Patient Safety Incident Response Plan

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	NAME	TITLE	DATE
Author	**Sarah Shelley**	**Patient Safety Specialist**	**15/01/24**
Reviewer	**Trish Cooper**	**Deputy Director of Safety and Quality**	**15/01/24**
Authoriser	**Geoff Baines**	**Director of Safety and Quality**	**15/01/24**

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."
Aiden Fowler, National Director of Patient safety, NHS England.

PSIRF is very different. Unlike previous frameworks, PSIRF is not a tweak or amendment of what came before but a whole system change to how we think and respond when an incident happens to prevent recurrence.

The previous Serious Incident Framework mandated when and how to investigate a serious incident whereas PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles which we need work to but outside of that, we determine what we will investigate and how.

The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

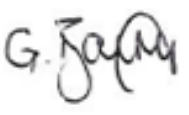
We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak up. PSIRF is a core component in this journey, ensuring we create a psychologically safe culture where people are confident to speak candidly about patient safety events and to simply express their opinion.

There are already early adopters of this process who have provided us with insights into the new way of working. We know every organisation is different, this is the start of our journey, and we may need to change things on the way, but we will monitor the impact and effectiveness of implementing PSIRF.

We are excited to be working in a new way together to make a difference to the safety of care delivered to service users of Livewell whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Geoff Baines

Deputy Chief Executive and Director of Safety and Quality



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Introduction

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

These requirements are reflected in actions taken by the NHS nationally, changing the way in which healthcare organisations and Livewell Southwest (LSW) think about safety.

The NHS Patient Safety Strategy (2019) builds on the two foundations of a patient safety culture and a patient safety system by defining the three following aims:
Improving an understanding of safety by drawing intelligence from multiple sources of patient safety information (**insight**).
Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**involvement**).
Designing and supporting programmes that deliver effective and sustainable change in the most important areas **(improvement**).

The NHS Patient Safety Incident Response Framework (2022) supports the development and maintenance of an effective safety incident response system that integrates four aims:
Compassionate engagement and involvement of those affected by patient safety incidents.

Application of a range of systems-based approaches to learning form patient safety incidents.
Considered and proportionate responses to patient safety incidents.
Supportive oversight focused on strengthening response system functioning and improvement.

This patient safety incident response plan sets out how LSW intends to respond to patient safety incidents over a period of 12 to 18 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 should be read in conjunction with the “Incident reporting policy” and “patient safety incident response policy”.

LSW had hoped to change the term “patient” to “people” in its safety work which would allow for a more generic term across our services which includes adult social care, we were advised against this for the purpose of all our services the term patient is used to describe an individual in receipt of services.

Our services

Livewell Southwest is an independent, social enterprise providing integrated health and social care services for people across Plymouth, South Hams and West Devon, as well as some specialist services for people living in parts of Devon and Cornwall.

We are at the forefront of integrating health and social care, which means that we care for people in new ways that are more efficient, with health and social care professionals who would have previously worked in individual teams now working together. This helps us to deliver the right care for people, in the right place and at the right time.

