Patient safety incident response plan 2020/21

Template

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| NHS providers should follow this template when developing their local patient safety incident response plan. |

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# 1. Purpose, scope, aims and objectives

## 1.1 Purpose

1.1.1 This patient safety incident response plan (PSIRP) sets out how **[NHS TRUST]** will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

1.1.2 This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

1. refocusing PSII towards a systems approach[[1]](#footnote-1) and the rigorous identification of interconnected causal factors and systems issues
2. focusing on addressing these causal factors and the use of improvement science[[2]](#footnote-2) to prevent or continuously and measurably reduce repeat patient safety risks and incidents
3. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders’ (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
4. demonstrating the added value from the above approach.

1.2 Scope

1.2.1 A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.2.3 We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation’s local commissioner(s).

1.2.4 The aim of this approach is to continually improve. As such this document will be reviewed annually to start with.

1.3 Strategic aims

1.3.1 Improve the safety of the care we provide to our patients, and improve our patients’, their families’ and carers’ experience of it.

1.3.2 Further develop systems of care to continually improve their quality and efficiency.

1.3.3 Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

1.3.4 Improve the use of valuable healthcare resources.

1.3.5 Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

1.4 Strategic objectives

1.4.1 Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

1.4.2 Develop a climate that supports a just culture[[3]](#footnote-3) and an effective learning response to patient safety incidents.

1.4.3 Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

1.4.4 Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

* make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
* engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
* develop and implement improvements more effectively
* explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

# 2. Situational analysis – national

2.1.1 Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

2.1.2 When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

2.1.3 Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or ‘trigger list’. When this approach was developed it was not clear that:

a. Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident.[[4]](#footnote-4) As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to ‘organisational learning’.[[5]](#footnote-5)

b. There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.20

2.1.4 An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[[6]](#footnote-6),[[7]](#footnote-7),[[8]](#footnote-8),[[9]](#footnote-9),[[10]](#footnote-10)

2.1.5 In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (eg professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

2.1.6 Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (eg the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

2.1.7 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (eg mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future PSIIs

b. conducting PSIIs purely from a patient safety perspective

c. reducing the number of PSIIs into the same type of incident

d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

2.1.8 This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or

b. the subject of current improvement work that can be shown to result in progress or

c. listed for PSII work to be scheduled in the future.

2.1.9 In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

2.1.10 As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

1. professional conduct/competence – referred to human resource teams
2. establishing liability/avoidability – referred to claims or legal teams
3. cause of death – referred to the coroner’s office
4. criminal – referred to the police.

# 3. Situational analysis – local

3.1 Results of a review of activity and resources

3.1.1 Patient safety incident investigation (PSII) activity: Jan 2017 to Dec 2019:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2017** | **2018** | **2019** | **Ave** |
| Never Events |  |  |  |  |
| Serious Incident investigations (ie StEIS reportable and including IMRs submitted to DHR,SCR etc) |  |  |  |  |
| ‘Coroner-initiated’ patient safety investigations |  |  |  |  |
| ‘Coroner-requested’ signed statements following patient safety incidents |  |  |  |  |
| Patient/Family/Carer complaint-initiated patient safety investigations |  |  |  |  |
| Other PSIIs (currently classed as ward, department or directorate-level root cause analyses) |  |  |  |  |
|  |  |  | **TOTAL** |  |
| Incidents investigated locally but including/requiring a **funded independent specialist** on the investigation team |  |  |  |  |
| Independent PSIIs **sourced and funded** directly by the local provider |  |  |  |  |
|  |  |  | **TOTAL** |  |
| Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/PHE, etc) for independent PSII |  |  |  |  |
| Independent PSIIs **commissioned** nationally or regionally on behalf of the local provider |  |  |  |  |
|  |  |  | **TOTAL** |  |

3.1.2 Estimate of current Serious Incident (SI) resources: 2019 (a snapshot, baseline measure):

| **For SI investigations** | **Frequency** | **Grade(s)** | **Hours/year** | **~£/year** |
| --- | --- | --- | --- | --- |
| Patient safety team hours dedicated to SI-level PSIIs |  |  |  |  |
| Risk management team hours dedicated to SI-level PSIIs |  |  |  |  |
| Complaints team resources dedicated to SI-level PSIIs |  |  |  |  |
| Patient Advice and Liaison Service (PALS) team resources dedicated to SI-level PSIIs |  |  |  |  |
| Duty of Candour/’being open’ resource (if not included above) dedicated to SI-level PSIIs |  |  |  |  |
| SI-related PSII panels |  |  |  |  |
| SI-level PSII leads |  |  |  |  |
| SI-related PSII team members/assistants |  |  |  |  |
| SI-related PSII subject matter experts |  |  |  |  |
| Staff involvement in SI-level PSIIs |  |  |  |  |
| Resources offering support of staff involved in SIs and throughout any subsequent SI-level investigation |  |  |  |  |
| Resources offering SI-level PSII investigator support throughout an investigation |  |  |  |  |
| SI-related PSII reviewers |  |  |  |  |
| Board/executive team sign-off of SI-level investigations  |  |  |  |  |
| Solution/improvement identification, design and development costs (action planning) – resulting from SI-level investigations (if not included above) |  |  |  |  |
| Solution/improvement implementation costs – resulting from SI-related investigations |  |  |  |  |
| Solution/improvement monitoring/review – resulting from SI-level investigations (if not included above) |  |  |  |  |
| Staff RCA/PSII training time (SI level) |  |  |  |  |
| PSII trainer time/training fees (for SI-level courses) |  |  |  |  |

3.1.3 Estimate of current non-SI resources: 2019 (a snapshot as a baseline measure):

| **For non-SI investigations** | **Frequency** | **Grade(s)** | **Hours/year** | **~£/year** |
| --- | --- | --- | --- | --- |
| Patient safety team hours dedicated to ward/department-level non SI-related PSIIs |  |  |  |  |
| Risk management team hours dedicated to non-SI PSIIs |  |  |  |  |
| Complaints team resources dedicated to non-SI PSIIs |  |  |  |  |
| PALS team resources dedicated to non-SI PSIIs |  |  |  |  |
| Duty of Candour/’being open’ resource (if not included above) dedicated to non-SI PSIIs |  |  |  |  |
| Non SI-level PSII panels |  |  |  |  |
| Non SI-level PSII leads |  |  |  |  |
| Non SI-level PSII team members/ assistants |  |  |  |  |
| Non SI-level PSII subject matter experts |  |  |  |  |
| Staff involvement in non-SI PSIIs |  |  |  |  |
| Resources that support staff involved in non-SI level incidents and throughout any subsequent investigation |  |  |  |  |
| Resources that support non-SI PSII investigator throughout an investigation |  |  |  |  |
| Non-SI PSII reviewers |  |  |  |  |
| Board/executive team sign-off of non-SI investigations  |  |  |  |  |
| Solution/improvement identification, design and development costs (action planning) – resulting from non-SI investigations (if not included above) |  |  |  |  |
| Solution/improvement implementation costs – resulting from non-SI investigations |  |  |  |  |
| Solution/improvement monitoring/review – resulting from non-SI investigations (if not included above) |  |  |  |  |
| Staff training time for non-SI PSIIs |  |  |  |  |
| Non SI-level PSII trainer time/training fees  |  |  |  |  |

3.2.1 The patient safety incident risks for this organisation have been profiled using organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, PSIIs, mortality reviews, case note reviews, staff survey results, claims, staff suspensions, risk assessments, etc. Resources mined for this data include:

1. staff survey explorer tool results:
	* <https://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/>
2. organisation patient safety reports:
	* <https://report.nrls.nhs.uk/ExplorerTool/Report/Default>

* + <https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/>

3.3 Conclusions from review of the local patient safety incident profile

3.3.1 The current top10 local priorities/risk register for PSII are:

|  | **Incident type**  | **Specialty** |
| --- | --- | --- |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |
| 10 |  |  |

