Royal Berkshire
NHS Foundation Trust

Patient Safety Incident Response Plan

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Authoriser	**Policy Approval Group**			**April 2024**

Foreword

“The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. “

Aidan Fowler, National Director of Patient Safety, NHS England

The Patient Safety Incident Review Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different, but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework, towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to:

- Compassionate engagement & involvement of those affected
- Application of a range of system based approaches
- Considered and proportionate responses
- Supportive oversight

We welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn, but we acknowledge that we have been distracted by the emphasis on the production of a report, rather than on showing how we learn and improve to keep our patients safe.

We need to engage meaningfully with our patients, families, carers and staff, to ensure that their voice is the golden thread in any of our patient safety responses and we commit to the patient and staff involvement at all stages of our patient safety processes.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as required. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care

of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead!

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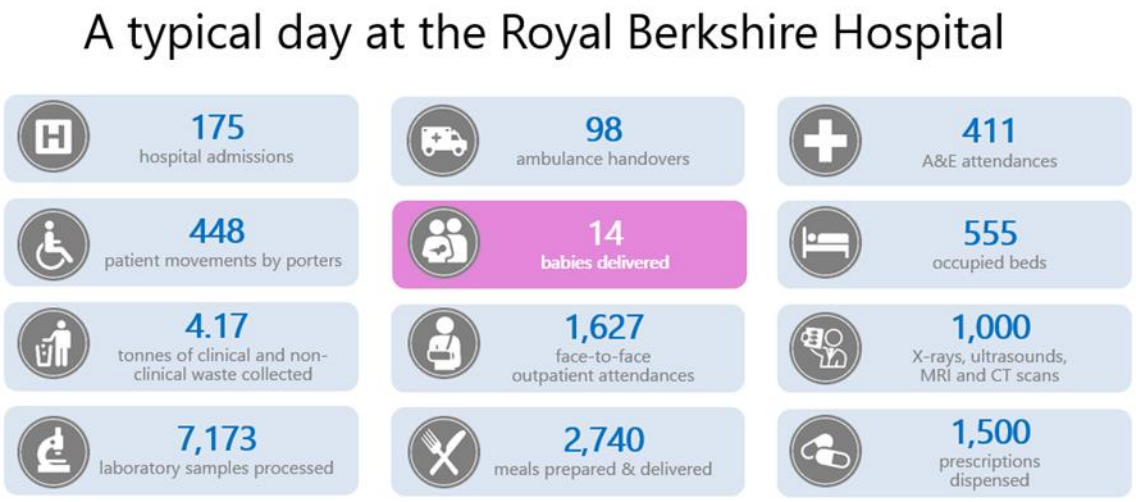
Introduction

This patient safety incident response plan sets out how the Royal Berkshire NHS Foundation Trust (the Trust) intends to respond to patient safety incidents over a period of 12 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.

This plan is underpinned by our existing Trust policy on Serious Incident (SI) reporting and learning (CG553), currently in redraft and the new Trust patient safety incident response policy which this plan will inform.

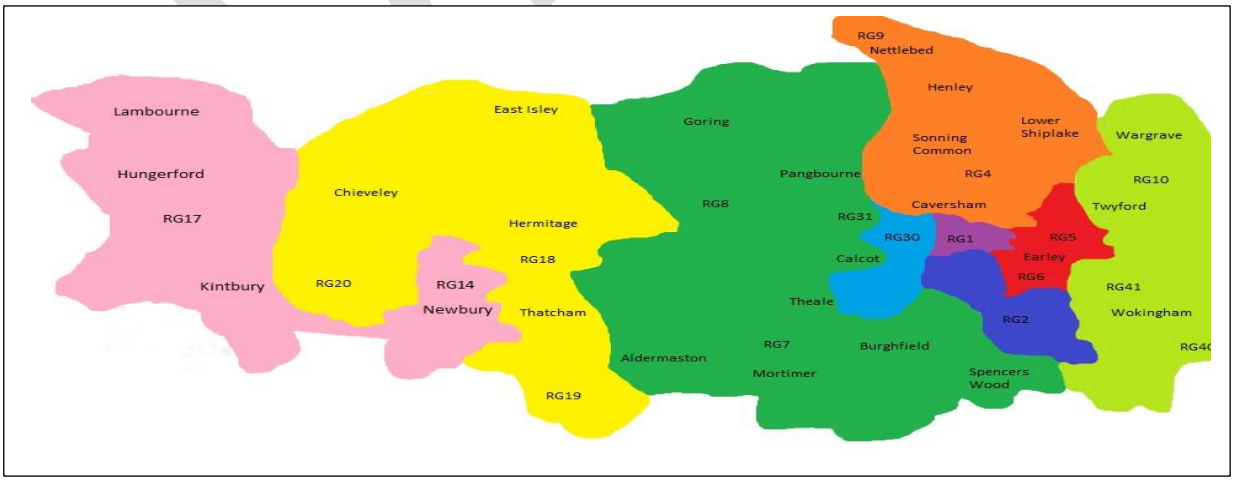
Our services

Royal Berkshire NHS Foundation Trust (the Trust) is one of the largest general hospital foundation trusts in the country, serving a population of more than 500,000 people, and the main provider of acute and specialist care services for Berkshire West.



We serve a local population that includes residents of Reading, Wokingham, and Newbury, This incorporates both inpatient services and satellite outpatient services across Reading and West Berkshire. We are one of the largest hospital foundation trusts in the country, and currently touch the lives of half a million patients in the west of Berkshire every year by providing high quality acute medical and surgical services for our local communities.

These services are provided for our local communities in a variety of locations including the Royal Berkshire Hospital, numerous satellite health centres and clinics and Urgent Treatment Centres. These services serve a population of all ages from birth to end of life:



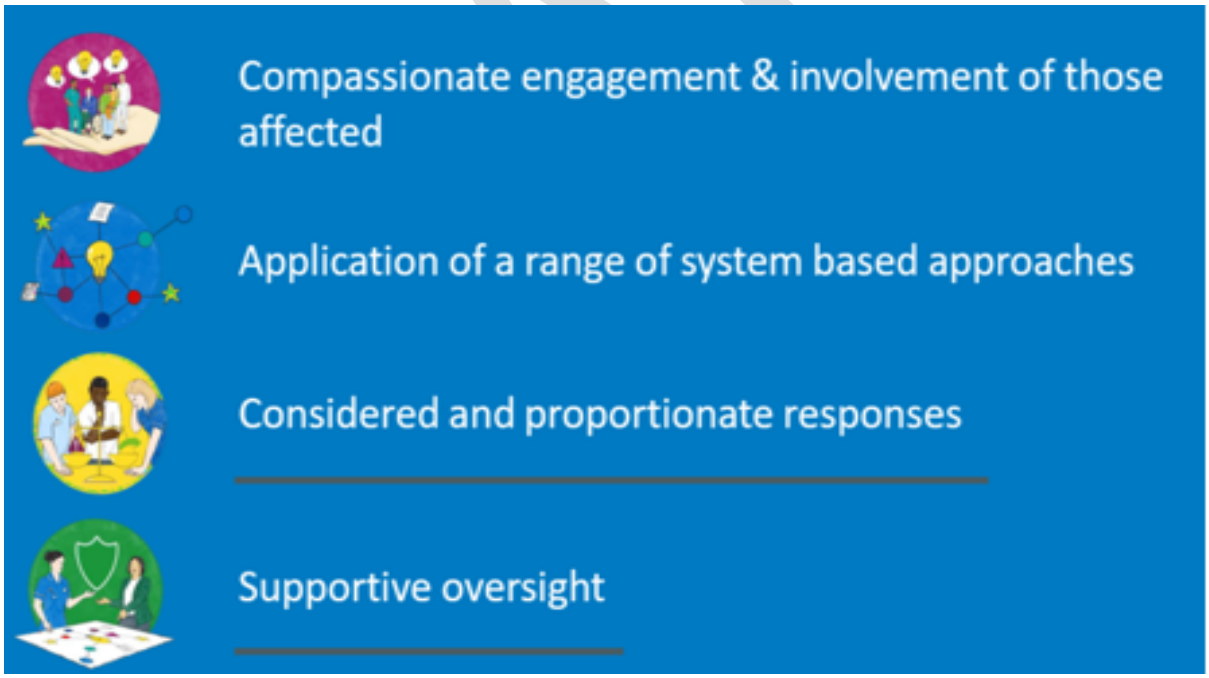
The scope of PSIRF and our vision

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based 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. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests, although PSIRF will support us with triangulating the data.

This Plan explains the scope for a systems- based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities - an analysis of which is explained later within this document.

There are four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based:



The strategic aims are aligned with our own Trust vision statement, strategic objectives and CARE values. The Royal Berkshire NHS Foundation Trust vision statement is:

'Working together to provide outstanding care for our community.'

The implementation of PSIRF will see both the strategic aims and our Trust vision, strategy and values embodied in our work.

Defining our patient safety incident profile

The Trust has a continuous commitment to responding to, and learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years. We have regular Executive-led Safety huddles and our Patient Safety Incident Review Group (PSIRG) was created in early 2020 to have additional oversight of the Trust's patient safety responses and improvement activity.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p14-16 below. To fully implement the Framework the Trust has completed a review of what types of patient safety incidents and activities occur to understand what needs to be learned from to improve.

