TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

# Patient Safety Incident Response Policy

## October 2023 - October 2025

| Document Control | |
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| Document Owner: | Chief Medical Officer |
| Document Author(s): | Patient Safety Specialists |
| Approved By: | Trust Board |
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| **Document Summary** | |
| Target audience: | All Trust staff |
| Document purpose: | To set out the requirements and standards for patient safety incident reporting and management at MKUH. Outlines the processes that must be followed to meet the requirements of the National Patient Safety Incident Response Framework (PSIRF) for all patient safety incidents. This includes the reporting process, how to support those involved, timescales, decision making pathways, response levels, and the associated learning, improvement, and oversight. |
| To be read in conjunction with other MKUH policies: | Being Open policy<br>Complaints and PALS Policy<br>Equality, Diversity, and Inclusion Policy<br>Freedom to Speak Up Policy<br>Health and Safety Policy<br>Incident Reporting Policy and Procedure<br>Learning from Deaths Policy<br>Litigation and inquests policy<br>Risk Management policy<br>TRiM Maternity Staff Support Following Incidents |

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| v.0.1 | 20-07-2023 | Head of Quality Improvement & PSIRF Steering Group | Updates included |
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| v.0.1.2 | 18-09-2023 | Quality & Clinical Risk Committee | |
| v.0.1.3 | 21-09-2023 | PSIRF Steering Group | Amendments included |
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# Contents

# 1. Introduction and Purpose

The NHS Patient Safety Strategy (PSS) was published in July 2019 and described the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (SIF). The SIF provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best described as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety. It is more than just a framework for how we respond to incidents. One of the underpinning principles of PSIRF is to be proportionate in our approach. This means doing fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them and supporting those affected.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Milton Keynes University Hospital's 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 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 development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

### Table 1: The four key aims of the PSIRF

| Aims | Objectives |
|---|---|
| Compassionate engagement and involvement of those effected by patient safety incidents | A timely connection with those impacted (patient, families, carers, and staff) by any patient safety incident or event where there are learning opportunities.<br>Collaborate with relevant parties including patients, families, carers to co-design change ideas and implement these into the Trust.<br>Offer flexible individualised access to support following patient safety incidents (patients, families, and staff). |
| Application of a range of system-based approaches to learning from patient safety incidents | Provide easy access to training in relevant skills:<br>• Human Factors including an introduction to the Systems Engineering Initiative for Patient Safety (SEIPS)<br>• Patient Safety Syllabus eLearning modules (levels 1 and 2)<br>• In-house PSIRF training<br>• Appreciative inquiry<br>• Quality Improvement<br>Embed the SEIPS model into response methods and templates.<br>Encourage the use of system-based thinking and conversations at all levels, e.g., team meetings, care review panels, Patient Safety Board. |

| Aims | Objectives |
|---|---|
| Considered and proportionate responses to patient safety incidents | • Provide immediate acknowledgement and feedback to those reporting incidents via Radar including the offer of involvement in the response process and regular updates.<br>• Application of new techniques in response to patient safety incidents to optimise learning and improvement (*Appendix 1*).<br>• Prevent repetition of patient safety incident reviews where contributory factors are already understood.<br>• Resource to be focused where greatest learning and improvement opportunities lie. |
| Supportive oversight focused on strengthening response system functioning and improvement | • Recognise emerging themes within safety intelligence and explore these, regardless of their level of harm.<br>• Develop system improvement plans based on triangulated incident response data.<br>• Improve ability to evidence and measure the impact of improvement initiatives.<br>• Collaborate with BLMK Integrated Care Board to ensure wider sharing of learning between organisations and at regional and national levels. |

## 2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Milton Keynes University Hospital (MKUH) NHS Foundation Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are identified as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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.

# 3. Our Patient Safety Culture

Ensuring a 'Just Culture' is a key priority for MKUH. In 2021, MKUH saw the introduction of a new reporting system, Radar. This involved a substantial change for staff and, as such, created opportunities to review our reporting culture and improvement work is now underway.

The introduction of Radar coincided with the addition of the new NHS national reporting form; the Learn from Patient Safety Events (LFPSE) form. Staff have been supported to use the new national LFPSE form and have been encouraged to share feedback which has been welcomed, and responded to, by both the local and national teams. This is ongoing work and changes to the system are being made frequently in response to staff feedback and to meet the requirements of PSIRF. The safety team recognise that it takes time and effort to complete a Radar and all efforts will continue to be made to ensure the process is as quick and simple as possible to reflect feedback from staff.

MKUH promotes a system-based approach to learning from incidents and events. The SEIPS (Systems Engineering Initiative for Patient Safety) model (*Appendix 2*) is used during all response types. By utilising a system thinking approach, we are confident this will reduce any blame culture that has formed using previous incident review processes. The focus will be shifted from individuals to wider system functions and processes. The skills required to use SEIPS is taught during a trust wide well-established human factors workshop which is held monthly.

To encourage a positive reporting culture, a personalised response will be sent to all reporters, explaining the response type the incident will receive, along with a description of the processes and timeline. Staff will be thanked for their contribution to patient safety at MKUH and given a named staff member to contact should they wish to know more or offer more details about the incident in question. Updates will be sent during the process, and at the end, to explain findings and actions. Each reporter will be offered the opportunity to be part of the review process if appropriate.

When discussing incidents in any forum, such as during a After Action Review (AAR) either at a board meeting, or during a more personal 1:1 meeting for example, the focus will always remain about how individuals, teams and the Trust can learn from the event. The use of positive appreciative language will be encouraged, and any deviation will be challenged in a supportive way as a continued learning approach and develop clinical curiosity, such that challenge will be normalised. Learning from excellence (GREATIx) and using 'Safety II' principles (patient safety initiative that starts by looking at everyday practices and focuses on what's going well in a system or process) will also be encouraged during discussions.

During interactions with those involved in incidents, the Trust will strive to dedicate time to those involved to really hear what matters to them and understand their experience. Certain tools to support these interactions and conversations include appreciative touch points and LIFE (Learning and Innovation from Events) sessions (*Appendix 3*).

The safety team appreciate that these new approaches to incident reporting and reviewing will require new skills for staff both for reporting and reviewing. A training needs analysis has been designed which reflects the learning requirements for different staff groups. A more detailed breakdown has been captured in *Appendix 4*.

# 4. Patient Safety Partners (PSPs)

At MKUH we are fortunate to have a team of engaged Patient Safety Partners (PSP) who report into the Patient Safety Specialists team. Their addition to the Patient Safety team has enhanced the patient engagement in safety work across the Trust, raising the voice of patients and their families by bringing their ideas to the centre of investigations, reviews, and improvement work.

The PSPs have been involved right from the outset of the development of the PSIRF plan and related policies. A designated PSP is a key member of our Trust PSIRF Steering Group, as well as representing MKUH at regional PSIRF workshops.

The team of PSPs have led and facilitated focus work with patients and families who have lived experience of previous incident review and complaints processes using the Serious Incident Framework (2015)[1]. Using appreciative inquiry techniques, the PSPs were able to understand from their focus group, what had worked well for the patients and their families, what could have been done differently and have utilised key messages from these conversations to co-design the new process and templates with particular focus on the use of appropriate language.

Our PSP team will continue to work with the patients and their families to ensure their voice is heard and are at the centre of incident review processes and improvement plan development. Moving forward the PSPs will be part of any groups or committees responsible for the monitoring and review of the PSIRF plan and policy such as Patient Safety Board.

# 5. Addressing health inequalities

MKUH is committed to preventing and tackling discrimination, promoting human rights, equality, diversity, and inclusion by promoting equal opportunities and fair treatment in all areas of employment practice and service delivery for our workforce and in the delivery of our services to our employees, patients, service users and carers. It is the responsibility of everyone within the Trust to ensure that they behave and conduct themselves in such a way as to ensure work colleagues, patients and families are treated with dignity and respect. This is particularly important when responding and reviewing patient safety incidents and supporting those involved.

All patients and families involved in a patient safety incident requiring a Patient Safety Incident Investigation (PSII) will be offered a named contact (engagement lead) for the investigation. Terms of reference will be developed between the engagement lead and the patient/family to ensure the investigation is conducted in a way that meets the emotional, psychological, and physical needs of each family. It is recognised that that each patient/family have different needs, and these must be considered when investigating incidents, agreeing time frames, writing the report, and arranging to meet with individuals.

PSIRF aims to remove the ‘blame’ culture that currently manifests itself in traditional incident investigation process by focusing on learning through a systems-thinking lens and not on individuals. The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. For any

[1] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

circumstances where an individual's actions or behaviours are in question, the NHS 'Just Culture' guide (*Appendix 5*) is recommended with the purpose of:

- Supporting a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.
- Asking a series of questions that help clarify whether there truly is, something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counterproductive.
- Helping to reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

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

MKUH and PSIRF recognise 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.

## 6.1 Engaging and involving patients and families

There is national guidance[2] for how we, as a Trust, should work with our patients and their families. There are 9 key principles to uphold. These include:

1. Apologies are meaningful.
2. Approach is individualised.
3. Timing is sensitive.
4. Those affected are treated with respect and compassion.
5. Guidance and clarity are provided.
6. Those affected are heard.
7. Approach is collaborative and open.
8. Subjectivity is accepted; everyone's experience of the same moment or interaction is different but of equal importance.
9. Strive for equity.