3.4 Gap analysis

3.4.1 Refer to the [national PSII standards](https://improvement.nhs.uk/resources/patient-safety-investigation/) to identify gaps in dedicated PSII personnel, seniority, PSII skills, etc to enable delivery of the potential PSII programme; that is:

a. National priorities:

* Never Events
* ‘Learning from Deaths’-related incidents (identified via structured judgement review to be more likely than not due to problems in care)
* unexpected incidentswhich signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.

b. Local priorities identified in 3.3.1 above.

c. Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

3.5 Strategic plan

* + 1. Using the following steps, develop a strategic plan to address the above findings:

a. Plan consultation work with commissioners and other stakeholders, including patient and staff groups, to review and develop a prioritisation plan for local PSIIs.

b. Develop a prioritised register of patient safety incident types by identifying and ranking them according to the risk they present locally (severity, likelihood, concern, cost etc) and the opportunity they present for new knowledge and improvement. Use the register as an active document.

c. Acknowledge that, wherever available, PSII findings and analysis from more than one similar incident provides an opportunity to identify common causal factors by cross-referencing and corroborating them. Robust thematic analysis can be achieved by selecting a few very recent and typically similar incidents and investigating each one individually with skill and detail to determine the causal factors that effective improvements can be designed to address. PSII of recent rather than historical incidents allows information gathering and analysis of the system as it currently is.

d. From the gap analysis, identify how many good quality PSII can be conducted each year.

e. Agree the number of PSIIs to be conducted for each very similar, prioritised incident-type, ahead of thematic analysis (three to six is suggested).

f. Divide the number of good quality PSIIs currently able to be conducted per year – (in (d) above), by the number of PSIIs to be conducted for each very similar, prioritised incident- type selected (in (e) above).

g. Subtract the anticipated number of ‘national priority’ PSIIs, to identify the number of incident types from the top priorities register that can be addressed during the period of the plan.

g. Declare the register of incident types to be investigated over the period of the plan, ensuring each type has a narrowly defined focus.

h. Declare the number of each of these incident types and the total number of PSIIs planned for the period of the plan.

i. Agree a means of selecting each of the top-ranking incidents (eg the first five or every 10th incident) to ensure the following criteria are met:

* conduct five exemplar PSIIs for each incident type agreed in the plan
* select very similar incident types to make up each set of five patient safety incidents for PSII
* select a range of severity levels for each set of five incidents.
	+ 1. Agree interventions for incidents that fall outside the PSII plan but require action or new insight, eg:
* incident report or timelines (for Duty of Candour disclosure)
* structured judgement review (to identify whether they are issues of concern)
* after-action review (for rapid local team review)
* audit (to measure/monitor compliance against policy/guidance)
* HR investigations (for concerns about individual competency/ performance)
* legal investigations (for concerns surrounding liability, avoidability, etc).
	+ 1. Document the data review process and rationale for prioritisation of local PSIIs.
		2. Complete the PSIRP document together with stakeholders and agree it with them.
		3. Publish a summary PSIRP on the organisation’s website.
		4. Plan activity for the immediate future based on the above plan.
		5. Develop and implement plans to:
* address any shortfall identified in capacity and capability
* meet requirements of the PSIRF and PSII standards
* maintain capacity and capability to sustain the meeting of these requirements.

3.5.2 For each comprehensive PSII:

1. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8 and has received a minimum of two days’ training.
2. Refer to training and the [national PSII standards](https://improvement.nhs.uk/resources/patient-safety-investigation/) and conduct PSIIs as per the plan and in line with national good practice for PSII.
3. Use the national standard template to report the findings of the PSIIs.
4. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).
	* 1. For each group of PSIIs dedicated to a similar/narrow focus incident type:
5. Design strong/effective improvements to sustainably address common interconnected causal factors.
6. Develop an action plan for implementation of the planned improvements.
7. Monitor implementation of the improvements.
8. Monitor effectiveness of the improvements over time.
	* 1. Monitor the quality of PSII findings and progress against this PSIRP:

a. Are the actions likely to achieve improvement?

b. