Royal Cornwall Hospitals
NHS Trust

# Patient Safety Incident Response Plan (PSIRP) and Strategy for 2025/2026

# Contents

# Definitions

**Duty of Candour**- The organisational (and professional) obligation to hold open and transparent conversations when a notifiable patient safety incident occurs.

**NHSE Patient Safety Strategy** – published in July 2019 and updated February 2021, the strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework and provides the vision for patient safety in the NHS.

**Patient Safety Incident Response Framework (PSIRF)** – NHSE framework which outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. Replaces the Serious Incident Framework (SIF).

**Patient Safety Incident Response Plan (PSIRP)** – Individual to each organisation but a mandatory requirement (as part of PSIRF), this plan sets out how we will seek to learn from patient safety incidents. To be used in consultation with commissioners to review and develop a prioritisation plan for local Patient Safety Incident Investigations (PSII).

**Learning Responses** – systems-based tools used to explore learning from patient safety incidents. These will be used to respond to the majority of patient safety incidents and include tools such as after-action reviews and case note reviews.

**Patient Safety Reviews**- A form of system-based learning response applied where there is moderate level of risk or higher where a further review is required. At RCHT, these have two levels, one and two, which reflect the depth of investigation. Each level has a defined process and expected outcomes, a range of learning tools such as after action review, swarm or huddles can be utilised to compete these reviews.

**Patient Safety Incident Investigation (PSII)** – Investigation method conducted to identify new opportunities for learning and improvement from an organisation's patient safety priorities or from an individual event or near miss that indicates significant patient safety risks and potential for new learning. PSIIs focus on improving healthcare systems; they do not look to blame individuals. The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive. A PSII can take the form of a thematic analysis.

# Introduction

The NHS Patient Safety Strategy published in 2019 builds on the two foundations of a patient safety culture and a patient safety system by defining the three following aims:

- Improving an understanding of safety by drawing intelligence from multiple sources of patient safety information (insight).
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (involvement).
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (improvement).

The NHS Patient Safety Incident Response Framework (PSIRF) published in 2022 supports the development and maintenance of an effective safety incident response system that integrates four aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

This plan with the associated policies, particularly the Patient Safety Incident Management Policy (Version 5, December 2024) describes how will respond to all patient safety incidents within RCHT and interactions with our partners in the health and social care system including NHS Cornwall and the Isles of Scilly Integrated Care Board.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. There will be more exploration of learning as a focus from patient safety incidents using learning response tools rather than a primary focus on investigation (see table 1). To achieve this, we have a dedicated team to provide expertise, oversight and engagement throughout learning responses and investigations.

This revised PSIRP sets out how the Royal Cornwall Hospital Trust (RCHT) intends to respond to patient safety incidents over a period of 12 to 18 months. It demonstrates how we will achieve the **Patient safety incident response standards** defined by NHS England**.** The plan is a living document; we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur, and the needs of those affected and our community.

# Our services

The Royal Cornwall Hospitals NHS Trust is the main provider of acute and specialist care services in Cornwall, a key stakeholder in the emerging Cornwall and Isles of Scilly Integrated Care System. Serving a population of around 587,000 people, the Trust employs approximately 6,500 staff across all locations.

The Trust is responsible for the provision of services at four main sites:

- Royal Cornwall Hospital – Truro.
- West Cornwall Hospital – Penzance.
- St Michael's Hospital – Hayle.
- Elective Surgical Hub – St Austell.

RCHT is part of the NHS Cornwall and Isles of Scilly Integrated Care System, working in partnership with other providers to deliver high quality services across the county. An example of this would be Urgent and Emergency Care; the Trust has a main Emergency Department; Urgent Care Centres and also supports Minor Injury Units. In addition to this, the Trust oversees the governance arrangements for the provision of services by Kernow CIC  This care model includes both out of hours and NHS 111 services as well as access to a clinical advisory service and single point of access.

# Our Approach to Preventing and Learning From Patient Safety Events

The methodology at RCHT blends the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF) alongside good clinical governance to create a system of surveillance and response. Producing a sound learning response is underpinned by understanding how a system of work operates to produce its outcomes, wider threats to safety in the organisation, or healthcare system and delivering a safety culture where there is a positive attitude towards safety with clear responsibilities. This section outlines how we will do this at RCHT. The following table outlines our approach to safety, we have learning responses and investigations which considers the level of safety risk, and the level of improvement work already underway. Both approaches are based on systems-based thinking and link to the underpinning enablers, but there is a difference in the application of safety science. This is reflected in the use of the PSIRF Learning Response Toolkit and the associated RCHT capability plan to deliver PSIRF which draws on a higher level of expertise to apply varying methodology including the identification of human factors and ergonomics.

| **Methods and Approaches to Learn from Patient Safety Events** | | |
|---|---|---|
| | Learning Response<br>(Patient Safety Reviews) | Patient Safety Incident Investigation |
| Approach | • Systems-based exploration of work through appreciate enquiry.<br>• Focus on identifying local learning.<br>• Likely focus on small areas of care. | • Systems-based investigation.<br>• Focus on key lines of enquiry (KLOE).<br>• Likely focus on large areas of care. |
| Method | • Debrief approach.<br>• Team based learning.<br>• Hot & Cold debrief.<br>• After Action Review/Case note review. | • Defined investigation approach.<br>• Observation.<br>• Cognitive walkthrough.<br>• Interviews. |
| Outcome | • New learning.<br>• Safety improvement actions.<br>• Share the learning and improvement at local level. | • SMART actions.<br>• Improvement plans at Care Group/Organisation/ICB level. |
| ← **Systems-Based Thinking** → | | |
| Systems Engineering Initiative in Patient Safety (SEIPS), Appreciative inquiry, After action review, MDT review, post incident review or SWARMs) | | |

| |
|---|
| **Safety Management System**<br>Triagulation of information across the organisation and wider system to understand risks/ threats to safety. |
| **Safety Culture**<br>Commitment of Leadership and Leadership Development, Restorative Just Learning Culture (RJLC), all voices are heard, involving staff and patient voice in improvements, training and development |

Table 1: Methods And Approaches To Learning From Patient Safety Events

## Systems Thinking

Systems thinking is a way of analysing systems by considering how parts work together and how they may change overtime. To do this, we look at the components of the systems and their interconnectedness to form the whole system. Causality looks at how things influence each other within the system, synthesis is taking this understanding of the system factors to create something new as a potential safety improvement and feedback loops identify how well the systems is working to determine if further changes are required.

## Safety Management System

A safety management system is a proactive and integrated approach to achieve patient safety through organisational structures, accountabilities and improvement actions. To be effective, a safety management system needs to be integrated into day-to-day activities which are built on four pillars:

- Safety policy – the commitment to improve safety and clear responsibility for delivery to meet organisational need and safety goals.
- Safety risk management – early identification of hazards (things that may cause harm) and risk (likelihood of a hazard causing harm), alongside the assessment and mitigation of risks through safety actions.
- Safety assurance – the monitoring and measuring of safety performance and continuous improvement through risk controls (which patient safety actions).
- Safety promotion- including training, communication and other actions to support a positive safety culture at all levels of the workforce and including patients and families.

The revised PSIRF safety management system for 2025/2026 is designed to strengthen the sharing and synthesis of information to understand the safety profile of RCHT and threats to safety to deliver the insights element of the NHS patient safety strategy.

## Safety Culture

Safety culture is one of the two key foundations in the NHS Patient Safety Strategy (2019). A positive safety culture provides a collaborative environment where staff, teams, patients, service users, family and carers can flourish to ensure brilliant safe care by:

- Continuous learning and improvement of safety risks.
- Supportive, psychologically safe teamwork.
- Enabling and empowering speaking up by all.

This PSIRP further supports the maturing safety culture at RCHT through:

- Continued appointment of Director of Patient Safety.
- Strengthening information regarding PSIRP delivery within sub-board and board agendas.
- Continued co-leading of the SAFE and Compassionate Leadership Programme.
- Demonstrating the commitment to patient safety within capacity and capability builds.
- Continued application of system- based methodology to move away from blame.
- Support for the restorative just learning culture programme alongside creating psychological safety in all interactions to ensure voices are heard.
- Continue to be part of external audits which review our progress in PSIRF maturity.

# Compassionate Engagement And Involvement Of Patients, Families And Staff In Patient Safety

This section sets out how RCHT will achieve involvement and engagement of patients, families, staff and patient partners to improve patient safety.

# Those Affected by Patient Safety Incidents

## Duty of Candour and Being Open

Being open encourages a culture of safety that supports organisational and personal learning. Transparency and openness with patients, their carer's, and/or family promotes open discussion of concerns and prompts action for the mitigation or prevention of recurrence of incidents. Duty of Candour is a statutory organisational requirement that requires health providers to act in an open and transparent way when a notifiable patient safety or complaint occurs. The detail of how RCHT responds to Being Open and Duty of Candour is detailed in the Trust policy. Both being open and Duty of Candour involve apologising and explaining what happened to patients and/or their family or carers following a patient safety incident.

## Supporting Patients and Families

Our ambition within the previous 2023/2024 PSIRP was to improve our engagement with patients and families affected by patient safety incidents. We have revised our approach which now includes a comprehensive booklet with the support available to patients and their families to assist us in our compassionate and restorative conversations. We have clear processes in place to support conversations and involvement throughout learning responses.  As part of the 2025/2026 PSIRP, we will be further embedding this work including capturing the experiences of those involved in learning from patient safety events.

## Supporting Staff

Restorative and Just Learning Culture (RJLC) is an approach to responding to adverse incidents with a focus on learning. An RJLC allows colleagues to talk openly and honesty, allowing empathy and support to be offered to those affected by incidents. The People and Organisational Development team have been leading on this work across RCHT with support from the Patient Safety Team. RJC has become embedded within patient safety reviews and patient safety incident investigations, it is also woven into all patient safety training offered across the Trust.

Within our 2023/2024 PSIRP we set our ambition to reduce the emotional impact on staff involved in adverse events through increased access to a range of resources including advocates, mental health first aiders, trauma informed practitioners, and specialist counselling . For 2025/2026 we will continue to embed this programme alongside the People and Organisational Development team.

# Engagement and Involvement in Patient Safety

## Patient Leaders

We want to ensure our community has a voice in patient safety and improvement. The Patient Engagement Team have successfully recruited Patient Leaders who are involved in improvement work across the Trust. The Patient Leader Programme involves volunteer Patient Leaders with a range of experience and skills work within teams to ensure the patient/public voice is represented in all aspects of service design and delivery. Patient Leaders have the knowledge, qualities, and lived experience to shape the quality agenda, work collaboratively with others and improve patient care. Patient Leaders are available to support the co-production of quality improvement projects, review services and to participate in staff recruitment.

## Patient Safety Partners

The Patient Safety Team also has a Patient Safety Partner (PSP)to join strategic safety conversations as part of the NHS England Framework for involving patients in patient safety (2021), a second recruitment is planned by March 2025. Our PSP is an established member of our Patient Safety Team and plays a key role in our clinical governance meetings, bringing the voice of our communities into safety and quality conversations. They have experience of delivering quality public services to communities throughout Cornwall and are assisted by a strong regional and national network of patient safety professionals from both within and outside the NHS acute trusts.

Key responsibilities undertaken by our patient safety partners will include helping RCHT to:

- Promote openness and transparency: Helping RCHT to understand what patients, carers and their families think and feel about their experience:
- Identify safety risks: Understand what patients find unsafe and how such risks might be minimised.
- Develop action plans: Develop action plans that address the needs of patients in order to improve safety.
- Create patient information: Create patient information that is easy to understand and access for One and All.
- Ensure patient confidentiality: Protect patient confidentiality throughout the organisation without compromising the rapid and timely exchange of information necessary for safe, quality care.

PSP's bring their expertise in safety from another field, from a role or profession that they had into our organisation. They do not just represent themselves; they represent the community and should be considering a wider range of voices which does include their own but also should indicate that they are engaging with our community here in Cornwall. Roles for PSP's can include members of quality and safety committees, involvement in safety Quality Improvement projects, working with boards to consider how to improve safety, involvement in safety training, and participation in investigation oversight groups.

## Staff Engagement and Involvement

Involving staff in safety conversations occurs via several routes which is link to the safety management systems and culture. On a local level, raising concerns and ideas within the team and to local management provides a good forum for discussion. Safety messages are shared via team huddles and through governance structures involves Care Group Governance Managers and Specialist Governance Leads alongside the Care Group senior leadership team.

At a Trust level there are annual events such as the NHS Staff Survey where specific questions linked the NHS People promise, and the Trust Freedom to Speak Up (F2SUP) Guardian who provides an independent route to raise concerns. The Trust has a range of subject matter experts who check and improve practice within their field, each are consulted as part of  safety concerns and responding to patient safety events. The Trust has a Quality Improvement Hub, and an opportunity to connect via a range of programmes including QI Ideas. The People and OD team engagement programme also offers a further route as part of team development.

## Subject Matter Experts (SME's)

There is close working with subject matter experts who provide specialist knowledge within their area of expertise supporting learning by sharing best practice, incident reporting, risk management and improvement.

# Delivering Systems Thinking and Proportionate Responses

Systems thinking relates to a mindset which is shaped by knowledge, skills and experience. It means we are able to identify the components of a system of work that work well, and areas for improvement.. In 2025/6 we will continue to growth systems-based thinking through our training programme. The NHS England PSIRF Learning Response toolkit outlines the methodologies to be used when analysing patient safety. We will continue to this toolkit at RCHT but will also be growing appreciate inquiry as part of understanding everyday work.

As part of the application of the Patient Safety Incident Response Framework (PSIRF) at RCHT, we have developed four levels of learning response shown in the graphic below. The consideration for further review is based on risk rather than severity to provide a proportionate and meaningful learning response. The higher level of risk investigations are overseen by a specialist incident investigator who is fully trained in PSIRF and system-based investigation. The full approach to proportionate responses to patient safety incidents is outlined in the Trust policy but an infographic is shared here as an overview.

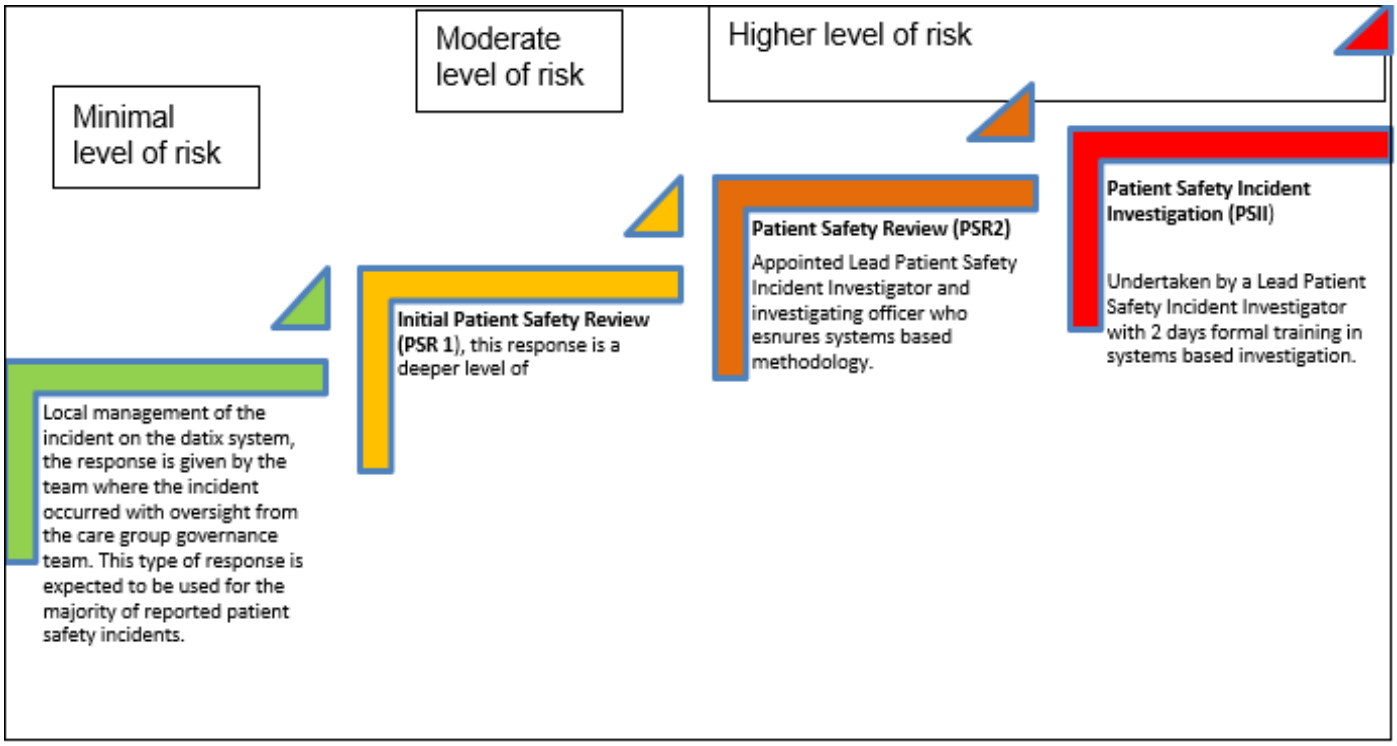



Figure 1: Infographic of Proportionate Learning Responses at RCHT

# Our Capacity and Capability to Learn from Safety Incidents

To deliver PSIRF, RCHT has trained and developed staff to ensure high quality learning responses and investigations. The Patient Safety Team deliver the training programme, sharing their expertise in safety science through teaching, mentorship and coaching.

RCHT has the following substantive resources dedicated to patient safety with links to culture change and improvement:

- 1 WTE Patient Safety Specialist.
- 1 WTE Head of Patient Safety.
- 2 WTE Lead Patient Safety Incident Investigators (also engagement leads).
- 1 WTE Patient Safety and Learning Facilitator.
- 1 WTE Patient Safety Officer.
- 1 WTE Patient Safety Administrator.

In addition to our internal training programme, we have implemented the NHS England Patient Safety syllabus which forms part of the RCHT patient safety curriculum and capability build. For 2025/20266 we will refresh the Patient Safety Curriculum with all our training offers to support patient safety and revised key performance indictors (KPIs).

| NHS Patient Safety Syllabus Level | Training offer | Target Audience |
|---|---|---|
| Level 1 | Essentials for Patient Safety. | All staff. |
| Level 1+ | Essentials of patient safety for boards and senior leadership teams. | Board members. |
| Level 2 | Patient Safety Access to Practice. | All staff who have manager/supervisor/leader in their job title. |
| Level 3/4 | Patient Safety Specialist Training. | Patient Safety Specialists. |
| Additional Training: | Oversight of learning from patient safety incidents. | Those commissioning and approving learning responses and investigations. |
| | Involving those affected by patient safety incidents in the learning process. | Lead Patient Safety Incident investigators and Patient Safety Specialist. |
| | Systems approach to learning from patient safety Incidents. | Lead Patient Safety Incident investigators, Patient Safety Specialist and Investigating Officers. |

# Delivering Supportive Oversight

Oversight focuses on engagement and empowerment rather than more traditional command and control; NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight in a way that allows organisations to show improvement, rather than compliance with prescriptive, centrally mandated measures. At RCHT, our system, standards and oversight mechanism are overseen by the Director of Patient Safety and outlined in the Patient Safety Incident Response Policy.

## Internal Quality Assurance

- Internal quality audit of learning responses and investigations to ensure the PSIRF standards are being met by the Patient Safety Partner and Patient Safety Specialist.
- Feedback from those affected will be monitored and included in the Trust Board assurance reporting detailed below.
- Patient and Staff Safety triangulation meetings will be started from March 2025 with key stakeholders to share intelligence around the priorities and understand any emergent threats to safety.

## Patient Safety Response & Oversight Group

The Patient Safety Response and Oversight Group (PSROG) is the primary forum for proving the application of PSIRF and delivery of the PSIRP. This weekly forum will continue to receive learning responses, investigations, and performance reports for approval. Additionally, the workplan of PSROG will include the receipt of associated improvement plans aligned to this PSIRP.

## Board Assurance Reporting

It is important that the Trust Board receives regular information about patient safety. In addition to the existing weekly executive quality and safety huddles, activity regarding this PSIRP will be reported through the following routes.

- A monthly report from the Patient Safety Incident Response And Oversight (formerly the Incident Review learning Group) is presented to the board each month to update on PSIRF and PSIRP activity and to raise any issues.
- A quarterly update on the delivery of the PSIRP will be included in the Patient Safety Incident Response And Oversight (formerly the Incident Review learning Group) report to the Quality Assurance Committee which feeds into the Trust Board. The report will be curated by the Head of Patient Safety, Patient Safety Partner and Patient Safety Specialist reflecting strategic performance and cross-cutting issues.
- The Patient Safety Partner will continue to be linked with the Non-Executive Director for Patient Safety join up board level intelligence with public voice with context of safety reporting/emerging issues and ensure operational learning is symbiotic to strategic planning.

- There will be a quarterly review of the PSIRP delivery risk (reference 9733) to understand if delivery is on course or interventions needed.

## External Quality Assurance

- Annual Audit Southwest PSIRF maturity audit.
- Integrated Care Board Oversight via representation on the following groups and committees:
  - Patient Safety Incident Response And Oversight (formerly the Incident Review learning Group).
  - Mortality Review and Oversight Group.
  - Patient Experience Group.
  - Quality Assurance Committee.

# Defining Our Patient Safety Incident Profile For 2025/2026

The safety priorities for 2025/2026 have been derived from PSIRF guidance on proportionate response to our safety management system and work involving maturing the safety culture at RCHT.

## Stakeholder Engagement

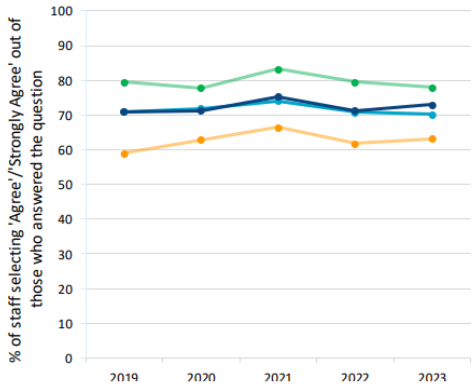
The review has involved engagement with several key stakeholders in clinical and safety from across RCHT. We have discussed the approach to be taken, sharing information and data to deliver a PSIRP based on our safety profiles.

## Raising Concerns

Within the annual NHS staff survey questions are asked about how staff feel to raise concerns and how confident they feel that the organisation would take action to address the concern. When reviewing staff survey results for 2023/20244 staff did feel positively able to report their concerns and that the organisation would take action, continuing to create the conditions for safety is part of our cultural work for 2025/20266.

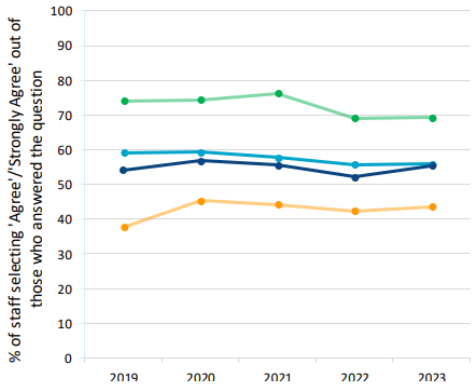
---

Q20a I would feel secure raising concerns about unsafe clinical practice.




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 71.01% | 71.26% | 75.36% | 71.23% | 72.92% |
| Best result | 79.47% | 77.87% | 83.19% | 79.44% | 77.96% |
| Average result | 71.00% | 71.89% | 74.07% | 70.82% | 70.24% |
| Worst result | 58.96% | 62.81% | 66.44% | 61.78% | 63.19% |
| Responses | 3056 | 3682 | 3060 | 3204 | 3447 |

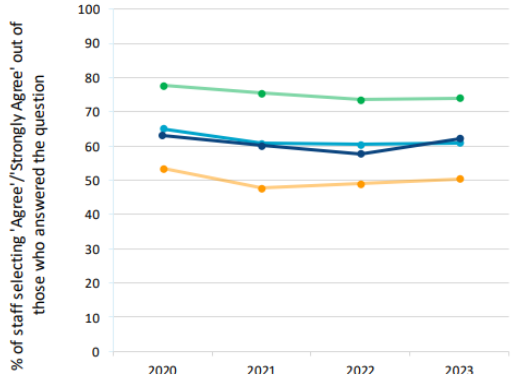
Q20b I am confident that my organisation would address my concern.




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 54.23% | 56.74% | 55.49% | 52.21% | 55.36% |
| Best result | 73.99% | 74.33% | 76.17% | 69.05% | 69.29% |
| Average result | 59.15% | 59.22% | 57.69% | 55.75% | 55.90% |
| Worst result | 37.69% | 45.27% | 44.13% | 42.27% | 43.62% |
| Responses | 3054 | 3684 | 3054 | 3202 | 3433 |

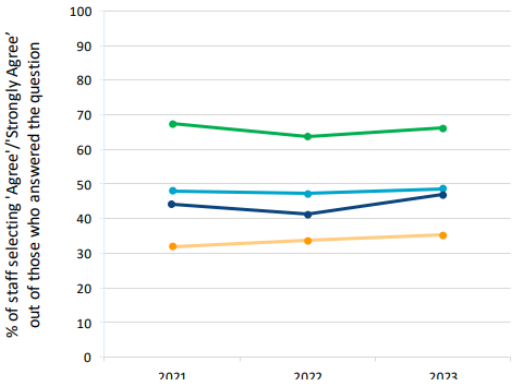
Royal Cornwall Hospitals NHS Trust Benchmark report

Q25e I feel safe to speak up about anything that concerns me in this organisation.




| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Your org | 62.96% | 60.18% | 57.71% | 62.24% |
| Best result | 77.58% | 75.47% | 73.58% | 73.98% |
| Average result | 64.99% | 60.71% | 60.36% | 60.89% |
| Worst result | 53.35% | 47.60% | 49.01% | 50.32% |
| Responses | 3685 | 3073 | 3198 | 3456 |

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.




| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 44.25% | 41.21% | 46.85% |
| Best result | 67.43% | 63.87% | 66.13% |
| Average result | 47.97% | 47.28% | 48.65% |
| Worst result | 32.02% | 33.68% | 35.26% |
| Responses | 3076 | 3197 | 3453 |

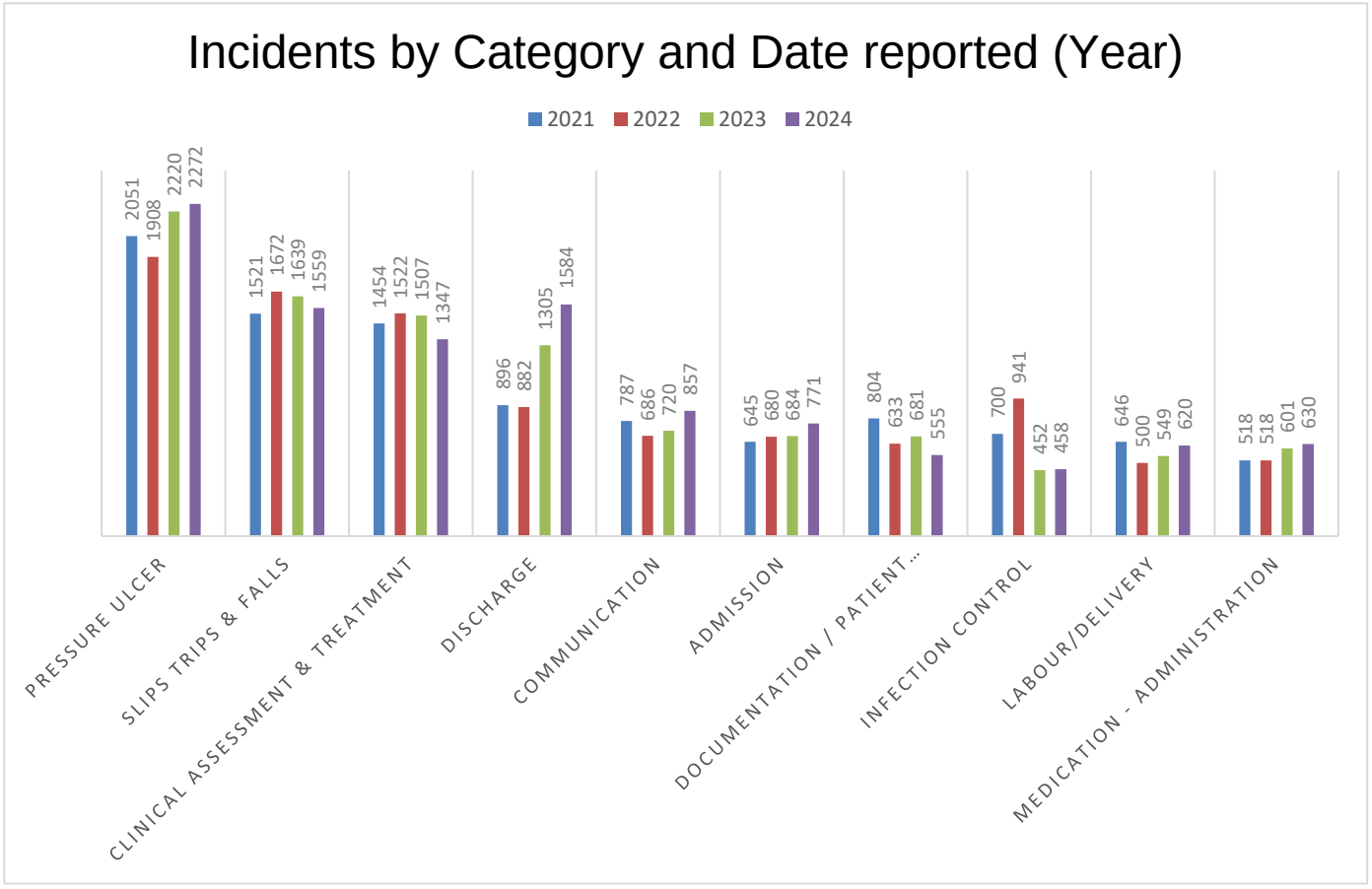
Royal Cornwall Hospitals NHS Trust Benchmark report

## Understanding our Safety Data

**Author/Owner:** Naomi Burden, PGCert, PGCE, MSc, Patient Safety Specialist and Lead for Safety Culture.
**Due for Review:** July 2027

Whilst we know many adverse incidents do not result in harm or changes to a patients care plan, we understand the impact they can have on those affected. We have reviewed data from 1st January 2021 to 31st December 2024, noting that PSIRF was first implemented PSIRF on the 1st December 2021. When looking at all the 68, 423 incidents reported, we can see the top six reported categories are:

- Pressure ulcers.
- Slips, trips and falls.
- Clinical assessment and treatment.
- Discharge.
- Communication.
- Admission.




When comparing this data to other sources such as litigation cases, inquests, GIRFT (getting it Right First Time), quality accounts and data from patient experience, the same categories are seen in terms of delays to diagnosis/ treatment, communication, admission and discharge.

This is also reflected within freedom to speak up conversations too. Looking at the incident reporting, we are seeing admission areas in emergency medicine reporting the most incidents alongside maternity services. Pressure ulcers have a high reporting level which also reflects harm in the wider healthcare system as we ask staff to report pressure ulcers all whether they occurred in RCHT or prior to admission. Areas such as medication relate to when medication wasn't given as expected or when there are issues with the availability of medications as part of supply issues. There were 867 reported incidents in relation to communication, 858 of these did not result in significant harm. There is a theme of communication breakdown regarding transfers of care between teams within RCHT and to external providers also.

The experience of staff in terms of violence, bullying and harassment was also highlighted in incident reporting, freedom to speak up conversations and the NHS staff survey. The staff survey a higher-than-average experience of aggression at work. On reviewing the data, this is largely due to clinically driven behaviour where the patient has a cognitive impairment (acute or chronic) and is not fully aware of their actions. There are also a few instances of staff behaviours outside of Trust values which are addressed through the organisational development plan at RCHT.

## Safety Data from 2021 to 2024

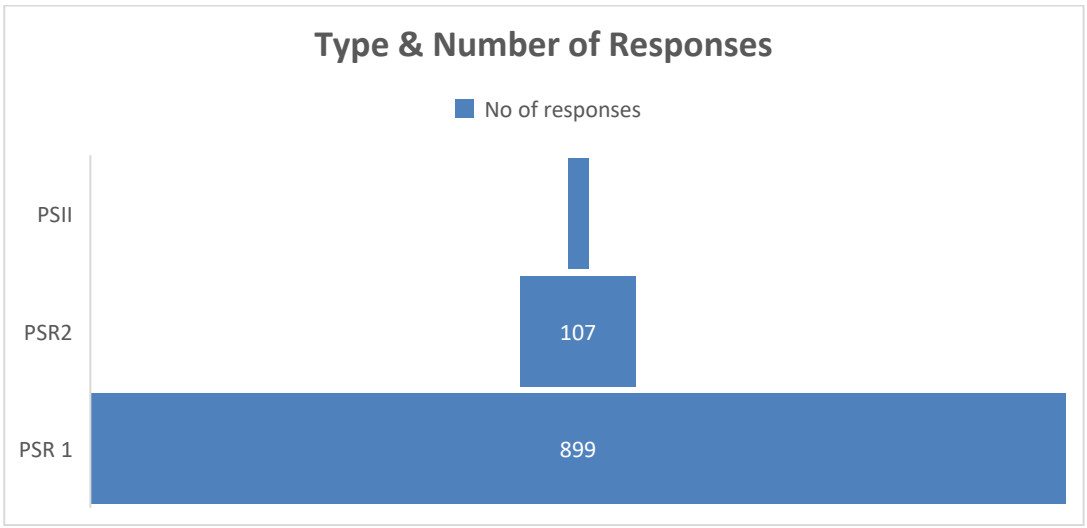
Our top ten reporting categories are shown in the graph below, these have remained largely unchanged in the previous 3 years and are aligned to data available regarding litigation, complaints, staff feedback and effectiveness of care. The 25 highest reporting categories are shown here as a potential of the total incidents reported.

| Category | 2021 | 2022 | 2023 | 2024 | Total |
|---|---|---|---|---|---|
| Pressure Ulcer | 3.37% | 3.14% | 3.65% | 3.74% | 13.9% |
| Slips Trips & Falls | 2.5% | 2.75% | 2.7% | 2.56% | 10.51% |
| Clinical Assessment & Treatment | 2.39% | 2.5% | 2.48% | 2.22% | 9.59% |
| Discharge | 1.47% | 1.45% | 2.15% | 2.6% | 7.67% |
| Communication | 1.29% | 1.13% | 1.18% | 1.41% | 5.02% |
| Admission | 1.06% | 1.12% | 1.12% | 1.27% | 4.57% |
| Documentation / Patient Information | 1.32% | 1.04% | 1.12% | 0.91% | 4.4% |
| Infection Control | 1.15% | 1.55% | 0.74% | 0.75% | 4.19% |
| Labour/Delivery | 1.06% | 0.82% | 0.9% | 1.02% | 3.81% |
| Medication - Administration | 0.85% | 0.85% | 0.99% | 1.04% | 3.73% |
| Health and Safety | 0.43% | 0.7% | 1.05% | 1.08% | 3.26% |
| Medical Equipment | 0.79% | 0.77% | 0.92% | 0.74% | 3.22% |
| Surgery/Theatre | 0.89% | 0.92% | 0.7% | 0.68% | 3.19% |
| Appointment/Booking | 0.72% | 0.61% | 0.77% | 0.67% | 2.76% |

| Category | 2021 | 2022 | 2023 | 2024 | Total |
|---|---|---|---|---|---|
| Medication - Dispensing | 0.57% | 0.63% | 0.7% | 0.79% | 2.69% |
| Aggression or violence towards staff (Physical) | 0.64% | 0.68% | 0.72% | 0.65% | 2.69% |
| Transfer | 0.46% | 0.54% | 0.7% | 0.67% | 2.38% |
| Infrastructure/Resources | 0.55% | 0.65% | 0.45% | 0.46% | 2.11% |
| Medication - Prescribing | 0.38% | 0.4% | 0.44% | 0.54% | 1.76% |
| Aggression or violence towards staff (Verbal) | 0.31% | 0.34% | 0.5% | 0.52% | 1.66% |
| Other / Miscellaneous | 0.5% | 0.45% | 0.27% | 0.28% | 1.51% |
| Blood Transfusion | 0.34% | 0.32% | 0.4% | 0.4% | 1.45% |
| Laboratory Investigations | 0.29% | 0.3% | 0.48% | 0.3% | 1.38% |
| Data Protection / Cyber Security | 0.3% | 0.27% | 0.38% | 0.4% | 1.35% |
| Fire | 0.36% | 0.35% | 0.31% | 0.2% | 1.21% |
| Total | 24.01% | 24.27% | 25.83% | 25.9% | 100% |

Whilst most of the harm related top patient safety events is none or minor (97%), we do recognise that each event has an impact, and we are working to reduce this. We have seen harm being reduced through our improvement programmes and we will continue to implement these.

Since we implemented PSIRF in December 2021, we have undertaken 899 learning responses, which are either a PSR1, PSR2 or a PSII. Our highest category was clinical assessment and treatment, followed by slips trips and falls which had seen an increase in 2024. Surgery and theatres saw an increase in 2024 in relation to complications associated with surgery. We have undertaken 107 patient safety review 2's since December 2021 There have been 19 PSII's since December 2021 which include nationally led investigations such as the maternity and neonatal safety investigations (MNSI) and locally led investigations such as never events.

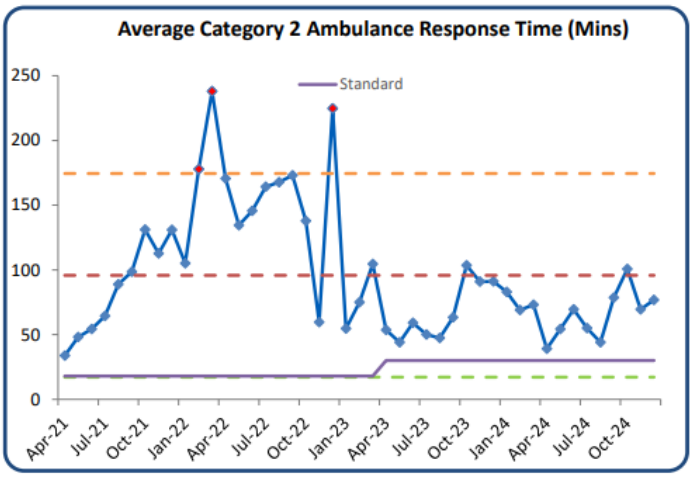


# Defining Our Organisational Patient Safety Improvement Profile

RCHT is committed to improving safety and experience for both staff and patients. There are several improvement programmes happening across the trust and in collaboration with the wider healthcare system. We have summarised four key programmes as an example of this work.

## Improving Emergency and Urgent Care

The Trust has a range of initiatives to improve to delivery of the constitutional standards of access for Urgent and Emergency Care (UEC) and in doing so will mitigate the risk of crowding in the Emergency Department (Risk 9048, score 25).




The Trust is incurring significant patient safety issues as a consequence of poor flow within the main hospital site, which is impacting negatively on, both patient and staff experience, which is also a driver for the delivery of these changes.

The areas of improvement for 2025 /2026 are:

- Acute Medical Model Changes and implementation of the Clinical Vision for Flow.
- Timely Handover Protocol (THP) implementation.

This improvement programme is overseen a fortnightly steering group chaired by the Chief Executive.

## Prevent Deconditioning Harm Programme

There has been a system-wide call to deliver a sustainable deconditioning prevention programme, fully supported by our Dual Chief Nursing Officer, across all of our CFT / RCHT in-patient wards to maximise patient readiness for discharge for our bed-base this winter. Hospitalisation and particularly prolonged bed rest can lead to deconditioning syndrome. Deconditioning syndrome is defined as the condition of physical, psychological and functional decline that occurs because of complex physiological changes induced by prolonged bed rest and associated loss of muscle strength. The prevent deconditioning harm programme looks to replicate the work undertaken as Falmouth Hospital as an exemplar into areas of 6 wards at RCHT. The improvement programme involves the expertise of meaningful activity coordinators, process changes and adaptions to the ward environment and leadership to drive changes forward. Outcomes will be measured in real time to give timely feedback and help drive forward further improvements.

## Improving Maternity and Neonatal Care

Maternity and Neonatal services continue to have many ongoing workstreams developed from local, regional and national recommendations and priorities. Actions from any plans, identified improvement areas or lessons learned are openly monitored and progress to completion evidenced in care. We assess that actions and practice is embedded and recorded dynamically into one overall document, known as the Maternity Improvement Programme (MIP). Any identified risks, successes or reporting requirements are made to the Quality Assurance Committee and Trust Board monthly.

## Patient & Family Voice in Patient Safety

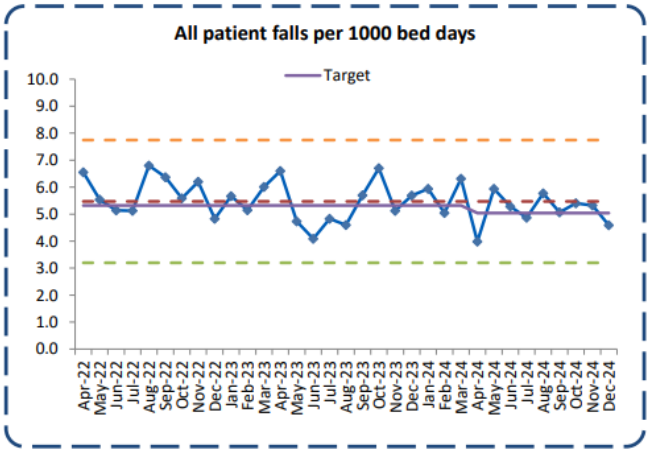
Call for concern fulfils one of the 3 elements of Martha's rule. It is a patient safety initiative that allows patients, and families/friends to escalate concerns of a clinical deterioration after they have discussed those concerns with the wards teams. We are one of NHS England's 143 pilot sites.

## Reducing Avoidable Harm

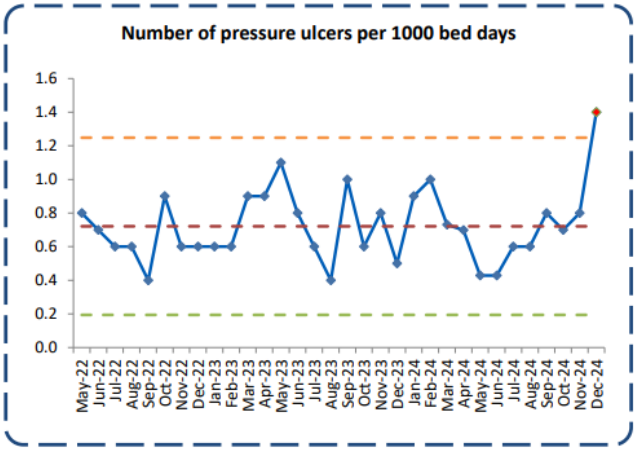
There are existing improvement plans in place for a number of areas to reduce the impact and frequency of the patient safety event.

### Falls Improvement Plan

To reduce the number and impact of in-patient falls across RCHT. We know that an in-hospital fall results in a longer stay in hospital, and once a fall has occurred there is an increased likelihood of the patient failing again. The improvement work has included identifying patients who are at risk of falling due to age, mobility levels, and co-morbidities, care during the hospital stay and a rapid response when a fall occurs to prevent further falls. We have seen an overall reduction in the harm level associated with falls and a reduction in the number of incidents being reported. Compliance with falls prevention work has been increasing over 2024 but more work is needed to prevent multiple falls and falls which result in head injury. The Improvement Practitioner for Falls, Delerium and Dementia reviews all incidents in the organisation and provides feedback on all learning responses. The effectiveness of the falls improvement plan is monitored through a monthly falls report and national audit data with further improvements planned for 2025/6.



## Pressure Ulcer Reduction Programme




Reducing the number of pressure ulcers that cause moderate harm remains a key priority for the RCHT. The improvement plan for 2024 / 2025 identified 3 key actions which support an integrated approach across the health community for the prevention of pressure ulcers.

- To develop an Integrated Pressure Ulcer Prevention Strategy which incorporates recommendations from the National Wound Care Strategy programme of work. The pressure ulcer risk assessment and the SSkin bundle tool to nationally recognised risk tool (Purpose T).

- To improve the communication processes between health care providers with regards to patients with pressure ulcers. This will incorporate transfer of care, health inequalities and joint patient safety meetings.

- To sustain a 10% reduction in pressure ulcers resulting in moderate harm. This includes training and also incorporate learning from patient safety reviews which have been piloted in the peripheral sites care group.

## Venous Thromboembolism (VTE) Risk Assessments

The Trust appointed a dedicated VTE Improvement Practitioner April 2023 who is focused on delivering the trust improvement program for hospital acquired thrombosis which refers to a venous blood clot that develops while a patient is in the hospital or within 90 days after discharge. There are a number of prevention actions such as undertaking a VTE risk assessment on admission, ensuring medications are prescribed or mechanical interventions such as anti-embolic stockings are applied. The Trust has not met its targets for preventing HAT in 2024 due to a combination of factors, but there have been improvements.in reducing declined doses of medicine, revising guidance and improving reporting to highlight patients who require an assessment or medication prescription. The VTE Improvement practitioner provides feedback on all learning responses. The effectiveness of the VTE improvement plan is monitored through a monthly falls report and national audit data.

## Sepsis Improvement Plans

The Trust improvement plan incorporates sepsis awareness initiatives, a conference, an update in policy to align with NICE guidance from 2024, learning from incidents, and knowledge development. The Trust's lead Sepsis Nurse undertakes a monthly audit. The Audit reviews a hundred patients who have been triggered for sepsis via the Nervecentre (NC) screening tool. Each of these entries is investigated via NC, Pharmacy, Enotes, Maxims, and RADAR to identify if the patient has a working diagnosis of Sepsis. Finally, if Sepsis is confirmed, then success is indicated by antibiotic delivery within one hour of identification. From June 2024 to December 2024, we have met the national target of 90% on three occasions and narrowly missed the target in December. The 2025 sepsis improvement work will include the transition to eCare, the single electronic patient record which will support clinical teams to reduce harm caused by sepsis.

## Reducing Violence and Aggression

### Violence Prevention Reduction Strategy 2023-2026

Our primary aim is for our staff to be and feel supported, safe and secure at work through preventing and reducing incidents of violence and abuse against them. To support this approach, the strategy places the Trust's workforce at its heart; fostering a culture whereby all incidents are reported (irrespective of how small they may be perceived to be) and that this becomes the norm, and more crucially; each and every incident will be acted upon with each and every incident having a fit for purpose process in place. Staff's health and wellbeing is paramount to delivery of outstanding care for one + all.

### Improving women's experience of the workplace, eliminating sexual harassment and inappropriate sexualisation of women.

Sexual safety is an important topic and one being addressed nationally in the NHS to ensure women have a better in the workplace where  is the workplace, Currently, at CFT and RCHT nearly 10% of respondents have been the target of unwanted behaviour of a sexual nature in the workplace from patients/service users, their relatives or other members of the public. We can also see that colleagues across the healthcare system are experiencing unwanted behaviour of a sexual nature in the workplace from staff/colleagues. There is work aligned to the southwest equality, diversity and inclusion programme to remove this behaviour from our organisation.

## Digital Transformation

### Implementing The Electronic Patient Record

Royal Cornwall Hospitals NHS Trust (RCHT) is making a significant change to improve healthcare in the region with the development of a new electronic patient record (EPR) system. The new EPR system will provide a single platform for RCHT, replacing several digital and paper-based systems to provide clinicians with the most up-to-date patient information, while enabling them to spend more time with their patients.

# Our Patient Safety Incident Response Plan for 2025/20266

## National Requirements Set by NHS England

Safety events which meet the national requirements for referral to external investigation or commissioning a local investigation will be managed as per the Trust incident policy. The following sets out how the Trust will respond to the nationally required investigations.

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII) | Locally-led PSII | Create local organisational actions |
| Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria) | Locally-led PSII | Multiagency response required with support from the Integrated Care Board |
| Incidents meeting the Never Events criteria 2018, or its replacement | Locally-led PSII | Create local organisational actions. |
| Mental health-related homicides | Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII locally-led PSII may be required | Multiagency response required with support from the Integrated Care Board |
| Maternity and neonatal incidents meeting Maternity and neonatal Safety Investigation (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place | Refer to MNSI or SpHA for independent PSII | Create local organisational actions and feed into quality improvement strategy |
| Child deaths | Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel. | Create local organisational actions |

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Deaths of persons with learning disabilities. | Refer for Learning Disability Mortality Review (LeDeR). A patient safety review learning response may be required alongside the LeDeR process. | Create local organisational actions. |
| Safeguarding incidents in which:<br>• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence.<br>• adults (over 18 years old) are in receipt of care and support needs from their local authority.<br>• the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence. | Referred to local authority safeguarding lead and contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards. | Multiagency response required with support from the Integrated Care Board. |
| Incidents in NHS screening programmes. | Refer to local screening quality assurance service for consideration. A locally led patient safety review learning response may be required to support wider work. | Respond to recommendations as required and feed actions into the quality improvement strategy. |
| Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS. | Patient safety learning response to support external investigation. | Create local organisational actions as required. |
| Domestic homicide. | A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.<br>Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and | Multiagency response required with support from the Integrated Care Board. |

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| | requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs | |

## Our Patient Safety Incident Response Plan: Local Focus

| | Aim | Patient safety incident type or Issue | Description | Data Sources(s) | Organisational Priority | Board Assurance Framework Risk | How we will respond | Anticipated improvement route |
|---|---|---|---|---|---|---|---|---|
| **1** | To improve the recognition of patient deterioration by reducing outstanding inpatient assessments by March 2026. | Clinical Assessment and Treatment in emergency care pathways. | Delays to recognise the deteriorating patient. | • Nervecentre / eCare outstanding assessments dashboard.<br>• Incident reporting.<br>• Legal services data. | | 1<br>9048 | Two PSIIs one in medical admissions and one in surgical admissions. | Deteriorating patient group |
| **2** | To improve patient discharges by understanding what works well and where the system can be improved to reduce readmission within 30 days. | Discharge inappropriate or planning failure. | Re-admission following discharge from RCHT. | • Incident reports and complaints.<br>• Triangulation from patient and staff safety data. | | 1<br>9048 | Thematic review captured in two PSII's for:<br>• Vulnerable adult.<br>• End of life care. | Clinical vision for flow project. |
| **3** | To improve our patient experience by being timely with Duty of Candour | Compliance with timely duty of candour. | Incidents reported at moderate and above requiring duty | • Incident reports.<br>• Duty of candour performance | | | Systems based Review and Quality Improvement Project | Patient safety incident response oversight group |

| | Aim | Patient safety incident type or Issue | Description | Data Sources(s) | Organisational Priority | Board Assurance Framework Risk | How we will respond | Anticipated improvement route |
|---|---|---|---|---|---|---|---|---|
| | conversations within 10 days of the incident being reported. We plan to achieve 90% compliance by September 2025 without reducing our compassionate response. | | of candour conversations | reporting.<br>• Internal duty of candour audits. | | | | |
| **4** | To improve the experience of work for staff by reducing violence and aggression as a result of behaviours of concerns (previously described as clinically driven behaviours). | Violence and aggression towards staff. | Violence and aggression from clinically driven behaviour due to cognitive impairment | • PSR1's related to clinically driven behaviour.<br>• Patient and Staff safety Triangulation Group. | | | Thematic review captured in two PSII's for:<br>• Eldercare<br>• Neurological condition | Violence and aggression reduction strategy |

## Other Learning Responses

All incidents will be reviewed as per the Patient Safety Incident Response Policy, with those determined to have a moderate level of risk or harm reviewed via a patient safety review (PSR). The PSR1 may involve a range of learning response tools such as after-action reviews, SWARMS and MDT reviews.

| Patient Safety Event | Learning response | Mechanism for monitoring |
|---|---|---|
| Patient events with a moderate level of risk or harm. | PSR1 to be undertaken. | Monthly Patient Safety Response and Oversight Group. |
| Fall resulting in moderate harm or higher. | PSR1 including post falls after action review captured on the bespoke trust template involving subject matter expert. | Monthly falls improvement report.<br>NHS national audit. |
| New pressure ulcer presenting a moderate level of risk. | PSR1 on the bespoke trust template involving subject matter expert. | Monthly pressure ulcer improvement report. |
| Hospital acquired thrombolysis (HAT) presenting a moderate level of risk. | PSR1 on the bespoke trust template involving subject matter expert. | Monthly HAT improvement report.<br>NHS national audit. |
| Infection prevention and control where the IPAC team determine the infection was caught in hospital. | PSR1 on the bespoke trust template involving subject matter expert. | Monthly integrated performance report.<br>NHS national audit. |
| Poor communication during care where concerns are raised. | Complaint responses.<br>Freedom to speak up concerns.<br>Incident reporting.<br>People experience. | Patient and Staff safety triangulation. |
| Digital transformation (a previous theme identified in patient safety incidents is a lack of system interoperability, multiple electronic platforms and how clinicians use existing systems). | PSR1 where significant concerns with IT systems are raised, working with Clinical Safety Officers and the Chief Information Officer. | The Trust's digital transformation has been identified as a core piece of work under the strategic objective (RCHT's 10-year Strategy) of 'Journey of Improvement'. |

## 3 Risks associated with the areas covered in this report

The Patient Safety Team have considered the current risks relating to the implementation of PSIRF, the following risk was identified at the start of implementation, it has been regularly reviewed and at the time of reporting is scored at 6.

| Risk Title | Risk Update | Score |
|---|---|---|
| Delivery of Patient Safety Incident Response Plan 2025/2026 | 9733 | 6 |

## 4 Recommendation

The Committee is asked to receive this report for:

- Consideration of the completed PSII's and action plans.
- Consideration of the proposed report format and presentation options to the Board.

**Compiled by:** Naomi Burden, Clinical Lead for Culture Change and Improvement.

**Presented by:** Naomi Burden, Clinical Lead for Culture Change and Improvement.

**Date:** 01/05/2025.