At MKUH, we work by these values to involve patients and their families in our safety reviews and activity. Moreover, as mentioned in Section 4, when our Patient Safety Partners engaged with a focus group of patients and families with lived experience their feedback echoed these 9 key principles. These individuals have been instrumental in co-designing how our safety reviews support and involve those affected, with compassion and care.

We believe, being open about what happened and using restorative care practices can help those involved to cope better and heal. Speaking with patients and families openly and honestly should

[2] B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk)

take place regardless of the level of harm caused by an incident and is a requirement of professional duty of candour. Statutory Duty of Candour, as per regulation 20 from the Care Quality Commission (CQC)[3], must also be completed when relevant, such as a 'notifiable safety incident' and involves a formal written apology. To be a notifiable safety incident, an event must meet all three of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity regulated by MKUH.
- In the reasonable opinion of a health care professional the event has or might result in death or severe or moderate harm to the person receiving care

Further information on Duty of Candour is covered under MKUH 'Being Open Policy'.

All incidents requiring a PSII will have a designated learning response lead and engagement lead. For Level 2 learning responses, an engagement lead will be available if required. The named engagement lead will be agreed by the patient safety team in conjunction with the clinical ward/department and is responsible for ensuring appropriate support is offered to the patient and their family, answering questions they may have and providing relevant information. The engagement lead will ensure that the patient/family/carer are:

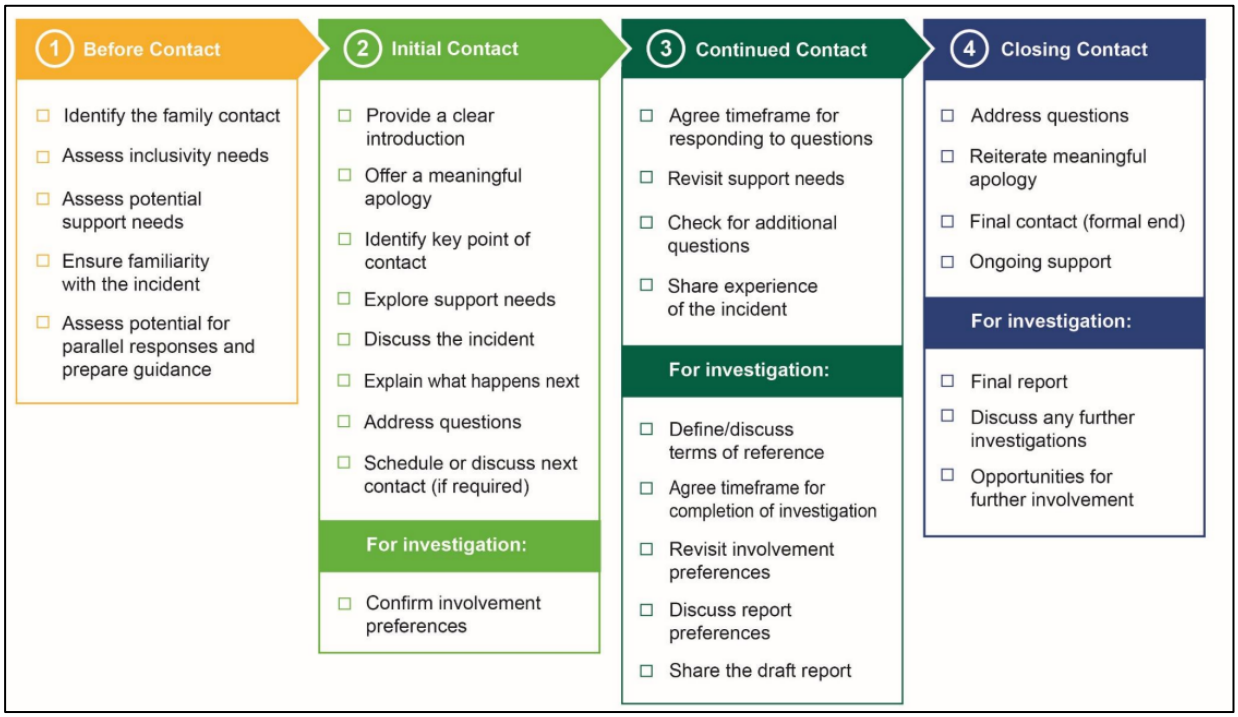
- involved in developing the terms of reference for the PSII.
- provided with an opportunity to provide their account of the incident.
- offered the opportunity to meet at a time and place that works for them and their needs.
- are kept up to date with the investigation and the next steps.
- given the opportunity to review and provide feedback on draft reports.
- supported when there are concurrent reviews taking place, such as a complaint or a coroner inquest.

At MKUH we plan to use 'The 4 Steps of Engagement' as described in 'Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident'[4], written by co-authors NHS England, HSIB and Learning Together. This resource offers a checklist (Table 2) to support our engagement leads when involving and engaging with patients and their families.

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

[4] https://www.england.nhs.uk/patient-safety/incident-response-framework/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident/

### Table 2: Reference Checklist




## 6.2 Engaging and involving staff

Following a patient safety incident, it is common to feel worried, apprehensive, and vulnerable. The Patient Safety team and line managers offer support to any staff involved. This process starts with a 'check in' as soon as possible after an event has occurred, ideally offered by a peer/ member of the immediate team. Everyone involved should feel heard with compassion and empathy. Capturing staff experience of what happened is vital. For learning responses, written staff statements are no longer required. Depending on the level of response, staff involved will be offered one or a combination of:

- A one-to-one conversation with a member of the patient safety team or line manager to share their thoughts and account of what happened and how they are feeling.
- An invitation to a learning event such as a Hot Debrief, After Action Reviews (AAR), or Multi-Disciplinary Team (MDT) round table review.
- If appropriate, contribute to the development of a patient safety incident investigation (PSII) report, including the co-design of safety actions and improvement ideas.

Staff will be kept informed throughout the process and treated fairly, feeling they can speak out in confidence. This will adhere to 'Just Culture' principles. Most importantly, staff will be included in shaping the report, developing safety actions, co-designing improvements and sharing the learning.

When it comes to support, it is recognised that one size does not fit all, and support can mean different things to different people. This may be having the opportunity to share thoughts and accounts with someone who cares, or it may be more practical support such as arranging a lift home or providing a buddy to work with next time they are on shift or in a similar scenario. It is known that for many staff initial psychological first aid and peer support is sufficient following involvement in an incident at work. However, others may need additional support from colleagues or specialist professionals and services. Table 3 below lists the local support and services available.

### Table 3: Local support and services available

| Service | Contact details |
|---|---|
| Patient Safety Team | patientsafety@mkuh.nhs.uk |
| Trauma Risk Management (TRiM) | MaternityTRiMManagers@mkuh.nhs.uk |
| Peer to Peer Listening Service (P2P) | p2p@mkuh.nhs.uk |
| Freedom To Speak Up (FTSU) Service | freedomtospeakup@mkuh.nhs.uk |
| Chaplaincy Service | chaplaincy@mkuh.nhs.uk |
| Mental Health First Aid | mentalhealthfirstaid@mkuh.nhs.uk |
| Staff Health and Wellbeing | Staff.hwb@mkuh.nhs.uk |

# 7. 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.

## 7.1 Resources and training to support Patient Safety Incident Response

**Resources**

The central patient safety team is led by a Head of Patient Safety and Legal Services, a Head of Patient Safety and Learning, and a Lead Patient Safety Doctor. The wider team consists of patient safety learning leads (PSLL), coordinators, administrative support staff and patient safety partners. This team works closely with:

- Quality Improvement (QI) team
- Trust Risk Manager
- Safety/Risk/Governance Leads from other specialist departments, including Maternity and Paediatrics
- Medication Safety Officer
- Medical examiners
- Patient experience/complaints team
- Safeguarding
- Senior leaderships teams (nursing & medical)
- Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care Board (ICB) Quality & Safety Lead

The heads of patient safety, the patient safety doctor and the patient safety learning leads are skilled trained investigators, learning response leads and engagement leads, all of whom have completed the nationally recognised PSIRF training. To ensure seamless pathways between safety reviews and local and trust wide learning and improvement, the central safety team work collaboratively with the QI team.

As well as the central patient safety team, it is recognised that there is great skill and resource in the wider organisation and all MKUH staff are encouraged to engage with incident reviews and learning events. Experts in each ward/department can offer personal support to colleagues from a practical and psychological perspective as well as offer specialist clinical guidance to the central patient safety team to enhance learning responses. Individual roles and responsibilities are covered in more detail in Section 9:Oversight, Roles, and Responsibilities.

## 7.2 Training

As recommended in the PSIRF standards[5], in 2023 approximately 60 staff members with key safety roles, relating to the review of patient safety incidents, successfully completed the nationally recognised PSIRF training provided by Facere Melius. The training included:

- Systems approach to learning from patient safety incidents (2 days)
- Patients and staff involvement in learning from patient safety incidents (1 day)
- Oversight: Systems approach to learning from patient safety incidents (1 day)

In order to embed the PSIRF methodology, practical based training will be delivered to upskill and support staff. For example, how to conduct a learning event or how to undertake a high quality PSII. There is sufficient expertise and availability of existing training, within the Trust to deliver 'in house' training. Table 4 below, summarises the training courses available to MKUH staff.

[5] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

## Table 4: Summary of training courses

| Course title | Mode of delivery | Duration | Course description |
|---|---|---|---|
| Patient Safety Syllabus Level 1: Essentials for all staff | eLearning | 30 mins | The starting point for all NHS staff and includes sections on listening to patients and raising concerns, the systems approach to safety, avoiding inappropriate blame when things don't go well, creating a just culture that prioritises safety and is open to learning about risk and safety.<br><br>There is no skills assessments although a certificate of completion will be received. |
| Patient Safety Syllabus Level 1: Essentials for Boards and Senior Leadership teams | eLearning | 30 mins | Additional session for senior leaders and executive teams, covering the human, organisational and financial costs of patient safety, benefits of a framework for governance in patient safety, understanding the need for proactive safety management and a focus on risk in addition to past harm, key factors in leadership for patient safety, the harmful effects of safety incidents on staff at all levels.<br><br>There is no skills assessment although a certificate of completion will be received. |
| Patient Safety Syllabus level 2: Access to Practice | eLearning | 1 hr | Intended for all clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are two sessions: 'systems thinking and risk expertise' and 'human factors and safety culture'.<br><br>Includes an assessment, which on completion staff will receive a certificate and will have access to the sector specific sessions covering Mental Health, Primary Care, Maternity Care, Acute Care, and Management and Administration |
| Patient Safety Syllabus levels 3 and 4 | Blended | * *To be confirmed by Health Education England* | The next levels of patient safety syllabus training available to named patient safety specialists. |
| Patient Safety Incident Response Training: Session 1 & 2 | In Person | 2 x 3 hrs | • Safety culture<br>• Appreciative inquiry techniques<br>• Systems thinking model<br>• Practical scenario-based learning including SEIPS analysis, cognitive interviewing, using learning response tools<br>• Report writing skills<br>• Engaging with those involved<br>• Safety action plan development |

| Course title | Mode of delivery | Duration | Course description |
|---|---|---|---|
| Learning & Innovation from Patient Safety Incidents | In Person | 3 hrs | Develop skills in how to share learning following a patient safety incident, including running a LIFE session. |
| Quality Improvement: An introduction | In Person | 1 Hour | Brief introduction to the Trust QI strategy and its linkage with the Patient Safety strategy. It delivers on the Trust vision, methods and Appreciative Inquiry approach and is incorporated into workshops and away days. |
| Quality Improvement: Fundamentals | In Person | 1 Day | Enables staff to 'kick-start' improvement projects, from defining aims to completing measurement and spread plans.<br><br>CPD accredited. |
| Quality Improvement: Practitioner | In Person | 4 Days | Support clinical and non-clinical colleagues to design and implement more efficient patient-centred services. The QI toolkit is explored in detail and a requirement is that candidates identify a QIP to work on alongside course attendance. |
| MKUH Human Factors Training workshop | In Person | 1 day | Introduction to the SEIPS model and the common factors affecting human and system performance |

The detailed training needs analysis (TNA) is available in *Appendix 4* and further information can be found in B1465 5. Patient Safety Incident Response standards v1 FINAL.pdf.

For further clarity on specific staff roles, please see the relevant department's TNA.

Staff working in patient safety, quality and governance roles where incident reviews are considered part of an individual's job plan will also need to commit to maintaining their competencies by involvement in at least 2 PSIIs per year and be able to evidence active involvement in other patient safety learning response methods such as AAR, MDTs. This will be part of staff personal development planning during annual appraisals.

## 7.3 Our Patient Safety Incident Response Plan

Our plan sets out how MKUH intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules and changes can be made when necessary. The Trust 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.

## 7.4 Reviewing our Patient Safety Incident Response 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. The plan will be reviewed every 12 months to ensure the focus remains up to date in line with ongoing improvement work to our patient safety incident profile. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months. Updated plans will be version controlled and published on our website.

A rigorous planning exercise will be undertaken on a regular basis, as agreed with the BLMK Integrated Care Board (ICB) to ensure efforts continue to be balanced between learning and improvement. This 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.

# 8. Responding to Patient Safety Incidents

## 8.1 Patient safety incident reporting arrangements

Each member of staff employed by the Trust is expected to ensure that all patient safety incidents, including near misses, are reported in a timely manner. The safety of the patient is paramount and without reporting, there will be minimal learning to prevent incidents recurring.

**Internal Notification Requirements**

The Trust's incident reporting system (Radar) is used to capture incidents, accidents and near-misses reported by staff. Relevant staff are automatically notified by Radar should an incident occur in their area or department. Distribution of these notifications is based upon the location and type of incident reported and reliant on an up-to-date staff list. Wards/departments will be asked regularly to update the patient safety team and Radar team when staff changes occur. The reporter of every incident receives an automatic acknowledgement from Radar.

MKUH also encourages staff to share Learning from Excellence through GREATix reporting.

**External Notification Requirements**

MKUH have been reporting live incidents to NHS England via the Learning from Patient Safety Events (LfPSE) system since autumn 2021. The LfPSE system supersedes the National Reporting & Learning System (NRLS). Anonymised incident data is sent automatically at the time of reporting to support wider analysis and learning from incidents across the whole NHS. The data the LfPSE system captures will be expanded in 2024 to record response data following PSIRF reviews/investigations and will also include data currently captured on Strategic Executive Information Systems (StEIS).

For notification requirements to other external agencies, please see Incident Reporting Policy and Procedure *(please note; whilst there is an overlap of the previous serious incident process and the new PSIRF, this policy will remain in use. Once full transition to PSIRF is complete, this policy will be updated accordingly).*

**Cross-System reporting**

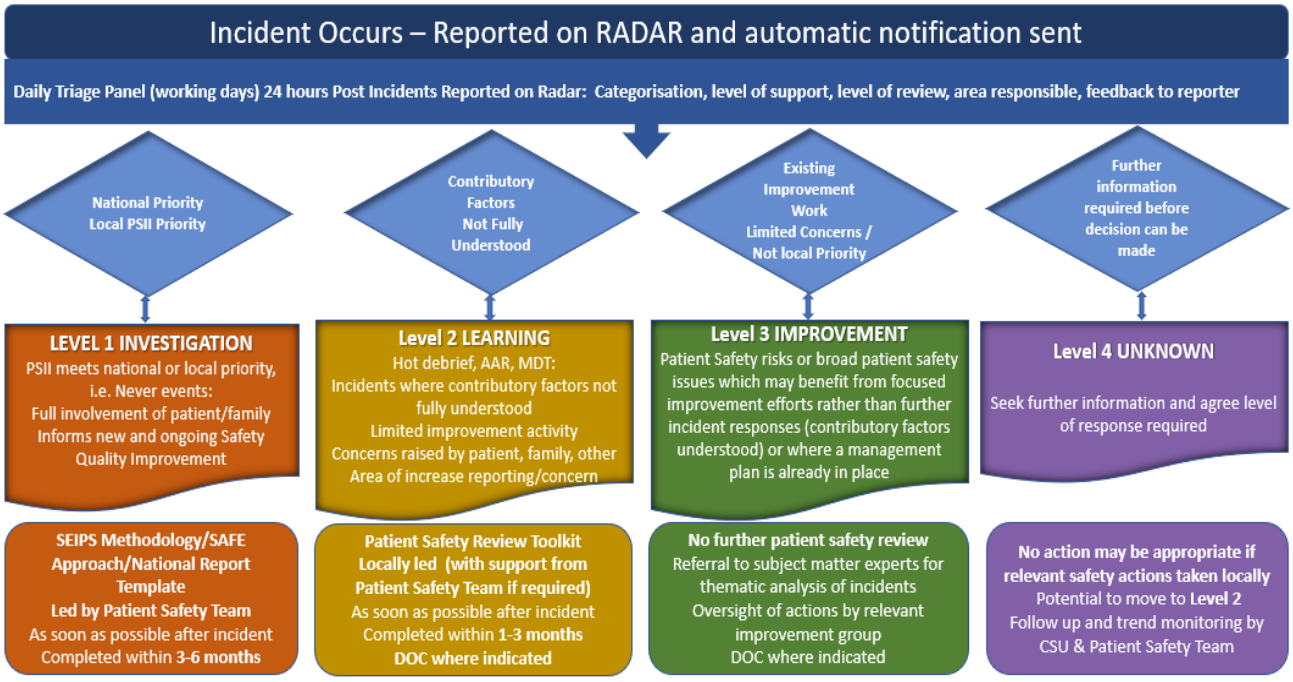
- *Inward reporting* - External agencies and care providers needing to inform MKUH of a patient safety incident can email radar@mkuh.nhs.uk with details of the incident and patient information.

  The email inbox is managed by the central patient safety team and is monitored daily as part of the triage panel and any incidents that need reporting are added to Radar on behalf of the external agency/care provider and reviewed appropriately.

- *Outward reporting* - Patient safety incidents that require reporting to external care providers, such as the Ambulance Service, care homes or GP practices, are discussed at the daily patient incident triage panel. For those incidents which are identified as presenting potential or significant learning and improvement for an external care provider, the MKUH safety team will liaise directly with their relevant contact. Such incidents would then be closed internally on Radar. This task is completed by the patient safety team as part of the response tasks for that day.

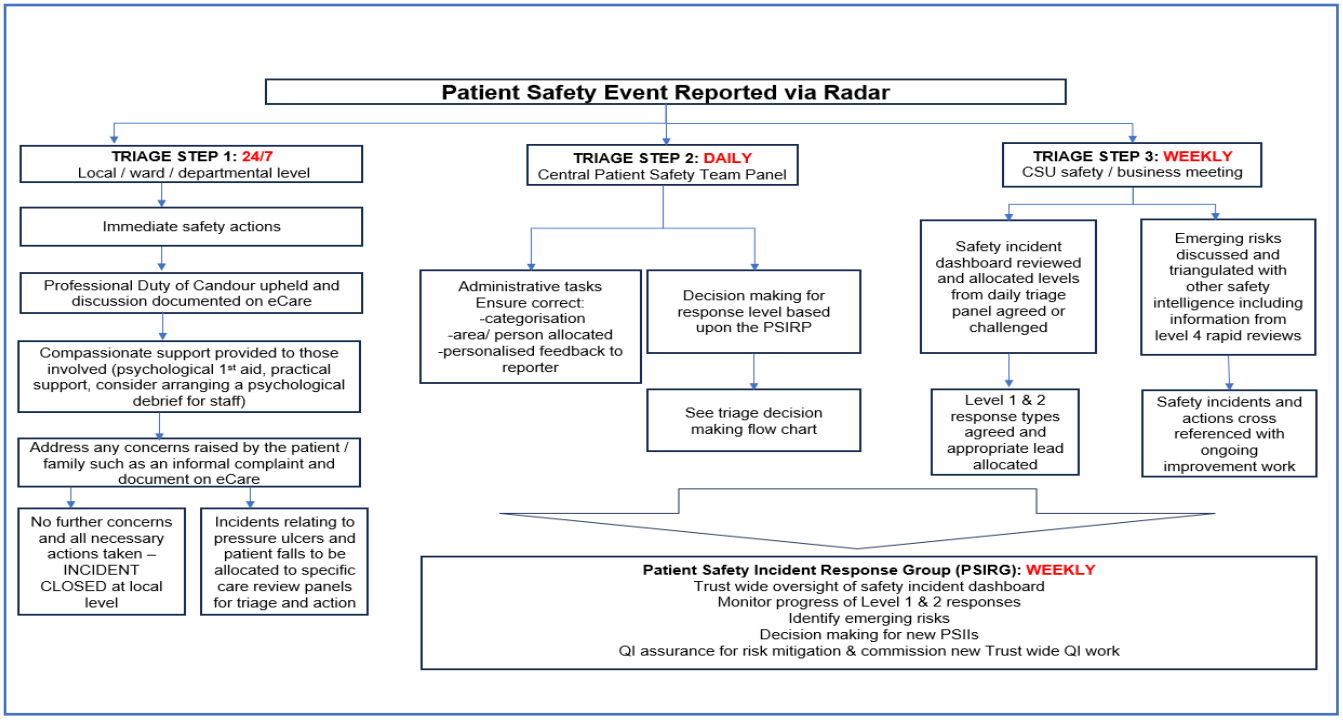
## 8.2 Patient safety incident response decision-making

There are 4 levels of incident response as detailed in the diagram below. Appropriate, considered decision making is essential to ensure that each incident gets a proportionate response.




There are 3 steps to patient safety incident triage: local/ward/departmental level, central patient safety team panel, CSU level as outlined in flow chart 1.

## Flow Chart 1: Incident Triage Levels

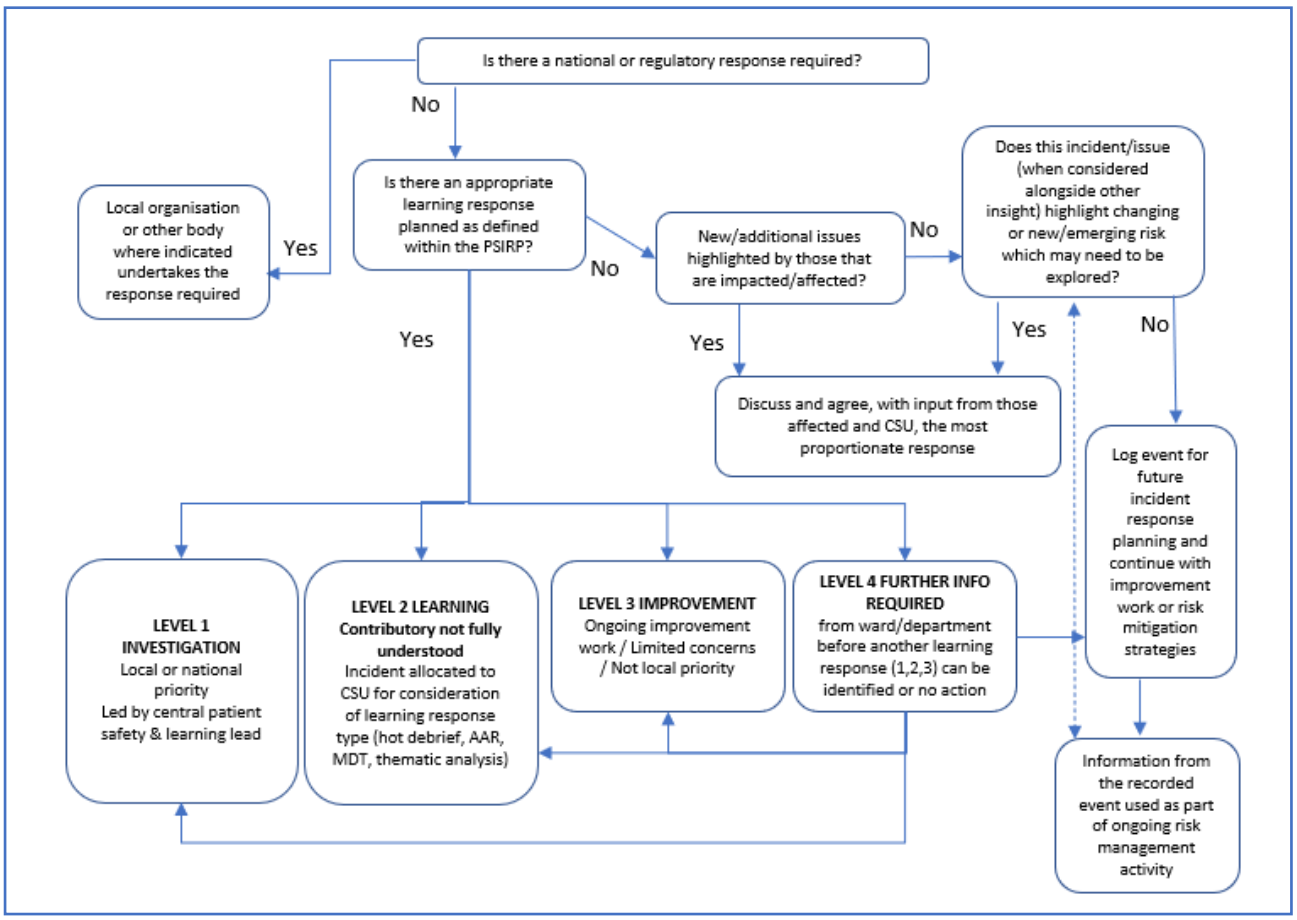



The central patient safety team triage panel is held daily (working days only). The panel meets virtually, and the Trust is working towards having representatives from the executive team, patient safety, risk, quality improvement, corporate nursing, medical, maternity, and members from the core clinical services, such as pharmacy and imaging.

This panel is responsible for:

- Identifying all incidents reported in the preceding 24 hours (72hrs on Mondays).
- Ensure incidents are appropriately categorised and allocated to the correct area/individual for monitoring and review. This includes both internally and externally.
- Scanned emails for inward reportable incidents from external care providers are sent to the Radar inbox radar@mkuh.nhs.uk
- A personalised email is sent to each reporter thanking them for their input and for their role in supporting patient safety at MKUH, whilst also describing the outcome of the triage panel and the anticipated response.
- Determining the initial level of response required (1,2,3, or 4), based on the Trust Patient Safety Incident Response Plan (PSIRP). See flow chart 2 below.

## Flow Chart 2: Incident Triage Decision Making Flowchart




Following this triage panel, the patient safety team members designated as the 'response team' for that day meet to discuss the actions required and to allocate jobs and roles for the day ahead. Outstanding jobs and reviews are also discussed and allocated to individuals.

For any patient safety incident where the level is not clear, or for most Level 4 responses, a quick assessment is completed as soon as possible, and ideally by the ward/department. This assessment aims to gather any additional information required to determine the most appropriate response, which could include 'no action' needed. This decision can be made by the response team that day or discussed at the next appropriate weekly Clinical Service Unit (CSU) safety/business meeting. Decisions must be based upon the following criteria:

1. Potential for learning in terms of:
    - Enhanced knowledge and understanding
    - Improved efficiency and effectiveness
    - Opportunity for influence on wider system improvement

2. Actual and potential impact of outcome of the incident (to people, service quality, public confidence, products, funds etc)

3. Likelihood of recurrence (including scale, scope and spread)

***Please note - Relationship to harms***

In line with the principles of PSIRF, triage panel decision making is focused on learning and improvement rather than specific harm incidents. Consideration is taken of ongoing improvement work and assurance in the Trust.

