Oxford University Hospitals
NHS Foundation Trust

Patient safety incident response plan

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	TITLE	DATE
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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.

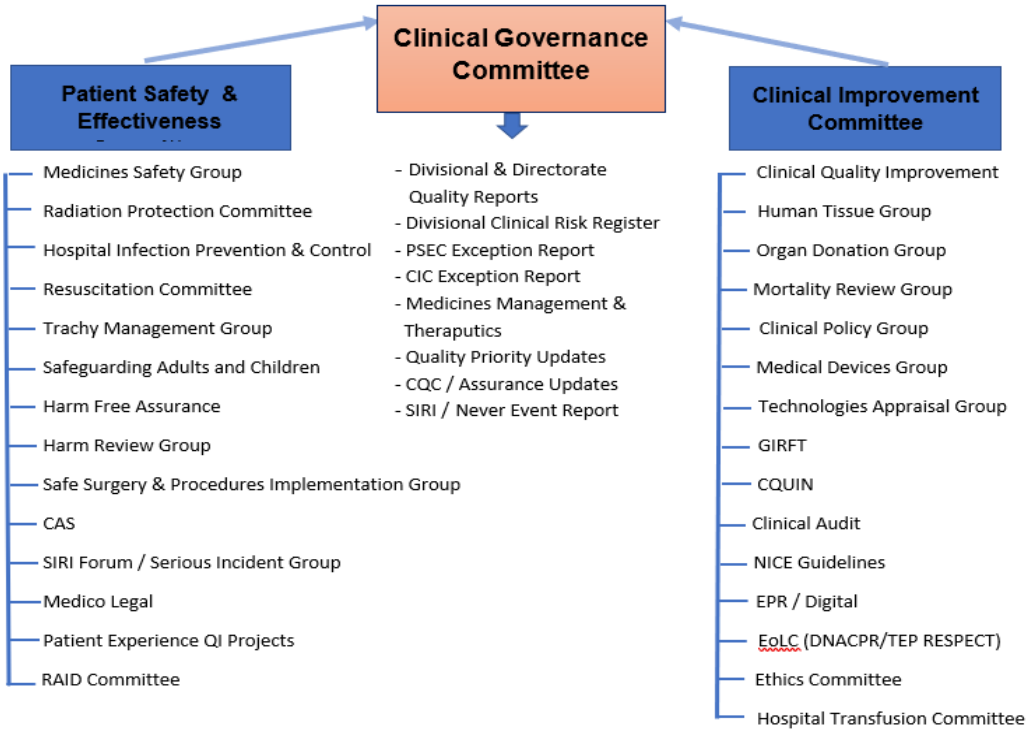

Figure 1: Clinical Governance Committee Reporting Committees

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.

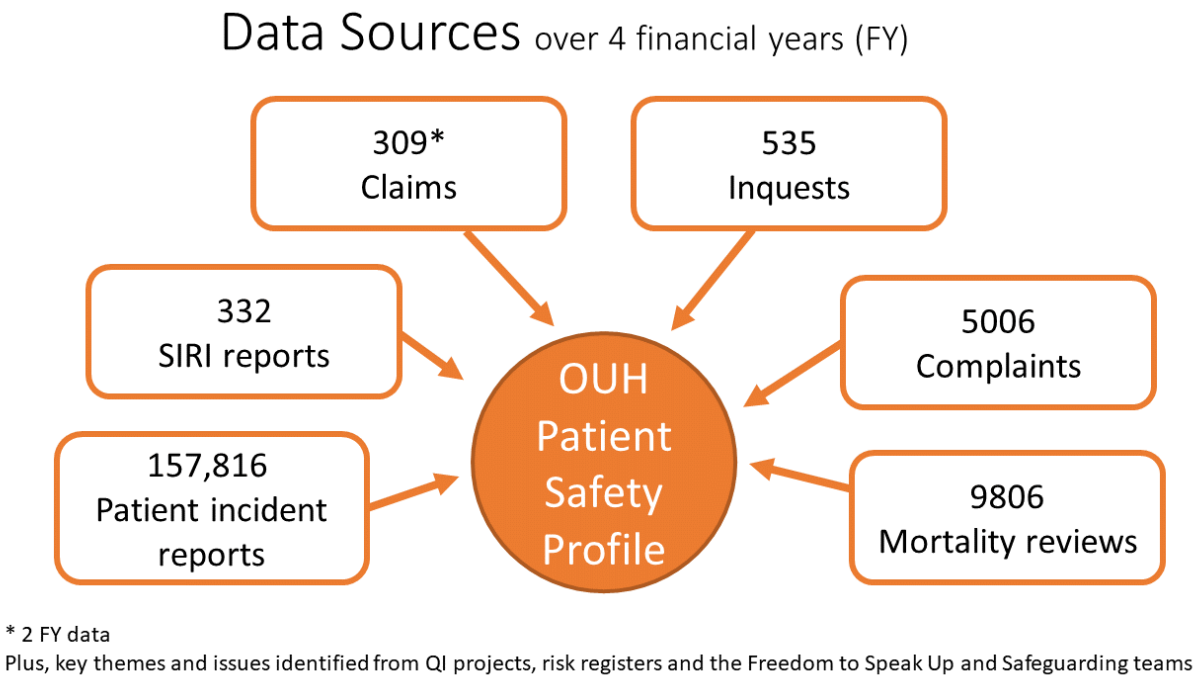

Figure 1: Data sources used to develop the OUH Safety Profile

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. Patients at risk (People with learning or intellectual disabilities, safeguarding 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.

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.

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. 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.
3. Learning MDT Review
   i. a follow up-multidisciplinary meeting to understand the wider organisational issues, including subject matter experts and other relevant stakeholders.
4. Hot debrief – a rapid meeting to review the event to answer the same questions as for the AAR review and to provide staff support.
5. 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	PSII	Create local organisational actions and share learning through the weekly SLIC.

for patient safety incident investigations (PSIIs))		
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and share learning through the weekly SLIC.
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	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC.

wilful neglect or domestic abuse/violence. • adults (over 18 years old) are in receipt of care and support needs from their local authority. • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Issues and learning opportunities shared with the PSIRF improvement workstream.
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 methods of After Action Review and Learning Multi-disciplinary Team 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 **Error! Reference source not found.**. 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.

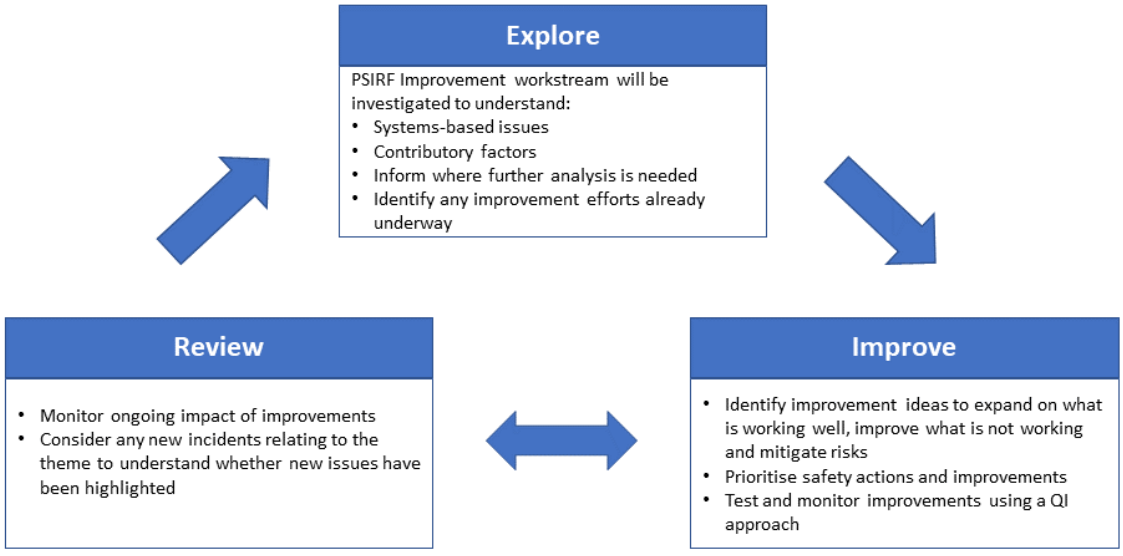

Figure 1: PSIRF workstream learning process.

Table 2: PSIRF Workstream improvement process

Patient safety issue	Planned response	Anticipated improvement route

Handovers - including communication and documentation	Thematic review of completed serious incident reports (SIRI, Divisionals, PSII, Learning MDT Reviews and AARs) 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.	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.
Referral and MDT processes and pathways		
Reporting and pathology/imaging endorsement		
Care of vulnerable people (safeguarding, learning difficulties and disabilities, autism and mental health issues)	As above, plus: Perform benchmarking exercise using the Learning disability improvement standards self-improvement tool to identify areas for improvement.	
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.	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.	Development of an improvement plan for key areas identified in analysis. Learning shared through the weekly SLIC.
Other identified episodes of good practice, good care or excellence where wider learning has been identified.		

Our patient safety incident response plan: Established processes

As described above, and as shown in Figure , 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

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

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

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