NHS
The Princess Alexandra Hospital
NHS Trust

Patient Safety Incident Response Framework Implementation plan

January 2024

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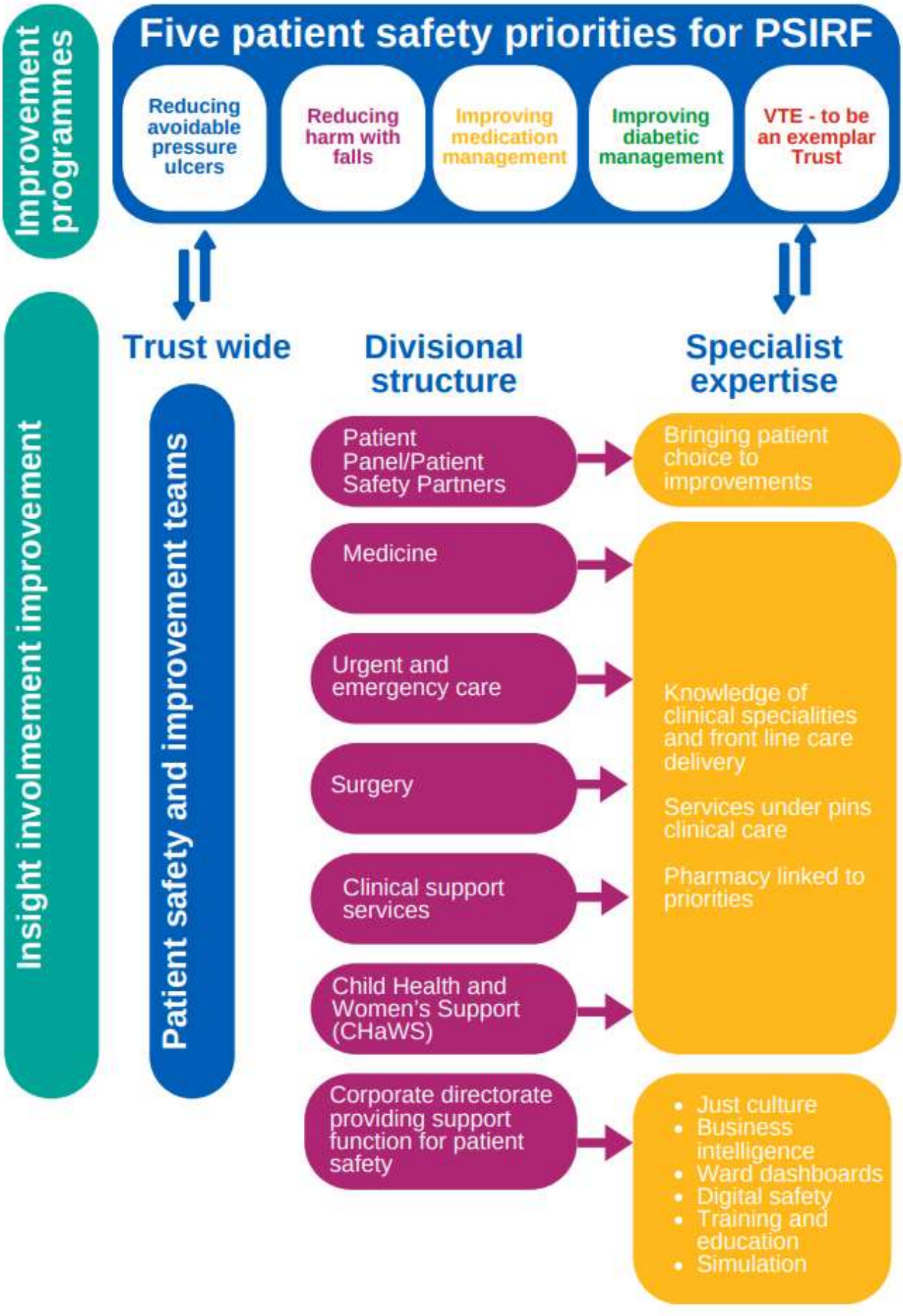
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1.0 Purpose/scope/objectives and aim

Purpose

Continually improve the quality and safety of care we provide by learning from safety incidents reported by staff and patients, their families and carers.

The patient safety incident response framework (PSIRF) sets out how we will manage incident responses and:

- Replaces the serious incident framework and removes the serious incidents classifications and threshold for it.
- Embeds patient safety incidents responses within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management.
- The PSIRF will replace existing incidents management process.

This implementation plan will help us improve local patient safety investigations (PSIs) by:

- Identifying interconnected causal factors and system issues
- Using causal factors, and use of improvement science, to prevent/reduce incidents
- Placing emphasis on quality not quantity to increase stakeholder confidence
- Demonstrating the added value available from the above approach

Scope

A patient safety incident response plan is a requirement of each provider or group/network of providers delivering NHS-funded care.

The document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed.

We have developed the planning aspects of this patient safety incident response plan with the assistance and approval of Herts and West Essex Integrated Care Board (ICB).

The aim of this approach is to continuously improve. As such this document will be reviewed annually and will be included on our patient safety group workplan.

Aims

The aim is to improve the safety of the care we provide to our patients, their families' and carers' and their experience of it.

We also plan to further develop systems of care to continuously improve quality and efficiency, through quality improvement programmes with our quality first partners.

We will achieve this by:

- Improving the use of valuable healthcare resources, and create time to support quality improvement.
- Improving the working environment for staff in relation to their experiences of patient safety incidents.
- Supporting a restorative just culture and continue to enhance our patient safety culture at PAHT.

We also plan to develop our restorative, just and learning culture strategy as part of the ICB strategic engagement. We have also undertaken a patient safety culture assessment within clinical divisions, support a continuous drive to improve, and are working to develop our leaders as part of our PAHT2030 strategy, linking with our Quality and Patient Safety Strategy published in 2022.

Strategic objectives

Act on feedback from patients, families and our people about the current problems with patient safety incident responses and investigations in the NHS, following recommendations in the Kurkup report 2023.

Develop a trust wide restorative just culture strategy, in partnership with our people team, to create a climate that supports our people and an effective learning response to patient safety incidents.

Enhance our local oversight and governance around patient safety investigations and alternative responses to patient safety incidents, which promotes accountability, 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.

