Chesterfield Royal Hospital NHS Foundation Trust

Patient safety incident response plan

October 2020-September 2021

Contents

1. Purpose, scope, aims and objectives

1.1 Purpose

1.1.1 This patient safety incident response plan (PSIRP) sets out how Chesterfield Royal Hospital 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.

1.1.2 This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues

b. focusing on addressing these causal factors and the use of improvement science[2] to prevent or continuously and measurably reduce repeat patient safety risks and incidents

c. 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

d. demonstrating the added value from the above approach.

1.2 Scope

1.2.1 A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

[1] The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.

[2] "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) https://www.health.org.uk/publications/improvement-science.

1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.2.3 We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation's local commissioner(s).

1.2.4 The aim of this approach is to continually improve. As such this document will be reviewed annually to start with.

1.3 Strategic aims

1.3.1 Improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it.

1.3.2 Further develop systems of care to continually improve their quality and efficiency.

1.3.3 Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

1.3.4 Improve the use of valuable healthcare resources.

1.3.5 Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

1.4 Strategic objectives

1.4.1 Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

1.4.2 Develop a climate that supports a just culture[3] and an effective learning response to patient safety incidents.

1.4.3 Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured

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

architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

1.4.4 Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

2. Situation analysis – national

2.1.1 Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

2.1.2 When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

2.1.3 Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

a. Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident.[4] As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[5]

b. There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.[20]

2.1.4 An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS

[4] Health and Safety Executive (2014) Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals.

[5] Vincent C, Adams S, Chapman A et al (1999) *A protocol for the investigation and analysis of clinical incidents*.

organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[6,7,8,9,10]

2.1.5 In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (eg professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

2.1.6 Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (eg the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

2.1.7 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (eg mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future PSIIs
b. conducting PSIIs purely from a patient safety perspective
c. reducing the number of PSIIs into the same type of incident

6 Public Administration Select Committee (2015) *Investigating clinical incidents in the NHS. Sixth report of session 2014–15*.
7 Parliamentary and Health Service Ombudsman (2015) *A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*.
8 Care Quality Commission (2016) *Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*.
9 NHS Improvement (2018) *The future of NHS patient safety investigation*.
10 NHS Improvement (2018) *The future of NHS patient safety investigation: engagement feedback*.

d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

2.1.8 This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or
b. the subject of current improvement work that can be shown to result in progress or
c. listed for PSII work to be scheduled in the future.

2.1.9 In some cases where a PSII for system learning is not indicated, another response may be required. This will depend on the intended aim and required outcome and might include; case note review, timeline or chronology, learning review meeting or sharing of an anonymised incident report. All information relating to PSIs and the insight generated from all responses must be recorded within Datix™ our local risk management systems and shared with the National Reporting and Learning System (NRLS) or its successor. PSIIs will also be recorded on the Strategic Executive Information System (StEIS) or its successor to allow organisation to monitor progress of PSIIs.

2.1.10 As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

a. professional conduct/competence – referred to human resource teams
b. establishing liability/avoidability – referred to claims or legal teams
c. cause of death – referred to the coroner's office
d. criminal – referred to the police.

3. Situation analysis – local

3.1 Results of a review of activity and resources

3.1.1 A review of the PSII resource and activity (associated with patient safety incident investigation) for the period January 2018 to December 2019 has been undertaken to determine how many PSIIs can be supported during October 2020 to September 2021. This review has been undertaken alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

3.1.2 This review has been undertaken by the Trust's patient safety team with support and involvement from the divisional leadership teams, the complaints and clinical effectiveness teams.

3.1.3 In summary Chesterfield Royal Hospital has identified that with its current resources it is able to undertake 25 PSII across the organisation. Each lead investigator will be supported centrally by the patient safety incident investigator and subject matter experts as appropriate. Further support in terms of administrative support and patient/family/staff liaison will also be provided by the patient safety incident investigation coordinator. Lead investigators will not be expected to manage any more than two full PSIIs at any one time.

3.1.4 To improve our ability to deliver against PSII standards we plan to:

- Assign an appropriately trained board member to oversee delivery of the PSII standards and support the sign off of all PSIIs
- Train 30 staff in system based training to support either leading or reviewing and investigation.
- Develop an incident review toolkit to support the review of patient safety incidents where a PSII is not indicated.

3.2. Review of Patient Safety Incident Risks

3.2.1. The patient safety incident risks for this organisation have been profiled using organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, PSIIs, mortality reviews and case note reviews etc. Resources mined for this data include:

a. staff survey explorer tool results:
   - https://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/

b. organisation patient safety reports:
   - https://report.nrls.nhs.uk/ExplorerTool/Report/Default
   - https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/

3.2.2 To support the assessment of risk and to agree patient safety incident priorities we undertook an in depth thematic analysis of patient safety incidents We then held discussions on the themes identified at the clinical effectiveness and safety group and quality delivery group to agree local priorities for investigation. Due to restrictions in place in relation to the COVID-19 pandemic it wasn't possible to fully engage with our patients and their families. However an in-depth review of formal complaints received by the Trust was undertaken to support reflection of patients and their family's views.

3.3 Conclusions from review of the local patient safety incident profile

3.3.1 The current top10 local priorities/risk register for PSII are:

	Incident type	Specialty
1	Invasive procedures	Surgical Services and Women's health
2	Ongoing Assessment of Patient Status	Trust wide
3	In-patient falls (witnessed and unwitnessed)	Surgical Services/ Medicine and Emergency care
4	Medication	Trust wide
5	Diagnostic related incidents	Trust wide
6	Development and/or deterioration of Pressure Ulcers	Surgical Services Medicine and Emergency care
7	Discharge and follow-up	Trust wide
8	Documentation	Trust wide
9	Radiological/Imaging Investigations and/or Interpretations	Trust wide
10	Laboratory Investigations and/or interpretations	Trust wide

4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1 PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.1.2 There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

4.1.3 There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

4.2 Nationally-defined priorities to be referred for PSII or review by another team

4.2.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are:

a. **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)

- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- all perinatal and maternal deaths must be referred to MBRRACE

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

g. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation

e. **incidents in screening programmes:**

- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

h. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.3 Nationally-defined incidents requiring local PSII

4.3.1 Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

a. **incidents that meet the criteria set in the** Never Events list 2018

b. **incidents that meet the** ‘Learning from Deaths’ criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient’s care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:

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

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

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

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

Based on our analysis of patient safety risks and previous incidents captured by national priority incidents we have ring-fenced resource to support 5 national priority PSIIs.

4.4 Locally-defined incidents requiring local PSII

4.4.1. Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation for the period October 2020 to September 2021.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the

potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. Locally-predefined patient safety incidents requiring investigation.

Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

- **Criteria for selection of incidents for PSII:**
    a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
    b. likelihood of recurrence (including scale, scope and spread)
    c. potential for learning in terms of:
        - enhanced knowledge and understanding
        - improved efficiency and effectiveness (control potential)
        - opportunity for influence on wider systems improvement.

- Based on our analysis of patient safety risks and previous incidents we have ring-fenced resource to support 20 local priority PSIIs.

- As outlined in section 2.1.3. the number of PSII planned in response to each incident type has been restricted to 3-6 to support in depth analysis and identification of common interlinked causal factors.

- To support the identification of common causal factors, incident types are narrowly defined. This means from a large group of incidents, a smaller subset of incidents (which may be specific to an area, process, and/or presentation of a patient or other characteristic) will be identified.

- Not all PSIs require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Where this is the case, we will adopt relevant techniques. Further information relating to review tools and techniques is

available online: https://www.england.nhs.uk/patient-safety/patient-safety-investigation/

For the period October 2020 to September 2021 local priorities for PSII have been agreed as illustrated below.

Incident type and description	Number
Incidents relating to invasive procedures outside of theatres, excluding never events	5
Incidents relating to recognition of the deteriorating patient; specifically patients within ED/EMU/SSU	5
Incidents relating to diagnosis; specifically delay or failure to follow-up on abnormal scan/test results	5
Incidents relating to documentation/handover; specifically patients at risk of self-harm admitted through ED and transferred to EMU/SSU or in-patient ward	5

4.4.2 A number of incident types such as in-patient falls, development/deterioration of pressure ulcers and medication-related incidents have been excluded from the priority categories as they have active improvement delivery plans in place based on learning identified from previous patient safety incident investigations. Delivery of these improvement plans will be monitored by the central patient safety team and via their respective specialist sub-group. A combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

4.4.3. All incidents will be reported in line with existing patient safety incident reporting guidance and principles described in the PSIRF.

4.4.4 In some cases, incidents may need to be reported to other bodies as described in the Incident Management Policy

4.4.5 Any incident resulting in moderate harm or above will continue to be managed in accordance with Being Open and Duty of Candour.

4.4.6 Any request for information about a patient safety incident – by the patient, families and/or staff – will be responded to openly and as much information as possible will be provided regardless of severity of outcome or the type of response required under this plan.

4.5 Completing PSII

4.5.1. Each comprehensive PSII will be:

a. Conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8 and has received a minimum of two days' training.
b. Undertaken as per the PSIRP and will adhere to the national PSII standards and with national good practice for PSII.
c. Use the national standard template to report the findings of the PSIIs.
d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

4.5.2. For each group of PSIIs dedicated to a similar/narrow focus incident type we will:

a. Design strong/effective improvements to sustainably address common interconnected causal factors.
b. Develop an action plan for implementation of the planned improvements.

NB: while some actions may be needed after only one investigation, where possible, we will wait until all investigations for each incident types are completed and common causal factors identified so that solutions/action plans can be developed to address them

c. Monitor implementation of the improvements.
d. Monitor effectiveness of the improvements over time.

4.5.3. To monitor the quality of PSII findings and progress against this PSIRP we will seek answers to the follow:

a. Are the actions likely to achieve improvement?
b. Is there evidence of improvement?

4.6. Timescales for patient safety PSII

4.6.1. Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSIIs should ordinarily be completed within one to three months of their start date.

4.6.2. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

4.6.3. No local PSII should take longer than six months. A balance must 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. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

4.7. Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents

4.7.1. A valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2. The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

4.7.3. Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

5. Roles and Responsibilities

This organisation 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.

Chief executive

- Overall responsibility for the effective management of all patient safety incidents, including contribution to cross-system/multi-agency reviewed and/or investigations where required.
- With the executive and non-executive team, models behaviours that support the development of patient safety reporting, learning and improvement system.
- Ensure that systems and processes are adequately resourced including; funding, management time, equipment and training.

The **Chief Nurse,** supported by the **Medical Director,** is the executive lead responsible for supporting and overseeing implementation of the Patient Safety Incident Response Framework (PSIRF) and includes;

- Ensuring processes are in place to support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Oversee development and review of the organisations PSIRP.
- Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families and carers where required.
- Ensures the organisation complies with the national patient safety investigation standards.
- Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards.
- Develops professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management.

Patient Safety Team

- Ensures that patient safety investigations are undertaken for all incidents that require this level of response (as directed by the organisation's PSIRP)
- Develops and maintains 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 the organisation's PSIRP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).
- Established procedures to monitor/ review investigation progress and the delivery of improvements.
- Works with executive lead to address identified weaknesses/areas for improvement in the organisations response to patient safety incidents including gaps in resource including skills and training.
- Supports and advises staff involved in the patient safety incident response

Investigation leads

- Ensure that investigations are undertaken in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

Investigators

- Under the direction of investigation lead undertake investigations in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

Named contact for patients, families and carers

- Identify those patients, families and carers affected by patient safety incidents and provide them with timely and accessible information and advice
- Ensure they are provided with an opportunity to access relevant support services

- Act as liaison between patients, families and carers and investigation teams to help manage expectations.

All named contacts for patients, families and carers must have;

- Received appropriate training in communication of patient safety incidents including 'being open' and Duty of Candour.
- Sufficient time to undertake their role; that is they should be staff dedicated to the role or with dedicated time for this role.

More information can be found in the Trust's Being Open (Duty of candour) Policy.

Named contacts for staff

- Provide advice and support throughout the investigation process to staff affected by a patient safety incident.
- Facilitate their access to additional support services as required.
- Act as liaison between these staff and investigation team as required.

Department Leads/managers

- Encourage reporting of all patient safety incidents including near misses and ensure all staff in their area is competent in using the Datix reporting system and are provided sufficient time to record incidents and share information.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in investigations as required.
- Liaise with the patient safety team 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 patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

All Staff

- Understand their responsibilities in relation to the organisations PSIRP.
- Know how to access help and support in relation to patient safety incident response process.

6. Patient Safety Incident reporting arrangements

The process of complying with both internal and external notification requirements for the reporting of patient safety-related incidents can be found within the Trust's Incident Management Policy.

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

Local arrangements for supporting patients, families and carers are detailed within the Trust's Being Open (Duty of Candour) Policy and associated toolkit.

8. Procedures to support staff affected by PSIs

The local arrangements for supporting staff affected by patient safety incidents are detailed within the Supporting Staff affected by an Incident, Complaint, Claim or Inquest toolkit:

General arrangements for supporting staff health and wellbeing are detailed on the Trust's intranet and include occupational health support and employee assistance programme.

National sources of support are given in Appendix 3 of the PSIRF.

9. Mechanisms to develop and support improvements following PSIIs

The Trust utilise the Quality, Service, Improvement and Redesign (QSIR) quality programme through their Royal Academy of Improvement. The Academy provides training, education and support for a wide variety of improvement projects. There is a cohort of improvement ambassadors and educators who have undergone training to support teams throughout the Trust with implementing improvements/solutions arising from patient safety incident investigations.

10. Evaluating and monitoring outcomes of PSIIs, Reviews etc

10.1 Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

10.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

10.3 Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

10.4 Reports to the board will be monthly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view
- 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 and appeals

Local arrangements for complaints and appeals relating to the organisation’s response to patient safety incidents are detailed within the Trusts Complaints, Concerns, Comments and Compliments (4Cs) Policy

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Publication approval reference: