Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 13 September 2023

TB2023.87

Title:	**Patient Safety Incident Response Framework (PSIRF) Policy and Plan**

Status:	**For Decision**
History:	**21 June 2023 CGC**
	13 July 2023 TME
	26 July 2023 Trust Board Seminar

Board Lead:	**Chief Medical Officer & Chief Nursing Officer**
Author:	**Dr Rustam Rea, Helen Cobb, Caroline Armitage, Cate Leon, PSIRF Implementation Team**
Confidential:	**No**
Key Purpose:	**Assurance and Policy**

Executive Summary

1. The NHS Patient Safety Strategy, safer culture, safer systems, and safer patients was launched in July 2019 by NHS England and NHS Improvement. This was presented to Clinical Governance Committee (CGC) in July 2019. Part of this Strategy was the development of the Patient Safety Incident Response Framework (PSIRF) which was published, August 2022.
2. PSIRF replaces the current serious incident framework (SIF).
3. PSIRF is a contractual requirement under the NHS Standard Contract.
4. As part of PSIRF, a PSIRF Policy and Plan must be developed (using NHSE templates) and signed off by the Trust Board and BOB ICB before implementation.
5. The Policy and Plan is to be signed off by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) at their System Quality Group (SQG) 20 September.
6. The ICB have received a draft copy of the Policy and Plan and recommended changes have been made alongside recommendations from PSIRF Steering Group, Clinical Governance Committee (CGC), Trust Management Executive (TME) and following a Trust Board seminar July 2023.
7. PSIRF implementation across the Trust is scheduled to take place Monday 2 October 2023.

Recommendations

8. The Trust Board is asked to approve the PSIRF Policy and Plan subject to any minor amendments recommended by the BOB ICB in SQG.
9. It is requested that any minor changes are delegated to the Trust Board Chair to review and approve in order to keep the planned roll out date 2 October 2023.

Patient Safety Incident Response Framework (PSIRF) Policy and Plan

1. Purpose

1.1. This paper provides a background to the Patient Safety Incident Response Framework (PSIRF) Policy and Plan which are required to be approved and in place in order to implement the Patient Safety Incident Response Framework.

2. Background

2.1. The National Patient Safety Strategy, safer culture, safer systems, and safer patients was launched in July 2019 by NHS England and NHS Improvement. This was presented to the Clinical Governance Committee (CGC) in July 2019. Part of this Patient Safety Strategy was the national development of PSIRF; this was delayed during the pandemic and published August 2022.

2.2. The four key aims of PSIRF are:

2.2.1. Compassionate engagement and involvement of those affected by patient safety incidents

2.2.2. Application of a range of system-based approaches to learning from patient safety incidents

2.2.3. Considered and proportionate responses to patient safety incidents

2.2.4. Supportive oversight focused on strengthening response system functioning and improvement.

2.3. PSIRF is a contractual requirement under the NHS Standard Contract.

2.4. The publication of a PSIRF Policy and Plan are part of PSIRF implementation and are written using the national NHSE templates.

3. PSIRF Plan and PSIRF Policy approval pathway

3.1. The BOB ICB have held four workshops during the implementation phases of PSIRF which the PSIRF Implementation Team and other OUH representatives have attended. These workshops have assisted in informing the Plan and Policy.

3.2. The PSIRF Plan and Policy documents have been developed over time and consulted on in the PSIRF Steering Group as well as the committees detailed below.

3.2.1. 16 June BOB ICB Quality Leads for review and comments

3.2.2. 21 June CGC for review and comments

3.2.3. 13 July TME for review and comments

3.2.4. 19 July CGC for review and comments

3.2.5. 26 July BOB ICB Quality Leads follow up of amendments

3.2.6. 26 July Trust Board Seminar presentation and discussion

3.2.7. 13 September Public Trust Board approval

3.2.8. 20 September BOB ICB System Quality Group approval

4. The PSIRF Policy (appendix 1)

4.1. This policy supports the requirements of PSIRF and sets out the Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The policy has been developed using the national NHSE template and will be supported by a detailed Incident investigation, reporting and learning procedure.

4.2. The policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

5. The PSIRF Plan (appendix 2)

5.1. The Plan sets out how the Trust intends to respond to patient safety incidents in accordance with PSIRF.

5.2. It sets out four main workstreams which has been decided upon following internal and external stakeholder engagement and quantitative data over 4 years.

5.3. The plan is not a permanent rule that cannot be changed. It will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

5.4. The Trust will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within plan.

5.5. The whole plan will be reviewed every 12 to 18 months to ensure the workstreams fully reflect the patient safety issues with the greatest potential for learning and improvement.

6. Conclusion

6.1. This paper provides a background to the PSIRF Policy and Plan

6.2. The mandated move from SIF to PSIRF is to occur on 2 October. The Policy and Plan must be signed off by both Trust board and the ICB before implementation can occur.

6.3. A detailed incident investigation, reporting and learning procedure will accompany the PSIRF Policy and Plan and will be signed off through the Clinical Policies Group

7. Recommendations

7.1. The Trust Board is asked to approve the PSIRF Policy and Plan subject to any minor amendments recommended by the BOB ICB in SQR.

7.2. It is requested that any minor changes are delegated to the Trust Board Chair to review and approve in order to keep the planned roll out date 2 October 2023.

Appendix 1

Oxford University Hospitals	NHS Oxford University Hospitals NHS Foundation Trust

Patient safety incident response policy

Effective date: 02/10/2023

Estimated refresh date: 02/10/2026

	NAME	TITLE	SIGNATURE	DATE
Author	Caroline Armitage Cate Leon Helen Cobb Rustam Rea	PSIRF Implementation Team		02/08/2023
Reviewer	Anny Sykes Paula Gardner	Interim Chief Medical Officer Interim Chief Nursing Officer		
Authoriser				

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Appendix 1

1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Oxford University Hospitals NHS Foundation Trust (OUH) approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The policy has been developed using the national NHSE template and will be supported by a detailed Incident reporting and learning procedure.

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports and promotes the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Use of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening system functioning and improvement.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust. Related documents include:[1]

- Incident reporting and Investigation Policy 2020
- Duty of Candour (Being Open) Policy 2019
- Information Governance Policy 2018
- Complaints Policy 2020
- Medicines Policy 2020
- Medical Devices Policy 2021
- Pressure Ulcer Prevention and Management Policy and Guidelines 2022
- Procedure for Ensuring Children and Young people's access to healthcare is Safeguarded 2013
- Freedom to Speak up Policy 2022
- Risk Management Strategy 2021
- Safeguarding Vulnerable and At-Risk Adults Policy and Interim PREVENT Policy for All Patients 2019
- Safeguarding Children Child Protection Policy 2019
- Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER 2017) Policy 2022
- Blood Transfusion Policy and Procedures for all patients requiring blood and blood component transfusions 2021
- Venous Thromboembolism (VTE) Prevention and management in patients aged 16 years and above Policy 2020
- Prevention and Management of Adult Inpatient Falls Policy 2020

PSIRF uses a "systems-based approach" to learn what risks there are for patient safety and how to respond to these to improve safety. A system-based approach recognises that healthcare takes place in a work system composed of people, tasks, equipment and the different environments in which care is provided. All these aspects of the system vary and interact with each other to produce different outcomes. By exploring how these different aspects are working together in different situations, a deeper understanding of the risks and issues facing patients and staff can be gathered, and more effective learning can be identified. Several systems based tools, for example the Systems Engineering Initiative for Patient Safety (SEIPS) will be used to support learning from patient safety events and to support responding to broad patient safety issues.

Human error is understood to be a symptom of an issue in the healthcare system, rather than a cause of an incident. When responding to incidents and safety events under PSIRF, the aim is on learning for improvement and there is no remit to determine liability, preventability, or cause of death. Other processes outside of the scope of this policy are listed below:

- Claims handling,
- Human resources investigations into employment concerns,

[1] These links will only work internally (within the OUH) if these documents are required, please contact the PSIRF team

- Professional standards investigations,
- Coronial inquests, and criminal investigations,
- Complaints and Safeguarding concerns (except where a significant patient safety concern is highlighted)

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Patient safety learning responses are used to investigate and identify learning and improvement opportunities from incidents reported in the Ulysses incident reporting system.

3. Our patient safety culture

The OUH supports a Just Culture, ensuring consistent, constructive, and fair treatment of staff who have been involved in patient safety incidents. All meetings and investigations are held in accordance with the Trust's Just Culture (Just culture guide). The OUH conduct patient safety incident responses for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability and cause of death). This principle is reinforced at the beginning of each Trust-wide safety or governance related meeting and during any type of incident training. It is communicated verbally and in writing to anyone that is interviewed as part of a learning response.

A review of the OUH safety culture was undertaken as part of the PSIRF implementation process. While the organisational values and systems in place support a strong safety culture, the implementation of PSIRF is anticipated to improve this further. For example, the responses to the relevant questions in the NHS staff survey asking about whether staff feel safe to speak up about unsafe clinical practice or any concerns about the organisations, believe organisations act on concerns raised by patients or service users or raised by staff member completing the survey were similar to the national average, they have much room for improvement. A safety culture questionnaire was disseminated and promoted throughout the Trust. Extensive communication and awareness raising by staff bulletins, being mentioned at the All Staff Briefing events, being sent to all staff by SMS and cascaded through divisional governance meetings, resulted in just over 200 responses received (July 2023). This will continue to be promoted in order to allow definitive analysis and extrapolation to the rest of the Trust while raising awareness of the transition to PSIRF.

The new procedures and forums being implemented as part of PSIRF will support the improvement of the Trust's safety culture through compassionate engagement during learning responses, and through the weekly Safety Learning and Improvement

Conversation (SLIC) where the focus will be on sharing learning, supporting improvement and identifying opportunities to spread good practice.

To communicate and share understanding of the Trust's Just Culture, human factors (HF) training has been offered to staff through in house training and external providers. This training provides information about how healthcare is provided as part of system, and that safety is shaped by all the different factors that contribute to the system.

1. Meetings to support learning from adverse events and safety issues
2. Encouraging and supporting incident reporting to enable individuals, teams, departments, and divisions to share and learn from incidents and safety issues
3. Through a commitment to the Trust Values
4. Through the Kindness into Action Quality Priority.

1. Meetings to support learning from adverse events and safety issues

Over the last 3 years the Trust's safety culture has been transformed through the introduction of several workstreams. These have included several safety meetings and assurance forums. The aim of learning and improving and not blaming or shaming highlighted at the beginning of each meeting and is upheld by the meeting chairs. In recognition of the work that the Trust has done to improve its Safety Culture, it was awarded the HSJ Patient Safety Award 2022.

The following meetings have been put in place to develop patient safety across the Trust,

- **Patient Safety Response (PSR)** is chaired by a senior Trust clinician or manager and identifies any support required for staff involved in the event, and immediate safety concerns. Support to staff is provided through visits from executive and Divisional colleagues.
- **Serious Incident Requiring Investigation SIRI Forum** is a meeting held weekly to review incidents that have occurred that may require an investigation under the Serious Incident Framework. The multidisciplinary members of the meeting discuss the incidents and agree the level of impact to the patient, and what kind of investigation should be undertaken.
- **Serious incident group (SIG)** meets weekly to hear the initial findings from incident reports and provide an opportunity for additional aspects to be considered and potential actions to be decided.
- **Triangulation of patient safety information** occurs monthly with the patient safety team (PST), Legal team, safeguarding team, assurance team, safeguarding and complaints department to triangulate patient safety information and capture any incidents that have

come through Patient Advice and Liaison Service (PALS) and the Legal team that may have not been reported through the Patient Safety Team.

- **Patient Safety and Effectiveness Committee (PSEC)** receives reports from these groups describing the issues and risks that have been identified or discussed during the above meetings.

Some of these will remain as part of PSIRF (PSR, PSEC, safety messages and Safety huddles) as these embrace the culture of PSIRF. SIG and SIRI forum will change to a new forum called the weekly Safety Learning and Improvement Conversation (SLIC) which incorporate more learning and improvement from learning responses and to build on our open and transparent culture.

2. **Encouraging and supporting incident reporting to enable individuals, teams, departments, and divisions to share and learn from incidents and safety issues**

- **Safety Messages**
  Weekly Safety Messages are emailed to all OUH staff every Tuesday with a clear message highlighting actions that can be taken to improve patient safety. This information should be shared in staff Safety Huddles. And cascaded accordingly.
  These Weekly Safety Messages are developed following issues identified at patient safety meetings where Trust-wide communication is required. Action plans developed as part of an incident investigation may also recommend highlighting an issue by sharing a weekly safety message.
- **Safety Huddles**
  Safety Huddles were introduced to the Trust as an OUH Quality Priority. They enhance teamwork, communication, and co-operative problem sharing. They provide an opportunity for staff to share concerns about patient or staff safety and to share other information from safety messages or meetings.

3. Trust Values

Additional work to improve the safety culture of the OUH includes the ongoing focus on working with the Trust Values of excellence, compassion, respect, delivery, learning and improvement. By incorporating these values in our recruitment and appraisal processes, the key drivers of a just culture, of respect, compassion and learning are embedded within our organisation. More information can be found in the OUH Strategy 2020-2025

4. Kindness into Action

One of the current Quality Priorities is Kindness into Action. This programme aims to support the development and understanding of kindness at work and how working in this way can support safety by promoting trust and civility and creating a safe space to work.

This programme is being delivered across the Integrated Care System BOB (Buckinghamshire, Oxfordshire, Berkshire West). It supports OUH's commitment within the OUH People Plan Themes 1 and 2:'Health, wellbeing and belonging for all our people' and 'Making OUH a great place to work' to address poor behaviours and instil a more civil, respectful, and kinder culture within our workplaces. The sessions are for leaders and managers within the OUH.

Listening to staff

There are initiatives throughout the Trust to ensure that staff are listened to. These include:-

- Monthly virtual Staff Briefing sessions with the Exec team
- Monthly FtSU listening events
- Annual NHS Staff Surveys
- Quarterly 'Pulse Surveys'
- Ad hoc listening events and virtual Q&As as and when required e.g in advance of industrial action
- Annual Texas Safety Attitudes
- Annual Internal Communications Survey
- Freedom to Speak Up (FtSU) team including Freedom to speak up champions

We will utilise findings from our annual NHS Staff Survey and Texas Safety Attitudes Survey metrics to assess if we are sustaining our ongoing progress in improving our safety culture.

Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK.

At OUH, we are excited to welcome PSPs two Patient Safety Partners (PSP) who started their roles with the Trust in April 2023, with a plan to recruit further PSP in the future. They will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in the OUH the main purpose of the role is to be a voice for the patients and community who use our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that the patient voice is heard and included in our safety and governance processes. This may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that the patient perspective is fully considered and included in our efforts to improve patient safety.

The PSPs will be supported in their honorary role by the Lead for Patient Experience for the Trust who will provide expectations and guidance for the role.

PSPs will have regular scheduled reviews and regular one-to-one sessions with our Patient Experience Lead and training needs will be agreed together based on the experience and knowledge of each PSP.

The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

4. Addressing health inequalities

Reducing health inequalities is a key objective running through the Trust's Clinical Strategy. Key to understanding, improving, and monitoring health inequalities are good quality data on the key determinants of inequality including ethnicity. This year one of the Trust Quality Priorities aims to improve the data to capture health inequalities including ethnicity, which will be reported in our Annual Quality Account. This data will support a better understanding of issues related to local health inequalities and provide information that can be used to target interventions to improve care for these populations and measure their impact. The Quality Priority also focusses on understanding better how health inequalities impact on cancer and antenatal care. Poor engagement with antenatal care is a major risk indicator for adverse maternal and perinatal outcomes. As part of this Quality Priority, the Health Inequalities Steering Group will provide high-level oversight and direction of the OUH Health Inequalities Programme. It will explore local demographics and barriers associated with low engagement with antenatal care and co-develop strategies to overcome these barriers with maternity service users including maternity advocate/community organisers and locality partners in health. The PSIRF Implementation Team are a part of the Health Inequalities Steering Group and provide a link between the two workstreams so that health inequalities in patient safety can be addressed and reduced. One of the OUHs chosen workstreams for the safety profile (as detailed in the PSIRF plan) is the Care of vulnerable people, who are a group of people at risk of health inequalities. This includes people who have safeguarding concerns, learning difficulties and disabilities and

mental health issues. By including this as a PSII workstream, improvements in health equality for these vulnerable populations are anticipated.

The OUH Health Inequalities Programme has been set up to deliver on three main objectives:

1. To address health inequalities across our services, applying the Core20PLUS5 framework. To achieve this, we will standardise reporting on health inequalities data ensure local champions across all services and share best practice across our organisation
2. To ensure that we are mindful of and take action to address health inequalities in our approach to elective recovery
3. To build longer-term capability to promote the reduction of health inequalities and improved population health through population health management and through recognising our role as an anchor institution.

5. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. All learning responses will be undertaken in a psychologically safe environment, and where further emotional support is required, staff, patients families and carers will be provided advice for how to obtain this, as described below.

Patients, families, and carers

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

We recognise and acknowledge 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.

Appendix 1

All staff are encouraged to be transparent and open whenever there is a concern about care not being as planned or expected, or when a mistake has been made regardless of the level of harm involved. This is emphasised in patient safety training and at the beginning of corporate governance meetings. All staff follow the Trust's Duty of candour (being open) policy. Saying sorry is always the right thing to do. It is not an admission of liability. It acknowledges that something could have gone better and is the first step to learning from what happened and prevent it happening again.[2] The regulatory aspects of Duty of Candour are monitored through the weekly Safety Learning Improvement Committee (SLIC). Any patient safety incident that has an impact of moderate or above is monitored for verbal and written duty of candour. This is shared in the Trusts Quality accounts. Written information provided to patients and families, including in fulfilment of duty of candour, will be tailored to the individuals taking into consideration their questions, concerns and wishes.

Patients and their families will be supported throughout the Patient Safety Incident Investigation process by Patient Engagement Leads. Each division will have trained Engagement Leads who will be available to liaise with patients and staff members following a patient safety event. They will ensure that patients are supported and that the Trust can learn and make sure their perspective and questions are addressed by our learning responses. Patient engagement leads will have undertaken specific training to perform this role. We will work with Divisions and the Chief Nursing Officer to ensure that the appropriate number of people in each Division are trained as engagement leads, supporting the learning response leads in ensuring robust patient voice.

The Head of Patient Experience will work with PSPs to implement the NHS PSIRF policy outlining patient engagement for PSIIs and the ways in which patients are involved when other learning responses are more appropriate.

Patients and families can contact the OUH Patient Advice and Liaison Service (PALS). This team is committed to improving the service we give to our patients.

It is a confidential service that aims to:

- advise and support patients, their families, and their carers
- listen to patients' concerns, queries and suggestions
- help sort out problems quickly on your behalf
- inform patients, their families, and their carers about the Trust's Complaints Procedure

[2] https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

- assist you if you have any concerns about your rights as a patient and how the OUH is fulfilling its part of the NHS Constitution about your own care.

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist. We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

Some other organisations and references and support systems are:

- National guidance for NHS trusts engaging with bereaved families
- Learning from deaths – Information for families - explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received
- Help is at Hand – for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.
- Mental Health Homicide support for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.
- These two websites offer support and practical guidance for those who have lost a child in infancy or at any age death support:
    - Child Bereavement UK
    - Lullaby Trust
- Complaints advocacy - The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints
- Healthwatch - an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site.
- The Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.
- The Citizen's Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

Supporting Staff

When things go wrong in healthcare, the staff who are involved can be impacted significantly. The emotions and stress involved can impact their health and ability to continue to work.

OUH provide a range of psychological support services. Details can be found on the Occupational Health intranet site, and include access to counselling and other one to one

support services. There is also information for staff, managers and employees following critical incidents.

The OUH also has seven members of staff trained in Trauma Risk Injury Management (TRiM). This is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. TRiM originated in the UK Armed Forces and the model is based on 'watchful waiting', that means keeping a watchful eye on individuals who have been exposed to a traumatic event, whether that person has been directly involved or involved from afar. The following list illustrates when a TRiM risk assessment may be carried out but is not exhaustive, as trauma is both personal and subjective.

When Risk Assessment interviews are conducted;

- Serious injury to self and others, particularly colleagues
- Personnel have been disabled or disfigured
- The trauma involves death, particularly grotesque death
- The trauma is complex, long lasting or multiple
- Personnel have been involved in a 'near miss'
- Personnel experience overwhelming distress after the event

Additional factors that could contribute to making incidents traumatic include;

- incidents that are unpredictable or caused deliberately
- incidents that have a personal relevance for those involved
- losing control of the situation or lacking control
- situations attracting a lot of media attention or where the actions of those involved are questioned

TRiM Practitioners are non-medical personnel who have undergone specific training allowing them to understand the effects that traumatic events can have upon people. They are not counsellors or therapists but understand confidentiality and are able to listen and offer practical advice and assistance. They are trained to spot signs of distress in people that may go unnoticed, they carry out TRiM assessments and TRiM planning meetings and signpost people to support if required.

Trauma Incident Briefing (TIB) and Risk Assessments

Trauma Incident Briefings are an important part of the TRiM process as they promote education and awareness about normal responses to abnormal situations. Everyone involved in a potentially traumatic incident should be invited to a TIB but only a handful may then go on to be offered an individual or group Risk Assessment. TRiM Risk Assessments ask open questions, allowing the colleague to only go into a level of detail they're comfortable with. The Practitioner will not ask for further details as it's important to adhere to NICE guidelines and not risk retraumatising individuals and teams.

Appendix 1

Types of TRiM

Type 1 TRiM response is described above and occurs after a one off, unexpected event and can involve large numbers of colleagues who are affected. Type 2 trauma is likely to occur on an individual basis and arises when a colleague's resilience has been worn away and they are showing signs of unresolved trauma. This could happen post redeployment if they struggle to reintegrate into their team or several months after a traumatic incident which they have not recovered from. In these instances, TRiM Practitioners could carry out an individual Risk Assessment, addressing risk factors 5 to 10 and follow up one month later or other types of conversation.

6. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold. Although there are no additional resources provided to implement PSIRF, there will be a focus on areas where there is potential for learning, and using the newer learning response types, safety processes will become more efficient and existing resources can be used more effectively. Where required, the OUH will collaborate, lead and/or participate in cross-organisational PSIIs where a need is identified, with support from the ICB.

Figure 2 gives further details of how the current resources used to carry out the SIRI investigations in 2022-23 could be mapped to delivering the new learning responses.

Resources and training to support patient safety incident response

Resources

Clinical Governance and Risk Practitioners (CGRPs) work within each of the 4 clinical divisions and specific OUH employees are/will be trained to the expected level to undertake learning responses. They will work with subject matter experts to undergo a learning response.

No paid time is given to clinical staff to complete or help with a learning response, but Continuing Professional Development and participation in Audit and Clinical Governance does form part of medical staff job plans.

Training

Table 1: Training available for staff to support PSIRF

General	Course/Topic	Staff group/Role	Training available	Provided by
Patient Safety Syllabus	Level 1 a - Essentials for all staff	All staff	e-LMS	Health Education England
	Level 1 b - For senior leaders and board members	Senior leaders and board members		
	Level 2 - Introduction to systems thinking and human factors	Staff who will undertake any learning response		
	Systems-based approach to incident investigation	Investigation Lead	2-day in-person training	HSIB

Appendix 1

General	Course/Topic	Staff group/Role	Training available	Provided by
PSIRF-mandated			or online course.	
	Involving those affected by patient safety incidents in learning process	Engagement leads	1 day in-person or online course	HSIB
Optional	Investigative interviewing	Learning Response Leads	1 day online course	HSIB
	Demystifying Thematic Review	Learning Response Leads/Patient Safety Team/Workstream leads	½ day online course	HSIB
	PSIRF Oversight	Oversight lead	½ day online course	HSIB

Additional training

Table 2: Additional training that may be required for learning responses

Topic	Staff group/role	Training need	Suggested provision
After Action Reviews (AARs)	Staff members who will be responsible for facilitating AARs For example: CGRPs, Subject Matter Experts, e.g. Falls, Tissue Viability, Medication Safety team, Medical Device team, Governance leads, Matrons	Facilitation of challenging conversations with multiple participants including: • Just culture and safe space • Supporting staff and patients involved in patient safety events • Focus on systems issues and learning opportunities • Escalating important issues	In person 2 cohorts of 18 participants and train the trainer. Full day training including opportunities for practicing through role-play. Training by iTS
Hot Debriefs	Staff members who will be responsible for performing hot de-briefs. For example: all those who facilitate AARs, plus ward managers, operational managers, shift leaders, team leads.	• The aims and goals of a hot de-brief • Focus on supporting those involved • Identifying initial learning • Escalating urgent issues	Online training Short videos explaining purpose of hot debriefs and providing examples of good hot de-briefs Patient Safety Academy

There is support from the Patient Safety Academy to help with training required for PSIRF and they provide regular human factors training.

Our patient safety incident response plan

Our plan sets out how OUH intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Draft Patient Safety Incident Response Plan

Reviewing our patient safety incident response policy and plan

Our patient safety incident response *plan* is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.
Updated plans will be published on our website, replacing the previous version.

We will meet quarterly with the ICB to discuss trends across the areas we have looked at to inform our initial Patient Safety Profile.

This PSIRF *policy* will be reviewed every 3 years as set out in the policy for the development and implementation of procedural documents. It is supported by the Incident reporting, investigation and learning procedure which describes the processes for reporting, investigating and learning from incidents.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

7. Responding to patient safety incidents

Patient safety incident reporting arrangements

There are several mechanisms in place to allow staff, patients, and the public to record patient safety incidents. These include:

Internal process

- All OUH employees and private finance initiative (PFI) employees have access to the Trust incident management system. There is a video provided on the Ulysses website on How to report and manage an incident. Depending on the type of incident a notification will be automatically sent to the relevant people in that Division and/or area of expertise. An automatic feedback function is also available for staff who have reported an incident. Since 2020, the number of incidents reported has been growing while the number causing significant harm to patients has remained small in comparison. This is an indication of a good safety culture as it highlights a good reporting culture where risks
- Any moderate or above impact incidents are discussed at PSR as described previously.
- All of the internal processes are described in the Trusts Incident reporting and investigation policy 2020 - this will be fully updated in line with PSIRF Plan and Policy

External Process

- Via the NHSE website NHS England » Report a patient safety incident
- GP's have their own reporting system which the ICB and OUH can view and respond through
- External Trusts contact the OUH through a dedicated and secure nhs.net email address.
- The public can raise an incident/concern through PALS
- Patients can raise a complaint which may then be triangulated with the patient safety team and an incident form generated
- The public can report via LFPSE

Supporting open and transparent reporting

Incidents are reported to external and internal stakeholders to enable identification of risks for patient safety and potential opportunities for learning and improvement both locally within the OUH and nationally.

External stakeholders include:

- Buckinghamshire, Oxfordshire and Berkshire West Integrated care board (BOB ICB)
- Learning from patient safety events (LfPSE) (replacing the national Reporting Learning System (NRLS) and Strategic Executive information System (StEIS),
- Care Quality Commissioners (CQC),
- National Health Service England/Improvement (NHSE/I).

- Ionising Radiation (Medical Exposure) Regulations (IRMER),
- Health and Safety Executive (HSE) for patients involved in Reporting of Injuries, Diseases, Dangerous occurrence Regulations (RIDDOR) incidents,
- NHS digital via the information Governance (IG)
- Medicines and Healthcare Products Regulatory Agency (MHRA)
- Learning Maternity and neonatal systems (LMNS), this includes Maternity Voices partnership.

Internal stakeholders include:

- Medication Safety Team
- Falls prevention team
- Venous thromboembolism team
- Infection prevention control team
- Information Governance team
- Safeguarding team
- Health and Safety team
- Bereavement team
- Legal and complaints team
- Patient experience team
- Learning Disabilities team

8. Patient safety incident response decision-making

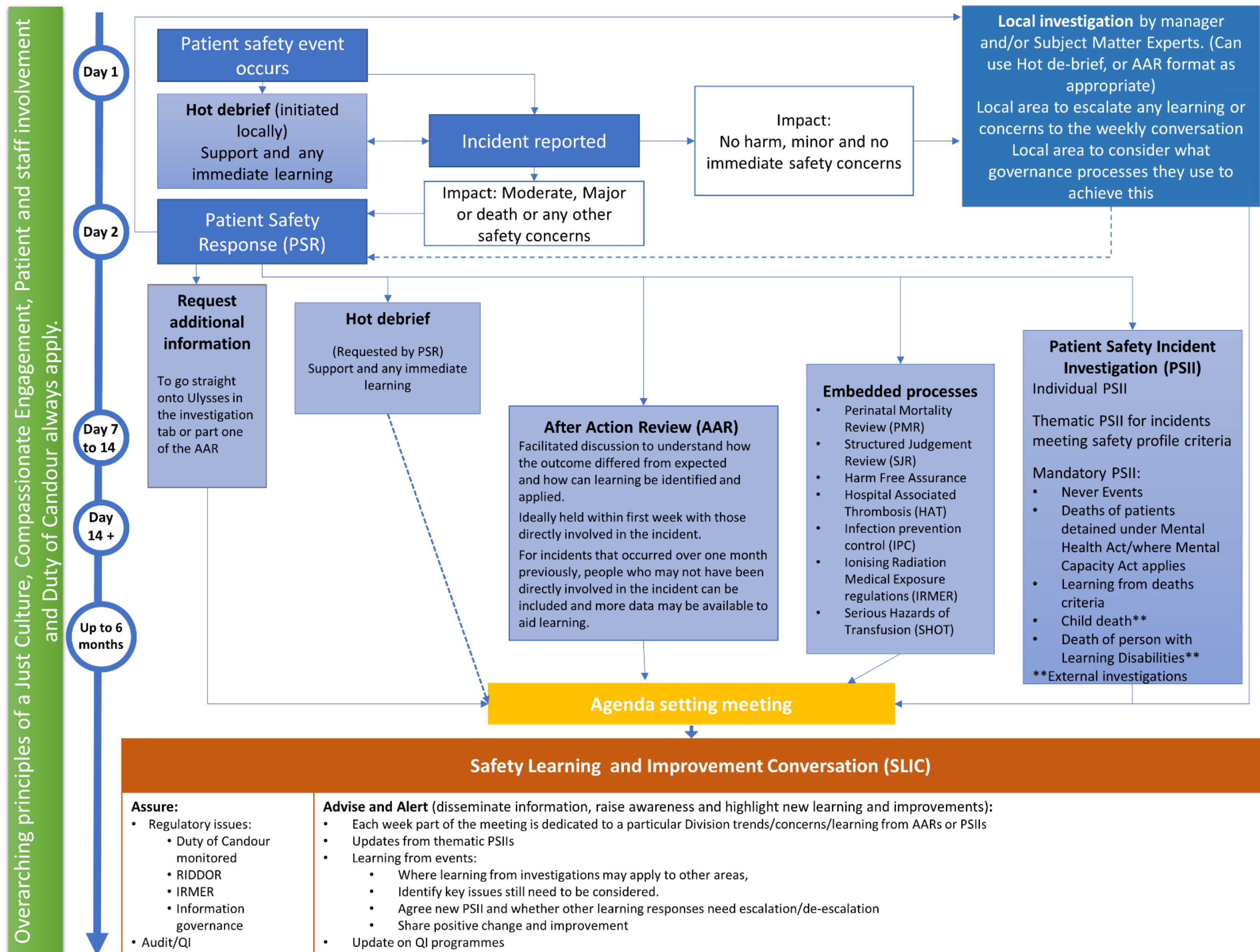

Figure 1: Incident reporting, review and learning response decision making process

Figure 1 shows the process that has been agreed to date with internal and external stakeholders for reviewing incidents and determining the appropriate learning response to use. There methods for learning from patient safety incidents have been updated, and there are now four new or adapted methods which may be used to develop learning. These are hot debriefs, After Action Reviews (AAR) (Part 1 and 2), and Patient Safety Incident Investigations (PSII), which may be for a single incident or a cluster or theme. The types of learning response and the are described in Table 1.

We will continue to work with stakeholders to iterate the process to efficiently and effectively deliver improvements in patient safety. This governance process will be subject to changes as the PSIRF process is embedded. The weekly SLIC meeting will review learning from key incidents and will provide an opportunity for the wider multidisciplinary team and other stakeholders to contribute to the learning and add further safety actions, and request additional learning response types, for example a PSII if significant Trust-wide issues are identified. SLIC will provide external and independent scrutiny for AARs to ensure robust investigation and appropriate improvement plan.

Figure 2 shows how the incidents over 2022/2023 that were investigated as Serious Incidents Requiring Investigation (SIRIs) under the Serious Incident Framework would be responded to under PSIRF.

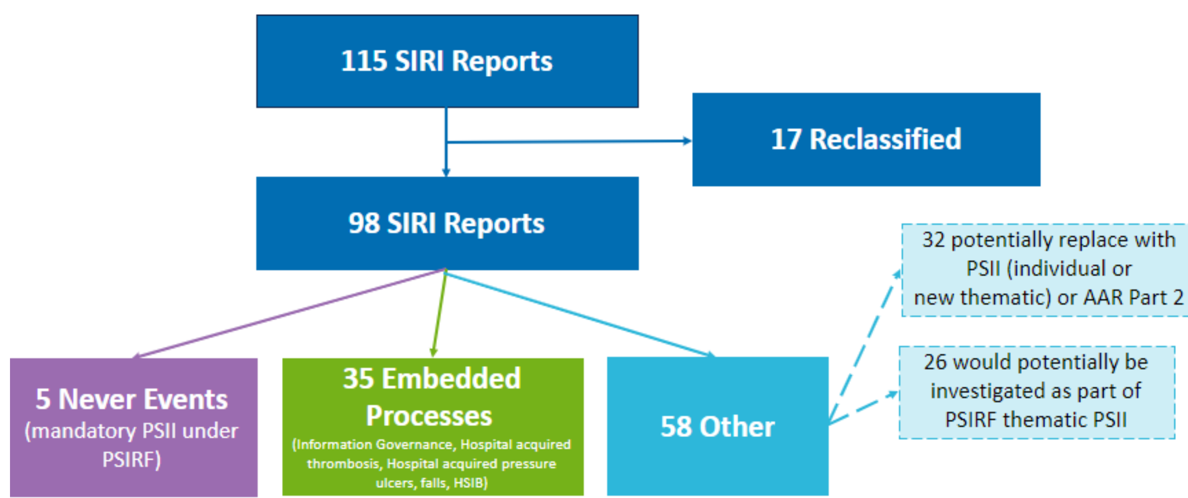

Figure 2: Baseline incident response types for 2022/2023 and how this may map to PSIRF learning response types

During 2023, in preparation for transitioning to PSIRF, After Action Reviews (AAR) were trialled as a learning response method for incident investigation. Throughout this time the AAR template has been improved iteratively. There have been approximately 32 performed, of which four consisted of the initial Part 1 as no learning opportunities were

identified (for example, no omissions in the care provided by OUH), The remainder (28) were followed up with an AAR part 2.

The learning identified from these 28 Part 2 AARs was reviewed at SIG. Initial feedback of the AAR processes has been that this method of learning response is less time consuming, results in improved collaboration and engagement from staff involved in the incident, and more accurate learning is identified. There are challenges around meeting in person and virtually, skilled facilitation is needed for which training is required, and there have been difficulties identifying the correct participants to be involved. These challenges will reduce over time as staff become more familiar with the learning response method and training is cascaded throughout the organisation.

Some of our existing governance processes are remaining as part of PSIRF. (See section 3 for full details). This is because they align with PSIRFs principles of Just culture, proportionate investigation, maximise learning and have shown to improve patient safety. We will continue to review the effectiveness of these processes with the Quality Improvement Team

Figure 1 takes into account all incidents that are reported within the Trust and how they can be managed whilst providing internal and external stakeholders assurance that the incidents has been responded to in a proportionate way. Each incident presented will be considered on the basis of whether or not there is learning. These decisions will be made either locally, within the PSR meeting or at the agenda setting meeting; all of which will be attended by a multi-disciplinary team and will be achieved in an open and transparent way. A weekly meeting will be attended by a large multi-disciplinary team (with ICB attendance) where emergent issues, positive change, improvement, concerns, and themes from learning responses will be reviewed.

This process is in line with the safety profile within the incident response plan and incorporates the use of the Trusts incident management system to help identify any incidents that may fit the safety profile.

Table 3: Types of learning response used and associated timeframes

Learning response	Purpose and time frame	Notes
Hot debrief	Immediate while the team are still present	Where staff are upset after a difficult event this should be a primarily supportive role. Where staff do not need emotional support, this should aim to identify any immediate actions or learning that may be required.

Learning response	Purpose and time frame	Notes
After Action Review (AAR) – Part 1	The purpose of this AAR is to gather those involved in the incident together in a safe space to look at what happened, what should have happened, why there may have been a difference, and is there any learning identified. This should be caried out as soon as possible after the event and have the right people there. An AAR may be requested through PSR, locally or the SLIC pre-meet	AAR's can also be carried out for older incidents. A template to facilitate the AAR discussion is available on the OUH intranet.
After Action Review – Part 2	Where additional learning or systems issues are identified during the AAR – Part 1, a more in-depth multidisciplinary learning conversation may be used. Wider stakeholders and subject matter experts should be involved to identify wider learning.	All AAR – Part 2 learning and improvement plans will be shared at the weekly Safety Learning and Improvement Conversation. A template to facilitate the AAR discussion is available on the OUH intranet.
PSII - Thematic reviews and comprehensive reports.	Up to 6 months	Time frames for PSIIs will be decided upon when a PSII is declared.

Responding to cross-system incidents/issues

The ICB will help to facilitate any incident that crosses more than one Trust. This encourages a more cohesive and effective method of learning from incidents that are cross system. It will also include the patient/family proportionately, i.e. from one source rather than multiple sources

The Local Maternity and Neonatal Systems (LMNS) will continue to monitor maternity investigations either from HSIB or investigations within the Trust, Gynaecology (pregnancy) issues may also be added to this group.

Common partners include private providers, Primary care, ambulance services, any other Trust, ICB patient safety. More information about this can be found in the BOB ICB policy for management of cross-organisational Patient Safety Incidents

Safety action development and monitoring improvement

Development of actions

Safety actions will be developed with the Divisions involved in the area that the incident occurred and be based on the recommendations of the investigators. The actions should be signed off by the Divisions and then monitored by them via the Trusts incident reporting action module. All actions should be **Specific, Measurable, Achievable, Relevant and Time-bound** (SMART) and have QI input. Guidance from NHSE (PSIRF) for the development of actions is provided to investigators.

Monitoring improvement

PSII and other specific action plans will be monitored by the patient safety team alongside a fortnightly meeting with each Division. This is an existing process which is working well. All other improvements plans will be monitored within the Divisions.

Progress of actions will also be included in Divisional papers submitted to the Clinical Governance Committee (CGC) and the SLIC meetings. Any actions that are difficult to resolve should be escalated to the SLIC meeting.

Monitoring the effectiveness of actions is a work in progress but meetings have been set up with the quality improvement time to aid this.

Safety improvement plans

Safety improvement plans will be a mixture of approaches depending on the incident. The OUH may

- create an organisation-wide safety improvement plan summarising improvement work
- create individual safety improvement plans that focus on a specific service, pathway or location
- collectively review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- create a safety improvement plan to tackle broad areas for improvement (I.e. overarching system issues).

Whichever approach is taken the rationale for that approach will be fully explained in the learning response process and agreed upon with stakeholders.

9. Oversight roles and responsibilities

The OUH will work with the ICB for oversight arrangements and ensure active participation within local networks. Below is the BOB ICB approach to oversight of patient safety.

Figure 3: Proposed oversight arrangements for OUH by the BOB ICB

Provider's Processes

- Providers consider inviting ICB representation within internal provider processes/meetings. This approach has been used successfully elsewhere in that it offers an independent viewpoint, can gain immediate ICB support and can facilitate wider system learning. Provider to determine where and when to invite ICB in order to see maximum benefit.
- ICB may be represented by different people depending on place, or learning focus and should be agreed collaboratively between provider and ICB. Regardless of who attends this person should role model the behaviours critical to PSIRF.
- As should be clearly agreed and articulated in PSIRP & Policy, the provider leads/chairs their own processes.

Peer Reviews

- Undertaken to support providers by reviewing against PSIRF standards.
- Strong focus on supporting providers to ensure that learning taking place and leading to meaningful quality improvement.
- Comprised of ICB, other providers and Patient Safety Partners - this is to ensure that a range of views can be heard and experiences of those who approach safety differently. Opportunity for "critical friends" to focus on specific areas to improve the management of patient safety within the organisation.
- Timescales or "triggers" to review to be built into wider Quality Assurance Framework
- Subject to agreement with providers

Quarterly PSIRP Review

- A quarterly 1:1 session between the ICB & provider.
- For purposes of assurance against implementation of the provider's PSIRP, intelligence obtained and progress of improvement work.
- This is an opportunity for providers to highlight strengths and weaknesses of their current PSIRP and discuss potential changes, supporting a continuous evolution of PSIRPs, streamlining future development and sign off for future versions.
- Led/chaired by ICB who should be represented by Patient Safety and Quality Leads, with safety/governance & QI leads from providers.
- Trialled for one-year post-implementation for each provider

BOB PSSF & QI Working Group

- Building on the existing BOB Patient Safety Specialist Forum and use this as a route to share patient safety incidents and learning.
- Cases/issues to bring to be driven by the following considerations:
  - "I want my peers to know about this"
  - "Fixing this involves more than just my organisation"
  - "I want to know how others have addressed this"
- As learning and safety issues are identified as needing some focused QI work, these feed into a QI Working Group, where expertise is invited on a case by case basis to ensure that the right personnel to undertake improvement work are present.
- Some areas may have separate groups, such as medicines safety, primary care etc., learning should also be shared with ICS-wide groups (e.g. discharge, urgent care etc.)
- Some workstreams suit specifically managing Patient Safety due to their specificity.
- E.g. Maternity via the LMNS and Medicines Safety via the Medicines Safety Group.
- Held every 2-months, including the AHSN, QI leads, Patient Safety Partners
- Each organisation will chair the meeting on a rotation basis

Workshops

- Held for areas of work in common between providers where cross-organisational work would benefit from extended sharing and improvement.
- Frequency to be determined as appropriate, but likely to be single or limited series.
- Likely to be a specific focused area. Possible examples may include pressure ulcers, falls, digital safety, etc.
- This would have the potential to inform QI work at organisation and system level.
- Leadership should be open to anyone subject to interest and capacity (providers, ICB, NHSE SE, AHSN or other system partners)

11. Complaints and appeals

Please see the patient safety culture section above. In addition to this the Trusts Complaints Policy can be found in this link. It is linked to the Trusts Incident and investigation policy. This policy can be used for OUH staff.

If a patient or family wish to complain or appeal about an incident, then they can use the following resources:-

- PALS
- Legal Services
- Health Service Ombudsmen
- Heath watch
- Buckinghamshire, Oxfordshire and Berkshire West ICB
- Care Quality Commission

Patient safety incident response plan

Effective date: 02/10/2023

Estimated refresh date: 02/05/2025

	NAME	TITLE	SIGNATURE	DATE
Author	Caroline Armitage Cate Leon Helen Cobb Rustam Rea	PSIRF Implementation Team		08/08/2023
Reviewer	Anny Sykes Paula Gardner	Interim Chief Medical Officer Interim Chief Nursing Officer		
Authoriser		Trust Board		

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Appendix 2

Introduction

This patient safety incident response plan sets out how Oxford University Hospitals NHS Foundation Trust (OUH) intends to respond to patient safety incidents in accordance with the Patient Safety Incident Response Framework (PSIRF). 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. The Trust will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within plan. The whole plan will be reviewed every 12 to 18 months to ensure the workstreams fully reflect the patient safety issues with the greatest potential for learning and improvement. This review of the plan will involve re-engagement with stakeholders to discuss and agree changes made in the previous 12 to 18 months and agree proposed updates to the plan. These will be published as a new version of the plan.

Our services

OUH is one of the largest NHS teaching trusts in the UK. It is made up of four hospitals - the John Radcliffe Hospital (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre, and Women's Centre), the Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, north Oxfordshire.

The Trust provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation) medical education, training, and research. Most services are provided in our hospitals, but over six percent are delivered from 44 other locations across the region, and some in patients' homes.

The OUH is governed by a Board of Directors. Day-to-day running of the hospitals and their clinical and non-clinical services is delegated to Executive Directors and senior clinicians and managers. The Board has overall responsibility for the activity, integrity, and strategy of the Trust. Its role is largely supervisory and strategic. The Trust Management Executive is the senior managerial decision-making body for the Trust. It is chaired by the Chief Executive, and consists of the Trust's Executive Directors, and four Divisional Directors. The Council of Governors holds the Trust Board to account. Governors are democratically elected, and roles are unpaid. They represent the interests of Trust members and the public.

The clinical services at the OUH are grouped into Divisions. Each Division is headed by a Divisional Director, a practising clinician who is supported by a Divisional Nurse and General Manager. The four divisions are:

1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children’s, and Neonates (NOTSSCaN)
2. Medicine, Rehabilitation and Cardiac (MRC)
3. Surgery, Women’s, and Oncology (SUWON)
4. Clinical Support Services (CSS)

The Divisions are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies, and procedures. The Divisions include Directorates, each of which contain clinical service units covering specific areas of services. Directorates are led by Clinical Directors and supported by Operational Service Managers,

Matrons, and other relevant experts. The Directorates include those with services on one or more sites, such as surgery and women's services, and those which are based on a single site, such as cardiac services and neurosciences.

Safety and governance are embedded within the organisations through the corporate and divisional structure. The Chief Executive Officer is supported by the Chief Medical Officer and the Deputy Chief Medical Officer (DCMO) for Patient Safety and Clinical Effectiveness. Within the corporate team, there is also an Assurance team, led by the Chief Assurance Officer, which is responsible for overseeing the management of risks, regulation, and accreditation. The corporate structure highlighting can be viewed on the OUH Internet site. There is a central Patient Safety Team within the Clinical Governance Team and the processes for managing incidents and investigations are described in detail in the PSIRF Policy. Each division have between two to four Clinical Governance Risk Practitioners (CGRPs) who have a dedicated role within their division for improving overseeing and co-ordinating governance-related activities to ensure patient safety. There are four Trust-wide Patient Safety Specialists who perform this role jointly in addition to their usual role, and a Medicine Safety Officer, a Medical Device Safety Officer, and a Digital Clinical Safety Officer.

The Trust's Clinical Governance Committee has responsibility for monitoring the Trust's Governance (including patient safety) framework. The reporting structure of CGC can be seen in Figure 1.

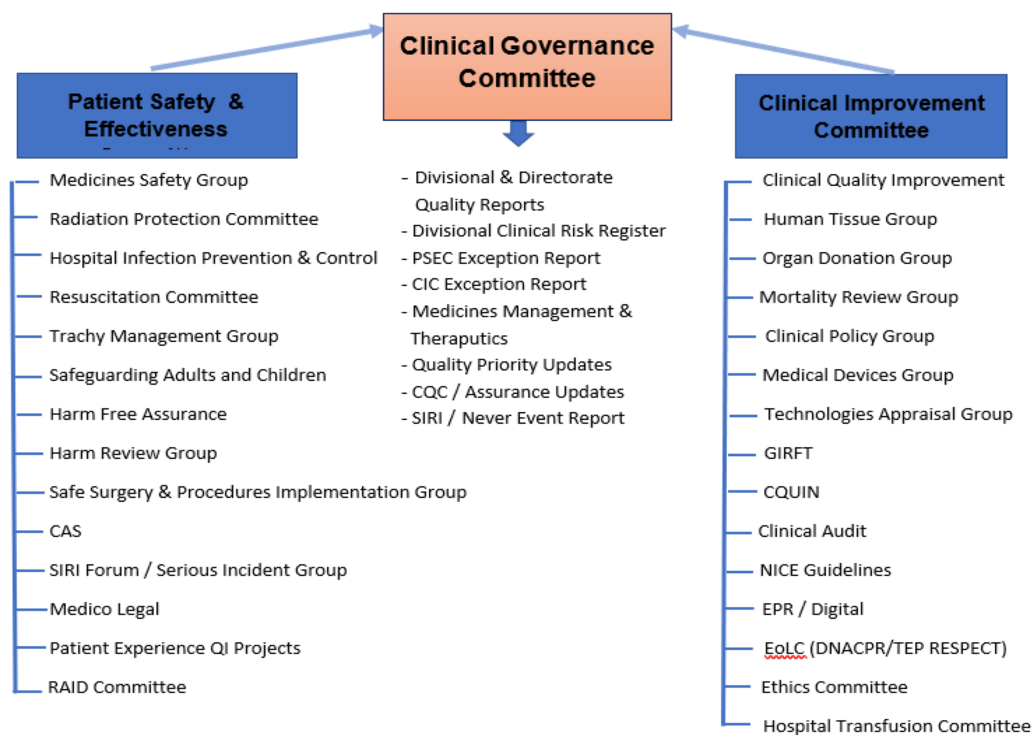


Figure 1: Clinical Governance Committee Reporting Committees

Appendix 2

Defining our patient safety incident profile

A key part of developing the PSIRF Plan is understanding the key issues that lead to risks for patient safety within the OUH, known as the Patient Safety Profile. To understand the patient safety incident profile, a wide source of information about risks to patients are reviewed and evaluated. The process of developing the patient safety incident profile is described below.

Stakeholder engagement

The OUH patient safety incident profile which has informed the PSIRF plan has been developed in collaboration with stakeholders from across the organisation, with patient representatives and with relevant external organisations. Key stakeholders were identified and invited to form the membership of the PSIRF steering group. These include:

- Deputy Chief Medical Officer (DCMO) Patient Safety
- DCMO, Clinical Improvement
- Head of Clinical Governance
- PSIRF Implementation Project Leads
- Patient Safety Specialists
- Patient safety Champions
- Divisional Leads for each Division
- Patient Experience & Engagement Lead
- Portfolio & Quality Improvement Team Lead
- Deputy Chief Nursing Officer (CNO)
- Representative from Legal Services
- Quality Assurance Manager
- Culture & Leadership Lead
- Communication team link person
- Chief Clinical Information Officer (CCIO)
- A member of the Clinical Governance team (minute taker)
- A patient representative/Patient Safety Partner

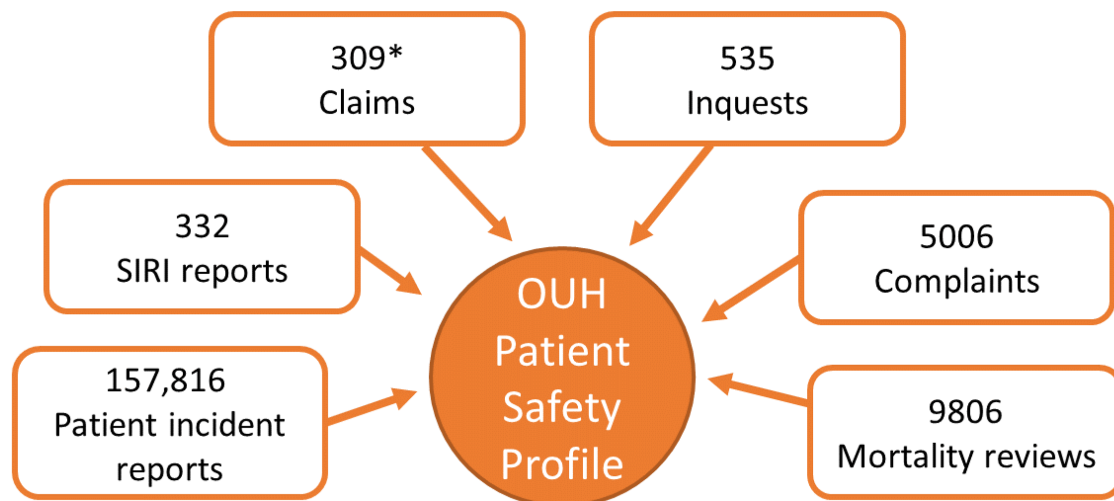
Additionally, the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB), jointly with the OUH during our Serious Incident Closure Meetings, have identified potential themes which have helped to shape our Patient Safety Profile.

Other stakeholders have been kept informed using a comprehensive communication strategy (see **Appendix I: Communication Strategy**).

Data Sources

The PSIRF implementation team used multiple sources of information and data to identify the overarching and key patient safety issues that are contributing to risk at the OUH (Figure 1). Additionally, conversations were held with representatives from each division to identify the key issues affecting patient safety within their division. Open sessions were held over Microsoft Teams where any staff member was able to hear about PSIRF and share safety concerns. The data sources were collated and mapped according to frequency of occurrences (where information is available), and by the breadth of impact across different sources of information. Where available, data was collected from the previous four financial years, dating from 2020/21 through to the present 2022/23.

Appendix 2



* 2 FY data
Plus, key themes and issues identified from QI projects, risk registers and the Freedom to Speak Up and Safeguarding teams

Figure 1: Data sources used to develop the OUH Safety Profile

The top ten patient safety issues, identified by the above process, were shared, and discussed at a PSIRF Summit with 72 key stakeholders (which included the BOB ICB, Oxford Academic Health Science Network (AHSN) regional representatives from NHSE, Maternity Patient Voices Partnership, and our new Patient Safety Partner) who provided feedback on these and issues they felt were not represented. Following compilation of the data and feedback, the following four topics were chosen as the first PSIRF improvement workstreams:

1. Handovers including communication and documentation.
2. Referral and MDT processes and pathways.
2. Reporting and pathology/imaging endorsement.
4. Care of vulnerable people (safeguarding, learning difficulties and disabilities and mental health issues).

The impact of estates and facilities, staffing and workforce and IT issues were also considered to be significant issues contributing to patient safety risks. It was felt that there are other Trust-wide strategies responsible for delivering improvements in these areas that will address these issues (Our Strategy, Our People Plan, Our Digital Strategy, Our Clinical Strategy). Therefore, they have not been proposed as PSIRF workstreams for 2023-24. Each patient safety incident investigation will be asked to consider each of these factors as part of the learning response to feedback into the Strategies above.

In April 2023, a report was published "Prevention of future death reports in inquests – what are the recurring themes?" This summarised a review of all the Prevention of Future Death (PFD) reports issued by Coroners in 2022. Many of the key themes align with the proposed PSIRF workstreams, including communication between and within teams, handovers, record keeping (for example electronic systems and flagging of abnormal results) and imaging results not being detected or acted on.

Appendix 2

The OUH patient safety culture analysis is described in the PSIRF Policy and were considered during the development of the PSIRF themes. This analysis showed that the OUH have a good reporting culture, and the high rates of incidents reported relating to medication safety and pressure damage show good rates of reporting. As there are already processes and structures in place to oversee these risks and issues, they were not selected as PSIRF improvement themes.

PSIRF Improvement workstreams will follow a Quality Improvement process to understand these areas of risk in detail and at a deeper level. Once this analysis has been performed, areas where improvements could be made to reduce risk and potential for harm are identified. Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined. This will be an iterative process and will continue over 12 to 18 months. As the workstreams are very broad, resources may be focused on one aspect of the issue at a time. The PSIRF improvement workstreams will share and be monitored by the weekly Safety, Learning and Improvement Conversation (SLIC) (described in the PSIRF Policy).

Where other issues or risks to patient safety are identified that span different locations and many different incidents that share likely contributory factors and would benefit from a co-ordinated response, these may be added as additional PSIRF Improvement workstreams. Issues will be escalated, monitored, proposed, and accepted as PSIRF workstreams through the weekly SLIC meeting.

Defining our patient safety improvement profile

The OUH safety improvement profile is developed by identifying the organisational improvement activity already underway. At OUH, there is an abundance of patient safety improvement work in progress. This includes, amongst other programmes:

- Integrated Quality Improvement Programme
    1. Quality Improvement Education and Community building
    2. Urgent and Emergency Care Programme
    3. Cancer Improvement Programme
    4. Harm reduction program
        1. Reducing avoidable unwitnessed inpatient falls
        2. Reducing medication errors
        3. Increasing dementia and delirium assessments
- OUH Quality Priorities
    1. Medication Safety – Opiates & Insulin
    2. Care of the Frail Elderly – focussing on the urgent care pathway
    3. Reducing Inpatient Falls
    4. Reducing unwarranted hospital outpatient cancellations
    5. Rolling out and embedding the Surgical Morbidity Dashboard
    6. Helping more patients through Tissue Donation for Transplant
    7. Health Inequalities – Improving data capture including ethnicity.
    8. Empowering Patients – building partnerships and inclusion.
    9. Kindness into Action – improving patient and staff experience.

Appendix 2
There are also many locally initiated and led quality improvement projects throughout the Trust. These are registered and approved by the division, and learning is shared at the QI stand up events and through the QI Improvers Hub Community.

Learning Response Methods

PSIRF uses new methods to learn from issues and incidents. These are described in more detail in the PSIRF Plan. In brief, there are four main learning responses:

1. Patient Safety Incident Investigation (PSII) – an in-depth system-based investigation that seeks to identify and understand all the factors and issues that contribute to the incident.
2. After Action Review (AAR)
    i. Part 1 – a meeting with those involved in the incident and local area seeking to understand what happened, what had been expected to happen, why was there a difference and is there any local learning from the event, and whether there may be wider issues requiring further learning responses.
    ii. Part 2 – a follow up-multidisciplinary meeting to understand the wider organisational issues, including subject matter experts and other relevant stakeholders.
3. Hot debrief – a rapid meeting to review the event to answer the same questions as for the AAR review and to provide staff support.
4. Local learning – a brief investigation and response by the local manager where local actions may be identified and implemented.

Our patient safety incident response plan: national requirements

Table 1: Learning response methods with a national response required

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and share learning through the weekly SLIC.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and share learning through the weekly SLIC.
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	PSII	Create local organisational actions and share learning through the weekly SLIC.

to problems in care (incidents meeting the learning from deaths criteria)		
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and share learning through the weekly SLIC.
Incidents meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and share learning through the weekly SLIC.
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.	Create local organisational actions and share learning through the weekly SLIC.
Deaths of persons with learning disabilities or an autistic person (LeDeR)	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC. Issues and learning opportunities shared with the PSIRF improvement workstream.
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	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)	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC. Issues and learning opportunities shared with the PSIRF improvement workstream.

(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	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]	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC.
Serious Adverse Events in relation to haemovigilance[1]	PSII	Create local organisational actions and share learning through the weekly SLIC.

[1] Haemovigilance is the set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, through to their provision and transfusion to patients, and including their follow-up.

Our patient safety incident response plan: local focus

Incidents relating to the OUH PSIRF Improvement workstreams will be included in the improvement activities being undertaken. Any new incidents or events reported will be included in the workstream for review to understand whether they highlight any new issues that may not have already been identified. By proactively focusing on the four thematic workstreams, resources for investigation are used more efficiently. The newer learning response method of After Action Review provides a robust learning response with a more effective use of time, allowing a focus on learning and improvement. It is anticipated that in addition to the four thematic PSII workstreams being undertaken, there may be an additional five to fifteen PSII being undertaken each year depending on risks and issues being identified.

The table below outlines the initial plans for how to address the issue, and how to respond to new incidents that relate to these themes. Quality improvement methods will be undertaken to explore the issues in detail, identify the factors contributing to the risks, areas for improvement and recommendations to address these, see Figure 3. As these are live projects, the detail of the progress and planned responses will be maintained in a project plan that will be monitored and shared with the weekly SLIC, as described in the PSIRF Policy.

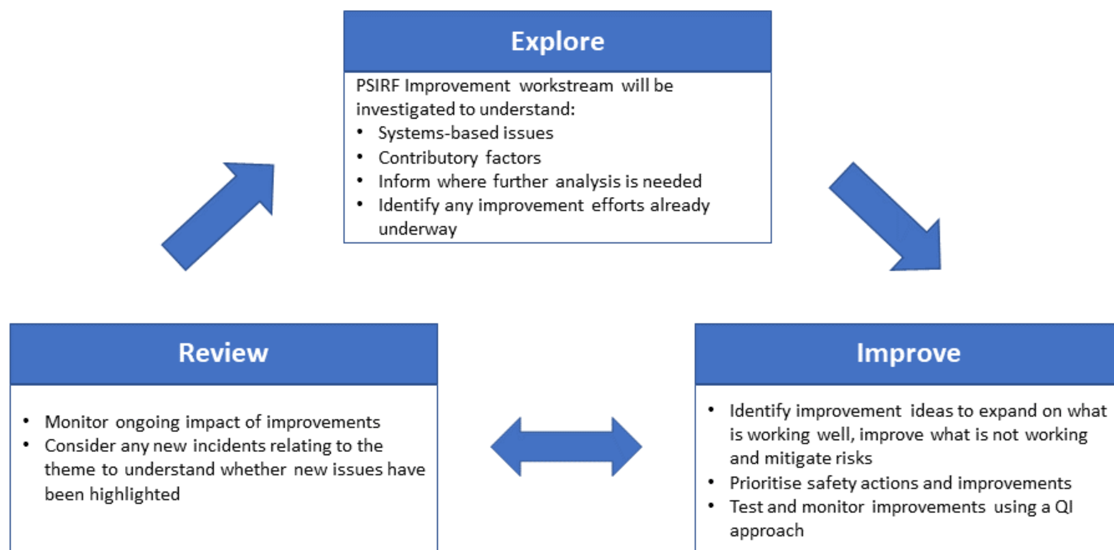


Figure 1: PSIRF workstream learning process.

Appendix 2

Table 2: PSIRF Workstream improvement process

<table>
<tr><th>Patient safety issue</th><th>Planned response</th><th>Anticipated improvement route</th></tr>
<tr><td>Handovers - including communication and documentation</td><td rowspan="3">Thematic review of completed serious incident reports (SIRI, Divisionals, PSII and AAR) to identify systems-issues contributing to events.

Quality Improvement methods will be used to understand the contributory factors and systems-based issues contributing to the risks to patient safety from handover, identify potential areas for improvement and actions to address these.</td><td rowspan="4">Develop an improvement plan for key areas identified in analysis.

Explore each new incident to identify whether any additional learning highlighted. If significant new issues are raised, perform an appropriate learning response.

Update improvement plan with any new actions.

Share progress, actions and monitor impact via SLIC.</td></tr>
<tr><td>Referral and MDT processes and pathways</td></tr>
<tr><td>Reporting and pathology/imaging endorsement</td></tr>
<tr><td>Care of vulnerable people (safeguarding, learning difficulties and disabilities, autism and mental health issues)</td><td>As above, plus:

Perform benchmarking exercise using the Learning disability improvement standards self-improvement tool to identify areas for improvement.</td></tr>
<tr><td>Other reported incidents where significant systemic issues identified.

For example, incidents relating to Positive Patient Identification (PPID) or WHO checklist completion or any other clinical issue where a significant need for organisational learning has been identified.</td><td rowspan="2">Incidents with the potential for organisational learning due to systemic issues will be identified by reviewing incidents graded moderate and above, by referral from subject matter experts and governance practitioners. A PSII will be considered as the most appropriate learning response.</td><td rowspan="2">Development of an improvement plan for key areas identified in analysis.

Learning shared through the weekly SLIC.</td></tr>
<tr><td>Other identified episodes of good practice, good care or excellence where wider learning has been identified.</td></tr>
</table>

Our patient safety incident response plan: Established processes

As described above, and as shown in Figure 2, there are already many committees within OUH who have a role in monitoring and learning from incidents. Where incidents occur in these specialist areas, the subject matter experts will be involved in determining whether there is any potential for learning, and the need for a learning response.

Ongoing safety management and improvement work is overseen by many groups with a focus on ensuring good safety practice is in place, maintained and improved where required. See Appendix II for a list of these pathways. Those safety issues with improvement plans in place are listed below.

Table 3: Safety issues addressed by current OUH Safety Programmes

Patient safety issue	**Planned response**	**Anticipated improvement route**
Quality Improvement Harm Reduction Programme • Reducing inpatient avoidable unwitnessed falls • Reducing medication errors • Increasing dementia and delirium assessments	Where incidents occur, they will be reviewed individually using updated processes to include systems-based learning	Learning and improvement activity identified, developed, and shared as part of the Harm reduction quality improvement programme and through the relevant committees such as the Harm Free Assurance group and the Medicines Safety Group.
Quality priorities 2023/24: • Medication Safety – Opiates & Insulin • Care of the Frail Elderly – urgent care pathway • Reducing Inpatient Falls • Hospital outpatient cancellations • Surgical Morbidity Dashboard • Helping more patients through Tissue Donation for Transplant • Health Inequalities • Empowering Patients • Kindness into Action	Where incidents occur that relate to any of the Quality Priorities, the level of investigation will be decided according to potential for learning (either PSII or After-Action Review)	Learning and improvement activity identified, developed, and shared through the Trust's Quality Priority processes.

Appendix I: Communication Strategy for involving stakeholders and keeping informed of key updates

Group	Frequency	Type of communication	Role
PSIRF Implementation Team	Weekly	Face to face/teams meeting	Implementation
Chief Medical Officer, Chief Nursing Officer	Ad Hoc for important decisions	Email/teams meeting/phone call as needed Invite to PSIRF Summit to contribute to Safety profile development	Supervision and organisational responsibility
Clinical Governance Committee (CGC)	Monthly	Report Representative invited to PSIRF Summit	Oversight
Integrated Assurance Committee (IAC)	Up to every 2 months as required	Report Representative invited to PSIRF Summit	Oversight
Trust Management Executive (TME)	Via GGC monthly report	Report Representative invited to PSIRF Summit	Oversight
PSIRF Steering Group	Monthly	Meetings, minutes, briefing documents (A4 newsletter format) Invitation to PSIRF Summit	Communication - both disseminating information to local areas and raising issues and contributing to development of PSIRF
Divisional teams	Monthly	Via PSIRF Steering Group meeting feedback from Divisional Representative Briefing Document/newsletter Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Patient Safety Team	Monthly	Via briefing document/newsletter from PSIRF steering group meetings Invitation to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Patient Safety and Effectiveness Committee (PSEC)	Ad hoc	Verbal update on request	Potential Subject Matter Experts for key themes/risks Keep up to date with progress and aware of potential implications of future changes

Appendix 2

Group	Frequency	Type of communication	Role
Quality Improvement Team	Monthly	Via representation on Steering Group Representative invited to PSIRF Summit	
Assurance Team	Monthly	Via CGC Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Divisional Education Teams	Ad hoc	Bespoke as required	Make aware of new training required, what it is, who it is for, and the resource required to complete it.
Digital teams	Monthly	Via representation on steering group Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Freedom to Speak Up Team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Safeguarding Team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Legal team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Patient Experience team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
LMNS	Monthly	OUH Link person is a member of the PSIRF steering group Invitation to PSIRF Summit	
BOB ICB	Monthly	Via Patient Safety Specialist meetings Reports likely to be required Will need to approve draft policy etc Via regular workshops based around different PSIRF phases Invitation to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes Will need to approve Trust Process and provide oversight

Appendix 2

Group	Frequency	Type of communication	Role
Patients	Monthly	Involve in Summit for planning Publicity once plan and policy are developed and approved Invite a PSP or representative to join the Steering group Representatives invited to PSIRF Summit	Patient Safety Partner involvement
All staff	Regularly: - Initial communication to highlight that PSIRF is coming, and new e-learning is now required (Level 1 and Level 2) - Update when plan and framework agreed	Staff Briefing - presentation Email bulletins - brief description and link to intranet site Corporate e-mail - longer description, link to intranet site and new policies, flowchart, at a glance documents, video etc Staff Text - direct to internet site with news item e-Learning - highlight some of the changes, introduce system thinking Intranet site with information - PSIRF plan and policy, at a glance document, flowcharts, guidance, FAQs, video from national site, contact details for further information Cascade via governance pathways Listening events and focus groups	Make aware of changes Highlight systems-based approach to incident review Share information and updates around involving staff and patients after a patient safety event
NSHE	Via regular ICS workshops arranged by BOB ICS or through ICS team	Face to face or email Representative invited to PSIRF Summit	Escalate any issues that may be relevant to other Trusts, e.g. so far highlighted different processes required for maternity who may need two systems due to other regulatory requirements. Also IPC reporting requirements to be discussed with NHSE to make sure systems are aligned. Duty of Candour wording in PSIRF being reviewed.
Coroner	Bespoke conversations Collaborative conversations with ICS involvement	Teams calls or in person conversations	Make aware of changes Highlight systems-based approach to incident review

Appendix 2

Group	Frequency	Type of communication	Role
			Explain likely changes in reports that will be available once transition to PSIRF is completed.

Appendix II: Established processes

Incidents relating to the specialist areas below will be monitored and reviewed by the relevant subject matter experts. The specialist teams will be involved in relevant learning responses and have oversight of these. They may steer the appropriate learning response for specific incidents depending on the level of issues identified. Improvement activity will be overseen by the relevant Trust group as listed in the table below.

Patient safety issue	**Overseeing Group managing improvement**
Harm Free Assurance (Hospital Acquired Pressure Ulcers, Inpatient Falls, Nutrition and hydration)	Harms Free Assurance group
Hospital Acquired thrombosis	Thrombosis Working Group
Hospital acquired infections	Hospital Infection Prevention and Control Committee
IRMER	Radiation Protection Committee - Learning and improvement activity reported to CQC.
Positive Patient Identification, WHO checklists, Never Event assurance related to surgery	Safe Surgery and Procedures Implementation Group