University Hospitals Dorset
NHS Foundation Trust

# Patient Safety Incident Response Plan 2026-2028

2nd edition

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

# Contents

# Introduction

The Patient Safety Incident Response Framework (PSIRF) outlines the NHS's approach to developing and maintaining effective systems for responding to patient safety incidents, with the ultimate goal of learning and improving patient safety.

Patient safety incidents are defined as **"Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm for one or more persons receiving healthcare."**

The PSIRF promotes a proportionate and balanced approach to incident response, ensuring that resources dedicated to learning are aligned with those required to drive meaningful improvement.

The principles and practices of the PSIRF are aligned with the NHS Patient Safety Strategy and its associated initiatives. Importantly, the PSIRF is not simply a rebranding of previous frameworks, it represents a fundamental shift in how the NHS approaches patient safety incident response. It is not a prescriptive investigation framework. Instead, it:

- Advocates for a coordinated, data-driven approach that prioritises compassionate engagement with those affected.
- Embeds incident response within a broader system of continuous improvement, supporting a cultural shift toward systematic patient safety management.

University Hospitals Dorset's (UHDs) commitment to this framework reflects our determination to learn from every event, prevent future harm, and continuously enhance the quality of care for all patients.

## Introducing Our Second Patient Safety Incident Response Plan

We are delighted to present our second Patient Safety Incident Response Plan. This document outlines our second plan, which sets out how we intend to respond to patient safety incidents over the next 18-24 months. This plan builds on the learning from our first PSIRP and aligns with the National Patient Safety Strategy and PSIRF.

Our priorities are clear:

- **Compassionate engagement** with patients, families, and staff
- **Sustainable improvements** that make care safer
- **Deeper insight** into systems to prevent harm

This plan is not fixed or inflexible. The Trust remains committed to adapting its approach based on the specific circumstances of incidents and the needs of those affected, ensuring a responsive and compassionate safety culture.

This plan should be read in conjunction with UHDs Patient Safety Incident Response Policy and NHS Patient Safety Incident Response Framework.

# Changes since our last Patient Safety Incident Response Plan

The key changes to the Trust's plan since our first plan in 2024 are:

- The focusing of efforts and resources on four patient safety priorities for learning and improvement.
- Updates to our learning response tools/templates including the addition of monitoring standards.
- Growth and development of our organisational structure and the role Care Groups now play in the overarching plan.
- Greater links to our Patient First Improvement methodology and our strategic themes, enabling programmes, accountability framework and strategic deployment review (SDR) process.
- Recognition of the importance of leadership and management behaviours and our people and culture strategy to support staff at all levels of the organisation.
- Changes to the NHS landscape and the role of the ICB in oversight of performance and patient safety. The development and importance of more internal rather than external oversight.

# Our Services

## Who we are

University Hospitals Dorset (UHD) is a leading integrated acute NHS Trust in the south west, bringing together the Royal Bournemouth, Poole, and Christchurch Hospitals.

- We serve over 750,000 local residents plus visitors, with one of the oldest populations in the UK
- We have almost 10,000 staff, and spend £900m
- We are part way through our £550m transformation programme
- Each year we assess around 160,000 patients in our Emergency Departments, help deliver more than 3,500 babies, perform over 98,000-day case treatments, and care for more than 635,000 people in our outpatient clinics
- We are one of largest hip and knee replacement centres in Europe
- We are the largest non-surgical cardiac centre in the UK
- We deliver the 14th highest number of cancer treatment pathways in England
- Over 3,900 of our patients have been recruited to 37 different research studies via our UHD Research Hub
- We support the training of 100s of students each year via partnerships with Bournemouth University and other local Higher Education Institutions

Over the next three years we will progress towards our goals. This will be assisted by working with partners to complete:

- Our service reconfiguration, delivering our planned and emergency hospitals.
- Our digital system upgrade by 2028

We will become a very different organisation, so we are taking time to review our long-term vision and work with patients, volunteers, public, staff and partners will develop the next chapter of our clinical strategy. This is informed by the government's 10 Year Health Plan for England which:

Describes the three major shifts needed in how we deliver healthcare:

- From hospital to community: more care will be available on people's doorsteps and in their homes.
- From analogue to digital: new technology will liberate staff from administrative tasks and allow people to manage their care as easily as they bank or shop online.
- From sickness to prevention: the NHS will reach patients earlier and make the healthy choice the easy choice.

# Strategic aims

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 five 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 away from trying to do too many things, and towards working together on fewer improvement goals and doing them well - with the patient at the heart of everything we do.

# Defining our Patient Safety Profile

One of the core principles of the Patient Safety Incident Response Framework (PSIRF) is to conduct fewer investigations but to do them better. “Better” means taking the time to carry out thorough, systems-based reviews led by individuals who are appropriately trained. There are multiple ways to respond to a patient safety incident, and this plan, alongside associated policies and guidelines, outlines how these responses are structured and implemented. The PSIRF emphasises the importance of robust support systems for both staff and patients involved in safety incidents. Central to this is the cultivation of a psychologically safe culture, reflected in our leadership, trust-wide strategy, and reporting mechanisms. Importantly, the PSIRF does not seek to assign blame, determine liability, assess preventability, or establish cause of death. Its sole purpose is to support learning and improvement. As such, it does not encompass reviews related to complaints, HR processes, legal claims, or inquests. This plan defines the scope of a systems-based approach to learning from patient safety incidents. Incidents selected for review will be identified through a combination of nationally and locally defined patient safety priorities, with further detail provided later in this document.

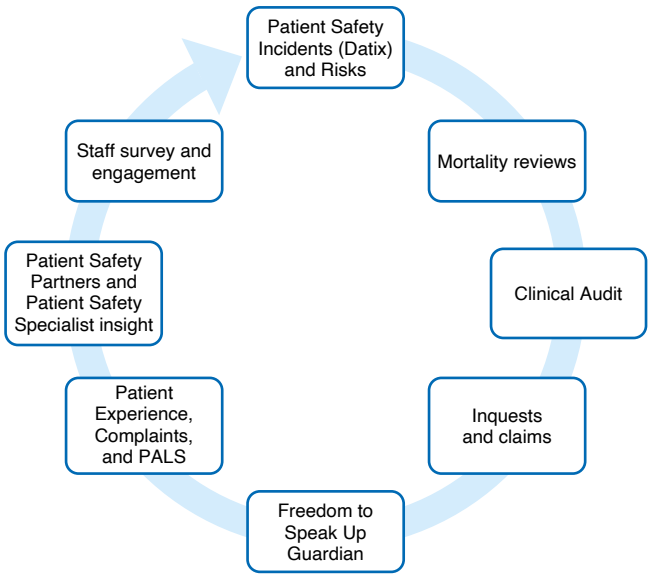
To define our patient safety incident profile, we asked ourselves **“what are the main issues/incident types that need to be better understood (from a systems perspective) to support the delivery of system improvement”**

The development of our patient safety profile has been a collaborative process over two stages; data analysis and engagement and consultation.

## What the data tells us:

Over the past two years, we have significantly deepened our understanding of how to implement the Patient Safety Incident Response Framework (PSIRF) effectively and apply proportionate learning responses. This evolving insight has been shaped not only by our own experiences but also by the integration of a broader spectrum of patient safety intelligence extending beyond incidents involving severe harm or death.

To support this, the Trust has profiled patient safety incident risks using a combination of organisational data, incorporating both qualitative and quantitative sources:



# What our stakeholders told us


We undertook a comprehensive engagement process to inform the development of the PSIRP. This included facilitating a PSIRP development workshop, presenting at relevant governance forums, and disseminating surveys to key stakeholders. We are fortunate at UHD to work alongside four Patient Safety Partners (PSPs) - volunteers with lived experience as patients, carers or service users who collaborate with staff to strengthen patient safety. PSPs contribute their perspective to safety committees, governance, investigations and quality-improvement work, helping ensure services are shaped by patient experience and insight. As part of this process, our PSPs reviewed and provided valuable feedback that directly informed and strengthened this plan.

The priorities emerging from our analysis reinforce long-standing trends observed in patient safety incident reporting and areas with the greatest opportunities for learning and improvement. As locally defined priorities, the PSIRF enables us to focus on these risks through a structured framework for patient safety incident responses. Through this data-driven approach, we have identified the current top patient safety issues across the organisation, which will inform our learning responses and improvement strategies for the year ahead.

As a result of the analysis undertaken and stakeholder engagement, the high level themes identified to focus on over the next 18-24 months are:

| Incident type | |
|---|---|
| Recognition and escalation of the deteriorating patient | Recognition and escalation of the deteriorating patient is a key patient safety priority because timely identification and response to early signs of deterioration significantly reduces avoidable harm, improves outcomes, and supports safe, effective care. We aim to strengthen the reliability of observations, ensure prompt escalation when concerns arise, improve communication between teams and with patients, and build staff confidence through training and clearer processes, helping us deliver faster intervention, reduce emergency deterioration events, and improve patient experience and recovery. |
| Cross site transfer and handover | Cross site transfer and handover has been chosen as a patient safety priority as we enter into a period of transformation, creating an acute site at RBH and elective site at Poole. Moving patients between hospital sites is a point of increased risk, where delays, missed information or unclear responsibility can affect care. We are strengthening and standardising our transfer and handover processes to ensure information is reliably shared, patients are monitored appropriately throughout their journey, and receiving teams are fully prepared. Our aim is to make every transfer safe, well-coordinated and centred on a positive patient experience. |
| Care in non-clinical areas/ ‘corridor care’ | Providing care in non-clinical areas, such as corridors or waiting spaces, carries clear risks to patient safety, dignity, and timely clinical monitoring. By making this a priority, we are committed to reducing the need for such areas, ensuring patients are cared for in environments designed to support safe assessment and treatment. Our improvements focus on strengthening oversight and visibility of patients, enhancing privacy and essential equipment provision where temporary use is unavoidable, and tackling the wider flow and capacity challenges. |
| Medication relating to discharge | Making sure patients receive and use their medicines safely when leaving the hospital is important. When care changes from one place to another, mistakes can happen because details about medicines may be missing or incorrect. Studies show that unclear communication between hospitals, GPs, and community services can lead to preventable problems, confusion about prescriptions, and unexpected returns to the hospital. We aim to give clear medication information, encourage teamwork among healthcare providers, and help patients understand and use their medicines safely after discharge. |

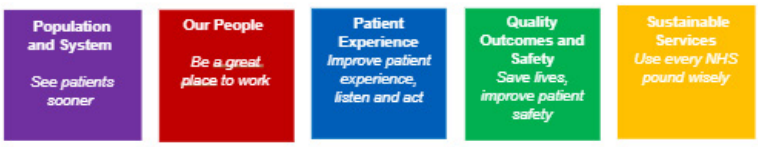
# Defining our Patient Safety Improvement Profile

