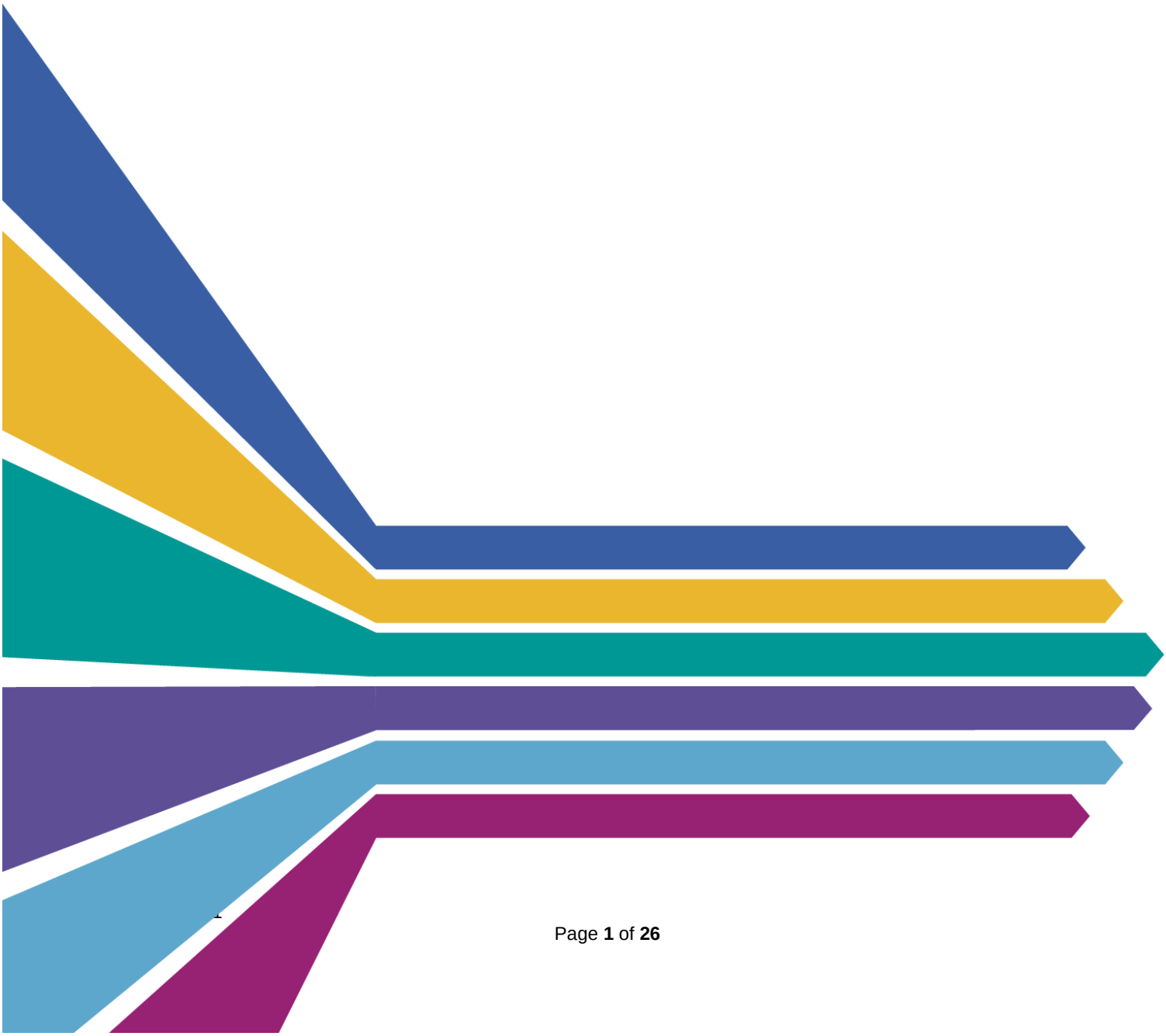
Bridgewater Community Healthcare
NHS Foundation Trust

Patient Safety Incident Response Plan



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	NAME	TITLE
Author (s)	Alan Lee Sharan Arkwright	Head of Risk Management & Patient Safety Project Support

Version Control Sheet

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Contents

Foreword

“The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them”. Aidan Fowler, National Director of Patient Safety, NHS England.

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again.

Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously we have had set timescales and external organisations to approve what we do, PSIRF gives us a set of principles that we will work to with the aim of learning and improvement. We know that we investigate incidents to learn, but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We will continue to engage meaningfully with our patients, families, and carers to ensure that their voice is the thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and with the support of patient safety partners this will ensure that the patients voice is heard at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe.

PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved.

The process of reviewing an incident can help our staff validate their decision making when caring for and treating patients and facilitates psychological closure as part of the PSIRF process.

A glossary of terms is included in appendix C.

1 Introduction

This Patient Safety Incidents Response Plan (PSIRP) sets out how Bridgewater Community Healthcare NHS Foundation Trust (hereafter referred to as the Trust) intends to respond to patient safety incidents over a period of 24 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on reporting, management, review and learning from incidents which is currently under review as the new Trust Incident Response Policy.

The plan will focus on:

1. Refocusing patient safety incident investigations (PSII) towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues

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

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

2 Trust policies that support the Patient Safety Incident Response Plan

Patient Safety Incident Response Policy

Dignity & Respect at Work Policy & Procedure Dignity and Respect at Work Policy and Procedure

Freedom to Speak Up in the NHS Freedom to Speak Up in the NHS

Clinical Supervision Policy Clinical Supervision Policy.

Complaints, Compliments, Comments & Concerns Handling Policy Complaints Compliments Comments Concerns Policy.

Duty of candour (Being Open) Policy Duty of Candour (Being Open) Policy

Incident Investigation Procedure

Learning from Death Policy

Managing Allegations of Abuse Policy

Medication Incident Policy

Safeguarding Adults Policy

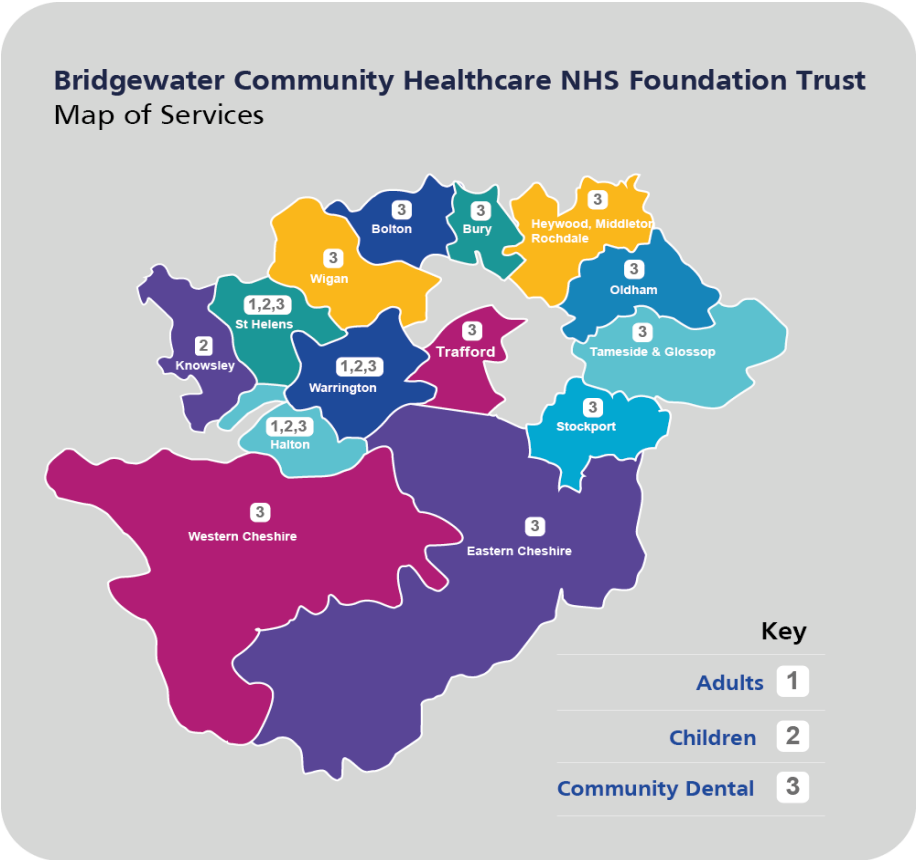
Safeguarding Children Policy

Safeguarding Supervision Policy

3 Our Services

The Trust is a leading provider of community services in the Northwest of England. We provide high quality community and specialist services to the populations of:

- Halton
- St Helens
- Warrington
- Community Dental Network which includes areas of Bury, Bolton, Heywood, Middleton, Rochdale, Tameside, Trafford, Glossop, Stockport, and Western Cheshire.



The majority of our services are delivered in patients' homes or at locations close to where they live, such as:

- Clinics
- Health centres
- General practitioner (GP) premises
- Community centres
- Schools.

As a provider of both mainstream and specialist care our role is to focus on providing cost effective care. We do this by keeping people out of hospital and supporting vulnerable people throughout their lives.

As a dedicated provider of community services our strategy is to bring care closer to home. This means providing a wide range of services in community settings and to keep people healthier for longer by developing more specialist services to support people to live independently at home.

4 Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years. The effectiveness of this approach is monitored through the Trusts Quality and Safety Committee.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements. To fully implement the Framework the Trust has completed a review of what types of patient safety incidents occur to understand what needs to be learned from to improve our services to patients.

The Patient Safety team has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement.

5 Stakeholder engagement

The Patient Safety team commenced planning for PSIRF by consulting extensively with several PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF and their assistance and support has been invaluable.

We are conscious that PSIRF requires a very different approach to the oversight of patient safety incidents. We commenced discussions with the Integrated Commissioning Board (ICB) place-based commissioners currently responsible for the oversight of our application of the Serious Incident (SI) Framework. This was carried out with the understanding that early engagement due to the changing nature of responsibilities within PSIRF was essential and we needed to work collaboratively together on this.

We also engaged with Healthwatch in order to understand if the community had any concerns over patient safety issues for our Trust.

Internally, a presentation was created to outline the major significant differences between PSIRF and the SI Framework and awareness raising through our Trust communication channels such as team brief and the Trust bulletin.

PSIRF implementation meetings were held from May 2023 onwards with key stakeholders from various disciplines and directorates to begin to explore the nature of incidents reported, what processes are in place to currently manage and review these and what such reviews might look like under PSIRF. Views were collated to support the diagnostic and discovery phase for the implementation of PSIRF.

We also undertook an analysis exercise to review all of our organisational data and how they were used to define our patient safety profile. Once the data was collated, we reviewed this to finalise our local priorities for review by PSII. We also carried out a series of engagement sessions with our clinical directorates and others to identify our approach to other patient safety incidents requiring a response.

6 Data sources

To define our patient safety response profile, we drew data from a variety of sources including the incident reporting system module of the Trust's risk management reporting system Ulysses. We collated data on the actual incidents that had taken place over a 2-year period, covering the years 2021 / 2022 and 2022 / 2023.

We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process. Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident investigation reports
- Patient Advice & Liaison Service (PALS) /complaints
- Freedom to Speak Up reports
- Safeguarding reviews
- Staff survey results
- Claims
- Trust risk profile
- Coroners' reports.

Where possible, we have considered what any elements of the data tell us about inequalities in patient safety. As part of our review, we have also considered any new

and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

6.1 Safety issues highlighted by the data

From the original data pull, we were able to identify three distinct types of incident described within.

6.2 Categories identified from Ulysses cause group analysis

These are shown in the table below:

Category	Descriptor
Access/admission/transfer/discharge	All incidents relating to the stated stages in the patient journey.
Accidents	All incidents with accidental injury to patients and others.
Breach in security	All incidents recording any breach or lapse in security arrangements and processes.
Catheter related and Urinary Tract Infection (UTI)	All incidents where problems with urinary catheter management or UTI were recorded.
Communication/consent	All incidents where there have been consent issues either in a legal or statutory framework, it also captures problems with documentation within the Mental Capacity Act (MCA), Mental Health Act (MHA) / Deprivation of Liberty Scheme (DOL's) processes.
Death	All deaths reported.
Deterioration in Health	All incidents in which it was reported that a patient's physical health deteriorated.
Documentation/information governance (IG) breach	All incidents of breach of IG or relating to issues with recording and storage or management of patient and staff information.
Environment, Estates, Facilities	All incidents involving environmental matters, estates, or facilities provision.
Equipment failure	All incidents with equipment including failure or difficulties with supply or use.
Fire	All fire related incidents.
Health and safety	All incidents relating to staff welfare and wellbeing.
Infection prevention and control	All incidents relating to infection prevention and control events or processes.

