Patient Safety Incident Response Plan

NHS
North Bristol
NHS Trust

2021 – 2023

Exceptional healthcare, personally delivered

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Foreword from our Associate Director of Patient Safety

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

I can assure you, PSIRF is ***very different***. And it is very exciting.

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to but outside of that, it is up to us, which of course can feel a bit scary!

When asked "why do we investigate incidents?" the common response is to learn, but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that. How often is the answer to what did we do about an incident "we investigated it"? How much has demonstrably changed/improved in 20 years using these methods?

Over the past 2 years, North Bristol NHS Trust has focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved.

In doing so, we will support our core ambition of working in partnership with patients to improve safety.

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

We have made significant progress over the past 2 years in developing and fostering a restorative just culture in which people feel psychologically safe. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak. PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture where people are confident to about patient safety events and to simply express their opinion.

As an early adopter, we are part of a group of organisations that will be actively learning through the process. We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF, we will talk and respond, adapt as and when our approach is not achieving what we set out to achieve.

Thank-you for being part of this extremely exciting opportunity.

Christopher Brooks-Daw
Associate Director of Patient Safety

An introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at North Bristol NHS Trust to prepare for "go live" with PSIRF, as an early adopter organisation and what comes next.

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean "do nothing", it means respond in the right way depending on the type of incidents and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems.

We have developed our understanding and insights over the past two years, including regularly discussions and engagement through our committees and group. Most recently, in March 2021, the Patient Safety and Clinical Risk Committee and the Quality and Risk Management Committee received and supported the thematic analysis and patient safety priorities that informs our patient safety priorities for PSIRF. This plan provides the headlines and description of how PSIRF will be apply in NBT.

The scope of PSIRP 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.

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 statements. The North Bristol NHS Trust vision statement is:

"we will realise the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, financially sustainable services in state of-the-art facilities. Clinical outcomes will be excellent and with a spirit of openness and candour we will ensure an outstanding experience for our patients."

The implementation of PSIRF will see both the strategic aims and our Trust visions embodied in our work.




NBT Values	Putting the patient first	Recognise the person	Striving for excellence	Working well together
PSIRF Strategic Aims	Improve the safety of the care we provide to our patients	Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.	Improve the use of valuable healthcare resources.	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

System overview of North Bristol NHS Trust

We reviewed our local system to understand the people who are involved in patient safety activities across NBT, as well as the systems and mechanisms that support them. NBT is a centre of excellence for health care in the South West in several fields as well as one of the largest hospital trusts in the UK. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

NBT is a complex system with many interrelated components that are crucial to ensuring that everything works. We have reviewed all patient safety activities and our network of key stakeholders across NBT who are integral to the Patient Safety agenda.

This Trust has 7 Corporate Directorates. The central Patient Safety Team works alongside the Patient Experience Team and Quality Governance Team, within the Nursing & Quality Directorate. The QI team sits within the Research & Strategy Directorate and the Improvement Team sits within the People & Transformation Directorate.

There are 5 clinical Divisions consisting of Medicine, Women and Children's Health (WaCH), Neurosciences and Musculoskeletal (NMSK), Anaesthesia, Surgery Critical Care and Renal (ASCR) and Core Clinical Services (CCS).

Over the past two years, NBT has been in a transitional period which included a review of the internal governance structures across the clinical divisions.

This was overseen by the Quality Governance Improvement Programme, which formed the Divisional Quality Governance and Patient Involvement & Experience teams. These teams provide operational support, working collaboratively with the central governance, safety and experience teams.

Core patient safety activities undertaken at NBT include:

- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Clinically Challenging Behaviours
- Central Alert System (CAS)
- Supporting improvement programmes

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths, complaints and feedback and inquest responses.

The operational 'work-as-done' for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed with expert support from their respective Divisional Quality Governance colleagues who are supported through strategic, educational and subject matter expert support flowing from the Corporate Directorates.

This emergent system has been built to fit and respond to the size of hospital we are and the nuances of the teams, services and structures we work in. We call this system our 'Patient Safety Network'. This involves key people & teams within NBT who are integral in facilitating our patient safety system and patient safety culture, on our road to implementing PSIRF.