2.0 Context

2.1 Background

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

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

2.1.3 Historically, the NHS has set out plans to investigate each incident reported that meets a certain outcome threshold, or has features on a specific trigger list. When these plans were set it was not clear that the investigation of incidents with a severe outcome may not always be the most productive for 'organisational learning' that informs risk management activity. Since luck often determines whether an undesirable circumstance translates into a near miss or an incident.

2.1.4 Each and every incident report does not need to be investigated to identify the common causes and improvement actions required to reduce the severity and/or likelihood of repeat incidents, because in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.

2.1.5 In addition, an increased openness to report incidents has placed greater demands on the limited patient safety services which are struggling to meet the task of investigating a high number of repeat investigations with the level of rigour and quality required. Available investigation resources, by the investigation process itself, leave little capacity to carry out the very safety improvement work the NHS originally set out. In addition, the remit for patient safety investigation 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 (e.g. professional conduct, fitness to practise; establishing and defending liability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning, thus the NHS has not achieved its aims.

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

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

- improving the quality of future patient safety incidents (PSI)
- conducting investigations purely from a patient safety perspective
- reducing the number of repeat investigations
- aggregating and confirming the validity of learning and improvements by basing PSIs on a small number of similar repeat incidents.

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

- being explored and addressed as a priority in current investigation work or
- the subject of current improvement work that can be shown to result in progress or
- listed for learning investigation work to be scheduled in the near future.

2.1.9 As part of this approach, incidents requiring other types of investigation and decision-making will be appropriately referred as follows:

- professional conduct/competence – referred to people teams
- establishing liability/avoid ability – referred to our legal team
- cause of death – referred to the coroner's office.

2.1.10 In some cases where an investigation for learning is not indicated, another response may be required. Options which meet the needs of the situation more appropriately should be considered; these are listed in section 4.

3.0 Analysis

3.1 Situational analysis – local

3.1.1 Results of a review patient safety investigation activity: 2017 to 2023

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Average per year
Incidents reported (total)	9568	9392	10145	10220	12088	12234	10607.7
Severity Reporting							
No harm	7583	6964	7540	7133	8816	9517	7925.5
Minor	1690	2273	2438	2803	3085	2487	2462.6
Moderate	282	139	137	172	159	206	182.5
Severe	11	12	21(1)	23	23	21	18.5
Death	2	4	9	89(2)	5	3	18.6*

*Data collected February 2023
(1) Fractured neck of femur national requirement to grade as severe harm commenced
(2) Impacted by hospital associated Covid-19 infection

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Average per year
Externally Reported							
Never events(1)	0	0	0	1	2	4	1.0
Serious Incidents (SI's)	29	36	41	32	22	18	28.6
C19 SI (removed from SI numbers and counted as 1)				60(2)	1(2)		1.0
De-escalated SI's	2	12	6	3	2	2	4.1
							Total Average 34.7 per year

*2017/18 – 2019/20 internal investigations (Amber/RED)
(1) Also declared as SI's but not included in the SI numbers to avoid double counting
(2) Increased number due to hospital acquired Covid-19

Internal Investigation	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Average per year
Internal REDs / Amber	27	43	72				23.6
Falls cluster	0	0	2	1	0	0	0.5
Pressure Ulcer Cluster	0	0	34	34	0	0	11.3
Pressure Ulcer RCA/RR (cat 3, unstageable, cat 4)	18 (1 removed as SI)	31 (1 removed as SI)	11 (24 removed as included in SI's / REDs 1/23)	37 (2 removed as SI's)	45 (2 removed as SI's)	69 (1 removed as SI)	35.2
Falls (Mod,Sev,Death graded harms)	23 (1 removed as SI)	31 (4 removed as SI / RED 3/1)	24 (16 removed as SI / RED 7/9)	23 (4 removed as SI's)	34 (2 removed as SI's)	27 (1 removed as SI)	27
Rapid Review				85	110	107	50.3
VTE	0	0	0	1	5	7	2.1
							Total Average 150 per year

Top five serious incidents: 2017 – 2023 (financial year)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Average
Implementation of care or ongoing monitoring	3	3	11	2	3	1	4.4
Slips, trips, falls	1	4	8	4	2	1	4
Labour or delivery	1	7	3	2	5	1	3.8
Possible delay or failure to Monitor	2	7	1	1	1	0	2.4
Images for diagnosis (scan / x-ray)	2	2	1	4	0	0	1.8

Top five Incidents: 2017 to 2023 (financial year)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Ave
Slips, trips, falls	1186	1346	1358	1336	1304	1157	1281.1
Implementation of care or ongoing monitoring	941	1030	1575	1498	1212	1090	1224.3
Adverse events that affect staffing levels	1000	511	488	682	875	762	719.6
Pressure sore / decubitus ulcer	295	405	443	688	1046	936	635.5
Admission	158	110	199	159	683	1335	440.6

*Data collected February 2023 via Datix

Implementation and ongoing review

This category is diverse which makes it challenging to analyse. The top 10 adverse events across the financial years are detailed below.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Ave
Implementation & ongoing monitoring/review	426	404	633	482	325	308	429.6
Deprivation of Liberty	142	276	373	485	566	464	384.3
Hospital Acquired Moisture Lesion	0	53	320	293	0	0	111
Delay or failure to monitor	58	52	90	77	80	69	71
Safeguarding Adult – raised against the Trust	66	50	43	58	42	43	50.3
Safeguarding – Children	24	29	29	4	95	58	39.8
Sensitive incidents for central PS&Q team only	17	13	26	18	45	83	33.6
Delay in DOLS assessment	39	34	3	16	6	10	18
Increasing risk of aspiration pneumonia	9	4	2	12	17	3	7.8
Poor Mouth Care/Oral Hygiene	20	6	5	7	0	7	7.5

Admission

The top 10 adverse events across the financial is detailed below.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Lack of/delayed availability of beds (general)	5	3	2	35	523	1172	1740
Same Sex Accommodation Breach	3	36	121	25	14	13	212
Unexpected re-admission or re-attendance	50	32	17	14	32	33	178
Access, admission, transfer, discharge other	30	19	37	29	22	26	163
Delay	37	8	5	19	40	29	138
Unsafe / inappropriate clinical environment	10	2	2	14	17	15	60
Delay / difficulty in obtaining clinical assistance	1	0	3	7	19	27	57
Unplanned admission / transfer to specialist care unit	8	5	10	10	5	3	41
Admission could not be arranged / failure to admit	11	5	2	4	3	11	36
Lack of/delayed availability of beds (high dependency/ICU)	1	0	0	0	7	3	11

3.2 Patient safety incident risk profile

3.2.1 The patient safety incident risks for PAHT have been profiled using organisational data from recent patient safety incident reports, quality and patient safety strategy, claims (patient property, failure to treat), complaints (nursing and medical care, poor communications), mortality reviews (medical outliers facture neck of femur, sepsis), staff survey results, health safety investigation branch report, quality first improvement projects, whistleblowing incidents, risk register, etc.

3.3 Conclusions from review of the local patient safety incident profile

3.3.1 The agreed local priorities for full patient safety investigation are all subject to review after six months and additional ones may be added such as:

- Improving diabetic management – five incident reviews per year
- Missed/delayed cancer, ophthalmology, women's health, urology from long wait – five incident reviews per year
- Maternity themes- see **appendix three**

3.4 Gap analysis

3.4.1 Through gap analysis, in total over the year we expect patient safety incident investigations (PSIIs) to be completed in line with PSII standards, and these will be distributed across our trained investigators across PAHT within the divisions to support shared learning and matrix working.

3.4.2 All investigators will be supported by our patient safety and quality teams which will include a supporting investigator and dedicated patient/family point of contact though our patient experience team. Executive support will be made available from the chief nurse and the medical director as required also support from the director of clinical quality and governance.

3.4.3 Investigators will not be expected to manage more than five PSIIs at any one time. Full details of the management of all incidents and resulting outcomes, actions and improvement management are included in the PAHT Incidents Management Policy.

3.4.4 Patient safety partners/Patient Panel:

PAHT has had a Patient Panel in place since 2013 following the Frances Enquiry, to ensure our patient voices are heard. As part of the Patient Panel's oversight and commitment to patient safety, they are an active member of the patient safety group and quality and safety committee as part of the Board. The Patient Panel have kindly agreed to undertake the role of patient safety partners for PSIRF. They are active members of the PSIRF implementation team and have undertaken the national and local PSIRF training for patient engagement.

3.4.5 Workforce:

Central team

- Director of clinical quality and governance
- Associate medical director of patient safety and risk
- Associate director of clinical quality and governance
- Patient safety management x 2
- Patient safety facilitators x3

Divisional:

UEC/Medicine/Surgery each have

- Patient safety and quality (PS and Q) lead (currently vacancies in surgery and medicine)
- PS and Q nurse
- PS and Q facilitators

Clinical Support Services:

- PS and Q lead – nursing
- PS and Q lead – medical (vacant)

CHAWS:

- PS and Q governance lead - plus two PS and Q managers in women's health
- PS and Q lead in child health
- PS and Q medical

All patient safety and quality team members have undertaken five days PSIRF training, provided by the ICB or regional commissioned trainers including investigation training.

Two/three team members have undertaken Masters in patient safety. A number of associate directors of nursing, heads of nursing and operational leads have also undertaken PSIRF training.

All PS and Q staff have undertaken additional training resources linked to Health Education England (HEE) and undertaken Health Services Safety Investigation Body (HSSIB) investigation training.

We will need to ensure we have the resources for our people to undertake the required training. The team are also working with the learning and organisational development team to agree ongoing training resources, and will utilise our AlexNet patient safety page to support.

Training undertaken: see **appendix one**.

3.5 PAHT Alignment to learning and improvement approaches:

Quality first and quality improvement methodologies are in place and are closely aligned with PSIRF.

3.6 Strategic plan

3.6.1 There will be engagement work with stakeholders, including internal: the board, Patient Safety Group, all staff groups and communications in the monthly InTouch magazine; along with external stakeholders that include Herts and West Essex Integrated Care Board, CQC and a local hospice. PAHT has developed a prioritisation plan for local safety investigations and this is identified in **section 4**.

3.6.2 Investigation findings and analysis from more than one incident (thematic analysis) provide an opportunity to cross-reference and corroborate findings to identify common causal factors. More robust thematic analysis can be achieved by selecting a few very recent and typically similar incidents and investigating each one with skill and detail to determine the causal factors that effective improvements can be designed to address. Investigation of recent rather than historical incidents allows information gathering and analysis of the system as it currently is.

3.6.3 PAHT has identified, through a training needs analysis, the training resource required to ensure progress against the plan which is detailed within the PAHT Incident Management Policy.

3.6.4 Progress against the plan and improvements will be monitored through the weekly incident management group, chaired by the director of clinical quality and governance. Progress will be monitored through the Patient Safety Group, Quality

and Safety Committee and Trust Board. Progress will also be monitored externally by the ICB. Further details are included in the PAHT Incident Management Policy.

4.0 Selection of Incidents for Investigation

4.1 Aim of a patient safety investigation

4.1.1 Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors, that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent, or continuously and measurably reduce, repeat patient safety risks and incidents.

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

4.2 Selection of patient safety incidents for investigation

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

- **a)** actual and potential impact of the incident's outcome such as harm to people, service quality, public confidence, products, funds etc)
- **b)** likelihood of recurrence such as 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.

4.3 Timescales for patient safety investigation

4.3.1 Where a patient safety investigation for learning is indicated, the investigation must be started as soon as possible after the incident has been identified.

4.3.2 Patients and family to be advised and full duty of candour given by the clinical team.

4.3.3 Patient safety investigation terms of reference to be developed, in partnership with the patient/family, and supported by the named patient lead contact.

4.3.4 Patient safety investigations should ordinarily be completed within 60 working days of the start date.

4.3.5 Where a longer timeframe is required for completion of the patient safety investigation, this can be agreed by PAHT in consultation with the patient/family.

4.3.6 No local patient safety investigation should take longer than six months. A balance must be drawn between conducting a thorough investigation, 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 local safety investigation can be reviewed to determine whether new information indicates the need for further investigative activity.

4.4 Nationally-defined priorities requiring referral for investigation advice

National priorities for the reporting and referral of patient safety incidents to other bodies for investigation are described in the PSIRF, and other national initiatives for the period 2019 to 2021 within **appendix two**.

4.5 Locally-defined incidents requiring local investigation

4.5.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for patient safety investigation have been set by this organisation for

the period 2023-2024 within **appendix three**. These will be reviewed on an on-going bases and priorities refreshed.

4.5.2 Locally-defined emergent patient safety incident requiring investigation.

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 investigation response.

- Locally predefined patient safety incidents requiring investigation. Key patient safety incidents for investigation 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 patient safety investigation:
    a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
    b. likelihood of recurrence (including scale, scope and spread)
    c. potential for learning in terms of:
        - enhanced knowledge and understanding
        - improved efficiency and effectiveness (control potential)
        - opportunity for influence on wider systems improvement
- Thematic analysis of patient safety investigations. A valuable way of accomplishing thematic analysis of patient safety investigation findings is to select a few (3–6) very recent and typically similar incidents and investigate each one with skill and in detail to determine the common interconnected contributory and causal factors, on which effective improvements can be designed. Importantly, recent incidents will allow information gathering and analysis about the system as it currently stands.
- Some patient safety incidents will not require investigation but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Such as after-action review, round table/Multi discipline team discussions, gap analysis.

4.5.3 For **2023/24**, we remain committed to reviewing single episode of care that has resulted in moderate or above harms or frequently occurring incidents that do not have any quality improvement project in place as agreed at incident management group. Rapid review or harm

4.5.4 Learning from all patient safety incident reviews, including good practice, will be monitored and shared via the patient safety incident assurance panel and shared via a variety of methods, such as sharing the learning templates that we currently use for all serious incidents, inquests, complaints, clinical audits, claims; we will also utilise our patient safety page, support monthly medical Grand Rounds, on boarding, governance days and appraisals. Reviews may be requested in line with our revised incident management policy.

5.0 Map oversight and governance of learning from patient safety incidents:

- Daily divisional incident oversight
- Incident management group – bi weekly
- Patient safety incident assurance group - fortnightly
- Patient safety group - monthly

- Quality and safety committee - monthly
- Public Trust Board meeting - bi-monthly

6.0 Transitional arrangements

Within our PSIRF implementation plan, we began transitioning from the current system in August 2023 with full implementation completed by 1 January 2024. Since 1 August 2023, all incidents graded as serious continued to be reported via STEIS, however we began to use the new investigation methodology and engagement with families.

From August 2023, our patient safety and quality papers submitted to both the Patient Safety Group and the Quality and Safety Committees began to move away from data, and focus on learning from incidents and culture changes with family/patient engagement.

During the period of transition, we closed as many incidents as possible to avoid running on two systems.

7.0 Incident reporting arrangements

7.1 Full details of incident reporting arrangements are detailed in the PAHT Incident Management Policy and Patient Safety Incident Response Framework. This includes internal and external notification requirements for the reporting of patient safety-related incidents. All staff are required to:

- Report all incidents and near misses via the trust's electronic incident management system, Datix
- Ensure the details of any incident are contemporaneously and objectively reported in the patient's clinical healthcare record
- Raise any concerns about situations that led to, or could lead to, an incident or a near miss with their line manager, divisional leads or the Patient Safety & Quality Team
- Actively participate in any subsequent incident investigation such as: providing a written account of the incident; attending multidisciplinary factfinding and feedback meetings
- Attend a coroner's inquest on behalf of the trust if called to do so
- Undertake mandatory training in the reporting of incidents
- Undertake additional training, as required, to ensure competence in relation to the Datix system

7.2 The Trust will make appropriate support available to those staff involved in an incident, where this is required. There are specific incidents which may require reporting externally under specific criteria, these are detailed within the revised PAHT Incident Management Policy for the reporting and management of incidents and Patient Safety Incident Response Framework.

8.0 Procedures to support patients, families and carers affected by patient safety incidents

8.1 The national and local arrangements for supporting patients, families and carers are:

- Named contacts for patients, families and carers
- Each patient/carer will have a named contact identified to facilitate their access to relevant support services, and supported by our patient experience team

- The named contact will have received training in 'being open' and duty of candour and will have sufficient time to undertake this role
- Support staff training in openness and transparency

8.2 Characteristics considered in appointing the named contact will include:

- be able to establish a relationship with those affected (and become known to and trusted by the patient, their family and carers)
- be able to offer a meaningful apology, reassurance and feedback to patients, their families and carers
- have a good grasp of the facts relevant to the incident but be sufficiently removed from the incident itself
- be senior enough or have sufficient experience of and expertise in the type of patient safety incident to be credible to the patient, their family and carers, and colleagues
- have excellent interpersonal skills, including being able to communicate with the patient, their family and carers in a way they can understand, without excessive use of medical jargon
- have a good understanding of how the incident will be responded to and ensure realistic expectations are set
- be able to liaise with several different individuals and be prepared to help those affected navigate complex systems/processes
- actively listen to patient, family and carer queries/concerns and engage with other staff to ensure these are responded to openly and honestly
- be knowledgeable about and provide access to different types of support (including independent advocacy services as required)
- be able to maintain a medium to long-term relationship with the patient, their family and carers where possible, and to provide continued support and information
- be culturally aware and informed about the specific needs of the patient, their family and carers.

8.3 For continuity and consistency of communication, a co-contact will be assigned to support the lead contact and to act as lead contact during times when the first named contact is absent. Junior staff or those in training must not be appointed as lead named contacts unless accompanied to all meetings with patients, families and carers and supported by a senior team member.

9.0 Procedures to support staff affected by patient safety incidents

9.1 All staff have access to the PAHT staff health and wellbeing (SHaW) service which focuses on the physical and mental wellbeing of employees in the workplace. Managers can refer a member of staff for support or alternatively, staff members can self-refer.

9.2 The Trust has a chaplaincy team who are available 24/7 on site or via switchboard for support for staff or patient/carer support following incidents. The Chaplaincy Team are trained to offer diffusing and debrief sessions, as well as offering guidance and signposting for further support. The chaplains are on site Monday to Friday 8am-4pm, when they can respond to requests for support very quickly, usually within minutes. Out of hours they can respond within the hour.

9.3 Professional nurse/midwife advocates (PNA/PMA). The trust has appointed a named lead to provide support and guidance with nominated leads in each division.

9.4 SHaW support:

9.5 Free counselling, support and advice is available via the Well-Online website which is available through the Trust's intranet.

9.6 The Trust has five identified Freedom to Speak Up Guardians available via a designated email address. The Trust Freedom to Speak Up and Whistleblowing policy available on Trust AlexNet Page.

The Trust has a number of Mental Health First Aiders who are accredited with Mental Health First Aid England. The Mental Health First Aiders can listen nonjudgmentally and hold supportive conversations and support with identifying further professional support. A full list is available on the Trust Intranet.9.7 Named contacts for staff

- Facilitate private and confidential conversations with staff affected by a patient safety incident.
- Work with line managers to provide advice and support to these staff.
- Facilitate their access to additional support services as required.
- Liaise between these staff and review/PSII teams as required.
- Support staff training in recognising the signs of stress and post-traumatic stress disorder in themselves and others and how to access help and support.
- Work with the patient safety team and other services to prepare/inform the development of different support services.

10.0 Mechanisms to develop and support improvements following patient safety investigations

10.1 The local mechanisms to develop and support improvements are:

- Completion of an Incident Evaluation Form following review of all incidents identified as Incidents for Review (IFR) will be required. The Incident Evaluation Forms will be reviewed through the Divisional Governance structure and weekly at the PSIRP Assurance Group.
- PSIs will be stratified by divisions to decide the degree to which improvement methodology needs to be applied to address the quality issue identified. For simple less complex quality issues a series of tasks may adequately achieve the improvement required, for other more complex adaptive problems Quality Improvement methodology will need to be applied and a programme of work or a project may need to be established.
- Stratification will be undertaken by the clinical leadership team with local Quality Improvement support provided by: Business Change Managers, Quality Improvement Practitioners and Improvement Partners. The Quality First team will provide advice and guidance to support this process as required.
- All PSI's, regardless of the approach agreed upon to address, will require the following managed locally:
- An action log to be completed to ensure all actions have a named owner and timeline for addressing.
- Monthly reporting will be required on the above in local divisional governance structures to support and ensure improvements are being actioned.
- A measurement plan to understand the impact of any improvements made to ensure they are having the intended effect.

- For PSIs that are identified as complex and adaptive in nature i.e. the root cause of the problem and solution are unclear and require learning a more structured approach using our core QI roadmap will be adopted (see below) along with the Model for Improvement (from the Institute of Healthcare Improvement). There are a number of tools and methodologies that will be utilised at each step of the roadmap dependent upon need and context.

- This structured approach will be supported locally by: Business Change Managers, Quality Improvement Practitioners and Improvement Partners. The Quality First team will provide advice and guidance to support this process as required.
- If a Trust wide improvement priority is identified this will be discussed with Director of Clinical Quality and Governance at IMG/PSIAP to agree a plan of support from the Quality First team.

10.2 Supporting corporate teams:

A general principal is that quality improvement is led and owned by the individuals and team that are accountable/responsible for the delivery of services and care. However: there are a number of corporate teams that support and enable the delivery of quality improvement and transformation at PAHT. These teams include the following:

- Strategy team
- Quality First team this includes the: Programme Management Office (PMO) and Quality Improvement Team
- Organisational development
- Patient Safety and Quality (PS&Q) Teams
- Business partners (finance and people)
- Information Management and Technology
- System partners (wider integrated care system)
- Patient Panel and Patient Experience Team
- Patient Safety Partners

10.3 Our progress: Updates on key projects and programmes

Outlined below are some summary updates from key quality improvement and transformation projects and programmes.

Improving patient outcomes (mortality improvement)

Summarised below are the key highlights/progress related to mortality improvement:

Learning from deaths software and mortality dashboard

- The ongoing development of an automated learning from deaths dashboard with SMART software including dashboards to better target our improvement efforts.

Aspiration Pneumonia

- Launch of shallow screening tool pilot on older people assessment and liaison (OPAL)
- Development of a number of patient leaflets including modified diets & fluids, risk of feeding
- Mouth care audits in partnership with ward-based teams to target improvement efforts.

Fractured Neck of Femur

- Improved the time it takes for this cohort of patients to be transferred from the emergency department to Tye Green ward through early identification of patients, including use of a 'Femur facture alert group' on Alertive to ensure fast track transfer of patients to ward.

Acute Kidney Injury

- Providing ongoing training and awareness with deep dives into Acute Kidney Injury (AKI) deaths to identify learning needs
- Ongoing development of a e-referral for rental patients

Sepsis

- Providing ongoing training and awareness with deep dives into sepsis
- Deteriorating Patient Group re-established
- Sepsis & AKI lead nurse in place
- Ongoing development of a Sepsis digital assessments for both adult & paediatric patients to support their treatment using the sepsis 6 screen protocol

Remote patient monitoring

- Implementation of a remote monitoring pilot on the respiratory ward to increase the frequency of patient monitoring at the bedside by capturing NEWS2 compliant vital signs in real-time. The system use of automatic EWS calculations improves accuracy and automates cascading escalations to recognise and rescue deteriorating patients.

Outpatients

Patient initiated follow up (PIFU)

- This pathway allows patients to determine whether their condition requires clinical intervention and allows access to a specialist when needed. In turn this reduces the number of follow up appointments needed.
- This pathway is now available to all specialties and circa seven thousand appointments have been saved. Fracture, Neurology and Physiotherapy are all exceeding the 5% target for PIFU.
- Plans are being developed for 23/24 to explore further the use of the pathway for those patients who are admitted into hospital rather than automatically booking an outpatient appointment for review.

Long term condition – patient managed pathway

- This pathway will allow our patients with long term conditions, who cannot be discharged from secondary care, to determine when their condition requires clinical intervention allowing rapid access to a specialist when needed.
- A pilot is ready to go live within Gastroenterology for those patients with Inflammatory Bowel Disease (IBD). Breast Cancer Surveillance patients and Multiple Sclerosis (MS) will follow as part of the pilot.
- Following the pilot this pathway will be rolled out across all appropriate conditions with a planned completion date in Q1 2024.

Medicine's Optimisation

Antibiotic stewardship

- Further development of an antibiotic dashboard that identifies antibiotic prescribing habits throughout the Trust. The data from the dashboard is being utilised within divisional performance reviews. Ongoing development of tests of change supporting the ongoing reduction in antibiotic usage across the Trust.

STOPIT

- STOPIT supports pharmacists and doctors to systematically review continuing medication in individuals who come into hospital with medicine related problems. The STOPIT process is currently embedded on a number of wards throughout the trust. The team are working further with teams to embed and adapt the process throughout the Trust.

Venous thromboembolism (VTE)

- Implementation of VTE dashboard to support the monitoring and development of related improvements.
- Development of an automated breach report to support improvements in patient safety.

Urgent and emergency care improvement programme

IN Improvement Programme

- Enhanced triage methodology and digital solutions have led to improvement from 60 minutes to below 30 minutes average time from arrival to triage/observations.
- ED streaming kiosk – Development of the directory of service to facilitate the implementation of the kiosks to support alignment of patients to the correct area
- In (Assessment) – Implementation of a 'back to assessment' model in AAU to facilitate greater flow thru the emergency department.
- In (Frailty) – Development of a plan to recover the core functionality including pulling patients from the front door. Development of a 'back to assessment' model including
- In (ED) – Implementation of a further assessment model including increased assessment space for clinicians. Reduced patient safety risks by bringing decision making closer to the front door with the introduction of the Manchester Triage System.

OUT Improvement Programme

- SAFER and R2G – Implementation of the SAFER Patient Flow Bundle 'to make maximum use of capacity within acute care settings to support patient safety

- Criteria led discharge - Embed criteria led discharge (CLD) in to practice across our inpatient wards, implementation of a pilot process on the respiratory ward. To improve patient and staff experience
- Site team and transport – Development of a standard operating procedure to facilitate the establishment of a new discharge lounge including changing the skill mix of the staff.
- Integrated discharge – Moving from <30% to >80% SRF form first time acceptance has demonstrated improvements in quality as a result of training and targeted feedback
- Care Coordination Centre (CCC) and Virtual Ward. Pilot work with the Integrated Discharge Team to establish proof of concept for discharge pathways that enable a move from a push to a pull model for pathways 2 and 3. Working with Virtual ward team to support a new way of working
  TTAs – Implementation of a portering service to support earlier discharge on the wards.

Nerve centre ED module

- Implementation of the NerveCentre in Emergency Department (ED) as dedicated solution in both adult and paediatric ED's. To support improving patient safety, patient experience and patient outcomes. The module and functionality enable us to address concerns raised by our clinical staff and by the CQC in repeated reports.
- Moving from three ways of documenting patient information in ED to one single solution which releases time to care for staff, avoids duplication of documentation and will help to ensure patients are seen within the national four-hour standard. The solution enables swifter assessment, treatment and departure of patients. Teams will also have better visualisation and oversight of patients, Improving patient prioritisation and flow.

Patient and clinical administration

- To deliver a patient and clinical administration function that is modern, integrated and outstanding (PAHT2030) by:
  - Embracing digital solutions where possible reduce duplication and human error.
  - Provide efficient and effective care for patients and an enhanced experience for our people
- Between August and September 2023, we ran a series of listening events (workshops), gathered responses via a survey and attended the medical advisory committee (MAC) to inform the development of a ‘to-be’ operating model to provide efficient and effective care for patients and an enhanced experience for our people.

General Medical Council (GMC) improvement programme

- Development of a programme to comply with the GMC and HEE standards and requirements for the delivery of all stages of high-quality medical education and training. In addition to support an improvement in the experience of our trainees to positively influence the results of the GMC survey to ensure we benchmark nationally at average or better.
- Supporting quality improvement within this programme around resus, too tired to drive, a standardised approach to induction, listening events and escalation of clinical concerns.

Clinical strategies (PAHT2030: Transforming Our Care)

- Programme of work developed including workshop template to support teams to progress their clinical strategies into delivery plans, which will support patient safety culture work and drive improvements.

11.0 Evaluating and monitoring outcomes following patient safety investigation and reviews

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

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

11.3 The Quality First team can provide support with building capability in QI methodology, there are a range of training offers offered by the team which can be accessed via PAHT's learning and performance hub (This is Me System (TiMS)). In addition to this support and coaching can be provided by the Quality First team.

11.4 A measurement plan must be in place for all improvement initiatives developed and once the initiative has demonstrated sustained measurable improvement and is fully implemented a Quality Control plan must be established to ensure the new level of performance is maintained which will include the ongoing measurement of data by the team closest to the improvement work.

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

- patient safety incident reporting
- audit and review findings
- findings from patient safety incidents
- 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.

12.0 Complaints and appeals

12.1 Local arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are:

- The Trust's Complaints Policy is for patients, their carers, relatives or friends to raise concerns regarding the care and treatment of a patient. Concerns are raised via PALS or through formal Complaint. The Complaints Team and Patient Safety Team work closely to ensure aligned and effective approaches in response to patient safety incidents.
- Patient Advice and Liaison Services (PALS) offers patients, families and carers confidential advice, support and information on health-related matters. As well as informally helping to resolve issues, PALS can guide people on filing a formal complaint and advise on accessing advocacy services.
- NHS complaints. Everyone has the right to make a complaint about any aspect of NHS care, treatment or service. The NHS website gives guidance on how to do this and details of local advocacy providers. The independent NHS Complaints Advocacy Service will provide someone to help navigate the NHS complaints

system, attend meetings and review information given during the complaints process. Local Healthwatch also provides information about making a complaint, including sample letters.

12.2 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.

Author: Finola Devaney
Date: 19 December 2023

Appendix one: Training needs analysis and provision and completed

	Level 1 elearning essentials of patient safety for all staff (on TIMS from July)	Level 2 e-learning access to practice (on TIMS from July)	Elearning: essentials of patient safety for Board and senior leadership (on TIMS from July)	Systems approach to learning – 2 days £££	Involving those affected by patient safety incidents in the learning process £££	System approach to learning – oversight £££	Restorative Just Culture 5 days £££
All staff	X						
Trust Board	X		X				
PS&Q teams	X	X					X (1)
ADONS/Matrons	X			X	X	X	
ADOPS x2	X			X	X	X	
Patient Experience	X			X	X	X	
Patient Safety Partners	X				X		
Patient safety specialist	X	X	X	X	X	X	X
People team	X						X

All PS&Q members have also undertaken HSIB Bronze, Silver or Gold investigation training in 2022/23 and plan to roll out after action review training from maternity in Q3 23/24. Patient safety specialist will be required to attend level 3&4 patient safety training at WARWICK University in 2024 at cost – 5 courses at 5 days each hybrid model.

Appendix two: Patient safety incident response plan - national requirements

Patient safety incident types	Required response	Anticipated improvement route
Each baby counts/maternal death criteria The patient safety incidents that are referred to us are babies born following labour after 37 weeks and where the outcome is: • Baby dies during labour and before birth (intrapartum stillbirth). • Baby born alive and dies in the first week (0-6 days) of life (early neonatal death). • Baby born with a potential severe brain injury diagnosed as occurring in the first 7 days of life. We also investigate when mothers die whilst pregnant or within 42 days of the end of their pregnancy.	Patient safety investigation with maternal and newborn safety investigation (MNSI) MBRRACE UK add criteria PMRT Independent PSI	Referred by maternity PS&Q The aim is for the investigations to be completed within 60 days from start date. ToR in partnership with family
Child death (Child death review statutory and operational guidance):	Refer for child death panel review Locally led Patient safety investigations (or other responses) may be required alongside the panel review – organisations	Incidents must be referred to child death panels for investigation see policy – Child death overview panel

	should liaise with the panel.	
Death of a person with a learning disability:	Patient for learning disability mortality review (LeDeR) SJR Locally led Patient safety investigations (or other responses) may be required alongside the LeDeR – organisations should liaise with this.	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/) - May require local PSI
Safeguarding incident • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • Adults (over 18 years old) are in receipt of care and support needs from their local authority. • The incident relates to Female Genital Cutting (FGC), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence • Domestic homicide	Refer to local authority	Local authority lead with speciality input and review if it meets the requirements to progress with safeguarding enquiry and liaise with the Trust Safeguarding team.
Notification of infectious diseases:		Incidents must be reported to the local organisation's Director of Infection

		Prevention and Control (DIPC) and Chief Nurse for review/multi-professional investigation. Incidents will be managed locally through local review of the incident and process audit.
Information Governance (data and systems)	Where incidents meet the reporting thresholds within UK General Data Protection Regulations (UKGDPR) and The Security of Network & Information Systems (NIS) Regulations. The incident must be discussed at Incident Management Group (IMG) with reporting decision documented on meeting notes	Incidents previously reported under the Serious Incident Framework 2015 must - be responded to according to Data Security and Protection toolkit guidance. This includes reporting via the data security and protection toolkit as required: https://digital.nhs.uk/dataand-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Ionising Radiation Medical Exposure Regulations (IRMER) incidents	Nationally reportable	Investigation reports to be submitted to CQC
Blood transfusion incidents meeting criteria for reporting to Serious Hazards of Transfusion (SHOT)	Review all incidents using appropriate methodology – Rapid review	Investigation of both incidents to be submitted to SHOT or Serious Adverse Blood Reactions and Events (SABRE)
Never events list 2018	Patient safety investigation	Led by corporate and divisional PS&Q Completed within 60 working days from start date ToR in partnership with patient/carer/family Submitted to ICB – often request from CQC to see a final report For Maternity Incidents the final reports are shared with the Local Maternity and Neonatal System (LMNS)

'Learning from Deaths' criteria; that is, deaths which – following a case note review – are considered more likely than not due to problems in care.	Medical examiner review Structured Judgement Review (SJR)	Any concerns identified will be raised at IMG for determination of appropriate investigation method. All maternity deaths go through MBRRACE-UK
Falls	Case note review National audit	#NOF Complete initial review against themes identified in Trust Falls strategy Incidents with themes outside the current strategy will have agreed investigation.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Health and safety Executive (HSE) reportable	HSE reportable template
12-hour breaches	Reportable to ICB	Incidents reported to General Manager in ED and Trends to be analysed Gynaecology breaches will be reviewed by the Gynaecology Lead Consultant.
Incidents in NHS screening programmes	Refer to local screening quality assurance services for consideration of local led learning response. National guidance for managing incidents in NHS screening programmes.	Respond to recommendations and report to the clinical compliance group for oversight.
Death in custody (e.g. police custody, in prison on detention) where health provision is delivered by the NHS	All death in prison or police custody will be referred and investigated by the Police & Probation Ombudsman or independent office of police conduct. PAHT will fully support any investigations	Any learning to be shared via the PSIAP

Appendix three: Patient safety incidents response plan - Local requirements

Suggested methodologies:

- Rapid reviews
- Patient safety investigation
- Harm reviews
- After action review
- Round table
- Aggregate/Cluster reviews
- Local audit – increase learning profile (e.g. Avoiding Term Admissions into Neonatal Units (ATAIN)
- Coroner's inquest
- Claims
- Complaints Themes and Trends

Patient safety incident type	Requires response	Anticipated improvement route
Delay or Failure to monitor – ✓ Cancer ✓ Ophthalmology ✓ Urology ✓ Maternity	Suggest as key Full patient safety investigation with max of 5 reviews in year Rapid review (PSI) Limit to 2 per speciality.	Full investigation Incident management group Patient safety incident assurance panel Both these groups report into Patient safety group
Return to theatre	Planned or expected complication Harm review	Incident management group Patient safety incident assurance panel Surgery PS&Q review group Maternity/Gynaecology PS&Q review group CSS PS&Q All reporting into PSG
Missed or delay in recognition of fracture	Harm review	Radiology and division Incident management group Patient safety incident assurance panel UEC failsafe on patients within UCE
Extravasation	Harm review	Quality improvement (to confirm)
Long waiters >52 weeks	Harm review at time of review	If a harm incident to be put on Datix and presented to IMG

Sensitive incidents – People related; IG breaches amongst staff; safeguarding of staff	Level of investigation depending if any patient safety identified	Discussed at IMG
Other identified episodes of good practice, good care or excellence where wider learning has been identified.	AAR MDT	Patient safety incident assurance panel Message of the week Staff awards and recognition Schwartz rounds Grand rounds Intouch briefings
Safeguarding		
Safeguarding Adult – - raised against the Trust	Safeguarding report template	Safeguarding scrutiny panel Vulnerable patient group Incident management group Patient safety incident assurance panel – learning
Safeguarding – Children	Safeguarding report template	Divisional CHAWS PS&Q team Safeguarding steering group Vulnerable patient group Incident management group Patient safety incident assurance panel – learning
Delay in DOLS assessment	Follow local authority process	Reported via Datix for audit only
Safeguarding Adult – - raised against the community	Refer to local authority	Local authority safeguarding lead and review if it meets the requirements to progress with safeguarding enquiry and liaise with the Trust Safeguarding team.
Learning from deaths		
Increasing risk of aspiration pneumonia	Medical examiner SJR Case review	Strategic learning from deaths Incident management group Patient safety incident assurance panel – learning
Resuscitation/Cardiac arrest review panel (CARP)	CARP to continue with monthly oversight by resuscitation lead.	Report into the Strategic learning from death group and divisional M&M meetings Incident management group Patient safety incident assurance panel – learning Deteriorating patient group
Deteriorating patient Sepsis	AAR/Round table Harm review	Report into the Strategic learning from death group and divisional M&M meetings Incident management group Patient safety incident assurance panel – learning

		Deteriorating patient group
AKI	AAR/Round table Harm review	Report into the Strategic learning from death group and divisional M&M meetings Incident management group Patient safety incident assurance panel – learning Deteriorating patient group
Failure to escalate/failure to rescue	AAR/Round table Harm review	Report into the Strategic learning from death group and divisional M&M meetings Incident management group Patient safety incident assurance panel – learning Deteriorating patient group Intensive Care National Audit and Research Centre (ICNARC)
Venous Thromboembolism (VTE)	Trust wide action plan – gap analysis Complete initial review to identified any themes outside the action plan using a VTE template	Thrombosis group
Poor management of diabetes	Patient safety investigation	National audit Incident management group Patient safety incident assurance panel – learning Medicine optimisation group
Medicine reconciliation – ✓ Critical medications ✓ Anti-coagulation ✓ Insulin ✓ Unaccounted controlled drugs	Harm review required for anti-coagulation, critical medications, insulin CD – separate review – externally reported	Medicine optimisation group
Essentials of care		
Pressure ulcers all categories (excluding category 1)	Hospital acquired pressure ulcer investigation template	Pressure ulcer investigation oversight group (PUIOG) which feeds into the Improving Essential Care group (IECG) feeding into the Patient Safety Group (PSG)
Pressure ulcers present on admission	Reporting in order to raise with the ICB	Raised as a community incident for investigation by ICB
Falls with harm	Falls Prevention strategy	Falls template and essential of care review

Falls without harm	Falls Prevention strategy	Falls template and essential of care review
Catheter care	Exception reporting for confirming Catheter Associated Urinary Tract Infection (CAUTI)	IPC Essential of care review
Mouth/oral hygiene care	Incident review	Essential of care review
Nutrition and Hydration	Exception reporting where: Emergency patient >55 years old, fasted longer than 6hrs from arrival in A&E without IV fluids being commenced Patient waiting longer than 12hrs from specialist assessment/ prescription for TPN to commence	Nutrition steering group Incident management group Patient safety incident assurance panel – learning
Maternity	**New guidance due January 2024 subject to change**	
CTG misinterpretation/fetal monitoring concerns	Potential patient safety investigation Review by Lead Midwife and Consultant for Fetal Monitoring Harm Review	Local Audit and Action Plan Individualised learning plans Discussed at local CTG meeting
Obstetric haemorrhage	Reviewed by Lead Midwife for PSQ and Consultant Harm Review	Local Audit and Action Plan Learning shared monthly Discussed through Audit and M&M
Neonatal death	National mandated	Referred to appropriate agency (MNSI,MBRRACE, CDOP)
Maternal death	National mandated	Referred to appropriate agency (MNSI,MBRRACE, CDOP)
Delay in care	Thematic Review Quarterly	Presented at Divisional Audit Reported through Local Divisional Governance
Compliance with guidance	Harm Review Round Table	Individualised learning plan
Intrauterine death	National mandated	Referred to appropriate agency (MNSI,MBRRACE, CDOP)
Lack of Escalation	Harm Review AAR/Round Table	Individualised learning plan
Hypoxic ischemia encephalopathy	National mandated	Referred to appropriate agency (MNSI,MBRRACE, CDOP)

Fetal growth	Harm Review Quarterly Audit as per Saving Babies Lives Care bundle v3	MDT approach with obstetrics and sonography.
Screening incidents	Harm Review SIAF	Screening incident assessment form (SIAF) to be completed. Action plan shared with national team.
Incorrect clinical diagnosis	Potential patient safety investigation Harm Review AAR/Round Table	Individualised learning plan
IPC		
CDiff	Gap analysis	Improvement plan in place – gap analysis
MRSA/MSSA	Full investigation (IPC rapid review)	External reportable (MRSA)
Gram negative blood stream infections (Ecoli, Klebsiella, Pseudomonas)	Full investigation (IPC rapid review)	National directive reduction by 50% by 2025 Checklist against the action plan
Surgical site infection	Harm review	Surveillance programme – hip and knee – joint practitioner nurse – reports 1/4ly to IPC committee. Breast and dermatology – gap Unsure women's health – 6 monthly audits
Incident reported that not directly Patient safety but may impact		
Estates and Security		Health and safety group reports to Performance and Finance Committee
Absconsion	Report via Datix; to security and police	
Visitor injury	Report via Datix	
Violence and aggression	Report via Datix; escalate to security and police	
Health and safety		
RIDDOR	Report to RIDDOR, report via Datix	
Staff harms	Report via Datix, SHAW	
Sensitive incidents for central PS&Q team only	Link to People team and managed via HR	Human resource review

Appendix four: Quality and Patient safety priorities 2022-2025

Patient safety priorities/ambitions	Planned responses	Anticipated improvement route
Falls prevention: to reduce falls with harm by 50% by 2025. Venous thromboembolism (VTE): to become an exemplar trust for VTE in the UK. Diabetes: to run an outstanding service to all patients with diabetes whether or not diabetes was the reason for admission. Pressure ulcers: to reduce all hospital acquired pressure ulcers that could not otherwise be avoided, with the ambition of 0% preventable harms by 2024. Medicines optimisation: to increase the reporting of medicine incidents while reducing harm.	Where incidents occur that relate to any of the quality and patient safety priorities, the level of investigation will be decided according to the potential for learning (either patient safety investigation, incident template or after-action review.	Learning and improvement activity identified, developed and shared through the Trusts Patient Safety Group and Quality and Safety Committee.