



# Patient safety incident response plan 2023/24

|                   | <b>NAME</b>                                  | <b>TITLE</b>                            | <b>DATE</b> |
|-------------------|--|---|-------------|
| <b>Author</b>     | Alma O'Rourke                                | Head of Governance and Quality          | 16/10/2023  |
|                   | Emma Millar                                  | Clinical Governance and Quality Officer | 16/10/2023  |
| <b>Reviewer</b>   | Executive Team                               |   | 23/10/2023  |
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## Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework which changes how the NHS responds to patient safety incidents with increasing focus on how incidents happen.

PSIRF does not mandate investigation as the only method for learning from patient safety incidents; nor does it prescribe what to investigate. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

There are many ways to respond to an incident and this document covers responses conducted solely for the purpose of systems-based learning and improvement.

## Purpose

This patient safety incident response plan sets out how Everyturn intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

## Our Services

We provide the following range of services within care homes, the community and people's homes:

- Dementia services
- Housing and 24-hour nursing care
- Community and wellbeing services
- Community crisis support
- Crisis houses
- NHS Talking therapies services
- Employment services



## Our locations

|  |   |
|--|---|
| Talking Therapies                            | Nottingham and Nottinghamshire  |
|  | Derby and Derbyshire  |
|  | Peterborough  |
|  | Wirral  |
| 24-hour specialist adult care                | Coalway Lane, Gateshead   |
|  | Jubilee Mews, Newcastle   |
| 24-hour specialist older adult care          | Alderwood, Gateshead  |
| Dementia care                                | Briarwood, Gateshead  |
|  | Pinetree Lodge, Gateshead   |
| Supported Housing                            | Newcastle and Gateshead   |
| Community Crisis Support                     | Newcastle, Sunderland, North Tyneside, South Tyneside, Northumberland, Teesside |
| Community Mental Health and recovery support | Newcastle, North Tyneside, South Tyneside, Northumberland, Teesside             |

Further information about our organisation can be found on the Everyturn website <https://www.everyturn.org/>

## Defining our patient safety incident profile

In order to identify the patient safety issues most prevalent and pertinent to our organisation, a review of activity, insights and resources was considered to define our incident profile. This included triangulate of information from a wide range of sources including:

- Incidents reported: 2022/23
- Risks
- Audit – Internal and Clinical
- Staff survey feedback
- Clinical Governance Maturity Matrix
- Freedom to Speak Up reports 2021 - 2023
- Patient / service user feedback: 2022/23
- Quality Account 2022/23

The organisation will incorporate wider patient perspectives into our future patient safety incident response planning through the introduction of our Patient Safety Partners and through meaningful engagement with our patients, families and carers involved in patient safety incident responses over the next 12 - 18 months.

## Defining our patient safety improvement profile

Our patient safety improvement profile has been identified and agreed via insights from our patient safety incident profile and quality improvement work underway and planned. This is not an exhausted list and our processes for centralising and formalising our quality improvement activity will also aid future development of our improvement profile.

**The current top local priorities are:**

|   | Transformation and Improvement Priorities | Specialty           |
|---|---|---------------------|
| 1 | Brilliant Basics Programme process        | All services        |
| 2 | Journey to CQC Outstanding                | Registered services |
| 3 | Replacement of our clinical systems       | All services        |
| 4 | Development of our patient involvement    | All services        |

|   | Incident types                       | Specialty                                    |
|---|--------------------------------------|--|
| 1 | Disruptive / Aggressive Behaviour    | Specialist Residential services              |
| 2 | Falls                                | Older People's services                      |
| 3 | Self-harm                            | All services                                 |
| 4 | Information governance / data breach | Talking therapies                            |
| 5 | Physical illnesses and deterioration | Housing and Specialist Residentials Services |

## Our Patient Safety Incident Response Plan

The table below details the response methods which will be used for issues / incidents identified in the section 'Defining our patient safety incident profile'. The type of response to an event will depend on:

- the views of those affected, including patients and their families
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors
- whether there is evidence that improvement work is having the intended effect/benefit
- if an organisation and its ICB are satisfied risks are being appropriately managed.

| Local Requirements                          |  |  |
|---|--|--|
| Patient safety incident type or issue       | Planned response   | Anticipated improvement route  |
| Falls                                       | Falls rapid review tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). Falls learning response tool to be used where indicated.  | Create local safety actions and feed these into the clinical leads and operational groups.               |
| Physical illnesses and deterioration        | Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by clinical governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review) | Create local safety actions and feed these into the clinical leads and operational groups.               |
| Information governance / data breach issues | Local review by service to identify if an individual learning response may be required (where there is potential for new   | Create local safety actions and feed these into Information Governance Committee and operational groups. |

|  |   |   |
|--|---|---|
|  | learning). Oversight by information governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)  |   |
| Disruptive / Aggressive Behaviour  | Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by information governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review) | Create local safety actions and feed into operational, H&S and peoples groups   |
| Self-harm (excluding deaths)   | Local review by service to identify if an individual learning response may be required (where there is potential for new learning). Oversight by clinical governance to consider tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)    | Create local safety actions and feed into clinical leads and operational groups                                       |
| Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern | After Action Review, Case/Peer Review, Thematic Review  | Create local safety actions and feed these into existing workstreams where applicable and into PSIRP future planning. |

| National Requirements   |                                       |   |
|---|---------------------------------------|---|
| Patient safety incident type or issue                                 | Planned response                      | Anticipated improvement route   |
| Unexpected deaths which may be due to problems in care / Never Events | Patient Safety Incident Investigation | Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy |