Sheffield Health and Social Care NHS Foundation Trust

Patient Safety Incident Response Plan 2024/25

Sheffield Health & Social Care NHS Foundation Trust

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NHS England and NHS Improvement

Contents

1 Purpose, Scope, Aims and Objectives

1.1 Purpose

1.1.1 This Patient Safety Incident Response Plan (PSIRP) sets out how Sheffield Health and Social Care NHS Foundation Trust (SHSC) will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

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 Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving care from SHSC.

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

1.2.4 Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Incident Learning Responses (PSILRs)

1.2.5 Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, disciplinary investigations into employment concerns, safeguarding investigations, professional standards investigations, coronial or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety learning response and are outside the scope of this plan.

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

- Human Resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators.
- Corporate Governance teams for clinical negligence claims.
- Medical Examiners and if appropriate local coroners for issues related to the cause of a death.
- South Yorkshire Police for concerns regarding criminal matters
- Health and Safety Executive for concerns about staff safety at work.

1.3 SHSC's Aims and Objectives

1.3.1 Table 1 describes the four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based and sets out how these overarching aims will be achieved by SHSC through specific objectives.

Table 1 Overarching aims and Objectives:

Overarching aims	Specific objectives
1. Improve the safety of the care SHSC provide to our patients.	• Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. • Respond to patient safety incidents purely from a patient safety and learning perspective. • Reduce the number of duplicate investigations into the same type of incident, to enable more resources to be focused on effective learning and enable more rigorous investigations that identify systemic contributory factors. • Aggregate and confirm validity of learning and improvements by basing investigations on a small number of similar repeat incidents. • Consider the wider safety issues that contribute to similar types of incidents. • Develop system improvement plans across aggregated incident response data to produce systems-based improvements. • Better measurement of improvement initiatives based on learning from incident responses.
2. Improve the experience for our 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 safety concerns and their experience of incident responses.

	• Support and involve patients, families and carers in incident response, for a better understanding of the issues and contributory factors. • Promoting Being Open.
3. Improve the use of valuable healthcare resources.	• Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement. • Develop a local board-led system around responses to patient safety incidents, which promotes ownership, accountability, rigor, expertise and efficacy and partnership.
4. 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 in SHSC. • Support and involve staff in patient safety incident response, for better understanding of the issues and contributory factors

[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. [NHS England » A just culture guide]

2 Resources

2.1 Background

2.1.1 There are several system-based approaches that SHSC can utilise to respond to a patient safety incident to learn and improve.

2.1.2 Different Patient Safety Incident Learning Response (PSILR) techniques can be adopted depending on the intended aim and required outcome. All PSILRs are conducted internally by our organisation.

2.1.3 There are five broad categories of Patient Safety Incident Learning Responses (PSILRs)

- After Action Review (AAR)
- Local Learning Review (LLR)
- Coordinated Learning Review (CLR)
- Structured Judgement Review (SJR)
- Thematic Review (TR)

2.1.4 Patient Safety Incident Investigations (PSIIs) are distinct from PSILRs and include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

2.1.5 While most PSIIs are undertaken internally by our organisation, some will be conducted independently (externally). Independent investigations can be commissioned and funded by our organisation or regionally/nationally.

2.1.6 Some types of patient safety incidents have been identified as national priorities and require a specific response.

2.1.7 All patient safety incidents leading to moderate harm or above and all incidents for which a PSII is undertaken should trigger consideration of the Statutory Duty of Candour.

2.1.8 Understanding our organisation's capacity to respond to incidents enables us to be strategic in proactively allocating resources to responding to patient safety incidents that are not included in the list of national priorities.

2.1.9 The following section outlines our approach to understanding our available resources, it describes how we will ensure our resources meet the standards required in the National PSII standards and details how much resource we have available to proactively plan how we will respond to key risks that fall outside national priorities.

2.1.10 How we defined our key risks is outlined in Section 3 - Risk Analysis.

2.2 Understanding our Patient Safety Responses

2.2.1 A data review of SHSC's Incident Management System (Ulysses) and other specialist teams' information systems was undertaken for incidents reported between April 2020 and March 2023 to establish the number of investigations that took place within the categories listed below. The data includes events reported as part of SHSC's complaints procedure and coronial activity.

Table 2: Average annual response activity for April 2020 to March 2023

Response type	Category	Average annual number of responses
National priorities requiring patient safety incident investigation	Incident investigation into Never Events	0
	Structured Judgement Reviews	48
	Incidents referred for independent investigation (e.g. to HSSIB/Regional independent investigation teams (RIITs)/Public Health England(PHE))	0
	Deaths of persons with learning disabilities	2
	Adult Safeguarding incident reviews	0
	Safeguarding Provider Enquiry Reports	0
	Independent Enquiry Reports	0
	Serious Adult Case Reviews	2
	Domestic Homicide Reviews	3
	Joint Statutory Reviews	7
	Children's Safeguarding incident reviews	0
	Child Safeguarding Practice Reviews	0
		3

Patient safety incident investigations conducted locally	Coroner initiated patient safety incident investigations	0
	Patient/family/carer complaint-initiated patient safety incident investigations	0
	Level 3 Serious Incident investigations (Independent Investigations under the current NHS Serious Incident Framework and reported to StEIS)	2
	Level 2 incident investigations	130
	Level 1 incident investigations	84

2.3 Patient safety incident response skills - gap analysis

2.3.1 A review of the resource and activity associated with the current Serious Incident Framework (SIF) for the period 2020 - 2023 has been undertaken to determine how many investigations can be supported during 2023/24. This review was carried out alongside the NHS National standards for patient safety investigation to ensure that all future investigations are compliant with these standards.

2.3.2 In addition, a review has been completed to determine the current level of resource for Patient Safety Incident Learning Responses. This supports planning of appropriate responses – using different techniques – where investigation is not indicated.

2.3.3 This review has been led by the Patient Safety Specialist with support and involvement from the Clinical Governance & Risk department, Patient Safety Partners and the wider Quality Directorate.

2.3.4 In order to meet the requirements of the new NHS National Standards for Patient Safety Incident Investigation we will:

- Assign appropriately trained members of the Executive Team to oversee delivery of the Patient Safety Incident Investigations standards and support the sign off of all Patient Safety Incident Investigations.

- Provide access to update training for current staff who provide the incident investigation oversight function on use of updated analytical tools, use of improvement science approaches and utilisation of the national report template.

- Provide access to update training for existing investigators or investigation teams/staff in specific areas. This will include:

    - Application of updated analytical tools to support PSII.
    - Instruction in identifying and addressing unconscious bias.
    - Using Quality Improvement (QI) methodology and improvement science approaches.
    - Report writing and use of the national PSII report template.

- Review the current training for new investigators of PSII's in SHSC in order to ensure the standard required by PSIRF is met (e.g. minimum of two days). We will use a targeted approach to identify a number of investigators from a range of professional backgrounds i.e. medical, nursing, allied health professionals, psychology.

- Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our webpage.

- Work with Directorate Leadership Teams and Professional Leads to review the existing tools for Patient Safety Incident Learning Responses (PSIRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.

- Negotiate time in job plans for a core group of senior clinical staff to undertake PSIIs every year.

- Modify the existing internal training course for staff who are required to undertake Patient Safety Incident Learning Responses to include:

    - Application of updated analytical tools
    - Principles of PSIRF
    - Using QI methodology and improvement science approaches

2.4 Resources for proactive planning

2.4.1 The current structure relies heavily on senior clinicians, employed by SHSC but independent of the clinical area where the incident occurred, undertaking reviews in their allotted management/clinical time. The Clinical Governance & Risk department do not have any line management responsibilities with regards investigators and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have executive level sign off.

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

2.4.3 PSIRF Implementation Project Group planning, is underway to address the above and expected to take twelve to 24 months to rollout and fully embed once the switch from the current SIF to PSIRF takes place. The planning and restructuring exercise will:

- Enhance patient safety management and leadership support.

- Enhance resource and skills to conduct alternative PSILRs.

- 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.

Table 3. Proactive response planning: overview of estimated resource allocation for patient safety incidents that fall outside national priorities.

Response type	Category	Total number of responses	Hours
PSII	Locally defined PSIIs	5	Minimum 450 hours in total 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 (including pre-completion presentation to Panel) • administration support • interview and statement time of staff involved in the incident • Panel and Executive approval and sign off
	Unanticipated incidents	5	Minimum 450 hours in total 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 (including pre-completion presentation to Panel) • administration support • interview and statement time of staff involved in the incident

			• Panel and Executive approval and sign off
PSILR's	All types	30	Maximum 150 hours per response

3 Risk Analysis

3.1.1 The patient safety incident risks for SHSC have been profiled using *organisational data between the years 2020 to 2023 from:

- Patient safety incident investigation reports, including **S42's SEA's and 48hr reports.
- Ulysses incident reports.
- Complaints' themes.
- Coroner's findings including prevention of future death notifications.
- Mortality Structured Judgement Reviews and the ***Learning Disabilities and Autism Mortality Review Process (LeDeR).
- Staff survey results.

**A number of incidents profiled included incidents reported by the Sheffield Treatment and Recovery Team (START); it should be noted that these services are no longer commissioned from SHSC.*
***In 2023 the delegated duties for Safeguarding Adults were handed back to the Local Authority.*
****Firshill Rise, Learning Disability Inpatient Facility closed in 2021.*

3.1.2 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.

3.1.3 A range of staff, including leads for each of the above data collection systems and members of the Clinical Quality & Safety Group, were consulted and a prioritised list of incidents for the next 18 months was agreed.

3.1.4 The review also highlighted areas which required the collation of further intelligence to inform subsequent plans which included data related to ethnicity and gender diversity.

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

3.1.6 Key stakeholders have been consulted throughout the process to agree the identified priorities and SHSC Patient Safety Incident Response Plan including:

- Commissioners
- Members of staff
- Board, Quality Assurance Committee and the Clinical Quality & Safety Group
- Members of Partner organisations
- Patient Safety Partners, patients and carers
- The national patient safety team

3.2 SHSC patient safety risk profile

3.2.1 Table 4 lists SHSC's patient safety risks that fall within the national priority:

Table 4. SHSC patient safety risks that fall within national priorities

National priority	Incident type	Specialty
Never Events	All	All
Learning from Death	Where a patient death is thought more likely than not to be due to problems in care	All
Safeguarding Incidents	Where a serious incident is linked to safeguarding concerns and causes a Section 42 enquiry Where there are safeguarding concerns in relation to a patient death and this causes a Safeguarding Adult Review	All
Death of people with a Learning Disability and/or Autism	Where a patient death is thought more likely than not to be due to problems in care	Community Learning Disabilities
Homicide due to Mental Illness	Where the death is perpetrated by a patient that has an open episode of care with SHSC, or has had, within the preceding 6 months.	All

Table 5. Criteria for defining top internal patient safety risks:

Criteria	Considerations
Potential Harm	• People: physical, psychological, loss of trust (patients, family, caregivers). • Service delivery: impact on quality and delivery of healthcare services; impact on capacity. • Public confidence: including political attention and media coverage.
Likelihood	• Persistence of the risk. • Frequency. • Potential to escalate.

3.2.2 The current internal top five patient safety risks for SHSC as identified via the analysis described in section 3.1 are presented in table 6 below.

Table 6. Top internal patient safety risks

	Incident Type	Description	Specialty	Type of Response
1	Unexpected Deaths	Incidents where a patient death is thought more likely than not to be due to problems in care delivery, or unnatural inpatient deaths	All	Structured Judgement Review Patient Safety Incident Investigation
2	Slips, Trips and Falls	Patient falls that lead to injury	All	Local/Coordinated Learning Review After Action Review Thematic Review Patient Safety Incident Investigation
3	Self-Harm	Patients that seriously self-harm during their treatment	All	Local/Coordinated Learning Review After Action Review Thematic Review Patient Safety Incident Investigation
4	Restrictive practice	Incidents where harm is caused by seclusion, restraint or chemical restraint	Inpatient Services	Local/Coordinated Learning Review After Action Review Thematic Review Patient Safety Incident Investigation

5	Medication Errors	Harm caused to patients by medication administration errors	All	Local/Coordinated Learning Review After Action Review Thematic Review Patient Safety Incident Investigation

3.3 Internally defined responses

Table 7. Criteria for selecting risks for PSII response:

Criteria	Consideration
Potential for learning and improvement	Increased knowledge: potential to generate new information, unique 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 quality improvement work; adequacy of past actions
Systemic risk	Complexity of interactions between different parts of the healthcare system

3.3.1 Based on the analysis and selection criteria described above, internal priorities for PSII have been set by SHSC for the period 01 January 2024 to 31 April 2025.

3.3.2 The priorities have been agreed with our commissioning organisation, NHS Sheffield Clinical Commissioning Group, and SHSC's Quality Assurance Committee.

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.

3.5 Timescales for PSIIs

3.5.1 The requirement for a PSII will be agreed at the Patient Safety Overview Panel, following completion of a 48hr report.

3.5.2 PSIIs will ordinarily be completed within one to three months of their start 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 Sheffield Health & Social Care NHS Foundation Trust and the patient/family/carer or nominated significant other.

3.5.4 No 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 they remain relevant.

3.5.5 Where the processes of external agencies 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.

4 Learning from incident responses

4.1 Findings from PSIIs and PSILRs provide key insights and learning opportunities, but they are not the end of the story. Findings will be translated into effective improvement design and implementation with the support of the Quality Improvement Team.

4.2 The Clinical Quality and Safety Group and the Patient Safety Overview Panel, on behalf of the Board and the Quality Assurance Committee, will oversee collation and execution of all required system improvements.

4.3 If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, these actions will be made as a priority at the earliest opportunity.

4.4 All other recommendation development will consider aggregated findings across all or a subset of responses into a single risk.

4.5 To aggregate learning, findings from each individual response linked to a specific risk 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 summarised in a System Improvement Plan that is approved by the Patient Safety Overview Panel.

4.6 Consideration will be given to the timeframe taken to complete a System Improvement Plan and the impact of extended timescales on those involved in the incident.

4.7 System Improvement Plans will be shared with those involved in the incident including patients, families, carers and staff.

5 Roles and responsibilities

5.1 SHSC describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

5.2 **All Staff**

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this Patient Safety Incident Response Plan. Information regarding the reporting and management of incidents is provided for new staff at induction. Information for existing staff is available on the Trust intranet pages. Electronic Incident Reporting: A guide for staff reporting incidents | JARVIS (shsc.nhs.uk)

5.3 **The Daily Incident Safety Huddle (DISH)**

- The DISH membership will ensure that all reported incidents are appropriately reviewed and where required that action is taken to escalate patient safety concerns and make recommendations for further review and investigation. Action required to mitigate risk/s that present a clear and imminent danger to patients and/or staff will be taken immediately. The DISH will report directly to the Executive Director of Nursing, Professions & Quality, and the Heads of Nursing/Professional Leads.

5.4 **The Patient Safety, Safeguarding and Clinical Governance & Risk departments**

- Responsible for ensuring the organisation's legal duty of candour is discharged and personally approved and signed by the Director of Nursing, Professions and Quality for appropriate incidents.
- Identify those affected by patient safety incidents and their support needs by being or identifying the single point of contact.
- Provide them with timely and accessible information and advice.
- Facilitate their access to relevant support services.
- Obtain information from review/PSILR teams to help set expectations.
- Work with the wider Quality Directorate and Clinical Directorates to prepare and inform the development of PSIIs and PSILRs.

5.5 **Clinical Directors, Directorate Leadership Teams, and Associated Profession Leads**

Have a responsibility to:

- Encourage the reporting of all patient safety incidents and ensure all staff in their directorate are competent in using the reporting systems and have time to record and share information.
- Ensure that incidents are reported and managed in line with internal and external requirements.

- Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.

- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.

- Provide protected time for participation in PSILRs/PSIIs as required.

- Work with the Clinical Governance & Risk department and others to ensure those affected by patient safety incidents have access to the support they need.

- Support development and delivery of actions in response to PSILRs/PSIIs that relate to their area of responsibility (including taking remedial action to achieve the desired outcomes).

5.6 Patient Safety Partners (PSPs)

As part of SHSC's commitment to working with members of the public we will develop a Patient Safety Partner (PSP) programme. This is where members of the public join our Quality and Safety Improvement work. Those who partner with us have expectations as part of their contribution to the PSIRF:

- PSP's will undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as any other relevant training.

- Participate in Clinical Quality and Safety Group and be active members of the PSRIF Implementation Group, Patient Safety Oversight Panel, and other work streams with the aim of helping SHSC design safer systems of care and prioritise risk.

- Encourage patients, families and carers to play an active role in their safety.

- Contribute to action plans following investigation, particularly around actions that address the needs of patients.

- The organisation commits to protecting our partners from emotional harm which may arise from their work with us therefore, they are able to access the support detailed for staff in section 8.

5.7 Patient Safety Oversight Panel

- The Patient Safety Oversight Panel will meet on a weekly basis to review reported incidents and ensure that PSIIs and PSILR's are undertaken for all incidents that require this level of response (as directed by this Plan). The Panel will receive updates on PSIIs and PSILRs underway and those that have been completed, prior to Executive sign off, where required. The Panel will ensure that all PSIIs are conducted in accordance with the national standards outlined by the PSIRF.
- The Panel will be co-chaired by the Deputy Director of Nursing and the Patient Safety Specialist.

5.8 The Clinical Governance & Risk department

- Develop and maintain the local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.

- Ensures the organisation has procedures that support the management of patient safety incidents in line with this Plan (including convening review and PSII teams as required and appointing trained named contacts to support those affected).

- Establishes procedures to monitor/review PSILR and PSII progress and the delivery of improvements.

- Ensure staff members involved in the management of patient safety incidents have access to the requisite knowledge, skills and tools to undertake patient safety reviews to the required national standards.

- Works with the Executive lead, Patient Safety Specialist, Heads of Nursing, Clinical Leadership and the Clinical Risk and Patient Safety Advisor to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents, including gaps in resource, including skills/training.

5.9 **Patient Safety Incident Investigators**

- Patient safety incident investigators will have been trained over a minimum of two days in systems based PSII.

- Ensure that PSIIs are undertaken in-line with the national PSII standards.

- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.

- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.

- Provide liaison with patients and families subject to a patient safety incident investigation.

5.10 **Clinicians/Specialist Advisors**

Incident investigators/reviewers may need to involve specialist advisors to assist in their Investigation/review (e.g. Safeguarding, Health and Safety, Medical staff, Pharmacy, Infection Prevention Control Advisor, Clinicians with experience in a particular specialities). Patient safety investigators/reviewers are responsible for determining when specialist advice is required, and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, review of recommendations.

5.11 **The Quality Improvement Team**

Using the model for improvement framework the Quality Improvement team will support the development of System Improvement Plans. The Model for Improvement framework will assist us to drive continuous improvement. SHSC use an adapted version of the Model for Improvement framework that includes co-production and co-design.

5.12 **The Clinical Quality & Safety Group (CQ&SG)**

The Clinical Quality and Safety Group (CQ&SG) has responsibility for reviewing the incident management function and learning from patient safety incidents. The CQ&SG reports to the Quality Assurance Committee and provides assurance on reports/evidence received. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of the CQ&SG

will seek assurances from Heads of Nursing and Clinical leads that risks are being adequately addressed. Where there are remaining concerns, these will be escalated to the Quality Assurance Committee in the quarterly learning report.

5.13 **Quality Assurance Committee (QAC)**

The Quality Assurance Committee has responsibility for reviewing learning and system improvement plans for effectiveness. The Committee will receive a quarterly learning report outlining progress against this PSIRP.

5.14 **Patient Safety Specialist/s**

The Patient Safety Specialist will provide expert support to SHSC, and will have direct access to the Executive team, in order to facilitates the escalation of patient safety issues or concerns. The Patient Safety Specialist will play a key role in the development of a patient safety culture, safety systems and improvement activity.

5.15 **Executive Director of Nursing, Professions & Quality**

The Executive Director of Nursing, Professions & Quality has delegated responsibility for Patient Safety and Risk Management and has the organisational lead for ensuring that there are adequate arrangements in place for patient safety incident investigations and responses and for monitoring, reviewing and updating these arrangements. In addition, that there is adequate assurance to demonstrate learning is being shared and changes to practice, as a result of patient safety incident investigations and reviews, are implemented across SHSC.

5.16 **Chief Executive**

The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974). As part of this role the Chief Executive has overall responsibility for ensuring there are effective risk management systems and processes in SHSC to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff and visitors. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

5.17 **The Trust Board**

The Trust Board of Directors has a responsibility to ensure that it receives assurance that this plan is being implemented, that lessons are being learnt, and areas of weakness are improving. This will be achieved through reporting processes as well as receiving assurance via the Quality Assurance Committee and the Audit Committee. The Trust Board receives a quarterly report on patient safety incident investigations within SHSC and monitors the lessons learned from these. Where concerns are identified relating to the robustness of lessons learned or actions planned the Trust Board will seek assurances that these concerns are being acted upon.

6 Patient Safety Incident reporting arrangements

6.1 Local reporting of patient safety incidents (PSIs)

6.1.1 The full details of the Patient Safety Incident reporting arrangements are detailed within SHSC Patient Safety Incident Response Policy. The procedure provides a structure for reporting incidents at Sheffield Health & Social Care NHS Foundation Trust, including external notification requirements.

6.1.2 All staff (including bank, agency, locum and volunteers) have the responsibility to report all incidents and near misses via the SHSC electronic risk management system, Ulysses.

6.1.3 A record of the incident or near miss should be contemporaneously and objectively reported in the patient's clinical records.

6.1.4 All incidents reported as causing moderate, severe, catastrophic harm will be discussed at the SHSC Daily Incident Safety Huddle to determine if further information is required and advise on type of investigation required.

6.1.5 Incidents requiring consideration for a patient safety incident response (PSILR or PSII) will be reviewed and discussed at the Daily Incident Safety Huddle to determine the type of investigation required. Incidents which meet the criteria for a PSII will be reported onto the Strategic Executive Information System (StEIS) or its successor system by a member of the risk team once a 48hr report has been received.

6.2 National reporting of patient safety incidents (PSIs)

6.2.1 SHSC will undertake its external reporting and notification requirements in line with national guidance available at appendix 6 of the Patient Safety Incident Response Framework (PSIRF - 2022).

6.2.2 SHSC currently reports patient safety incidents to the Learning from Patient Safety Events (LFPSE) system.

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

6.2.4 Management and monitoring of individual PSIIs, previously the responsibility of the local commissioning organisation, will be the responsibility of SHSC's Trust Board.

6.2.5 Statutory Care Quality Commission (CQC) notification requirements will be met by reporting incidents to the LFPSE 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.

7 Procedures to support patients, families and carers affected by PSIs

7.1 Patient and Family/Significant Other Liaison

7.1.1 SHSC is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned, and harm has occurred. The Duty of Candour and Being Open Policy (MD 010 V5 Dec 2021) sets out SHSC's responsibilities of being open with patients, families and carers. Duty of Candour and Being Open Policy (MD 010 V5 Dec 2021) | JARVIS (shsc.nhs.uk)

7.1.2 The healthcare professional nominated to be the key contact for communication with patients, families and carers during a patient safety incident review will be a senior member of the clinical and nursing teams responsible for the service users care and/or someone with experience and expertise in the type of incident that has occurred. In the tragic circumstances of a patient suicide the SHSC Family Liaison Officer will also contact the family.

7.1.3 The Family Liaison Officer is responsible for:

- Contacting the family and/or carer involved in a patient suicide to explain what type of investigation will be taking place and provision of contact detail.
- Hearing the family and/or carer account of the incident from their perspective and gathering any questions they would like the review to answer.
- Ensuring that the family and/or carer has been provided with appropriate ongoing support.
- Documenting the details of all discussions with the family and/or carer, copies of letters relating to the patient safety review ensuring this documentation is uploaded to the relevant incident record on Ulysses.
- Keeping in close communication with the family and/or carer as per their wishes. Contact will also take place following the conclusion of the investigation to share the findings, lessons learned, and actions being taken.
- Delivering an annual performance report to the Quality Assurance Committee.

7.1.4 For the Patient Safety Incident Investigations identified in this Plan (Table 8) family liaison will be overseen directly by the Clinical Governance & Risk department and PSII investigation team. For all other types of Patient Safety Incident Responses, patient and family liaison is the responsibility of the nominated senior member of the clinical and nursing team.

7.2 Local support

7.2.1 The Family Liaison Officer at SHSC can offer confidential signposting and support to patients and their families.

7.2.2 The Family Liaison Officer and members of the Quality Team work independently of clinical teams when managing patient and family concerns. The team will liaise with staff, managers and, where appropriate, with other relevant organisations to pass on and highlight concerns raised.

7.2.3 SHSC 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 SHSC aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

7.2.4 SHSC 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 SHSC services are encouraged to speak with a member of their care team.

7.2.5 Should the care team be unable to resolve the concern then the Complaints department contact details should be provided.

The Complaints department can help and support with:

- Advice and information
- Comments and suggestions
- Compliments and thanks
- Informal complaints
- Advice about how to make a formal complaint .

7.3 National sources of support

- 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. NHS England » Learning from deaths: Information for families

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

- Healthwatch Sheffield provides information to help make a complaint, including sample letters. Healthwatch Sheffield | Your spotlight on health and social care services

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

8 Procedures to support staff affected by Patient Safety Incidents

8.1 The national and local arrangements for supporting staff following Patient Safety Incidents

8.1.1 Sheffield Health & Social Care NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles into our procedures for the review of incidents. 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.

8.1.2 SHSC's Clinical Governance & Risk department and the Patient Safety Specialist will advise, and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident response process and further support functions.

8.1.3 Psychological Interventions for SHSC Staff - there are a variety of psychological interventions available for staff. NHS Sheffield Talking Therapies

8.1.4 Occupational Health Service, Occupational health | JARVIS (shsc.nhs.uk)

8.1.5 Workplace Wellbeing. Health and wellbeing | JARVIS (shsc.nhs.uk)

8.1.6 Freedom To Speak Up Guardian - A confidential service for staff if they have concerns about the organisation's response to a patient safety incident. Freedom to Speak Up | JARVIS (shsc.nhs.uk)

8.1.7 Second Victim - A website resource for healthcare staff and managers involved in patient safety incidents. Learning hub | JARVIS (shsc.nhs.uk)

8.2 Support from Patient Safety Incident Investigators

8.2.1 All staff with knowledge of the events being reviewed are encouraged to actively participate in the patient safety incident response. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

8.2.2 Response teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of response method being utilised.

8.2.3 All contact with staff will involve the collection of their account of the events and also their views and opinions on how systems can be improved in line with Just Culture guidance and the Human Factors methodology.

