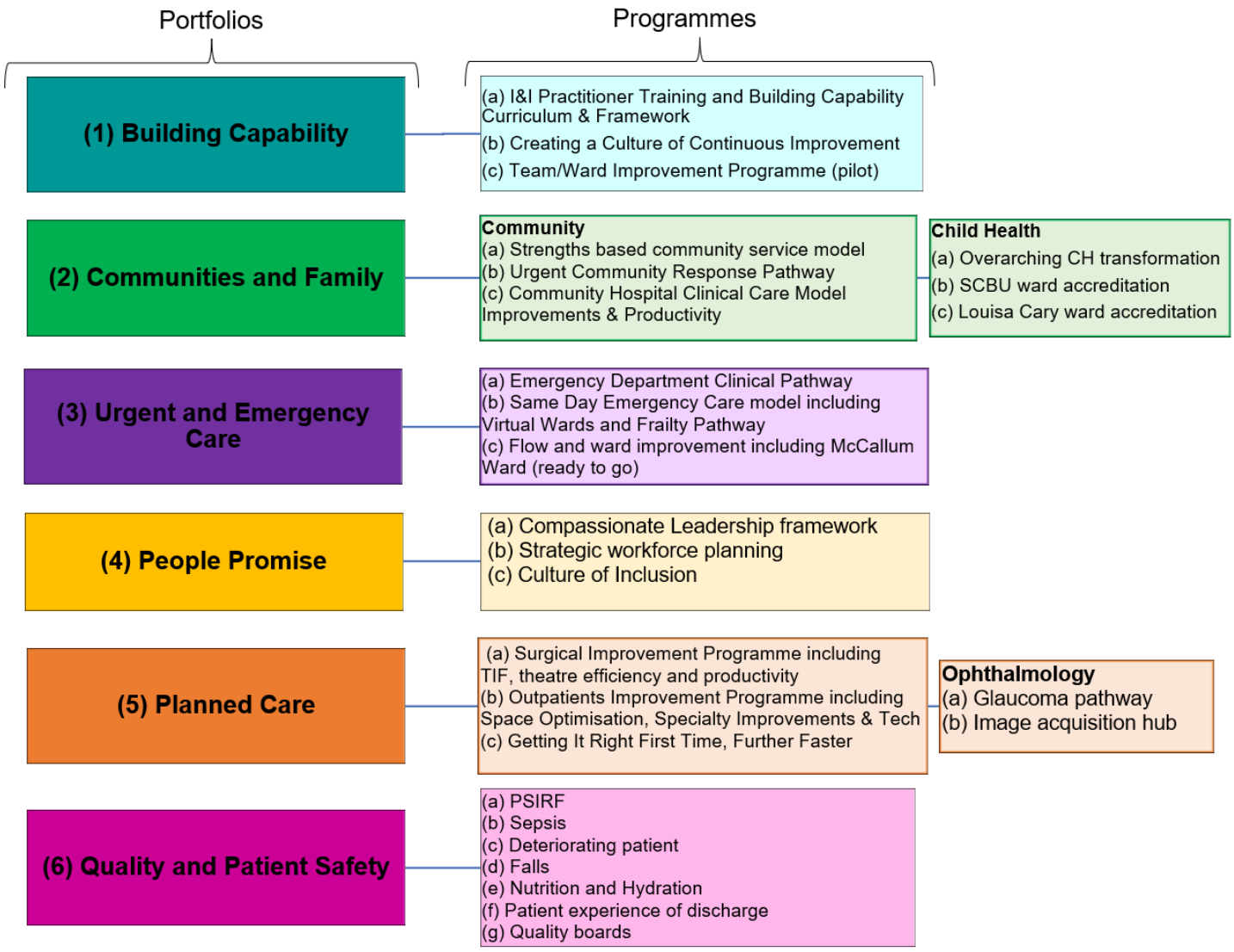
This patient safety intelligence has been complied to form a patient safety profile for the Trust which has considered incidents which present the greatest risk (severity, likelihood, concern, cost) and an opportunity for new knowledge and improvement. This indicated that delayed access to emergency and elective care was a theme of concern for patients in terms of litigation and complaints, which correlates with safety

concerns shared by our staff and with a likely increase in mortality. Whilst delays are realised across the System, the Trust considers there is value in these areas being priorities for PSII to realise local learning and improvement. Consultation with our staff has informed this PSIRP and staff have advised us that there was still learning to be found across emergency and planned care pathways related to access to services for specific patient pathways (such as stroke, frailty) and access to those who may be impacted by inequalities.

