NHS
Kernow
Clinical Commissioning Group

Paper number: GB2122/081

Governing Body
Meeting front sheet

Summary sheet

Date of meeting: 5 October 2021
For: Public session (part 1)
For: Discussion

Agenda item: Cornwall Partnership NHSFT patient safety incident response plan (PSIRP)

Author(s): Kerry Crowther CFT,
Caroline White CFT
Lisa Nightingale, Kernow CCG

Presented by: Nikki Thomas
Lead director or GP from CCG: Nikki Thomas, interim director of nursing
Clinical lead: Maria Patterson, head of patient safety

Executive summary

The national patient safety strategy

NHS Kernow CCG, Cornwall partnership Foundation Trust (CFT) and Royal Cornwall Hospitals NHS Trust (RCHT) governing body/ boards agreed to be national early adopters to test an introductory version of the patient safety incident response framework (PSIRF) prior to the national roll out in Spring 2022. These organisations formed a PSIRF steering group and have worked collaboratively over the past 18 months with other stakeholders to co-develop patient safety incident response plans (PSIRP) for each provider (RCHT and CFT).

Under the current serious incident framework (SIF) commissioners have the responsibility to ensure that providers quality assure the robustness of providers incident investigations and action plans. PSIRF now places the responsibility for the sign-off of provider led patient safety incident investigation's (PSII's) and improvement plans, with the board(s) /leaders of the organisation involved which is a significant change in governance.

Providers should agree the PSIRPs with their lead commissioners who will assure effective application of local PSIRPs and PSII standards.

CFT Patient safety incident response plan (PSIRP) 2021/22

This PSIRP sets out how Cornwall Partnership NHS Foundation Trust (CFT) will respond, learn and improve from patient safety incidents reported by staff and patients, their families and carers as part of work to continually improve the quality and safety of the care provided. The plan is founded upon the key aim of promoting a just culture, providing staff with a psychologically safe space to discuss and learn from events and proactively reduce the risk of harm.

This PSIRP was co-developed with services users, colleagues from across the Trust, Royal Cornwall Hospitals, local commissioners and the national patient safety team. The draft plan has been shared with NHSE/I regional and National teams who support the content of the draft. CFT request that Kernow CCG agree the PSIRP to enable the switch from the serious incident framework (SIF) to PSIRF starting 6 October 2021 and propose a 3-month transition period to enable the completion of existing serious incidents.

The PSIRP sets out how aggregated learning from incident responses will be transformed wherever possible to measurable systemic recommendations and actions to improve patient safety. The plan aims to better use valuable healthcare resources by transferring the emphasis from quantity of investigations to a higher quality, more proportionate response to patient safety incidents, and the implementation of meaningful actions which lead to demonstrable change and improvement.

The PSIRP describes the risk prioritisation approach utilised by the Trust to identify the top patient safety risks and priorities for CFT (section 3.0). 6 local priorities for PSII for the period 6 October 2021 to 30 September 2022 are detailed (see table 5, page 12):

1. self-harm (under 25 years)
2. patient falls (age over 80)
3. pressure ulcers (grade 2 and above)
4. access to services/ treatment waiting times
5. care delivery/ implementation of care
6. unsafe / complex discharge

The findings from PSII's will be translated into improvement plans (section 5) which will be overseen by the Trust board.

Incidents outside of the above categories will undergo a patient safety review and all patient safety incidents leading to moderate harm must meet duty of candour requirements (see section 4).

As an early adopter, the Trust is part of a group of organisations that will be actively learning through the PSIRF process and shaping the national roll out. Throughout implementation, the Trust will monitor the impact and effectiveness of the plan and the wider PSIRF. The Trust will continue to provide ongoing feedback to NHS Kernow, NHS England & Improvement as early adopters in preparation for national roll out of PSIRF.

Recommendations and specific action to take at the meeting

The committee is asked to:

1. Receive the report and request further information, where necessary.
2. Acknowledge the transition point for the cessation of the serious incident framework (SIF) and commencement of PSIRF, for CFT from 6 October 2021 with a 3 month transition period for the completion of existing SI's.
3. Request that regular updates regarding the progress, implementation and effectiveness of the PSIRP be provided to the Quality Assurance Committee to enable assurance regarding the quality of patient safety incident response.

Additional required information

Cross reference to strategic objectives

☒ Improve health and wellbeing and reduce inequalities
☒ Provide safe, high quality, timely and compassionate care
☒ Work efficiently so health and care funding give maximum benefits
☒ Make Cornwall and the Isles of Scilly a great place to work
☐ Create the underpinning infrastructure and capabilities critical to delivery
☒ Commissioning supports COVID-19, recovery plans and long-term plan expectations

Evidence in support of arguments: NHS England » Patient Safety Incident Response Framework

Engagement and involvement: PSIRF steering group, NHS Kernow quality assurance committee, CFT quality assurance committee and board

Communication and/or consultation requirements: feedback from governing body to CFT

Financial implications: as noted

Review arrangements: Forms part of in-depth monthly review of quality information at quality assurance meeting.

Risk management: Corporate risks are discussed at the joint finance, performance and quality meeting

National policy or legislation: Covers constitutional, national and locally determined quality and performance metrics

Public health implications: Consideration given to public health implications, particularly with respect to inequalities

Equality and diversity: Equality and diversity is considered through all of NHS Kernow's work.

Climate change implications: Meetings are now being held virtually, papers are no longer printed, and travel no longer required.

Other external assessment: The PSIRP has been shared with NHSE regional and national teams and CFT board. A considerable amount of the information is nationally submitted and informs discussions with regulators

Relevant conflicts of interest: None known other than those recorded within the declaration of interest register

For use with private and confidential agenda items only

FOI consideration – exemption*: None - item may be published

Qualified or absolute? None - item may be published

If exemption is qualified, then public interest test required. Check to see if the public interest in the information being released outweighs the exemption being used and record your consideration here to justify inclusion on the private and confidential agenda. Note the information commissioner states that there is a public interest in transparency. For advice, contact kccg.foi@nhs.net.

Main report

See attached report.

Cornwall Partnership
NHS Foundation Trust

.

Patient safety incident response plan 2021/22

FINAL v1.0

Finalised date: 01 October 2021

Estimated refresh date: 01 October 2022

Cornwall Partnership
NHS Foundation Trust

Table of Contents

1. Purpose, scope, aims and objectives

1.1. Purpose

1.1.1. This patient safety incident response plan (PSIRP) sets out how Cornwall Partnership NHS Foundation Trust (CFT) will respond to patient safety incidents reported by staff and patients, their families and carers as part of work to continually improve the quality and safety of the care provided.

1.1.2. This plan also sets out how aggregated learning from incident responses will be transformed wherever possible to measurable systemic recommendations and actions to improve patient safety.

1.2. Scope

1.2.1. There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

1.2.2. There is no remit to apportion blame or determine liability, preventability or cause of death in an incident response conducted for the purpose of learning and improvement.

1.2.3. Responses covered in this plan include:

- Patient safety incident investigations (PSIIs)
- Patient safety reviews (PSRs)

1.2.4. Other responses to incidents exist for purposes other than learning. Examples include complaint, claims, human resource (employee relations), professional regulation, coronial or criminal investigations. The aims of each of these responses differ and are outside the scope of this plan.

1.2.5. To be effective in meeting their specific intended purposes, responses that are not conducted for learning and improvement are separate entities and will be appropriately referred to as follows:

- professional conduct or competence – human resource (employee relations) teams
- establishing liability or avoidability – claims or legal teams
- cause of death – coroner's office
- criminal – police

1.3. Strategic aims and objectives

Strategic aims	Strategic objectives
Improve the safety of the care we provide to our patients.	• Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. • Conduct PSIIs purely from a patient safety perspective. • Reduce the number of PSIIs into the same type of incident to enable more rigorous investigations that identify systemic contributory factors. • Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of specifically similar repeat incidents. • Consider the safety issues and contributory factors that are common to specifically similar types of incident. • Develop system improvement plans. across aggregated PSIIs and, where appropriate, other incident response data to produce systems-based improvements. • Better measurement of improvement initiatives based on learning from incident responses.
Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.	• Act on feedback from patients, families, carers and staff about their concerns relating to patient safety incident responses and PSIIs in the NHS. • Support and involve patients, families and carers in PSIIs and PSRs, for better understanding of the issues and contributory factors.
Improve the use of valuable healthcare resources.	• Transfer the emphasis from quantity of investigations to a higher quality, more proportionate response to patient safety

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

	incidents, and the implementation of meaningful actions which lead to demonstrable change and improvement. • Develop a local board led, commissioner and integrated care system (ICS) assured architecture around response to patient safety incidents, which promotes ownership, rigor, expertise and efficacy.
Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.	• Act on feedback from staff about their concerns with patient safety incident responses and PSIIs in the NHS. • Support and involve staff in PSIIs and PSRs, for better understanding of the issues and contributory factors.

2. Resource analysis

2.1. Background

2.1.1. There are many ways an organisation can respond to a patient safety incident to learn and improve.

2.1.1. Patient safety incident investigations (PSIIs) systematically identify the circumstances surrounding incidents and the systems-focused, interconnected contributory factors.

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

- Locally investigated PSIIs
- Externally investigated PSIIs funded by the organisation
- Independent PSIIs funded regionally/nationally

2.1.3. Patient safety reviews (PSRs) include several techniques to gain insight into incidents to inform improvement plans and immediate safety actions, and to respond to any concerns raised by the affected patient, family or carer.

2.1.4. Patient safety reviews (PSRs) can be divided into four broad categories:

- Incident recovery
- Team reviews
- Systematic reviews
- Monitoring

2.1.5. Understanding the capacity to respond to incidents enables the trust board to be strategic in allocating resources based on a systematic review of a range of patient safety information to identify key risks (see section 3, risk prioritisation analysis).

2.2. Understanding incident response activity

2.2.1 A review has been undertaken of the current resource and activity associated with existing serious incident investigation for the period 2018 to 2021. A review of the resource was conducted against the patient safety incident investigation standards.