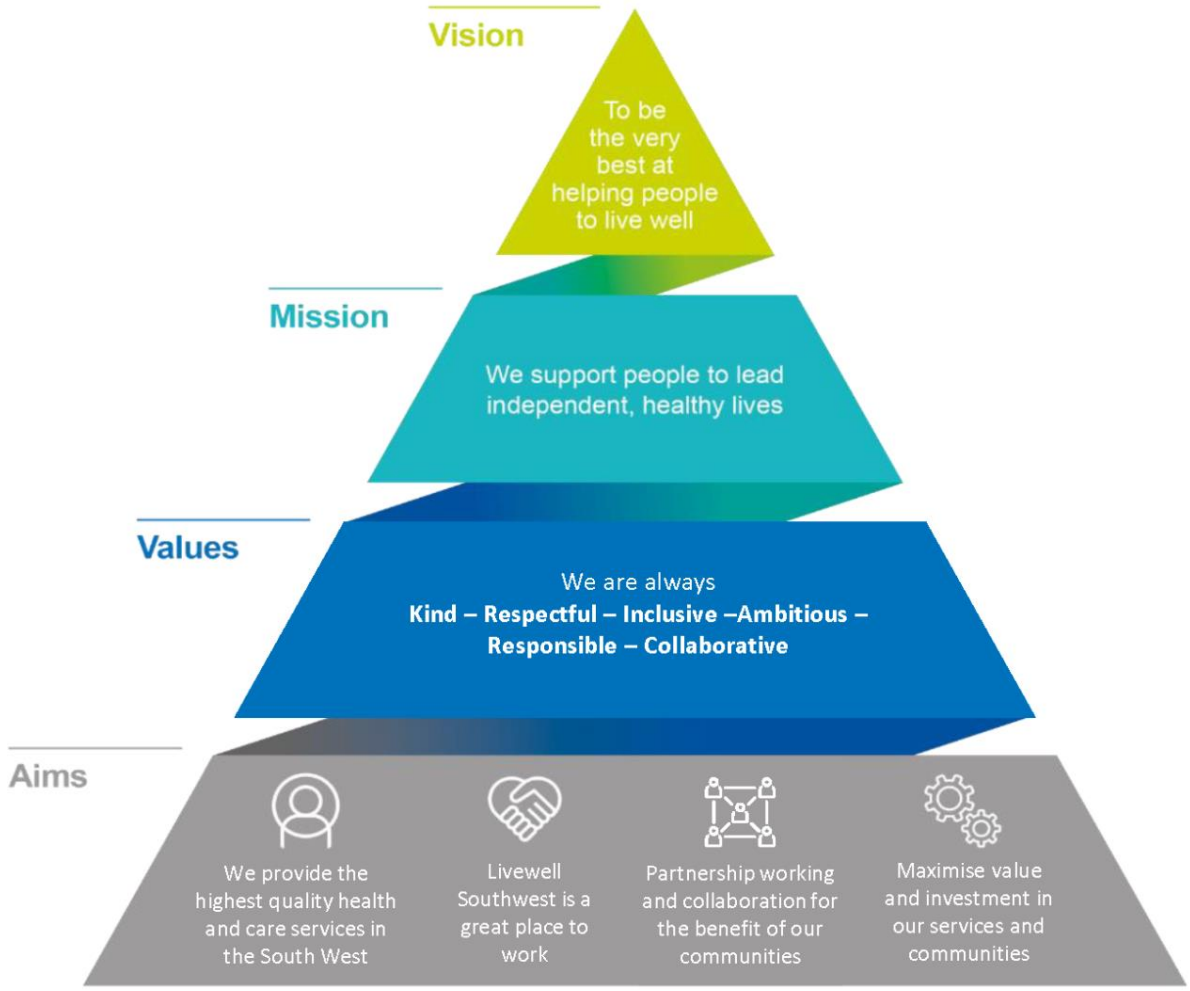
You will find our teams in community hospitals, GP practices, sports centres, health and wellbeing hubs, at community events and even at football matches.

In 2019 Livewell Southwest was inspected by the Care Quality Commission (CQC) and received a rating of 'good' overall. Our mental health inpatient unit (Glenbourne) and our community learning disabilities team received an exceptional rating of 'outstanding'.

Livewell Southwest's mission is to support people to lead independent, healthy lives in the place, and the community, in which they live. Having a strategy for the future means that we can prioritise how we will continue to improve the lives of the communities we support and shape the development of our dedicated staff.

We have refreshed our strategy to keep in step with the changing needs of the population and wider health and care priorities. Our strategy is guided by our vision, which is to be the very best at helping people to live well.

This is underpinned by our values – we are always Kind, Respectful, Inclusive, Ambitious, Responsible and Collaborative – and the four strategic aims we have set for ourselves.



We have also published our people strategy for 2021 – 2024, which you can view by clicking here.

As an employer, we recognise the importance of kindness and listening to our people in transforming their experience of working at Livewell Southwest. As a result, this strategy has been heavily influenced by feedback from our workforce, both formal and informal, in addition to national and local strategy.

We are proud to be the main provider of mental health services to people in Plymouth, and have also published our mental health strategy for 2019 – 2024 which you can view by clicking here. This document outlines our key priorities for the next five years which will guide our work.

Our people strategy also has priorities which support our patient safety work which include;

- We will embed the principles of a just and learning culture.
- We will ensure everyone's voice is heard.
- Prevent and control violence in the workplace.

PSIRF is also aligned with LSW strategic aims.

Livewell strategic aim	PSIRF theme
We put people at the centre of everything we do.	By definition, PSIRF is all about patient safety, which is an integral part of quality and is at the forefront of everything we do. Inclusion of staff, patients and carers in the reviewing process allowing for everyone's contribution.
We value, support, and empower each other.	PSIRF includes a whole framework for engaging and involving patients, families and staff following a patient safety incident.
We are an organisation with a strong social conscience.	Ethically, prioritising reviewing and learning will help to keep staff, colleagues, and service users safe.
We transform services to make them sustainable.	PSIRF is the changing face of the incident reporting framework in being able to respond quicker and align our services to meet the safety of patients, carers, and staff. In seeking those in-depth insights into our safety systems, PSIRF will help us reduce unwanted variation and feed those insights into continuous improvement work.

We are commissioned by the NHS and by Plymouth City Council to provide a wide range of services, including:

- Community and district nursing, including out-of- hours, crisis response and end-of-life care.
- Social work intervention and social care support, working in the community and in hospitals and urgent care, supporting people to retain or develop independence and wellbeing.
- Physiotherapy and occupational therapy.
- Mental health services, in the community, at our in-patient units at Lee Mill, Mount Gould Hospital and the Glenbourne Unit, at Derriford Hospital and GP practices. We also have a specialist mental health service to help refugees, asylum seekers and people released from prison, psychotherapy and anxiety and depression services.
- Older persons' mental health services, such as dementia diagnosis and dementia advisor service.
- Specialist maternity mental health services
- Perinatal mental health service
- Health improvement services, such as smoking cessation, alcohol awareness and weight management, as well as Workfit, a programme to help people to stay in work.
- Children, young people and family services, including breastfeeding support, health visiting and school nursing, the family nurse partnership and children and young persons' mental health services including Plym Bridge House. We also have a new Early Help Partnership helping families across Plymouth -this launched in 2022.
- Prosthetics and rehabilitation for stroke patients and people with neurological damage.

We work in partnership with University Hospitals Plymouth in a Healthy Lives Partnership. This launched in July 2021 and means people locally are experiencing more joined up health and social care.

Population data

The city of Plymouth has an estimated population of around 264,700 residents, as recorded in the last official census in 2021.

As of 2021, 93% of the population is white British, and the largest ethnic groups in Plymouth are Chinese, Polish and Kurdish.

While the average age of the population in the Southwest is more mature, approximately 20% of the population of Plymouth are children under the age of 18 years. Additionally, approx. 27,000 students increases the number of 18 - 24-year-olds.

Plymouth has higher levels of deprivation and poverty than the national average. The mental health needs of Plymouth are estimated to be over 20% higher than would be expected for a city this size, indicating that the city has a high burden of mental ill health. This is closely linked to higher levels of deprivation. This means that the weighted population for Plymouth is more than 350,000.

Plymouth has a higher number of military veterans than the average population.

There are higher than average levels of homelessness and alcohol use in ex-service personnel, both of which are linked to mental health problems. A significant number of veterans experience high levels of mental health problems, such as anxiety, depression, and post-traumatic stress disorder.

Defining our patient safety incident profile

LSW has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over several years.

We have a regular Executive-led Senior Management meeting and Directorate Safety meetings, and our Safety Quality Partnership has additional oversight of LSW patient safety improvement and activity.

The launch of PSIRF will see the development of the Executive led “People Safety Forum”.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on page 17 below. To fully implement the framework LSW has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve.

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. This has led to the development of the local focus for our incident responses listed on page 20.

Stakeholder engagement

The patient safety team commenced planning for PSIRF following the publication of the PSIRF documents in August 2022.

We have been fortunate to have a PSIRF early adopter in our Patient Safety Specialists Collaborative Network in Devon & Cornwall which has been invaluable in our understanding of PSIRF and their assistance has been invaluable. The wider network is an opportunity on a monthly basis to share and learn from all Patient Safety Specialists within Devon and Cornwall whilst also being supported by the Health Innovation Southwest.

