NHS
Great Western Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

2023

	Title
Author	PSIRF Implementation Group
Reviewer	Associate Director of Nursing – Insights and Learning
Authoriser	Trust Board and BWS ICB

Contents

About the Patient Safety Incident Response Plan

The Patient Safety Incident Response Framework (PSIRF) was released in August 2022 and is one of the deliverables outlined in the NHS Patient Safety Strategy (PSS) released in July 2019.

The Framework was released following a period of consultation with earlier adopters, replacing the Serious Incident Framework. PSIRF outlines how providers should respond to patient safety incidents for the purpose of learning and improvement, prioritising compassion and involving those affected by patient safety incidents. PSIRF outlines the requirement for a system-based approach to learning and improving from patient safety incidents, ensuring that a considered and proportionate response occurs and there is robust oversight of how the Trust learns from incidents.

The Trust will transition from the Serious Incident Framework to PSIRF from September 2023. Preparation for this transition has included, understanding the existing patient safety processes and culture, developing a robust oversight and governance structure, considering the four main aims in PSIRF.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them.

The principles of PSIRF also include using different learning responses to respond to patient safety incidents and this patient safety incident response plan will outline the array of learning responses that should be used proportionately when a patient safety incident occurs. The Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Our vision

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

We will aim to ensure that whatever approach we take to learning from an incident, that there is a key focus on meaningful actions and improvement. A priority for us is to learn from patient safety events and approach that learning in a way that does not apportion blame, treats all those involved in a just and fair way and promotes system wide learning and improvement.

There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. This plan explains the scope for a systems-based approach to learning from Patient Safety Incidents (PSIs). We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Our values

	Service	Teamwork	Ambition	Respect
Our values	• Effective communication • Prioritise customer care and safety • Flexibility and meeting patient need • Be professional • Take personal responsibility for the service we provide • Take pride in our work	• Treat everyone as equal • Work effectively in partnership with others • Appreciate different levels of responsibility • Recognise diversity • Be friendly and supportive • Be reliable • Be open to change • Use resources effectively	• Strive for excellence • Act as a good role model • Be creative and proactive • Have a positive attitude • Encourage others • Recognise and celebrate achievement • Reflect and improve from feedback	• Be open and honest whilst maintaining confidentiality • Be an advocate for the Trust • Demonstrate compassion and empathy • Treat others with dignity • Value everyone's contribution
PSIRF aims	Compassionate engagement and involvement of those affected by patient safety incidents	Considered and proportionate responses to patient safety incidents	Application of a range of system-based approaches to learning from patient safety incidents	Supportive oversight focused on strengthening response system function and improvement

Our services

We reviewed the services we provide focussing on what we could learn and what we could improve. This was achieved through mapping of current services and the direction or input of patient safety concerns to the organisation. It has been identified that there are many different routes for a patient safety incident to be identified and many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

Responses covered in this plan include:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews
- Multidisciplinary Team Reviews
- Patient Safety Reviews
- Other types of response may be considered and used if it is agreed that these will be best in deriving optimal learning and improvement. An example of this may be a case study.
- Immediate learning reviews (Timeline mapping, Risk assessment, Debrief)
- Systematic learning reviews: (Case record/note review)
- Specialised reviews (e.g., Falls, pressure ulcers, IPC reviews)
- Appreciative inquiry

- Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests or criminal investigations. The principal aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- Human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- Legal teams for clinical negligence claims
- Medical examiners and, if appropriate, local coroners for issues related to the cause of a death
- The police for concerns about criminal activity.

Defining our patient safety incident profile

A review of the data and activity (associated with patient safety incident investigation) has been completed. This has included a review of; risks on the Trust wide risk register, complaints, concerns and queries, and patient safety incidents raised on Datix.

Risk register

A review of the risk themes under the 'Safe' category on the risk register has identified the following themes:

- Staffing (safe staffing levels and staff competencies)
- Infection, prevent and control (Infection rates)
- Medicines (Medicines Safety)
- Environment (Space)
- Medical devices/equipment (maintenance)

Complaints, concerns and queries

A review of 12 months of complaints, concerns and queries that have been managed via the Patient Advice and Liaison Service (PALS) has identified the following themes:

- Access and waiting
- Better information, communication, and choice
- Behaviour and attitude
- Clean comfortable place to be
- Safe, high quality co-ordinated care

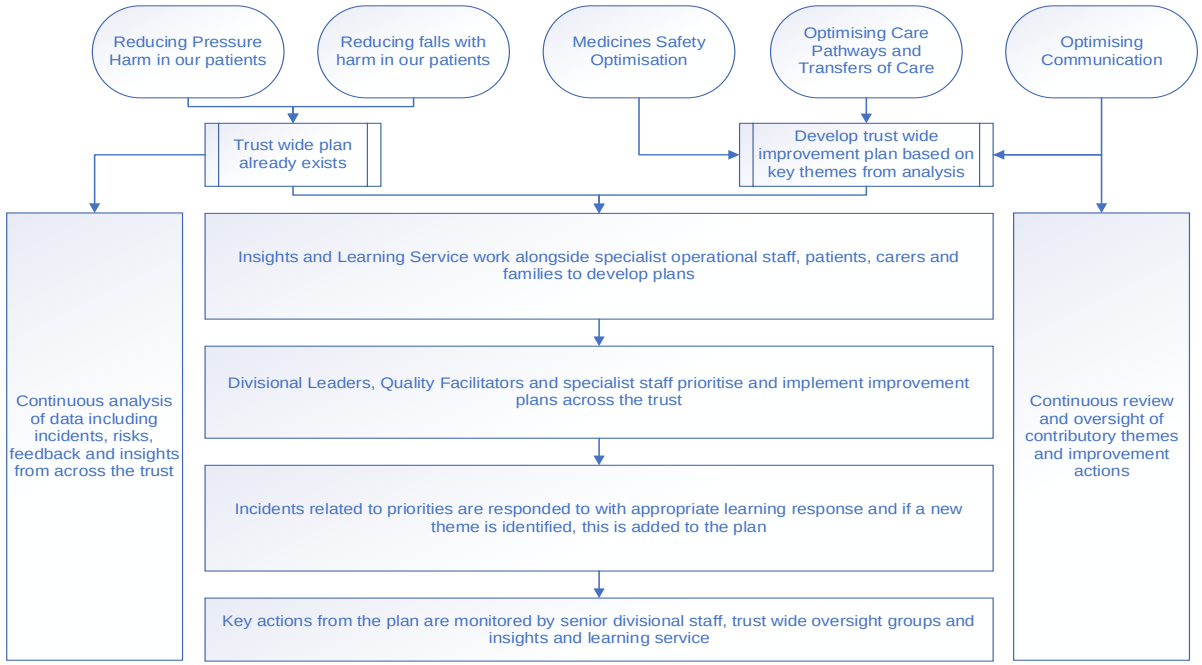
Patient safety incidents

A review of the patient safety management system (Datix) since July 2022 has identified the top three categories (graph one) as:

- Tissue Viability
- Patient accident/falls
- Medication

Review of the incidents, risks and complaints that support us to identify patient safety issues has helped us understand five key priorities which we as a Trust would like to focus on.

This does not mean that other incidents will not have adequate focus. It means that for the five key priorities we have identified, we will develop Trust wide improvement plans to increase learning and reduce the risks to patient safety that these areas pose.



Where there is already a Trust wide improvement plan, these will be reviewed and enhanced ensuring they are optimised, reflective of PSIRF values and understood across the Trust. Where new themes are identified, consideration will be given to developing a new improvement plan. Where improvement plans reach the desired patient safety targets, they may be stepped down and monitored.

How we agreed our patient safety learning responses

The chart shows Serious Incidents that were reported from June 2021 to June 2023 from the Trust. Whilst this has provided us with some valuable information around what caused some of these incidents, we also thematically analysed each serious incident report to show us more about the common themes that arose. These included:

- Communication issues
- Missed opportunities
- Documentation issues
- Training
- Delays

We also reviewed complaints, concerns and queries into the Trust and found that the top themes of these were:

- Access and waiting
- Information, communication and choice
- Behaviour and attitude
- Clean and comfortable place to be
- Safe, high quality coordinated care

Figure 1: Serious incidents by cause reported 06/21 – 06/23

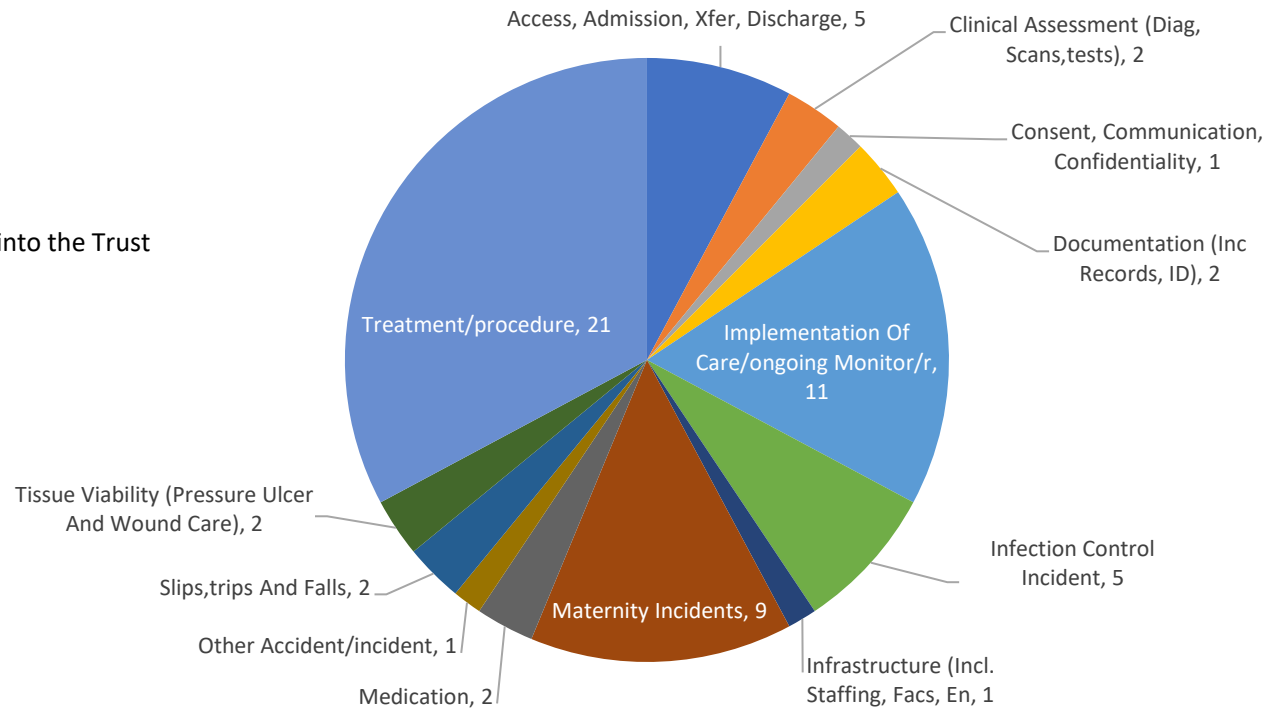
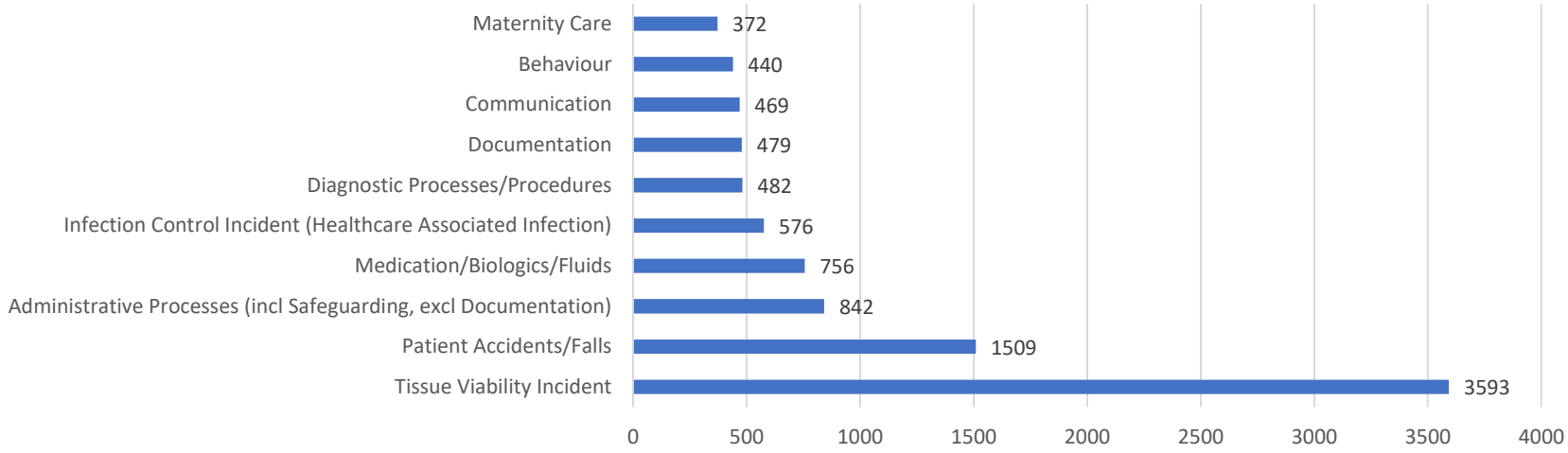