In addition, a review has been undertaken to determine the trust's level of resource for carrying out non-SI PSI related activity. This includes clinical reviews; structured judgement reviews, learning from experience reviews; audits etc. This review was undertaken by the governance team with support and involvement from the executive lead for patient safety.

2.3. Understanding incident response resources

2.3.1. A review of current (2021) patient safety related incident investigation resource and activity was conducted using information and intelligence available within the trust.

2.3.2. The review separated this activity into patient safety incident investigation types, patient safety incident review types, personnel involved in patient safety incident investigation activity, and the associated meetings and support activities.

2.4. Gap analysis

2.4.1 The current structure includes seven dedicated investigating officers, employed by the trust but independent of the clinical area where the incident occurred. Investigating officers are line managed and supported by the governance team. Investigation reports have executive level sign off.

2.4.2 Resource, restructuring and training is needed to meet the requirements of the patient safety incident investigation standards and the PSIRF.

2.4.3 Executive level planning to address the above is underway and expected to take twelve to 24 months to rollout and fully embed. The planning and restructuring exercise will:

- Enhance patient safety management and leadership support
- Enhance resource and skills to conduct alternative patient safety reviews
- Enhance patient safety investigation with a lead and supporting investigator, subject matter experts, administrative support, patient and family liaison, and executive level oversight and support
- Enable each investigator to:
  - receive systems-based patient safety incident investigation training.
  - be dedicated to one PSII at any time

2.5. Understanding incident response capacity

Table 1: estimated resources required for responding to national priorities

	Category	No. of incidents	Hours
National priority Patient safety investigations (PSIIs) into:-	Never events	0	**Min 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident • board committee approval and sign off
	Learning from deaths	5	
	Death or long-term severe injury of a person detained under the Mental Health Act	1	
	(Domestic homicide)	(5)	(safeguarding team resources)

Table 2: overview of estimated resource allocation for local PSIIs and PSRs

Response type	Category	No. of incidents	Hours
Local priority PSII	Locally defined PSIIs	25-30	**Min 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident • board committee approval and sign off
	Unanticipated PSIIs	5	**Min 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident • board committee approval and sign off
Patient safety reviews (PSRs)	All types of PSR	120	Maximum eighteen hours per response review

3. Risk prioritisation analysis

3.1. Risk prioritisation approach

3.1.1 The following key stakeholders have been identified and involved in developing the PSIRP or defining the patient safety risks and priorities for incident response for the coming year (2021-22).

Key Stakeholders

- NHS Kernow Clinical Commissioning Group
- Patient representatives of Cornwall Partnership NHS Foundation Trust
- Staff of Cornwall Partnership NHS Foundation Trust
- Royal Cornwall Hospital NHS Trust
- South West Ambulance Service NHS Foundation Trust
- The Duchy Hospital
- University Hospitals Plymouth NHS Trust
- Northern Devon Healthcare NHS Trust
- Third sector representatives
- Cornwall Council
- NHS England and Improvement national patient safety team

3.1.2 A review of patient safety data and intelligence was conducted using reports from the local 'Ulysses' incident and risk management system, NRLS explorer tool; clinical governance; complaints; claims; PALS (patient advice and liaison service); and 'freedom to speak up' between the years 2018 to 2021.

3.1.3 Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place.

3.1.4 A range of staff, including leads for each of the above data collection systems, were consulted and a prioritised list of incidents for the year ahead was agreed.

3.1.5 The review also highlighted areas which required the collation of further intelligence to inform subsequent plans.

3.1.6 In the years ahead, the trust will seek data and insight from stakeholders to inform potential future categories for local patient safety incident investigation and system improvement.

3.2. Local patient safety risk profile

3.2.1 The current local top ten patient safety risks are presented in table 3. Presumed suicide, whilst identified as a patient safety incident risk category, will be reviewed in line with the learning from deaths national priority and those incidents meeting the criteria for investigation will proceed as a patient safety incident investigation. In line with this arrangement, therefore, not all suicides will be selected as a local priority for review and investigation.

Table 3: key patient safety incident risk categories identified

	Incident type	Description	Specialty
1	Presumed suicide	Whilst receiving care within the community	Mental health services
2	Self-harm	Whilst receiving care within the community	Mental health services
3	Patient fall	Unwitnessed	Community hospital care and mental health inpatient services
4	Pressure ulcer	Categories 2 and 3	Adult community services
5	Access to care	Child and adolescent mental health services (CAMHS)	Mental health services
6	Waiting time	Mental health services. Parkinson's and palliative care	Includes a variety of specialty areas
7	Care delivery / implementation of care	Delay in treatment; CAMHS (child and adolescent mental health services)	Mental health services
8	Unsafe Discharge	Complications in transitions of care	Includes a variety of specialty areas
9	Safeguarding	Section 21A deprivation of liberty safeguarding challenges	Includes a variety of specialty areas
10	Medicines Safety	Prescribing; missed dose; discharge	Includes a variety of specialty areas

3.3. Locally defined priority incidents for PSII

Table 4: criteria for selection of priorities for PSII for the coming period of one year

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: with the potential to generate new information, novel insights, or bridge a gap in current understanding. • Likelihood of influencing: healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII. • Value: extent of overlap with other improvement work[2]; adequacy of past actions.

[2] To assist with defining the potential for learning and improvement, and to ensure our PSII priority areas do not unnecessarily duplicate improvement work we reviewed all locally designed and national improvement plans underway. Only full plans were reviewed: individual actions designed to address previous findings from PSIIs, reviews, audits or risk assessments were not included.

Potential for harm	• People: physical, psychological, loss of trust (patients, families or care givers). • Service delivery: impact on quality and delivery of healthcare services; impact on capacity. • Public confidence: including political attention and media coverage.
Systemic risk	• Complexity of interactions between different parts of the healthcare system. • Persistence of the risk. • Potential to escalate.

3.3.1 Based on the analysis and selection criteria described above, local priorities for PSII have been set by this organisation for the period 01 October 2021 to 30 September 2022.

3.3.2 The priorities have been agreed with our commissioning organisation, NHS Kernow Clinical Commissioning Group, and the national patient safety team at NHS England and Improvement. Priorities are listed in table 5 below.

3.3.3 Each PSII will be conducted separately, in full and to a high standard, by a team whose lead investigator is appropriately trained (see PSIRF Part C: governance arrangements for training requirements).

3.3.4 Findings from investigations conducted from the same narrowly specified incident type will be analysed for commonalities and opportunities for system improvement.

Table 5: Local priorities for PSII for the coming period of one year

	Incident type	Description	Specialty	Number of PSIIs
1	Self-harm	• Currently under community based care programme • By hanging; strangulation suffocation • Under 25 years old	Mental health services	1 severe harm 1 moderate harm 1 no harm Any death related to this incident type where the learning from death criteria for investigation was met will progress as a PSII
2	Patient fall	• Unwitnessed • Occurring on route to ward toilet • Patients over 80 years old	Inpatient adult community services (ACS) and mental health care wards	1 severe harm 1 moderate harm 1 no harm/near miss
3	Pressure ulcer	• Category 2 or unstageable • In the community • Occasional visit by district nurse	Cross setting	3 moderate harm

		• Care provided by residential home or care agency		
4	Access to services/ treatment waiting times	Delay in initial start of treatment following referral: - • For children and adolescent mental health service (CAMHS) (under 18s) • With moderate/severe mental health condition	Community CAMHS	1 resulting in harm 1 resulting in admission 1 breach
5	Care delivery/ implementation of care	Interruption in continuity of care: - • In community nursing • Involving more than three deferred visits • Where the team was unable to treat as planned or expected	Adult community services	1 resulting in admission 1 moderate harm (resulting in the need for referral / increased level of care) 1 no harm/near miss
6	Unsafe/complex discharge	Complications in transition of care: - • For a young person with a moderate or severe mental health diagnosis transitioning from CAMHS to adult mental health services	Cross setting (community CAMHS and adult mental health services)	1 resulting in harm 1 resulting in admission 1 no harm/near miss

3.4 Approach to local PSII selection

3.4.1 For each priority area and specified incident listed in 3.3, the incidents for investigation will be selected by the patient safety and risk team on the basis of the next incident reported from that category.

3.4.2 The PSII will be allocated to an investigator once that investigator has completed an investigation which did not relate to the incident category to be investigated.

3.4.3 Incidents reported from each category, that are not elected for investigation, will be reviewed by the patient safety and risk team against the patient safety review (PSR) plan in section 4 below, to determine which may require a patient safety review.

3.5 Timescales for PSIIs

3.5.1 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.

3.5.2 PSIIs will ordinarily be completed within one to three months of their commencement date.

3.5.3 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 member or carer.

3.5.4 No local PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure findings remain relevant.

3.5.5 Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

4 Selection of incidents for patient safety review (PSR)

4.1 Patient safety review types

4.1.1 Patient safety incidents that do not require a PSII will benefit from a patient safety review (PSR) to gain insight or address queries from the patient, family, carers or staff.

4.1.2 Different PSR techniques can be adopted, depending on the intended aim and required outcome. These are presented in table 6 below.

4.1.3 All patient safety incidents leading to moderate harm or above and all incidents for which an investigation is undertaken must meet duty of candour requirements.

Table 6: types of patient safety incident reviews

PSR type	Methods	Objective
Incident recovery Immediate measures taken to: • address serious discomfort, injury or threat to life. • respond to concerns raised by the affected patient, family, or carer. • determine the likelihood and severity of an identified risk.	Immediate actions	To take urgent measures to address serious and imminent discomfort, injury, or threat to life or damage to equipment or the environment.
	Risk assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'.
Team reviews Post-incident review as a team to: • identify areas for improvement. • celebrate success. • understand the expectations and perspectives of all those involved. • agree actions. • enhance teamwork through communication and collaborative problem solving.	Debrief	An unstructured, moderated discussion. The simplest and most informal method to gain understanding and insight soon after an incident. Debriefs held immediately after an incident are known as 'hot' debriefs.
	Safety huddle	**Proactive:** a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive:** triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions.
	After action review	A 'cold' structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What is expected to happen?

