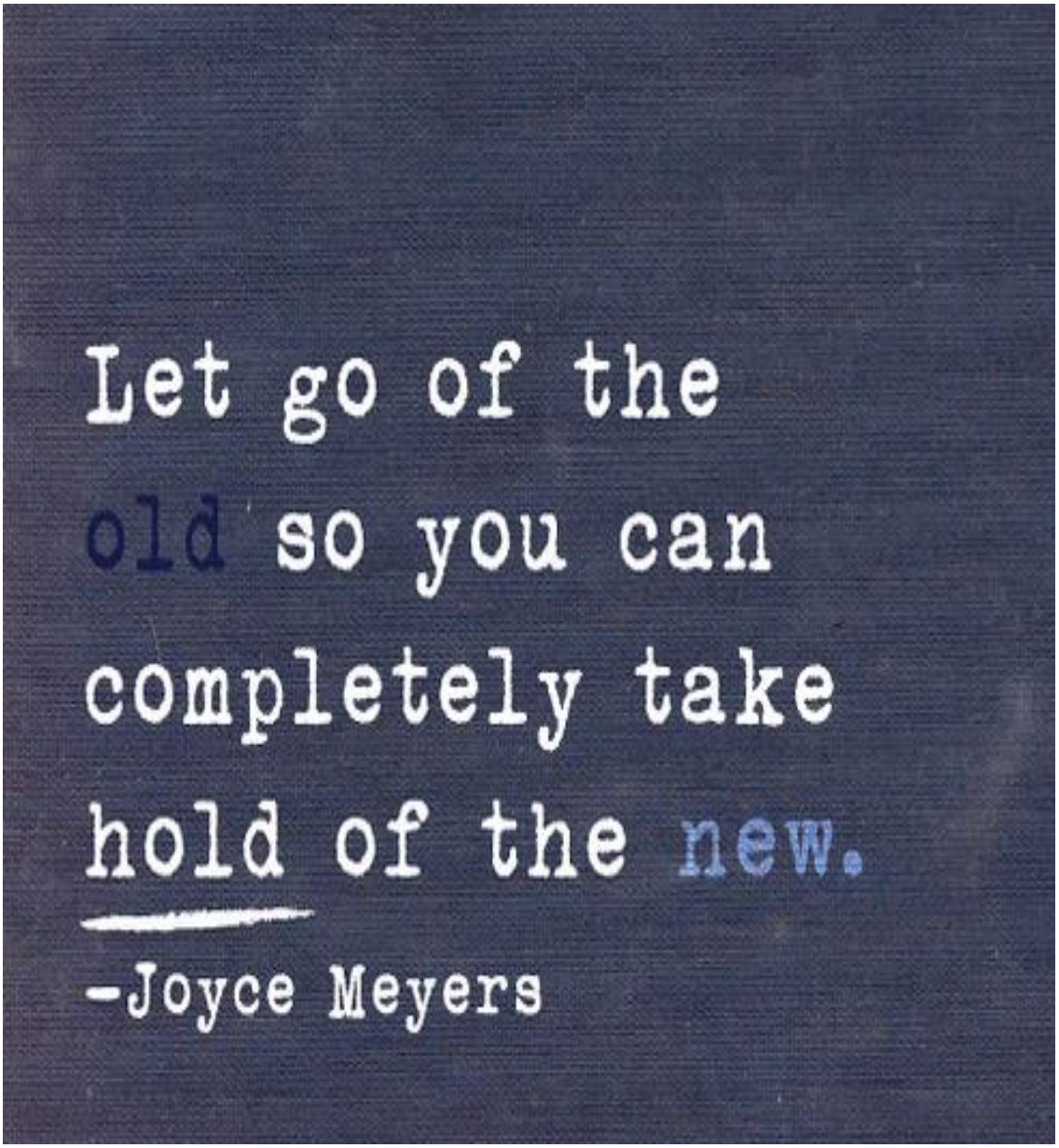
Solent NHS Trust Patient Safety Incident Response Plan (PSIRP)

2023/24

Effective date: 30th October 2023

Estimated refresh date: 31st March 2024 (Re Project FUSION)

	NAME	TITLE	DATE
Author	**Teresa Power**	**Patient Safety Specialist, Operational Lead**	**06.08.2023**
	Pauline Jeffrey	**Head of Quality and Safety**	**06.08.2023**
Reviewer	**Aderemi Aderibigbe**	**Associate Director for Quality, Safety, Governance and Risk**	**22.08.2023**
Authoriser	**Trust Public Board**		**2.10.2023**
	Integrated Care Board		**19.10.2023**


Let go of the
old so you can
completely take
hold of the new.
-Joyce Meyers

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

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 and calling it something different but a cultural and system shift in our thinking and our response to patient safety incidents and how we learn from them and make improvements to prevent a recurrence.

Previously we have had set timescales and external organisations to approve what we do. PSIRF gives us is a set of principles what we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that PSIRF gives us the opportunity to use a variety of learning response tools, not just investigations, to understand our learning and to determine our areas of improvement to keep our patients safe.

PSIRF rightly has an important focus on engaging with our patients, families, and carers to ensure their voice is the golden thread in any of our patient safety investigations. Our Patient Safety Partners are integral in this approach to provide a fair challenge to us to ensure the patient voice is involved at all stages in our patient safety responses.

PSIRF recognises the importance of engaging with staff, providing an inclusive and supportive approach to their learning**.** The support of our staff following a patient safety incident has been a fundamental focus for Solent. We have developed a staff support model, which includes safety chats and signposting to support within Solent (RIPPLE model). We have fostered a culture that encourages staff to report patient safety incidents and to be supported to do so, without fear of blame.

As we move into adopting this new way of managing our patient safety incidents, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF Implementation, responding and adapting as needed if our approach is not achieving what we expect it to, with support from our Stakeholders, including our Integrated Care Board.

We really welcome the implementation of our plan to provide us with further opportunity to learn and improve to provide safe, effective, and compassionate care of our patients, their families and carers whilst protecting the wellbeing of our staff.

Angela Anderson, Chief of Nursing and Allied Health Professionals

Dan Baylis, Chief Medical Officer

Contents

Foreword 3
Introduction 6
Our services 7
Defining our patient safety incident profile 8
Stakeholder engagement 9
Data Analysis 9
Defining our patient safety improvement profile 11
Our patient safety incident response plan: national requirements 11
Our patient safety incident response plan: local focus 14
Learning Response Methods 16
Appendix A - Patient Safety Incident Response Escalation Process 19
Appendix B 20
Appendix C - Patient Safety Training in Solent 21
Appendix D 24
Appendix E 26

Introduction

This patient safety incident response plan sets out how **Solent NHS Trust** intends to respond to patient safety incidents over the period until 31st March 2024. Its aim is to inform staff and our people of the new ways we will be working.

The plan is not a permanent rule that cannot be changed, and it is anticipated that the plan will be combined with plans from other organisations within project FUSION in readiness for transition to the new organisation from 1st April 2024. In addition, the Integrated Care Board will also be undertaking quarterly review meetings.

Solent will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The plan is underpinned by our Patient Safety Incident Response Policy.

Our services

Solent NHS Trust provides community and mental health services to people who live in Portsmouth, Southampton, Hampshire, and the Isle of Wight. Our overall aim is keeping more people healthy, safe, and independent at or close to home.

Solent have eight service lines providing the following.

- Mental Health Services - Inpatient and Community Mental Health for people who require specialist assessment, care and treatment by a dedicated multidisciplinary team and learning disability services.

- Adults Portsmouth – Inpatient rehabilitation and discharge to assess. Specialist Palliative care, rehab and reablement, community nursing, urgent Community Response, diabetes, occupational therapy, physiotherapy, speech and language therapy, pulmonary rehabilitation and home oxygen, care home support, heart failure, bladder and bowel, community neuro service, clinical advisory team, admission avoidance and supported discharge services.

- Children and Family Services - Childrens nursing, child and adolescent mental health, health visiting, paediatric medical, paediatric therapies, and school nursing

- Adults Southampton – Neuro rehab services, rehab and reablement, community nursing, neuro inpatient unit, Parkinson's, epilepsy, multiple sclerosis specialist nursing, elderly frail inpatient unit, occupational therapy, physiotherapy, speech and language therapy, care home support, admiral nursing, bladder, and bowel, respiratory, diabetes, tissue viability, heart failure, admission avoidance, stoma care and supported discharge services.

- Primary Care – GP and homeless healthcare services

- Muscular skeletal physiotherapy and podiatry – tuberculosis, rheumatology, specialist physiotherapy, physiotherapy, long COVID, chronic pain and podiatry.

- Sexual Health – Genitourinary medicine, reproductive health, HIV outpatient services, sexual health promotion, termination of pregnancies, psychosexual counselling, vasectomy services and sexual assault referral centre.

- Specialist Dental –Oral health care and dental treatment (including treatment under conscious sedation) for children and adults that have a special need or an impairment, disability and/or complex medical condition. This includes those with Learning Disabilities, Severe physical problems, Challenging Behaviour, Autistic Spectrum Disorders, Frail/elderly or housebound (delivered in Care Homes and patient's homes), Bariatric difficulties, Severe Mental Health Conditions, Severe or debilitating dental phobia, Patients who have undergone head and neck radiotherapy.

Defining our patient safety incident profile

We have a continuous commitment to learning from patient safety incidents as demonstrated in our response to the Patient Safety Strategy 2019. We have developed our approach to be a learning Organisation over many years. Solent has a nationally recognised Academy of Research and Improvement which has supported many Quality Improvement initiatives in Solent and directly supported the Quality and Safety team in the implementation of Safety, Excellence, and Improvement Forums. In addition, we have a strong safety thread running from Service Lines to our Board. As shown in appendix A.

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 12. To fully implement the Framework, the Trust has completed a review of the types of patient safety incidents occurring in our services to understand where we need to focus to enable continuous learning and improvement.

The PSIRF Implementation 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 identifying and specifying the methods to be used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on page 14.

Stakeholder engagement

The PSIRF implementation team commenced planning for PSIRF in advance of the release of documents in August 2022. We worked closely with our neighbouring Trusts and would like to say thank you, to the Isle of Wight Trust, as early adopters of PSIRF the insight into their journey has been invaluable. We also accessed information from several PSIRF early adopter organisations to enable us to understand the practicalities of planning for and implementation of PSIRF. This included gathering information on the learning response tools they were using. Which has been invaluable in helping us determine which we will use.

In 2022 the Trust Board, Quality Assurance Committee, Quality, Improvement and Risk Committee all received presentations on the fundamental changes that PSIRF would bring to how we understand, learn, and improve Patient Safety.

A PSIRF Implementation team was formed and following a team briefing we commenced our preparation. Our Integrated Care Board colleagues were part of this team along with our Patient Safety Partners. We also had the Head of Improvement attend from a Quality Improvement perspective.

The development of our Patient Safety Incident Response Framework plan followed the nationally recommended implementation project phases and a summary of how we did this is outlined below:

- Patient Safety Specialists attending NHSE PSIRF webinars.
- Patient Safety Specialist, Operational lead to develop plan and monitor workstreams.
- Implementation Team meetings
- Workstreams for Learning Responses, Communication, Involving those affected by patient safety events, Safety data analysis, Training and education and Oversight/Governance.
- Oversight Group meetings with Chief of Nursing and Allied, Healthcare Professionals and Deputy Chief Medical Officer.
- Updates provided to Quality, Improvement and Risk Group, Quality Assurance Committee, and the Trust Board.
- Hampshire and Isle of Wight Patient Safety Incident Response Framework group
- Project Fusion PSIRF Group

During the latter part of the development of our plan we have shared and sought support from our Community Partners with a robust sign off process as detailed in appendix B.

We considered our capacity to respond to patient safety incidents and the level of training our staff would require. See appendix C.

Data Analysis

To define our Patient Safety Incident Response profile, we conducted an analysis of our safety data from a variety of sources, qualitative and quantitative. They are as follows.

- Patient Safety Incidents from our Incident system between 1st April 2021 to 31st March 2023. It was suggested by NHSE that Organisations analyse two - three years

of data. Solent agreed to analyse two years of data, as the patient safety profile in Solent for the previous year was heavily impacted by the pandemic.

- Serious Incidents and High-Risk Incidents
- Complaints and Service Concerns
- Freedom to Speak up cases.
- Patient and staff surveys results
- Risks
- Claims
- Coroners feedback
- Mortality and Structured Judgement Reviews
- Health and Safety Reports
- Thematic Reviews
- Audits
- Inequalities data

From the data analysis we were able to identify the top patient safety issues across the organisation and some which were specific to just one service line as detailed in Table 1.

Table 1

Category	Detail
Medication Incidents	Administration of medication - top primary cause of medication incidents
Pressure Ulcers	Developed or deteriorated in Solent's care
Communication in Mental Health Services	With relatives and/or next of kin
Communication in Child and Family Services	With patients/parents/carers/legal guardians
Transferring care between Organisations in Adult Services Southampton, Adult Services Portsmouth, and Mental Health Services	Documentation and Communication
Slips, trips, and falls	Inpatients are the highest reporters
Do not Attempt Cardiopulmonary Resuscitation (DNACPR)	Advanced care planning and locating documentation
Staffing/ workforce and capacity	Identified as a safety risk, but no evidence of patient harm because of the risk
Recognising physical deterioration in inpatients	Focus is on inpatient wards due to incident levels
Waiting Lists	This is a safety risk, not seeing evidence of significant patient harm as a result, but emerging picture with the implementation of formal assessment using the harm tool
Suspected Suicides	In Mental Health Services
Clinical Delay involving more than one patient	In Dental Services

Following analysis, the Safety Data workstream agreed a recommended list of priorities for Solent's first PSIRP. Page 14

Defining our patient safety improvement profile

The Trust has consciously developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. Improvement events are held annually, the services consider what audit, evaluation, and quality improvement projects, they plan to undertake. The Trust will not wait until these planning events but use the skills and support available to them from the Academy of Research and Improvement, ensuring that staff within the Patient Safety team are also skilled in Quality Improvement methodology. We have reviewed our Quality, Improvement and Risk Group and divided into a two monthly cycle. Month one focusses on Safety and Risk and the following month on learning and Improvement.

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 National Patient Safety Strategy has identified National improvement programmes for Mental Health, Managing the Deteriorating Patient, Safety of Older people, Medicines Safety and Antimicrobial Resistance and Healthcare Associated Infections, all of which we are actively engaged in as an organisation. More information is found in appendix D.

Our patient safety incident response plan: national requirements

Given that we have finite resources for patient safety incident responses, we intend to use those resources to maximise improvement. The framework allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

The national framework includes a list of incidents that require a mandated patient safety incident response as set out in table 2 and we fully endorse this approach as it supports the aim to learn and improve within a Just Culture. The table reflects the national priorities that are relevant to us, and our approach to these incidents are described below.

Table 2

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria)	Locally led Patient Safety Incident Investigation (PSII).	Create local organisational actions and feed these into Quality Improvement processes
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	Create local organisational actions and feed these into the Quality Improvement processes
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team for consideration for an independent patient safety incident investigation. Locally led Patient Safety Incident Investigation may be required	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and changes to practice as a result.
Domestic homicides	Referred to the NHS England Regional Independent Investigation Team for consideration for an independent patient safety incident investigation. Locally led Patient Safety Incident Investigation may be required	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and changes to practice as a result.
Incidents meeting the Never Events criteria 2018: for our Trust this relates specifically to non-collapsible curtain rails which may be used as a ligature point plus falls from poorly restricted windows, head, or neck entrapment in bed rails, misplaced naso or oro gastric tubes, overdose of insulin due to abbreviations or incorrect devices, scalding of patients.	Locally led Patient Safety Incident Investigation	Create local organisational actions and feed these into the Quality Improvement processes to evidence learning and changes to practice as a result.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led Patient Safety Incident Investigation (Or other response) may be required alongside the LeDeR – organisations should consult.	Respond to recommendations as required and feed actions into Quality Improvement processes to evidence learning and changes to practice as a result.
Child deaths	Joint Agency Team to lead the review in collaboration with the internal Safeguarding Team as per the Trust Safeguarding Policy.	Respond to recommendations as required and feed actions into the Quality Improvement processes to evidence learning and

	Refer for Child Death Overview Panel review.	changes to practice as a result.
Safeguarding incidents in which: Babies, children, and 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 by their Local Authority The incident relates to female genital mutilation, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead as per the Trust Safeguarding Policy. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations as required and feed actions into Quality Improvement processes to evidence learning and changes to practice as a result.
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	Create local organisational actions and feed these into the Quality Improvement processes to evidence learning and changes to practice as a result.

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 data from a variety of sources, we have determined that the Trust's local patient safety priorities will be as described in table 3 below.

Table 3

Patient safety incident type or issue	Planned response	How will findings from planned response lead to improvement?
Medication Administration errors	Review by Medicines Safety Officer using bespoke template followed by monthly thematic analysis to medicine management group. After Action Review where significant learning has been identified.	It will identify any themes or trends that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Pressure Ulcers (In Solent Care newly acquired or deterioration)	Review by Tissue Viability specialists using bespoke template followed by monthly thematic analysis to Tissue viability steering group. After Action Review where significant learning has been identified	It will identify any themes or trends that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and Quality, Risk, and Improvement Group.
Communication issues with relatives when patients are receiving care from Mental Health Services	Multi-Disciplinary Team Review	It will identify any themes that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.

Communication issues with patients/ parents/carers and Legal Guardians receiving Child and Family Services care	Multi-Disciplinary Team Review	It will identify any themes that require a local safety action and any areas that require a quality improvement (QI) approach. Improvements will be monitored through Service line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Inpatient slips, trips and falls	SWARM Huddle (Also known as Hot debrief)	It will identify any immediate local safety actions from all those involved. It may also identify any themes that require a quality improvement approach (QI) Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Delayed Recognition of Physical Deterioration in all inpatient services	After Action Review	It will identify local safety actions from those involved and any areas that require a quality improvement approach (QI) Improvements will be monitored through Service Line Governance, Learning from Incidents and Deaths Panel and the Quality, Risk, and Improvement Group.
Suspected completed /attempted Suicides in inpatients and patients receiving care under crisis pathway	After Action Review / Patient Safety Incident Investigation	It will identify any relevant local and organisational safety improvements based on an individual case or themes. A quality improvement approach will be considered.
Clinical Delay involving one patient where significant learning has occurred or multiple patients where significant learning may or may not have occurred	Multidisciplinary team (MDT) review / Patient Safety Incident Investigation	It will identify any local and organisational safety improvements. A quality improvement approach will be considered.

Whilst this list has been agreed, it is not fixed and will be subject to continuous review and update in the context of emerging safety issues. Within our resource analysis, we have also established capacity for additional ad-hoc PSII or thematic analysis where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

All incidents will continue to be reported in line with the Trusts existing patient safety incident reporting guidance. (Appendix E details provides more detail on these incidents) and principles described in the framework.

For near miss or no harm incidents we propose to manage these at a local level with ongoing thematic analysis via existing Trust processes which may lead to new, or supplement existing improvement work.

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

Completed thematic reviews will be reviewed and discussed at their appropriate forums to identify required improvement actions.

Mortality reviews will not form part of the process unless they are a safety incident. The Trust's learning from deaths policy will apply for mortality reviews.

Learning Response Methods

We will be using the following learning response methods which all include our frontline team's involvement to respond and learn from our local patient safety priorities:

Table 4

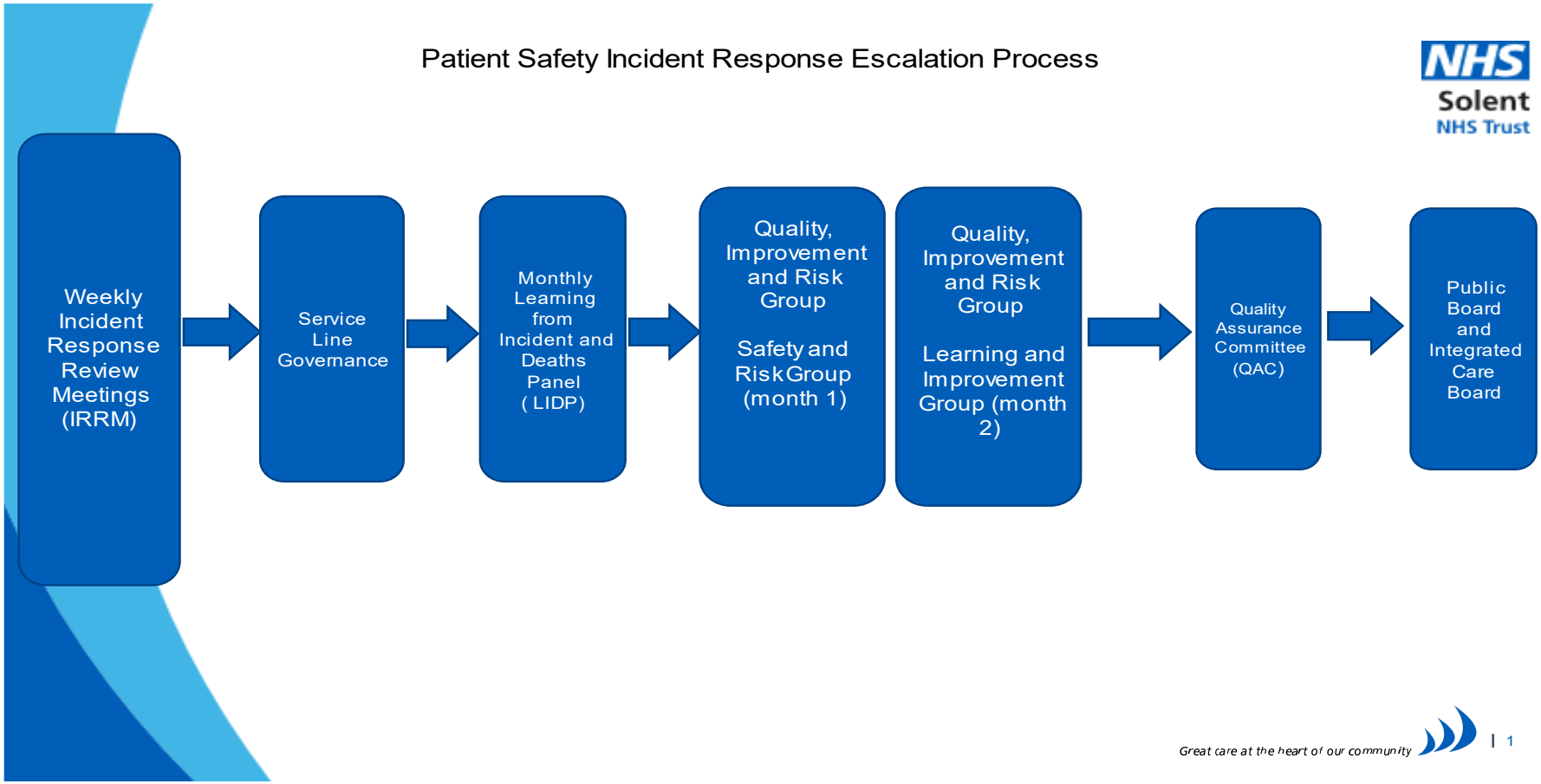
Learning Tool	What is it?	Who leads it?	Timeframes
SWARM Huddle (Hot Debrief)	SWARM-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. It occurs straight after the incident, where the team involved get together to discuss the incident and identify immediate learning or actions to be taken forward	Senior Lead who was not involved in the incident	Day of the event, but in exceptional circumstances within forty-eight hours.
Thematic review	An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e., work as done. A thematic review can identify patterns in data to help answer questions, show	Trained Investigating Officers.	Within forty to sixty calendar days

	links, or identify issues. Typically involves using qualitative (e.g., open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) rather than quantitative data to identify safety themes and issues		
After Action Review	An After-Action Review is 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 tasks to and promote success for the future. It is a structured, facilitated discussion of an event, the outcome of which gives the individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement or why the action was particularly successful. After action review generates insight from the various perspectives of the multi-disciplinary team.	Led by a trained After-action review Conductor - this could be anyone from within the multi-disciplinary team, local or remote to the participants	Within thirty calendar days
Patient Safety Incident Investigation	An in-depth review of a single patient safety incident or cluster of events to understand what happened and how (replaces the Serious Incident/Red Root Cause Analysis investigations)	Trained Investigating Officers	Within six months but it is dependent on the complexity of the case and in agreement with patient/family
Multi-Disciplinary Team Review	The multidisciplinary team (MDT) review supports teams to: 1. Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents) 2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. 3. To explore a safety theme, pathway, or process. 4. To gain insight into 'work as done' in a health and social care system.	To be led by a patient safety facilitator who will use the MDT as source of data for learning about a series of events or a theme	Within thirty calendar days

Clinical Teams will be responsible for undertaking local learning responses such as Swarm Huddle, After Action Review and Multi-Disciplinary Reviews/ However during the transition phase they will receive support from the Quality and Safety Team.

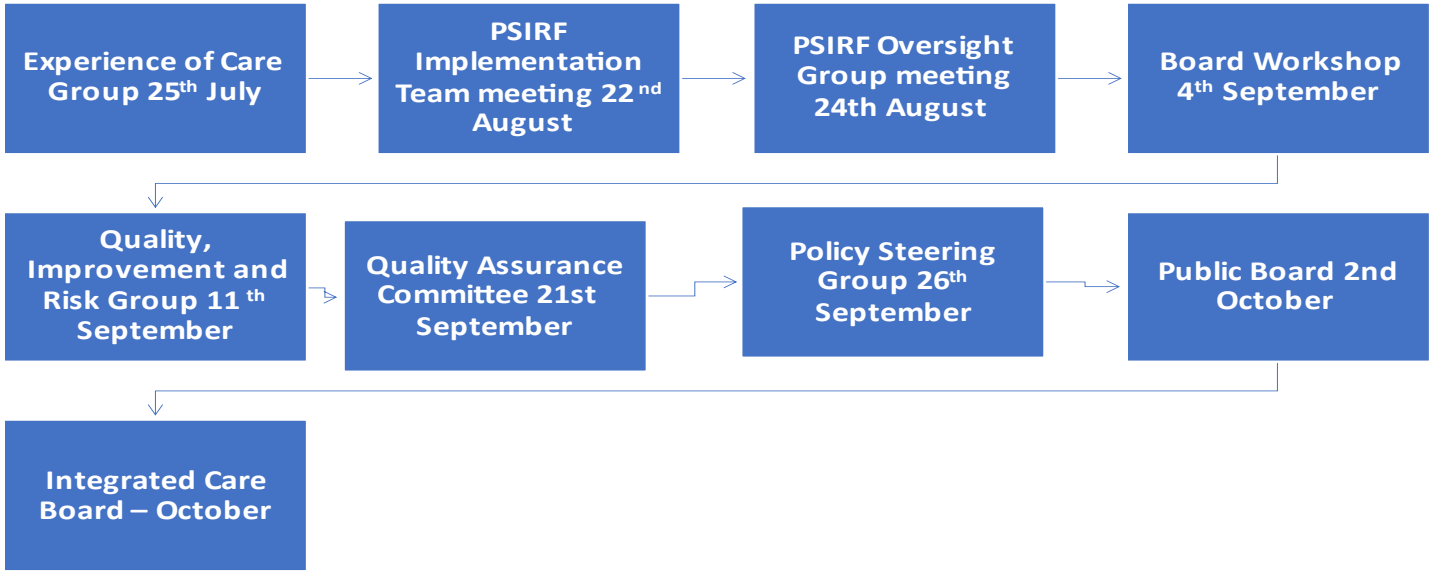
In addition, support training on the learning response tools will be delivered across the Trust via our Quality and Safety Team. A trained patient safety event response lead will undertake all Patient Safety Incident Investigations.

Appendix A - Patient Safety Incident Response Escalation Process



Appendix B

Approval process for Solent's Patient Safety Incident Response Plan and Policy



TP August 2023 V2

Appendix C - Patient Safety Training in Solent

The Patient Safety Incident Response Framework identifies the following patient safety training requirements.

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety incidents	2 days/12 hours	• Introduction to complex systems, systems thinking, human factors • Learning response methods • Safety action development, measurement and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of candour; just culture, being open and apologising • Effective communication and involvement • Sharing findings; Signposting to support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • Systems approach to safety • Avoiding inappropriate blame; creating a just culture	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• Stay up to date with best practice • Contribute to minimum of two learning responses	✓	✓	✓

Solent has considered how the training will be provided and following a training options appraisals, the following was agreed as detailed in the table below.

Solent's approach to PSIRF training

All staff	Registrants, Managers and Patient Experience and Safety roles	Board	Learning Response leads	Engagement Leads	Oversight Roles
•Level 1- Essentials for Patient Safety	•Level 1 – Essentials for Patient Safety •Level 2 – Access to Practice	•Level 1 – Essentials for Patient Safety •Level 1 – Essentials for Patient Safety (Board and Senior leadership team)	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process • Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Involving those affected by patient safety incidents in the learning process •Expected to stay up to date and contribute to two learning responses, annually	•Level 1 – Essentials for Patient safety •Level 2 – Access to Practice •Systems Approach to Learning from Patient Safety •Involving those affected by patient safety incidents in the learning process •Oversight of learning from patient safety incidents •Expected to stay up to date and contribute to two learning responses, annually

The Oversight role

The Oversight role has always been important in the approval of Patient Safety Investigations however it is even more important due to the changes PSIRF brings with Organisations overseeing their own learning responses. It has been agreed that the following roles are an integral part of this process and will receive the Oversight training.

- Chief of Nursing and Allied Health Professionals
- Chief Medical Officer
- Deputy Chief of Nursing and Allied Health Professionals
- Deputy Chief Medical Officers
- Associate Director of Quality, Safety, Governance and Risk
- Head of Quality and Safety
- Heads of Quality and Professions for all service lines
- Clinical Directors for all service lines
- Patient Safety Specialist, Operational Lead

Appendix D

National Patient Safety Improvement Programmes

	Programme Title	Details of local aims	Monitoring
National Improvement Programmes	**Preventing deterioration and sepsis**	• Continue to embed NEWS2 recognition, response, and escalation. • Introduction to PEWS, in community Paediatric services.	• Quarterly Deteriorating Patient and Resuscitation Steering Group. • Engaged in Wessex Academy Managing Deteriorating Patients Programme
	Mental health programme	• Reduction in self-harm • Suicide prevention • Improving therapeutic inpatient environments • Reducing restrictive practice • Improving sexual safety • Improving access to physical health and primary care services in all settings	• Restrictive Practice Management Group • Engaged in Reducing Restrictive Practice Improvement Programmes • Engaged in Wessex Academy Mental Health Programme
	Medicines safety	• Roll out of Electronic Prescribing and Medicines Administration (EPMA) Local priorities also include: • Service user involvement with medication treatments • Self-administration	• Medicine Management Group with Chair's Assurance reporting to QIR
	Learning Disabilities programme	• Embed STAMP and STOMP • Embed Ask, Listen, Do • Ensure timely access to care and treatment reviews.	• Learning Disabilities Strategy Group

		• Improved access to physical health and primary care services	
	Safety of older people	• Improving nutrition and hydration • Safer mobility – reducing falls. • Safer skin – reducing pressure damage. • Increase in healing rates and compression for leg ulcers following the lower limb pathway. • Identifying and care planning for frailty	• Nutrition and Hydration Steering Group • Fall improvement project. • Tissue Viability Steering Group with Chairs Assurance reporting to QIR
	Antimicrobial resistance and healthcare-associated infections	• Strengthen antimicrobial stewardship. • Reduce healthcare acquired infections	• Medicine Management Group with Chair's Assurance reporting to QIR

Appendix E

Patient safety incident type or issue	Planned response	Anticipated improvement route
Death's that do not meet Solent's PSIRP	Review by Mortality process and SJR/SJR plus (including family input)	Create local safety actions and feed these into the quality improvement programme when required.
Documentation/IG Breach	Review by operational managers in conjunction with IG team with cross system reporting, as necessary. Continued monitoring through IG/Security meetings. IG team to organise the IG breach strategy meetings and any subsequent investigations, except when there are patient safety concerns, these will be organised by the Quality and Safety team. Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Patient Violence and aggression	Review by operational managers in conjunction with Security Management Specialist Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Equipment failure of Medical Devices	Review by operational managers in conjunction with Medical Devices Safety Officer Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Missing patient/Absconding/Absence without leave	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Safeguarding	Review by operational managers in conjunction with Safeguarding to ensure referrals made to facilitate external review. Continued monitoring of records to determine any emerging risks/issues outside of Safeguarding remit	Create local safety actions and feed these into the quality improvement programme when required.

Access / admission/ transfer / discharge	Review by operational managers in conjunction with service leads and cross system reporting, as necessary. Continued monitoring of records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Infection prevention and control incidents such as: • Patients who are clostridium difficile toxin positive (>48 hrs after admission) • Escherichia coli, Methicillin-Sensitive Staphylococcus Aureus (MSSA), Methicillin-Resistant Staphylococcus Aureus (MRSA), Pseudomonas, Klebsiella blood stream Infections (>48hrs after admission) • Deaths from health care associated infections (inpatient and community settings where staff have given hands on care) • Any incident of concern can be added to the process at the time e.g., outbreak causing ward closure or decontamination issue	Review by operational managers in conjunction with Infection Control and Prevention team and cross system reporting, as necessary. Continue holding outbreak meetings. Provide a report following closure of the outbreak, to include good practice and areas of learning. Continue nationally required external reporting for specific infection groups. Continued monitoring of incident records to determine any emerging risks/issues. Infection Prevention and Control team to undertake initial review and identify learning. To escalate to Quality and Safety team if there are significant safety concerns. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised	Create local safety actions and feed these into the quality improvement programme when required.
Self-harm	Review by operational managers in conjunction with subject matter experts	Create local safety actions and feed these into the quality

	Continued monitoring of incident records to determine any emerging risks/issues. Risks/issues to be reviewed by learning response tool, if required, where patient safety is compromised.	improvement programme when required.
Venous thromboembolism	Review by operational managers in conjunction with subject matter experts. Risks/issues to be reviewed by learning response tool if required, where patient safety is compromised.	Create local safety actions and feed these into the quality improvement programme when required.