The network also allows for ongoing support and communication from the ICB with an understanding of early engagement being essential in a collaborative approach.

We also engaged with provider collaborative commissioners who oversee our Children's mental health in-patient and secure services.

Reports and papers were presented internally to describe the changes needed in our transition from SIF to PSIRF. This has been delivered to the executive team, senior leadership team (now senior management team) and directorate meetings as invited.

We have also produced a local video recording of "PSIRF for LSW" to support the national recording. Both have been placed on the screensaver of every employee of LSW with a QR code to allow them to access the information.

All of this information is on the PSIRF intranet page.

March 2023 saw the launch of the PSIRF core project group with key stakeholders including representation from Devon ICB and Provider Collaborative this was supported from the project management office to give support and guidance on project delivery and provide a framework to monitor progress and effectiveness.

It included an executive lead, representation across all directorates including adult social care.

Core Group also included representation from:

- Training and development
- Suicide prevention
- HR

- Communications
- Patient experience
- Organisational development
- Business Intelligence
- Quality Improvement
- Digital
- Customer care team
- Learning from Patient Safety Events (LFPSE) implementation
- Risk

This group formed 6 workstreams:

1. **Engaging and involving workstream** - Lead for Patient Safety Partner recruitment and includes the oversight and knowledge from a co-production perspective. Led by the communications team and people with lived experience.
2. **Proportionate response -** Responsible for how we will respond in an appropriate and proportionate way using the different methodologies that are described in the guide to responding proportionately to patient safety-incidents and PSIRF toolkit. How we define and review different types of PSI's and will support the further development of the PSIRF on a page. Led by patient safety specialist.
3. **Governance and process workstream - Oversight** and responsibility for connections with external agencies. Focused on the role of the Board and oversight of the PSIRP. Led by Deputy Director of Safety and Quality.
4. **Communications Strategy workstream -** Included how we communicate the details of the PSIRF and the changes it will mean and how we communicate the learning from the new investigations. This was separate to the 'engagement' workstream. Led jointly by Communication team and Quality Improvement.
5. **Culture change and OD -** Led from the workforce and OD teams. It focused on how we manage the cultural change needed, capacity to deliver the expected changes to the way we work and how we support the workforce and development of the appropriate training, and the development and implementation of the restorative, just and learning culture within our PSIRP.

6. **Transition -** The process and implementation of changing from the current ways of working to the new PSRIF, linking in with the other workstreams and ensure that there is a robust plan for transition.

We also undertook a resource analysis exercise leading to a successful business case for additional capacity in the patient safety team, alongside a vacancy due to retirement allowed us to scope the function and roles of the team.

The patient safety team now includes;

- Deputy Director for Quality and Safety*
- Patient Safety Specialist*
- 2 full time Lead Reviewers
- Business Manager*
- Administrative Support*

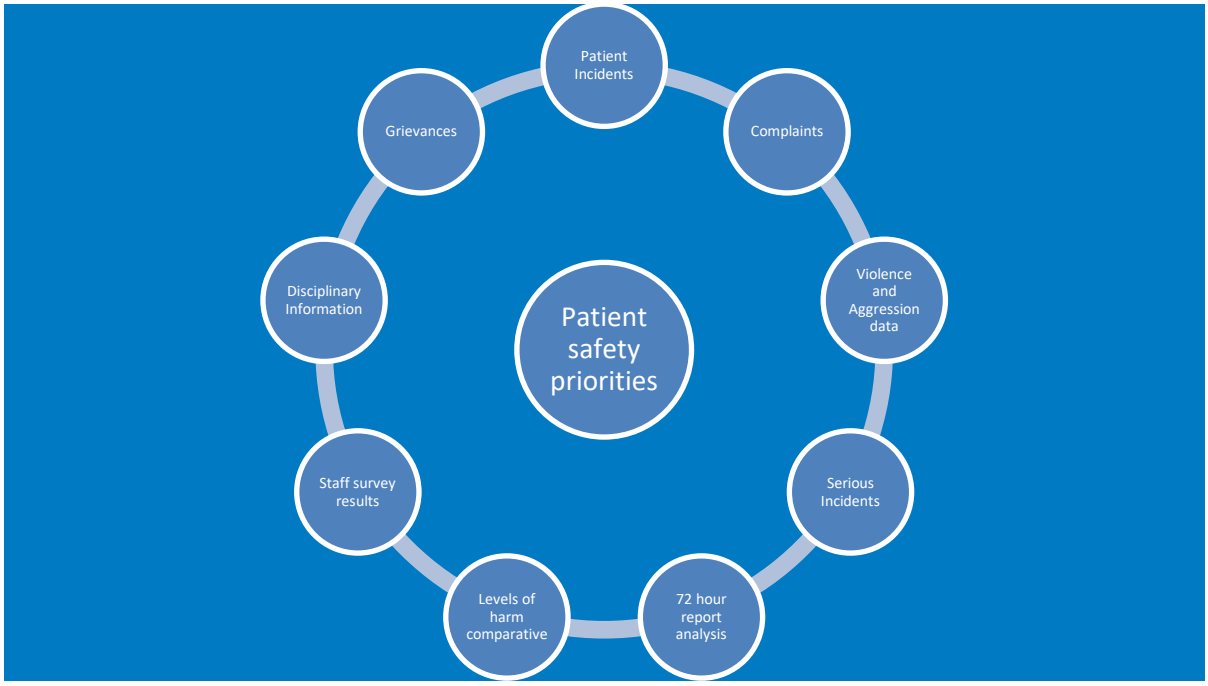
*** These roles are not limited to PSIRF they cover a breadth of responsibilities within the wider team for example CQC, NICE, Audit, Customer services, Coronial processes.**

Data sources

A key part of developing the new national approach was to understand the amount of patient safety activity LSW has undertaken over the last few years (2020-2023).

We reviewed data from a variety of sources and considered feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process.

In July 2023 the PSIRF core group dedicated the time to review the emerging themes to start to develop our priorities.



Data and information have been received from the following which includes both quantitative and qualitative sources:

- Incident reporting system three years of data (Ulysses).
- Serious incidents requiring investigations.
- Internal Reviews and case reviews.
- Complaints, concerns, and compliments.
- Safeguarding reviews.
- Domestic homicide reviews.
- Learning from deaths.
- Freedom to Speak Up reports.
- Staff survey results.
- Risk profile.
- Claims.
- Data from quality improvement processes.
- Inequalities data.
- Violence and Aggression data.
- Medicines.

Through this analysis our safety issues started to emerge.

Defining our patient safety improvement profile

Analysis of data

The safety issues from the data were themed and considered in patient safety management meeting it gave us opportunity to consider subcategories to develop our overall profile.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge alongside safety intelligence and data from complaints, claims, Freedom to Speak up and patient experience.

This information was then analysed and cross referenced against existing improvement activity, risks, and stakeholder feedback to develop our profile.

We also considered the Quality Account annual report and the quality of services offered by LSW and our ability to demonstrate improvements in the services we deliver. The quality of services is measured by considering patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

Following this the profile was shared with the PSIRF core group as well as the senior management team for endorsement of their value.

This led to seven areas we felt needed consideration for our priorities under PSIRF:

- Values and behaviours of staff impact on patient safety and experience.
- Reducing the rates of serious self-harming behaviours across all age groups in inpatient and community settings.
- Improve the transition process from children to adult services (Health).
- Reducing the number of incidents associated with the deterioration of a patient's physical health of
    - a MH inpatient requiring admission to a general hospital.
    - a poor response to deteriorating health in Community setting.
- Reducing the number of incidents of violence and aggression to staff.
- Reducing the need for Physical Intervention.
- Reduction in pressure ulcers acquired or deteriorated on caseload.

A consultation took place to a range of stakeholder groups alongside existing programmes of improvement work to identify where we should focus our in-depth insight resource to best effect.

As part of the shortlisting and refining process we adapted a prioritisation framework an approach used by the Continuous Quality Improvement team to prioritise their work. The intention was to highlight those requiring greater focus at a system level, whilst maintaining accountability across all areas of PSIRF.

Long list theme	Existing Improvement work	Shortlisted as key patient safety risk for PSIRP	Rationale
Values and behaviours of staff impact on patient safety and experience.	Yes, more focus needed on improve communication, engagement and involvement of patients and carers	Yes	Behaviours of staff is a theme in our complaints. Communication is cited as a contributory factor in reported incidents.
Reducing the rates of serious self-harming behaviours across all age groups in inpatient and community settings.	Suicide prevention Work.	Yes	Refreshed approach incorporated broader understanding of contributory factors and to be broader than suicide prevention.
Improve the transition process from children to adult services (Health).	Yes	No	Current improvement work following incidents. Significant work following SEND inspection.
Reducing the number of incidents associated with the	Yes	No	Systemic contributory factors well understood,

deterioration of a patient's physical health of • a MH inpatient requiring admission to a general hospital. • a poor response to deteriorating health in Community setting			and a comprehensive programme of improvement work underway.
Reducing the number of incidents of violence and aggression to staff.	No An organisational wide approach is needed.	Yes	Focus on staff communication. Risk understood but further work to support staff.
Reducing the need for physical intervention.	Yes Numerous workstreams which require alignment.	Yes	Focus on reporting. More in depth insight of areas.
Reduction in pressure ulcers acquired or deteriorated on caseload.	Yes QI work at system and local level.	No	Establish "Pressure Ulcer Group" which will report to "people safety forum".

Our patient safety incident response plan: national requirements

The information below describes how we will respond to patient safety incidents that meet the national event response requirement as set out in PSIRF.

Our new patient safety incident response policy will describe how our learning responses feed into future patient safety improvement plans.

Patient safety incident type	Required response	Lead for Response
Incidents meeting the Never Events criteria.	Patient Safety Incident Investigation (PSII)	LSW
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII).	PSII	LSW
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria),	PSII	LSW
Mental Health related homicides.	Referred to the NHS England Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required.	As decided by NHS Regional Independent Investigation team.

Child deaths.	Refer for Child Death Overview Panel review. If incident meets the learning from deaths criteria for PSII.	Child Death Overview Panel. LSW
Deaths of persons with learning disabilities.	Refer for Learning Disability Mortality Review (LeDeR). If incident meets the learning from deaths criteria for PSII.	LeDeR programme LSW
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 inquiries, joint targeted area inspections, child safeguarding practice reviews, safeguarding adults' 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.	Multi Agency Response
Domestic Homicide	A domestic homicide is identified by the police	CSP

	usually in partnership with Plymouth 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 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.	
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

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 and workshops we have determined that LSW requires four patient safety priorities as local focus.

We aim to undertake a minimum of four index case PSII in each of the types of incidents proposed. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work for the future.

Patient safety incident or issue	LSW planned response
Values and behaviours of staff impact on patient safety and experience.	Initial patient safety review using the incident reporting form which may identify a requirement for an additional patient safety learning response using toolkit item. Continued monitoring of patient safety incident records and complaints to determine any emerging risks/issues and alert Directorate Manager for joint review using mutually agreed toolkit item. Patient Safety Incident Investigation where agreed.
Reducing the rates of serious self-harming behaviours across all age groups in inpatient and community settings.	Initial patient safety review using the incident reporting form which may identify a requirement for an additional patient safety learning response e.g., AAR, observation, case review. PSII for cases which resulted in severe harm or death (maximum of two unless meets learning from death criteria). Being open conversation. Mortality review process and completion of a structured judgement review. Presumed suicide deaths will be prioritised for mortality review.

	Any death related to this incident type where the death was thought more likely than not due to problems in care will progress as a PSII.
Reducing the number of incidents of violence and aggression to staff.	Initial patient safety review using the incident reporting form which may identify a requirement for an additional patient safety learning response e.g., AAR, observation, case review. PSII for cases that result in harm, physical or psychological, to the staff member.
Reductions in the use of Restrictive Intervention.	Initial patient safety review using the incident reporting form which may identify a requirement for an additional patient safety learning response e.g., AAR, observation, case review. PSII for cases that result in harm, physical or psychological, to the patient. A minimum response of an AAR for any physical restraint that lasts for an extended period.
Incident resulting in moderate or severe harm.	Statutory Duty of Candour. Patient Safety Review.
Incident resulting in moderate or severe harm linked to an existing Quality Improvement Programme.	Statutory Duty of Candour. Review at a local level.

Pressure ulcers were in the highest incident categories reported from the analysis. However, we already understand the contributory factors well and these are already part of active improvement plans which are being monitored to determine efficacy, so they have not been selected as a priority for PSII.

LSW response to pressure ulcers will be led by a “Pressure Ulcer Reduction Group”.

The above improvement activity will be led by a tissue viability specialist. Themes, trends, concerns, and actions are discussed at clinical forums and feed into “People Safety Forum”.

How we will respond to patient safety incidents

Deciding what to investigate through a PSII process will be a flexible approach, informed by the local and national priorities discussed.
LSW aims to facilitate an approach that involves decision making through a multi professional approach for investigations, findings, and recommendations.

Initially we will use existing structures to support the process of decision making.

There is a twice weekly established meeting where potential serious incidents are discussed alongside notification of all incidents reported as moderate harm or above are reviewed.

Through our PSIRF journey we plan to have more localised incident review groups to move away from command-and-control decision making in relation to patient safety review activity. These groups aim to support staff to speak up about safety concerns enabling us to move from a reactive position to a more proactive method which incorporates a risk-based approach which aims to embed and empower safety into the frontline and up through the organisation. Allowing for compassionate engagement which is equitable to all regardless of role within LSW.
The incident review groups will be supported by the patient safety team and openly discuss incidents to inform and support recommendations for further levels of review. It is hoped it will lead to individual learning leading to an improvement in the quality of incident reviews and a feeling of being supported and safe to speak openly.

In PSIRF the approach of harm will no longer apply, and we will be guided by the national and our local patient safety priorities.

The process will be described in detail in LSW Patient Safety Incident Response Policy.

Patient safety incidents that have resulted in severe harm

These incidents would have automatically been a serious incident under the Serious Incident Framework (SIF). These incidents will not be routinely investigated as a PSII as we would be recreating the Serious Incident Framework.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements and undertake a Patient Safety Review.

This will provide insights to thematic learning and provide information about the events to share with those involved.

Incidents that meet the Statutory Duty of Candour thresholds
There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Care Quality Commission (CQC) Regulation 20 says we must:
1. Tell the person/people involved (including family where appropriate) that a safety incident has taken place.
2. Apologise for what has happened.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking to them about what happened and what we have learned.
6. Keep a secure written record of all meetings and communications, this can be done on the Incident reporting system (Ulysses).

Patient Safety Incident Investigations (PSII)

Patient safety investigations are undertaken to identify the circumstances and factors that result in patient safety incidents.

Investigations and reviews will examine the system in which we work by collecting and analysing evidence to identify system- based contributing factors. It will look at the wider picture without focussing on a search of a single root cause. This supports us looking at the system and not the people as individuals who work within it.

Safety recommendations will be created from this analysis, to target systems-based improvement.

LSW will conduct PSII using the Systems Engineering Initiative for Patient Safety (SEIPS) model to explore care system interactions and outcomes.

During this year (2023) 25 staff members across health and social care have completed the 2 day investigation training using the SEIPS model and are now equipped with knowledge and tools to support high quality investigations in LSW.

An important Patient Safety Review methodology that LSW will be using to review incidents at a local level will be After Action Review (AAR). This is a facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to look at improvement. It is a methodology that can be used to discuss positive outcomes as well as incidents.

LSW intends to complete up to twelve patient safety incident investigations in year 1 and will continue to undertake patient safety reviews using other learning responses where indicated.

Evaluation and monitoring following PSII

The “Patient Safety Learning Group” will be the repository for all learning providing an opportunity for the recognition and determination of themes and trends and identification of patient safety priorities which develop into patient safety improvement programmes and identify any emerging themes for future patient safety response plans. This will replace the current “Serious Incident Requiring Investigation Panel” with a membership across many areas including operational leads, subject matter leads, consultants, quality improvement, workforce, patient safety and risk, and ICB which allows for discussion and challenge.

The “Patient Safety Learning and Improvement Group” will report to the “People Safety Forum” and will include:

- Patient safety incident reporting.
- Findings from patient safety incidents.
- Progress against PSIRP.
- Results from monitoring of improvement and transformation plans.
- Results of any surveys or feedback from patients/ families/ carers on their experiences of LSW response to patient safety incidents.
- Results of any surveys or feedback from staff on their experiences of LSW response to patient safety incidents.

Improving safety culture and wellbeing

Restorative and just culture work

Improving safety relies on a culture where staff feel safe to speak up, where there is a balance between fairness, learning and accountability and where fear, blame and

reprisal cease to exist. Staff need to know that when they speak up, they will be treated fairly, with compassion and be supported.

Livewell has a number of colleagues who have attended the restorative just culture training programme and are leading a programme of work and who support with aligning just culture principles, and ways of working influencing policy, procedures, patient safety, and governance.

In terms of work already done, it has been one of the organisations priorities to reduce the number of formal grievances and instil a culture of early resolution. We have implemented a resolution policy which focuses on early resolution and is supported by the new facilitated conversation provision. Several colleagues undertook mediation training and use the skills and learning to support colleagues to resolve issues by providing a neutral impartial person to help resolve differences, build understanding and strengthen relationships.

Involving patients in patient safety

LSW are in the process of recruiting to the Patient Safety Partner (PSP) role. The aim will be to recruit Patient Safety Partners to represent the diversity of our services.

Patient Safety Partners are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who will work in partnership with staff to influence and improve the governance and leadership of safety within LSW. They will represent the voice of the wider community and provide LSW with a real opportunity for building on the vision of developing a collaborative approach, supporting a leadership culture that initiates and facilitates the opportunity for co-production and co-design in service improvements and patient safety. This will be facilitated through their participation in safety and quality committees, involvement in patient safety projects, working with the board to consider how to improve safety, involvement in staff patient safety training and participation in investigation oversight groups.

Additional to the PSP role, LSW has a Service User Experience Manager and a Participation and Involvement Specialist who work with individuals (Participation Partners) with lived experience of our services whether that be personally or as a patient carer/ relative. They participate in various co-production activities across services and ensure the patient and carer voice is heard and included in quality improvements across LSW. Recruitment of Participation Partners will commence late 2023 once relevant processes have been put in place. Currently, a Co-Production Working Group is actively attended, including those with lived experience which is led by LSW's Participation and Involvement Specialist.

There is a vision to form a wider "Patient Forum" which will enable additional opportunities to gather feedback on projects and initiatives from individuals with lived experience of LSW's services. LSW also has access to an online platform together with UHP and the ICB which could be used in future to involve patients in specific projects such as PSIRF.

Supporting those affected by a patient safety incident

Patients, families, and carers

LSW is committed to supporting and involving patients and families in line with the patient safety incident response standards and the PSIRF supporting guidance: engaging and involving patients, families and staff following a patient safety incident. During a patient safety incident investigation, the patient, family, or carer will be provided with a dedicated point of contact from LSW who will explain the investigation process and discuss the level of involvement and support preferred.

A patient, family member or carer is asked to contribute to a patient safety review (regardless of the methodology being used) in several ways, by fostering a collaborative and open approach to patient safety reviews we will ensure they can share their experience and ask questions. Our ambition is to ensure that patients, families, and carers have a voice throughout patient safety reviews and have the right level of support through the process and receive appropriate feedback about the outcome of any review. This will be done in a compassionate way without causing any further trauma to those involved. (The Harmed Patient Alliance)

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

Staff

We acknowledge the impact that patient safety incidents can have on staff and are continuing to work on developing our just culture approach for learning, so staff feel safe to speak up about safety. The impact of staff fatigue on patient safety has also been recognised and wellbeing is being addressed within other aspects of the organisation.

Staff involved in patient safety incidents may experience emotional distress and/or well-being issues, this may be exhibited in emotional, behavioural, cognitive, and physical responses (Healthcare Safety Investigation Branch, 2021). PSIRF recognises the need to identify, inform and support staff following patient safety incidents.

Staff through involvement in incident review groups can share their concerns and discuss incidents openly, contributing to the overall decision-making process for learning responses. Staff who are actively involved in patient safety reviews and investigations their engagement and contributions will be encouraged.

We will seek staff feedback about their experience of our patient safety review/investigation process to ensure that we continually review the support available and as a cultural measure of psychological safety.