		2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?
Systematic reviews To determine: • The circumstances and care leading up to and surrounding the incident. • Whether there were any problems with the care provided to the patient.	Case record or note review (e.g. structured judgement review)	To determine whether there were any problems with the care provided to a patient by a service. To routinely identify the prevalence of issues; or when bereaved families, carers or staff raise concerns about care.
	Mortality review	A systematic review of a series of case records using a structured, or semi-structured, methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients.
	Specialised reviews	Examples can include falls and infection prevention and control reviews.
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Audit can be observational or include documentation review.
	Survey	Local and national surveys seek to elicit patient views on the service they have received. Surveys provide a structured measure of patient experience. Staff surveys provide insight into staff experience and an opportunity to monitor change over time.

4.2 Local patient safety review (PSR) responses

4.2.1 Based on the analysis conducted in sections 3.1 to 3.3, table 7 shows anticipated responses to the remaining categories within the key list of patient safety risks.

4.2.2 Responses to patient safety incidents, not listed, will be determined on a subject matter or case by case basis. Not all incidents will require a response. The decision to conduct a patient safety review will be based upon the opportunity for new learning, the planned need to gather insight for future prioritisation work, or the need to provide a description of the incident for the patient or for relatives of the patient involved in an incident.

Table 7: anticipated responses to remaining categories of patient safety risks

	Incident type	Description	Specialty	Planned PSR	Responsibility
1	Presumed suicide	Whilst receiving care within the community	Mental health services	Structured judgement review Where indicated on review by patient safety team or medical examiner	Patient safety team allocates to a relevant clinical lead for delegation of the task to a reviewer. Findings are reported to the mortality review and oversight group If the learning from deaths criteria for investigation are met, then a PSII will be undertaken.
2	Self-harm	Whilst receiving care within the community	Mental health services	After action review or clinical review where indicated on a local basis	Local team matron or operational manager for allocation. Findings reported to service line clinical quality assurance group and patient safety committee.
3	Patient fall	Unwitnessed	Community hospital care and mental health inpatient services	Incident risk and mitigation form or safety huddle or after action review where indicated locally or by falls lead	Local team matron and or operational manager for allocation. Findings reported to service line clinical quality assurance group and patient safety committee.
4	Pressure ulcer	Category 2 and 3 pressure ulcers	Adult community services	Incident risk and mitigation form or safety huddle or after action review indicated locally or by tissue viability team	Local team matron and or operational manager for allocation. Findings reported to service line clinical quality assurance group and patient safety committee.
5	Access to care / waiting time	Access to CAMHS	Mental health services	Audit to inform future specification(s) for PSII	Quality lead and operational managers for CAMHS. Findings reported to clinical quality assurance group and patient safety committee.
6	Waiting time	Parkinson's care and	Includes a variety of	Audit to inform future	Nurse consultant, quality lead and operational

		mental health services	specialty areas	specification(s) for PSII	managers for Parkinson's service. Findings reported to clinical quality assurance group and patient safety committee.
7	Care delivery/ implementation of care	Delay in treatment	Mental health services	Audit to inform future specification(s) for PSII	Quality lead and operational managers. Findings reported to clinical quality assurance group and patient safety committee.
8	Unsafe discharge	Meaningful follow-up on patient discharge from mental health services	Includes a variety of specialty areas	Audit to inform future specification(s) for PSII	Local matron, quality lead and operational managers. Findings reported to clinical quality assurance group and patient safety committee.
9	Safeguarding	Section 21A deprivation of liberty safeguarding challenges	Includes a variety of specialty areas	Audit to inform future specification(s) for PSII as time allows	Local matron, quality lead and operational managers, supported by safeguarding and mental health act teams. Findings reported to clinical quality assurance group and patient safety committee.
10	Medicines safety	Prescribing; Missed dose; discharge	Includes a variety of specialty areas	Data mining or audit to inform future specification(s) for PSII	Medicine safety officer. Findings reported to medicines optimisation safety committee (MOSC), clinical quality assurance group and patient safety committee.

5 Aggregating learning from incident responses

5.1 Findings from PSIIs and PSRs will be translated into improvement plans for implementation wherever possible.

5.2 If a single response reveals significant risk(s) that require(s) immediate action to improve patient safety, these actions will be undertaken as soon as possible.

5.3 Other recommendations will be aggregated from all, or a subset of, responses into a single local priority area.

5.4 To aggregate learning, findings from each individual response linked to a local priority will be collated to identify common contributory factors and any common interconnections or associations upon which effective improvements can be designed. Associated recommendations and monitoring arrangements will be translated into a more detailed system improvement or action plan.

5.5 Consideration will be given to the timeframe taken to both develop and complete a system improvement plan, and the impact of extended timescales on those involved in the incident and those delivering or receiving care in the future.

5.6 System improvement plans will be shared with those involved in the incident including patients, families, carers and staff.