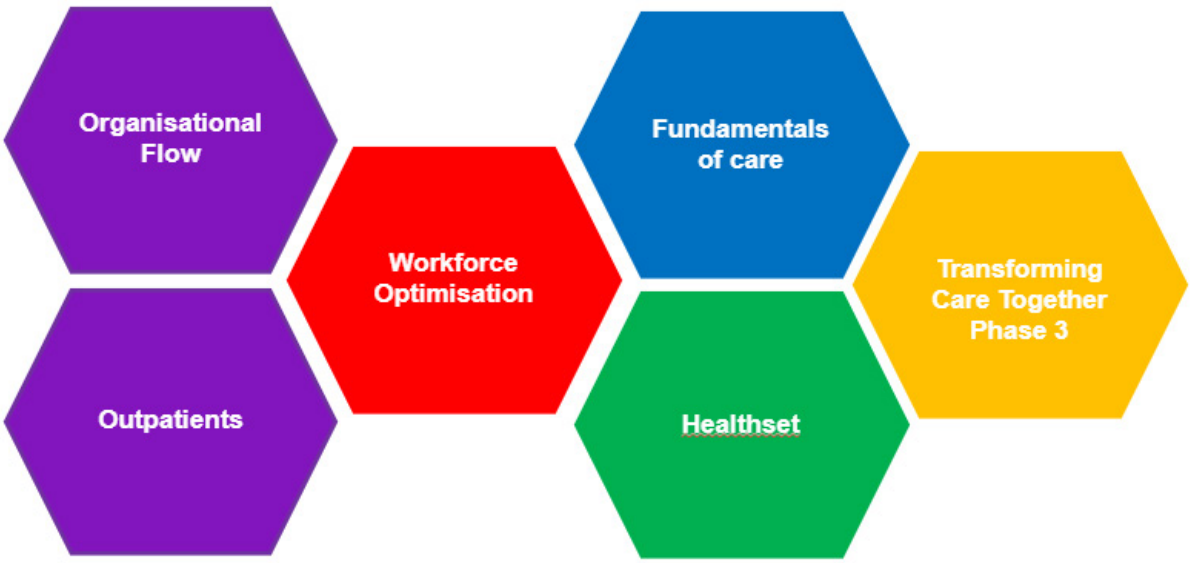
| Patient safety theme(s) | Group/committee(s) with responsibility for improvement delivery |
|---|---|
| Falls | Falls Steering group |
| Pressure Ulcers | Pressure Ulcer Prevention Steering Group |
| VTE prevention | Thrombosis Group, Medicines Optimisation Group |
| Mental Health | Mental Health Steering Group |
| Deteriorating patient - including sepsis, AKI, fluid management, resuscitation and Martha's Law | Deteriorating patient Steering group |
| Learning from Deaths | Mortality Surveillance Group |
| Term admissions to Neonatal Unit | ATAIN Group<br>Maternity and Neonatal Governance Group<br>Maternity and Neonatal Safety Champions |
| Postpartum Haemorrhage | Maternity and Neonatal Governance Group<br>Maternity and Neonatal Safety Champions |
| Stillbirth | Maternity and Neonatal Governance Group<br>Maternity and Neonatal Safety Champions |
| Medicines management | Medicines Optimisation group |
| Blood transfusion safety | Hospital Transfusion group |
| Infection Prevention and Control - e.g. MRSA, MSSA, E.coli C.difficile, Water safety | Infection Prevention and Control Group |
| Medical gas safety | Medical Gases Group, Medicines Optimisation Group |
| Recognition and management of the dying | End of Life Group |
| Radiation - Ionising and Non-Ionising | Radiation Protection Group |
| Nutrition and hydration | Nutrition Steering group |
| Medical equipment | Medical Devices Group |
| IT systems and processes | Digital Governance Group |

# Improvements at UHD

UHD 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 the key programmes as an example of this work.

## Corporate Projects 2026/27



# How we will respond to Patient Safety Events

Given that the Trust has finite resources for patient safety event response, we intend to use those resources to maximise improvement. PSIRF enables us to use this resource to focus on improvement, rather than repeatedly responding to and reviewing patient safety events based on thresholds and definitions of harm that can often be subjective. This is important as reviewing a number of similar events will result in very limited new learning, whereas focusing on improving systems, including those that impact on the wider Trust will bring greater benefits for patients and staff.

## Learning Responses

A learning response is used when the contributory factors behind a patient safety incident are not yet well understood, or when existing improvement work is unlikely to address the issue effectively. This approach helps the organisation fully explore the context, system influences, and underlying factors that contributed to the incident.

Learning responses are particularly valuable for new, emerging, or escalating patient safety concerns that have not previously been examined in depth. They may be applied to a single incident or to a cluster of related incidents.

## Improvement Responses

An improvement response is appropriate when the safety issue is already well understood, for example where previous learning responses or investigations have been completed. If improvement actions are in place - and their effectiveness is being monitored - it is more beneficial to focus resources on delivering and strengthening those improvements rather than undertaking further learning responses.

In these cases, an improvement response is used. This still requires the Trust to follow compassionate engagement principles and maintain open communication, but a new learning response is not required because the underlying system issues are already known.

# Systems based approaches

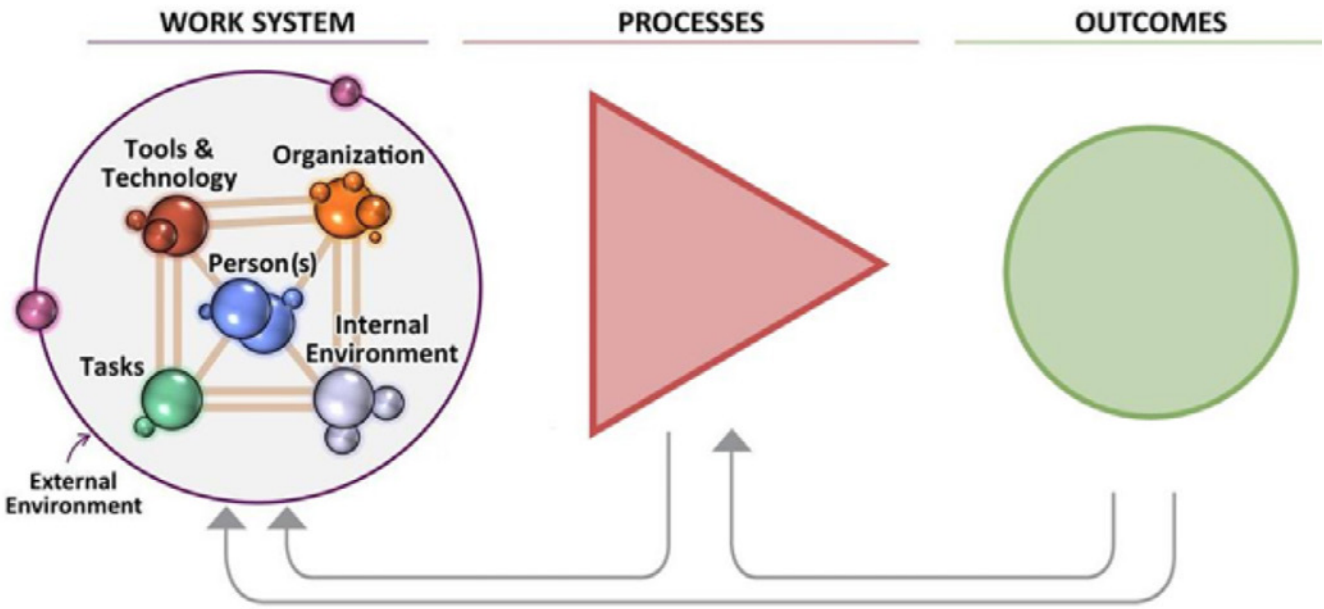
At UHD, we recognise that safety incidents rarely result from the actions of one individual. A systems based approach helps us understand the complex set of factors that shape care in our hospitals.

A system based approach to learning looks at all the components within a work system, including people, tasks, tools and technologies, the environment, and the wider organisation. It helps us understand how these elements interact, influence one another, and collectively contribute to patient safety outcomes.

The systems-based methodology adopted at UHD is System Engineering Initiative for Patient Safety (SEIPS).

A system-based approach also acknowledges that outcomes in complex systems are shaped by lots of contributory factors, not by a single 'root cause'. Therefore, learning responses to patient safety incidents aim to explore this wider context to understand the full picture rather than attempt to attribute blame or identify a singular cause.

By using a range of structured system-based tools and templates we can identify where changes are needed within the system, make improvements that address the real issues, monitor these issues over time and strengthen patient safety across the organisation.



| Method | Description |
|---|---|
| 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 reviewed and potential areas for improvement within the Trust's systems and processes are identified. A PSII can also take the form of a thematic analysis. A PSII can take up to six months to complete. |
| After Action Review (AAR) | AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions:<br>• What was the expected outcome/expected to happen?<br>• What was the actual outcome/what actually happened?<br>• What was the difference between the expected outcome and the event?<br>• What is the learning? |
| Multidisciplinary Team (MDT) Review | An MDT review helps teams learn from patient safety incidents that happened some time ago, or where staff recollections are harder to gather due to the passage of time or staff availability. Through open discussion - supported where needed by observations and walk-throughs carried out before the review meeting - the aim is to identify the main contributory factors and system gaps affecting safe patient care. |
| Swarm Huddle | The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future. |

In addition to our systems-based investigation tools, we have developed a suite of structured templates to support memory capture and event specific learning including:

- Hot debrief
- Reflection tools
- Case-note review including timelines
- Falls Swarm
- Pressure Ulcer Event Review
- Medication Safety Event Review

All of the tools are available to staff on the PSIRF pages of the Trust intranet.

The learning identified from patient safety events will be incorporated into the electronic incident record for organisational learning and ongoing improvement.

During 2026-2028, we will continue to strengthen staff capability and confidence in applying systems based approaches through structured training, targeted support, and clear guidance.

# How we will respond to National Priorities

Certain 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. Please refer to the Guide to responding proportionately to patient safety incidents for the full list of national priorities.

The table below provides a summary of the guidance on nationally mandated responses to specific categories of events. It clarifies whether the required response should be a PSII or another type of action, such as referring the event to an external organisation for management. This ensures that each event is handled appropriately, in line with national expectations, and supports consistent, effective responses across the healthcare system.

PSIRF enables organisations to focus on patient safety incidents most relevant to their context and the populations they serve. Based on our analysis, the Trust has identified four key patient safety priorities. With limited resources, our goal is to maximise improvement by moving away from reactive responses based on subjective harm thresholds and approaches that often yield limited new learning. Instead, we will apply a targeted, systems-based approach, examining the complex factors behind incidents. Insights from these learning responses will directly inform our patient safety improvement planning, ensuring our efforts are strategic, impactful, and aligned with Trust priorities.

# How we will respond to patient safety incidents

Patient Safety Event Occurs

Patient Safety Incident Investigations

| | Event | Approach | Improvement |
|---|---|---|---|
| National Priorities | Incidents meeting 'each baby counts' criteria | Refer to Maternity and Newborn Safety Investigation (MSNI) | Respond to recommendations from external referred agency/organisation as required |
| | Incident meeting maternal death criteria | | |
| | Child death | Initiate child death review process | |
| | Death of a person with learning disabilities | Initiate Learning Disability Mortality Review (LeDeR) | |
| | Safeguarding incidents meeting criteria | Refer to UHD's safeguarding lead | |
| | Incidents in screening programmes | Refer to 'Managing Safety incidents in NHS screening programmes' guidance | |
| | Death of patients in custody/prison/probation | Local learning response to support external investigation | |
| | Incidents meeting the Never Event Criteria | Incidents meeting the Never Event Criteria | Create local organisational recommendations and actions and incorporate insights into ongoing improvement plans |
| | Deaths thought more likely than not due to problems in care | Local learning response to support external investigation | |
| Trust Priorities | Patient Safety Priority:<br>• Recognition and escalation of the deteriorating patient<br>• Cross site transfer and handover<br>• Care in non-clinical areas/ "corridor care"<br>• Medication relating to discharge | Proportionate learning response - SWARM, After Action Review, MDT review or PSII | Create local organisational recommendations and actions feeding into patient safety priorities improvement programmes |

# How we will respond to Local Priorities

| Safety Challenge | Learning response | Improvement response and monitoring group |
|---|---|---|
| Recognition and escalation of the deteriorating patient | • Immediate safety actions<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>Discussion at rapid review/PSIRF Insight to agree proportionate learning response.<br>A thematic review will be undertaken to identify the contributing factors and inform the improvement plan. | Apply the Trustwide Patient First approach.<br>Implement recommendations and actions from the thematic review and incorporate insights into ongoing improvement plans.<br>Oversight at Deteriorating Patient Steering Group and PSIRF Oversight. |
| Cross site transfer and handover | • Immediate safety actions<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>Discussion at rapid review/PSIRF Insight to agree proportionate learning response.<br>A thematic review will be undertaken to identify the contributing factors and inform the improvement plan. | Apply the Trustwide Patient First approach.<br>Implement recommendations and actions from the thematic review and incorporate insights into ongoing improvement plans.<br>Oversight at steering group (to be established) and PSIRF Oversight. |

| Safety Challenge | Learning response | Improvement response and monitoring group |
|---|---|---|
| Care in non-clinical areas/ 'corridor care' | • Immediate safety actions<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>Discussion at rapid review/PSIRF Insight to agree proportionate learning response.<br>A thematic review will be undertaken to identify the contributing factors and inform the improvement plan. | Apply the Trustwide Patient First approach.<br>Implement recommendations and actions from the thematic review and incorporate insights into ongoing improvement plans.<br>Oversight at steering group (to be established) and PSIRF Oversight. |
| Medication relating to discharge | • Immediate safety actions<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>Discussion at rapid review/PSIRF Insight to agree proportionate learning response.<br>A thematic review will be undertaken to identify the contributing factors and inform the improvement plan. | Apply the Trustwide Patient First approach.<br>Implement recommendations and actions from the thematic review and incorporate insights into ongoing improvement plans.<br>Oversight at steering group (to be established) and PSIRF Oversight. |

UHD considers all the event types listed above to be relevant across the organisation. As such, this document serves as a Trust-wide PSIRP, and no separate plans have been developed for individual specialties

In addition to the new priorities identified in this plan, we will continue to learn from events that remain known safety challenges as shown below:

| Safety Challenge | Learning response | Improvement response and monitoring group |
|---|---|---|
| Inpatient Falls | • Immediate safety actions<br>• Post falls checklist and huddle<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• LERN review and triage<br>If patient safety concern is highlighted and/or patient sustains a fracture or serious head injury:<br>• Falls SWARM | • Local Patient First improvement process<br>• Dashboard to review themes<br>• Oversight at Falls steering group |
| Pressure Ulcers | • Immediate safety actions<br>• Compassionate engagement/ Duty of Candour (DoC)<br>• Pressure ulcer checklist<br>• LERN review and triage<br>If patient safety concern is highlighted or the Pressure ulcer is graded as 'hospital acquired' and category 3 or above:<br>• Pressure Ulcer Event Review<br>• Discussion at rapid review/PSIRF Insight to agree proportionate learning response if required | • Local Patient First improvement process<br>• Dashboard to review themes<br>• Oversight at Pressure ulcer prevention steering group |
| Healthcare Associated Infections such as: MRSA, MSSA, *E.coli, Klebsiella, Pseudomonas or C.difficile*. | • Immediate safety actions<br>• Compassionate engagement/DoC<br>• LERN review<br>• LERN review and triage<br>If hospital acquired MRSA or patient safety concern for any of the organisms is highlighted:<br>• After Action Review<br>• PSII to be undertaken if trend data and thematic review identifies the need for in depth system analysis for additional learning and improvement | • Local Patient First improvement process<br>• Dashboard to review themes<br>• Oversight at Infection Prevention and Control Group |

| Safety Challenge | Learning response | Improvement response and monitoring group |
|---|---|---|
| Post-Partum Haemorrhage (PPH) (in excess of 1.5L requiring activation of Massive Obstetric Haemorrhage (MOH) protocol | • Immediate safety actions and staff support (e.g. hot debrief/TRiM)<br>• Compassionate engagement/DoC<br>• LERN review and triage<br>• PPH review via UHD's PPH Microsoft forms | • Local Patient First improvement process<br>• Dashboard to review themes<br>• Oversight at Maternity and Neonatal Governance Group<br>• Oversight at Maternity and Neonatal Safety Champions |
| Unexpected term admission to neonatal intensive care (NICU) | • Immediate safety actions and staff support (e.g. hot debrief/ TRiM)<br>• Compassionate engagement/ DoC<br>• Individual LERN review of the event and triage by lead for the area<br>• Case presentations reviewed at monthly ATAIN meetings<br>If patient safety concern is highlighted:<br>• Discussion at rapid review/PSIRF Insight to agree proportionate learning response if required | • Review at ATAIN (avoiding term admission into neonatal unit) improvement programme<br>• Oversight at ATAIN Group<br>• Oversight at Maternity and Neonatal Governance Group<br>• Oversight by Maternity and Neonatal Safety Champions |
| Stillbirth | • Immediate safety actions and staff support (e.g. hot debrief/TRiM)<br>• Compassionate engagement/ DoC<br>• Immediate individual event review<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>• Discussion at rapid review/PSIRF Insight to agree proportionate learning response if required | • Local Patient First improvement process<br>• PMRT programme to review themes<br>• Oversight at Maternity and Neonatal Governance Group<br>• Oversight at Maternity and Neonatal Safety Champions |
| Medication incident | • Immediate safety actions<br>• Compassionate engagement/ DoC<br>• LERN review and triage<br>If patient safety concern is highlighted:<br>• Medication safety event review<br>• Discussion at rapid review/PSIRF Insight to agree proportionate learning response if required | • Local Patient First improvement process<br>• Dashboard to review themes<br>• Oversight at Medication Optimisation Group |

# Compassionate Engagement and Involvement of Patients, Families and Staff in Patient Safety

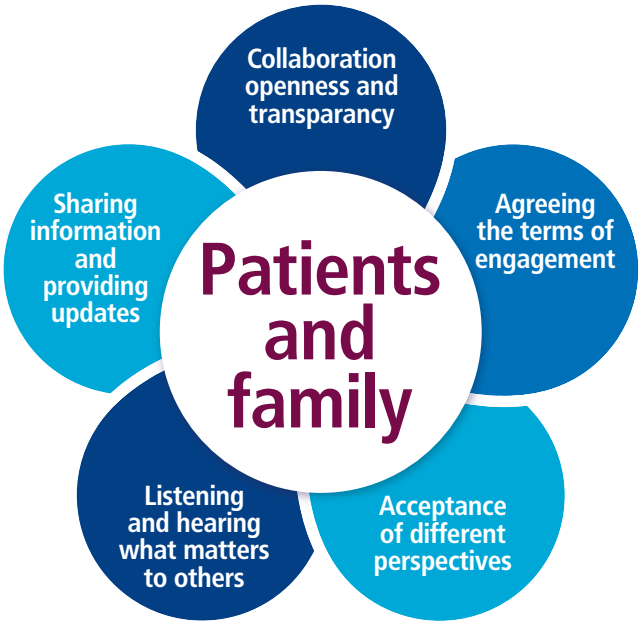
We understand that patient safety incidents can have a significant impact on patients, families, carers and everyone involved. It is important that we respond openly and supportively, and that patients and families are included at every stage in line with our 'Duty of Candour'.

Patients, service users and families should have the process clearly explained to them and be offered meaningful opportunities to take part. We know that every situation is different, so our approach will always be flexible and based on individual needs.

In line with our Trust values, we have clear guidance to help our staff talk with patients, service users and families when an incident occurs. Patient and their family members' voice is essential. Hearing directly from patients and their families helps us understand what happened, learn from the event and make improvements to reduce the chance of similar incidents in the future. Being involved can also support understanding, recovery and closure.

Patient and family involvement begins early in the learning response process. This gives the chance to ask questions, share concerns and understand what will happen next, including the type of learning response and the expected timelines.

If a Patient Safety Incident Investigation (PSII) is started, a Patient Safety Investigator and Liaison Lead will be assigned to support the patient or family, guide them through the process and ensure they are involved in a way that works for them.



# Supporting Staff

At University Hospitals Dorset, we recognise that patient safety events can have a profound emotional and practical impact on the staff involved. Our commitment is to respond in a way that is fair, compassionate and grounded in learning. We know from national evidence that creating an open, supportive culture improves staff wellbeing and leads to safer care for our patients.

When an incident occurs, our focus will be on understanding what happened, not assigning blame. The NHS Resolution Just and Learning Culture Charter makes clear that most things that do not go to plan arise from unintentional acts within complex systems, and that organisations should respond by prioritising learning and improvements rather than punitive measures. In line with this, we will ensure staff are supported to speak openly about their experiences and that they feel safe to raise concerns, contribute to learning and ask for help.

We are committed to providing timely, compassionate support for all staff involved in patient safety events. This includes access to wellbeing resources, Occupational Health support, and psychologically safe spaces to debrief.

If a patient safety investigation is required, it will be conducted with fairness, transparency and care. We will ensure staff understand the process, are treated with dignity, and have access to appropriate advice and support.

Finally, our approach places learning at the heart of our response. Staff, patients and families affected by an incident will be engaged in understanding what could be done differently in future, and their voices will help shape improvements to our systems and care processes.

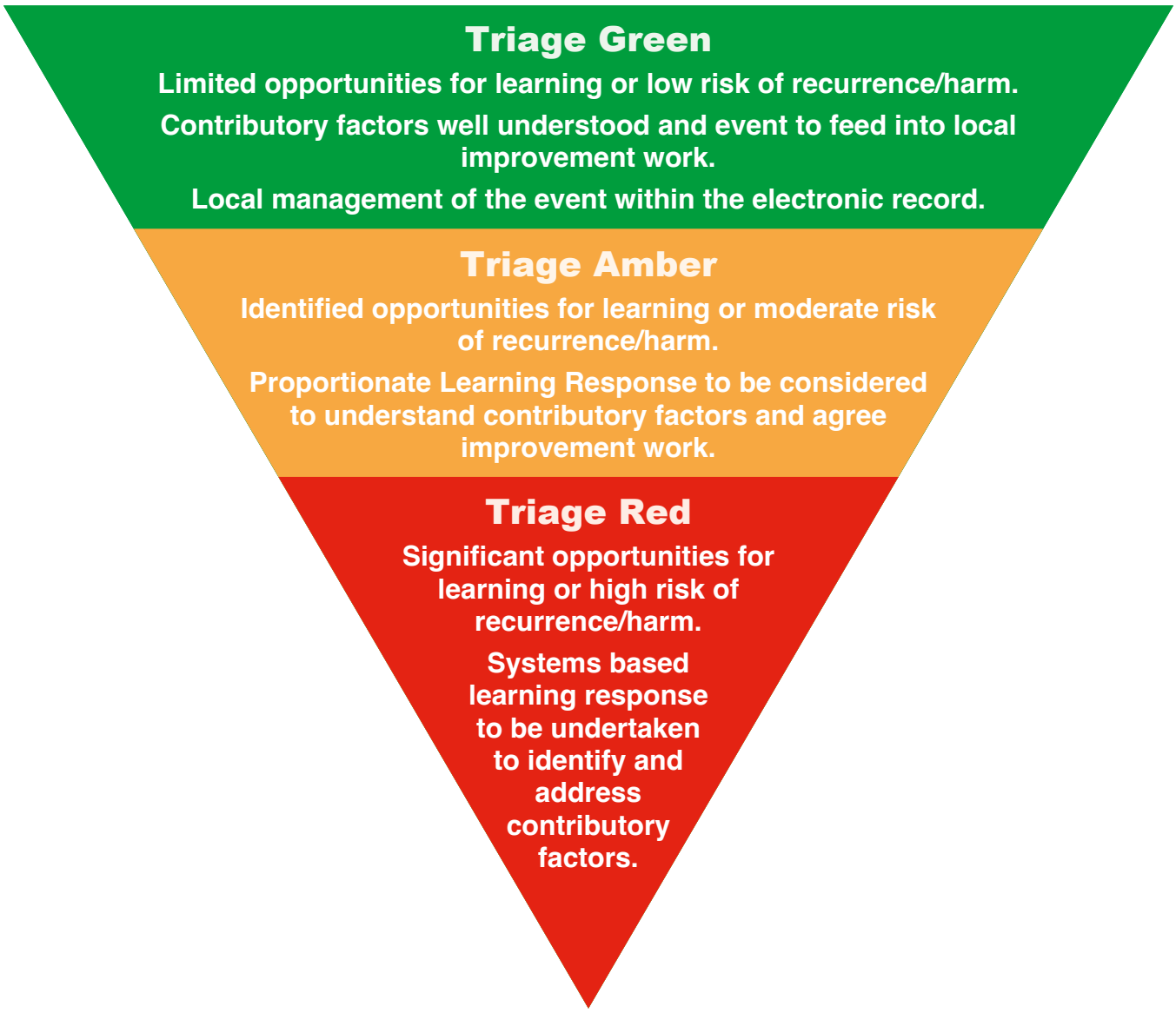
# Oversight of compassionate engagement

| | Minimum standards | Monitoring |
|---|---|---|
| **Patient engagement** | • Patient informed that a patient safety event has occurred timely and compassionately<br>• Apology provided<br>• Patient/family questions incorporated into learning response<br>• Provide patient/family with support including leaflet<br>• Duty of Candour letter (if required) is attached to the LERN<br>• Outcome letter (if required) is attached to the LERN | Audit against NHSE engagement principles.<br>Duty of candour compliance BI tool.<br>Quality audit of duty of candour letters.<br>Learning response checklist (audit) confirming engagement within learning responses.<br>Direct patient/family feedback after completion of learning response. |
| **Staff engagement** | • Compassionate leadership behaviours are defined and expected<br>• Psychological safety and welfare checks are routine after incidents<br>• Fair, transparent, evidence based incident processes<br>• Equity and inclusion embedded in post incident support<br>• Open, timely communication with staff throughout | Wellbeing metrics - sickness/ absence, Occupational health referrals, national and local (people pulse) staff survey.<br>Cultural intelligence - Freedom to speak up data.<br>Quality measures - timeliness, staff involvement, compassionate practice.<br>Learning and improvement measures- actions implemented, thematic learning shared.<br>Direct staff feedback after completion of learning response. |

# Delivering Proportionate Responses

To support the proportionate use of learning and improvement resources, a structured triage process has been developed, as outlined below. Decisions regarding the need for further review of an event are based on the potential for system-wide learning and the assessed level of risk-taking into account both likelihood and potential severity- rather than the level of harm experienced in the index patient safety event.

Events triaged as Amber or Red will undergo a structured and proportionate learning response to develop a clearer understanding of what happened, why it occurred, and where opportunities for improvement exist. If, following completion of a learning response, it is determined that additional insight is required, an alternative systems based learning response methodology may be selected to further enhance organisational learning.



# Oversight of proportionate response

| | Minimum standards | Monitoring |
|---|---|---|
| **Triage** | All events that result in patient harm are triaged to identify opportunities for learning.<br>All events that are triaged amber or red have a learning response agreed.<br>When a learning response is agreed, it will be completed and uploaded to the LERN. | Datix dashboard to provide assurance that all events of harm are triaged.<br>Audit to provide assurance that all LERNs triaged amber or red have a learning response uploaded within 8 weeks (unless PSII)- results presented to PSIRF Oversight Group.<br>Learning shared at Care Group Quality and Safety meetings. |
| **System based learning** | A range of learning responses are available, and all events triaged Amber or Red will have a learning response completed and uploaded to the LERN.<br>On completion of the learning response, the 'investigator' will assess whether all the contributory factors have been identified or whether a further learning response is required.<br>The learning response will be reviewed and signed off by the directorate or care group leadership team. | Audit to provide assurance that all LERNs triaged amber or red have a learning response uploaded within 8 weeks (unless PSII)- results presented to PSIRF Oversight Group.<br>Quarterly audit to provide assurance that response was proportionate.<br>Learning response checklist quality audit to include 'sign off'. |
| **Action and improvement** | Actions are written in a SMART format.<br>Actions are completed within the timeframe set.<br>Actions relate to improvement and include how the improvement will be monitored.<br>Evidence of action completion is uploaded to the LERN. | BI tool of action completion.<br>Bi-annual audit of actions. |

# Oversight of systems-based learning

| Response | Minimum standards | Monitoring |
|---|---|---|
| **PSII** | Completed by trained Patient Safety Investigator.<br>Completed within 6 months.<br>Patient/family questions documented and responded to in report.<br>SEIPS model completed Recommendations identified. | PSII Checklist completed.<br>Sign off by Care Group.<br>Sign off by Exec.<br>Report presented to PSIRF Oversight .<br>Post event review follow up of action plan. |
| **AAR/MDT** | Completed within 30 days.<br>Standard template used.<br>Actions identified.<br>Evidence of Patient/family engagement/ questions included.<br>Evidence of staff involved engagement/ questions included.<br>Document uploaded to Datix. | Quarterly audit of 20% of completed AARs/ MDTs by Patient Safety Team.<br>Results presented to PSIRF Oversight Group. |
| **Local learning response e.g. Swarms, pressure ulcer event review** | Completed by ward/dept.<br>Actions/learning identified and documented on Datix record.<br>Closed within 30 days. | Open LERNS reviewed monthly as part of care group Quality and Safety meeting. |

# Our Capacity and Capability to Learn from Safety Incidents

To effectively deliver the Patient Safety Incident Response Framework (PSIRF), University Hospitals Dorset (UHD) has invested in the development and training of staff to ensure high quality learning responses and robust patient safety investigations. The Patient Safety Team leads and delivers the organisation's comprehensive training programme, supporting a consistent and skilled approach to safety management.

UHD has dedicated the following substantive resources to patient safety, aligned with our commitment to culture change and continuous improvement:

- **1.0 WTE Head of Patient Safety and Risk**
- **1.2 WTE Patient Safety Investigation and Liaison Leads**
- **2.0 WTE Patient Safety Facilitators**
- **2.0 WTE Patient Safety Coordinators**
- **3.0 WTE Patient Safety Administrators**

In addition to the core team, UHD benefits from the expertise and support of two Patient Safety Specialists and four Patient Safety Partners, strengthening co production, learning and system insights across the organisation.

Alongside our internal training programme, UHD has fully implemented the NHS England Patient Safety Syllabus Level 1, which forms part of the Trust's mandatory training requirements, ensuring all staff have a foundational understanding of modern patient safety principles.

Looking ahead to 2026–2028, UHD will undertake a full refresh of the Patient Safety Curriculum. This work will ensure all training offers remain aligned with PSIRF, national requirements, and emerging best practice.

The following training sessions complement other UHD training and development offers.

| NHS Patient Safety Syllabus | Training offer | Target Audience |
|---|---|---|
| Level 1 | Essentials for Patient Safety. | All staff- mandatory |
| Level 1+ | Essentials of patient safety for boards and senior leadership teams. | Board members- mandatory. |
| Level 2 | Patient Safety Access to Practice. | Clinical staff. |
| PSIRF Learning Response training | Face to face session providing a concise overview of PSIRF, compassionate engagement, system based learning (including SEIPS), proportionate learning responses, and the development of effective safety actions to support continuous safety improvement. | Staff with responsibilities in patient safety, incident response or safety improvement. |
| Patient and family engagement (Duty of Candour) training | Face to face training providing staff with the knowledge, skills, and confidence to deliver open, compassionate communication following patient safety incidents, including duty of candour regulations and requirements. | All staff involved in communicating with patients and families after a patient safety incident, as well as those who support the learning and improvement process. |
| LERN reporting training | Face to face training on how to record high quality, accurate incident reports that support patient safety learning. | All staff. |
| LERN reviewing training | Face to face training on how to review incidents including themes and trends, triage opportunities for learning and selecting proportionate learning responses. | Staff with responsibilities in patient safety, incident response or safety improvement. |

Oversight is conducted through the analysis of Electronic Staff Record (ESR) training data.

# Delivering Supportive Oversight

Oversight at UHD is centred on engagement and empowerment rather than traditional command and control approaches. UHD is working with the integrated care board (ICB) and regulators to design an oversight system that demonstrates improvement rather than simple compliance with prescribed measures. Oversight of our systems and standards is led by the Chief Nursing Officer and set out in the Patient Safety Incident Response Policy.

## Governance and escalation

### Care Group rapid review/Governance

**Role:** Local oversight, delivery and assurance.

**Responsibilities:**

- Ensure incidents are reported, screened and triaged in line with the Trust's PSIRP
- Support proportionate, system-based learning responses
- Monitor completion and quality of investigations; ensure learning actions are realistic and owned locally
- Escalate significant risks or themes to PSIRF Insight / Oversight Groups
- Ensure staff engagement and provide protected time for safety activities
- Report assurance and exceptions upward into the Clinical Governance Group/PSIRF Oversight

**Escalation:** PSIRF Insight or Clinical Governance Group. Care group compliance via PSIRF oversight.

### PSIRF Insight

**Role:** A trust wide group focused on generating and interpreting patient safety insights and supporting proportionate responses to events.

**Responsibilities:**

- Review the evidence that has been gathered thus far and collaboratively make decisions regarding potential PSIIs
- Supports care groups to determine type of learning response as required
- Analyse aggregated incident data to identify themes and systemic contributors
- Pull insights from qualitative sources (family interviews, staff experience, complaint correlations)
- Review outputs of learning responses and consider if further methodology is needed to gain deeper learning
- Escalate system wide learning

**Escalation:** PSIRF Oversight.

## PSIRF Oversight

**Role:** Trust wide monitoring and improvement. Provides formal oversight of PSIRF delivery across UHD, ensuring the response system is functioning safely, proportionately and consistent with the national framework.

**Responsibilities:**

- Provide supportive oversight of the whole incident response system, not individual incidents
- Monitor adherence to the PSIRP and national PSIRF policy requirements
- Review assurance on:
  - timeliness and appropriateness of response types
  - quality of investigations
  - learning implementation and evaluation
- Ensure a balanced performance picture using multiple data sources
- Escalate risks, resource gaps or repeated safety concerns to the Clinical Governance Group or Quality Committee

**Escalation:** Clinical Governance Group (CGG).

## Clinical Governance Group (CGG)

**Role:** Receives escalations from operational governance and acts as the Trust-wide assurance body for clinical quality, including PSIRF.

**Responsibilities:**

- Provide assurance that PSIRF is embedded into clinical governance systems and is functioning effectively across the Trust
- Review high-level trends, themes and improvement plans generated through the PSIRF Insight and Oversight Groups
- Ensure alignment to broader quality governance (risk, audit, compliance)
- Approve Trust-wide patient safety improvement priorities informed by PSIRF insights
- Escalate significant risks and assurance gaps to the Quality Committe

**Escalation:** Quality Committee.

## Quality Committee

**Role:** Provides independent, Non Executive scrutiny of PSIRF implementation, learning and improvement, on behalf of the Trust Board.

**Responsibilities:**

- Receive assurance reports from CGG and PSIRF Oversight Group
- Scrutinise whether the organisation is meeting its obligations in the PSIRF Oversight Specification (provider responsibilities)
- Review effectiveness of learning actions and organisational safety improvement
- Confirm that appropriate resources, capability and leadership are in place for PSIRF delivery
- Escalate areas of concern to the Trust Board

## Trust Board

**Role:** Holds the organisation to account for the safe functioning of the patient safety incident response system.

**Responsibilities:**

- Ensure the Trust meets the organisational responsibilities under PSIRF (leadership, culture, capacity, learning infrastructure)
- Receive high-level assurance on:
  - incident response functioning
  - key themes and risks
  - progress toward sustained safety improvement
- Ensure the Trust is compliant with statutory obligations including Duty of Candour and Quality Account reporting (PSIRF sits within the Quality Account).
- Foster a culture of openness, learning and psychological safety in line with NHS Patient Safety Strategy principles

# Patients' Right to Raise Concerns or Appeal

## Ongoing communication during the investigation

Throughout the investigation, patients and their families will receive regular updates from a designated point of contact. If at any stage they feel unsure, dissatisfied, or would like more involvement in the process, they are encouraged to share these concerns directly with their named Duty of Candour Lead. We want to ensure those affected feel informed and supported at every step.

## If concerns remain after the investigation

Once the investigation is complete, the findings will be shared with those affected. If they still have questions or feel that aspects of their concerns have not been fully addressed, they may choose to raise this as a formal complaint through the Patient Experience Team.

## Review and learning

The outcome of the investigation, along with any learning identified, will be shared with the Complaints Team. This allows for an impartial review of any outstanding issues and ensures that the patient or family's remaining concerns are considered.

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:
**Uhd.patientexperienceteam@nhs.net**

# 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

**www.uhd.nhs.uk**

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