System overview – our networks

North Bristol NHS Trust Patient Safety Network

Improvement Programmes

Insight

Involvement

Improvement

5 Patient Safety Priorities for PSIRF

- **Inpatient falls**
- **Medication**
- **Responding well to clinically changing conditions**
- **Pressure Injuries**
- **Discharge**

The system

Trust-wide	Divisional Structure	Specialist Expertise
Patient Safety and Improvement Teams	Patient Partnership	Bringing the patient voice to improvement
	Core Clinical Divisional Patient Safety & Quality Leads	Services that underpin clinical care e.g. pharmacy
	Anaesthetics, Surgery, Critical Care & Renal Divisional Patient Safety Leads	Knowledge of clinical specialities and frontline care delivery
	Medicine Divisional Patient Safety Leads	
	Neurosciences and Muscular-Skeletal Divisional Patient Safety Leads	
	Women's and Children's Health Patient Safety Leads	
	Corporate directorates providing support functions for Patient Safety	Business intelligence, digital solutions. education and simulation

Situational Analysis of Patient Safety Activity

In the last three years, more than 36,000 patient safety incidents have been reported in NBT with <0.4% of these being investigated as a Serious Incident as per the Serious Incident Framework.

A large portion of the work our Divisional Quality Governance colleagues undertake in is serious incident investigations. These can be a very time-consuming process.

Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99.6% of patient safety incidents. In short, the burden of effort is placed on fewer than 0.4% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as possible within Serious Incident Framework but simply calling them something else.

A key part of developing the new national approach is to understand the amount of patient safety activity the trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

The patient safety PSIRF related activity undertaken prior to PSIRF can be broken down as follows:

Patient Safety Activities	Activity	Definition	Av. of prev. 2 financial years	Last financial year
National Priorities	Incident resulting in death	Serious incident requiring investigation which met the standard investigation timeframe and resulted in patient's death.	8	9
	Never Events	Incident meeting criteria for never events framework and reported to STEIS as a SIRI	3	1
Local Patient Safety Activities	Serious Incident Requiring Investigation (SIRI)	Serious incident requiring investigation (SIRI) which met the standard investigation timeframe.	59	44
	Patient Safety Incident reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SIRI criteria	839	1217
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring validation at department/ward level.	11582	13584

Thematic analysis and our ongoing patient safety risks

We used a thematic analysis approach to determine which areas of patient safety activity we focussed on to conduct a thematic analysis, to identify our patient safety priorities.

Our analysis used additional sources of patient safety insights, beyond that of incidents which resulted in severe harm or death. The initial thematic review looked at patient safety activity between April 2017 and September 2020.

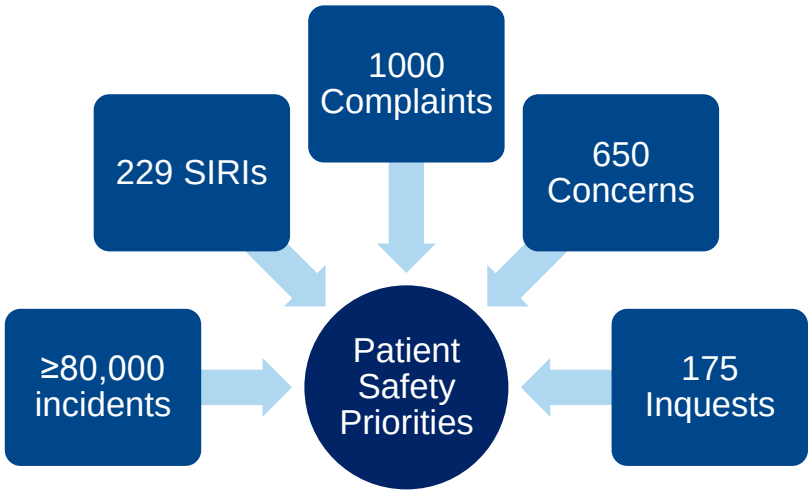
The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting for many years. As locally defined priorities, PSIRF allows us to focus on these risks with our framework for patient safety incident response.

NBT began seeing an increase in admissions of patients with Covid-19 from October 2020 following the second wave of the pandemic. The incident data for October 2020 to March 2021 was reviewed in addition to ensure that there were no new emergent risks because of the pandemic.

We have developed patient safety recommendations overleaf which are based on both the original thematic analysis and the updated incident review.

Sources of insights from this analysis included:

1. Serious Incidents Requiring Investigation (SIRI)s. Including Falls and Pressure Injuries.
2. Patient Safety Incidents reported including all no, low or moderate harm incidents.
3. Trust level risks relating to patient safety
4. Outcome of Inquests
5. Complaints and concerns received relating to clinical care and treatment.



Our Patient Safety Priorities

Through our analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, we have determined 5 patient safety priorities we will focus on for the next two years.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews.

The patient safety priorities were agreed at the Quality and Risk Management Committee in March 2021.

Theme	Key Theme	Key Risks from Activity
1	Inpatient Fall	Patient falls were the most reported patient safety incident category, with a rate increase per 1,000 bed days seen in wave 2 of the pandemic. They are the most reported SIRI. Falls is noted as a trust level risk, is a theme in the outcome of inquests and is noted within the nursing care theme emerging from complaints and concerns.
2	Medication	Medication was indicated as a theme through the SIRI review. Medication is the second most reported patient safety incident and an increase in medication errors was noted in wave 2 of the pandemic. Complaints and concerns indicated that medication and pain management is a patient safety theme. Medication management is noted on the risk register.
3	Responding well to clinically changing conditions	The SIRI review indicated two related themes of clinical review/recognising deterioration as well as treatment/diagnosis. The combined incident category of treatment and clinical review highlighted the risk area of review/recognising clinical condition. Two inquest outcomes noted areas for improvement in responding to deterioration. Complaints and concerns highlighted risks in treatment and care planning, delayed treatment and treatment complications.
4	Pressure Injury	Pressure injuries are one of the top 5 patient safety incidents and an increase was seen in the first wave of the pandemic. Pressure injuries are a noted theme of SIRIs. They were also noted within the nursing care theme emerging from complaints and concerns.
5	Discharge	The combined category of service provision and admission highlighted the risk area of discharge. Issues with discharge also emerged as a risk area from complaints and concerns.

How we will respond to patient safety incidents

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through a "convening authority" approach that is commonly used in the military and aviation to commission investigations and receive findings and recommendations.

At the onset, we will use existing structures to support the process of decision making. There is an established weekly meeting with the Director of Nursing and Quality and Medical Director, in which potential serious incidents and other emerging patient safety issues are discussed. This meeting is presently called the Executive Incident Review Group (EIRG) – for PSIRF, we will slightly change the name and purpose, calling it the Executive Incident Response Group.

Our medium to longer term aim is to support each Division across the Trust to establish their own convening authority. We envisage this being in place by PSIRF year 2.

As we transition into PSIRF, the Patient Safety team will continue to work closely with the Divisional Quality Governance teams to review and identify incidents that may require a patient safety incident investigation. In PSIRF, the approach of ≥severe harm will no longer apply, and we will be guided by the national and local patient safety priorities.

The process will be described in detail in the associate policies, particularly in new policies that describe Patient Safety Incident Investigations, Patient Safety Incident Responses and involving patients in discussions about incidents, learning and improvement.

Core to deciding what to investigate was the situational analysis. The analysis identified five Patient Safety Priority incident categories that learning will be structured against over the first stage (2 years) of PSIRF.

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 20-25 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Patient Safety incidents that must be investigated under PSIRF

1. Patient safety incident is a Never Event
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
3. National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above. We will include any new priorities as they emerge).

Patient safety incidents are events where a patient experienced or could have experienced harm during an encounter with healthcare. An incident is the system showing us symptoms that something is wrong with it.

Apart from the "must investigate" points above, the decision to carry out a patient safety incident investigation should be based on the following:

- the patient safety incident is linked to one of North Bristol NHS Trust's Patient Safety Priorities that were agreed as part of the situational analysis

- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, "we are very sorry that this happened"
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

Patient safety incidents that have resulted in severe harm:

These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.

How we will respond to patient safety incidents

Patient Safety Event Occurs

Patient Safety Incident Investigations

Patient Safety Review

	Event	Approach	Improvement
National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required.
	Incidents meeting maternal death criteria		
	Child death	Initiate child death review process	
	Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR)	
	Safeguarding incidents meeting criteria	Reported to NBT's named safeguarding lead	
	Incidents in screening programmes	Reported to Public Health England (PHE)	
	Death of patients in custody/prison/probation	Reported to Prison and Probation Ombudsman (PPO)	
	Incidents meeting the Never Event criteria	Patient Safety Incident Investigation	Create local organisational recommendations and actions.
	Incidents resulting in death		
Trust Priorities	Patient Safety Priority Index Case: • Patient Falls • Medication • Responding well to clinically changing condition • Pressure Injuries • Discharge Emergent area of risk	Patient Safety Incident Investigation where agreed (detail provided in NBT policies)	Create local organisational recommendations and actions feeding into patient safety priorities improvement programmes.
Local Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and timeline chronology	Inform thematic analysis of ongoing patient safety risks.
	No/Low Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	

Patient Safety Incident Investigations

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents.

Investigations analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors.

Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

NBT moved away from using Root Cause Analysis (RCA) as the recognised tool to investigate in Winter 2019. We were informed by and aligned to the approach taken by the Healthcare Safety Investigation Branch (HSIB). Since then, we have developed and fine-tuned a systems-based investigation tool. We have seen an improvement in the systems-thinking approach to these investigations.

We no longer search for a single root cause; we look at the different events that occurred leading up to the incident and analyse the possible causes. This has supported us in looking at the system and not the people as individuals who work within it.

2021 saw the first group of staff join a week-long healthcare incident investigation training course provided by Cranfield University & Baby Lifeline in preparation for us going live with PSIRF.

This course included theory and simulation training and was attended by all Divisions, as well as the Patient Safety Team, who have now been equipped with knowledge and tools to support high quality investigations at the Trust.

To provide detailed guidance we will be formalising our policy framework, beginning June 2021 through our Patient Safety and Clinical Risk Committee, to support this Plan in practice.

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

As part of our new policy framework, we are developing procedures and guidance to support staff in how to discuss incidents with patients and family.

The patient voice is very much an integral part of our work at NBT; we share below insights from the Chair of our Patient Partnership, to explain our vision for PSIRP.

"

The importance of the involvement of the patient and families in any incident/investigation into their treatment and care cannot be underestimated. It is a recognised National Standard and NBT has had it at its heart for many years.

The patient and family voice are vital for both hospital learning from incidents and for putting actions in place to prevent them in the future. It is also key in finding closure, aiding recovery and healing of those involved in the incident together with their families.

The strongest of people cannot appreciate the impact of going from living as normal a life as they do to that of putting on a hospital gown and receiving hospital care whilst in a hospital bed. Unless this has been a lived experience, it is almost impossible to understand how that feels, the vulnerability and lacking control of one's life.

This is why it is of huge importance to involve past and present patients together with carers, in order to give them a voice within hospital trusts at the highest level participating in committees etc., to assure patients and families that independent oversight is in place, whilst being a critical but constructive friend.

NBT has been ahead of the game in this regard for well over 15 years and as Chair of the Patient Partnership Group I am honoured to work with such dedicated staff who strive to involve and support patients and families in the investigation process and to effect change to improve safety, care and treatment.

"

Christine Fowler
Chair, NBT Patient Partnership

Involvement and support for staff following incidents

We are on an ambitious journey at the Trust to ensure it is a safe and fair place, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff. This includes, but is not limited to:

ACT for Wellbeing: self-care, team care courses
Tailored support and consultation for teams
Support for Managers and Me +MyTeam Sessions
OurSpace – facilitated spaces for sharing, listening and doing what matters
Work-based incidents and TriM peer-support network

*"**Accountability** can mean letting people tell their account, their story."* - Sidney Dekker

PSII is not the only tool we will use to respond to incidents. Our policy framework will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents.

We have outlined several ways we can respond to individual incidents, including:

Debrief: An unstructured, moderated discussion.
Safety huddle proactive: A planned team gathering to regroup, seek advice, talk about the day.
Safety huddle reactive: Triggered by an event to assess what can be learned.
After action review: A structured facilitated debrief.

Roles and responsibility in the new system

North Bristol NHS Trust is a complex system and has been building a comprehensive patient safety network. The governance structures at the Trust were considered earlier in this plan, so here we outline the following core meetings and committees which represent our trust-wide approach to bringing NBT together as a system which will support the implementation and progression of PSIRF.

The **Trust Management Team** oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Divisions and the Executive Team.

The **Patient Safety and Clinical Risk Committee** is chaired by an Executive Director, the Director for Nursing & Quality. This monthly meeting will have oversight, review and act as the approval mechanism for risks, PSII and other types of patient safety reviews.

Progress of PSII, risk and other types of patient safety reviews will be supported by **Patient Safety Group**. Safety recommendations from PSII approved by Patient Safety Committee will be reviewed through Patient Safety Group in support of the five patient safety priority improvement programmes.

The **Patient & Carer Experience Board Sub-Committee** chaired by a Non-Executive Director supports the Board oversight in this area.

The **Quality and Risk Management Committee (Board Sub-Committee)** with a Non-Executive Director chair scrutinises quality information and that provided through sub-committees on the quality of care provided.

The **Trust Board** seeks assurance that high quality services are being delivered. Through its sub-committees and presentation of data within the monthly Integrated Performance Report.

Yearning for a new way will not produce it. Only ending the old way can do that.

You cannot hold onto the old, all the while declaring that you want something new.

The old will defy the new;
The old will deny the new;
The old will decry the new.

There is only one way to bring in the new. You must make room for it.

- Neale Donald Walsch