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NHS
Cambridgeshire Community Services
NHS Trust

Patient Safety Incident Response Plan

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Document Number:	Insert if known		
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Document Service:	Corporate		
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Scope:	This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the services that we provide. Response types that are outside the scope of this plan include those resulting from: • Complaints • Human resources investigations • Professional standards investigations • Coronial inquests • Criminal investigations • Claims management • Financial investigations and audits • Safeguarding concerns • Information governance concerns • Estates and facilities issues		
Standards and legislation & key related documents:	It is the responsibility of the relevant staff groups to act in accordance with this document. Key related documents include: • Complaints Concerns and Compliments (Patient Experience) • Supporting Staff Involved in an Incident, Complaint or Claim. • Duty of Candour Policy 2.2 • Patient Safety Incident Response Framework Policy (link here) • Incident and Near Miss Reporting and management • Freedom to Speak Up Policy 7.0 • Reward and Recognition for Involvement Partners V2.1		
Approved by:	Quality Improvement & Safety Committee		
Date approved:	Click here to enter a date.	**Expiry date:**	April 2025
Financial Implications:	Where a document has any financial implications on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document in regards to current fraud and bribery legislation and to ensure appropriate counter		

	fraud measures are in place. LCFS contact details are available on the Trust's Intranet.
Equality Impact Assessment (Policies only):	The author has carried out an Equality Impact Assessment (EIA) and, there are no negative impacts. The form is attached to this document.
Trust Values	This policy has been developed to ensure it aligns with our Trust values of honesty, empathy, ambition, and respect.
Diversity & Inclusion Statement	Cambridgeshire Community Services NHS Trust will ensure that this policy is applied in a fair and reasonable manner that does not discriminate on such grounds as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex & sexual orientation.
Keywords:	PSIRF, patient safety, patient safety incident response plan
This is a controlled document. Whilst it may be printed, the electronic version on the Trust's Intranet is the controlled copy. Any printed copies are not controlled.	

Cambridgeshire Community Services NHS Trust

VERSION CONTROL SUMMARY

Version:	Page or section:	Description of change:	Date approved:
1.0	N/A	First issue	

Cambridgeshire Community Services NHS Trust

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1.0	**INTRODUCTION**
1.1	This Patient Safety Incident Response Plan sets out how we intend to respond to patient safety incidents over a period of 18 months, from September 2023 to April 2025. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred, the needs of those affected and take a proportionate response that is fair and promotes a just and learning culture.
2.0	**OBJECTIVES**
2.1	This plan will help us improve our response to local patient safety incidents by: • refocusing Patient Safety Incident Investigations (PSIIs) and learning responses towards a systems approach that considers how multiple factors interact together, and one that promotes a fair, just and learning culture. • focusing on addressing these factors with the use of improvement methods to prevent or continuously reduce repeat patient safety risks and incidents. • moving the emphasis from the quantity of PSIIs to quality to ensure the continuous improvement of patient safety through learning from incidents and Quality Improvement (QI).
3.0	**OUR SERVICES**
3.1	Quality is at the heart of all we do and we are proud to provide high quality services that enable people to live healthier lives and receive care closer to home. We provide the following extensive portfolio of services: • a range of children's services to children, young people and families (Cambridgeshire, Norfolk and Waveney; as well as Peterborough in partnership with Cambridgeshire & Peterborough NHS Foundation Trust) • Bedfordshire Community Health services for the residents of Bedfordshire (provided in partnership with East London NHS Foundation Trust) • Children and Adults' community health services for the residents of Luton • Dental HealthCare services (Cambridgeshire, Peterborough, Norfolk and Suffolk) • Dynamic Health specialist and musculoskeletal physiotherapy services (Cambridgeshire and Peterborough) • iCaSH: integrated Contraception and Sexual Health services (Bedfordshire, Cambridgeshire, Milton Keynes, Norfolk, Peterborough and Suffolk) • Neuro-therapy services in Bedfordshire We believe that community based health services are fundamental to the success of an NHS that gives people more choice and control over their health.

The populations we serve are approximately:

Bedfordshire	437,817
Cambridgeshire	644,000
Luton	214,000
Milton Keynes	264,479
Norfolk	883,000
Peterborough	193,000
Suffolk	743,000

4.0 DUTIES, ROLES & RESPONSIBILITIES

4.1 It is the duty of all staff to be aware of the patient safety incident response plan, policy and Patient Safety Incident Response Framework (PSIRF), and their responsibilities as part of these.

5.0 TRAINING & COMPETENCY

5.1 Learning Response Training

Learning responses will be led by learning response leads who have experience and training in conducting patient safety incident responses. They will contribute to a minimum of two learning responses per year.

Learning response leads will have completed level 1 (essentials of patient safety), and level 2 (access to practice) of the patient safety syllabus in addition to undertaking continuous professional development in incident response skills and knowledge. They will have undertaken at least two days formal training and skills development in learning from patient safety incidents / safety events.

All our staff leading learning responses will be equipped to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

5.2 Engagement and Involvement Training

Engagement and involvement with those affected by patient safety incidents will be led by learning response leads who will have had at least six hours of training in involvement and engagement.

In addition, competencies and behaviours include:

	• Communicating and engaging with patients / service users, families, staff, and external agencies in a positive and compassionate way. • Listening and hearing the distress of others in a measured and supportive way. • Maintaining clear records of information gathered and contact with those affected. • Identifying key risks and issues that may affect the involvement of patients / service users, families, and staff. • Recognising when those affected by patient safety incidents require onward signposting or referral to support services.
5.3	**Oversight training** All patient safety incident response oversight is led / conducted by those with at least two days formal training and skills development in learning from patient safety incidents, and one day training in oversight of this.
6.0	**DEFINING OUR PATIENT SAFETY INCIDENT PROFILE**
6.1	**Situational analysis: National** Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. When things go wrong, people are at risk of harm and many others may be affected; the emotional and physical consequences for people and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not errors by individuals. Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold, or 'trigger list'. In addition, the remit for these has become unhelpfully broad and mixed over time which has obstructed the original patient safety aim and blocked the intended learning. To increase opportunities for continuous improvement, we need to remove these barriers. This approach will allow us to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are being explored / addressed as a priority in current PSII work, or are the subject of current improvement work, or listed for PSII work to be scheduled in the future.

6.2 Situational analysis: Local

Our patient safety incident risks have been profiled using organisational data from a range of sources including patient safety incidents and reports, complaints, staff survey results and responses to safety culture surveys. A resource analysis has also been undertaken looking back at the period June 2019 to June 2022 to estimate resource need and capacity.
The table below shows PSII activity for the period June 2019 to June 2022:

01/06 – 01/06	2019 - 2020	2020 - 2021	2021 - 2022	Average
Never Events	0	1	0	0.33
Serious Incidents overall (but not resulting in death)	4	8	7	6.33
Serious Incidents resulting in death	0	0	1	0.33
Coroner-initiated investigations	0	0	0	0
Incidents referred for independent investigation	1	0	0	0.33
Other investigations (root cause analyses, rapid reviews directorate/department investigations). CCS Incidents	24	39	18	27
Patient Safety Incident reviews - including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SI criteria. CCS Incidents	67	86	93	82

Top themes emerging from the data include those related to:

- Safeguarding
- Record keeping
- Preventable wounds in adults
- Communication
- Clinical care
- Waiting times

6.3 Conclusions from review of the local patient safety incident profile

The current top local priorities are highlighted in the table below:

	Incident type	Specialty
1	Preventable wounds	All
2	Wrong drug / person / route or dosage medication errors leading to incidents	Medicines management
3	Patient safety incidents that identified poor record keeping in the learning response	All
4	Patient safety incidents resulting from errors or delays in clinical pathways or processes	All
5	Missed opportunities to professionally challenge and escalate when there are professional disagreements or disputes about care management or decisions	All

With Nationally defined criteria for learning response types and / or review by another body below:

Patient safety incident type	Required response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII by the organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII by the organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII by the organisation in which the never event occurred
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII, with consideration of any local learning response
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII
Child Deaths	Refer for Child Death Overview Panel review. Liaison with the panel to agree local response type

	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Liaison with the LeDeR to agree local response type
	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 (over 18 years old) are in receipt of care and support needs from their local authority - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.
	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response
	Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant Investigations. Healthcare organisations must fully support these investigations where required to do so
	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case
7.0	**STAKEHOLDER ENGAGEMENT**	
7.1	The National Patient Safety Strategy was introduced at our Leadership Forum to a wide range of staff from clinical, non-clinical and corporate support services in December 2022. Local priorities were shared for comment and feedback. Stakeholders, including a representative from workforce / human resources, the improvement and transformation team, service user voice via our Patient Safety Partners and clinical representation have also been involved in the planning and implementation of the National Patient Safety Strategy and Patient Safety Incident Response Framework.	
8.0	**DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE**	

8.1	Robust findings from investigations and reviews provide key insights and learning opportunities, but they are not the end of the story. Safety improvement plans bring together findings from learning responses to patient safety incidents and issues so that these can be translated into effective improvement design, implementation and the continuous cycle of Quality Improvement. These plans take different forms, including: • creating an organisation-wide safety improvement plan summarising improvement work, • creating individual safety improvement plans that focus on a specific service, pathway or location, • collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked issues, • creating a safety improvement plan to tackle broad areas for improvement (i.e., overarching system issues). All safety actions are developed with relevant stakeholders including those responsible for implementation. The implementation and effectiveness of all safety actions are monitored, and a named individual identified with responsibility for this. Reports to the board are shared through the oversight and governance structure and will include aggregated data on: • patient safety incident reporting and findings, • audit and review findings, • progress against the Patient Safety Incident Response Plan, • results from monitoring of improvement plans from an implementation and an efficacy view, • results of surveys and / or feedback from patients / service users / families / carers on their experiences of our response to patient safety incidents, • results of surveys and / or feedback from staff on their experiences of our response to patient safety incidents. Improvement projects / plans and service transformation work with an impact on patient safety already underway or planned across the Trust, including relevant national, regional and locally driven improvement, is held centrally via software used as part of the Executive Programme Board, within individual service plans or by the improvement and transformation team.
9.0	**OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL**

9.1 Nationally-defined priorities to be referred for PSII and / or external review

National event response requirements for the period 2023 to 2024 include:

- Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)
- Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)
- Incidents meeting the Never Events criteria 2018, or its replacement
- Mental health-related homicides
- Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place
- Child deaths
- Deaths of persons with learning disabilities
- 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 (over 18 years old) are in receipt of care and support needs from their local authority
  - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence
- Incidents in NHS screening programmes
- Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS
- Domestic homicide

We will also include any new national priorities, as they emerge.

9.2 Required responses by Patient Safety Incident Response Type

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII by the organisation in which the event occurred	Create local organisational actions and feed these into / create quality improvement strategy

	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII by the organisation in which the event occurred	Create local organisational actions and feed these into / create quality improvement strategy
	Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII by the organisation in which the never event occurred	Create local organisational actions and feed these into / create quality improvement strategy
	Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII In addition, consideration by subject experts as to one of the following: Locally led PSII After Action Review MDT review	Respond to recommendations as required and feed actions into / create quality improvement strategy
	Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	Respond to recommendations as required and feed actions into / create quality improvement strategy
	Child Deaths	Refer for Child Death Overview Panel review Liaison with the panel to agree one of the following: Locally led PSII After Action Review MDT review	Create / respond to recommendations / organisational / system actions as required and feed actions into / create quality improvement strategy

	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Liaison with the LeDeR to agree one of the following: Locally led PSII After Action Review MDT review	Create / respond to recommendations / organisational / system actions as required and feed actions into /create quality improvement strategy
	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 (over 18 years old) are in receipt of care and support needs from their local authority - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence	Refer to local authority safeguarding lead Contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards In addition, consideration by subject experts as to one of the following: Locally led PSII After Action Review MDT review	Create / respond to recommendations / organisational / system actions as required and feed actions into /create quality improvement strategy
	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of Locally led learning response	Create / respond to recommendations / organisational / system actions as required and feed actions into / create quality improvement strategy
	Deaths in custody (e.g., police custody, in prison, etc)	Any death in prison or police custody will be referred (by the relevant	Create / respond to recommendations / organisational / system

	where health provision is delivered by the NHS	organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Full support of these investigations where required to do so	actions as required and feed actions into / create quality improvement strategy
	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	Respond to recommendations as required and feed these into /create quality improvement strategy

10.0	**OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL**
10.1	Based on our situational analysis, review of data and insight, local priorities have been set for the period September 2023 to April 2025. These locally-predefined, key patient safety incidents have been agreed with the Integrated Care Boards (ICBs) in line with the following guidance: Criteria for selection: - actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc) - likelihood of recurrence (including scale, scope and spread) - potential for learning in terms of: – enhanced knowledge and understanding – improved efficiency and effectiveness – opportunity for influence on wider systems improvement. Locally-defined emergent or unexpected patient safety incidents which signify an extreme level of risk for patients / service users, families and carers, staff or organisations, and where the potential for new learning and improvement is great will also warrant the use of resources to mount a comprehensive PSII response. For the period September 2023 through to April 2025, intended responses for local priorities are as follows:

	Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
	Preventable wounds	To be agreed by subject experts as to one of the following: PSII After Action Review MDT review Swarm huddle	Create local organisational and / or system actions and feed these into the quality improvement strategy. Build case for new improvement plan if required
	Wrong drug / person / route or dosage medication errors leading to incidents	To be agreed by subject experts as to one of the following: PSII After Action Review MDT review Swarm huddle	Create local organisational and / or system actions and feed these into the quality improvement strategy. Build case for new improvement plan if required
	Patient safety incidents that identified poor record keeping in the learning response	To be agreed by subject experts as to one of the following: PSII After Action Review MDT review	Create local organisational and / or system actions and feed these into the quality improvement strategy. Build case for new improvement plan if required
	Patient safety incidents resulting from errors or delays in clinical pathways or processes	To be agreed by subject experts as to one of the following: PSII After Action Review MDT review	Create local organisational and / or system actions and feed these into the quality improvement strategy. Build case for new improvement plan if required
	Missed opportunities to professionally challenge and escalate when there are professional disagreements or disputes about care management or decisions	To be agreed by subject experts as to one of the following: PSII After Action Review MDT review	Create local organisational and / or system actions and feed these into the quality improvement strategy. Build case for new improvement plan if required
11.0	**MONITORING & AUDIT**		
11.1	There is a robust system of reporting, oversight and governance in place supporting the adoption of a proactive approach to the identification and management of incidents and any potential gaps. • Reports are provided to the Quality Improvement & Safety Committee (QISCOM) as per the annual reporting schedule.		

	• The safety actions and associated measure(s) will be appropriately reviewed to ensure they continue to be relevant and the issues of most concern. As part of this process, there will be documentation, recording and reviews of progress against actions and impact through governance groups and links to Quality Improvement, which may involve monitoring by a specific service area or through wider action oversight groups.

Cambridgeshire Community Services NHS Trust

Rapid Equality Impact Assessment Tool

When looking at the impact on the equality groups, you must consider the following points in accordance with General Duty of the Equality Act 2010:
In summary, those subject to the Equality Duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups

EQUALITY IMPACT ASSESSMENT – WHAT IS THE IMPACT TO DIFFERENT GROUPS IN SOCIETY?		
Choose either Positive or Negative impact. **POSITIVE it could benefit or would have very little or no impact. NEGATIVE it could disadvantage.** **Please provide supporting comments, both on positive and negative impacts.** **You may be asked to complete a FULL EQUALITY IMPACT ASSESSMENT to understand the impact further.**		**COMMENTS**
Age: Consider and detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.	Positive	
Disability: Consider and detail on attitudinal, physical and social barriers.	Positive	
Race: Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.	Positive	
Sex: Consider and detail on men and women	Positive	
Gender reassignment: (including transgender) Consider and detail on transgender and transsexual people. This can include issues such as privacy of data and harassment	Positive	
Sexual orientation: Consider and detail on heterosexual people as well as lesbian, gay and bi-sexual people.	Positive	
Religion or belief: Consider and detail on people with different religions, beliefs or no belief.	Positive	
Pregnancy and maternity: Consider and detail on working arrangements, part-time working, and infant caring responsibilities.	Positive	
Marriage and civil partnership status	Positive	
Environment: Consider impact on transport, energy and waste	Positive	
Other identified groups: Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.	Positive	
Were any NEGATIVE impacts identified?	NO	
If YES, you will need to complete a full Equality Impact Assessment. Please contact the Assistant Director of Corporate Governance who is the Equality & Diversity Lead for the Trust, for assistance to complete a full Equality Impact Assessment.		