Patient Safety Incident Response Plan 2024/25

Medway NHS Foundation Trust

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1. Introduction

## Foreword

I am really thankful for the ongoing commitment and dedication of all our staff, but particularly our clinical staff who play a key role in ensuring we deliver high quality, safe and effective care and services for our patients, their families and carers.

 The delivery of high quality, safe and effective care and good experience for our patients, their families and carers remains a key focus for Medway NHS Foundation Trust (MFT) in making sure that risk and harm to patients is minimised, whilst ensuring that a just and learning culture, which enables psychological safety is embedded in everyday practice across the Trust.

 I am delighted to introduce our new Patient Safety Incident Response Plan (PSIRP), highlighting our methodology for improving and providing high quality care, reducing harms and improving patient experience and outcomes. This plan will support the Trust’s philosophy of Patient First, delivering on the following two True North Domains;

Quality: Excellent outcomes, ensuring no patient comes to harm and no patients dies who should not have, and

Patients: Providing outstanding, compassionate care for our patients and their families every time

It has been compiled with our local system partners and aligns to the National Patient Safety Incident Response Framework to ensure we work collaboratively for the best outcomes for our patients

*Evonne Hunt, Chief Nursing Officer*

1. Trust Values & Patient First

At Medway NHS Foundation Trust (MFT ) we are dedicated to putting our Patients First, at the heart of everything we do. Over the past year Medway NHS Foundation Trust has improved its Quality Governance arrangements, systems and processes and is now in a position to implement a plan for continued improvement, ensuring we learn from incidents and near misses to prevent future harm.

Following the Covid-19 Pandemic there were a number of national backlogs across the integrated governance and quality agenda as business as usual systems and processes where placed on hold, including complaints, incident investigations, coroners inquests, clinical audit and the review of NICE Guidance.

As MFT reduce these back logs and return to business as usual, and in implementing the National Patient Safety Strategy, we have opportunities to review, revise and improve the business as usual systems and processes.

This Patient Safety Incident Response Plan (PSIRP), along with the different initiatives arising from it, will enable MFT to embed important and substantial improvements in the quality of our patient’s care and experience and to ensure they are kept safe from avoidable harms, and have the best possible outcomes.

Combined with our quality strategy, this is a critical and key part of our aspirational journey to provide care and treatment rated as ‘Outstanding’ by the Care Quality Commission (CQC).

## Core Values

The Trust’s values underpin everything we do, and we expect our staff to work to these values in the delivery of safe, consistent and high quality patient care. The guiding principles of our overarching Patient First programme highlights that the Quality Strategy is part of supporting our Trust’s True North vision for the future and journey of continuous improvement.



The PSIRP aligns to our True North Domain of Quality, ensuring that we are providing high quality care to improve outcomes and reduce harm to our patients. Further to this, there are a number of relevant strategies and policies Trust-wide that link into the PSIRP, (such as the Quality Strategy, Patient Experience Strategy and Infection Prevention and Control Strategy).

## Mission, Vision and Aspirations

Here at MFT we are dedicated to putting our patients first by continually improving. All staff are responsible for ensuring the safety of our patients, challenging poor practice, reporting and learning from incidents. Keeping our patients safe from harm is everyone’s business.

We know that there is still work to be done to recover from the Covid-19 backlogs, implement and embed the NHS Patient Safety Strategy and improve evidence based practice and outcomes for our patients, and this strategy will make sure that we;

* + 1. Reduce harm to patients and create a culture of safety responding to and learning from patient safety incidents
		2. Provide the best experiences of care for our patients, families and carers and respond appropriately when we get this wrong
		3. Provide evidence based and best practice care
		4. Develop, implement and monitor quality improvement plans

This Strategy supports the Patient First methodology and is our structured approach and plan to enhance our quality practices and improve our patients’ quality of care.

By implementing this plan, our vision is to be recognised by the Care Quality Commission (CQC) and our patients as an outstanding and innovative Trust, working collaboratively across the system.

1. Purpose, scope, aims and objectives
	1. Purpose

This patient safety incident response plan (PSIRP) sets out how MFT 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.

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

1. refocusing PSII towards a systems approach[[1]](#footnote-1) and the rigorous identification of interconnected causal factors and systems issues
2. focusing on addressing these causal factors and the use of improvement science[[2]](#footnote-2) to prevent or continuously and measurably reduce repeat patient safety risks and incidents
3. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders’ (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
4. demonstrating the added value from the above approach.
	1. Scope

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

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.

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

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

* 1. Strategic aims

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

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

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

Improve the use of valuable healthcare resources.

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

* 1. Strategic objectives

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

Develop a climate that supports a just culture[[3]](#footnote-3) and an effective learning response to patient safety incidents.

Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

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.
1. Situational analysis – national

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.

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.

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]](#footnote-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]](#footnote-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

An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS 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]](#footnote-6),[[7]](#footnote-7),[[8]](#footnote-8),[[9]](#footnote-9),[[10]](#footnote-10)

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.

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).

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

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

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.

In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

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:

1. professional conduct/competence – referred to human resource teams
2. establishing liability/avoidability – referred to claims or legal teams
3. cause of death – referred to the Medical Examiners/coroner’s office
4. criminal – referred to the police.
5. Situational analysis – local
	1. Results of a review of activity and resources

Patient safety incident investigation (PSII) activity: March 2020 to April 2023:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2020/21** | **2021/22** | **2022/23** | **Annual Average** |
| Never Events | 2 | 1 | 3 | 2 |
| Serious Incident investigations (ie StEIS reportable and including IMRs submitted to DHR,SCR etc) | 216 | 97 | 80 | 131 |
| HLI Investigations  | 87 | 82 | 47 | 72 |
| Local Investigations  | 8596 | 8756 | 13490 | 10280 |
| Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/PHE, etc) for independent PSII |  | 6 |

The patient safety incident risks for Medway NHS Foundation Trust have been profiled using organisational data from recent patient safety incident reports, complaints, Serious Incidents (SIs), High Level Incidents (HLIs), mortality reviews, case note reviews, claims, risk assessments. Resources mined for this data include:

1. staff survey explorer tool results:
	* <https://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/>
2. 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/>

* 1. Sources for analysis:

1489

Complaints

13472 PALs

398 Serious Incidents

216 High Level Incidents

>31000 datix

incidents

Patient Safety Priorities

Inquests, Claims, Risk (for triangulation and validation of thematic data)

The Trust is currently using the Manchester Patient Safety Framework (MaPSAF) to gauge the safety culture of the organisation, this work is ongoing at the time of this plan but will be included within the next plan. Work has been completed over the last 18 months to increase incident reporting across the organisation, and this has seen incident reporting double during this period. When reviewing staff survey results from 2022 (the 2023 survey is currently running at the time of this plan’s creation), the trust is generally just below the benchmarking group average for encouraging reporting , taking action and acting on incident s and near misses. Work is underway to improve the culture in the organisation including:

New methods of sharing learning

Staff involvement in investigation

Embedding of a just culture

An improvement plan will be devised following analysis of the results following the MaPSAF rollout across the organisation.

* 1. Conclusions from review of the local patient safety incident profile

Following thorough analysis of 3 years of safety data from the organisation, the current top 10 local priorities/risk register for a Patient Safety Response are:

|  |  |  |
| --- | --- | --- |
|  | **Incident type**  | **Investigation Type**  |
| 1 | **Escalation and care of Deteriorating Patients** | **PSII** |
| 2 | **Patient handover** | **PSII** |
| 3 | **Diagnostic Testing**  | **PSII** |
| 4 | **Medication Incidents**  | **PSII** |
| 5 | **Delays in treatment**  | **PSII** |
| 6 | **Falls where learning not addressed by QIP**  | **AAR + Toolkit** |
| 7 | **Pressure damage where learning not addressed by QIP** | **AAR + Toolkit** |
| 8 | **12 Hour breach in admission from DTA (Decision to admit)** | **Initial harm review + “further in care” review** |
| 9 | **Incidents where a patient that lack capacity absconds from a ward**  | **Harm review**  |
| 10 | **DOLS/MCA care**  | **AAR + Toolkit** |

* 1. Maternity Incidents

Following a review of the Trust’s maternity incidents and discussion with maternity stakeholders, it was felt maternity priorities align with those set out above. Current maternity themes in the organisation are:

* Post-partum Hemorrhage
* Labour and Delivery incidents
* Lack of/availability of beds/staff
* Third or fourth degree tears

If an emerging trend is identified, this will be reviewed against the PSIRP to identify opportunities for additional learning. The maternity team are working on a number of ongoing QI projects, and this may identify further themes within the next PSIRP.

* 1. Safeguarding

Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals. These will be reviewed by the Trust safeguarding team who attend the Trust IRG and PSIRG meetings.

* 1. Gap analysis

The Trust currently works on a clinically led investigative model. Root Cause Analysis (RCA) trained investigators conduct investigations as part of their daily workload. This does not allow staff the dedicated time and resource to complete full investigations and embed learning from these investigations. To ensure adequate resources are dedicated to Patient Safety Improvement the Trust has:

* Developed a dedicated Patient Safety Improvement Team (PSIT) who will:
	+ - 1. Be specialist investigators for PSII
			2. Work with a clinical lead as a subject matter expert to complete PSII investigations
			3. Co-ordinate Swarms, interviews and debriefs with staff and patients/ families/carers involved in a patient safety incident
			4. Act as a specialist liaison point for families involved in a PSII to ensure their voice is heard and they are involved with an investigation as much as they would like to be
			5. Ensure reports are easily understood, free from jargon and used a systems based approach to investigating outcomes and identifying learning
* Following a review of the Trust capacity for investigations the Trust will endeavour to complete 20 PSII per year, determined by the PSIRF priorities in addition to any mandated PSIIs. This is an estimated as 4 PSII per priority.
* The Trust has a number of Quality Improvement Plans which are held and monitored by specialist teams and overseen by the central Patient Safety Team
	1. Stakeholder engagement

The Trust has consulted and engaged with a range of stakeholders both internally and externally within the Trust.

This has included but not limited to:

* Patient Safety Leads
* Patient Safety Specialists
* Nursing staff
* Medical Staff
* Corporate teams
* Neighboring Organisations
* The local Health Care Partnership (HCP)
* Integrated Care Board (ICB)
* Academic Health Service Network (AHSN)
* Trust Executive Team
* Patients and relatives
* Quality Management System provider
1. Selection of incidents for patient safety incident investigation
	1. Aim of a patient safety incident investigation (PSII)

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.

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

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.

* 1. Selection of patient safety incidents for PSII

In view of the above, the selection of incidents for PSII is based on the:

a. actual and potential impact of the incident’s outcome (harm to people, service quality, public confidence, products, funds, etc)

b. likelihood of recurrence (including scale, scope and spread)

c. potential for new learning in terms of:

* enhanced knowledge and understanding of the underlying factors
* improved efficiency and effectiveness (control potential)
* opportunity to influence wider system improvement.

The Trust will use its Incident Review Group to review incidents meeting the objectives set out in the PSIRP and identify the appropriate response to such incidents in line with the PSIRP.

* 1. Timescales for patient safety PSII

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.

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.

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.)

* 1. Nationally-defined priorities to be referred for PSII or review by another team

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:

* 1. **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](https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/)
* all perinatal and maternal deaths must be referred to [MBRRACE](https://www.npeu.ox.ac.uk/mbrrace-uk/faqs)
1. **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)
2. **child deaths** ([*Child death review statutory and operational guidance*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf)):
* incidents must be referred to child death panels for investigation
1. **deaths of persons with learning disabilities:**
* incidents must be reported and reviewed in line with the [Learning Disabilities Mortality Review (LeDeR) programme](http://www.bristol.ac.uk/sps/leder/notify-a-death/)

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
1. [**incidents in screening programmes**](http://www.screening.nhs.uk/incidents)**:**
* 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.
	1. Nationally-defined incidents requiring local PSII

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

* 1. **incidents that meet the criteria set in the** [Never Events list 2018](https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018)
	2. **incidents that meet** [**the** ‘Learning from Deaths’ criteria](https://improvement.nhs.uk/resources/learning-deaths-nhs/); 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:
		1. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist’s** [mortality review tool](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts) and which have been determined by case record review to be more likely than not due to problems in care
		2. **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
		3. **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
	3. **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.**

Where the Trust has a regulatory or contractual duty to report an incident we will follow the recognised process for the type of incident.

* 1. Locally-defined incidents requiring local PSII

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 **January 2024 – January 2025**.

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:**
1. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
2. likelihood of recurrence (including scale, scope and spread)
3. 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 the analysis of historical data for the organisation, the most commonly occurring incidents were identified. Whilst a wide range of incidents occurring in the organisation, the incident categories selected for PSII represent the areas where the most incidents occur and robust exploration and improvement work could make a substantial impact in improving care and safety of our patients. Other common themes will be investigated locally, or via AAR, SWARM or thematic analysis. For the period January 2024– January 2025 local priorities for PSII have been agreed as follows:

|  |  |  |
| --- | --- | --- |
|  | **Incident type and specific description** | **Quantity** |
| 1 | **Escalation and care of Deteriorating Patients/Failure to Rescue**Incidents where failures in the early detection, escalation and care of a patient whose condition was deteriorating, led to an adverse outcome for that patient.  | 4 |
| 2 | **Patient handover**Incidents where the handover of a patient either internally or externally led to an adverse outcome for a patient or unnecessary readmission.  | 4 |
| 3 | **Diagnostic Testing** Incidents or groups of incidents where failure to follow up on diagnostic tests has led to an adverse outcome for that patient or where a misdiagnosis has been made  | 4 |
| 4 | **Medication Incidents** Incidents or groups of incidents where an error or delay in administration or prescribing of medication led to an adverse outcome for the patient. (The Trust rolled out EPMA in September 2022) | 4 |
| 5 | **Delays in treatment** Incidents or groups of incidents where a delay in treatment of a patient due to multifactorial issues had led to an adverse outcome for a patient.  | 4 |

Based on analysis of resources, the Trust plans to investigate a minimum of 4 PSII under each category. This is flexible to allow for variations within the incident profile. In addition, maternity have an additional 3-5 allocations within the Trust priorities for maternity specific incidents.

It is also possible that emerging or individual incidents may require a PSII. This decision will be made by the IRG. The trust will use an incident decision matrix to support these decisions, however this is not exhaustive and a multidisciplinary approach to decision making will be taken.

Using other learning response techniques the Trust will review incidents to identify learning. Not all incidents will require a full PSII. This methodology will support the Trust to use proportionate responses to incidents as they arise.

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

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.

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.

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.

Where it is felt a thematic analysis provides an opportunity for system learning, this will be shared throughout the Health Care Partnership and with the ICB for potential application across the system.

* 1. Continuous patient safety improvement plans underway

Locally designed patient safety improvement plans underway. This relates to full plans, rather than individual actions, designed and prescribed to address previous PSII, review, audit or risk assessment findings (e.g. national suicide prevention plan).

|  |  |
| --- | --- |
|  | ***Local* patient safety incident** **improvement plan/scheme title** |
| 1 | Falls  |
| 2 | Tissue Viability  |
| 3 | Deteriorating Patient \*under development\* |
| 4 | Infection Prevention and Control \*under development\* |
| 5 | Mental Health \*under development\* |
| 6 | Safeguarding \*under development\* |
| 7 | Maternity \*under development\* |
| 8 | Medication \*under development\* |

The Quality Improvement Plans described above will be monitored via specific committees such as the falls steering group. These will then be discussed at PSG with key matters escalated to QPSSC. Each plan has an owner who will regularly review the actions and escalate as appropriate.

1. Selection of incidents for review
	1. Learning review methods

Some patient safety incidents will not 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.

A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

| **Technique** | **Method** | **Objective** |
| --- | --- | --- |
| **Immediate safety actions** | Incident recovery | To take urgent measures to address serious and imminent:1. discomfort, injury, or threat to life
2. damage to equipment or the environment.
 |
| **‘**[**Being open’**](https://webarchive.nationalarchives.gov.uk/20171030124348/http%3A/www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) **conversations** | Open disclosure  | To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.  |
| [**Case record/note review**](https://improvementacademy.org/documents/Projects/avoidable_mortality/Case%20Note%20Review%20Guide%20FULL.pdf)  | Clinical documentation review  | To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.) |
| **Hot debrief** | Debriefing | To conduct a post-incident review as a team by discussing and answering a series of questions. |
| [**Safety huddle**](https://www.england.nhs.uk/atlas_case_study/improving-patient-safety-by-introducing-a-daily-emergency-call-safety-huddle/) | Briefing | A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to:* improve situational awareness of safety concerns
* focus on the patients most at risk
* share understanding of the day’s focus and priorities
* agree actions
* enhance teamwork through communication and collaborative problem-solving
* celebrate success in reducing harm.
 |
| **Incident timeline** | Incident review  | To provide a detailed documentary account of an incident (what happened) in the style of a ‘[chronology’](https://study.com/academy/lesson/what-is-chronological-order-definition-example.html). |
| [**After-action review**](https://improvement.nhs.uk/documents/2087/after-action-review.pdf) | Team review | A structured, facilitated discussion on an incident or event to identify a group’s strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. |
| SWARM  | Team review | 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. Swarms enable insights and reflections to be quickly sought and generate prompt learning.  |
| **LeDeR (Learning Disabilities Mortality Review)** | Specialist Review | [To review the care of a person with a learning disability](http://www.bristol.ac.uk/sps/leder/) (recommended alongside a case note review). |
| [**Perinatal mortality review tool**](https://www.npeu.ox.ac.uk/mbrrace-uk/pmrt)  | Specialist review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Mortality review** | Specialist Review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Transaction audit** | Audit | To check a trail of activity through a department, etc, from input to output. |
| **Process audit** | Audit  | To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended |
| **Outcome audit** | Audit | To systematically determine the outcome of an intervention and whether this was as expected/intended |
| [**Clinical audit**](https://www.hqip.org.uk/wp-content/uploads/2018/02/developing-clinical-audit-patient-panels.pdf) | Outcome audit | A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes. |
| **[Risk assessment](http://www.mtpinnacle.com/pdfs/Healthcare_Risk_Assess.pdf)** | Proactive hazard identification and risk analysis | To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business). |

* 1. Duty of Candour

Priorities for ‘being open’ conversations and Duty of Candour include:

* all patient safety incidents leading to moderate harm or above
* all incidents for which a PSII is undertaken.

*Engaging patients and families in patient safety incidents including being open and Duty of Candour policy and SOP*

* 1. Non- PSII Subject suggestions

Key subject suggestions for patient safety reviews (Non-PSII):

|  | **Incident type**  | **Specialty** | **Year** |
| --- | --- | --- | --- |
| 1 | **Falls**  | Corporate Nursing  | 2023-2024 |
| 2 | **Pressure damage**  | Corporate Nursing | 2023-2024 |
| 3 | **12 hour breaches**  | Acute and Emergency Medicine  | 2023-2024 |
| 4 | **Absconding patients** | All  | 2023-2024 |
| 5 | **DOLS/MCA care**  | Safeguarding  | 2023-2024 |

* 1. Specialty Nursing Incident Review

Some incidents need to follow a slightly different process. This relates to incidents where there is a corporate nursing team for specialist input. Current investigations in this category include: Tissue Viability, Falls, Infection Prevention and Control, Safeguarding specific incidents.

1. Roles, responsibilities and reporting arrangements

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 Officer:**

As Accountable Officer has overall responsibility for ensuring compliance with our regulatory and legal responsibilities, ensuring the Trust has a suitable and effective policy, standard operating procedures and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of incidents across the Trust. The Chief Executive will delegate specific roles and responsibilities as required, to ensure incident management is coordinated and implemented effectively.

**Chief Nursing Officer:**

Has delegated board level responsibility for ensuring that processes for investigating and managing incidents are devised, implemented and embedded, reporting to the Chief Executive Officer and Executive Team any significant issues arising from the implementation of this framework including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. They also have delegated board level responsibility for quality, and patient experience and hold the responsibility for risk of non-compliance with regulatory and legal responsibilities such as the CQC fundamental standards.

**Chief Medical Officer:**

The Chief Medical Officer will ensure that the Trust takes action upon issues arising from patient safety and clinical risk management. Together with the Chief Nursing Officer, they will champion a strong patient safety culture and lead on Sharing the Learning that arises from patient safety incidents investigations.

**Director of Integrated Governance, Quality and Patient Safety:**

Has the operational responsibility for ensuring the delivery and effectiveness of the processes for the management of patient safety incidents including timely engagement of patients and families in patient safety incidents, and the direct line management of the patient safety team through which their duties are discharged.

**Patient Safety Specialists:**

Have responsibility to ensure the principles of PSIRF are maintained at the organisation and have responsibility to support the implementation and embedding of the patient safety strategy within the organisation.

**All Staff:**

Have a responsibility to report patient safety incidents including near misses and no harm incidents via the Trust reporting system to ensure they can be reviewed and corrective and preventative action be put in place to prevent re-occurrence.

**Clinical Staff:**

Clinical staff involved in care are responsible for participating in learning events and investigations, to identify system concerns and remedial actions.

**Coroner:**

Has a Statutory Duty under Regulation 28 to issue a PFD Report where their investigation gives rise to a concern that circumstances exist which create a risk of future deaths.

**Medical Examiners:**

Have a responsibility to escalate to the Trust any deaths where there may be an area of concern which needs further exploration.

## Committees

**Incident Review Group:**

 Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all incidents to determine if they meet the threshold to be declared as a Notifiable Patient Safety Incident, confirming the level of harm and investigation to be completed. The IRG reports to the Patient Safety Group.

**Patient Safety Investigation Review Group (PSIRG):**

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all PSIIs to determine if appropriate learning has been established from the review. This group has board level authority to approve investigation reports. The PSIRG reports to the Patient Safety Group.

**Quality and Patient Safety Sub-Committee (QPSSC):**

Is co-chaired by the Chief Medical Officer and Chief Nursing Officer and has responsibility for monitoring the operational effectiveness of patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations. The operational management of this function is delegated to the Patient Safety Group.

**Quality Assurance Committee (QAC):**

Is chaired by a Non-Executive Director of the Trust Board and has responsibility to seek assurance on behalf of the Trust Board as to the effectiveness of the arrangements in place to manage patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations.

**Health & Care Partnership Quality & Safety Board**

Is co-chaired by the chief nursing officers from MFT and Medway Community Health and has a responsibility to assurance for system and partnership quality and patient safety improving outcomes for patients across Medway & Swale.

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

The Trust is dedicated to Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour.

* 1. Patient and Family Liaison

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. The Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour sets out the responsibilities and guidance surrounding being open and Duty of Candour.

For the Patient Safety Incident Investigations identified in this PSIRP family liaison will be undertaken directly by the PSIT Lead for the investigation. For all other types of Patient Safety Review family liaison it is the responsibility of the nominated Clinical Lead.

* 1. Local support

The Patient Advice and Liaison Service at Medway NHS Foundation Trust is a free and confidential service to support patients and their families

The PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

The trust is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, service users, family members or carers. On these occasions the trust aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

Trust staff are empowered to resolve concerns immediately and informally, where this is possible. People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the care team.

Should the care team be unable to resolve the concern then the patient advice and liaison service can provide support and advice to patients, families, carers and friends.

PALS can help and support with:

* advice and information
* comments and suggestions
* compliments and thanks
* informal complaints
* advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

* Telephone 01634 825004
* Email: medwayft.pals@nhs.net
	1. National guidance for NHS trusts engaging with bereaved families

 Learning from deaths – information for families explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

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

 Healthwatch Medway provides information to help make a complaint, including sample letters.

Address: Healthwatch Medway, 5A New Road Avenue, Chatham ME4 6BB

**Telephone :**0800 136 656  between the hours of 10:00 – 16:00 Monday to Wednesday and Friday. We are closed Thursdays, weekends and Bank Holidays

**Text :** 07525 861 639

**Post:** FREEPOST RTLG-UBZB-JUZA, Healthwatch, Seabrooke House, Church Rd, Ashford, TN23 1RD (please note that Freepost can take up to 10 days to reach us)

**Email:** enquiries@healthwatchmedway.com

 Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

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

1. Procedures to support staff affected by PSIs
	1. Local Arrangements

#### Medway NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles in to our procedures for the review of incidents. The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

#### Trust Patient Safety Team - The Trust Patient Safety Team will advise and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

#### Psychological support - [NHS Our People](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Flnks.gd%2Fl%2FeyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDksInVyaSI6ImJwMjpjbGljayIsInVybCI6Imh0dHBzOi8vd3d3LmVuZ2xhbmQubmhzLnVrL3N1cHBvcnRpbmctb3VyLW5ocy1wZW9wbGUvc3VwcG9ydC1ub3cvIiwiYnVsbGV0aW5faWQiOiIyMDIzMDgzMC44MTg0NzU1MSJ9.nkyHYrm6V_Y4iGcK8gjB8cmiJbOsJZp-fPc6PXk09CU%2Fs%2F2591622371%2Fbr%2F224997301461-l&data=05%7C01%7Ckatrina.andrew%40nhs.net%7Ccda3c7c480be4ad0e67e08dba95656f1%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638289960533478621%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=2mNSzcvwpJke9freNWOv3Jd2XoZQQgdMotj3uCX%2Bi18%3D&reserved=0) - for confidential support lines, free apps and resources. Carefirst 24/7 counselling on 0800 174 319. The Trust Wellbeing team are also available for support: Email medwayft.yourwellbeing@nhs.net for a listening ear or health and wellbeing advice

#### Occupational Health Service – The Trust has an Occupational Health service which managers or staff are able to refer to for further support.

#### Schwartz Rounds - Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience or simply listen to their stories. Sessions are themed and a place can be booked by emailing.

#### Freedom To Speak Up Guardian - A confidential service for staff if they have concerns about the organisation’s response to a patient safety incident.

#### Second Victim - A website resource for healthcare staff and managers involved in patient safety incidents.

* 1. Support from Patient Safety Incident Investigators

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

#### Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

#### All contact with staff will involve the collection of their account of the events and also their views and opinions on how systems can be improved.

1. Mechanisms to develop and support improvements following PSIIs

The Trust views learning from patient safety events as essential to the development of a safe and open culture. This includes learning from good or positive care in addition to learning from adverse or negative events.

At the conclusion of a Patient Safety Incident Investigation (PSII) the final report will be submitted to the Patient Safety Incident Review Group. The improvement plan will be agreed in collaboration with existing Trust quality improvement frameworks.

A Trust-wide Safety Improvement Group and Patient Safety Network will also be formed to facilitate cascade of relevant information across the organisation through various mediums including the safety bulletins, safety newsletters and existing communication functions. This will include involving patient safety leads in the dissemination of learning across the organisation.

Improvement plans will be reviewed by the Patient Safety Group to enable delivery of actions, monitoring and evaluation of improvement outcomes and provide Board assurance.

The Patient Safety Group will have oversight and undertake monitoring of all improvement plans created following a PSII. The Patient Safety Group reports to the Trust Quality and Patient Safety Sub-Committee. The group promote a positive culture of continuous learning and improvement using Improvement Methodology to facilitate Trust-wide learning and improvement.

Monitoring through the use of audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared and implemented with other areas of the organisation and shared with peer organisations.

1. Evaluating and monitoring outcomes of PSIIs, Reviews etc.

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

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.

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.

Reports to the board will be monthly via escalation 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.

The PSIRP will be reviewed annually with the ICB. This is a living document and may be subject to change upon discussion prior to it’s review date.

1. Complaints and appeals

The Trust has a Patient Complaint and Feedback Management Policy where concerns cannot be resolved as part of the investigative process.

The following routes are in place for the people who use our services, their families and carers to make a complaint, raise concerns or provide feedback:

* 1. Raising a concern – Don’t take your troubles home:

The people who use our services, their family or carer should be able to raise a concern or feedback with any member of staff during their care or treatment with the opportunity for this to be resolved locally without the need for intervention by the PALS or Complaints Team.

* 1. Patient Advice & Liaison Service (PALS):

The Patient Advice & Liaison Service (PALS) managed by the PALS and Complaints Manager offers confidential advice, support and information on health-related matters. They provide a point of contact/escalation for the people who use our services, their families and carers.

* 1. Informal Complaints:

The route for the people who use our services, their families or carers to informally raise concerns, issues or feedback for resolution at a service level, with the ability to escalate to a formal complaint should the issue remain unresolved. Submission can be verbal or in writing to the service or the PALS & Complaints Team. The service/care group will manage informal complaints.

Telephone 01634 825004

Email: medwayft.pals@nhs.net

* 1. Formal Complaints:

The formal route for handling complaints, managed by the PALS & Complaints Team, whereby a complaint can be made by:

Telephone: 01634 825216

Email: medwayft.complaints@nhs.net

Post: The Central Complaints

Medway Maritime Hospital

Gillingham

Kent

ME7 5NY

Complaints and concerns received will be assessed and where a formal complaint is received the PALS & Complaints Team will acknowledge the complaint within 3 working days. The Trust aims to respond to formal complaints within 25 working days, although complex complaints may take up to and over 60 days.

* 1. Friends & Family Test:

The Friends and Family Test (FFT) is a service level nationally mandated survey relating to the most recent episode of care and is usually sent by text message, card or electronic submission. The Patient Experience Team are responsible for the management of FFT across the Trust.

* 1. NHS Choices / Care Opinion:

Care Opinion is a system where the people who use our services, their families or carers can share their experiences of the care and treatment received at MFT. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

* 1. Local Surveys:

The Patient Experience Team is responsible for conducting local surveys of the people who use our services, their families or carers to enable them to share their experiences of the care and treatment received. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

* 1. National Surveys:

National Surveys are mandated by the Care Quality Commission and provide an opportunity for the people who use our services and/or their families and carers to provide feedback of the care and treatment received during the set survey period, with National benchmarking results published. The Patient Experience Team are responsible for ensuring the Trust participates within all mandated surveys, producing improvement action plans where required.

Contact us:

|  |  |
| --- | --- |
| NHS Improvement0300 123 2257enquiries@improvement.nhs.ukimprovement.nhs.uk @NHSEngland | NHS England |

This publication can be made available in a number of other formats on request.

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1. The approach is broken down into units to make it easier to understand the complexity, [interactive](http://www.businessdictionary.com/definition/interactive.html) nature and [interdependence](http://www.businessdictionary.com/definition/interdependence.html) of the various external and [internal factors](http://www.businessdictionary.com/definition/internal-factors.html). [↑](#footnote-ref-1)
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>. [↑](#footnote-ref-2)
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](https://www.eurocontrol.int/articles/just-culture). [↑](#footnote-ref-3)
4. Health and Safety Executive (2014) [Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals](https://www.hse.gov.uk/pubns/books/hsg245.htm). [↑](#footnote-ref-4)
5. Vincent C, Adams S, Chapman A et al (1999) [*A protocol for the investigation and analysis of clinical incidents*](http://www.patientsafety.ucl.ac.uk/CRU-ALARMprotocol.pdf)*.* [↑](#footnote-ref-5)
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7. Parliamentary and Health Service Ombudsman (2015) [*A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*](http://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has). [↑](#footnote-ref-7)
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10. NHS Improvement (2018) [*The future of NHS patient safety investigation: engagement feedback*](https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/). [↑](#footnote-ref-10)