Patient Safety Incident Response Plan

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Introduction

"I am excited to present our first Patient Safety Incident Response plan. It will provide an overview of our patient safety priorities for the next year and our new approach to how we will respond to patient safety events. The plan describes how we will connect with the people we care for and work with, in order to understand our patient safety events and, through the process of learning, determine where we need to improve to deliver the highest quality of care and outcomes and maximise the potential of our teams. This novel approach to patient safety is a key part of delivering our vision of:
The RUH, where you matter."

Andrew Hollowood, Chief Medical Officer

This Patient Safety Incident Response Plan (PSIRP) describes the way in which the Royal United Hospitals NHS Foundation Trust (RUH) intends to respond to patient safety events from April 2024 to April 2025.

The NHS Patient Safety Strategy 2019[1] acknowledges that the current Serious Incident Framework for managing patient safety events has not achieved expected improvements in care, it states that there is:

"*Little evidence to suggest that SI processes have led to widespread, sustainable improvement in patient safety or benefits to the patients, families, carers and staff who have been involved*".

In response to this NHS organisations are required to transition to a new framework for managing patient safety events, called the **Patient Safety Incident Response Framework (PSIRF).** This framework represents a significant shift in the way we respond to patient safety events, with increased focus on learning and improvement.

The Patient Safety Incident Response Framework integrates four key aims:

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

The approach aligns with our values: Everyone Matters, Working Together, Making a difference. Successful implementation of PSIRF will promote a proportionate approach to reviewing all patient safety incidents that generates a **response, with those affected by the event at its core, focused on opportunities for new learning and improvement.**

PSIRF focuses on learning from all patient safety events, adopting a safety management system approach in connecting safety control, learning, governance and improvement.

This will be achieved through a systematic combination of gaining insights through understanding the information reported through patient safety events, as well as other safety events. For example, by routinely analysing patient safety events data to identify trends and themes, improving our understanding of why things happen to inform improvements.

Although investigations will remain a valuable tool, their purpose should be clear and targeted. **To support improved learning, a variety of additional tools will be utilised, with increased focus on systems and thematic analysis.** Learning from all patient safety events will be fed into improvement work, and by freeing up time from repeated investigations, more time will be available for improvement work.

Involvement of patients and family, as well as staff, is crucial for the success of the new framework. Our aim is to develop an improved safety culture, where people feel confident to speak about safety and are supported by compassionate leadership, as well as working together to proactively identify risks before harm occurs. This is an essential element to successfully improving patient safety.

The aim is to begin the transition to the new framework in January 2024 and continue to learn and develop the new processes over the first year. This will enable continuous development and improvement of the processes to ensure the development at the RUH of the highest quality safety learning system. It is expected that it will take 3 to 5 years to fully transition to the new patient safety approach.

The ambition for the RUH is that we learn from each other to:

- Understand risk and implement improvements to the system to help staff deliver the safest care
- Be pro-active in identifying risks before they cause problems
- Identify and spread good practice
- Ensure all staff to feel involved in the improvement of quality and care.

Our strategic alignment

Transition to PSIRF is established as a key deliverable in the RUH's You Matter Strategy for 2023/24 to 2028/29. This is part of delivering the goal, 'Connecting with you, helping you feel safe, cared about and always welcome', under, 'The people we care for' group.

Our vision	**The RUH, where you matter**		
Our people groups and our goals	**The people we care for** • Connecting with you, helping you feel safe, cared about and always welcome • Consistently delivering the highest quality care and outcomes • Communicating well, listening and acting on what matters most to you	**The people we work with** • Demonstrating our shared values with kindness, civility and respect all day every day • Taking care of and investing in teams, training and facilities to maximise our potential • Celebrating our diversity and passion to make a difference	**The people in our community** • Working with partners to make the most of shared resources to plan wisely for future needs • Taking positive action to reduce health inequalities • Creating a community that promotes the wellbeing of our people and environment
How we will deliver	Everyone Matters Working Together Making a Difference **Our values**	Improving Together **Our improvement system**	Digitally enabled Culture and leadership Clinical transformation Future estates Financial resilience **Our enabling initiatives**

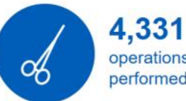
Our services

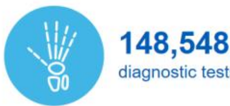
Royal United Hospitals NHS Foundation Trust

At the RUH we are proud to put people at the heart of what we do, striving to create an environment where everyone matters. Everyone means the people we care for, the people we work with and the people in our community.

We provide a wide range of services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services.

The RUH in numbers (2021/22)





The RUH, where you matter

(A breakdown of these figures is in appendix 1)

Care is organised into three divisions:

Medicine

- Acute Medicine
- Adult Fatigue
- Cardiology
- Care for older people
- Dermatology
- Diabetes & Endocrinology
- Emergency Department
- Gastroenterology
- Medical Physics & Bioengineering
- Neurology
- Radiology
- Respiratory
- Rheumatology
- Stroke
- Therapies

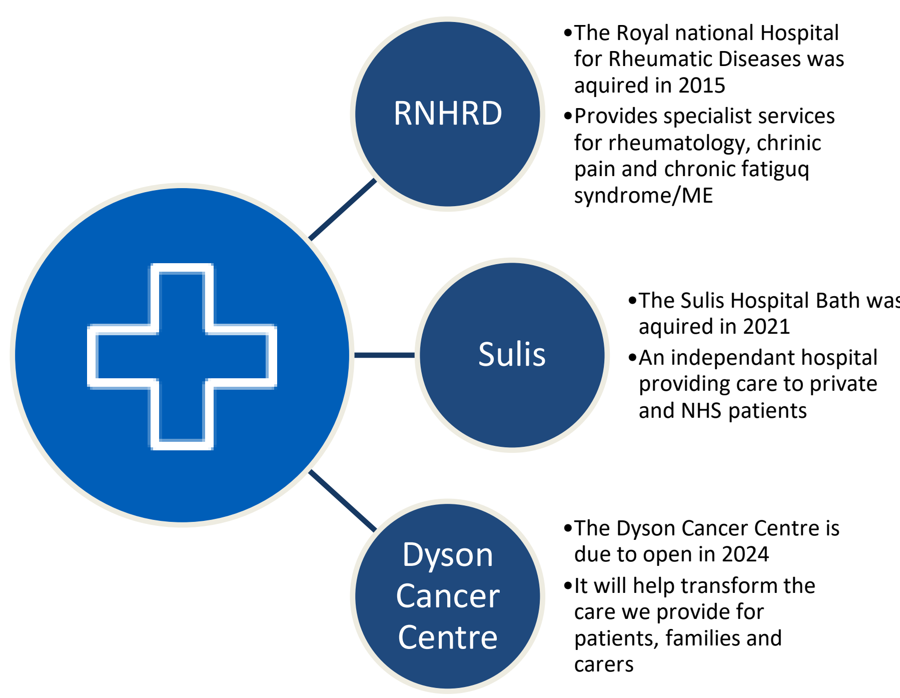
Family & Specialist Services

- Breast Unit
- Children's Therapies
- Haematology
- Maternity Services
- Neonatal Intensive Care Unit (NICU)
- Obstetrics & Gynaecology
- Oncology
- Paediatrics
- Pharmacy
- Sexual Health Services

Surgery

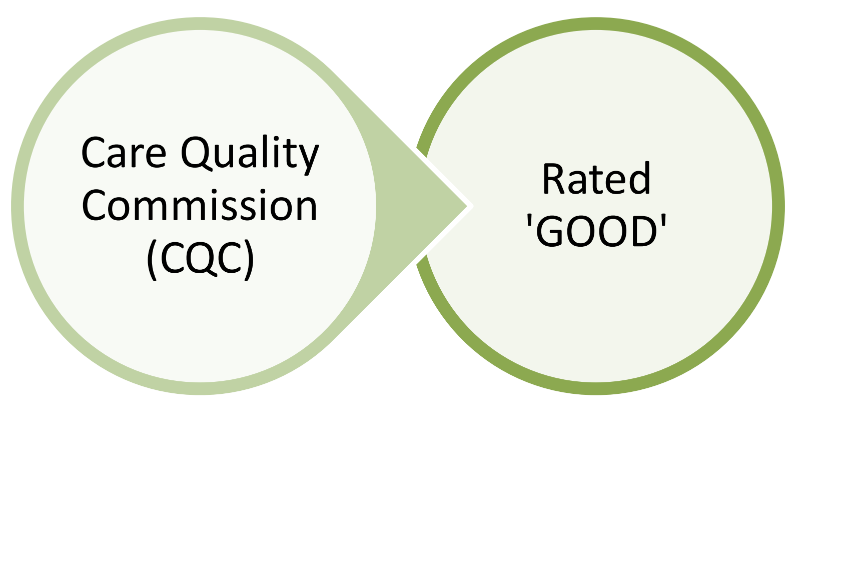
- Anaesthesia
- Audiology
- Critical Care
- ENT
- General Surgery
- Inpatient/Outpatient Booking
- Oral-Maxillo Facial Surgery
- Ophthalmology
- Pathology
- Pain Services
- Trauma and Orthopaedics
- Urology

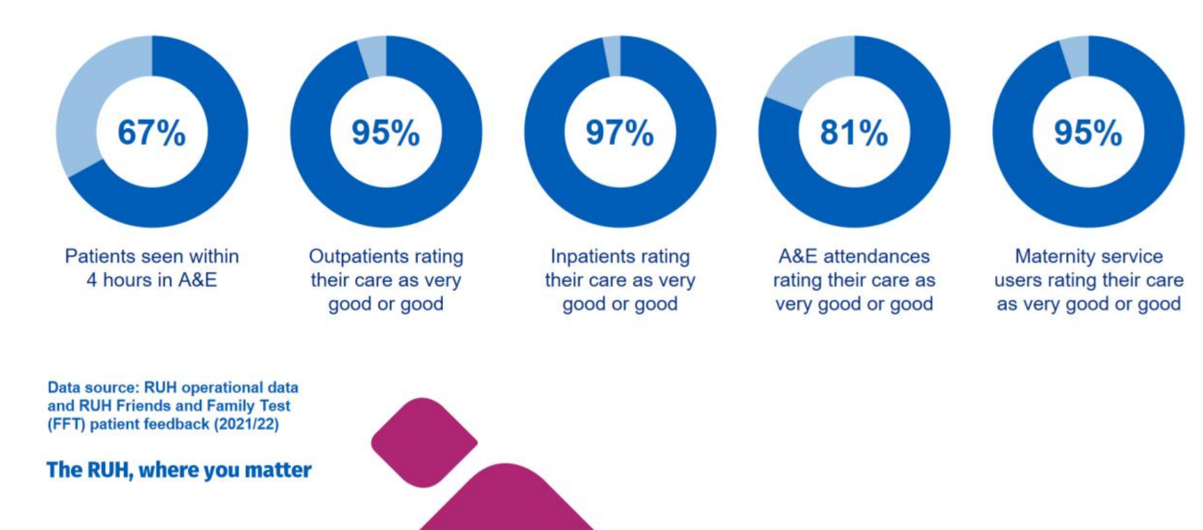
Other Services



We work closely with other healthcare organisations as members of the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board. We strive to improve the health and wellbeing of the people in our community by working together build one of the healthiest places to live and work.

We are rated 'Good' by the **Care Quality Commission (CQC)**.





Defining our patient safety event profile

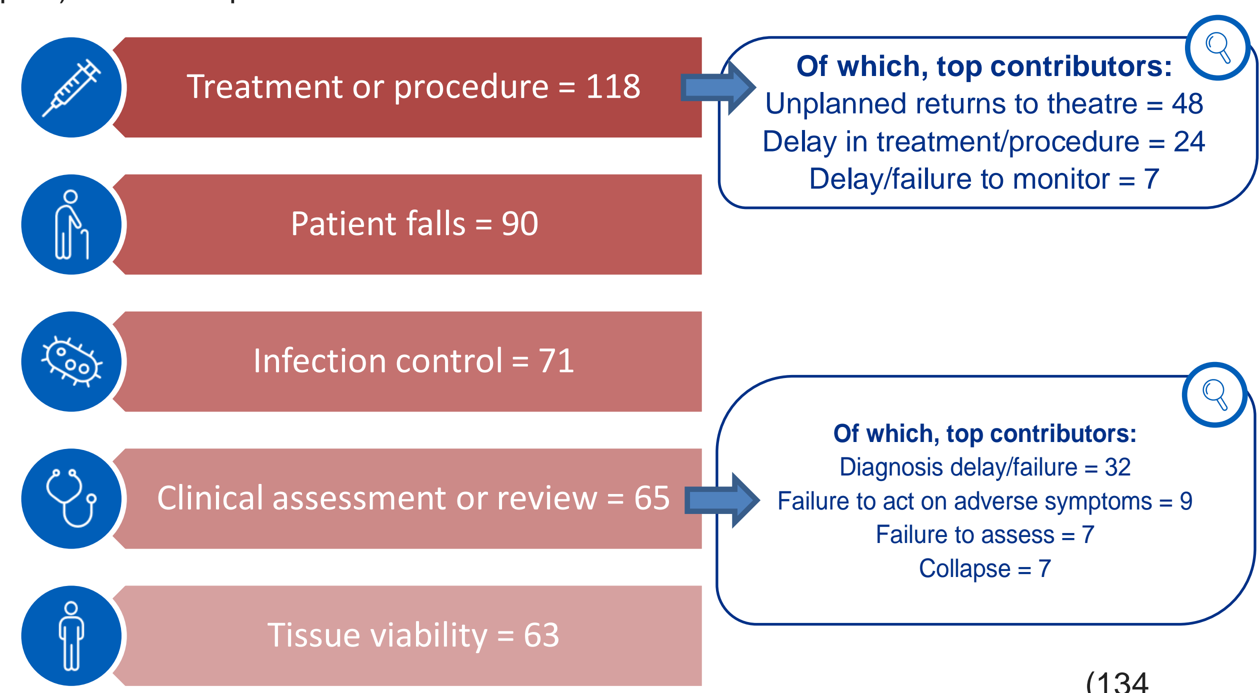
Analysis of harm events at the RUH was undertaken as part of the Quality A3 and Improving Together programme (Appendix 4), this was developed further to identify the RUH patient safety priorities through systematic review of all relevant data sources between April 2020 and March 2023. The review was completed by the Head of Quality Assurance, Lead for Claims and Inquests and the Head of Complaints and reported to the Quality Governance Committee.

The data sources and data reviewed to develop our patient safety priorities were:

- **Themes from patient safety incidents**
  - Root cause analysis investigations
  - Low or no harm patient safety incidents
- **Themes from learning from deaths**
  - Mortality / structured judgement reviews
  - Coroners' inquests
- **Litigation and claims**
- **Themes from patient experience**
  - Complaints
  - Concerns

Patient safety incidents resulting in significant harm

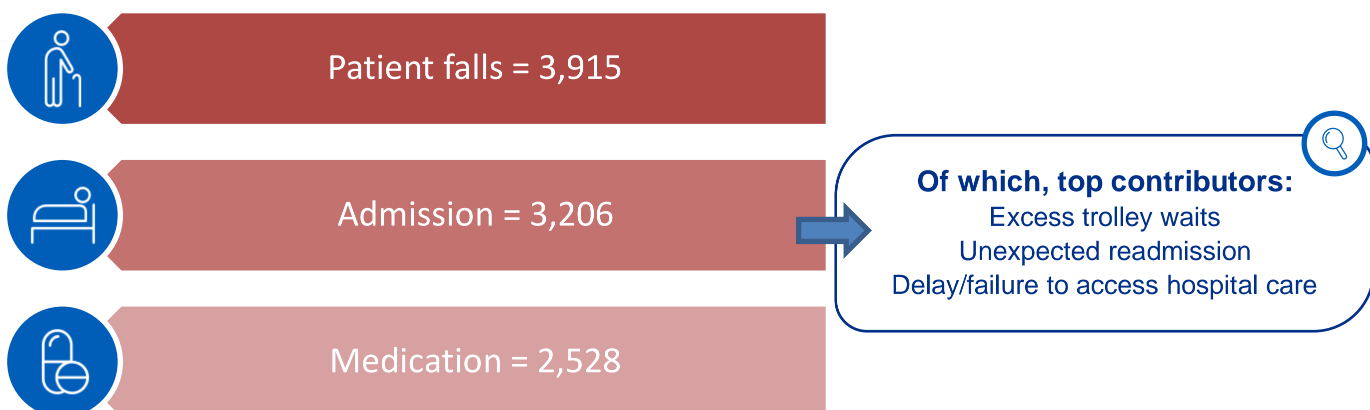
The top contributors to patient safety incidents causing **significant harm** moderate, major, catastrophic) between April 2020 and March 2023 were:



(134 incidents for significant harm related to COVID-19 have been excluded).

All patient safety incidents

The top contributors to **all patient safety incidents** between April 2020 and March 2023 were:



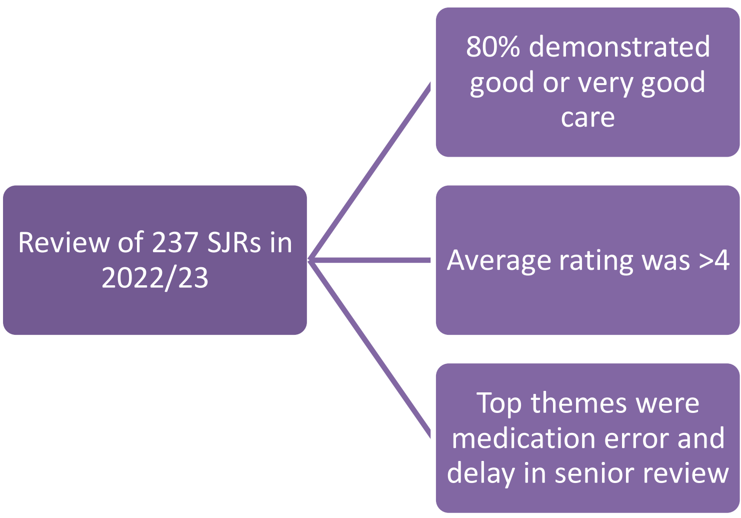
There were 25,135 patient safety incidents reported (484 reported incidents for COVID-19 have been excluded).

Themes from mortality reviews, Coroners' cases and litigation

The Trust has adopted the recommendation from The Royal College of Physicians to embed the Structured Judgement Review (SJR) as a means of standardising the way in which a review of patient care is conducted.

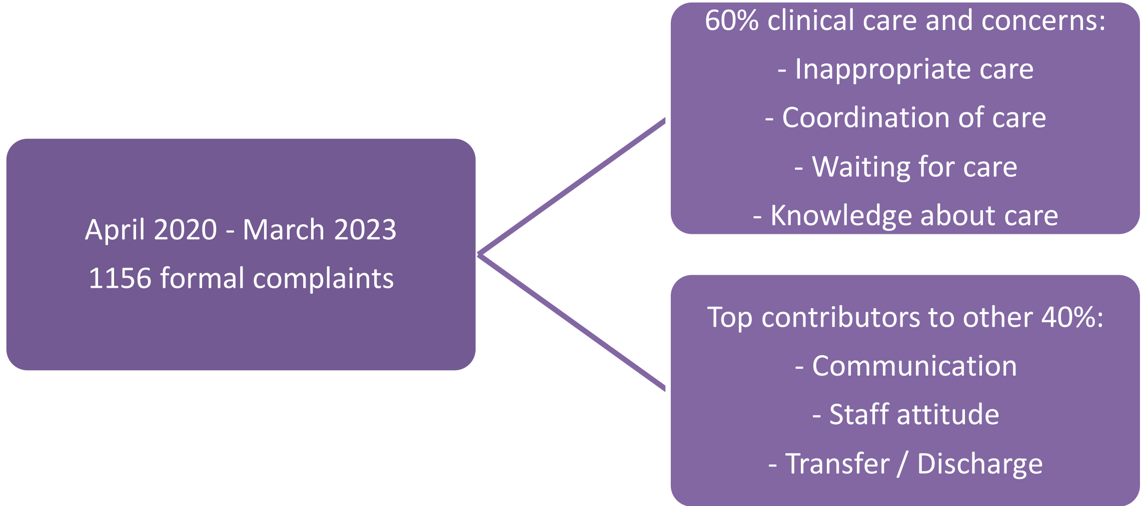
All surgical and medical deaths meeting certain criteria are reviewed utilising this approach, which is a type of case note review that provides both quantitative and qualitative information on care that goes well or not so well. The Mortality Review Committee receive and discuss a quarterly Learning from Deaths dashboard.

A review of the 237 SJRs completed in 2022/23 demonstrated:



Themes from concerns, complaints and PALS

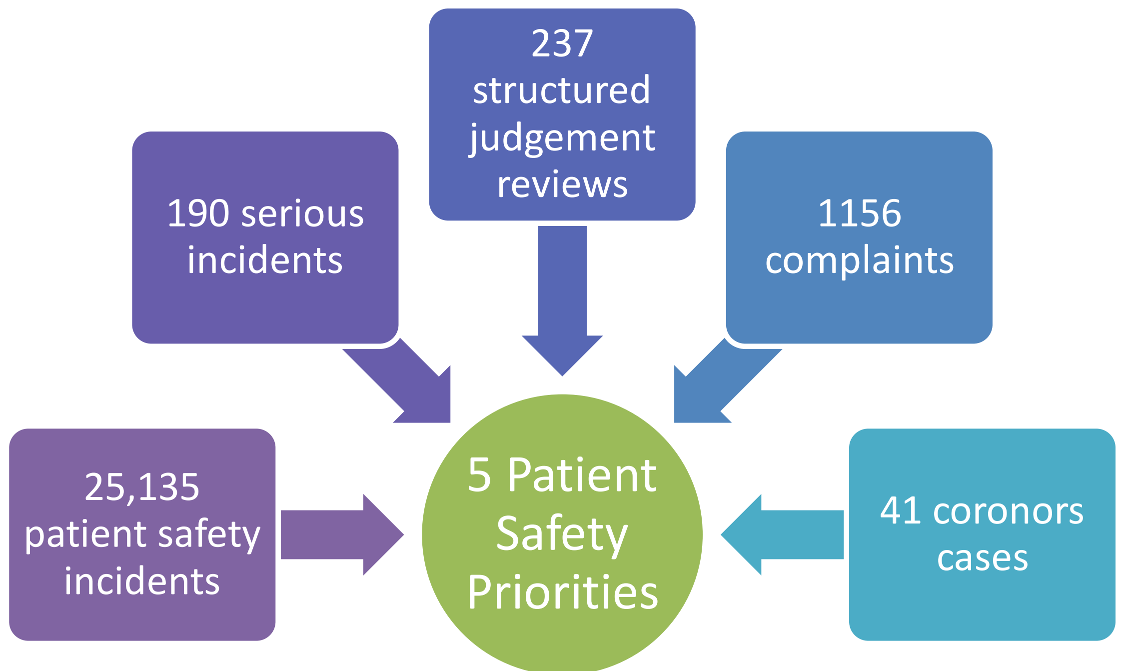
During the period April 2020 to March 2023, the Trust received 1156 formal complaints:



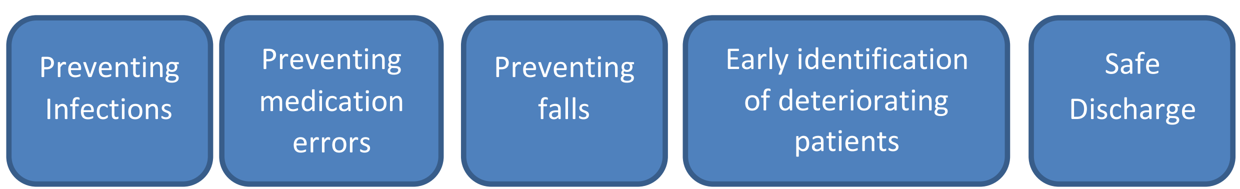
Defining our local patient safety priorities

Data sources and our priorities

A summary of each area analysed is shown below which has identified five Patient Safety Priorities. These will form the focus of the RUH Patient Safety Improvement Programme from 2022 to 2025.



Our five patient safety improvement priorities:

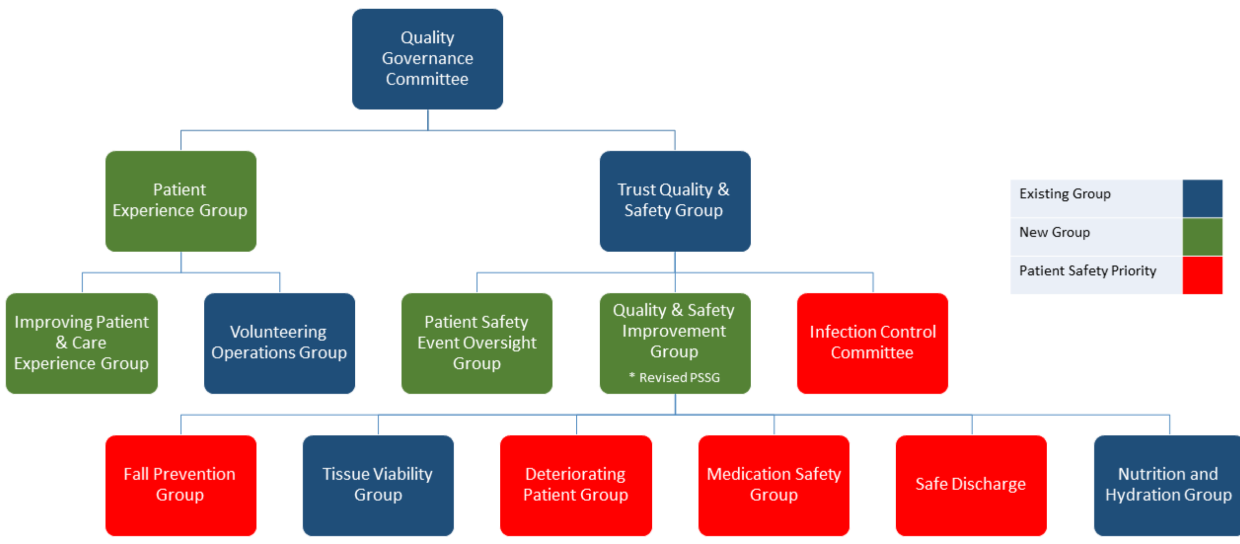


Local Patient Safety Improvement Work

Divisions and Specialist areas such as Maternity will develop patient safety improvement workstreams based upon local insights and activity.

Improvement related to our local patient safety priorities

The oversight and reporting structure for improvement and patient safety event response is shown below:



Quality and Safety Improvement Group (QSIG) - formerly Patient Safety Steering Group

The Quality and Safety Improvement group will provide oversight to the improvement work that aligns with the local patient safety priorities. QSIG will receive assurance reports from the Medicines Advisory, Infection prevention and control and Patient flow groups. It will provide governance to the deteriorating patient, falls prevention and safe discharge groups.

- **Safe discharge –** Quality and Safety Improvement Group (QSIG)
- **Medication errors** – Medicines Safety Group assurance to QSIG
- **Hospital acquired infection** – Infection Control Committee assurance to QSIG
- **Deteriorating patient** – Deteriorating Patient Group to QSIG
- **Falls** - Quality and Safety Improvement Group (QSIG)

Patient Safety Event Oversight Group (PSEOG)

The Patient Safety Event Oversight group will provide oversight to the management of patient safety events and emerging themes. It will report key performance indicators related to PSE management and any emerging themes for improvement. Patient safety event oversight group will work closely with the Quality and Safety improvement group and the associated workstreams to provide feedback from patient safety event learning that can inform future improvements.

Trust Quality and Safety Group (TQSG)

Trust Quality and Safety group will provide oversight to the safety and improvement processes. It will make recommendations on whether emerging themes in patient safety events necessitate additional improvement workstreams or the re-prioritisation of existing improvement work.

Patient Safety Incident Response Plan: National Requirements

In addition to the 5 locally developed patient safety priorities, the Trust must also comply with the national requirements for incident response. The patient safety incident responses to meet national requirements are set out below:

Incident	Action required	Lead response body	RUH 2022/23
Deaths thought more likely than not due to problems in care	Locally led PSII	The Trust	18
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, if the death may be linked to problems in care	Locally led PSII	The Trust	0
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally led PSII	The Trust	3
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT)	As decided by the RIIT	0
Maternity and neonatal incidents meeting Maternity and newborn Safety Investigations (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to MNSI or SpHA for independent PSII.	MNSI or SpHA Or if family decline, for internal PSII	1
Stillbirth and/or Neonatal death	Perinatal Mortality Review Tool review process	Organisation in which the event occurred	11 (no care concerns identified)
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	Child Death Overview Panel	5
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	LeDeR programme	0
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	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 by	Refer to local designated professionals for child and adult safeguarding	0

support needs from their local authority - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	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	Organisation in which the event occurred	0
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 reviews where required to do so	PPO or IOPC	0
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	CSP	0

Table 6: National requirements for incident reporting and response

Patient safety event response process

We will be flexible in our approach to investigating patient safety events. We will tailor our response to reflect the national and local priorities described in this document and the opportunities for further learning. The purpose of taking this approach is to ensure that resource is prioritised to improvement rather than unnecessary investigation

Process development

All data relating to patient safety; incidents, patient and staff experience, SJRs, claims and litigation alongside will be reviewed daily by the clinical divisions (appendix 7). The clinical divisions will be responsible for validating, triangulating and triaging this data and agreeing the most appropriate response based upon the opportunity for risk, learning and improvement. Oversight of the triage of incidents will be provided through the Patient Safety Event Response Review group which will meet weekly. If an incident of concern is identified, then this will be escalated to the Executive Review Group (ERG), chaired by the Chief Nursing Officer or Chief Medical Officer. An example of an incident of concern would be an incident that is considered to align with the national requirements for a response.

The ERG will be convened every week and will comprise the Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and one of the Executive Deputies with responsibility for Patient Safety, it will be supported by attendance by appropriate divisional representation. The ERG will provide support, oversight and challenge to the management of events of concern. If a time critical event of concern is identified outside of the timeframe of ERG then this should be escalated immediately to the CNO and CMO or their nominated deputy as described in the PSIRF policy.

Learning responses

The response to a patient safety event will be informed by the opportunity for learning. The three broad themes that will inform the response to a patient safety incident are described in the table below:

	Circumstances in which to apply activity type
Learning to inform improvement	Where contributory factors are not well understood, and activity has been identified as local priority: PSII performed to fully understand the context and underlying factors to support the improvement work.
Improvement based on learning	Where a safety issue or incident type is well understood (e.g. previous incidents have been thoroughly investigated and national/local improvement plans are being implemented and monitored for effectiveness): Theme fed into improvement. Resources directed at improvement rather than repeat investigation.

Assessment to determine required response	For issues or incidents where it is not clear whether a learning response is required, further analysis may be required to determine whether PSII is required

A number of tools are available to facilitate a learning response to a patient safety incident (appendix 9). It is anticipated that learning from the majority of events will take less time, enabling earlier focus on improvement and increase time for review and analysis of all patient safety events.

There will be more thematic analysis and increased engagement and involvement of the appropriate teams to identify and share new learning and develop robust responses.

Where more detailed review is required, a **Patient Safety Incident Investigation (PSII)** will be completed by staff who have suitable time allocated and who are appropriately trained. The PSII will focus on systems-based learning to inform current or future improvement work. Events which previously met the Serious Incident Frameworks definition of a 'serious incident' will not be routinely investigated using the PSII. If a PSII is determined necessary, then it will start as soon as possible after an incident is identified and will aim to be completed within one to three months and will not exceed six months.

The national PSIRF standards[2] stipulate specific roles required for PSII, each of which is aligned to accredited national training. RUH staff in patient safety roles have received nationally accredited training in preparation for the transition to PSIRF and in house training will be developed over the next 12 months to increase the capacity, as the framework embeds, and ongoing learning is established. Further details will be described in the PSIRF policy

Oversight of the PSII development and response will be provided by the Patient Safety Event Review Group and the findings will be reported through the Patient Safety Event Oversight Group to the Trust Quality and Safety Group.

Our commitment to patients, relatives, carers and colleagues:

We will be guided by our values when approaching those involved in a patient safety event.

Everyone Matters

We will be kind and caring; we will try to understand how patients, carers, families and colleagues who are involved with the event may feel. We will treat them with empathy, civility and compassion and take an interest in their wellbeing. We will ensure that apologies are meaningful. We will seek to understand patient safety events, and treat those involved as individuals, attempting to understand their needs as we respond. We will provide staff with any support required and approach the response to events in line with the principles of a Restorative and Just Culture.

Working Together

We will ensure that we support each other in patient safety event responses. We will actively listen to understand people's views and collaborate to improve our services in partnership with patients, relatives and carers. We will be open to challenge, and we will not be afraid to challenge each other to make meaningful change. We will utilise the learning opportunity to build relationships within and across teams and to continuously improve together.

Making a Difference

In our response we will encourage a culture where everyone can speak up to share ideas and bring their different perspectives. We will be fearless in challenging the status quo and relentless in identifying and addressing inequalities or inequities. We will ensure that we use everyone's time efficiently and ensure that it is used to best effect to create positive change.

The people we care for

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. We will appoint a nominated individual as a single point of contact for incidents where it has been determined that we need to undertake a PSII. It is likely that this will be the Lead Investigator for the incident or a member of the Patient Safety Team. The point of contact will be responsible for:

- Meeting with patient, families and carers involved in a patient safety event to explain what has happened and the proposed response
- Hearing the patient/family account of the event from their perspective and gathering any questions they would like the review to answer
- Providing a single point of contact to patients, families and carers during the course of the patient safety event response
- Ensuring that the patient has been provided with appropriate on-going support.

- Arranging for transfer of care where the patient (and/or carer) requests this.
- Documenting the details of all discussions with the patient (and/or carer), copies of letters relating to the patient safety event response ensuring this documentation is uploaded to the relevant incident record on Datix.
- Keeping in close communication with the patient, family and/or carer as per their wishes.
- Contact will also take place following the conclusion of any patient safety event response to share the findings and proposed improvements and how they may be delivered.

Patient Safety Partners

We have recruited patient safety partners to be key partners in delivery of our new framework and to inform our event response, with particular focus on development of our patient engagement pathway. These will be core members of the Quality and Safety Improvement Group, Patient Safety Event Oversight Group, Patient Experience Group and the Trust Quality and Safety Group.

Duty of Candour

Being Open' supports a culture of openness, honesty and transparency, and involves apologising and explaining to patients and carers what happened when things go wrong. The Being Open process applies to all patient safety incidents. We will apply Duty of Candour as described in the Being Open and Duty of Candour Policy.

The people we work with

We recognise that involvement with patient safety events can be stressful and traumatic for staff. We need to ensure that we view any patient safety event as an opportunity to learn and explore the system within which our staff work. We will listen without judgement and, where necessary, make every effort to support our colleagues. The support may be informal, more structured support from within the team leadership and could include support from occupational health or wider services. Use of the EAP programme and TRIM team will be encouraged where necessary as well as increased use of team immediate meetings to facilitate early TRIM support.

Anticipated Patient Safety Investigation activity during the next 12 months

National guidance recommends that 3-6 investigations are undertaken per year for incidents aligned to the local patient safety improvement priorities. We will aim to undertake 3 PSIIs related to each of our 5 improvement priorities.

This table describes the expected number of patient safety incident investigations that we would predict to undertake in the next year. Incidents that are referred to and investigated by external organisations have been excluded.

Incident	Action required	RUH 3-year average	Predicted 2024/25
Patient safety incidents related to local improvement priorities	PSII	N/A	15
Deaths thought more likely than not due to problems in care	PSII	18	18
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, if the death may be linked to problems in care	PSII	0	0
Incidents meeting the Never Events criteria 2018, or its replacement.	PSII	2	2
Total predicted PSII 2024/25	**35**		

Monitoring

How will we know PSIRF is a success?

Trust Goal:

- Decrease in incidents of moderate harm and above.

Outcome Measures:

- Improve the ratio of harm to no-harm reported incidents
- Continue to decrease HSMR to be the lowest in region

Tracker Measures:

- Staff Survey - “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again” - 75% at next Survey, with vision of 95% by year 3
- Improvement in the key outcome metrics for each of the Trust Patient Safety Priorities

Outcome Monitoring

Monitoring of success will be through the production of an A3 for each of the patient safety priorities which will describe measurable improvement outcomes related to each patient safety improvement priority. Success will be determined by progress tracked against these outcomes. The outcome measures will be monitored and reported through QSIG.

Process Monitoring

The PSIRF policy will describe the key performance indicators for oversight of:

- Delivery of PSIRF training relevant to staff role
- The process of incident management
- Undertaking statutory Duty of Candour

The process KPIs will be monitored at the Patient Safety Event Oversight Group.

Plan Review

This plan will be reviewed annually by the Trust Quality and Safety Group. The date of the next review will be March 2025.

References

1. National patient Safety Strategy: www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

2. National patient safety Standards: www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

Appendices

Appendix 1: About Our Services - Figures

Summary of Beds

Bed Type	Core Beds	Escalation Beds	Total Occupied (full year 2022)
FASS (Adult, non-Maternity)	16	0	5,674
Intensive Care Unit	17	0	4,744
Maternity	58	0	11,529
Medicine	334	18	122,006
Paediatrics	18	3	6,482
Surgery	156	0	59,689
Total	**599**	**21**	**210,124**

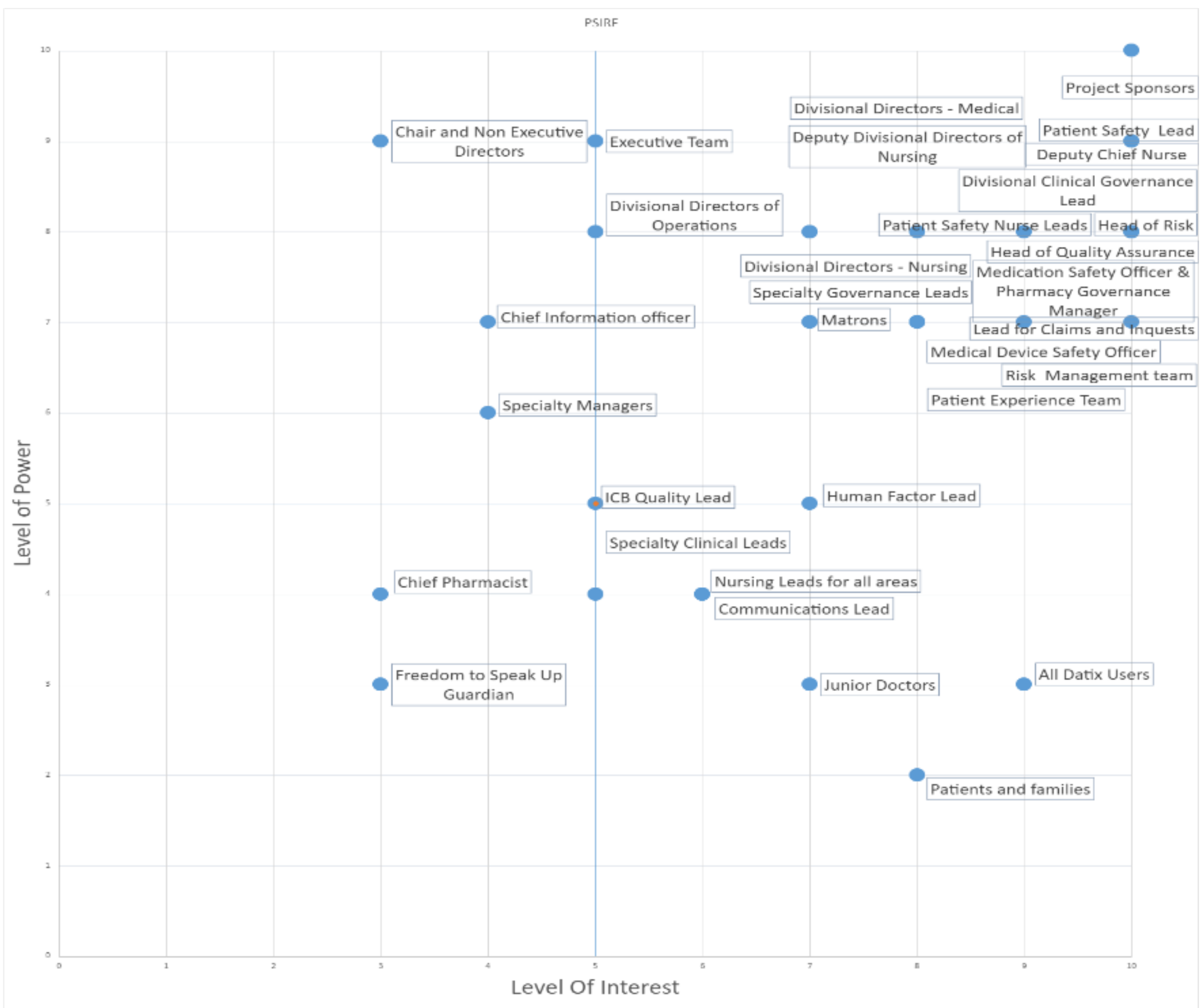
Summary of ED Attendances

ED Location	Q1	Q2	Q3	Q4	Total (2022/23)
Majors	7,770	7,708	7,720	8,111	31,309
Urgent Care	15,244	15,518	16,903	13,948	61,613
Total	**23,014**	**23,226**	**24,623**	**22,059**	**92,922**

Summary of Outpatients Attendances

Division	New	Follow up	Total
FASS	49,105	166,957	216,062
Medicine	63,283	96,050	159,333
Surgery	73,038	113,908	186,946
Total	**185,426**	**376,915**	**562,341**

Appendix 2: Stakeholder Mapping and Engagement



Stakeholder Engagement

Workshops were held between February and September 2023 with the Divisional and corporate Patient Safety Teams to review existing systems and capacity within teams. The group discussed their aspirations for success and defined a set of principles to ensure ambitions are met.

'Involvement and communication with patients and their families is paramount.' A specific pathway for patient communication is being developed.

'Involvement and communication to staff involved is essential to develop a culture of proactivity to identify potential risks. This is a key focus in the development of the new process.'

Figure 1: RUH principles for PSIRF transition designed from workshops

#	Stakeholder role/Group	Level of Interest	Level Of Power
1	Project Sponsors	10	10
2	Executive Team	5	9
3	Chair and Non-Executive Directors	3	9
4	Deputy Chief Nurse	10	9
5	Chief Pharmacist	3	4
6	Human Factor Lead	7	5
7	Lead for Claims and Inquests	9	7
8	Head of Quality Assurance	10	8
9	Head of Risk	10	8
10	Risk Management team	10	7
11	Deputy Divisional Directors of Nursing	7	8
12	Patient Safety Lead	10	9
13	Divisional Directors - Medical	7	8
14	Divisional Directors - Nursing	9	8
15	Divisional Clinical Governance Lead	8	8
16	Nursing Leads for all areas	6	4

#	Stakeholder role/Group	Level of Interest	Level Of Power
17	Specialty Managers	4	6
18	Specialty Clinical Leads	5	4
19	Specialty Governance Leads	7	7
20	Patient Experience Team	8	7
21	Patient Safety Nurse Leads	10	8
22	Matrons	7	7
23	Divisional Directors of Operations	5	8
24	ICB Quality Lead	5	5
25	All Datix Users	9	3
26	Chief Information officer	4	7
27	Communications Lead	6	4
28	Junior Doctors	7	3
29	Patients and families	8	2
30	Medication Safety Officer & Pharmacy Governance Manager	8	7
31	Medical Device Safety Officer	8	7
32	Freedom to Speak Up Guardian	3	3

Appendix 3: Quality A3

Title of A3; Patient Safety
A3 Lead; Toni Lynch, Andrew Hollowood
Team Members: Brian Johnson, Simon Sethi, Alfredo Thompson

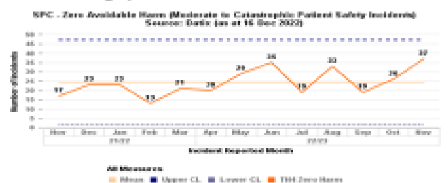
NHS
Royal United Hospitals Bath
NHS Foundation Trust

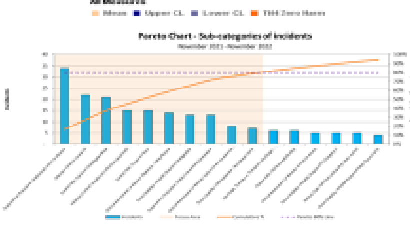
Step 1: Problem Statement

The people we care for tell us they want to feel safe while at the hospital and we know the quality of our care varies by day of the week, and patients experience harm through clinical error, contracting infections, but also decompensation as they wait to leave.

Step 2: Current Situation

The number of incidents that result in moderate to catastrophic harm is trending upwards.





The most frequent types of reported incidents between November 2021 and November 2022 are delays in treatment/procedure including unplanned returns to the theatre (n=34), infection control COVID-19 (n=22) and falls – from standing / walking (n=21) and hospital-acquired infections (n=15).

The patient safety programme has identified 5 priorities going forward which are; deteriorating patients (include return to theatre), preventing infection, medication errors, preventing falls and safe discharge. A3's are being developed for each of these.

Step 3: Vision/Goals

People Group Vision: Connecting with you – helping you feel safe, understood, cared about and always welcome. 95% recommend the RUH as a place to receive treatment
A3 vision: Deliver safe high quality care consistently
Trust Goal: Year on year reduction of harm events
Tracker measure: Harm events (moderate & catastrophic) & HSMR

Step 4: Analysis (Issues and Root Causes)

The top contributor to harm is delay in treatment or procedure. The top contributor for patient complaints is concerns regarding clinical care.

Delay in treatment or procedure are multifactorial but early identification of any deterioration will decrease harm. Electronic recording of observations has been implemented to support this but use of alerts to support early response is not well embedded. Response times within 30 minutes to NEWS increase if 5 or more is currently only 20%.

Medication safety was a key theme from the 'no harm' incidents and include 'near misses'. High-contributing medications which are also high risk for harm are anticoagulants and opiates.

Fishbone needed for return to theatre to identify causes?

Step 5: Counter Measures and Future State

Concern / contributor	Potential root cause	Countermeasure	Completed in yr 1-5?
Our HSMR is higher than expected with variance between weekdays and weekends	Reduce variance at weekends Reduce variance overall	H@N Deteriorating patient Data quality Best in class for patient outcomes for HSMR	Year 1 & 2 Year 3
Top contributor to harm	See pareto chart	Programme of improvement for patient safety priorities	Year 1,2,3
We do not always possess the skills to care for the most vulnerable	Rising incidence of mental health presentations (associated or not with physical health)	Development of a mental health strategy	Year 1
Patients come to harm due to our discharge processes	Lack of standardised discharge processes Lack of digital processes to support workflows	Integrated digital and health and social care systems	Year 1, 2, 3 & 4
We do not harness learning and apply this to practice consistently	Systems, process, culture	PSIF implementation Right workforce Right education Right culture	Year 1
Outcome variance in relation to IPC	Our Estate is not clean & does not have sufficient isolation capacity to support good IPC practices	Infection control programme incl estates plan	Year 1,2,3,4,5
Clinical standards vs practice mismatch	Lack of digitalised pathways to provide visible clinical outcomes data	We will deliver paperless inpatients, enhancing oversight of outcome data	Year 1
We do not always recognise & treat the most vulnerable in a person centred way	Lack of knowledge & skills Prejudice & bias Integrated working (Health & voluntary sector)	We will deliver Oliver McGowan MT	Year 1

Step 6: Actions and Risks

Actions

1. Develop a Hospital at Night service
2. Create a robust quality improvement programme to improve patient outcomes focused on the patients safety priorities (not limited to this)
3. Streamline and define discharge process
4. Create an integrated digital health and social care system
5. Implement PSIRF
6. 5-year estates plan to improve outcomes relating to infection
7. Implement paperless inpatients

Risks

1. Digital implementation
2. Ability to create an integrated digital health and social care system
3. Capital plan funding

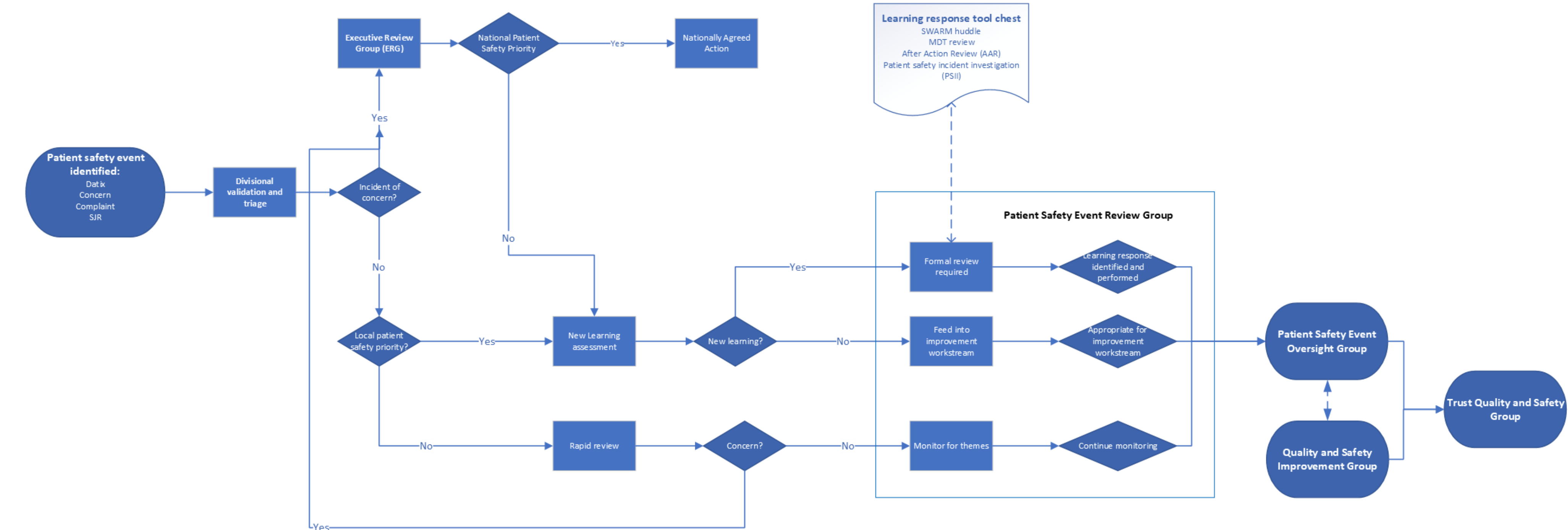
Step 7: Cost/Benefit

Step 8: Insights

Appendix 4: Summary RUH Patient Safety Priorities and Key Focus

Patient Safety Priority	Outcome Measure	Process Measure
Prevention of Medication Errors: (Issues: low rate of scanning wrist bands, higher than national average HAT)	Number medication errors	% bar code scanning. Target 80%
	Number of Hospital Acquired Thrombosis (HATS)	Compliance with VTE risk assessment Compliance with accurate VTE prophylaxis treatment
Prevention of Falls (Issues: deconditioning, postural drop, inappropriate footwear, enhanced observation patients)	Number of falls	% of patients sat out for lunch % of patients in their own clothes BIMS (Bath Inpatient Mobility Scale) Number of patients falling and wearing non-slip socks @ Stop the Socks Campaign Compliance and accuracy of enhanced observations tool
Prevention of Infection	Number HA Infection Number E.Coli infection / Number CD infections	Compliance with Fluid balance recording
		Compliance with AB prescribing
Early Identification of Deterioration (Issues: Lack of visibility E obs by bedside and availability devices Staff turnover and training Staff capacity if high acuity patients Daily availability of deteriorating support teams	Suspicion of sepsis mortality AKI mortality HSMR	Compliance with response to inpatient NEWS increases and sepsis screening on admission
		Response to NEWS increase if 5 or more within 30 minutes Compliance with escalation criteria for review deteriorating patients admitted to critical care (CQUIN)
	Incidence hospital acquired Acute kidney injury	Compliance with accurate urine output recording
	Implement 'Be Curious' soft signs tool	Compliance with recording of soft signs
Safe Discharge	Number complaints regarding discharge	Compliance with ward communication between MDT to patients and relatives and community
	Errors on discharge	Compliance with discharge checklist Quality audits discharge checklist

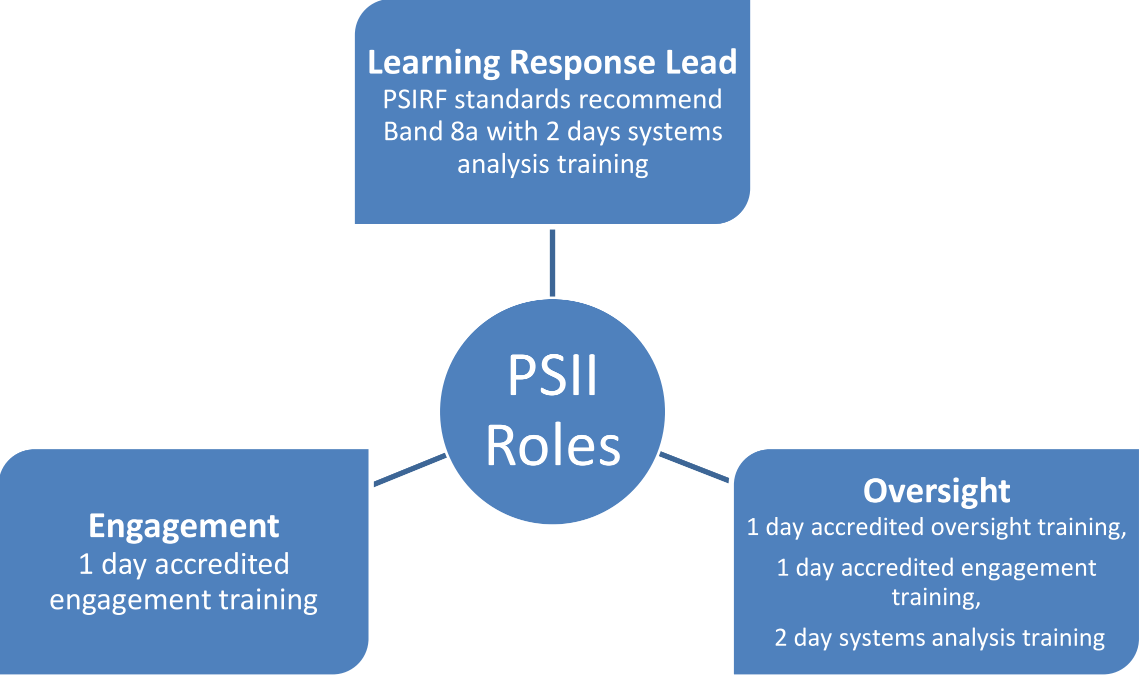
Appendix 5: PSIRF Process Map



Appendix 6: Training

Training Requirements for PSII and number RUH staff trained by December 2023

The national PSIRF standards[2] stipulate three roles required for PSII, each aligned to specific accredited national training. These are:



The summary of staff trained in specific nationally accredited PSIRF modules:

Staff groups and potential roles

Staff group	Breakdown of staff group	Total no. for training
Learning Response Leads (systems training) 8a and above	**Head of Risk and Assurance** **Divisional Patient Safety Nurse Leads** **Head of Therapies** **Medication Safety Officer** **Divisional Governance Leads** *Matrons* *Senior MNP* *Deputy Directors of Nursing and Midwifery*	40
Engagement roles	**Risk Management Team** **Divisional Patient Safety Nurses** **Patient Experience Team** Senior AHP Senior sisters Speciality managers	50
Oversight roles	PS Specialist Leads: ACMO Patient Safety & QI Deputy Chief Nurse Trust Quality Assurance Lead Head of Risk and Assurance Director of Pharmacy Chief Medical Officer Chief Nurse Directors of Nursing and Midwifery Divisional Medical Officers Deputy Directors of Nursing and Midwifery Head of Litigation	18

NHSE Patient Safety E-learning

NHS have developed a standard patient safety syllabus and produced level 1 and 2 patient safety training e learning for all staff.

This is aimed to increase awareness and human factors and improve safety culture.

The training has been approved as ‘essential for role’ and included in staff training requirements since January 2023.

By November 2023, 70% of all staff had completed this training

Appendix 7: Patient Safety Event Learning Tools

Tool	Description
Thematic review tips	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The 'top tips' document provides guidance on how to approach a thematic review.
Horizon scanning	The Horizon Scanning Tool supports health and social care teams to take a forward look at potential or current safety themes and issues. It can be used to proactively identify safety risks.
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk-throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on 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.
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: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?
Structured Judgement Reviews	
Observation guide	Observations help us move closer to an understanding of how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as disclosed).

Walkthrough Guide	Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (eg designing a new protocol). The tool is used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support human performance.
Link analysis guide	Link analysis creates a visualisation of the frequency of interactions observed in a specific location or environment. It can be used to highlight frequently used paths within an environment that are critical for safety. This can inform the design of the environment to locate items or areas based on what tasks are carried out most frequently.
Interview guide	This interview planning guide contains questions that help plan an interview with staff involved in a patient safety incident or with patients, families or carers.
Timeline Mapping	A working document to help create a narrative understanding of a patient safety incident. This can be added to as further information is collected. It is useful for understanding any gaps in information and defining early thoughts on lines of enquiry.
Work System Scan	A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (ie barriers and facilitators).
Structured Judgement Review	Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase
Perinatal Mortality Review Tool	Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care; Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

Appendix 8: Communications

A Communications Plan was developed with the RUH Communications Team and engagement with a wider ICB group. The key objectives of this are:

- To raise awareness that PSIRF has been published, what its key aims and principles are, and how it will support patient safety improvement
- To raise awareness in the Trust and our patients/public of the requirements and processes to prepare for PSIRF and of the support and resources available
- To clearly articulate how PSIRF is part of the You Matter strategy
- Ensure that PSIRF is high profile to ensure awareness and recognition
- Champion those who are advocates for PSIRF
- To raise awareness of the changes to patient safety reporting due to the NHS Improvement initiative; Learning from Patient Safety Events (LFPSE) which is to be implemented alongside PSIRF

The communication to the wider organisation started in April 2023 in the Executive Staff Brief and will continue, focusing of staff awareness of the patient safety priorities and completion of the national patient safety e learning. This sets out the principles and importance of raising awareness of patient safety risks and working together to improve them.

A general awareness of the importance of reporting any Patient Safety Events or risks as well as understanding of human factors has also been achieved through the NHS patient safety training level 1 and 2 e-learning.