The Patient Safety team has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on p17-19.

Stakeholder engagement

The Trust Patient Safety team commenced planning for PSIRF in advance of the release of documents in August 2022. PSIRF early adopters were consulted with extensively to enable understanding of the practicalities of planning for and implementation of PSIRF. It is acknowledged that their assistance has been invaluable.

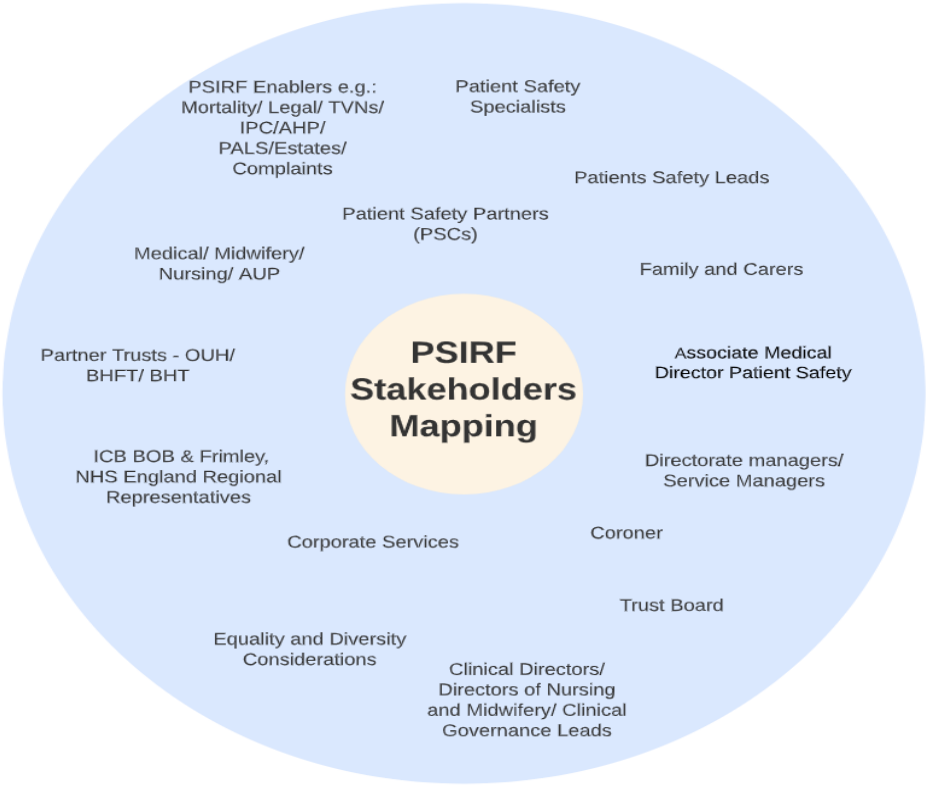
The Trust is conscious that PSIRF requires a very different approach to the oversight of patient safety incidents than the current application of the SI framework With this in mind the Patient Safety team have been actively involved with the Berkshire, Oxfordshire and Buckinghamshire (BOB), Integrated Care Board (ICB) PSIRF planning and preparation workshops since their commencement in early 2022. Early engagement due to the changing nature of responsibilities within PSIRF was essential, as is the need for continuous collaborative systems working.

Within the Trust, the new NHS England Patient Safety Strategy, that incorporates the implementation of PSIRF and the significant differences between PSIRF and the SI Framework, was first tabled in 2021 at the Patient Safety Committee Meeting and then escalated for presentation at the Trust Executive Management Committee Meeting. A paper detailing this has been updated periodically to illustrate the progress the Trust is making against the milestones set out in the new Patient Safety Strategy. Additionally, a presentation was developed and shared in the Clinical Governance Leads workshop, for dissemination to speciality Clinical Governance meetings, and also at Trust level Matrons forum.

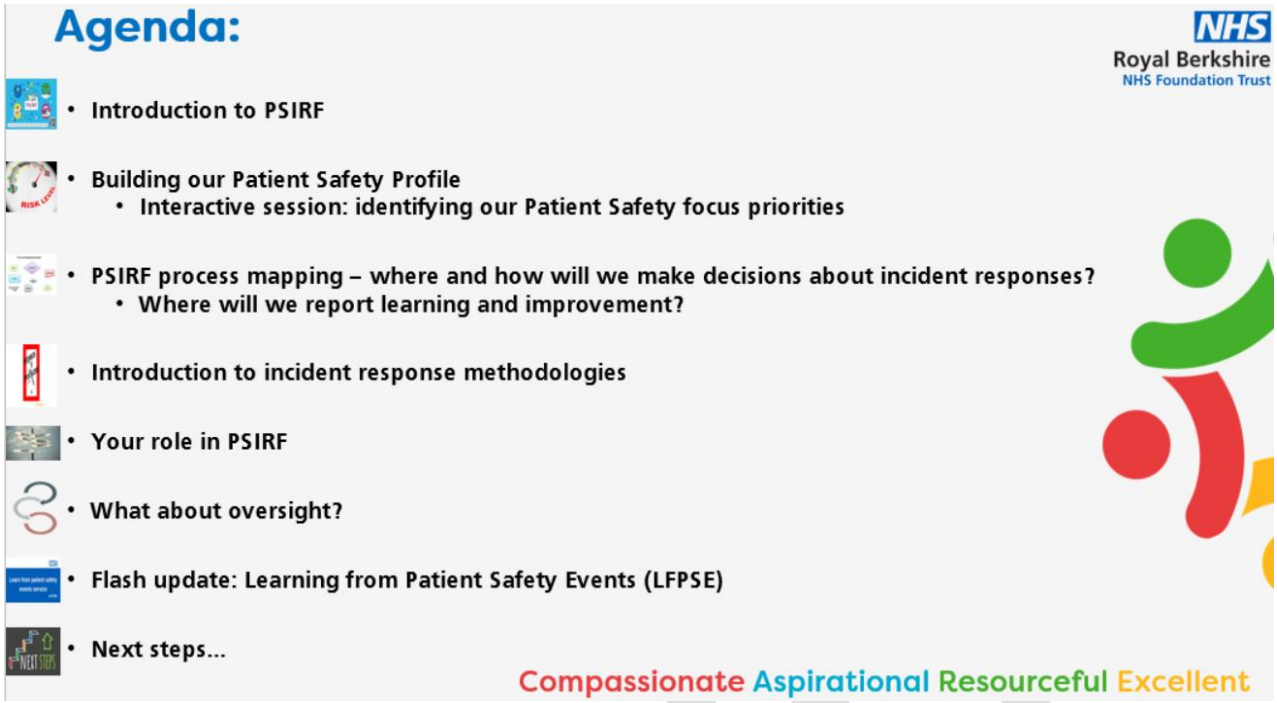
Stakeholder mapping was undertaken in January 2023, and this informed the planning of a series of seminars delivered during October 2023. They engaged key stakeholders from many diverse disciplines including but not exclusive to:

- Medical
- Nursing
- Midwifery
- Portering
- Clinical Engineering
- Patient Experience

- Mortality
- Catering
- Directorate Management.



The aim was to inform staff of the impact PSIRF may have on incident management and to begin to explore the context of 'proportionate response'. The seminars had a reach of over 1000 staff members. Over 200 attended the seminars and more than 2000 contacts were made with the interactive sessions that invited consultation on how the Trust Patient Safety Profile should be prioritised. A QR code was circulated Trust wide via the Workvivo intranet platform and additional shortened seminar presentations were also delivered in other forums such as the Theatre Safety Strategy Group; Operations Management Team and Matrons Forum, all staff attending these had the opportunity to take part in the interactive sessions. The following subjects were covered during the seminar:



Using the Trust Patient Safety expertise, we have undertaken an appraisal of review tools and templates that are available nationally, to identify our approach to other patient safety incidents that will require a learning response. Further details of the proposed templates will be detailed later in the plan.

Building our Patient Safety Profile

To define our patient safety response profile, data was drawn from a variety of sources including the trusts local risk management system (LRMS), Datix. Data was collected on the

incidents that had taken place over the 2 year period prior to March 2023, (from Q1 2020/21 to Q4 2022/23).

Data and information (both qualitative and quantitative) have been reviewed from the following additional sources:

- Patient safety submissions
- Serious Incidents - Patient safety incident investigation reports
- Local root cause analysis investigation reports
- Complaints
- Freedom to Speak Up reports
- Safeguarding reviews and reports
- Mortality reviews and Structured Judgement Reviews (Learning from Deaths)
- Prevention of Future Deaths (National recurring themes)
- Staff survey results
- Claims
- Trust risk profile
- Data from quality surveillance processes
- Medication safety reviews
- Quality priorities
- Inequalities data.

As part of the profiling, we have considered what the data tells us about inequalities in patient safety. We have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal. An example of this is the increasing risk of violence and aggression against staff.

Findings were triangulated and thematic analysis was undertaken to determine which areas of patient safety activity would inform the Trusts patient safety profile. It should be noted that this list is not fixed and where a new risk emerges, or learning and improvement can be gained from investigation of a particular incident or theme a flexible approach will be adopted.

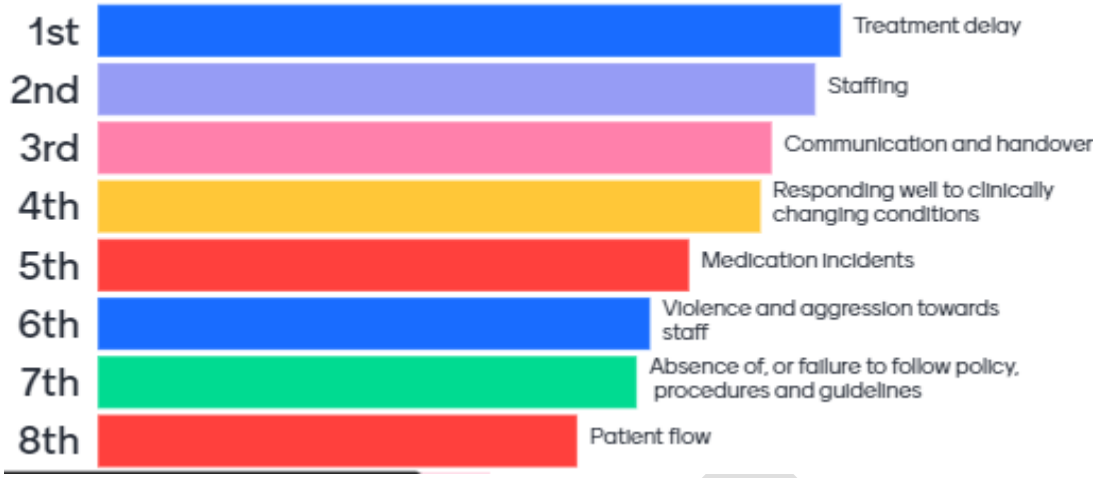
Patient Safety Profile:

DESCRIPTION	KEY RISKS
Treatment delay	Safety of patients on waiting lists.
Communication and handover	An issue where significant concerns about communication and/or handover, between staff, teams and/or departments have affected the patient journey and subsequent care.
Patient flow	Patient admission, transfer and discharge
VTE	An issue with omissions in anti-coagulant assessment and prescribing and ultimately preventable VTE's.
Responding well to clinically changing conditions	Recognition of the deteriorating patient, escalation of deterioration and subsequent treatment/diagnosis.
Falls	Falls with significant injury or harm.
Pressure Damage	Hospital acquired pressure ulcers.
Medication incidents	Medication errors.
Absence of, or failure to follow policy, procedures and guidelines	An issue where either the absence of, or the failure to follow a policy, procedure or guideline has affected patient treatment and/or care.
Staffing	An issue where either the lack/absence of, or the skill mix of staff has affected patient treatment and/or care
Digital tools	An issue where digital health tools used have failed to meet our clinical safety, data protection, technical security, usability and accessibility standards, and as such has affected patient treatment and/or care.
Violence and aggression towards staff	An issue where staff have been subject to acts of violence and/or aggression.
Estates	An incident where estates issues have affected patient treatment or care

NB: Maternity incidents have an additional separate criteria – see Appendix 1.

A key part of developing the new national approach is to understand on a local level not only the breadth of patient safety activity that the Trust has undertaken over the last few years, but also continuous improvement activity. Being aware of this means that we can plan an appropriate response to certain types of incidents quickly and efficiently, avoiding repetition and duplication of resource.

Some incidents that occur such as falls, are often unpreventable , and often the themes that are drawn from the learning are the same. However with the right improvement programmes in place that promote rapid learning into practice, harm can be significantly reduced.
The following graphs illustrate how the participants attending the seminars prioritised their top 8 safety activities:



This graph illustrates how the participants accessing the interactive tool outside of the seminars prioritised their top 8 safety activities:

As well as collaborating with stakeholders, when selecting the Trust patient safety priorities for PSIRF the potential for harm and likelihood of occurrence was also considered. These included the impact of both physical and psychological harm, as well as the loss of trust by patients and their families. The impact on capacity, quality and delivery of services, and both public confidence and reputational risk. Equally important was the emergence of, or the persistence of risk, frequency of incidents and the potential to escalate.

Examination of all insights and feedback initially determined the following patient safety priorities and how the Trust will respond to them over the next year:

THEME	DESCRIPTION	KEY RISKS
1.	Treatment delay	Safety of patients on waiting lists.
2.	Communication and handover	An issue where significant concerns about communication and/or handover, between staff, teams and/or departments have affected the patient journey and subsequent care.
3.	Responding well to clinically changing conditions	Recognition of the deteriorating patient, escalation of deterioration and subsequent treatment/diagnosis.
4.	Medication incidents	Medication errors.
5.	Patient flow	Patient admission, transfer and discharge

Having then reviewed these with the support of the ICB and being further through the PSIRF process these have been further refined to the below:

Theme	Description	Key Risks
1.	**Treatment delay within the two week wait pathway**	Safety and clinical stability of patients in pathway
2.	**Communication and/or handover between departments**	An issue where significant concerns about communication and/or handover, between staff, teams and/ or departments have affected the patient journey and subsequent treatment/diagnosis.
3.	**Recognition of the deteriorating patient**	Recognition of the deteriorating patient, escalation of deterioration, and subsequent treatment/ diagnosis,
4.	**Patient flow from ED**	Delays in patient admission, transfer and discharged from ED, leading to delays in subsequent specialist treatment
5.	**Medication errors- prescribing and administering**	Medication errors resulting in patient harm

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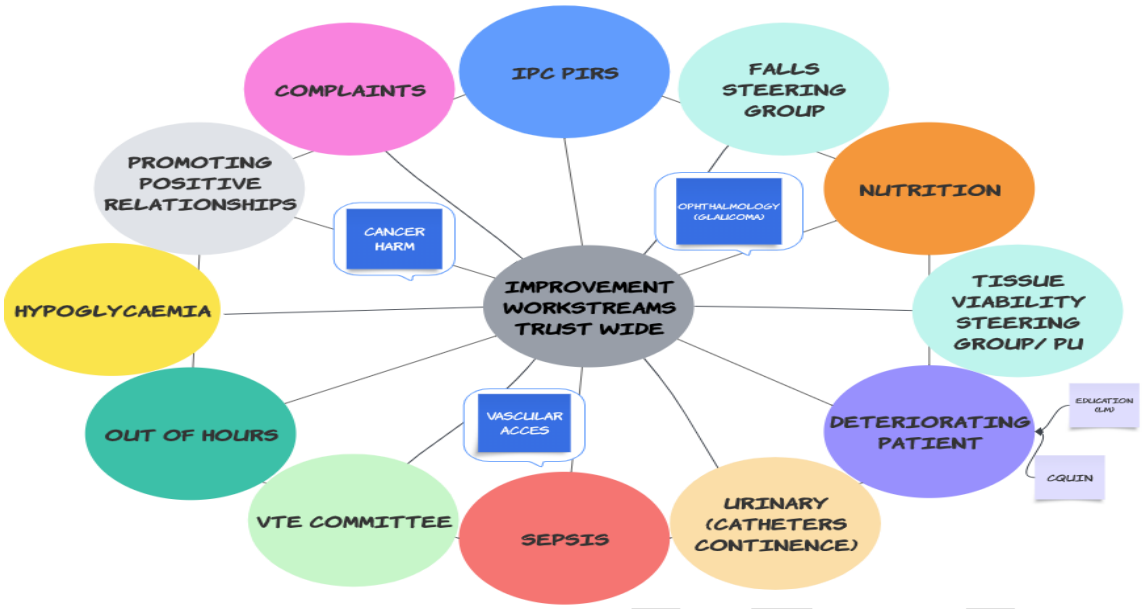
These patient safety priorities form the foundation for how we will conduct Patient Safety Incident Investigations (PSII) under PSIRF. Incidents that fall within this scope will be thematically reviewed more frequently in order to understand more about the incidents and to ensure that immediate learning has been identified and actioned in practice.

It is important to note that the type of response will depend on:

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

By identifying locally defined priorities, PSIRF allows us to focus on these risks with our framework for patient safety incident response and enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

Current improvement workstreams are already in place in the Trust that develop and monitor the improvement activity:



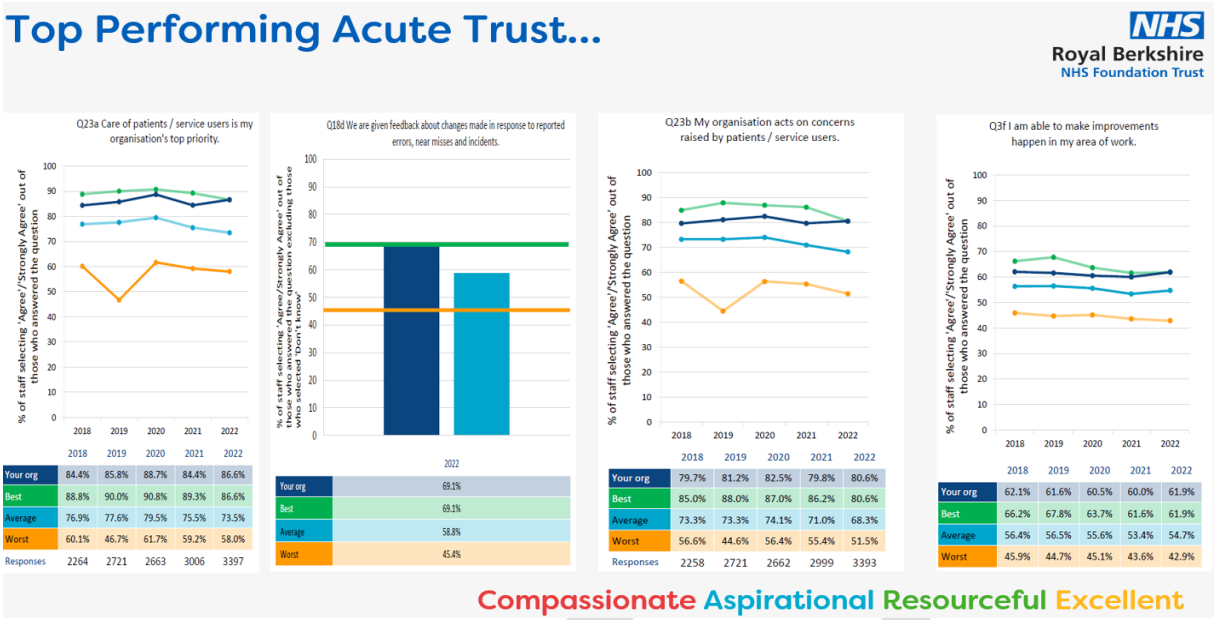
Mapping activity is ongoing to establish the appropriate governance processes to monitor and measure the learning, progress, and associated outcomes in line with PSIRF requirements.

It is important to remember that the Trust has some robust and rigorous processes already in place for reviewing our patient safety incidents and, as a result, some of these will remain as PSIRF is implemented. The Trust already use a multidisciplinary 'roundtable' team approach to complete some investigations which have been positively received by staff and are seen as a factor in supporting and developing the culture of psychological safety. Over the past 12 months, the Trust has commenced the use of multidisciplinary debriefs and After Action Reviews (AAR), to introduce staff to alternative methodologies to reviewing and responding to some incidents.

Safety Culture

Positive safety culture is fundamental in the implementation of PSIRF. As a Trust, RBFT has an ongoing commitment to fostering a culture of psychological safety and continuous quality improvement.
Over the last few years we have developed our understanding and insights into both patient, and staff, safety matters and sought to enable and equip staff in every area of the Trust to manage and improve the quality of care to patients and deliver patient experiences and outcomes that are "outstanding every day, everywhere".

Our positive safety culture is evidenced by our openness to both reporting, and responding to patient safety incidents, and also from the results of the staff survey, and will use this, and other methods to assess that we are sustaining our ongoing progress in improving our safety culture:



The Trust senior leadership have strongly embraced this work there are regular Executive-led safety huddles as well as the daily operational safety huddles that are undertaken across the organisation. Our executive led Patient Safety Incident Review Group (PSIRG) was reviewed in early 2020 to have additional oversight of the Trust's patient safety responses and improvement activity. These multidisciplinary meetings are held at least twice a week and give the opportunity to share learning widely, as well as consider emerging risks and insights from incidents.

Several initiatives have also been taken to support continuing development of psychologically safe environments. These include an enhanced staff wellbeing offer, implementation of Schwartz rounds, Trust wide staff experience insights through a patient safety lens, continued commitment to 'Freedom to Speak Up', a multidisciplinary 'roundtable' approach to incident investigations, and in addition to a refresh of our leadership behaviours framework that supports a restorative and just culture.

The trust also has an established call for concern service to provide independent second opinions when contacted by staff, patients and families/visitors. This is now being used to benchmark other organisations in the development of "Martha's rule"

Safety culture is additionally monitored through thematic analysis of incidents and patient and staff surveys.

How we will respond to patient safety incidents, including national requirements:

National requirements: Below are the patient safety incident types that must be responded to according to national requirements.

Events requiring a specific type of response as set out in policies or regulations:

Event	Action required
Deaths thought more likely than not due to problems in care	Locally-led Patient Safety Incident Investigation (PSII)
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Locally-led PSII
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally-led PSII
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required
Maternity and neonatal incidents meeting Maternity and Neonatal Safety Investigation (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to MNSI or SpHA for independent PSII See also Appendix 1
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the

	LeDeR – organisations should liaise with this
Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs

Our patient safety incident response plan: local focus and decision making:

The Trust local incident responses will be considered and proportionate with appropriate resource spent on learning. The Trust has identified a range of learning responses in the PSIRF plan to recognise there is no 'one size fits all' and the application of suitable learning methods needs to be based on the incident type, situation and what is already known about the safety topic. It is also important to note that "no response" is also valid as an approach Decision making tools will support this process, (Appendix 2). The Trust will use the methodology of Systems Engineering Initiative for Patient Safety (SEIPS) within its learning responses, further details can be found in this brief guide. SEIPs recognises the importance of exploring how work is occurring in reality and how people are routinely adjusting to match the ever changing conditions and demands of work. It is also important that learning from good or positive care is captured and shared.

Listed below are details about the local learning responses:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Agreed Trust Patient Safety priority cases meeting identified features: • Treatment delay • Communication and handover • Responding well to clinically changing conditions • Medication errors • Patient Flow	Consider Patient Safety Incident Investigation (PSII) or alternative appropriate response from learning methodologies. Inform an index case and/or thematic analysis of ongoing and emergent patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**

Incidents where existing improvement workstreams are already in place: • VTE • Falls • Pressure damage • Staffing • Violence and aggression towards staff	Review by speciality/ward managers in conjunction with improvement stream leads Risks/issues to be reviewed and appropriate response initiated where patient safety compromised as appropriate Continued monitoring through Trust specialist forums and committees to determine any new emerging risks/issues	Inform ongoing improvement plans
Other incidents identified from Trust Patient Safety Profile: • Digital tools • Estates • Absence of, or failure to follow policy, procedures and guidelines	Review by operational managers in conjunction with IM&T (Digital); Estates/Facilities; Clinical Leads/Operational Managers and Governance leads as appropriate Continued monitoring through appropriate Trust forums and committees. Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed and appropriate response initiated where patient safety compromised as appropriate	Inform ongoing improvement efforts Create local organisational recommendations and actions and feed these into the quality improvement strategy
Death	Review by Mortality process and possible SJR/SJR plus (including family input) and Mortality Surveillance Group (Review as PSII where index case or meets national priority criteria)	Create local safety actions and feed these into the quality improvement strategy as appropriate
Infection Prevention and Control (IPC)	Review by operational managers in conjunction with IPC and continued monitoring and audit HCAI Post Infective Reviews (PIRs), Outbreak reviews	Create local safety actions and feed these into the IPC prevention and improvement strategy

New and emergent incidents and Issues with learning potential	Learning response to be defined depending on incident(s). (We will not always respond to a specific incident if we are familiar with the factors that need addressing so that we can focus on sharing the learning and making the changes to improve the safety of care)	Managed at local level with ongoing thematic analysis via existing Trust assurance processes which may lead to new, or supplement existing improvement work.
Multi-organisational/cross system patient safety incidents	Consider Multi-organisational/cross system Patient Safety Incident Investigation (PSII) or alternative appropriate responses Continued monitoring through system Patient Safety Incident Review meeting	Create local and systems safety actions and feed these into quality and improvement forum.

Learning response methodologies:

An initial safety review of every incident raised on Datix will be undertaken by the Patient Safety Team. Speciality/ward managers will also review incidents for their areas and then share with relevant senior clinicians and/or managers on the day reported so that an appropriate response can be actioned.

This ensures that the Patient Safety team have Trust wide oversight of all incidents that are nationally mandated for a response, that feature with greater harm and/or have the potential for significant learning. Two or three times weekly Patient Safety Incident Review Groups (PSIRG) that focus on patient and staff safety will evolve to a forum that brings together a range of data and softer intelligence including incidents, learning response outcomes, positive/good practice and complaints, claims and inquest findings. Learning themes will be triangulated to help inform trends and emerging issues. This 'forum' will report into the Trust's Quality Governance Committee, via the Patient Safety Committee on a bi-monthly basis (NB this is subject to change as PSIRF governance arrangements are likely to evolve as implementation continues).

Learning response methodologies that will be used:

LEARNING RESPONSE METHODOLOGY	WHAT IS IT AND WHEN CAN IT BE USED?
Patient Safety Incident Investigation (PSII)	A PSII is a patient safety incident 'review methodology' adopting an 'investigative approach' for the incident response. This leads to an

	in-depth review of a single patient safety incident with the formulation of a comprehensive report A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
Swarm Huddle (Template attached as Appendix 4)	Swarm-based huddles are used to identify learning from patient safety incidents. 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.
After Action Review (AAR) (Template attached as Appendix 5)	An AAR is a method of evaluation that is 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 (MDT) review/roundtable	The MDT review/roundtable supports health and social care teams to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.
Thematic Analysis	This can identify patterns in data to help answer questions, show links or identify issues, typically using qualitative data to identify safety themes and issues

Proposed time scales for learning responses:

Much of the emphasis of PSIRF is on learning and improvement. This PSIRP has described how we have identified those areas we believe to have the most potential for learning and how we intend to use our resources proactively to investigate and learn from these priority areas and other areas which are identified in the future.

Appendix 1: Requirements for the Maternity Service

Once an organisation that provides maternity services begins working under the PSIRF, its maternity services will be subject to the PSIRF in the same way that all other secondary care services in that organisation are. This means that organisations must consider maternity services, maternity safety improvement and how to respond to maternity incidents as part of their PSIRF preparation, planning and implementation. Organisations must use insight and intelligence, including that obtained via the perinatal quality oversight tools and structures, to support the PSIRF planning process. Organisations should ensure that their collective and collaborative approach to developing their patient safety incident response plan (which may include a specific maternity section) includes input from regional maternity teams, local maternity and neonatal systems (LMNSs) and Maternity Voice Partnerships. Maternity patient safety incidents requiring referral to the Maternity and Newborn Safety Investigation Programme (MNSI)for investigation Patient safety incidents meeting the 'Each Baby Counts' and maternal deaths criteria listed below are national requirements for PSII. As such they must be referred to the MNSI or Special Healthcare Authority when in place, through the web portal provided to all trusts, for an independent PSII, and an organisation's patient safety incident response plan must make clear which maternity incidents will be referred to MNSI.

Maternity patient safety incidents requiring referral to MNSI for investigation Patient safety incidents meeting the 'Each Baby Counts' and maternal deaths criteria listed below are national requirements for PSII. As such they must be referred to the MNSI or Special Healthcare Authority when in place, through the web portal provided to all trusts, for an independent PSII, and an organisation's patient safety incident response plan must make clear which maternity incidents will be referred to MNSI. MNSI investigates the following maternity patient safety incidents:

• Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.

• Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).

• Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind.

• Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

Where such an investigation is undertaken, a separate local patient safety learning response is not required. However, organisations should complete Duty of Candour requirements (ahead of handover to MNSI for further involvement of patients/families in the investigation) as set out below, and report on the relevant incident reporting system(s) as described below.

Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant

cases, the organisation should also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of MNSI as it works through its independent investigation).

Appendix 2: Learning Response Decision Making Tool

Learning Response Decision Making Tool				
Refer to Trust Patient Safety			**Learning Response**	**Incident closure**
1. Incident meets national priority for escalation as PSII	**2. Incident meets local priority for escalation as PSII**	**3. Incident may meet criteria for ad-hoc PSII**	**4. Incident meets PSR criteria**	**5. Incident may be approved with local response**
☒ ***National*** priority to be referred for PSII/review by **another team**, please specify: e.g. 'for referral to LA Safeguarding' ☐ ***National*** priority incident requiring local PSII, please specify: e.g. 'Never Event'	☒ ***Local*** priority incident requiring local PSII, please specify: e.g. 'Deterioration in health of an inpatient requiring admission to a general hospital'	☐ ***Emergent*** patient safety risk or incident with learning and improvement potential possibly requiring ad-hoc local PSII, please specify e.g. 'xx incident - contributory factors not well understood, minimal improvement activity underway' or 'unexpected incident not accounted or in PSIRP'	☐ Learning and improvement to be captured by a learning response method Select toolkit item to be used: ☐ **Swarm**, specify team/s to be involved: ☐ **After Action Review**, specify teams/s to be involved: ☐ **Thematic review**, please specify scope:	☒ Incident not for further review, give rationale: e.g. incident type and contributory factors well understood and reflected in xx improvement work
Incident for closure Please capture any relevant learning and refer to relevant improvement plan holder	Immediate and short-term actions / learning - Medium to long term actions / learning			

Incident meets Patient Safety/Learning Response criteria	Please suggest any key lines of enquiry to be added to the toolkit item selected:
Incident meets national priority for escalation as PSII (1)	Please indicate other agency to be referred to and whether this has been completed – enter details in external links section
Incident meets national priority for escalation as PSII (2)	Please consider if specific notification outside of organisation is required and whether this has been completed – enter details in external links section
Incident meets national priority for escalation as PSII (2)	Please consider if specific notification outside of organisation is required and whether this has been completed – enter details in external links section
Incident meets local priority for escalation as PSII (3)	
Incident may meet local priority for escalation as PSII (4)	
Designated family liaison/duty of candour person identified for duration of incident investigation:	

Internal links

Internally reportable to another care group?	Yes / No	**Internally reported to:**	
Patient Safety team alerted	Yes / No		
Other Internal Links: e.g. TV team, Falls, H&S, IG:			
Necessity to remove/ restrict staff from normal tasks and details? Workforce aware?			

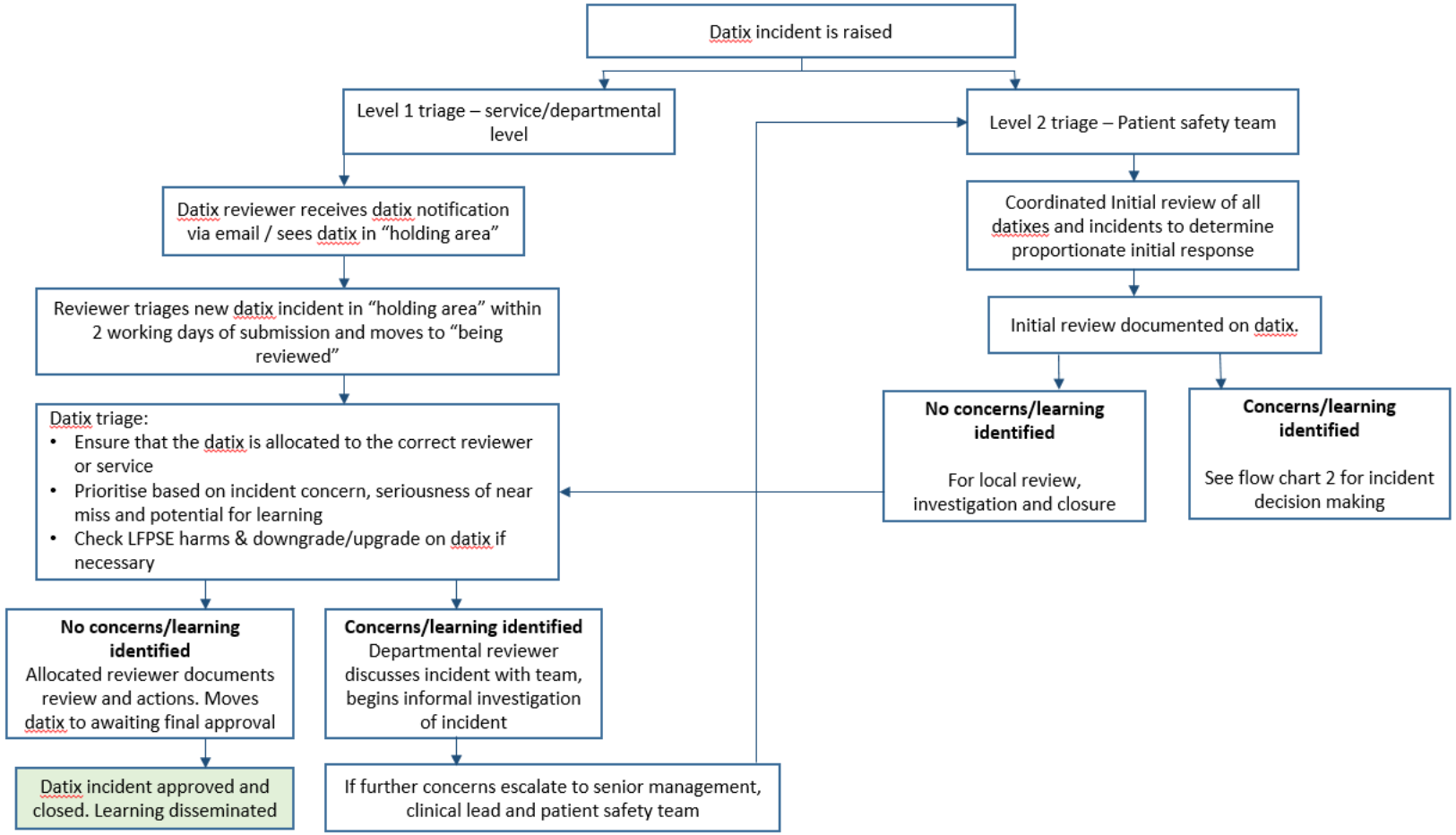
External links

Externally reportable?	Yes / No	**Externally reported to:**	
Media Interest?	Yes / No	**Comms team informed?**	Yes / No
Other External Links: e.g. ICB, multiagency, Police and/or HSE, Coroner's Inquest, CQC involvement			

Appendix 3: PSIRF Suggested Flow Document

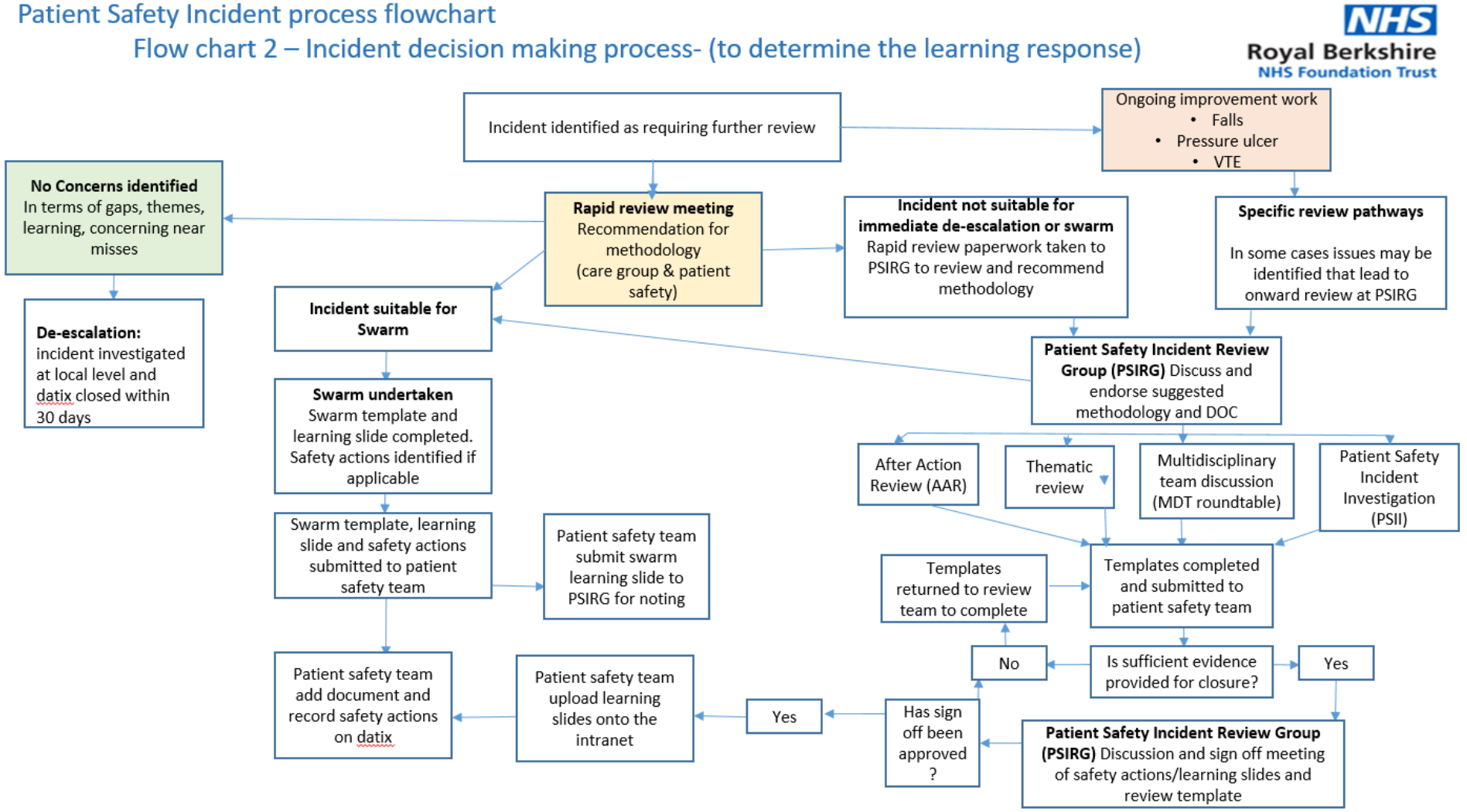
Patient Safety Incident process flowchart

Flow chart 1 – Datix triage and safety netting

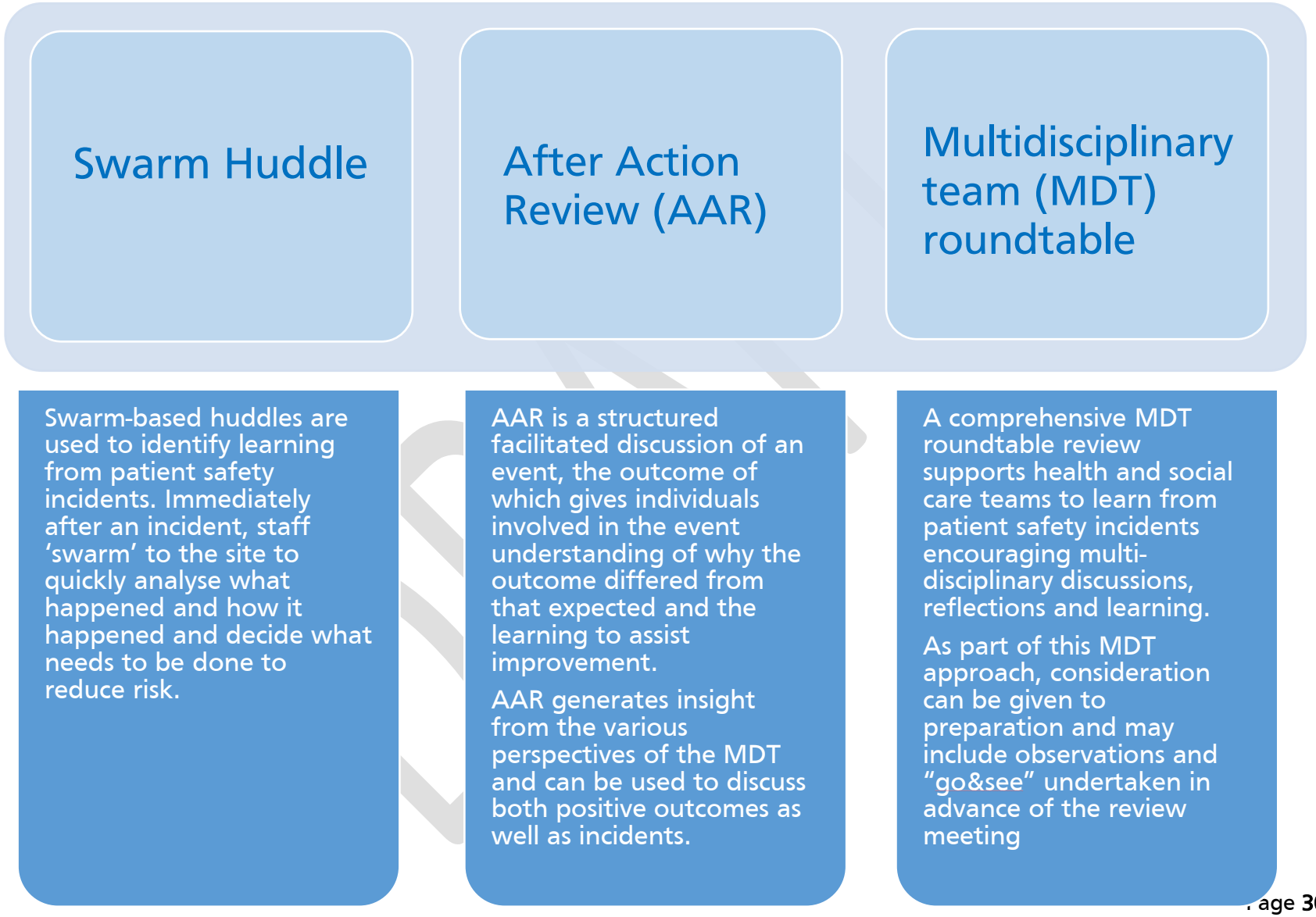


Patient Safety Incident process flowchart

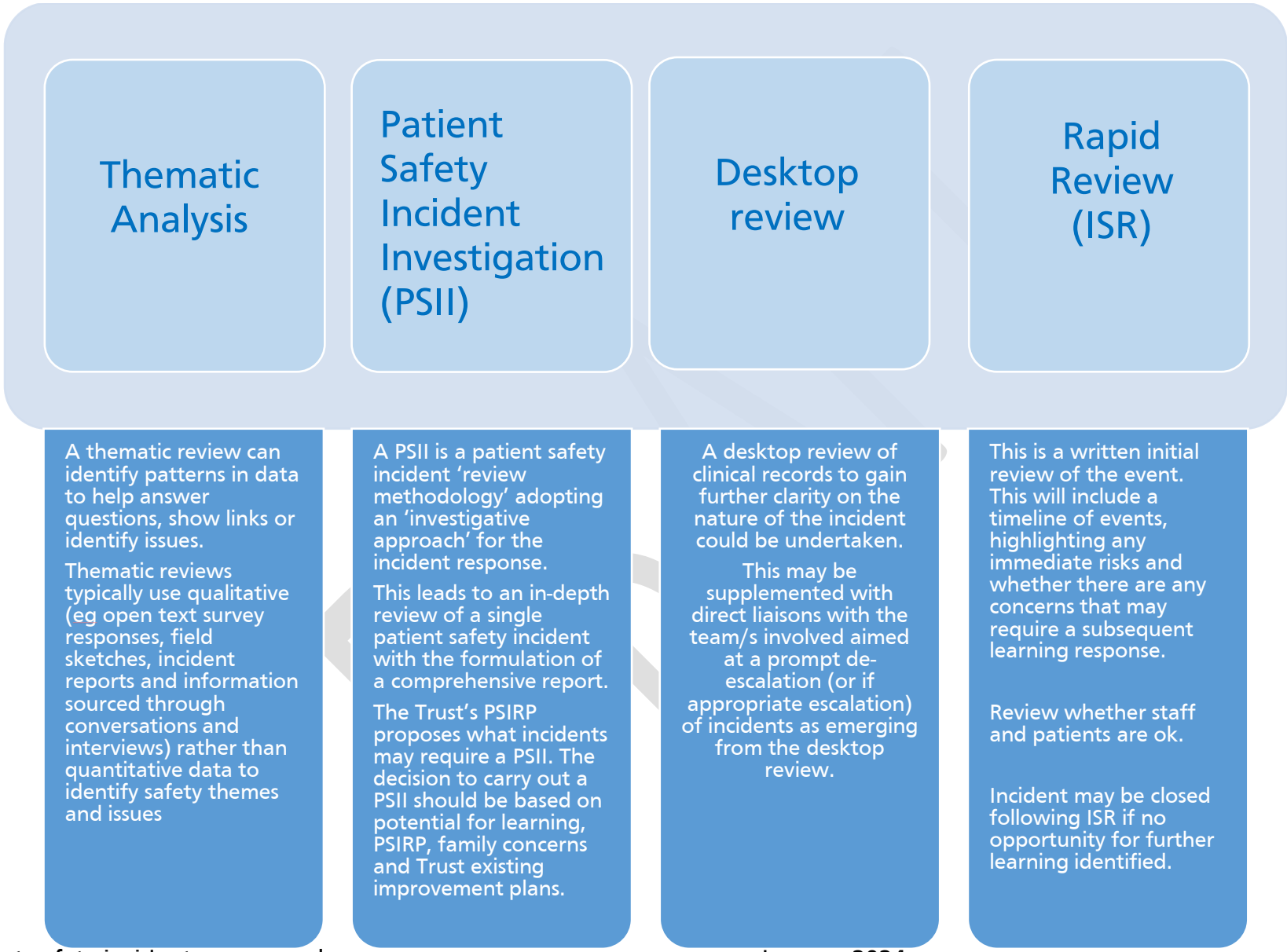
Flow chart 2 – Incident decision making process- (to determine the learning response)



Patient Safety Incident process flowchart



Patient Safety Incident process flowchart



Appendix 4: Swarm Huddle Learning Response Template

SWARM Huddle Template

Incident Reference:	Incident reference number	**Incident Date:**	dd/mm/yyyy
Incident Description:	From the rapid review (reference number)		
Swarm Reference		**Swarm Date and Time**	dd/mm/yyyy 00:00
Swarm facilitator name:		**Facilitator role:**	
DOC status:			
Attendees:			

Specific issue to be addressed by the Swarm:	This will be outlined following the Divisional or Trust Patient Safety panel.

What is it: *A meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.* *Safe space, invitees only (those involved in incident, agreed by the Division/Patient Safety team).* **When to use it:** *Swarms can be used soon after any activity or event (within a working week ideally) where care has not gone as planned - this can prevent key information being lost. Swarms can reduce blame and rumours about an incident by focussing on learning and improvement and an understanding of 'work as done'.*
Introduction and Create a safe and 'brave space'
Facilitator to introduce all participants and their role in the Swarm

Explore exactly what happened and why	
Replay the events that led to the Swarm	
Explore what happened and why, use the systems work prompts	
Identify where else in the organisation the learning may be relevant	
Are there any other services or Division where this learning needs to be shared?	
How you are going to share the learning more widely and who will take responsibility for this?	
Safety actions to be carried forward	
System Improvement Plan/Immediate Safety Actions to be taken with designated lead	
Does this contribute learning or confirm actions in any overarching safety improvement plan	Ensure details shared with patient safety lead and DoN

Date reviewed and approved at divisional clinical governance	
Actions/Next Steps agreed	

Work system prompts

Swarm work system prompts

Tools & Technology
Equipment/tools/IT:
- design (including how information is presented)
- availability appropriateness
- reliability
- positioning
- maintenance

Alarms and/or alerts
Automated tasks
Accessibility and usability of manuals, procedures, supports

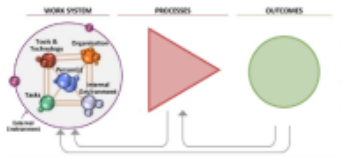
Organisation
- Patient pathways
- Information flow (how information is communicated)
- Communications workload
- How new information is flagged and where it is held
- Leadership and supervision
- Work scheduling and allocation
- Staffing levels and resourcing
- Safety/organisational culture
- Change management

Tasks
- Task demands (ie competing tasks)
- Task complexity
- Workload
- Time pressures
- Task repetition and monotony
- Task re-prioritisation or reorganisation

Person
- Patient mix
- The team (eg clinical, admin, domestic)
- Team familiarity with processes and pathways
- Clarity of roles and responsibilities
- Training and education
- Team dynamics
- Personal factors (eg stress, morale, tiredness)

Internal environment
- Physical workspace design
- Layout of the environment
- Workspace appropriateness for the tasks
- Distractions and their impact
- Interruptions and their impact
- Ambient environment (eg lighting, noise, air quality)

External environment
- Relevant national targets
- Policy and regulatory demands
- Accreditation standards
- Political decision making
- Global events



Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

Appendix 5: After Action Review Learning Response Template

After Action Review (AAR) Template

Incident Reference:	Datix number
Incident Description:	Please provide a brief description of the incident and specify level of harm to patient
Incident Date:	
AAR date and time:	
AAR facilitator:	
Attendees:	
Glossary of Abbreviations/Acronyms within text:	Please supply a key/list of any used

Rationale and Specific issues to be addressed by the AAR (From Terms of Reference):	This will be outlined in the decision making tool.

What is it: *A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. Safe space, invitees only.* **When to use it:** *AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is also often used at the end of a project to help populate a lessons learnt log. It is important to disseminate learning widely so that good practice can be shared and others can learn from mistakes.*

Creating a common understanding of the experience under review:	
What happened that we can learn from?	
What did we set out to do?	
What actually happened?	
Why were there differences?	
What went well? Why?	
Reflecting on the successes and failures:	
What could have gone better? Why?	
What would you do differently next time?	
What learning has been identified?	

How will the learning be shared within your service?	
Agree as a group on any actions that need to be taken	
How you are going to share the learning more widely?	
System Improvement Plan/Immediate Safety Actions	

Date reviewed and approved at Rapid Review Meeting:	
Actions/Next Steps agreed:	

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Appendix 6: Multidisciplinary Team Review Template

Multidisciplinary Team (MDT) Review

Top Tips:

When to use:

To identify learning from multiple patient safety incidents (including when multiple patients were harmed or where there are similar types of incidents) when it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.

Purpose:

To gain insight into the real world in which care is delivered. To agree, through open discussion, the key contributory factors and system gaps.

SEIPS is a framework for understanding outcomes within complex socio-technical systems. It describes how the system can influence processes, which in turn shapes outcomes.

The system consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s).

Examples:

- delayed recognition of deteriorating patients
- medication errors
- admission or discharge-related safety events
- safety issues relating to supported/therapeutic leave from a mental health unit
- burns or other injuries sustained by residents in a care home.

What is work as done?

By ‘work as done’ we mean how care is delivered in the real world, not how it is envisaged in policies and procedures (work as prescribed) or recounted in a walk through or a talk through (work as described).

You can find more information on how to carry out walk through in the brief guide to walk through analysis in the PSIRF learning response toolkit.

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Multidisciplinary Team (MDT) Review

Theme which has initiated this Review	

Incident Details included in this Review			
Datix WEB Number	**Care Group**	**Directorate**	**Ward/Department**

Quality Assured in the Division by:		**Designation(s):**	
Divisional Approval by:		**Date MDT Approved by the Division:**	
Attendance at Weekly Review and Approval Panel		**Date MDT document Approved at Weekly Review and Approval Panel:**	

Document Control		
Version Number	**Name of Person Updating**	**Date of Version**
1		

2		
3		
4		

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PART 1: Patient Safety Event			
Questions from the patients/families: *Ensure that you are aware which patient/family asked which questions.*			
1			
2			
3			
4			
5			
6			
Date of MDT Review:			
Meeting chaired by:		**Job Role:**	
Learning Response Lead Name:		**Job Role:** *Likely to be a member of the Divisional team*	
Engagement lead name: *May be the same person as the Learning Response Lead*		**Job Role:**	

Who is required at this review?
Who has insight - who works in the care setting or pathway (clinical and non-clinical)

MDT reviews are most useful when a wide range of stakeholders share their perspective on 'work as done'

Name	Job Role:

Note taker:
It is suggested that the meeting is recorded for the purpose of preparing notes to document the key information (this could be a recorded MS Teams meeting

PART 2: Preparatory work to scope the Review:
Review Of Notes:

Observational Work:

You might find that a process map is useful.
"Go and see" to understand and ask about the issue, be respectful, this is not about blame but understanding what happened for the purpose of problem solving.

PART 3: At the Multidisciplinary Team Meeting:

Create safe space at the outset

Introduce everyone.
State what prompted the MDT review and how its outputs will be used.
Co-create ground rules: "We want to hear everyone's insights in today's workshop. How might we best work as a team to ensure everyone's perspective is shared?"
Share any concerns they have around describing 'work as done' and answer any questions or concerns openly and honestly.
Remind participants that you will be keeping a record the insights shared.

Use the SEIPS work system explorer to gain insight into 'work as done'.

What is the desired outcome(s)?

For system performance and human wellbeing

Use the headings below, guided by the prompts in the SEIPS model (on the final page of this document), to explore how the system influences processes

Area for Improvement		**Yes/ No**	**Identify where improvement is needed**
Work system	People		*How **can individual or team characteristics** be modified or changed to reduce risk or improve performance?*
	Tasks		*How can the **task or activity** be modified or redesigned to reduce risk or improve performance?*
	Tools And technology		*How can **tools, equipment, or technology** be modified or redesigned to reduce risk or improve performance?*
	Internal Environment		*How can the **physical environment** be modified or redesigned to reduce risk or improve performance?*
	Organisation		*How can **organisational factors** be modified or redesigned to reduce risk or improve performance?*
	External Environment		*How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance?*

Wrap up, thank, and describe the next steps

At the end of the MDT review, summarise your understanding of the key insights identified about work as done. Clearly outline what the next steps will be, including:
How you plan to collate the outcomes of the MDT review
How you will keep participants updated after the MDT review

Remember to thank participants for their time.

PART 4: What do I need to do after the MDT review?

Triangulating of information and collating insights about work as done from the MDT review

You may or may not decide to gather further information relevant to the systems gaps and contributory factors identified in the MDT review. This may involve hosting another MDT review workshop with different participants or collecting further information relevant to the systems gaps and contributory factors identified.

How do I use the MDT review findings to support safety improvement work?

Do the findings link in with Improving Together?

Ensuring what you have learnt about 'work as done' is fed back and integrated into your organisation's patient safety improvement work.
Ensure details are added into the Safety Actions within this document.

Share insights into systems gaps and contributory factors identified in the MDT review with those who have patient safety improvement roles. Who these stakeholders are will depend on the focus of the review and its findings. They may include:
Members of the MDT who can influence safety improvement work locally.
Your organisation's patient safety improvement leads.
Stakeholders in the ICS who have a role in resolving systems gaps relating to commissioning decisions and pan-organisational problems.
External bodies, including equipment manufacturers, regulators, NHS England, MHRA, HSSIB, MNSI and others who have a role in national safety improvement work.

For more detail and an example of using this approach can be found at:
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-MDT-review-v1_FINAL.pdf

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Define Safety Actions
Develop SMART safety actions from the work system improvements identified.
(SMART: - **S – specific, M - measurable, A - achievable, R - realistic, T – Timely**)

Area for improvement: [e.g. *review of test results*]

	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight** ***(E.g. specific group/ individual, etc.)***	**Planned review date** ***(e.g. annually)***
1.								
2.								
…								

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The SEIPS work system Explorer:

Tools & Technology
- Describe the equipment/tools you use
- Describe the equipment design
- Share your insights into equipment availability and appropriateness
- Share your insights into equipment reliability
- Describe how information is presented (eg records/IT systems)
- Describe alarms and alerts
- Are any tasks automated?
- Describe where equipment is positioned. Is this optimal?
- Are tools/technology maintained and updated?
- Are manuals, procedures and supports accessible?

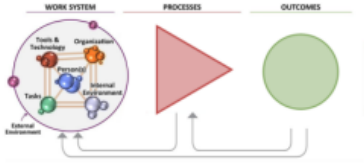
Organisation
- Tell me about how the patient pathways work
- Describe the information flow (how information is communicated)
- What is the communications workload like?
- Tell me how new information is flagged
- Where is new information held?
- Describe the leadership and supervision arrangements
- Describe how works is scheduled/allocated
- Describe staffing levels and resourcing
- Describe the safety/organisational culture
- Describe how change management works

Tasks
- Tell me about the task demands you face
- Describe the tasks which are complex or challenging to carry out
- Talk me through your experiences of the workload
- Are there time pressures? If yes please tell me more
- Does task repetition/monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

Person
- Tell me about the patient mix
- Describe the team who deliver patient care
- Who else is part of the team (eg admin, domestic)?
- How familiar are team members with care processes/pathways?
- Are roles/responsibilities clearly defined?
- Describe how training is organised to support safe care
- Describe the team dynamics
- Describe the impact of personal factors (eg stress, morale, tiredness)

Internal environment
- Does the workspace support safe patient care/task performance?
- Share your thoughts on the layout of the environment
- Is the workspace appropriate for the task?
- Where are tasks completed?
- Describe any distractions you experience regularly
- Do interruptions impact patient care/task performance? If yes, how?
- Describe the impact of the ambient environment (eg lighting, noise, air quality)

External environment
- Describe any relevant national targets
- Tell me how the following impacts (if at all):
  - Policy and regulatory demands
  - Accreditation standards
  - Political decision making
  - Global events



Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

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Quality Assurance Checklist to be used by Approver within the Division:

	Area of Review	Rating of Evidence			Comments to clarify rating - may be things that can be improved or content you thought worked well
		Good	Some	Little	
1	**People affected by incidents are meaningfully engaged and involved:** The report demonstrates evidence that all those affected by the incident such as staff, patients, families and carers have been actively listened to and emotionally supported where required.				*(i.e. interviews and perspectives of those affected are included in the report)*
2	**The systems approach is applied:** The report demonstrates consideration of system-based performance influencing factors (e.g. task complexity, technology, workplace design, information transfer, clinical condition of the patient, stress, fatigue, culture, leadership, policy/regulation) and how these interacted to contribute to the incident.				
3	**'Human error' is considered as a symptom of a system problem:** Human error is not concluded as the cause. Instead, multiple contributory factors which influence the event are explored.				
4	**Blame language is avoided:** Language does not directly, or indirectly infer blame of individuals or teams.				*(i.e. the nurse failed to follow policy; the doctor lost situational awareness)*
5	**Local rationality is considered:** The report clearly explains why the decisions and actions taken by individuals involved felt right at the time.				*(i.e. the situation and context faced by those individuals is explored and described)*
6	**Contrary to fact reasoning is avoided:** The report focuses on what happened and understanding why and NOT what people, departments or organisations could or should have done during or before the incident.				
7	**Safety actions are effective:** developed collaboratively with stakeholders with consideration of wider organisation priorities and improvement work. focus on system elements (IT, equipment, pathways, processes) not individuals. are specific, robust, and actionable (i.e., they don't add 'safety clutter'.				

	are accompanied by a plan to monitor progress over time. are demonstrably linked to the evidence and findings in the report.				
8	**The report is clear and easy to read:** It is concise and written in plain English.				*(i.e. no unexplained acronyms)*

Appendix 7: Learning Response Review and Improvement Tool

Learning Response Review and Improvement Tool

Report details:	ID:	Title:

Development of this tool was informed by a research study which identified 'traps to avoid' in safety investigations and report writing. The tool was originally developed by NHS Scotland. It has been further refined in collaboration with the Health Services Safety Investigations Body (previously the Healthcare Safety Investigation Branch) and NHS England after being piloted in approximately 20 NHS trusts and healthcare organisations in England. The content validity of the tool is currently being assessed.

How to use this tool	The tool is intended to be used by: 1 Those writing learning response reports following a patient safety incident or complaint, to inform the development of the written report. 2 Peer reviewers of written reports to provide constructive feedback on the quality of reports and to learn from the approach of others.

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Area of review (Descriptor)		Rating scale (Please insert 'X' in the applicable box)			Comments/examples of text quotes Add comments to clarify your ratings, this may be things that can be improved or content that you thought worked well and should be used in other reports
1	**People affected by incidents are meaningfully engaged and involved** The report demonstrates evidence that all those affected by the incident such as staff, patients, families and carers have been actively listened to and emotionally supported where required (i.e. interviews and perspectives of those affected are included in the report).	Good evidence ☐	Some evidence ☐	Little evidence ☐	
2	**The systems approach is applied** The report demonstrates consideration of system-based performance influencing factors (e.g. task complexity, technology, work procedures, workplace design, information transfer, clinical condition of patient, stress, fatigue, culture, leadership/management, policy/regulation) and how these interacted to contribute to the incident in question.	Good evidence ☐	Some evidence ☐	Little evidence ☐	

3	**'Human Error' is considered as a symptom of a system problem** 'Human error' or similar (e.g. nurse error, medical error, loss of situation awareness) is not concluded to be the 'cause' of the incident. Instead, multiple contributory factors which influenced the event are explored.	Good evidence ☐	Some evidence ☐	Little evidence ☐	
4	**Blame language is avoided** Language does NOT directly or indirectly infer blame of individuals, teams, departments, or organisations and/or focus on human failure (i.e. the nurse failed to follow policy; the doctor lost situation awareness).	Good evidence ☐	Some evidence ☐	Little evidence ☐	
5	**Local rationality is considered** The report clearly explains why the decisions and actions taken by individuals involved felt right at the time (i.e. the situation and context faced by those individuals is explored and described).	Good evidence ☐	Some evidence ☐	Little evidence ☐	
6	**Counterfactual reasoning is avoided** The report focuses on what happened and understanding why and NOT what people, departments or organisations	Good evidence ☐	Some evidence ☐	Little evidence ☐	

	'could' or 'should' have done during or before the incident.				
7	**Safety actions/recommendations are effective** Safety actions/recommendations proposed: • have been developed collaboratively with relevant staff/stakeholders and with consideration of wider organisation priorities and improvement work • focus on system elements (IT, equipment, care processes/pathways) not individuals • are specific, robust and actionable i.e. they don't add to 'safety clutter' • are accompanied by a plan to monitor progress over time • are demonstrably linked to the evidence and findings in the report.	Good evidence ☐	Some evidence ☐	Little evidence ☐	
8	**The written report is clear, easy to read and anonymised** The report is concise, written in plain English, uses inclusive language and anonymised i.e. it is written to 'inform rather than impress'.	Good evidence ☐	Some evidence ☐	Little evidence ☐	

9	**General comments** Is there anything else that can be improved or content that you thought worked well and should be used in other reports?				