These discussions have further informed the selection of our local safety priorities alongside our patient safety intelligence. The safety intelligence was shared across the Trust in key staff meetings and through circulation and dissemination at key meetings via Associate Directors, care groups and Clinical Leads. The priorities were also shared on our webpage in survey format for staff to comment upon. Feedback from staff is that they identified with elective care, access to emergency care (in particular for frail/ elderly patients) and gaps in our diagnostic/results pathways as key safety priorities.

This safety intelligence has been analysed and cross referenced against existing Quality Improvement (QI) and patient safety transformation programmes. There are currently a number of QI programmes (Figure 3) underway within the Trust which are directly linked to improving patient safety, in particular elective and emergency care. It is envisaged that the learning and recommendations from any safety investigations or reviews will feed into the relevant Quality Improvement workstream to further enhance this work by a representative of the Improvement & Innovation team attending the Patient Safety Group, also allowing for QI methodology coaching and support to be provided to project leads.

Figure 3: Existing Quality Improvement portfolios



6.0 National safety priorities

PSIRF stipulates that some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. These criteria have been determined nationally, and the Trust fully endorses this approach as it fits with our aim to learn and improve within a restorative just and learning 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 Table 4 below. For other types of incidents which may affect certain groups of our patients, a PSII will also be required.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 6 PSII reviews (where national requirements have been met) per annum.

Table 4: Nationally required patient safety incident investigations

			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	National Priorities	Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
			Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
			Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required. Refer for a Safeguarding Adult Review	
			Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults with care and support needs regardless of whether those care and support needs are met by the local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery	Refer to local authority safeguarding lead via TBSD named safeguarding lead TBSD will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews, safeguarding adult reviews and any other safeguarding reviews (and Enquiries) as required to do so by the local safeguarding partnership (for	

			and human trafficking or domestic abuse/violence.	children) and the local safeguarding adults boards	
			Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, TBSD will contribute as required by the DHR panel. Also need to consider whether referral for a Safeguarding Adult Review is appropriate	
			Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
			Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
			Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII, locally led PSII may be required. Also need to consider whether referral for a Safeguarding Adult Review is appropriate	
			Patient Safety incidents	Local Patient Safety	Create local

			meeting the Never Event criteria 2018 or its replacement	Incident Investigation. Also need to consider whether referral for a Safeguarding Adult Review is appropriate	organisational recommendations and actions and feed these into the quality improvement strategy
			Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care		
			Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care		

7.0 TSDFT local safety priorities

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. To decide upon our local priorities, we used the 'Guide to responding proportionately to patient safety incidents'.

Based on our analysis and the selection criteria described above, the Trust has identified 3 patient safety priorities for PSII which will be the focus for the next 18 months and the remainder of 2023/2024. We will aim to undertake 3 PSII's for each local priority in line with national guidance. We have selected this number based on consultation with and feedback from early adopters who advised that a higher number of PSII per priority was overambitious and unachievable and that 3 PSII's alongside other review methods realised learning and improvement. We consider this number of PSII's will allow us to apply an in-depth systems-based approach to learning from these incidents, exploring multiple interacting contributory factors to maximise the potential for learning and improvement.

We also recognise that this is a period of transition for the Trust, and we want to be realistic about what we can achieve whilst seeking to learn and improve our processes. The priorities have been discussed and agreed with Devon ICB. Attempting to undertake more than this number will impact upon our ability to focus upon learning and improvement.

Table 5: Local priorities for PSII

Priority number	Incident type	Description	Response type and number	Anticipated improvement route
1.	Delayed access to elective/ planned care	There are currently prolonged waits for access to elective and planned care which is contributing to patient harm. This risk is exacerbated by a lack of understanding regarding the prioritising of patients for specific pathways and the impact of health inequalities.	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.
2.	Delays across our urgent and emergency care pathway related to frailty/the elderly	Incidents related to delay across our urgent and emergency pathway inform that our elderly and frail population are at higher risk of harm.	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.
3	Diagnostic tests and testing	Safety incidents related to errors or delays across diagnostic and testing pathways	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.

7.1 Investigations requiring a multi-agency approach

The aim of the PSIRF is to create a safety system where learning responses are managed as locally as possible to facilitate the involvement of those affected by the event and those responsible for delivery of the service. Where more than 1 service or provider is involved, the Trust may seek to initiate a system response to maximise learning across pathways.

Where a patient safety incident is identified by the Patient Safety team as requiring a coordinated multi agency response, a member of the team will contact the ICB to advise of the incident and to request support to engage other services. Initial scoping with the ICB and partners will agree the role and responsibilities of the different agencies involved, including who should undertake the responsibility of lead agency for the purposes of family and staff liaison.

The Trust is committed to collaborative working with our partner Organisations and patient groups. We will engage in cross system investigations and are committed to sharing learning across our system and wider. Further detail can be found in our PSIRF policy.

7.2 Timescales for PSII's

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified as meeting the PSII inclusion criteria. Whilst there is no formal timescale, PSIIs should ideally be completed within six months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between the Trust and the patient/family/carer. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity. The outcomes of PSII's will be used to inform our patient safety improvement planning and work as agreed at the Trust Quality Assurance Committee (QAC).

7.3 Patient safety review methodology (non-PSII safety activity)

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents, we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work. Oversight of patient safety reviews categorised as 'moderate harm' or above will be monitored via the Incident Review Group (IRG).

We have explored the toolkit methods suggested for reviewing other incidents and decided that we will principally use the following tools for Patient Safety Reviews.

- Hot Debriefs
- After Action Reviews
- Case note reviews
- Thematic analysis
- MDT Roundtables
- Multi-agency review/panel

It is envisaged that under PSIRF, the care groups supported by the central team and CGC's will identify the most appropriate methodology to review non-PSII incidents, this process will be closely monitored and supported during transition to PSIRF. For certain patient safety incidents, such as falls and pressure ulcers, the Trust has

defined the best tool to achieve learning as an After Action Review. These incidents and the selected learning methodology are detailed below (Table 6).

The Trust is committed to ensuring that staff will be well prepared for their role in undertaking and facilitating these reviews, and we have worked with our education lead to develop a patient safety training plan for our workforce as part of a wider vision to achieve an integrated quality education framework. This process will be supported by robust 'ward to board' governance mechanisms and subsequent reporting to ensure that patient safety incidents and improvements are overseen effectively.

Table 6: Non-PSII activity

Patient safety incident type or issue	Planned PSR methodology	Anticipated improvement route
Patient safety concern associated with patient harm and identification of a new area for learning	Initial patient safety review to inform decision to be considered as PSII.	Incident review group
Death	Review by Mortality process including medical examiner. Possible Structured judgment review (SJR) and Mortality and morbidity meeting discussion. If concerns regarding care are raised during SJR */ mortality review, consider for review as PSII where index case or meets national priority criteria	Create local safety actions and feed these into the quality improvement strategy
Falls	After Action Review all falls Thematic review of falls resulting in fractured neck of femur.	Quarterly report shared to Executive quality group/ patient safety committee. Oversight of incidents with moderate and above harm to the incident review group. Annual thematic report (can focus on specific safety areas i.e.) to demonstrate improvement trajectory and inform revised PSIRP.

Pressure ulcer	Pressure Ulcer review tool and National Pressure Ulcer protocol	Quarterly report shared to Executive quality group/ patient safety committee Oversight of incidents with moderate and above harm to the incident review group. Also need to consider whether referral for a s42.1 (Care Act) Concern to the local authority is appropriate Annual report to demonstrate improvement trajectory and inform revised PSIRP.
Infection Prevention Control (IPC)	To report as per national standards for IPC incidents. Use of PSIRF alternative methodology tools and templates to be utilised were appropriate.	
Maternity	National maternity PSII's conducted via HSIB in line with national criteria. Other incidents meeting local PSII threshold Will continue to report and review incidents via the perinatal mortality review tool in line with national standards	Review at incident review group / patient safety committee.

7.4 PSII review and sign off

Once completed, all draft PSII reports will be reviewed at the Incident Review Group (IRG) for discussion and agreement of the safety recommendations. The IRG members will consider the quality and content of the PSII or safety review including the inclusion of systemic factors and to ensure that a restorative just and learning culture approach is evident. Identified areas for learning and improvement will be considered to ensure gaps in safety are addressed (please see PSIRF policy for more detail).

8.0 Supporting those affected by patient safety incident

8.1 Incidents that meet the duty of candour threshold

There is no legal duty to investigate a patient safety incident, however once an incident is identified that meets the statutory duty of candour threshold, our legal duty, as described in regulation 20, says we must:

- Inform the person or people involved, including the family where appropriate, that a patient safety incident has taken place.
- Apologise – 'we are very sorry this has happened.'
- Provide an account of what happened and explain the details you know at that point.
- Explain what you are going to do to understand the events.
- Follow up by providing a summary of events, a further apology, and an update in writing.
- Consider a referral of a Safeguarding Adult Concern to the local authority
- Keep secure records of all meetings and communication

These incidents would have previously automatically been reported as serious incidents under the serious incident framework. It is crucial these incidents are not routinely investigated using the PSII process, as PSIRF steers us away from this routine approach to a more individual local approach. Incidents that result in severe harm will still fall within the duty of candour requirements. Any safety review undertaken should enable the provision of information about events to be shared with those involved, the patient, their family, and staff.

8.2 Supporting patients, families, and carers

PSIRF asks that we engage in a meaningful way with those affected by any incident, this means showing compassion and involving them to understand and answer any questions they have in relation to an incident. The Trust is committed to supporting and involving patients and families in line with the Patient Safety Incident Response Standards and the PSIRF national guidance on engagement and involvement – NHS England » Engaging and involving patients, families and staff following a patient safety incident

During a patient safety incident investigation, the patient, family or carer will be provided with a dedicated point of contact from the Trust who will explain the investigation process and discuss the level of involvement and support preferred by the family, which will include agreeing the terms of reference for the investigation and factual accuracy review of the report should the family wish to be involved.

This will aid our learning and improvement but, more importantly, allow us to support patients, service users, families and carers effectively. We want to be open and transparent with those affected by a patient safety incident because it is the right thing to do, regardless of the level of harm caused by an incident.

A patient, family member or carer is asked to contribute to a patient safety review (regardless of the methodology being used) in several ways. By fostering a collaborative and open approach to patient safety reviews, we will ensure they have

the opportunity to share their experience and ask questions. Our ambition is to ensure that patients, families and carers have a voice throughout patient safety reviews and have the right level of support through the process and receive appropriate feedback about the outcome of any review.

On completion of a patient safety review the Trust will actively encourage feedback from patients, families or carers to continually improve the experience of patient involvement in the patient safety review process and to improve standards and quality of care. The Trust is committed to being open and honest with patients and their families/carers in line with our responsibilities under duty of candour and we are continually trying to improve our approach.

8.3 Supporting staff: Restorative Just and Learning Culture work

The Trust is committed to ensuring that patient safety incident responses are conducted for learning and improvement purposes only. Improving safety relies on a culture where staff feel safe to speak up, where there is a balance between fairness, learning and supportive accountability and where fear, blame and reprisal no longer exist. Staff need to know that when they speak up, they will be treated fairly, with compassion and be supported, and their concerns acted on.

The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. We value our staff, who can give us key insight into ‘work as done’ rather than ‘work as imagined’ and move towards a true safety culture. We want everyone’s voice to be encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

Staff, through involvement in care-group led incident review groups, can share their concerns and discuss incidents openly, contributing to the overall decision-making process for learning responses. Staff are actively involved in patient safety reviews and investigations and their engagement and contributions are encouraged. We will seek staff feedback about their experience of our patient safety review/investigation process to ensure that we continually review the support available and as a cultural measure of psychological safety.

An anonymous just culture survey was undertaken, alongside facilitated staff focus groups, by the Freedom to Speak Up (FTSU) Lead, Improvement & Innovation Project Support Lead and the Associate Director for Education and Workforce Development. The survey showed that further work is needed to improve safety culture with approximately 50% of respondents fearing disciplinary action when involved in an incident. This is concerning and indicates that staff may be hesitant to raise an incident for fear of reprisal. However, the survey also found that people recognised reporting an incident is important for improving patient safety. Staff were also concerned that a fair and balanced system would not be applied when they were involved in an incident. The NHS staff survey also found that staff scored lower than the national average in terms of being confident that the organisation would address concerns. We have taken this feedback on board and are committed to

embedding a restorative just and learning culture, where staff feel able to speak up and are listened to.

To support the embedding of a restorative just and learning culture, members of the People Directorate and the Patient Safety Specialist attended Just Culture training at Merseycare, following which the Employee Relations (ER) team will be leading on a just culture steering group, as well as having wider conversations to engage people across the Organisation. Key policies are being reviewed and reframed through a Just Culture lens in partnership with Staff Side and training and guidance will be developed for managers, both new and current, to support the use of consistent approaches and ensure principles are translated into practice. By ensuring that staff who raise concerns are supported and protected, we will create and embed a culture where staff feel able to speak up to raise concerns.

The Trust will have dedicated resources such as webpages for support and signposting, including the current Work In Confidence anonymous platform and Just Culture ambassadors. The Patient Safety team will continue to work with our People Directorate colleagues, Improvement & Innovation team, and the Freedom to Speak Up Lead to ensure we continue to develop and embed psychological safety and a restorative just and learning culture across the Organisation.

9.0 Our patient safety partners

We are excited to have recruited two volunteer Patient Safety Partner (PSP) roles. We see their role as a true partnership, drawing on their experience and having an active role in highlighting good practice and challenging where care, treatment or our processes are not as we would hope for, to ensure that the patient voice is heard throughout.

PSP's are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who will work in partnership with staff to influence and improve the governance and leadership of patient safety within the Trust. They will represent the voice of the wider community and provide the Trust with a real opportunity for building on the vision of developing a collaborative approach, supporting a leadership culture that initiates and facilitates the opportunity for co-production and co-design in service improvements and patient safety. This will be facilitated through their participation in safety and quality committees, involvement in patient safety projects, working with the Board to consider how to improve safety, involvement in staff patient safety training and participation in investigation oversight groups. Staff feedback in the NHS staff survey scored lower than the national average in terms of staff feeling that the organisation would act on concerns raised by patients or that patient care was the top priority – our patient safety partners will challenge us to improve this.

We will be supporting our selected PSPs with training and mentoring to ensure that they are able to fully contribute to the further developments of our PSIRF responses, safety improvement work and to codesigning our future processes with the patient voice at the forefront of what we do. PSP's will; be supported and coached during key meetings to be confident and supported to contribute. PSP's will be asked to

share their reflection's as to how the team can best support them to best deliver and achieve in their role.

10.0 Sharing learning to support safety improvement

The Trust has a number of ways to ensure that learning from safety reviews, including learning from excellence, is shared across the Organisation to support safety improvements. The Patient Safety Specialist and central team, supported by the Trust Communications team, will facilitate cascade of relevant content across the organisation through a range of media including safety bulletins, social media streams, videos and podcasts. Staff are currently asked to report examples of what went well to ensure learning from excellence, these examples will be shared regularly at the incident review group and incorporated into the terms of reference. Examples of Good Care are also reported on DCIQ under LfPSE.

Monitoring through Clinical Audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared, adapted and adopted with other areas of the Organisation and peer Organisations via the Patient Safety Specialist to the ICB Patient Safety Specialist Network and/or System Quality Group. Learning may also be shared from a safeguarding adults enquiry process and if a Safeguarding Adult Review is undertaken, from that process.

10.1 Evaluating and monitoring outcomes of PSIIs and Safety Reviews

Each of the care groups and agreed Trust Quality Improvement Programmes will receive the learning and recommendations from PSII's and local reviews to inform the improvement work as well as evidence improvement and impact learning. Close working between the Patient Safety team and Improvement & Innovation Team is central to this plan to ensure that data and learning is used to inform and align with Quality Improvement projects. Large scale improvement projects are underway in relation to elective and emergency care and recommendations and learning from these safety priorities will feed into these workstreams via Improvement & Innovation team representation at Patient Safety Group.

Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

The following mechanisms are used to develop and support improvements following PSIIs:

- The Trust uses a stepped Quality Improvement methodology as the way we do business across the Trust, constantly evaluating our work processes and making changes to improve services for patients and the working environment for staff.
- Our processes for improvement are described in our Building Capability Framework and our Quality and Patient Safety Strategy. The

recommendations from PSII's and other reviews will flow through these processes linking them in directly to the Trusts Quality Improvement and Transformation work.

Projects will follow Quality Improvement methodology, supported by members of the Improvement & Innovation team, to ensure consistency and careful monitoring of outcome, process and balancing measures. Work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents. Improvement plans will be shared with the relevant teams to enable delivery of actions, monitoring and evaluation of improvement outcomes. Clinical/operational project leads, supported by the Improvement & Innovation team, will provide update reports on progress to the Quality Assurance Committee.

Reports to the Quality Assurance Committee will be bi-monthly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of quality and safety improvement plans from an implementation and efficacy point of view
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents will be reported and disseminated via the feedback and engagement group.
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents will be reported and disseminated via the feedback and engagement group

10.2 Safety improvement plans

It is an ambition of the Trust that once the transition to PSIRF has been completed, the Trust will develop an Organisational safety improvement plan, the oversight of which will sit with Patient Safety Group. The safety improvement plan will reference and incorporate existing safety improvement work and will also review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues. The Organisational safety improvement plan will also seek to incorporate any broader areas for improvement which require systemic change and commitment from the executive team.

11.0 Complaints and appeals

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a service provided by the Trust will be taken seriously and will be managed in a way that reflects the Trusts' values. If following completion of a patient safety incident response there are concerns that a service user, family member or carer wished to raise, we would welcome the opportunity to review and discuss these. If, however we are unable to

resolve these concerns a complaint can be raised by contacting our Patient Advice and Liaison Service (PALS).

12.0 Governance, roles and responsibilities with the PSIRF approach

It is important that the Trust governance structures are robust to support the implementation and progression of PSIRF. The Trust core meetings and committees which represent our governance approach are detailed in the Trust PSIRF policy alongside core roles and responsibilities.