Medication	All incidents across the elements of the medication process.
Northwest Ambulance Service (NWAS)	Incidents reported on the main Trust Ulysses system relating to Trust patients accessing Services from the Northwest Ambulance Service.
Patient care and treatment	All incidents relating to issues with a patient's care or treatment.
Pressure and wound care	All incidents relating to pressure and related skin damage and other wounds.
Safeguarding adults and children	All incidents where it has been reported or noted that a patient has required to be safeguarded.
Serious allegation	Specific to Ulysses system to report incidents reported about staff.
Service provision	All incidents where a service has been impacted or not provided as expected.
Sexual incidents	All incidents of a sexual nature including historical reports.
Slips, Trips, Falls	All incidents where a patient fell, tripped, or slipped on or off Trust premises.
Staffing	All staffing related incidents.
Third party	All incidents occurring on, or off Trust premises reported by or concerning third parties to the Trust.
Vaccines and immunisations	All incidents related to vaccines/immunisation.
Violence and aggression	All incidents where violence and aggression has been witnessed or experienced by patients, staff, and others.

These were the themes considered in our review with further details on the subcategories within the themes considered to identify our overall profile.

This led to the local patient safety priorities being identified which will be our priorities for review under PSIRF.

Whilst the final list has been agreed we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

7 Defining our patient safety improvement profile

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity.

We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The Trust Patient Safety Incident Response Framework and Learning Panel (PSIRFLP) will provide assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard.

Our clinical and corporate directorates are required to report to our Trust PSIRFLP, in order to monitor and measure improvement activity across the organisation. This panel will also provide assurance during the development of any new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed a robust governance process during development and fulfil SMART requirements and are sufficient to allow the Trust to improve patient safety in the future.

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally.

We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

8 Our patient safety incident response plan: National requirements

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

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

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

For clarity, all types of incidents that have been nationally defined and are pertinent to the Trust, as requiring a specific response, will be reviewed according to the suggested methods, and are detailed in the table below.

			Event	Approach	Improvement
	Patient Safety Incident Investigation	National Priorities that are pertinent to Bridgewater Community Services	Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
			Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
			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 via BCHFT named safeguarding lead BCHFT will contribute to 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 the local safeguarding adults boards	
			Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, BCHFT will contribute as required by the DHR panel.	
			Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
			Patient Safety incidents meeting the Never Event criteria 2018 or it's replacement	Report to ICB/CQC and undertake a Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement work

			Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care		

9 National patient safety priorities not in scope for Trust Services

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 Patient Safety Incident Investigation (PSII).	The organisation in which the event occurred
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII may be required	As decided by the RIIT
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	HSIB (or SpHA)
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	PPO or IOPC
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. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and	CSP

	requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.	

10 Our Patient Safety Incident Response Plan: Local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and engagement meetings, we have determined that the Trust requires three patient safety priorities as a local focus.

We have selected this number from the data analysis the Trust undertook as part of the discovery and diagnostic phase of PSIRF implementation. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

10.1 Criteria for defining our top three local priorities.

Criteria	Considerations
Potential for 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 of occurrence	• Persistence of the risk • Frequency • Potential to escalate.

10.2 Planned responses for Trust local patient safety priorities

	Incident type	Description	Response type
1	**Pressure ulcers**	Incidents involving category 2,3,4	After Action Reviews (AAR) if determined to inform proportionate response and thematic analysis of ongoing patient safety improvement work
2	**Medicines management**	General Incidents Medication incidents which have caused 'Low Harm' or where the Local priority Incident Review Group decide if a more in-depth investigation and learning is required. Incidents that have caused severe harm or death	AAR if determined to inform proportionate response and thematic analysis of ongoing patient safety improvement work. Full PSII
3	**Inpatient falls**	Injuries that cause fractures (Statutory Duty of Candour) Other incidents	Full PSII AAR if determined to inform proportionate response and thematic analysis of ongoing patient safety improvement work

10.3 Planned responses for Trust local patient safety priorities

	Incident type	Description	Response type
1	**Dental Directorate**	Any incident that falls under the category of the National Priorities Other incidents	Full PSII AAR if determined to inform proportionate response and thematic analysis of ongoing patient safety improvement work.

	Incident type	Description	Response type
2	**Children's Directorate**	Any incident that falls under the category of the National Priorities Other incidents	Full PSII AAR if determined to inform proportionate response and thematic analysis of ongoing patient safety improvement work

10.4 Specialist Directorates

For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Patient safety incident type or issue	Planned response	Anticipated improvement route
IT systems	Review by directorate in conjunction with IT Continued monitoring through Directorate/Trust governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Staffing	Review by operational managers in conjunction with workforce and professional leads as appropriate Continued monitoring through Directorate/Trust safety/workforce meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Death	Review by Learning from Deaths process (including family input) and Mortality MDT Review as PSII where index case or meets national priority criteria	Create local safety actions if applicable and feed these into the quality improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Environment, Estates, Facilities	Review by operational managers in conjunction with Estates Continued monitoring through Directorate/Trust contract meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Inappropriate behaviour	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through Directorate/Trust safety huddles Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Fire	Review by operational managers in conjunction with Estates Continued monitoring through Trust Health & Safety meetings. Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Documentation/IG Breach	Review by operational managers in conjunction with IG team with cross system reporting as necessary. Continued monitoring through Trust DIGIT meetings. Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Breach in security	Review by operational managers in conjunction with Estates Continued monitoring through Trust Health & Safety meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Service provision	Review by operational managers in conjunction with service leads and cross system reporting as necessary. Continued monitoring through Directorate/Trust operational working groups Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Violence and aggression	Review by operational managers in conjunction with Health and Safety or relevant subject matter experts Continued monitoring through Trust Health & Safety meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Create local safety actions and feed these into the Health & Safety Policy
Equipment failure	Review by operational managers in conjunction with Estates and Equipment Services Continued monitoring through Directorate/Trust governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Safeguarding	Review by operational managers in conjunction with the Safeguarding Team to ensure referrals made to facilitate external review Continued monitoring through Directorate/Corporate Governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues outside of Safeguarding remit	Inform ongoing improvement work
Health and Safety	Review by operational managers in conjunction with Health and Safety team Continued monitoring through Trust Health and Safety meetings. External reporting to relevant bodies as required Continued monitoring of patient safety incident records to determine any emerging risks / issues	Inform ongoing improvement works
Infection Prevention and Control (IPC)	Review by operational managers in conjunction with Infection Prevention and Control team and cross system reporting as necessary Continued monitoring through Trust IPC governance meetings Continue post infection reviews for outbreaks Continue nationally required external reporting for specific infection groups Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Third party	Review by operational managers in conjunction with appropriate subject matter experts and cross system reporting as necessary Continued monitoring through Directorate governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Serious allegation	Review by operational managers in conjunction with Workforce and Safeguarding/Police Continued monitoring through Directorate governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Patient care and treatment	Review by operational managers in conjunction with relevant subject matter experts and cross system reporting as necessary Continued monitoring through Directorate/Trust governance meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Create local safety actions and feed these into the quality improvement work Review as PSII where index case requires as part of the national priorities
Catheter related and UTI	Review by operational managers in conjunction with Bladder and Bowel team and cross system reporting as necessary. Continued monitoring through Directorate/Trust CAUTI group Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Accidents	Review by operational managers in conjunction with relevant subject matter experts including Health and Safety Continued monitoring through Trust Health & Safety group meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Create local safety actions and feed these into the quality improvement work. Review as PSII where index case requires as part of the national priorities

PSIRF incident management flowchart

Incident occurs - patient safety incident reviewed and recorded on Ulysses within 48 hours of incident occurring

Compassionate engagement with patients & staff
Respond to those affected
Being open and Duty of Candour, when applicable
Incident to be reviewed at one of following weekly groups

Review of Incident
Is it a local priority? Incident added to Directorate log for consideration for AAR or further information requested from Directorate.

Pressure ulcer, medicines or falls incident?

Yes

Submit to relevant **Weekly Local Priority Incident Review & Learning Group**

- **Pressure Ulcer Incident & Learning Group**
- **Medicines Management Incident Review & Learning Group**
- **Falls Incident Review & Learning Group**

No

Submit to **Weekly Directorate Incident Review & Learning Group**

Group to:
Review ALL incidents & other data sets e.g., PALS and complaints & determine which proportionate response is required
Review & receive feedback from ALL local priority groups within Trust
To propose key lines of enquiry to inform reviews
Allocate Family Liaison Officer (FLO)
Track PIRSF related activity for directorate
To suggest relevant subject matter experts (SME)
To receive & consider completed reviews
To determine timescales for completion of reviews
To upload outcome of findings to Ulysses via SBAR tool
To complete monthly Incident Review & Learning Group report - to be submitted to the PSIRF & Learning Panel
To document monthly activity in directorates Quality Council

Group to:
Inform Directorates of changes to practice as a result of Quality Improvement work and learning from incidents.
Review progress of each priority group AAR's
Review trends and undertake thematic reviews of groups subject matter
Chair of each priority group to write quarterly reports to the Trust PSIRF & Learning Panel.

Recommend proportionate response -
After Action Review, MDR, PSII, SBAR, Quality Improvement

Fortnightly Trust Patient Safety Incident Response Framework & Learning Panel
Establish procedures for monitoring & agreeing PSII's
Discuss, approve & sign off Patient Safety Incident Investigations (PSII) reports
Monitor outcomes & learning from PSII's & other safety reviews
Review & discuss monthly incident data, identifying any new emerging trends in triangulation with other organisational data
Promote use of QI in response to identifying learning & receiving feedback
To review any related national strategies, policies & guidance ensuring appropriate action taken
To review any related Trust strategies, policies & guidance ensuring appropriate action taken
To write annual report for Quality Report
To write reports for Quality & Safety Committee & Trust Board

Executive sign off. Reports from the Trust Patient Safety Incident Response & Learning Panel will include:
Patient Safety Incident (PSI) reporting
Findings from PSII
Findings from Patient Safety Reviews
Progress on organisational After-Action Reviews (ARR)
Progress on any Quality Improvement (QI) activity following a Patient Safety Review
Results of any Patient Safety Surveys undertaken

Appendix B

Trust Improvement programme

Cross Directorate

Carers Strategy Action Plan			Action plan origin: NHSE	
	BLUE	**GREEN**	**AMBER**	**RED**
	10/11 (↑1)	**0/11 (↔)**	**0/11 (↔)**	**1/11 (↓)**
Comments	One red indicator relating to new codes on SystmOne. The codes are being tested ready for implementation.			

Insulin Aggregated Review			Action plan origin: Patient Safety Group	
	BLUE	**GREEN**	**AMBER**	**RED**
	15/16 (↔)	**0/16 (↔)**	**0/16 (↓1)**	**1/16 (↑1)**
Comments	One action turned Red from Amber – this is regarding development of the DN handover SOP. The action lead has been informed that SOPs have been prepared but has not had sight of these to evidence completion of the action.			

Community Nursing Halton and Warrington BOOST Plan			Action plan origin: BOOST	
	BLUE	**GREEN**	**AMBER**	**RED**
	0/11 (↔)	**11/11 (↔)**	**0/11 (↔)**	**0/11 (↔)**
Comments	The action plan is being further refined to reflect the individual workstreams within the Halton and Warrington elements of the plan.			

Halton Adult's Directorate

Drive Ability Northwest (formerly NWDAS) Improvement Plan			Action plan origin: Department for Transport	
	BLUE	GREEN	AMBER	RED
	16/21 (↑6)	0/21 (↓6)	4/21 (↔)	1/21 (↔)
Comments	One Red indicator regarding relocation of the service. A Business Case has been submitted to EMT 11/07/2023 – awaiting EMT decision.			

Warrington Adult's Directorate

Dermatology Service Improvement Plan			Action plan origin: Patient Safety Group	
	BLUE	**GREEN**	**AMBER**	**RED**
	18/58 (↑5)	**20/58 (↓3)**	**13/58 (↓2)**	**7/58 (↔)**
Comments	Nothing to escalate. Good progress with this plan this reporting period.			

Community Equipment Stores Improvement Plan			Action plan origin: Patient Safety Group	
	BLUE	**GREEN**	**AMBER**	**RED**
	37/42 (↔)	**5/42 (↔)**	**0/42 (↔)**	**0/42 (↔)**
Comments	Nothing to escalate.			

Children's Directorate

Community Paediatrics Improvement Plan Halton & Warrington			Action plan origin: BOOST	
	BLUE	**GREEN**	**AMBER**	**RED**
	0/20 (↔)	**20/20 (↔)**	**0/20 (↔)**	**0/20 (↔)**
Comments	Nothing to escalate.			

Children's Services BOOST Action Plan			Action plan origin: BOOST	
	BLUE	**GREEN**	**AMBER**	**RED**
	5/71 (↔)	**66/71 (↔)**	**0/71 (↔)**	**0/71 (↔)**
Comments	Nothing to escalate.			

Dental Directorate

Dental Nursing Triage Review			Action plan origin: Annual Operating Plan	
	BLUE	**GREEN**	**AMBER**	**RED**
	/ (↔)	**/ (↔)**	**/ (↔)**	**/ (↔)**
Comments	Plan is in development.			

Appendix C

Glossary of terms

Patient Safety Incident Response Framework (PSIRF)
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Patient Safety Incident Response plan (PSIRP)
Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

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

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

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

Never Event - patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

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

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

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

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

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

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