Figure 2 shows the top 10 incidents reported from July 2022 to June 2023. The top five reported themes are known safety challenges. The theme administrative processes often included issues around discharging patients and therefore a robust learning response is required to improve this area of care.

Colleagues in our Safeguarding department also undertook some analysis of safeguarding enquiries that had been raised the key themes that led to safeguarding enquiries were around Tissue Viability care and concerns in patients and issues with discharging patients from the hospital.

Figure 2: Top 10 reported incidents, July 2022 – June 2023



Our patient safety incident response plan: National requirements

	Patient safety event	Learning response		Improvement
National priorities	Mental Health Related Homicide	Recorded on Clinical Risk Management system and referral made to:	Relevant NHS England and NHS regional improvement investigation team	Recommendations are implemented and responded to, and improvement monitored through Trust wide learning and improvement governance meetings
	Maternity and Neonatal meeting HSIB criteria		Patient safety Event referred to Health care Investigation Branch	
	Deaths of Persons with Learning Disabilities		Reported and reviewed by Learning Disabilities Mortality Review	
	Safeguarding where various plans are in place for the patients		Learning response agreed with GWH Safeguarding lead	
	NHS screening Program Incidents		Reported to Public Health England	
	Domestic Homicide (including domestic suicide)		Relevant National and Local bodies	
	Death of Patients in Custody/prison/probation		Reported to Prison and Probation Ombudsman	
Locally led patient safety incident investigations	Deaths thought more likely than not due to problems in care	Round table/Huddle occurs with appropriate professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine Terms of Reference (ToR) and focus and any immediate learning	Patient Safety Incident Investigation	Recommendations are implemented and responded to, and improvement monitored through Trust wide learning and improvement governance meetings
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Mental Health Act (1983) or where the Mental Capacity Act (2005) applies			
	Incidents meeting Never Event Criteria 2018 or its replacement			
	Incidents where there may be significant new learning that is not being addressed through any other learning response			

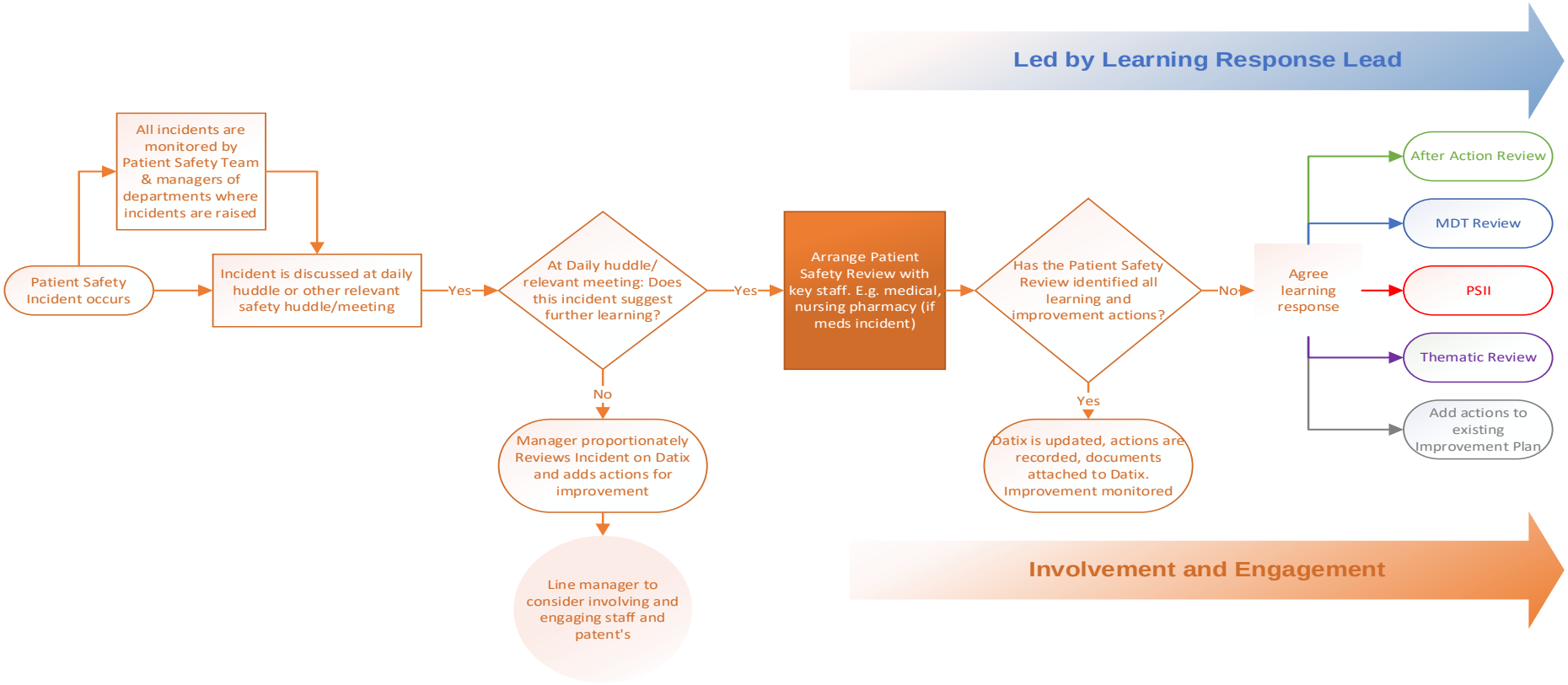
Our patient safety incident response plan: National requirements

	Patient safety event	Learning response		Improvement
Trust wide priorities	Reducing Pressure Harm in our patients	Improvement plans are developed and implemented to address Trust wide priorities. Where there are linked incidents, an appropriate learning response is utilised and if a new issue identified then added to improvement Plan. Plans are monitored through appropriate Trust wide learning and improvement governance meetings.	Trust wide improvement plans focussed on key issues identified through thematic review. Continuous Thematic Review to monitor improvement and flex improvement plans.	Improvement plans are monitored and reviewed through relevant specialist groups & Trust wide learning and improvement governance meetings
	Reducing falls with harm in our patients			
	Medicines safety optimisation			
	Optimising care pathways and transfers of care			
	Optimising communication			
Other incidents resulting or that could have resulted in harm to patients	Incidents that have not been managed through the above processes	Round table/Huddle occurs with correct professionals - nursing staff/medical staff/pharmacy and Quality professionals to determine appropriate learning response	Utilise suite of learning responses most appropriate and proportionate for deriving optimal learning. E.g., After action review, MDT Review, locally defined learning response.	Learning responses are saved/recorded on Clinical Risk Management Database and actions are completed and monitored through governance dashboards & reviews.

Our patient safety incident response plan: Local focus

All patient safety incidents that occur are discussed daily across the Trust in divisional huddle meetings. It is imperative that these daily meetings are attended staff who understand PSIRF principles and are trained and equipped to lead brief discussions regarding the next steps to learning and improvement from the incidents discussed. It is at these daily huddles that patient safety incidents will be briefly reviewed, discussed and further escalation agreed. Where further escalation is agreed due to the potential for learning and improvement, a Patient Safety Review will be convened at the earliest opportunity. The Patient Safety Review will be led by a trained facilitator with a view to deriving maximum learning and actions for improvement. On occasion the Patient Safety Review itself may provide enough learning to enable closure of the incident and monitoring of agreed actions. However, at the end of the Patient Safety Review, further agreement will be reached regarding the next stage of learning response.

Our local focus plan



Patient safety incident type or issue	Planned response	Anticipated improvement route
Any patient safety incident that occurs	Discussed at daily huddle	Discussion and agreement for escalation if required. If no escalation is required, then incident manager proportionately investigates the incident and sets appropriate local actions if required.
Patient safety incident escalated from Daily Huddle	A Patient Safety Review (see appendix 1) is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement. If necessary, further learning responses will be discussed these include	If the Patient Safety Review is confident that all learning has been derived, then actions will be assigned accordingly, and progress will be monitored through team/divisional and Trust wide clinical governance groups.
Incident escalated from Patient Safety Review	After Action review (see appendix 2)	Actions for improvement are agreed. Where they are already being managed through an improvement plan, the relevant plan is updated. Actions are monitored through departmental/divisional and Trust wide oversight groups. Where new emerging themes are identified, consideration is given as to whether this theme becomes a priority with an associated improvement plan.
	MDT Review (see appendix 3)	
	Patient Safety Incident Investigation (see appendix 4). Undertaken when there is significant learning to be gained from an in-depth investigation, or when this type of investigation is mandated due to meeting criteria	
	Further analysis/thematic review	Some learning responses may prompt the requirement for deeper analysis of data to understand whether there are key themes occurring that are contributing to patient safety issues.

How we will oversee learning actions and improvement

Discussion and agreement will be reached through the stages of learning response as described in our local focus plan.

The Datix database will be used to record the types of learning responses that are utilised to respond to patient safety events that occur.

At the transition stage (September 1st, 2023) the existing groups that discuss, monitor and make some decisions regarding patient safety investigations will continue, but transition into oversight groups will occur between September 2023 and January 2024. Primarily this will shift from any decision making to being informed of and having oversight of actions that have been agreed and their progress in improving safety for patients.

Meeting title	Current	Transition to
Incident Review Meeting	Reviews 72-hour reports & internal comprehensive investigations that have been drafted following an incident escalated for further investigation. Supports in decision making regarding whether the incident is a serious incident.	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate: • Patient Safety Review • After Action Review • MDT Review • Other proportionate learning responses
Serious Incident Review & Learning Group	Reviews Serious Incident reports and their actions and agrees closure or further amendments	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive.
Patient Safety Learning Group	Receives reports on Serious Incidents and other incidents of concern with a focus on the learning that has been identified	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART meaningful and making a difference.
Patient Safety & Quality Sub Committee	Receives reports on Serious Incidents and other incidents of concern	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

How patients, families and carers will be involved in learning responses

We Understand that patient safety incidents can have an impact on the people who are involved in them. Therefore, whenever there is a patient safety incident, we want to be open and honest with the person(s) who are affected by it. Where we escalate an incident for further learning as defined in, local focus plan we will always endeavour to work with the person(s) affected to understand what level of involvement they feel they require and what questions they would like answered in that learning response.

This is regardless of the level of harm that is recorded for that reported patient safety incident. For example, if a low harm incident is escalated for further learning, we will approach the person(s) affected as outlined above. Involvement and engagement with patients, families and carers will be coordinated by involvement and engagement leads who have been appropriately trained across the Trust.

Patient safety incident type or issue	Planned response	Patient, family, and carer involvement
Any patient safety incident that occurs	Discussed at Daily Huddle	We will apologise and explain what may happen because of the incident occurring
Patient safety incident escalated from Daily Huddle	A Patient Safety Review (see appendix 1) is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement. 	We will be open and honest regarding the incident and the next steps; we will let the person(s) affected know that we have escalated the incident and will consider how involved they want to be in the learning response and which questions they would like answered from the response.
Incident escalated from Patient Safety Review	After Action review (see appendix 2)	
	MDT Review (see appendix 3)	
	Patient Safety Incident Investigation (see appendix 4)	

Duty of Candour

Duty of Candour legislation still applies to patient Safety incidents and therefore where a patient safety incident is recorded and assessed as having caused moderate or above harm to a patient then the Trusts duty of candour policy and process will be followed alongside and supplementary to our involvement and engagement processes.

Supporting staff following patient safety incidents

We know that staff can sometimes be affected by incidents that occur (second victim), this can be due to the emotional impact that the incident itself has had on them to feelings of guilt and shame that an incident occurred that they were involved in. There is no place in Great Western Hospitals incident responses for blame, liability, or focussing on individuals' actions without a wider view of the whole system factors that contributed to the incident.

All learning responses will be undertaken by a trained senior member of staff and facilitated by the Trusts central Patient Safety Team. The standards that are required for each Trust are outlined in the Patient safety incident response standards, 2022. The Trust has developed a training analysis and has been working in collaboration with other member Trust across the Integrated Care Board to procure suitable training to ensure these standards are achieved.