This does not affect the national requirement to meet Duty of Candour Notifiable Safety Incidents (NSI) (incidents which are unintended/unexpected incidents that have occurred during the provision of a regulated activity and in the reasonable opinion of a healthcare professional, already had, or might, result in death, or severe or moderate harm to the person receiving care).

**Pressure Damage and Falls**

All pressure damage related incidents are monitored, and reviewed, where necessary, at the weekly care review panel. Incidents involving pressure damage lie within the level 3 decision making category, unless learning potential is highlighted which is not included in the active local improvement plan.

- Incidents relating to moisture lesions, grade 1 and grade 2 pressure damage will be closed at ward level once validation has confirmed the degree of damage and the Radar pressure damage investigation form/checklist has been completed by the ward manager/senior nurse.
- Grade 3 pressure damage, or anything above grade 3, will require a learning response (AAR, MDT, thematic review) and will be reviewed at the care review panel, which is overseen by the Harm Prevention Group.
- Any actions generated from learning responses will feed into the trust wide pressure damage improvement plan.
- All pressure damage numbers will be monitored by the Harm Prevention Group.

## 8.3 Responding to cross-system incidents and/or issues

Where cross system incidents have been identified, the Trust will work closely with external care providers and the relevant ICB to support the free flow of information and timely review of any incident. A nominated member of the patient safety team will be the liaison for cross system working.

In scenarios where a cross system incident is too complex to be led by a single provider, the Trust will approach the relevant ICB to help coordinate a multi-organisation review with the anticipated support guiding about the level of response required and the development, monitoring and sharing of any safety actions generated.

Should MKUH be asked either by an ICB or an individual external care provider to contribute to one of their PSII, an initial meeting will be held with representation from both organisations, to determine the level of input required, with whom oversight sits, how actions are to be agreed and how/where learning will be shared. Any report will need to be signed off internally at the Trust PSIRG prior to external submission including any improvement recommendations and safety actions.

## 8.4 Timeframes for learning responses

Where a PSII is required (as defined in the plan for both local and national priorities), the investigation will start as soon as possible after the incident has occurred. PSIIs will ordinarily be completed within three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of a PSII in which case, any extended timeframe will be agreed between the learning response lead, engagement lead and the patient/family. Ideally, PSIIs will be completed within six months.

It is recognised that for some patients/families, the right time to engage can vary and therefore the timescales will reflect and be respectful of this. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

## 8.5 Safety action development and improvement plans

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the learning of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed with sustainable change.

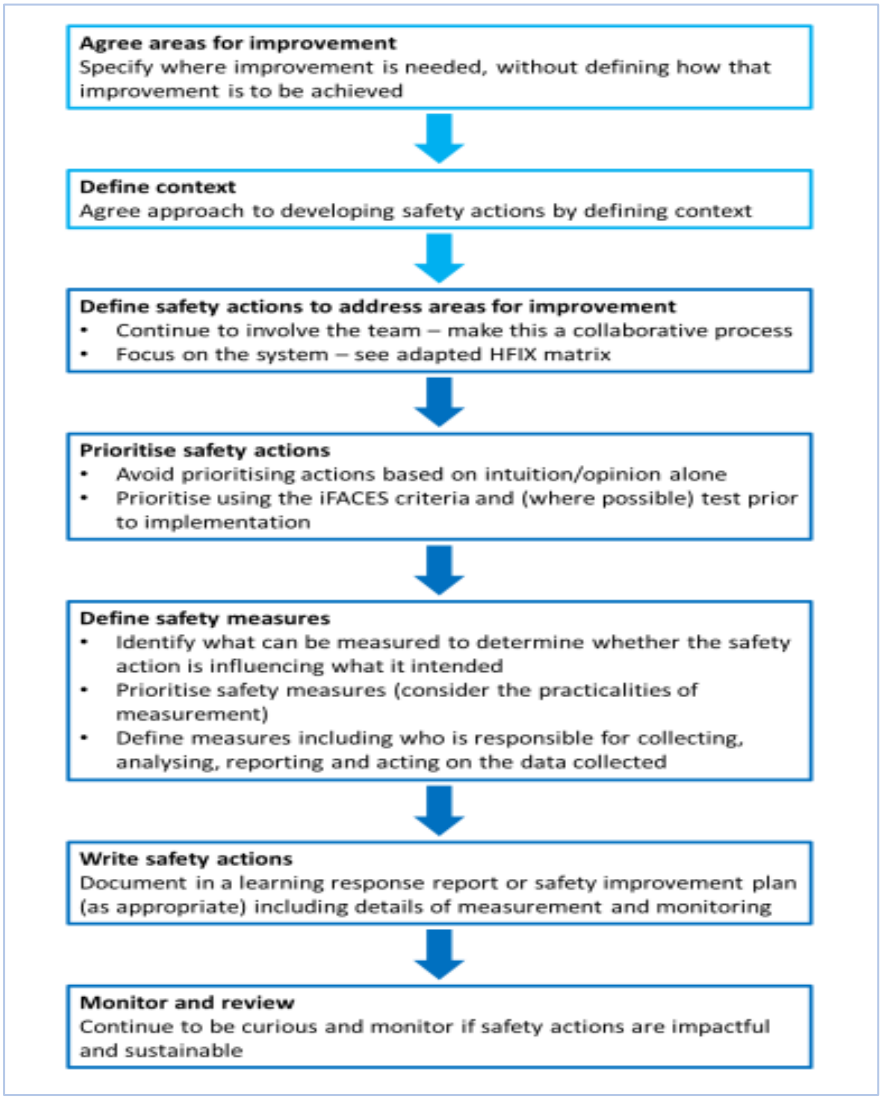
The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022)[6] as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions.
2. Define the context – this will allow agreement on the approach to be taken to safety action development.
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved,
4. Prioritise safety actions to decide on testing for implementation.
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics.
6. Safety actions will be clearly written and follow Specific, Measurable, Achievable, Realistic, Time-bound (SMART) principles and have a designated owner.

[6] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

How safety actions should be developed and overseen are summarised in the flow chart 3 below:

### Flow Chart 3




A Quality Improvement (QI) approach and collaborative working with the QI team will be valuable in aspects of learning and improvement following a patient safety investigation. The Trust will use the outcomes from previous patient safety incident investigations, quality improvement projects, national audits, GIRFT actions, NICE recommendations, CQUIN actions, CQC inspection actions and any relevant learning responses conducted under PSIRF, to create safety improvement plans to help streamline and focus improvement work. (Please refer to the glossary for a definition of terms).

It is necessary to ensure close links are developed and maintained with the Quality Improvement team and the healthcare team. Medical input will be key within the relevant CSUs for those working in safety and governance roles.

Safety actions arising from a learning response should follow the SMART principles and thought must be given to avoiding duplication with other quality workstreams, monitoring and measures of success.

Further guidance on this can be found in NHSE Guidance at https:// www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Safety actions created will feed into either Trust wide safety improvement plans or individual safety improvement plans that focus on a specific service, pathways, or location.

## 8.6 Safety Action Monitoring

It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk. The Trust must therefore develop governance systems focused more on measuring and monitoring these outcomes using a combination of quantitative and qualitative information, utilising subjective as well as objective measures.

Monitoring of completion and efficacy of safety actions will be through Trust QI and governance processes. The Patient Safety Team will maintain an overview across the Trust to identify themes, trends, and triangulation with other sources of information that may reflect improvements and reduction of risk.

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Trust Patient safety Board and Quality, Learning and Improvement board.

For some safety actions and improvement plans with wider significance, if broader issues for improvement are to be actioned (i.e., overarching system issues), this may require input and oversight by a corporate governance oversight group such as the Harm Prevention Group, Care of the Critically Ill Patient group or Medicines Management Group who report to the Trust Patient Safety Board or Quality Learning and Improvement Board.

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through divisional governance processes and reported to the Patient Safety Board who may commission a safety improvement plan. Again, the divisions will work collaboratively with the Patient Safety and the QI team and others to ensure there is an aligned approach to the development of the plan and resultant improvement efforts.

Monitoring of progress with regards to safety improvement plans will be overseen by reporting by the designated Patient Safety Learning Lead to the Patient Safety Board and Quality Learning and Improvement Board on a scheduled basis.

# 9. Oversight Role and Responsibilities

The Trust Board have overall responsibility for oversight of the PSIRF in the Trust. However, ultimately, everyone who works at MKUH has a responsibility for the delivery of high quality, safe care to patients and their families. This includes the recognising and reporting of near misses and patient safety incidents as well as engaging in any learning responses, incident investigations and relevant improvement work.

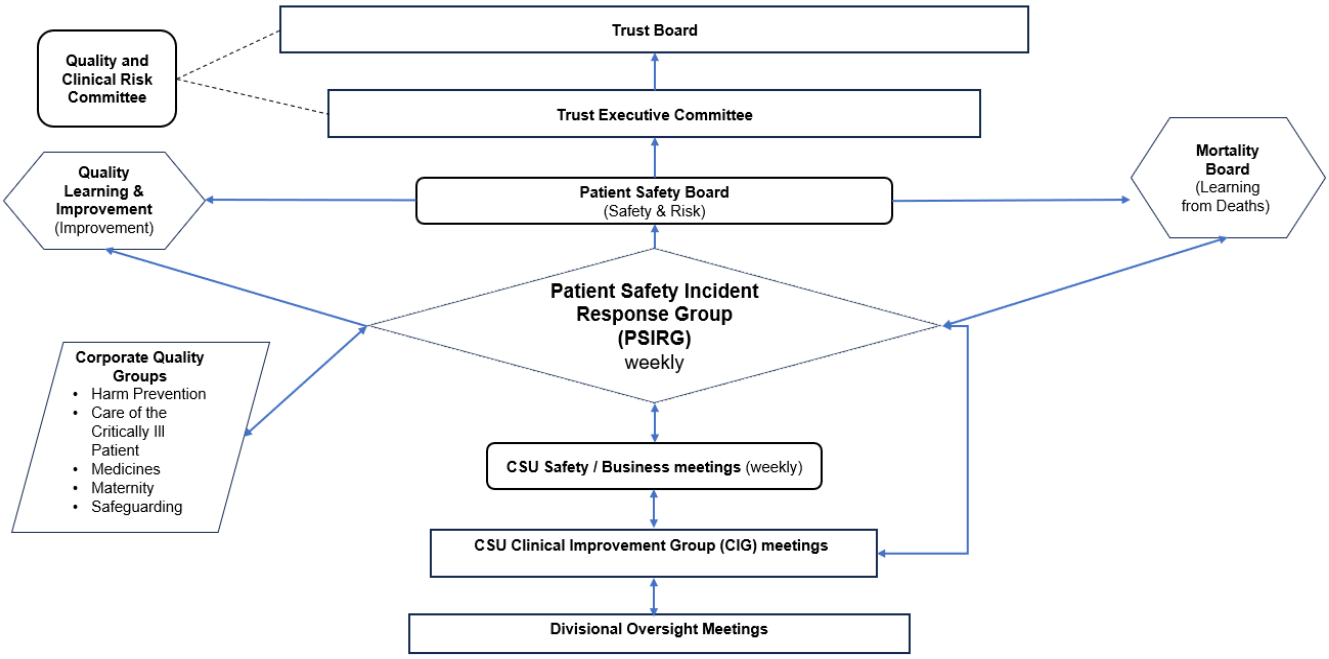
The Trust recognises and is committed to close working, in partnership, with BLMK ICB and other national commissioning bodies as required. Oversight and assurance arrangements have been developed through joint planning and arrangements and will incorporate the following key principles:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Policy, planning and governance.
3. Competence and capacity.
4. Proportionate responses.
5. Safety actions and improvement.

As referred to above, it is important that under PSIRF there is a paradigm shift from monitoring of process, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

It should be noted that similarly BLMK ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' a serious incident (SI) and have individual patient safety responses 'signed off' by commissioners. Existing groups and panels have been disbanded and a new oversight map for patient safety, learning and improvement has been developed. See image overleaf of an oversight map:

## Oversight Map:




### Patient Safety Incident Review Group (PSIRG)

This new weekly panel will have oversight of all patient safety incidents which have gone through the central patient safety team daily triage panel and the CSU weekly safety/business meetings.

Membership includes; Chief Medical Officer, Chief Corporate Services Officer, Chief Nurse, Associate Medical Director (Chair), senior nursing representation (Associate Chief Nurses/Divisional Chief Nurses), Lead Patient Safety Doctor, a Head of Patient Safety, Patient Safety Learning Leads, Medication Safety Officer, maternity and paediatrics Quality and Governance Leads, BLMK ICB Quality and Safety Lead, representation from each CSU (Safety lead (new role), nursing, medical or operations) and administrative support.

The functions of this group include:

- Trust wide oversight of safety incident dashboard.
- Monitor progress of Level 1 and 2 responses.
- Identify emerging risks.
- Decision making for new PSIIs.
- QI assurance for risk mitigation and commission new Trust wide QI work.

**Patient Safety Board**

The Patient Safety Board will have overall responsibility for:

- Supporting the development and review of the Trust's PSIRF policy and plan.
- Review of risks associated with the implementation and effective embedding of the PSIRF plan
- Receive reports of PSIRF activity as detailed in the oversight map.
- To review trends and clusters in patient safety incidents reported through the Patient Safety Incident Review Group (PSIRG) and make further recommendations to mitigate recurrence.
- To act as a point of dissemination for learning from incidents or other events/ information on safety.
- To act as a point of escalation for all sub-groups on matters of patient safety.
- To provide assurance to the Clinical Quality Board on overall patient safety performance.
- To ensure appropriate levels of engagement across the Trust in embedding PSIRF.
- To ensure that patient safety matters are appropriately cascaded for discussion and action at Clinical Improvement Group (CIG) meetings in every Clinical Service Unit (CSU).
- To ensure that any training, education, or awareness requirements for PSIRF are considered.

**Quality, Learning and Improvement Board**

The Quality Learning and Improvement Board has oversight of learning and improvement work for the national PSIRF priorities, the Trust identified local PSIRF priorities, the progress of learning actions from local incidents where learning response methods have been applied and thematic analysis of incident themes and trends.

**Chief Executive and the Board of Directors**

The Chief Executive and Trust Board have the ultimate responsibility for all aspects of safety and risk management, including the management of incidents. This includes ensuring that suitable arrangements are in place for the systematic investigation, analysis, and improvements, both locally and corporately, and that resources are available to comply fully with this PSIRF policy and plan.

**Chief Medical Officer and Chief Corporate Services Officer**

The Chief Medical Officer has overall responsibility for patient safety across the Trust.

Both the Chief Medical Officer and Chief Corporate Services Officer has joint responsibility for ensuring that all patient safety incidents are investigated in a timely manner and responded to in accordance with this PSIRF policy and plan. They will oversee the development and review of the organisation's PSIRF, ensuring there are sufficient resources to support the delivery of the plan (including support for those affected, such as staff, patients, families, and carers where required) and, that Duty of Candour is upheld.

The Chief Corporate Services Officer is responsible for managing the day-to-day strategic development and implementation of risk management in the areas of quality, patient safety and litigation. This includes ensuring an adequate system is in place for incident management, reporting at all levels up to Trust Board, and to inform the Board of significant patient safety incidents as they occur and emerging themes that require immediate actions to be taken.

**Divisional/CSU Managers, Clinical Leads, Lead Matrons/Matrons/Senior Nurses and Service Managers**

These individuals are required to attend (wherever possible) their relevant weekly CSU safety/business meetings and other safety and quality related CSU and divisional meetings to provide senior leadership and champion a safety culture of learning and continual improvement.

These team members are to ensure that appropriate staff members and subject matter experts are available to support the central patient safety team to carry out PSIIs and other learning responses within their relevant Divisions/CSUs. They will also ensure that all investigations are completed in a timely manner by supporting and releasing all staff involved in an incident to attend any investigation and learning discussions.

The Divisional Chief Nurses and/or Clinical Directors agree risk reduction action plans and ensure that all relevant risks identified from incident reports are included on the Divisional risk registers. They also ensure the completion of any safety improvement action plans arising from incidents and report as necessary to external or professional bodies where appropriate. Managers and clinical leads within each ward/department are responsible for sharing learning from patient safety incidents and events across the Trust.

**Heads of Patient Safety (Learning and Legal Services)**

The Heads of Patient Safety co-lead the patient safety team offering a multitude of different skills in the key areas of learning, engagement, litigation, incident management and support. A key responsibility will be to role model the PSIRF values and skills whilst supporting the rest of the safety team and wider Trust in the new approaches.

The Heads of Patient Safety are required to champion and challenge a new safety culture where the focus is on learning and supporting each other. Engaging and collaborating with key internal and external stakeholders such as the QI team, safeguarding team, complaints team, education and organisational development and the ICB and other local Trusts. The heads of Patient Safety will represent the safety team at corporate boards and committees. These roles will have direct access to the senior executive team to highlight emerging safety concerns quickly and effectively.

The Patient Safety heads have specific priorities and responsibilities as outlined below:

**Learning**

The head of patient safety (learning) will lead the patient safety team in ensuring that incident triage and response is completed in accordance with the PSIRP. They will role-model supporting staff, patients and families and prioritising learning in all safety reviews whilst providing seamless transitions of learning into local and Trust wide quality improvement work. They will lead the team to provide support for local and divisional leaning events whilst upskilling others to be able to lead their own local learning going forward. Skills such as human factors and appreciative inquiry will be utilised and embedded into all aspects of patient safety incident review and learning.

**Legal Services**

The Head of Patient Safety (legal services) will work closely with the litigation office, the Trust's legal providers and her majesty's coroner to ensure effective processes are in place to manage all investigations in relation to inquests and claims.

They will be available to attend formal hearings, as needed, and provide responses to the coroner, external legal teams, patients, families, and external bodies. This team member will work closely with the head of patient safety for learning to support the wider safety team to robustly review all patient safety incidents in a timely manner prioritising learning and the needs of those involved.

**Lead Patient Safety Doctor**

The Lead Patient Safety Doctor will work closely alongside the Heads of Patient Safety, Associate Medical Directors and the Chief Medical Officer, supporting trust wide safety and PSIRF work with the focus on learning, engagement and improvement. This team member will have a particular emphasis on engaging with the medical practitioners working in the Trust, role-modelling a safety culture where the support of each other, patients and families is prioritised. They will support safety leads within each clinical support unit to learn from any patient safety events in a collaborative, supportive manner that ensures learning is embedded within departments. They will represent CSU safety leads at committees and board meetings where appropriate.

**Patient Safety Learning Leads (PSLL)**

PSLLs are the key link between the divisions and the central patient safety and quality team to ensure that there are robust governance processes in place which support teams to monitor and respond to patient safety incidents effectively, share learning and develop sustainable safety improvement actions. Some of key functions that this role will perform are:

- Attend relevant CSU weekly safety/business meetings to ensure oversight of all levels of patient safety incidents and support the decision making of the level and types of learning responses.
- Support the wards/departments with their learning response types in collaboration with the patient safety and learning officer and a patient safety and engagement coordinator. This includes leading on PSIIs in collaboration with a nominated engagement lead and experts from the local area.
- Take improvement ideas from learning responses back to the weekly CSU meetings for the teams to agree the safety actions.
- Escalate emerging risks through the divisional risk process and PSIRG.
- Cross reference safety actions with ongoing local and Trust wide QI and audit activity including GIRFT, CQUINs and QIPs.
- Be an integral member of the patient safety daily triage panel and weekly PSIRG meeting.
- Provide a feedback loop to their divisions/CSUs with any actions required.
- Support their PSLL colleagues with PSIIs by acting as engagement leads for PSIIs they are not leading on.

**Patient Safety and Learning Officer**

The patient safety and learning officer will work closely with the PSLLs, Heads of patient safety and the QI team to ensure that patient safety incidents reviews are completed in a timely manner with the appropriate people involved. Daily tasks will involve the booking and coordination of learning responses such as AARs, supporting those facilitating the learning responses and capturing the actions generated.

They will work in parallel with the QI team to ensure that learning responses are recorded on Radar and actions are linked to existing quality improvement work.

They will also be a key member of the daily triage panel and liaise closely with wards and departments when further or updated information is required.

**Patient Safety and Engagement Coordinators**

The safety coordinators will support the safety and learning officers, patient safety and learning leads and the heads of patient safety with clerical and administrative tasks.

# 10. Complaints and Appeals

We value the comments and compliments about the services we provide. Learning from our patients, carers and relatives experience will actively contribute to the continued development of our services. We recognise that for patients, carers and relatives, participation in a safety incident investigation could be a distressing time as well as being an empowering experience.

In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, including any matters relating to the Patient Safety Learning response lead or engagement lead Investigator, we will:

- If appropriate, seek to resolve the matter locally through a discussion between the patient and/or relative the Patient Safety Learning response lead or engagement lead investigator.
- Escalate the concerns to the Heads of Patient Safety and/or Chief Medical Officer and/or Chief Corporate Services Officer and/or Chief Nurse for local resolution.
- Refer the matter as a formal complaint via the Trust's Complaints and PALS department for a CEO response.

# APPENDICES

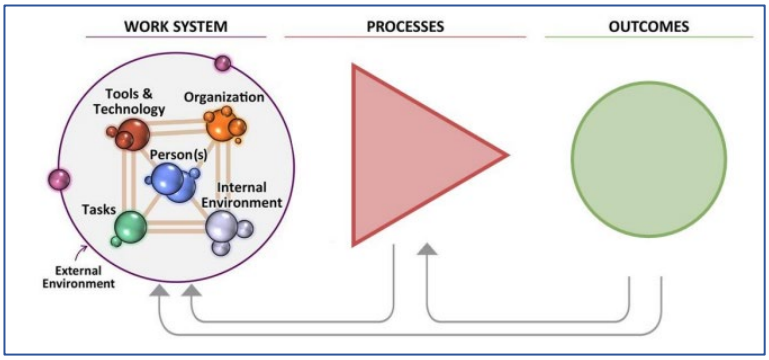
## Appendix 1 - National Learning Response Methods

| Method | Description |
|---|---|
| Patient Safety Incident Investigation (PSII) | A PSII offer an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. |
| Swarm Huddle | These are designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in the future. |
| After Action Review (AAR) | AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.<br>It is based around four questions:<br>What was the expected outcome/expected to happen?<br>What was the actual outcome/what actually happened?<br>What was the difference between the expected outcome and the event?<br><br>What is the learning? |
| Multidisciplinary Team review (MDT) | An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care. |

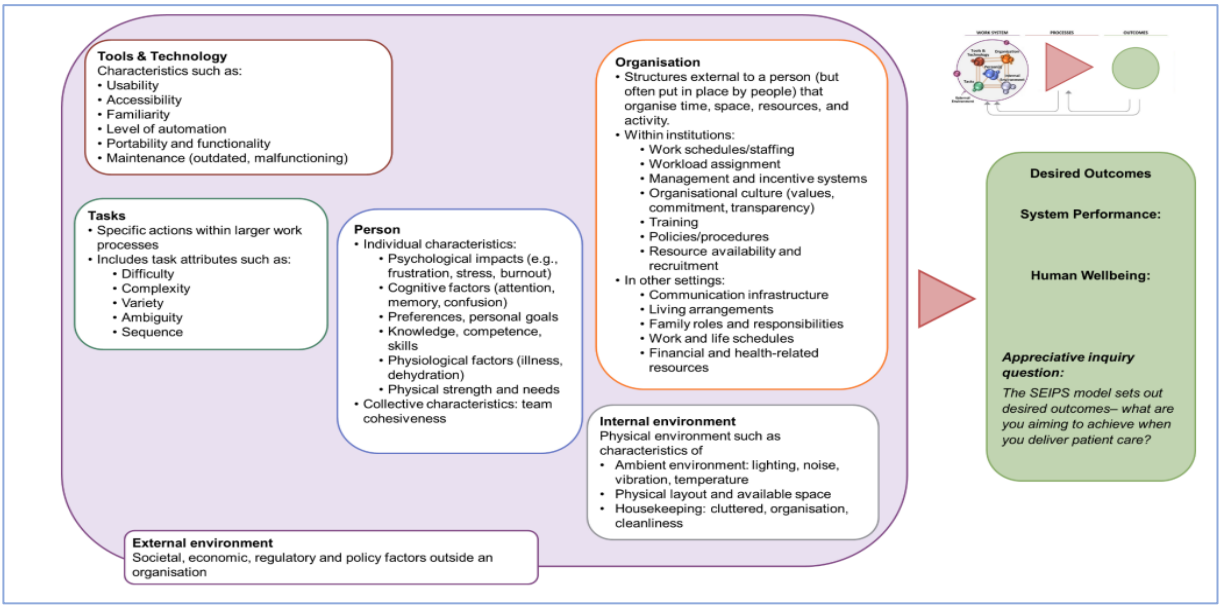
# Appendix 2 - SEIPS

[B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)]

The System Engineering Initiative for Patient Safety (SEIPS) is a framework for understanding outcomes within complex socio-technical systems. The image below describes how a work system (or socio-technical system, left) can influence processes (work done, middle), which in turn shapes outcomes (right).




A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks, and person(s). The image below provides a brief overview of the different elements and potential contributory factors to consider during a learning response. People cannot be separated from the work system; their deliberate placement at the centre emphasises that design should support – not replace or compensate for – people. SEIPS can be used as a general problem-solving tool (e.g., to guide how we learn and improve following a patient safety incident and to inform system design). Patient safety incidents result from multiple interactions between work system factors. SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships. When a learning response thoroughly examines the different work system components and their interactions safety actions can focus on wider system issues, not individuals.



# Appendix 3 – LIFE sessions (Learning and Innovation From Events)

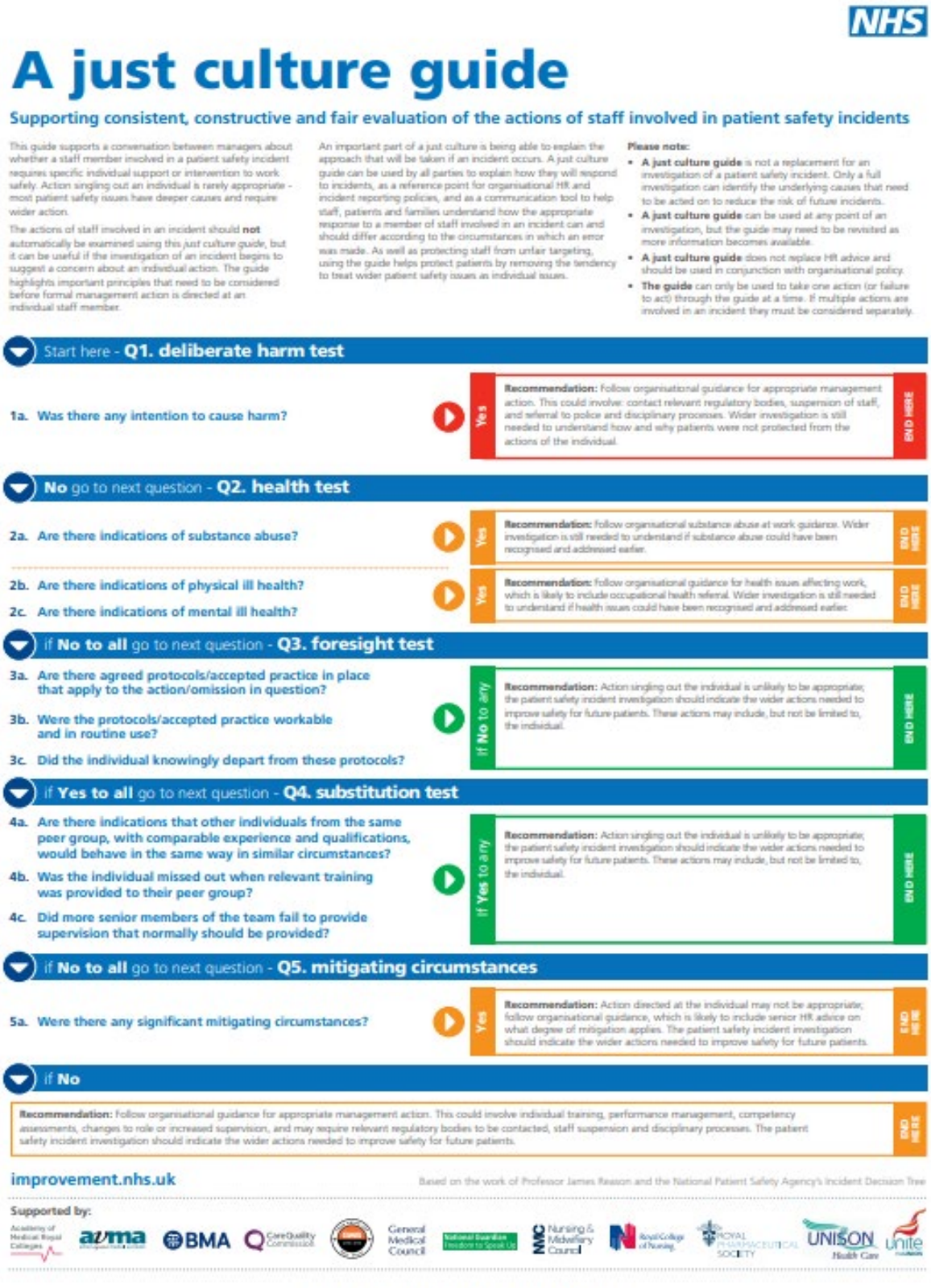
LIFE sessions aim to take stories/accounts from everyday events and incidents, and promote discussions that help people to use these stories/accounts as a prompt to collaboratively talk about what stood out for them, what there is to celebrate, what we are curious about and what are the ideals and practical ideas that can be taken forward to benefit those who live, work in or visit the care setting. LIFE sessions adopt a relational approach to learning and improvement, as they create space for multiple perspectives to be heard. LIFE sessions can be used to discuss stories/accounts from patients, family members or staff.

# Appendix 4 - Training Needs Analysis (TNA)

| Patient Safety Incident Response Framework (PSIRF) Training Needs Analysis | Mode of Delivery | Length of Course | Refresh time (years) | Medical | Medical Director | Associate Medical Directors | Medical Audit/QI/Governance Leads | All Doctors (All Grades) | Corporate | Chair | Non-Exectuvie Directors | Executive Directors | Divisional Directors | Governance/Safety Leads | Patient Safety Specialists | Patient Safety Partners | Associate Directors of Operations | Operational Managers | Quality Improvement team | Chief Pharmacist | Medication Safety Officer | Patient Experience/Complaints/PALS Team | Nursing & Midwifery | Chief Nurse | Associate Chief Nurse | Divisional Chief Nurses/Midwife | Heads of Departments | Senior Matrons | Matrons | Ward Managers | All registered Nurses & Midwives | Nursing Associate Trainees | Healthcare assistants & Support Workers | Nursery Nurses | AHPs & Healthcare Scientists | Team managers | Occupational Therapists | Dieticians | Physiotherapists | Pharmacists | Operation Department Practitioners/Assistant | Pharmacy Technicians | Radiographers & Assistants | Sonographers | Pathology Staff | Support Services | Administrative & Clerical roles | Chaplaincy Team | Bereavement Team | Housekeepers | Hotel Services | Students |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety Syllabus Level 1: Essentials for all staff | E-Learning | 30 Minutes | Once only | | E | E | E | E | | E | E | E | E | E | E | E | E | E | E | E | E | E | | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E | E |
| Patient Safety Syllabus Level 1: Essentials for Boards and Senior Leadership teams | E-Learning | 30 Minutes | Once only | | E | E | E | | | E | E | E | E | E | E | | E | E | E | E | E | | | E | E | E | E | E | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Safety Syllabus level 2: Access to Practice | E-Learning | 1 Hour | Once only | | E | D | D | D | | | | | D | E | E | D | | | E | E | E | E | | | E | D | D | D | D | D | D | D | D | | D | D | D | D | D | D | D | D | D | D | D | | | D | D | | | | D |
| Patient Safety Syllabus level 3 & 4 | Blended | TBC | Once only | | | | | | | | | | | | E | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Safety Incident Response Training: Session 1 & 2 | In Person | 3 Hours x 2 | Once only | | E | E | E | D | | | | D | D | E | E | D | D | D | E | D | E | E | | | E | E | E | E | E | E | E | D | D | | | E | D | D | D | D | D | | | | | | | | | | | D |
| Learning & Innovation from Patient Safety Incidents | In Person | 3 Hours | Once only | | | | E | D | | | | | D | E | E | D | | | E | D | E | D | | | | D | D | D | E | E | E | E | D | D | | | E | D | D | D | D | D | | | | | | | | | | | D |
| Quality Improvement: An introduction | In Person | 1 Hour | Once only | | D | E | E | D | | | | D | D | E | E | E | D | D | E | D | E | D | | | E | E | E | E | E | E | E | E | E | D | D | | E | D | D | D | D | D | D | D | D | D | D | | | | | | D |
| Quality Improvement: Fundamentals | In Person | 1 Day | Once only | | D | E | E | D | | | | | D | E | E | D | D | D | E | D | E | D | | | D | D | D | D | E | E | E | D | D | | | D | | | | | | | | | | | | | | | | | D |
| Quality Improvement: Practitioner | In Person | 4 Days | Once only | | | D | D | | | | | | | D | D | D | | | E | D | D | | | | | D | D | D | E | E | E | | | | | D | | | | | | | | | | | | | | | | | |
| Quality Improvement: Coach/Leaders | In Person | 4 Days | Once only | | | | | | | | | | | D | D | | | | E | D | D | | | | | D | D | D | E | E | D | | | | | D | | | | | | | | | | | | | | | | | |
| MKUH Human Factors Training workshop | In Person | 1 Day | Once only | | D | E | E | D | | D | D | D | E | E | E | E | D | D | D | D | E | E | | D | D | D | D | E | E | E | D | D | D | D | E | D | D | D | D | D | D | D | D | D | | D | D | D | D | D |
| Systems approach to learning from patient safety incidents | Virtual | 2 Days | Once only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient and staff involvement in learning from patient safety incidents | Virtual | 1 Day | Once only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Systems approach to learning from patient safety incidents - *Oversight* | Virtual | 1 Day | Once only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

# Appendix 5 - Just Culture

[NHS England » A just culture guide]



NHS

# A just culture guide

## Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

**Please note:**

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

### Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

### No go to next question - Q2. health test

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

### if No to all go to next question - Q3. foresight test

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

### if Yes to all go to next question - Q4. substitution test

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

### if No to all go to next question - Q5. mitigating circumstances

5a. **Were there any significant mitigating circumstances?**

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

### if No

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

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Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

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# Glossary

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| AAR | After Action Review |
| BLMK ICB | Bedfordshire, Luton and Milton Keynes Integrated Care Board |
| CSU | Clinical Service Unit |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| GIRFT | Getting It Right First Time |
| LfPSE | Learn from Patient Safety Events |
| LIFE | Learning and Innovation from Events |
| MDT | Multidisciplinary Team |
| NICE | National Institute for Health and Care Excellence |
| NRLS | National Reporting & Learning System |
| NSI | Notifiable Safety Incidents |
| PSII | Patient Safety Incident Investigation |
| PSIRF | Patient Safety Incident Response Framework |
| PSIRG | Patient Safety Incident Response Group |
| PSLL | Patient Safety and Learning Leads |
| PSP | Patient Safety Partners |
| PSS | Patient Safety Strategy |
| Safety II | Patient safety initiative that starts by looking at everyday practices and focuses on what's going well in a system or process |
| SEIPS | System Engineering Initiative for Patient Safety |
| SI | Serious Incident |
| SMART | Specific, Measurable, Achievable, Realistic, Time-bound |
| QI | Quality Improvement |
| QIPS | Quality Improvement and Patient Safety |