TheMKWay

NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Patient Safety Incident Response Plan

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1. Introduction

1.1 Purpose

This Patient Safety Incident response plan sets out how Milton Keynes University Hospital NHS Foundation Trust (MKUH) intends to respond to patient safety incidents over a period of 12 to 18 months, thus supporting the introduction of the Patient Safety Incident Response Framework (PSIRF) into the organisation. This plan is not permanent and will continuously be refined to remain flexible and, consider the specific circumstances in which patient safety issues and incidents occur and address needs of those affected.

1.2 Rationale

This plan has been developed based on an understanding that nationally the current NHS Incident Review processes are ineffective, and that learning is limited. We recognise that MKUH is no different and see this as a fantastic opportunity to support a change in culture within the Trust to ensure a 'just culture' is maintained with psychological and physical safety for the patients, families, carers, and staff and, where learning from incidents is prioritised to support organisational development.

1.3 Aims and Objectives

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. Collaborate with relevant parties including patient, families, carers to co-design change ideas and implement these into the Trust. Offer flexible individualised access to support engagement following patient safety incidents.
Application of a range of system-based approaches to learning from patient safety incidents	Provide easy access to training in relevant skills: • Human Factors including introduction to Systems Engineering Initiative for Patient Safety (SEIPS) • In-house PSIRF training • Appreciative enquiry • Quality Improvement Embed the System Engineering Initiative for Patient Safety (SEIPS) model into response methods and templates Encourage the use of system-based thinking and conversations at all levels, e.g., team meetings, care review panels, Patient Safety Board
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. Application of new techniques in response to patient safety incidents to optimise learning and improvement (*Appendix 1*). Prevent repetition of patient safety incident reviews. Resource to be focused where greatest learning and improvement opportunities lie.
Aims	**Objectives**

Supportive oversight focused on strengthening response system functioning and improvement	Recognise emerging themes within safety intelligence and explore these using thematic, regardless of their level of harm. Develop system improvement plans based on triangulated incident response data and the Improve ability to evidence and measure the impact of improvement initiatives. Collaborate with Bedfordshire Luton & Milton Keynes (BLMK) Integrated Care Board to ensure wider sharing of learning between organisations and at regional and national levels.

1.4 Scope

1.4.1. Patient safety incidents are unintended or unexpected events which could have, or did, lead to unwanted outcomes for patients in our care and/or the staff providing such care and any witnesses1. The purpose of any incident response detailed in this plan is not to apportion blame, determine liability or to identify the cause of death.

1.4.2. Other events such as near misses, everyday well managed events or reported excellence can generate learning opportunities. A response to these types of events will be encouraged to both celebrate good practice and to support 'Safety II' principles for learning and improvement within MKUH.

1.4.3. This plan will detail how MKUH will utilise these techniques to ensure incidents responses are appropriate, timely, proportionate and for the sole purpose of system learning and improvement. Novel ways to respond to incidents have been, and are being, developed.

1.4.4. For any incident which requires involvement from complaints, claims, human resources input, professional standards investigations, coroner inquests or criminal investigations there will be an alternative process which is outside the scope of this plan. However, we note that all incidents may require more than one response type and will likely have involvement from the patient safety team to ensure learning is prioritised. Support of those involved in any patient safety incident will remain our upmost priority.

1.4.5. Responses described in this review include:

- Patient Safety Incident Investigation (PSIIs)
- Patient Safety Reviews (PSR) including After Action Reviews (AAR) and, Multidisciplinary Team (MDT) reviews (*Appendices 1 and 2*)

[1] https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

2. Our Services

Milton Keynes University Hospital NHS Foundation Trust is a medium sized teaching hospital providing a broad range of acute hospital services including an Emergency Department, Maternity, Paediatrics and Cancer Services. We also offer an increasing number of specialist services to the growing population of Milton Keynes and the surrounding areas. With around 550 beds and employing more than 4,000 staff, we see and treat appropriately 400,000 patients each year comprising of both outpatient and emergency attendances.

We work closely with some key partners in and around Milton Keynes. These include Central Northwest London (CNWL), Primary Care, Milton Keynes Council, Ambulance Services and BLMK Integrated Care Board. We also have close links with our neighbouring hospitals for tertiary level care.

We work closely with the Thames Valley and East of England Academic Health Science Networks and in 2015, the Trust entered into a partnership with the University of Buckingham to establish the first independent Medical School in the country.

All inpatient services and most outpatient services are provided on the main hospital site. The Trust is organised into four clinical divisions (Medicine, Surgery, Women & Children & Core Clinical services which is supported by a number of corporate directorates. (Table 1)

Table 1

Director of Operations			
Medicine	Surgery	Women & Children's	Core Clinical Services
Acute medicine and Care of the Elderly	Head & neck	Women's health	Diagnostics & screening
Emergency Department	Anaesthetics	Paediatrics	Pharmacy
Internal Medicine	Musculoskeletal		Clinical support services
Speciality Medicine	Theatres and OPD		Hotel services
Cancer services	General surgery		Therapies

3. Defining our patient safety incident profile

3.1 Stakeholder Engagement

To fully appreciate and understand the current safety profile at MKUH, the patient safety leads consulted a wide spectrum of key stakeholders which include patients, families, staff and teams both within and outside of the Trust. The purpose of these consultations was to seek relevant data and gain insight from the key stakeholders as experts of their own experience and field of work.

Our engagement with key stakeholders is as follows:

- Academic Health Science Networks (Thames Valley and East of England)
- Associate Medical Directors for mortality
- Clinical Director of Pharmacy
- Clinical ward staff
- Care Quality Commission (CQC)
- Coroners
- Deputy Director of Human Resources
- Chief Corporate Services Officer
- Director of Patient Care
- Divisional Clinical Governance Leads
- Divisional Triumvirate Leads
- Equality, Diversity, and Inclusion Lead
- Freedom to Speak up Guardian Officer
- Head of Quality Improvement
- Head of Risk and Clinical Governance
- Health Services Safety Investigations Body (HSSIB) and Maternity and Newborn Safety Investigations Special Health Authority (MNSI) (formerly the Health Safety Investigation Branch (HSIB))
- Information Team
- Integrated Care Board Safety Leads (Bedford, Luton & Milton Keynes and Buckinghamshire, Oxfordshire & Berkshire West)
- Learning from Excellence team (GREATix)
- Litigation Officers
- Maternity Voices Partnership (MVP)
- Chief Medical Officer
- NHS Resolution (NHSR)
- Patient Experience Team
- Patient Safety Partners
- Patients and families
- Risk Manager
- Safeguarding team
- Trust Solicitors

3.2 Data Sources

3.2.1. The MKUH patient safety priorities have been identified using analysis and themes from the following data sources (2021-2023) unless otherwise stated:

- Audit
- Avoidable Term Admissions into Neonatal Unit (ATAIN)
- Complaints and PALS (Patient Advice and Liaison Service)
- Conversations with patients, families, carers, and staff
- Datix incident date from 2018-2021
- Freedom to Speak up cases
- Human Resources (Staff retention, suspensions, and sickness/absence)
- Inequalities data
- Learning from Excellence (GREATix) data
- Legal claims
- Local Maternity and Neonatal System (LMNS)
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)
- Mortality reviews and coroner inquests including preventing future death reports
- National Maternity reports, e.g., Ockenden and East Kent
- Nursing metrics - Tendable
- NHS Patient survey
- NHS Staff survey
- Perinatal Mortality Review Tool (PMRT)
- Quality Improvement programmes (current and planned)
- RADAR incident data
- Risk register
- Safeguarding data, including Section 42 cases
- Serious Adverse Blood Reactions and Events (SABRE)
- Serious Hazards of Transfusion (SHOT)
- Serious Incident Review Group learning (Spotlight on Safety)

3.2.2. Details of safety and incident data were explored including type, severity, occurrence, and location. This was used in conjunction with opportunities for safety improvement as well as interventions and improvement initiatives already in place.

3.2.3. An ‘Insights and Systems’ task and finish group was set up by the Trust’s PSIRF Steering Group chaired by the Trust Risk Manager. Membership of the Steering Group included key stakeholders representing the systems and services as described in 3.2.1.

Based on this data, each stakeholder was asked to provide a prioritised list of key themes/concerns for the year ahead.

3.2.4. In addition, the divisional triumvirate leads, and clinical governance leads were asked to suggest their top safety concerns/priorities for their clinical service.

3.2.5. This exploration process has highlighted that, at present, there is no overarching triangulation of safety data and therefore a plan is in place to create a safety dashboard to monitor future safety data and trends.

4. Defining our patient safety improvement profile

The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, organisations must be able to apply knowledge of the science of patient safety and improvement to identify:

- where improvements are needed
- what changes need to be made
- how changes will be implemented
- how to determine if those changes have the desired impact (and if they do not, how they could be adapted)

4.1. Our Quality improvement programme currently comprises of a combination of:

- Trust-wide harms reduction priorities (falls, medication errors, maternity/neonates, and hand hygiene)
- Other key improvement priorities arising from national reports/audit, incidents, and complaints e.g., Learning disabilities, Pressure Damage
- Directorate and Divisional quality improvement projects
- Quality improvement (QI) projects for clinicians in training

4.2. We have an active Improvement register with over 200 Improvement projects using various QI methods which are at different stages and priority levels.

4.3. Our improvement priorities are supported by QI coaches who work in our Improvement Hub. The team provide support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels.

4.4. Our approach to supporting improvement is tailored to support the needs of each priority, for example facilitation of large-scale improvement events, patient safety collaboratives, providing coaching and support for small scale projects.

4.5. We are building capacity and capability of staff participating in improvement training, ranging from a QI introduction QI Practitioner and QI Coach training (4 days).

4.6. Our patient safety improvement plans are underway and incorporate both national requirements as well as locally designed plans and supporting resources. Our local improvement plans are comprehensive and designed to address previous patient safety actions, reviews, audit and risk assessment findings as highlighted in Table 2.

4.7. Our future improvement priorities will be directly informed by the implementation of the PSIRF, providing us with an opportunity to streamline and prioritise future improvement activity.

Table 2

Topic	Area	Triggers	Monitored by
Discharge summary quality of information	Medicine Acute	Coroner Inquest	Acute Medicine CIG
Sentinel Stroke	Medicine Acute	National Audit	Acute Medicine / therapies
Infection prevention and control in ED	Medicine Emergency Department (ED)	National Royal College of Emergency Medicine (RCEM) Audit	Emergency Department CIG
Mental Health Self Harm	Medicine ED	National RCEM audit	Emergency Department CIG
Pain in Children	Medicine ED	National RCEM Audit	Emergency Department CIG
Identification and response to frailty in Emergency Departments	Medicine ED	CQUIN 05	Transformation Board
Inpatient Falls	Trust wide Corporate Nursing	National Inpatient Audit of Falls	Harm Prevention Group
Dementia Care	Trust wide Corporate Nursing	National Dementia Audit	Patient Experience Board
Hospital Acquired Pressure Ulcers	Trust wide Corporate Nursing	Incidents	Harm Prevention Group NB CQUIN 12 Assessment and documentation of pressure ulcer risk
Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Surgery – all	CQUIN 02	Transformation Board
Fracture Liaison Service	Surgery Trauma & Orthopaedics	National Clinical Audit	Trauma & Orthopaedics CIG
Flu vaccinations	Trust wide	CQUIN 01	Transformation Board
Recording of and response to NEWS2 score for unplanned critical care admissions	Trust wide	CQUIN 7	Transformation Board Care of the Critically ill Patient Group
Medication reconciliation, pharmacy intervention and medicines at discharge	Trust wide	Incidents Coroner Inquest	Pharmacy CIG

Topic	Area	Triggers	Monitored by
Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	Trust wide	CQUIN 04	Transformation Board Antimicrobial Stewardship Group
Reviewing all perinatal mortality	Maternity and Neonatal	Perinatal Mortality Review Tool (PMRT)	MBRRACE ATAIN Working Group Maternity CSU Maternity Assurance Group Local Maternity Neonatal System NHS Resolutions (Maternity Incentive Scheme)
Reviewing all term babies that are admitted to the Neonatal Unit	Maternity and Neonatal	Avoidable Term Admissions into Neonatal Unity (ATAIN)	ATAIN Working Group Maternity CSU Maternity Assurance Group Local Maternity Neonatal System NHS Resolutions (Maternity Incentive Scheme)

5. Defining our patient safety incident response plan

5.1 National Requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018)[2] and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

As MKUH does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types. Table 3 sets out the national mandated responses:

Table 3

Event	Response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII NHS England » National Guidance on Learning from Deaths)	Locally led PSII by MKUH
Incidents meeting the Never Events criteria 2018 NHS England » Never events, or its replacement.	Locally led PSII by MKUH
Maternity and neonatal incidents meeting Health Services Safety Investigations Body (HSSIB) and Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria	Refer to HSSIB or MNSI
Child deaths	Refer for Child Death Overview Panel Review. Locally led PSII by MKUH (or other response) may be required alongside the panel review.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII by MKUH (or other response) may be required alongside the LeDeR.
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence Adults (over 18 years old) are in receipt of care and support needs from their local authority The incident relates to FGM, prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. MKUH will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.
Event	**Response**

[2] https://www.england.nhs.uk/wp-content/uploads/2020/11/Revised-Never-Events-policy-and-framework-FINAL.pdf

Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
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)	Locally led PSII by the care provider in which the event occurred with MKUH participation if required.
Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. MKUH will fully support these investigations where required to do so.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII by the care provider in which the event occurred with MKUH participation if required.
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and integrated care boards of health services in relation to DHRs.

5.2 Local Focus

The local patient safety priorities for MKUH have been identified through the analysis of local data and intelligence from the last two years (2021-2023) and developed in conjunction with the BLMK ICB Quality & Safety Lead.

Table 4 shows the locally predefined patient safety incidents requiring a Level 1 investigation (PSII) as described in *Appendices 1 and 2*. For each of the areas of focus listed below there will be up to 5 PSIIs carried out per 12-month period.

Please note, despite being some of the Trust's most frequently occurring incidents, inpatient falls, development/deterioration of pressure damage and general medication-related incidents have been excluded from the local priorities listed in Table 4 as they already have active local and national improvement projects/programmes in place as detailed in Section 4 of this document. These improvement initiatives are based on learning identified from previous patient safety incident investigations. Delivery of these improvement plans will be monitored by an appropriate specialist sub-group and oversight assured by the relevant trust board which include the Patient Safety Board, the Quality, Learning and Improvement Board and the Transformation Board.

Table 4

Area of focus	Description	Rationale	Planned Response	Improvement Route & Oversight
Sepsis in the Emergency Department	Delay, or failure, to recognise and manage any adult patient presenting to the Emergency Department with signs of sepsis.	Increase in number of sepsis related incidents. Recommendations from coronial processes. Failure to recognise sepsis features in the top 3 claims. Sepsis features commonly and increasingly in the thematic learning from the serious incident review group (SIRG). ED triage and streaming feature high on the risk register for medicine.	PSII (+/- other local response methods)	Monitored through the Sepsis Quality Improvement Group and Care of the Critically Ill Patient Group. Upward reporting to the Patient Safety Board and the Quality, Learning and Improvement Board.
Surgical Inpatients	Delay, or failure, to recognise the deteriorating surgical patient resulting in: • Change of lead speciality team • Unexpected further surgery • Unplanned admission to ICU • Death Adult patients under surgical specialities or inpatients on wards 20, 21, 23 or 24.	Patient reported not being heard when sharing concerns. Increase in incidents relating to deteriorating clinical condition for surgical patients. In the last 2 years, sub optimal care for deteriorating patients has featured highly in the most commonly occurring serious incidents. Conversations with staff and patients have highlighted care concerns for those residing on surgical wards. Feedback from coronial processes have highlighted the need to review escalation processes, and support of junior colleagues when caring for deteriorating patients in surgical areas. Recognising, and escalation of, deteriorating patients and the contributing human factors feature commonly in the thematic learning from the serious incident review group (SIRG). Common issues from claims include 'care below standards', 'inadequate assessments' and 'supervision of colleagues' which all contribute to our ability to recognise and care for deteriorating patients.	PSII (+/- other local response methods)	Monitored through the Care of the critically Ill Patient group NB: CQUIN 07 relates to 'recording of and response to NEWS-2 score for unplanned critical care admissions'. Upward reporting to the Patient Safety Board and the Quality, Learning and Improvement Board.

Area of focus	Description	Rationale	Planned Response	Improvement Route & Oversight
Diagnostic Delays	Incidents relating to diagnosis, specifically delay or failure to follow up on abnormal scan/test results resulting in: • Unexpected progression or worsening of disease • Delay in surgical intervention • Need for additional tests or procedures.	Delays in imaging reporting for patients with cancer features highly on the risk register for the core clinical division. The core clinical risk register features 'Demand and access to MRI/CT scans' as a high-risk area. A top theme from patient complaints includes 'fast access to scans' and 'delayed treatment in surgery'. Delayed diagnostics and screening incidents feature in the top 10 of serious incidents in the last 2 years. Across all incidents delayed appointments and follow ups with results features in the top 10. Common thematic learning from the serious incident review group includes timely review of test results. The number one reason for a claim against MKUH is delay in diagnosis. Treatment delay is a common issue across all claims against MKUH.	PSII (+/- other local response methods)	To be monitored by the Diagnostic Delays Quality Improvement Group and relevant local CIGs. Upward reporting to the Patient Safety Board and the Quality, Learning and Improvement Board.
Inpatient Diabetes	Incidents relating to the prescribing and administration of insulin resulting in a patient's blood glucose of >20 mmol/l (on two consecutive readings) or < 4 mmol/l. Adult patient under acute medical care (ED, Ward 1 and ward 2)	Drug incidents relating to insulin feature in the top 10 serious incidents. Increase number of insulin related incidents, Diabetic Ketoacidosis (DKA) and the management of hypoglycaemia reviewed at the serious incident review group. Thematic learning from the serious incident review group has frequently featured checking and administration of high-risk medications. The surgical risk register features the need for more support with diabetes care during pre-assessment.	PSII (+/- other local response methods)	To be monitored by the Insulin Quality Improvement Group and the Internal Medicine CIG. Upward reporting to the Patient Safety Board and the Quality, Learning and Improvement Board.

5.2.1. We appreciate that despite the best planning and proactive approach, the trust needs to be reactive to unexpected patient safety incidents. For any incident which does not feature on the above local priority list but has been identified as one where significant learning could be generated or where there is a high-risk to patients, families, staff or the trust, a PSII will be completed.

5.2.2. The criteria for selection of incidents for a level 1 (PSII) or level 2 (PSR) response include the following:

i. potential for learning in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness (control potential)
   - opportunity for influence on wider systems improvement

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

iii. likelihood of recurrence (including scale, scope and spread)

Further details are included in *Appendix 3*

5.2.3. For those incidents that require a level 2 response a number of national and local response methods are available to optimise learning and improvement (*Appendices 1 and 2*).

5.2.4. All incidents will be reported via RADAR in line with existing patient safety incident reporting guidance and principles described in the Trust PSIRF policy.

5.2.5. In some cases, incidents may need to be reported to national agencies, or tertiary/other providers (Table 3).

5.2.6. All incidents will continue to be managed in accordance with Care Quality Commission regulation 20: Duty of Candour and Being Open principles where needed[3].

5.2.7. Any request for information about a patient safety incident – by the patient, families and/or staff – will be responded to openly and as much information as possible will be provided regardless of severity of outcome or the type of response required under this plan.

5.2.8. This plan, and the adjoining policy, will be reviewed regularly and amended based on the success of any improvement work and local safety intelligence.

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

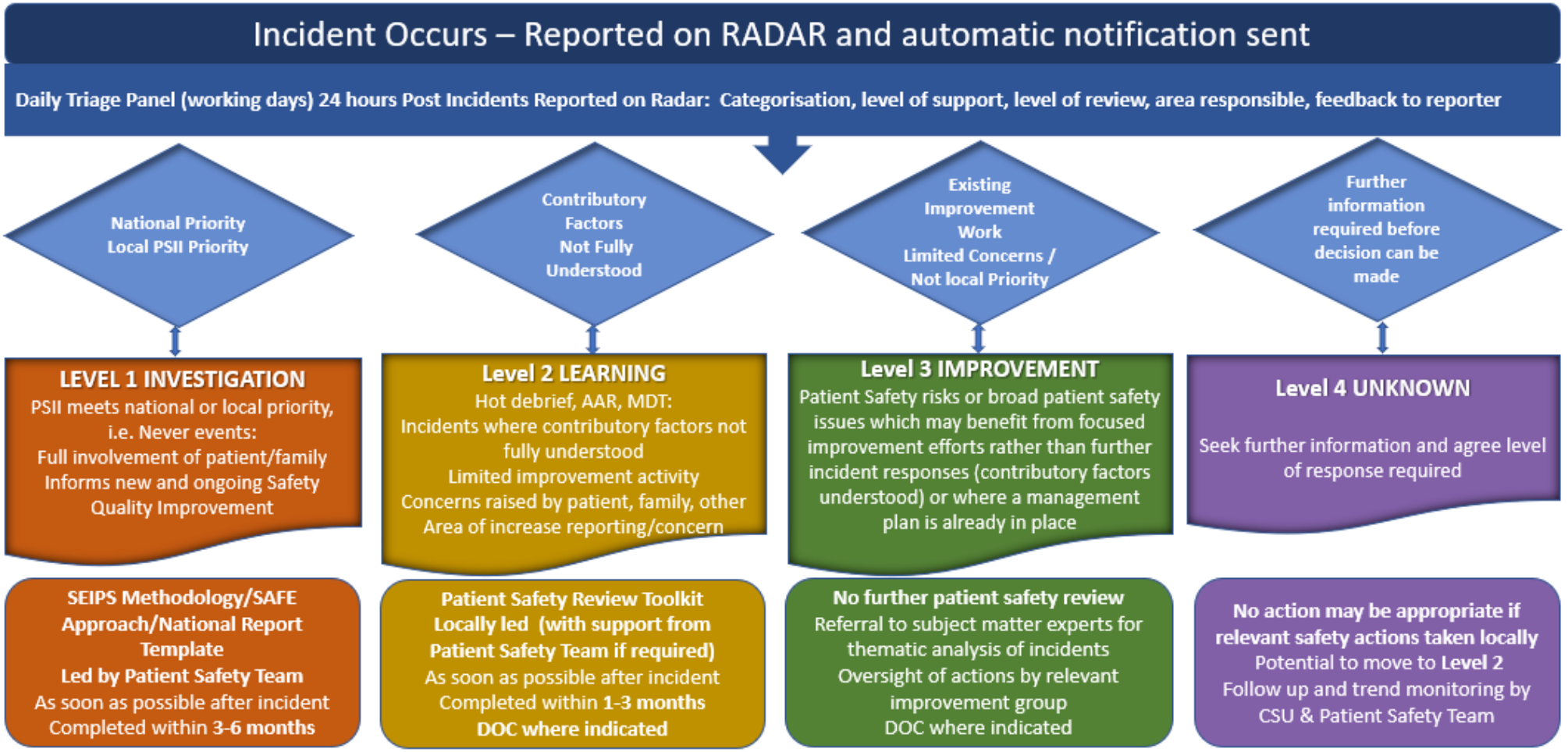
Appendix 1- National Learning Response Methods

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. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?
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 - Locally Agreed Learning Responses and Support 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.
Hot debrief	These are designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff come together to explore 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. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?
Clinical Reflective Debrief	An opportunity to talk through the clinical scenario with peers enabling an informal discussion about what went well and what could have been done differently. This provides a chance for staff to reflect on the events, be curious about colleagues' ideas and practices, draw on previous clinical experience and consider the impact for future care. These sessions are not compulsory and although there is no obligation to formally record discussion, the group are encouraged to share any significant learning (both excellence and challenges) with the patient safety team for wider sharing.
Psychological Debrief	Debrief sessions led by a trained team to reflect on the emotional impact of a particular event within their work. Detailed clinical discussion is avoided with the focus on an opportunity to share feelings. The purpose is not to problem solve or apportion blame. Recommended time frame is 7-10 days following the event.
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 3 - PSIRF Incident Response Levels



Glossary

AAR	After Action Review
AI	Appreciative Inquiry
ATAIN	Avoidable Term Admissions into Neonatal Unit
BLMK	Bedfordshire, Luton & Milton Keynes
CIG	Clinical Improvement Group
CNWL	Central Northwest London
CQUIN	Commissioning for Quality and Innovation
CSP	Community Safety Partnership
CT	Computerised Tomography
DHR	Domestic Homicide Review
DKA	Diabetic Ketoacidosis
ED	Emergency Department
FGM	Female Genital Mutilation
HSIB	Health Safety Investigation Branch
HSSIB	Health Service Safety Investigations Body
ICB	Integrated Care Board
IOPC	Independent Office for Police Conduct
LeDeR	Learning Disability Mortality Review
LMNS	Local Maternity and Neonatal System
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MDT	Multidisciplinary Team
MKUH	Milton Keynes University Hospital
MNSI	Maternity and Newborn Safety Investigations Special Health Authority
MRI	Magnetic Resonance Imaging
MVP	Maternity Voices Partnership
NHS	National Health Service
NHSR	NHS Resolution
OPD	Outpatient Department
PALS	Patient Advice Liaison Service
PMRT	Perinatal Mortality Review Tool
PPO	Prison and Probation Ombudsman
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSR	Patient Safety Response
QI	Quality Improvement
RCEM	Royal College of Emergency Medicine
RIIT	Regional Independent Investigation Team
SEIPS	System Engineering Initiative for Patient Safety