9 Mechanisms to develop and support improvements following PSIIs

9.1 SHSC uses Quality Improvement Methods to constantly evaluate our work processes and make changes to improve services for patients and the working environment for staff. The strategic triangle below shows how our vision, values and goals link together to enable us to provide the best possible care for our patients. All of this is underpinned by the SHSC Quality Strategy, spreading a consistent approach to continuous quality improvement. Quality Strategy 2022-2026 - Approved March 2022.pdf (shsc.nhs.uk)

9.2 Our processes for improvement are described in our Quality Strategy and Clinical and Social Care Strategy. The recommendations from our Patient Safety Incident Investigations and Patient Safety Incident Learning Responses will flow through these processes linking them in directly to SHSC Quality Improvement work.

9.3 At the conclusion of a Patient Safety Incident Investigation (PSII) the final report will be shared with patients [and/or significant others where appropriate], and further shared directly with the team involved. The team involved will develop the system improvement plan in collaboration with the Investigator and/or Patient Safety Investigator.

9.4 The final report will be submitted to the Patient Safety Overview Panel for discussion and agreement of the system improvement plan.

9.5 Final approval and sign-off of the report and system improvement plan will be obtained via the Board of Directors.

9.6 The improvement plan will be agreed in collaboration with existing SHSC quality improvement frameworks including the Clinical Quality and Safety Group and the Quality Improvement Team. The Patient Safety Specialist, or nominated person will facilitate cascade of relevant information across the organisation through various mediums including the quarterly Learning and Safety report and the lessons learned built in. All completed reports and approved improvement plans will be uploaded onto the Learning Hub, with the link to this cascaded weekly via the all-staff communication digest.

9.4 Improvement plans will be shared with the relevant Quality Improvement stakeholders, via the Clinical Quality and Safety Group, to oversee delivery of actions, monitoring and evaluation of improvement outcomes.

9.5 The Clinical Quality and Safety Group will have oversight and undertake monitoring of all improvement plans created following a PSII. The Clinical Quality and Safety Group reports to the Quality Assurance Committee. The group will promote a positive culture of continuous learning and improvement using quality improvement methodology to facilitate Trust-wide learning and improvement.

9.6 Monitoring through the use of 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 and implemented with other SHSC services and, where relevant partner organisations.

10 Monitoring outcomes of PSIIs and PSILRs

10.1 A quarterly Learning and Safety report will be created for the Quality Assurance Committee and Board to provide assurance. Contents may vary, but will likely include aggregated data on:

- Patient safety incident reporting
- Findings from 48hr reports, safeguarding enquiries, and complaints
- Findings from PSILRs and PSIIs
- Progress against the PSIRP
- Progress on System Improvement Plans
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

11 Complaints

11.1 SHSC 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(s) provided by Sheffield Health & Social Care NHS Foundation Trust will be taken seriously and will be managed in a way that reflects the organisation's intentions to provide care that is: Person-Centred, Strengths Based, Evidence-Led and Trauma-Informed) and supported by our core values of: Working together for our service users, Respect and kindness, Everyone counts, Commitment to quality and Improving lives.

11.2 SHSC encourages service users to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff. The complaints policy focuses specifically on those concerns or complaints that require formal management through the complaints process.

11.3 SHSC's Complaint Policy (CG010) sets out the principles and processes involved when any person wishing to raise a concern or complaint. This includes the need for SHSC to provide an apology and an opportunity for learning when complaints are responded to, where this is relevant. Complaints Policy (CG010 V17 April 23) | JARVIS (shsc.nhs.uk)

Contact us:

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