6 Roles and responsibilities

6.1 This organisation has clear roles and responsibilities in relation to its response to patient safety incidents and the national standards for patient safety incident investigations. These are being designed, developed, implemented and embedded over the coming twelve to 24 months (as an integral part of this plan) to align with those set out in appendix 2 of the PSIRF. They include the role of:

- trust board
- board quality committee and patient safety sub-committee
- chief executive
- governors
- executive lead for supporting and overseeing implementation of the PSIRF and PSIRP
- patient safety team
- patient safety incident investigators
- named contacts for patients, families and carers
- named contacts for staff
- all staff

6.2 In addition, the trust will, alongside neighbouring NHS organisations, work with one established medical examiner's office. The medical examiner's key role is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

Whilst medical examiners are NHS employees, they have separate professional accountability and their independence, which is vital to the scrutiny they provide, is overseen by the national medical examiner.

Medical examiners scrutinise all deaths to:

- agree the proposed medical cause of death and ensure the overall accuracy of the medical certification of the cause of death
- identify problems in treatment or care and, as necessary, report to the trust's clinical governance process
- discuss the cause of death with the bereaved and listen to any concerns
- ensure the referral of deaths to the coroner as required by the law; this includes deaths where there are concerns that failure in care contributed to death or where the bereaved raise significant concerns about the care provided to their relative
- liaise with, and assist, the coroner with medical information
- educate and provide advice to other clinicians about death registration and the coronial process

7 Patient Safety Reporting Arrangements

7.1 Local reporting of patient safety incidents (PSIs)

7.1.1 Reporting via the 'Ulysses' system

Executive leaders, managers and trainers in the trust advise, (via induction and mandatory training sessions) enable and support all staff to report and share information about:

- hazards, risks or incidents of all levels of severity
- good practice and actions taken to avoid or mitigate incidents

Staff who identify an incident must record this on the trust's incident reporting system (Ulysses) with factually accurate detail on the incident, including the circumstances that led up to the incident, to enable an appropriate PSI response. Staff should also inform their line manager, so that they may:

- inform others who need to know about the incident, particularly of any implications for care and how they can support patients and families emotionally and practically, as required e.g. safeguarding, PALS, etc
- ensure clinical staff involved in, or responsible for, a patient's care are given relevant information and support
- liaise with other healthcare providers and commissioners where a cross system response may be required

A clear record of what happened should be documented in the patient's clinical record.

7.1.2 Freedom to speak up reports

The trust also has clear and well developed 'speaking up' arrangements, which are fully supported by senior leaders and communicated to staff during induction.

7.1.3 Patient safety incidents: complaints or PALS reports

Patients, families, carers and the public are also advised and encouraged to record and share information about patient safety incidents through the PALS and complaints systems.

The local systems used in the trust to capture and manage patient safety incidents, risks or concerns enable incidents to be addressed through a single and consistent incident response pathway, regardless of how they were first raised or reported. The departments that manage patient safety incidents, complaints, claims, and freedom to speak up reports work closely together to align the approaches to respond to patient safety incidents and the resultant valuable opportunities for learning.

7.2 National reporting

7.2.1 The trust undertakes its external reporting and notification requirements in line with national guidance available at appendix 6 of the patient safety incident response framework (PSIRF - 2020). NHS England » Patient Safety Incident Response Framework. Some of the key national reporting activities are:

7.2.2 Reporting patient safety incidents to the 'NRLS' and its successor system

The trust currently reports patient safety incidents to the national reporting and learning system (NRLS) through weekly data uploads.

7.2.3 Reporting patient safety incident investigations to 'StEIS'

In line with the PSIRF, reporting incidents previously defined as 'serious incidents' to the national 'StEIS' database will cease and StEIS and, at a date to be determined nationally, the replacement system will be used to report and monitor all patient safety incidents including those identified as requiring a patient safety incident investigation.

Management and monitoring of individual investigations, previously the responsibility of the local commissioning organisation, will be the responsibility of the trust.

Reporting PSIs and PSIIs to the new 'learning from patent safety events' system will follow when this replaces the NRLS and further guidance is issued.

7.2.4 Reporting to the Care Quality Commission (CQC)

Statutory Care Quality Commission notification requirements will be met by reporting incidents to the national reporting and learning system (NRLS) and its successor system. One notable exception is the death of a patient detained under the Mental Health Act which, in line with national guidance, will be reported directly to the CQC.

8 Procedures to support patients, families & carers affected by PSIs

8.1 Local support

Patient advice and liaison service (PALS) at Cornwall Partnership NHS Foundation Trust

Patient Advice and Liaison Service | Cornwall Partnership NHS Foundation Trust (cornwallft.nhs.uk)

The trust is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, service users, family members or carers. On these occasions the trust aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

Independent advice and support

Trust staff are empowered to resolve concerns immediately and informally, where this is possible. People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the care team.

Should the care team be unable to resolve the concern then the patient advice and liaison service can provide support and advice to patients, families, carers and friends.

The patient advice and liaison service (PALS) is a free and confidential service.

The PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

Help and Support

PALS can help and support with:

- advice and information
- comments and suggestions
- compliments and thanks
- informal complaints
- advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

Contact Information

Address:	PALS Office, Cornwall Partnership NHS Foundation Trust, Room 11, Banham House, Bodmin Hospital. PL31 2QT
Tel:	01208 834620
Email:	cpn-tr.Palscft@nhs.net

8.2 National sources of support

- National guidance for NHS trusts engaging with bereaved families

- Learning from deaths – information for families explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

- Mental health homicide support materials for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

- The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.

- Healthwatch Cornwall provides information to help make a complaint, including sample letters.

Address:	Healthwatch Cornwall. 6 Walsingham Place, Truro. TR1 2RP
Tel:	0800 0381 281
Email:	enquiries@healthwatchcornwall.co.uk

- Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

- Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

8.3 Involvement of patients, families and carers

8.3.1 During the investigation process

The trust is committed to supporting and involving patients and families in line with the patient safety investigation standards[3] where a patient safety incident investigation is undertaken.

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.

During a patient safety incident investigation, a patient, family member or carer will be asked to contribute in several ways. This will include:

- advising the trust about any issues or concerns relating to the care and treatment provided.
- sharing questions to be answered.
- describing an experience and giving an account of what happened to help establish the facts about the incident and how it happened.
- reviewing the draft investigation report.
- helping to inform recommendations and actions for improvement.
- keeping the trust up to date with feeling and whether there is more that can be done to offer support.
- providing feedback about involvement in the patient safety incident investigation

On completion of the investigation the trust will actively encourage feedback from patients, families or carers to continually improve the experience of patients and to improve standards and quality of care.

[3] https://www.england.nhs.uk/wp-content/uploads/2020/08/Standards_for_PSI_Investigation.pdf

9 Procedures to support staff affected by PSIs

9.1 Local arrangements

Occupational health services

Occupational health services help keep employees healthy and safe while in work and manage risks in the workplace that are likely to give rise to work related ill health.
Email: cpn-tr.Enquiries@nhs.net
CFT support: 01208 834600

Freedom to speak Up

Staff are able to seek support from the freedom to speak up guardian to address concerns relating to patient safety.
Email: cpn-tr.Enquiries@nhs.net
CFT support: 01208 834600

9.2 National arrangements

Mental Health First Aid (MHFA) – England

Provides:

- workplace guidance for employers and employees
- information on mental health first aid training

Caring for the care givers

The Improvement Academy hosts the 'Second victim support' website. The term 'second victim' is under review but refers to healthcare workers who are impacted by patient safety incidents. While patients and families will always be the first priority following safety incidents, the wellbeing of staff involved is often overlooked but can leave staff lacking confidence or unable to perform their job. This can lead to time away from work or to leaving a profession.

Evidence exists of the importance and effectiveness of support programmes for such staff and their potential to counter the negative impact outlined above resulting in a more positive impact for staff and patients.

'Being open' – when things go wrong

The being open framework (2009) includes guidance on supporting staff when things go wrong.

A just culture guide

The just culture guide is useful when assessing concerns about individuals to ensure they are treated consistently, constructively and fairly. This should have a particularly positive effect on staff groups who have traditionally faced disproportionate disciplinary actions, e.g. black, asian and minority ethnic (BAME) groups.

The ASSIST ME model

Managers and others can use the ASSIST ME model (produced by the Irish Health Service Executive) to guide appropriate conversations and to develop the necessary procedures to support staff following their involvement in patient safety incidents.

The trust has a local web-based platform to support the NHS workforce to manage their own health and wellbeing whilst looking after others. There are a number of resources that provide support, education and signposting for staff and managers, these include helplines, apps, guides and opportunities for training.

10 Mechanisms to develop and support improvements following PSIIs

10.1 When a PSII has been finalised, recommendations will be formulated into action or improvement plans developed specifically to reduce the risk of an incident recurring by addressing key underlying causal factors.

10.2 People with relevant skills, experience and time to design and support the implementation of technical aspects of improvement plans are required. As part of its continuous improvement process, the trust will develop local skills and employ or seek specialist advice to support this important aspect of system improvement.

10.3 Measurement is fundamental to any improvement programme. Without it, organisations may invest time and effort implementing changes that have little or no impact or, in the worst case, increase the risk of further harm.

10.4 From the outset those responsible for designing and implementing improvement plans in the trust will be trained, this will include support in how to establish appropriate measures to enable meaningful and effective monitoring to determine whether the actions implemented are sustainable and are having the intended effect. Both outcome and process measures should be used to interpret the impact of action/improvement plan and to inform how actions should be adapted if they fail to have the intended effect.

10.5 Organisational escalation processes will be developed to manage situations where resources are insufficient to robustly implement actions or influence improvement, e.g. where an investment in technology or a widespread systemic change may be the better option but is out of reach or scope of local expertise and funds.

11 Monitoring outcomes of PSIIs and PSRs

11.1 Regular update reports will be created for board review and assurance. Contents may vary but will include aggregated data on:

- patient safety incident (PSI) reporting
- findings from patient safety incident investigations (PSIIs)
- findings from patient safety reviews (PSRs)
- progress against the patient safety incident response plan (PSIRP)
- progress on system improvement and action plans
- results of surveys or feedback from patients, families and carers on their experiences of the organisation's response to patient safety incidents
- results of surveys or feedback from staff on their experiences of the organisation's response to patient safety incidents

11.2 Evaluating and monitoring outcomes of PSIIs for the implementation, sustainability, and effectiveness of improvement plans will be undertaken using:

- options appraisal and impact analysis
- patient surveys on the openness and effectiveness of patient safety reporting and PSII procedures
- patients, relatives or staff voicing that they are appropriately supported
- staff surveys on the openness and effectiveness of patient safety incident reporting and PSII procedures
- PSI reporting levels, themes and trends
- consistency of understanding throughout the organisation of PSII risk or priority areas
- quality of improvement in PSIIs
- rate of repeat PSIs

11.3 To facilitate monitoring the trust will hold information on incident reports, PSIIs and improvement plans in 'Ulysses', the local incident and risk management system. Additionally, the trust will upload data in relation to findings from PSII to the national StEIS database and subsequently its successor system to further facilitate evaluation of data locally and nationally.

11.4 Findings from the above will be aligned with, and inform risk registers, risk management plans and risk management activity.

11.5 The operationally led clinical quality assurance group (CQAG) and board sub committees will also have a monitoring function.

11.6 The patient safety committee (to be established as sub-committee of the quality assurance committee) will have oversight and share data monthly with the board to include aggregated data on:

- patient safety incident reporting
- audit and review findings
- progress against the PSIRP
- findings from patient safety incident investigations
- findings from patient safety reviews

- results from monitoring of improvement plans from an implementation, sustainability and an efficacy point of view
- results from surveys and/or feedback from patients/families/carers on their experiences of the trust's response to PSIs

12 Complaints and appeals

12.1 How to make a complaint

Full details available at: How to make a complaint | Cornwall Partnership NHS FoundationtTust(cornwallft.nhs.uk)

The trust welcomes complaints as a way of learning from people's experiences and improving services.

If the trust hasn't been able to resolve concerns locally or through PALS, then the formal complaint process can be followed.

The PALS team provides help, advice and support to anyone wanting to make a complaint or can provide information on local advocacy services if support is required with the complaint process.

As a trust, complaints are taken very seriously and are treated in confidence. The trust aims to resolve complaints quickly and fairly and to rectify any mistake or misunderstanding straight away.

12.2 Contact Information – see page 33

13 Appendix A

13.1 National priorities requiring PSII

13.1.1 National priorities are set by the PSIRF and other national initiatives. These priorities require a PSII to be conducted by the organisation.

13.1.2 There are three categories of national priorities requiring local PSII: incidents that meet the criteria set in the never events list (2018); incidents that meet learning from deaths criteria; and death or long-term severe injury of a person in state care or detained under the Mental Health Act. Further detail is provided below.

13.1.3 **Incidents that meet the criteria set in the** NHS England » Never events **list 2018**

13.1.4 Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

13.1.5 **Incidents that meet the 'learning from deaths' criteria**;

13.1.6 Deaths clinically assessed as being more likely than not due to problems in care, using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local learning from deaths plan or following reported concerns about care or service delivery.

13.1.7 Examples include:

- deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care.

- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents or problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the learning from deaths review.

- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents or problems in the healthcare provided by the NHS.

13.1.8 Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

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

13.2 National PSII priorities to be referred to another team

13.2.1 The national priorities for referral to other bodies, or teams, for review or PSII (described in the PSIRF) for the period covered are as follows, further details are provided below:

- maternity and neonatal incidents
- mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- child deaths
- deaths of persons with learning disabilities
- safeguarding incidents
- incidents in screening programmes
- deaths of patients in custody, in prison or on probation

13.2.2 **Maternity and neonatal incidents:**

13.2.3 Incidents which meet the 'each baby counts' and maternal deaths criteria detailed in appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/).

13.2.4 All cases of severe brain injury (in line with the criteria used by the each baby counts programme) must also be referred to NHS Resolution's Early Notification Scheme.

13.2.5 All perinatal and maternal deaths must be referred to MBRRACE.

13.2.6 **Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge**

These incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT).

13.2.7 **Child deaths**

13.2.8 For further information, see: *Child death review statutory and operational guidance.*

13.2.9 Incidents must be referred to child death panels for investigation.

13.2.10 **Deaths of persons with learning disabilities**

13.2.11 Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme.

13.2.12 **Safeguarding incidents:**

13.2.13 Incidents must be reported to the trust's named professional safeguarding lead manager and director of nursing for review and multi-professional investigation.

13.2.14 **Incidents in screening programmes**

13.2.15 For further information see: **incidents in screening programmes.**

13.2.16 Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional screening quality assurance service (SQAS) and commissioners of the service).

13.2.17 **Deaths of patients in custody, in prison or on probation**

13.2.18 Where healthcare is, or was, NHS funded and delivered through an NHS contract, incidents must be reported to the prison and probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

Contact us:

Cornwall Partnership NHS Foundation Trust

T: 01208 834600
E: **cpn-tr.Enquiries@nhs.net**
W: Home | Cornwall Partnership NHS Foundation Trust (cornwallft.nhs.uk)

@CornwallFT

This publication can be made available in a number of other formats on request.

Publication approval reference: