NHS

University Hospitals Dorset

NHS Foundation Trust

Patient Safety Incident Response Plan

Version 1

We are caring one team listening to understand open and honest always improving inclusive

Foreword

"PSIRF is a fundamental cultural safety change in the way we think, report and investigate incidents..."

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

PSIRF is a fundamental cultural safety change in the way we think, report and investigate incidents. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, **PSIRF focuses on learning and improvement**.

Our staff work incredibly hard in UHD and the vast majority of the care we deliver is very good. However, it is very important for us to review our interventions and where harm has, or might have, occurred.

PSIRF and the responsibility for the entire process, including what to investigate and how, is down to our trust as a whole. There are now no set timescales or external organisations to approve what we do. There are a set of principles that we need to work towards but outside of that, it is up to us to agree and approve what is the right direction for finding the learning from each patient safety incident and this will be done in several ways.

The exciting change of implementing PSIRF is that we will focus on improving our approach to patient safety incidents and **develop a culture in which people feel safe to talk**.

We will be **working in partnership with patients to improve** and it is important to recognise that if there are good reasons to carry out an investigation, we will continue with the newly developed tools and thinking of PSIRF. Sharing findings, speaking with those involved, validating the decisions made in caring for patients, and facilitating psychological closure for those involved, are all core objectives of an investigation.

Compassionate engagement and developing the safety science of psychological safety, behavioural and human factors, will enable us to evolve our organisation, continue to learn, and crucially share that learning with our patients, staff, stakeholders and the NHS.

We are pleased to be introducing this plan to #TeamUHD for the benefit of all. We are thankful to the openness and sharing from the early adopter organisations.

When using this document please ensure that the version you are using is the most up to date either by checking on the trust intranet or if the review date has passed, please contact the author. Out of date policy documents must not be relied upon.

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1 Introduction, purpose, scope, aims and objectives

1.1 Introduction

We are delighted to present our first Patient Safety Incident Response Plan (PSIRP) for University Hospitals Dorset NHS Foundation Trust (UHD).

This plan sets out how we intend to respond to patient safety incidents over the next 12 to 24 months in line with the National Patient Safety Strategy for England (2019) and the new Patient Safety Incident Response Framework (PSIRF) 2022.

What is PSIRF?

PSIRF is a new approach to maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

It advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.

It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Our PSIRP aligns with our strategic priorities and our Patient First Improvement Strategy.

The aim is to continually improve.

The plan will be flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. The plan will be annually reviewed and approved by the trust Board, and the Dorset Integrated Care Board. Our patients and staff will be an being an integral part of the consultation and review process.

1.2 Purpose

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more of our patients receiving healthcare.

This plan sets out how we will seek to learn from patient safety incidents reported by staff, patients, their families and carers and how investigations will be used to deliver improvement and learning.

We will:

- refocus investigations towards a systems approach and rigorously identify interconnected causal factors and systems issues

- focus on addressing these causal factors and the use of quality improvement to prevent or continuously and measurably reduce repeat patient safety risks
- improve the emphasis away from quantity to the quality of investigations and increase our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents.

1.3 Scope

1.3.1 There are many ways to respond to an incident where harm has occurred or where it might have occurred. This plan details responses for the purposes of individual, organisational and system learning and improvement, and how we intend to maximise these opportunities.

1.3.2 This PSIRP applies to all permanent and temporary employees, volunteers, agencies and agency staff working for and on behalf of the trust. This includes staff whose role does not involve direct care.

1.3.3 This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all UHD services. Incidents that fall outside of the scope of the plan include information governance, security, health and safety and other non-clinical incidents. These types of events are managed in accordance with their own specific policy documents which are referenced in the resources section of this plan.

1.3.4 The plan does not include learning responses conducted for the purposes of claims handling, human resources investigations into employment concerns, professional standards investigations, complaints handling, coronial inquests, and criminal investigations. The principle aims of each of these responses differ from those of a patient safety incident response and are outside the scope of this plan.

1.4 Strategic aims

1.4.1 To improve the safety of the care we provide to our patients and improve our patients, their families and carers' experience of it.

1.4.2 To reduce harm to patients, to reduce and learn from safety incidents.

1.4.3 To continually look for innovative ways to improve, along with solutions and methods already available to sharing the learning.

1.4.4 To involve patients, relatives and carers in identifying potential solutions when something has gone wrong and let their voice be heard.

1.4.5 We will continue with the regulatory and mandatory requirements and share openly with patients, their families, and carers. Our patients are at the heart of "sharing our learning". We also recognise the valuable, hard work that all our staff contribute to patient safety every

day and how when something goes wrong, it has an impact psychologically and emotionally on staff and clinical teams involved, and families and friends.

1.5 Strategic objectives - linking with Patient First

High quality care is at the heart of everything we do and maintaining and improving the quality of patient care remains the top priority for the trust. This vision is underpinned by our values and is delivered through seven key strategic objectives.

PSIRF fits with our continuous improvement journey called Patient First. Patient First is a whole organisation focus on improvement work which will see us move from trying to do too many things, to working together on fewer improvement goals and doing them well - with the patient at the heart of everything we do.

The following diagram and table highlight how the UHD objectives link with Patient First and PSIRF.

Trust objective	Patient First theme	PSIRF objective
Improve patient experience, listen and act	Patient experience	Improve the experience for patients and families whenever a patient safety incident occurs.
Save lives, improve patient safety	Quality	Reduce harm from patient safety incidents through learning and improvement.
Be a great place to work	Our people	Support compassionate leadership, just culture and learning for improvement. Create a safe environment for staff to raise concerns and ensure staff receive feedback on action taken when they do. Improve our Staff Survey scores for safety culture.
Work as one team, fit for future changes	One team	Work with system partners to undertake thematic reviews of patient safety across care pathways.
See our patients sooner	Population and health system working	Improve the safety and care we provide to our patients.
Use every pound wisely	Sustainable services	Maximise our resources to support quality and safety.
Start our Patient First Journey	Patient First Programme	Train staff in improvement methodologies.

2 Local focus

2.1 Defining our patient safety profile

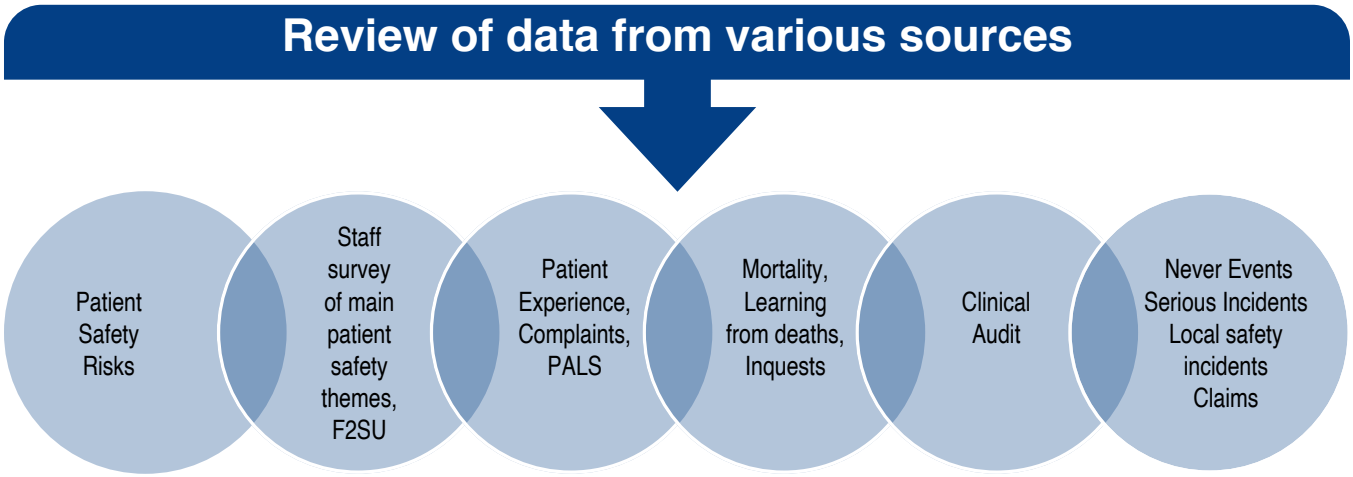
To develop this plan, a comprehensive situational analysis of the current patient safety risk profile across all services within UHD has been undertaken.

We have reviewed all patient safety activities with our network of key stakeholders across UHD. They will be key stakeholders in the PSIRP and our improvement journey. We have considered the results of the national NHS Staff Survey and national patient surveys to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with ICB colleagues and local and national patient safety specialist networks.

Full details of the data analysis are provided in an in-depth supporting document that holds the detail of the process completed and the conclusions of the review.

2.2 Patient safety incidents

Our risk management recording system (Datix) is the key source for patient incident report data. Ward, directorate and care group quality dashboards are used from ward to board. An Integrated Performance Report (IPR), which includes patient safety data, is discussed monthly at our Trust Management Group, Quality Committee and the Board of Directors. The IPR includes a defined set of key quality and patient safety metrics.



A review of the available patient safety data, including annual and quarterly reports for 2021-22 and 2022-23, was undertaken. It identified the following:

	2021/22	2022/23
Incidents meeting the Never Events criteria	**2**	**4**
Opened incident death or long-term severe injury of a person in state care or detained under the Mental Health Act 1983	**2**	**1**
Incidents meeting HSIB criteria	**7**	**1**
Serious incidents (excluding never events)	**36**	**43**
Local safety investigations	**85**	**56**

2.3 Risk register

The UHD risk register is maintained on the central local risk management system. Risks are rated in accordance with the trust Risk Management Strategy. A monthly report is submitted to our Clinical Governance Group, Trust Management Group and Quality Committee.

Analysis of risk register themes highlighted that the top five categories were; capacity and flow risks, equipment risks, mental health risks, medical staffing risks and patient care risks.

2.4 Complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, (total of 1896 for the 984 complaints) based on the Department of Health submission dataset can be seen in the table below; recorded by number and % of total. Any emerging themes or hotspots are identified and escalated to the directorate or care group triumvirate or to the relevant executive director, depending on the seriousness, complexity and/or frequency of complaint theme monitored. Complaints can have more than one theme assigned to them, for example the complaint could be about the clinical treatment and communication and administration.

	2021/22	2022/23
Clinical treatment	**44%**	**35%**
Communication	**1%**	**23%**
Delays and cancelled appointments	**2%**	**8%**
Access to treatment	**-**	**5%**
Admission, discharge, transfers	**5%**	**5%**
Number of complaints by patients, families and cares that were upheld and were considered high risk	**26**	**19**

2.5 Freedom to Speak Up

An annual Freedom to Speak Up (FTSU) report is produced each year. The information gained via the FTSU process provides a valuable source of quality improvement data.

The 22/23 annual reports highlight an increase in issues relating to attitudes, behaviours and civility. An increase in issues around staff wellbeing are also evident which include areas such as workload and burnout.

2.6 Learning from deaths

Our Learning from Deaths (Mortality Review) Policy outlines the process in the trust for undertaking structured case note reviews for hospital inpatient deaths. The UHD Medical Examiner Policy also highlights how learning is identified from medical examiner scrutiny and conversations with the bereaved.

Themes in 21/22 and 22/23 included; steroid management, discharge delays, communication, difficult IV access, diabetic management and delays in referral.

2.7 Claims and inquests

Themes from claims 2022/23	Themes from inquests 2022/23
Delays in diagnosis	Delays in diagnosis
Delays in treatment	Failure to act or escalate
Failure in the interpretation of X-rays/scans	Follow up of results
Failure to provide informed consent	Documentation
Sub optimal treatment	Pressure ulcer care

2.8 Clinical audit

Our annual Clinical Audit Plan covers national audits and locally selected topics. Audit results and actions are recorded on the clinical audit database. The completion of the action element of the audit cycle are followed up by the clinical audit team to ensure the record of each audit is as complete as possible. A clinical audit report is produced annually, which highlights action plans and learning. A similar approach is adopted for NICE guidelines implementation.

Trends and themes highlighted from audits undertaken in 22/23 include:

- communication
- delays in treatment
- delays in diagnosis
- medication

2.9 External bodies

Recent CQC reports have highlighted several areas for quality improvements across the trust. These areas include:

- medication
- medication prescribing and administration processes
- documentation
- staffing levels
- waiting times and access to services/ capacity and flow

2.10 Top patient safety themes (all sources)

As a result of the review, we have identified the top incident profiles occurring to be:

Trust top 9	Sources
Medication (Inc. VTE)	Patient safety incidents, complaints, risks, mortality reviews, inquests, clinical audit, CQC inspections
Patient falls	Patient safety incidents, risks, inquests, clinical audit, CQC inspections
Diagnostics	Patient safety incidents, complaints, risks, claims
Pressure ulcers	Patient safety incidents, risks
Deteriorating patients	Patient safety incidents, quality improvement plans, LERNS, mortality reviews, medical examiner reviews
Waiting times, access, capacity and flow	Patient safety incidents, GIRFT, CQC inspections, quality and performance data, patient feedback
Communication (inc. handover)	Patient safety incidents, complaints, mortality reviews, clinical audit, medical examiner reviews
Maternity care	Patient safety incidents, CQC inspections, clinical audit
Mental health	Patient and staff safety incidents, safeguarding cause for concerns, performance data

3 PSIRP priorities

3.1 Local priorities

As a result of the analysis undertaken, we have identified the following areas of patient safety priorities over the next 12-18 months:

PSIRP priority:
Improve the safety of the care we provide to our patients

Incident type	Speciality
Patient falls	Trust-wide
Medication (VTE)	Trust-wide
Pressure ulcers	Trust-wide
Diagnostics (follow up of radiology and laboratory investigations)	Trust-wide
Deteriorating patient	Trust-wide
Mental health (management and reducing restrictive intervention)	Trust-wide
Post partum haemorrhage	Maternity
Unexpected term admission to neonatal intensive care (NICU)	Maternity
Still births	Maternity

Our investigation and improvement response to each theme will be different (set out later in this plan) and will focus on maximising resources to seek early identification of learning outcomes and quality improvement.

3.2 How we will respond to national priorities

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by, or referral to, another body or team, depending on the nature of the event.

The table below sets out the local or national mandated responses.

Incident type	Incident response	Reference
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)
Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted either as part of a local Learning from Deaths Plan or following reported concerns about care or service delivery.	Structured Judgement Review (SJR) Coronial investigation (as applicable) Potential PSII	
Death of a person detained under the Mental Health Act 1983 (as amended 2007) or where the Mental Capacity Act applies, where there is reason to think that the death may be linked to problems in care.	PSII	
Death of persons with learning disabilities	Externally report for independent Learning Disability Mortality Review (LeDeR). Local enhanced learning response may be required alongside LeDeR	LeDeR - Home

3.3 How we will respond to national priorities in maternity

The table below sets out the agreed approach by Dorset Local Maternity and Neonatal System in each organisation's PSIRP in relation to maternity incidents.

	Incident type	Incident response	References
National Priorities	Never Events	Patient Safety Incident Investigation (PSII)	2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)
	Maternal deaths • All (direct or indirect deaths in the perinatal period-pregnancy, up to 12 months after childbirth):	Report to MBRRACE and PMRT review (Perinatal Mortality Review Tool). (If care graded C or D, Trust to determine level of response e.g. PSII, case review etc) Coroner	Perinatal Mortality Review Tool | MBRRACE-UK | NPEU (ox.ac.uk) NHS England » Learning from deaths in the NHS
	• From pregnancy up to 42 days after the end of the pregnancy	MNSI (Prev HSIB)	Maternity investigations (mnsi.org.uk)
	• After 42 days from the end of pregnancy, up to 12 months	Structured judgment review	
	Perinatal and neonatal deaths • All (22 weeks gestation to 28 days of age):	Report to MBRRACE and PMRT review (If care graded C or D, trust to determine level of response e.g. PSII, case review etc).	Perinatal Mortality Review Tool | MBRRACE-UK | NPEU (ox.ac.uk) NHS England » Learning from deaths in the NHS
	• Intrauterine deaths/late fetal loss	Structured Judgment review	
	• Antenatal stillbirth	Structured Judgment review	
	• Intrapartum stillbirth	MNSI MNSI Coroner	Maternity investigations (mnsi.org.uk)
	• Early neonatal death (day 0-6)	MNSI and subsequent Child death overview panel (CDOP) Coroner	CDOP
	• Neonatal death		

	Incident type	Incident response	References
National Priorities	Deaths of persons with a learning disability	Refer for LeDeR review	LeDeR - Home
	Adult and children's safeguarding incidents	Safeguarding alert and referral	See organisation Safeguarding policy
	Term neonatal severe brain injury	Refer to MNSI for triage. If not MNSI the Trust to determine level of response	
	Incidents in screening programmes	Refer to SW regional direct commissioning team	Managing safety incidents in NHS screening programmes

3.4 How we will respond to local PSIRF priorities

The table below describes how we will respond to patient safety incidents set out in the plan.

PSIRF priority	Learning response	Improvement response
Patient falls	• Immediate safety actions • Post falls checklist • LERN review and triage If patient safety concern is highlighted and/or patient sustains a fractured neck of femur or serious head injury: • Compassionate engagement/ Duty of Candour (DoC) • Falls After Action Review • PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement	• Review and update of ward/department quality improvement plan • Dashboard to review themes • Oversight at PSIRF oversight group

PSIRF priority	Learning response	Improvement response
Medication (VTE)	• Immediate safety actions • LERN review and triage • If criteria met - National VTE RCA review If patient safety concern is highlighted: • Compassionate engagement/ initial DoC • After Action Review • PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement	• Review and update of ward/department quality improvement plan • Dashboard to review themes • Oversight at PSIRF oversight group
Pressure ulcers	• Immediate safety actions • Pressure ulcer checklist • LERN review and triage If patient safety concern is highlighted or the Pressure ulcer is graded as 'hospital acquired' and category 3 or above: • Compassionate engagement/ initial DoC • After Action Review • PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement	• Review and update of ward/department quality improvement plan • Dashboard to review themes • Oversight at PSIRF oversight group
Diagnostics (follow up radiology and laboratory investigations)	• Immediate safety actions • LERN review and triage • Compassionate engagement/ DoC • PSIRF Insight Review to determine enhanced learning response e.g. Swarm, AAR, MDT review • PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement	• Dashboard to review themes • Task and finish group to be established to undertake thematic review • Oversight at PSIRF oversight group

PSIRF priority	Learning response	Improvement response
Deteriorating patient	• Immediate safety actions • LERN review and triage If patient safety concern is highlighted: • Compassionate engagement/ DoC • PSIRF Insight Review to determine enhanced learning response e.g. Swarm, AAR, MDT review • PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement	• Review and update of ward/department quality improvement plan • Dashboard to review theme • Task and finish group to be established to undertake thematic review • Oversight at PSIRF oversight group
Mental health (management and reducing restrictive intervention)	Violence and aggression incidents to staff: • Immediate safety actions and staff support (e.g. hot debrief/ Swarm/TRiM) • LERN review and triage • RIDDOR scoping meeting if appropriate Incidents when restraint is used: • Immediate safety actions and staff support (e.g. hot debrief/ Swarm/TRiM) • LERN review and triage If patient safety concern is highlighted: • Post restraint incident meeting (PRIM) to confirm learning response e.g. swarm, AAR, MDT review	• Mental health pathways are currently being reviewed at a system level. Reported issues relating to capacity and pathway delays will be reviewed as part of the system level QI project in 23/24 • Oversight in UHD at operations performance group, TMG and mental health steering group

Maternity		
PSIRF priority	**Learning response**	**Improvement response**
Post-partum haemorrhage (in excess of 1.5L requiring activation of MOH protocol)	• Immediate safety actions and staff support (e.g. hot debrief/ Swarm/TRiM) • LERN review and triage • PPH checklist • PSII will be undertaken if UHD Maternity Services become a regional or national outlier or if themes require further system analysis	• Thematic review in 23/24 to be undertaken • Oversight at LMNS
Unexpected term admission to neonatal intensive care (NICU) or special care (SCBU)	• Immediate safety actions and staff support (e.g. hot debrief/ Swarm/TRiM) • Compassionate engagement/ DoC • Immediate individual event review (Maternity 72-hour review template) • LERN review and triage • Consider referral to MNSI • PSII will be undertaken if UHD Maternity Services become a regional or national outlier or if themes require further system analysis	• Avoiding Term Admissions into Neonatal units (ATAIN) quality improvement project • Thematic review in 23/24 to be undertaken • Oversight at LMNS
Still birth	• Immediate safety actions and staff support (e.g. hot debrief/ Swarm/TRiM) • Compassionate engagement/ DoC • Immediate individual event review (Maternity 72-hour review template) • LERN review and triage • Report to MBRRACE • Perinatal Mortality Review Tool (PMRT) if grade C or D, PSIRF Insight Review to confirm learning response • Consider referral to MNSI • Consider Individual PSII	• ATAIN and Saving Babies Lives (SBL) v.3.1 quality improvement projects • External thematic review in 23/24 to be undertaken • Oversight at LMNS

3.5 Local standards for Patient Safety Incident Investigations (PSIIs)

PSIRF both requires and enables us to focus on our key patient safety risks and seek an in-depth understanding of the complexity of our safety systems that underpin these risks. It also enables more supportive engagement of patients, families and staff and inclusivity by considering multiple perspectives.
It's about understanding and learning together - "doing with, rather than doing to". Our key aims are outlined in the Risk Management Strategy and supports the delivery of:

- devolved decision making and accountability
- promoting a culture of assurance
- supporting patients, families and carers
- refining processes
- supporting trust Board and the ICB and other stakeholders in receiving and providing assurance

We will ensure that:

- PSIIs will be led by staff who have undertaken the required accredited training.
- PSIIs are not just for single item investigations. They are to be viewed as improvement projects where a critical mass of incidents following the same theme are reviewed and improvement plans developed.
- PSIIs will ordinarily be completed within three months of their start date and should take no longer than six months. A balance will be drawn between conducting a thorough PSII, and the impact that extended timescales can have on those involved in the incident, with the risk that delayed findings may adversely affect safety or require further checks to ensure findings remain relevant.
- Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further analysis.

4 Roles and responsibilities

This section describes clear roles and responsibilities in relation to our response to patient safety incidents, including accountability, investigator responsibilities and upholding national standards relating to patient safety incidents.

4.1 Chief executive

- The chief executive is ultimately responsible for implementation of the trust PSIRP and ensuring that relevant systems and processes are appropriately supplied in various capacities: funding, management time, equipment and training.
- The chief executive is responsible for modelling behaviour that facilitates the improvement of the patient safety reporting, learning and improvement system alongside the executive and non-executive teams.

4.2 Chief nursing officer and chief medical officer

The chief nursing officer and chief medical officer are the executive leads for identification, implementation and delivery of the PSIRF and PSIRP. This includes:

- Enacting processes to facilitate an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Overseeing development and review of the trust's PSIRP and Policy.
- Ensuring there are enough resources to support the delivery of the PSIRP (including time, capacity, training needs and provision for staff support and patient and family engagement).
- Ensuring the trust complies with the national patient safety investigation standards.
- Ensuring that staff at all levels of the organisation have the training, skills, and relevant experience for their roles in patient safety incident management.
- Ensuring the incident reporting and investigation processes are effective for learning and improvement.
- Ensuring Board level scrutiny and oversight of Patient Safety Incident Investigations (PSIIs).

4.3 Care group directors of nursing, medical directors and directors of operations

- Ensure the care group procedures supports the management of patient safety incidents in line with the trust's PSIRP (including convening Care Group Rapid Review meetings to agree the level of response to all patient safety incidents reported in the care group).
- Supporting lead investigators and investigation teams as required and appointing trained named contacts to support those affected.
- Ensuring patient safety incident investigations are undertaken for all incidents that require this level of response.
- Establishing procedures to monitor/ review investigation progress and the delivery of all improvements.
- Supporting action plans, innovation, learning, and improvement work identified from patient safety incident responses.
- Supporting and advising staff involved in the patient safety incident response.

4.4 Patient safety and risk team

- Promote the trust culture of open and honest reporting of a patient safety incident that may impact on the quality of patient care in accordance with trust policies on patient safety incident reporting and risk management.
- Oversee patient safety activity within directorates and support them to meet the needs of the PSIRF process.
- Ensure the principles of engaging with people affected by incidents are followed in line with the PSIRF standards.
- Promote the use of the quality improvement methodologies in responding to and identifying learning.
- Monitor recommendations arising from all patient safety activity.
- Share information, learning and examples of good practice.
- Ensures patient safety investigations are undertaken for all incidents that require this level of response (as directed by the trust's PSIRP).
- Develop and maintain local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Ensure the trust has procedures that support the management of patient safety incidents in line with the trust's PSIRP.
- Support and advise staff involved in the patient safety incident response.

4.5 Care group governance co-ordinators and quality managers

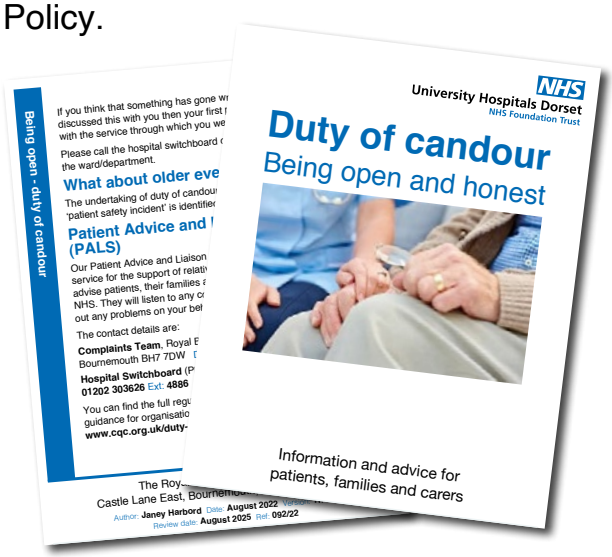
- Support local learning responses (swarm huddles, After Action Reviews, MDT reviews) occur in their care group in accordance with the PSIRP and the Patient Safety Incident Policy and that learning, and improvement actions, are captured and recorded on the Risk Management System.
- Support patients, families, and staff involved in incidents undergoing a patient safety incident investigation to ensure a joined-up approach for patients, families and staff involved.
- Provide advice relating to the PSIRP and operational policy to care group staff.
- Support the co-ordination of thematic analysis of incidents and assurance reporting is carried out in line with the standards in this policy and required by the PSIRF.
- Ensure new risks identified from recorded incidents are managed in accordance with the Risk Management Policy.

4.6 PSII investigators

- Undertake patient safety investigations and patient safety investigations related duties in line with latest national guidance and training.
- Ensure investigations are undertaken in line with the patient safety investigation standards.

4.7 Duty of Candour lead

- At the point of commissioning a PSII, a Duty of Candour lead will be appointed, and this lead will be the main point of contact for the patient, families and carers to ensure they are fully supported and informed of the investigation and its progress.
- Identify those patients, families and carers affected by patient safety incidents and provide them with timely and accessible information and advice.
- Ensure they are provided with an opportunity to access relevant support services.
- Act as liaison between patients, families and carers and investigation teams to help manage expectations.
- All main contacts for patients, families and carers must have;
  - Received appropriate training in communication of patient safety incidents including ‘Compassionate engagement’ and Duty of Candour.
  - Enough time to undertake their role; that is, they should be staff dedicated to the role or with dedicated time for this role. More information can be found in the trust’s Compassionate Engagement (Duty of Candour) Policy.



4.8 Directorate clinical leads/managers

- Encourage reporting of all patient safety events, including near misses, and ensure all staff are competent in using the Risk Management System and are provided enough time to record incidents and share information.
- Provide protected time for training in patient safety disciplines to support skill development within their area or responsibility.
- Provide protected time for participation in investigations as required.
- Liaise with the patient safety team and others to ensure those affected by a patient safety incident have access to the support they need.
- Support development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome).

4.9 Ward and department managers and senior clinicians/managers

- Ensure incidents relating to their ward/ department/speciality are reported as soon as reasonably possible.
- Ensure incidents are reviewed as soon as possible following reporting on the trust Risk Management System and an initial local learning response is recorded.
- Ensure acknowledgement, thanks and feedback are given to the person who recorded the incident, ideally in person.
- Check in with those involved in the incident and ensure access to any further wellbeing support is provided, including any local debriefing sessions.
- Ensure initial learning from the incident is shared with the ward/ department team e.g. at the daily safety brief/team meeting.
- When relevant, facilitate team members to participate in a more structured investigation or local learning response (if there is to be one) such as: After Action Review, SWARM huddle, MDT Review.
- Contribute to patient safety incident investigations and individual event reviews.

4.10 Consultant medical staff, staff grade, associate specialist and specialty doctor, senior doctors in training (ST3 upwards)

- Undertake initial compassionate engagement/Duty of Candour discussions with patients and families as required.
- Support colleagues involved in the incident and ensure access to any further wellbeing support is provided, including any local debriefing sessions.
- Ensure initial learning from the incident is shared with the specialist team pending a more structured investigation or learning response if there is to be one.
- When relevant, facilitate team members to participate in a more structured investigation or local learning response (if there is to be one).
- Participate in patient safety incident investigations, individual event reviews and local learning responses.

4.11 Trust wide subject matter experts and specialist leads (e.g. leads for falls, dementia, tissue viability, safeguarding, learning disabilities, medical equipment, digital, clinical specialists)

- Support learning responses by provision of expert specialist advice and participation in patient safety incident investigations, individual event reviews and local learning responses.
- Undertake thematic analysis of recorded incidents and other forms of quality intelligence related to their specialist area of expertise and identify and take forward quality improvement work in their specialist area as required.
- Ensure incidents are reported to external bodies relevant to their scope of practice.

4.12 All staff

- Report patient safety incidents via the Risk Management System as soon as reasonably possible.
- Understand their responsibilities in relation to the trust's PSIRP.
- Know how to access help and support in relation to patient safety incident response process.

4.13 Patient safety partners

- Support patient safety incident investigations as appropriate.

4.14 Clinical Governance Group

- The Clinical Governance Group will be the responsible group to monitor implementation of the UHD Patient Safety Incident Response Plan.

5 Training

It is important to continue to support staff through the current training and development programme.

This has included:

- national level 1 and 2 training
- root cause analysis and risk assessment training
- human factors training
- communication skills training
- Patient First training
- leadership training
- commissioning of external training

From early 2024 there will be internally available training and development opportunities for staff with specific investigation, improvement and/or oversight responsibilities under this plan.

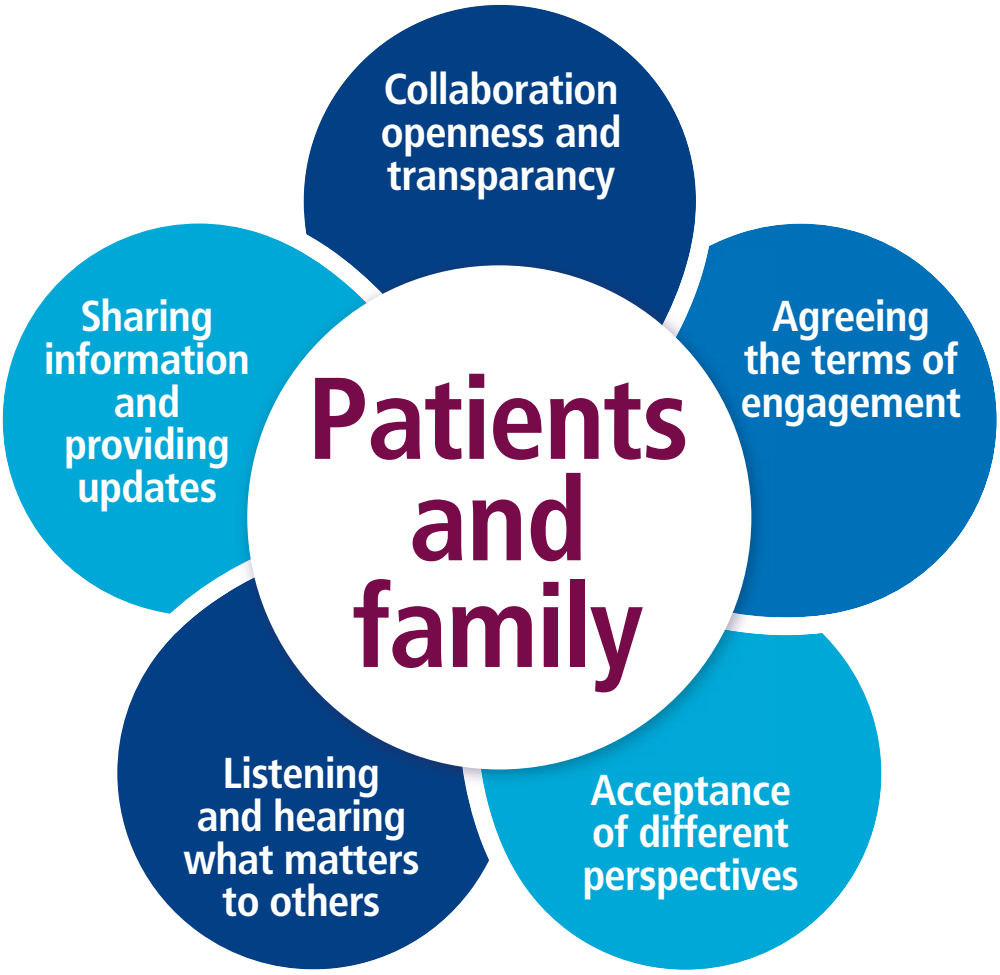
Table of training expectations:

Topic	Provision	All staff	Clinical staff	Learning response leads/ managers	PSIRF lead Roles	Oversight roles
National Patient Safety Level 1: Essentials for Patient Safety	eLearning - available via VLE Green Brain	✔	✔	✔	✔	✔
National Patient Safety Level 2: Access to Practice	eLearning - available via VLE Green Brain		✔	✔	✔	✔
Involving those affected by Patient Safety Incidents	External provider			✔	✔	
Approach to Patient Safety Reviews	3 day course - external provider			✔	✔	
Systems approach to learning from Patient Safety Incidents					✔	
Oversight of Learning from Patient Safety Incidents	External provider / e Learning					✔

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

Patients and families should be given every opportunity to be involved at every step and have the process explained to them. Involvement should be flexible and adapt to changing needs as each situation will be different. In line with our trust values and objectives, we will apply the following principles when working with patients and families:

Further resources will be developed and made available to support staff engaging and working with patients and families as part of patient safety reviews and investigations.



7 Procedures to staff affected by a patient safety incident

We are on an ambitious journey at UHD to ensure we are a safe and compassionate environment, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement.

It is essential that with any PSII the staff involved are well supported throughout the entirety of the process. It is well documented that staff that are involved in such incidents are potentially a 'second victim' and clear procedures to ensure and escalate the appropriate support is a key part of our toolkit to deliver PSIRF.

In keeping with the ethos of 'compassionate engagement' and 'just culture', staff should be informed as soon as possible that an incident they have been involved in is to be investigated as a PSII. A clear explanation of how the incident is to be investigated needs to be explained in a transparent way to ensure they are confident that the investigation is fair and appropriate.

The initial acknowledgement to staff is important and can 'set the tone' of the perceived investigation to follow in the eyes of the staff. Rather than being too prescriptive, the initial contact should be based on 'best for staff' using local management knowledge of the individual. A verbal and 'face to face' discussion with staff should always be followed up with an individualised written response to follow.

7.1 Hot debriefing

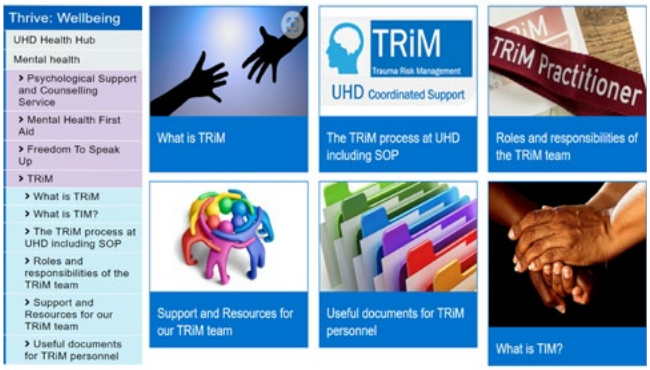
Hot debriefing is a clinical debriefing process that can take place immediately after a clinical event, often involving frontline staff who were involved in the care of a patient.

The aim of hot team debriefing is to:

- develop a shared understanding of events within your key team
- promote learning in a supportive environment
- provide an opportunity for reflection
- identify opportunities for improvements
- focus on process, systems, equipment, and interactions (i.e. communication)
- signpost and support individuals and team in the need for further support

7.2 Trauma Risk Management

TRiM or Trauma Risk Management, is a peer-led approach used at UHD to support our staff who have been through a traumatic event at work. TRiM is not treatment or counselling, but a recognised method of supporting and assessing risk after traumatic exposure while at work. TRiM can be found in the resource section of this document and on the UHD intranet TRiM (uhd.nhs.uk).



7.3 TIM

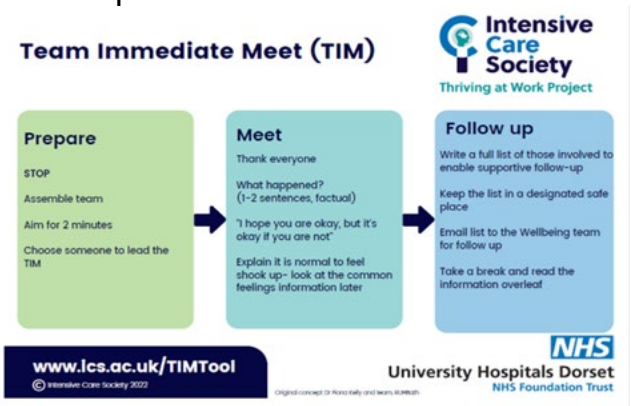
TIM - Team, Immediate, Meet - is a communication tool to guide a group conversation or individual conversations, using psychological first aid after any clinical event that may cause distress. It is not a clinical debrief but can be used immediately after the event to support the team/individual.

TIM is a team tool where anyone can lead it and do as a team together. It is voluntary.

The intention of the tool is to:

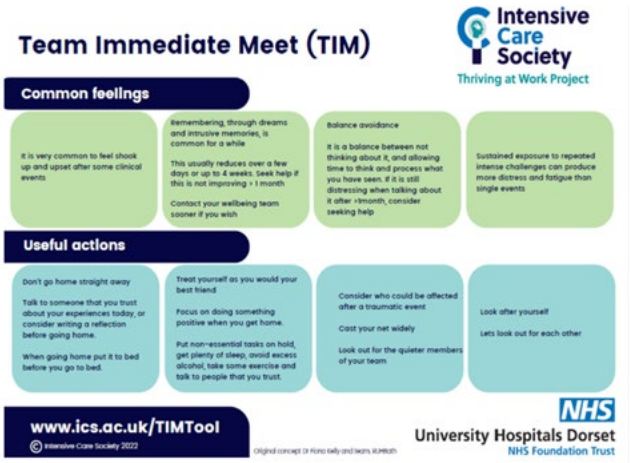
- enable staff to briefly check in with each other following any clinical event that causes distress (immediate or on same shift)
- acknowledge, monitor, offering that link to psychological first aid
- provide some short-term self-care advice
- identify those whom may need more supportive follow up after the acute stress response period such as TRiM

The tool is in three parts; Prepare, Meet, Follow up



The tool also gives the team some initial information and support including what to look out for in terms of how we may be feeling and some useful actions.

It provides time to come together to talk through the event and give initial support for staff. It also identifies who may benefit from starting the TRiM process.



The Coordinated support team is the initial and primary point of contact to assess support needs and coordinate support response, including TRiM.

coordinated.support@uhd.nhs.uk

8 Monitoring outcomes of PSIIs and PSRs

Robust findings from PSIIs and reviews provide key insights and learning opportunities.

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

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that any changes have measurably reduced risk of repeat incidents.

It is therefore proposed that programmed reports to the Board, Quality Committee and Clinical Governance Group will continue to include aggregated data on:

- patient safety incident reporting
- findings from PSIIs
- findings from PSR reviews
- progress against the PSIRP
- results of surveys and/or feedback from patients, families, carers on their experience of the organisations response to patient safety incidents
- results of surveys and/or feedback from staff on their experience of the organisations response to patient safety incidents

9 Complaints and appeals

Patient experience and feedback offer learning opportunities that allow us to understand whether our services are meeting the standards we set and are addressing our patients' expectations and concerns. We take all patient and stakeholder feedback very seriously, clearly identifying any lessons and using these to improve our service. We can collect learning and feedback from patient experience. These afford us greater insight into the provision of services in relation to our standards and patient expectations. Patient and stakeholder feedback is incredibly important and valuable in efforts to improve our service.

We report trends and emerging themes through our governance processes and, to widen the learning, we publish anonymised case examples on the trust website. With the implementation of PSIRP, we will continue to manage complaints in the usual way in accordance with trust policy and the NHS Complaint Regulations, in close consultation with the quality and risk teams to ensure repeated themes will come under a thematic review process.

If patients wish to make a complaint they can contact:

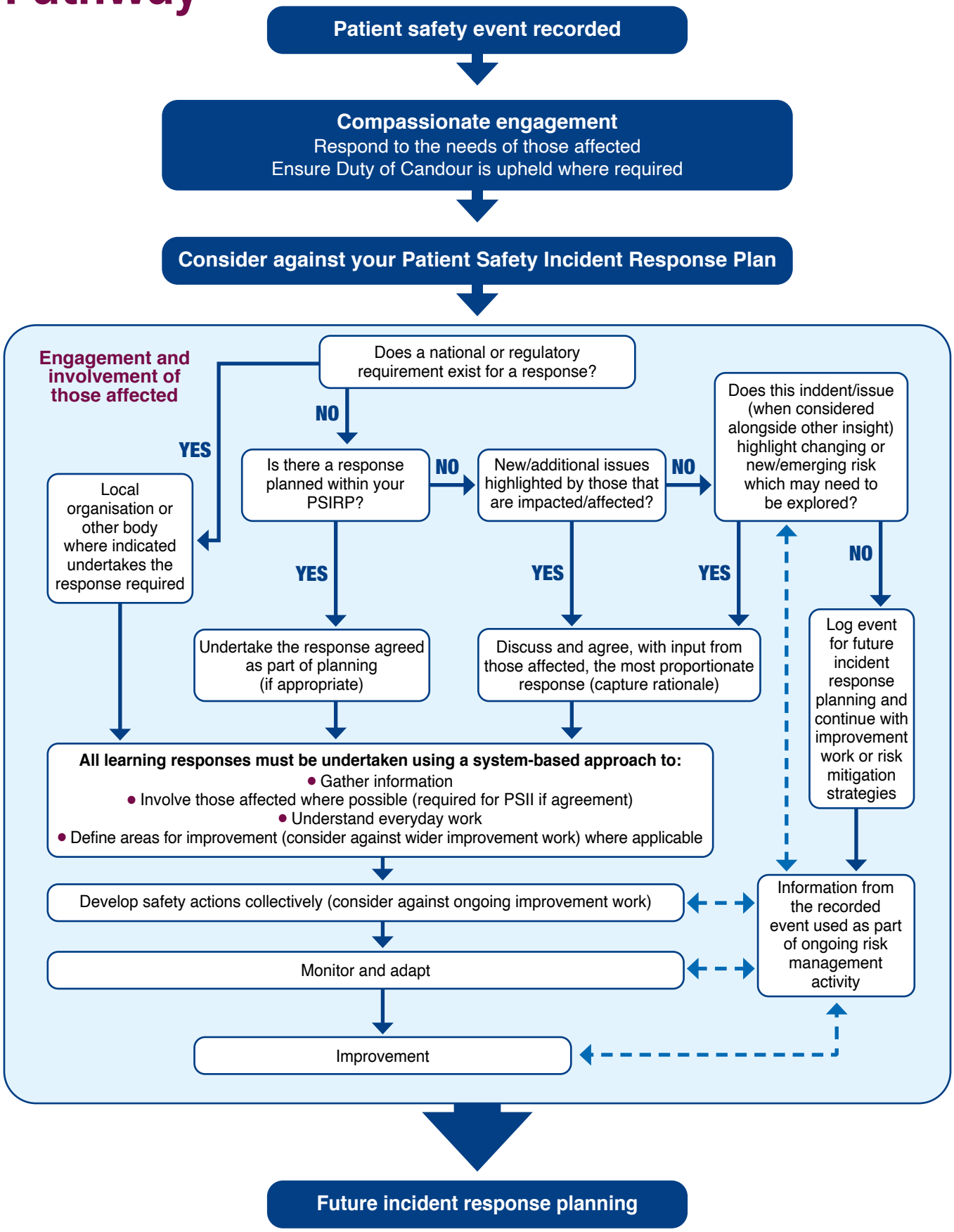
Patient experience team
University Hospitals Dorset
Longfleet Road
Poole
BH15 2JB

Telephone:
0300 019 8499

Email:
patientexperienceteam@uhd.nhs.uk

Appendix 1:

National Patient Safety Incident Response Pathway



Appendix 2:

Table of Resources

Item	Link/document
Improvement Science facilitates quality improvement Health Foundation (2011)	www.health.org.uk/publications/improvement-science
HSE (2014) Investigating Accidents	www.hse.gov.uk/pubns/books/hsg245.htm
Protocol for investigation and analysis clinical incidents	www.patientsafety.ucl.ac.uk/CRU-ALARMprotocol.pdf
CQC learning from SI incidents in NHS Acute Hospitals	www.cqc.org.uk/news/stories/care-quality-commission-reviews-how-nhs-acute-trusts-are-learning-serious-incidents
NHS (2018) The Future of NHS Engagement feedback	https://improvement.nhs.uk/resources/future-of-patient-safety-investigation
UHD Patient Satisfaction survey 2022/2023	
Organisational PSI Reports - UHD/other organisations tool	https://report.nrls.nhs.uk/ExplorerTool/Report/Default
NHSI patient safety reports	https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019
National PSII Standards	https://improvement.nhs.uk/resources/patient-safety-investigation
Each Baby Counts	www.hsib.org.uk/maternity
All cases of severe brain injury Early Notification Scheme	https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme
UHD Complaints Policy	
MBRRACE	www.npeu.ox.ac.uk/mbrrace-uk/faqs
Child Death review Statutory and operational Guidance	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf
Learning Disability Mortality Review (LeDer) Programme	www.bristol.ac.uk/sps/leder/notify-a-death
Managing Safety Incidents in NHS Screening incidents	www.screening.nhs.uk/incidents

Item	Link/document
Never Events NHSE 2018	https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018
NHSE Learning from Deaths Criteria	https://improvement.nhs.uk/resources/learning-deaths-nhs
UHD Medical Examiners Policy	
National archives Root Cause Analysis (RCA) investigation	https://webarchive.nationalarchives.gov.uk/20171030124348/http:/www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis
NHSE Safety Huddles	www.england.nhs.uk/atlas_case_study/improving-patient-safety-by-introducing-a-daily-emergency-call-safety-huddle
NHSE After Action review	https://improvement.nhs.uk/documents/2087/after-action-review.pdf
Study.com tool for chronological order definition	https://study.com/academy/lesson/what-is-chronological-order-definition-example.html
Prenatal Mortality Tool	www.npeu.ox.ac.uk/mbrrace-uk/pmrt
HOIP Clinical Audit	www.hqip.org.uk/wp-content/uploads/2018/02/developing-clinical-audit-patient-panels.pdf
NHSE Risk Assessment	Healthcare_Risk_Assess.pdf (mtpinnacle.com)
Staff support tools	coordinated.support@uhd.nhs.uk

Appendix 3:

Definitions of the National Learning Response Methods

Patient safety incident

A patient safety incident is any unintended or unexpected event (including omissions) in healthcare that could have or did harm one or more patients. This includes incidents related to direct care delivery and incidents relating to work systems that support care delivery. The incident may occur due to something that happened which should not have, or something that did not happen that should have and may or may not cause harm.

Work system

A work system comprises various components or inputs that interact with each other during a process for the purpose of delivering an intended outcome e.g., the delivery of safe and effective care with a good patient/family experience. A work system can include tools and technology, people, physical environments, external environments (such as regulation, societal and economic environments) and organisational factors (such as structures, culture, training, work schedules, resource availability).

Near miss

A near miss is an incident that very nearly happened that could have resulted in harm but did not do so due to chance, corrective action and/or timely intervention.

Never Event

Never Events are certain types of incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. NHS England maintains a list of incidents that are defined as Never Events on their website.

Incident leading to death thought more likely than not due to problems in care

An incident leading to death thought more likely than not due to problems in care is one that meets learning from deaths criteria for a patient safety incident investigation. More details are provided in the UHD Learning From Deaths Policy.

PSIRF Insight Review

A PSIRF Insight Review is a weekly meeting to review incidents that meet our local PSIRP priorities. The purpose of the meeting is to confirm incidents that meet the criteria for an enhanced learning response set out in the Patient Safety Incident Response Plan, and to consider other incidents of concerns escalated from care groups.

PSIRF Oversight Group

The PSIRF Oversight Group is a weekly meeting to gain assurance that UHD is learning from the patient safety incidents that meet the criteria for nationally or locally defined priorities as described in the UHD PSIRP.

Learning response

A learning response is a broad term for several ways in which an organisation can respond proportionately to recorded patient safety incidents for the purposes of learning and improvement. There are four nationally recognised enhanced learning responses in PSIRF:

- a patient safety incident investigation
- a swarm huddle(s)
- an after action review
- a multidisciplinary (MDT) review

Patient Safety Incident Investigation (PSII)

- A PSII is undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. Patient safety incident investigations (PSIIs) are conducted solely for the purpose of systems-based learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected contributory factors that may appear to be precursors to patient safety incidents. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Swarm huddle

Swarm huddles are used to identify learning from patient safety incidents. They are designed to start as soon as possible after a patient safety incident occurs and before those involved have finished their shift. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.

After Action Review (AAR)

An AAR is a method of evaluation used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

Multidisciplinary team (MDT) review

These support healthcare teams to:

- Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents).
- Agree, through open discussion, the key factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.
- Explore a safety theme, pathway, or process
- Gain insight into 'work as done' in a healthcare system.

We are #TeamUHD

University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East, Bournemouth, BH7 7DW
t: 01202 303626

Poole Hospital
Longfleet Road, Poole, BH15 2JB
t: 01202 665511

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX
t: 01202 486361

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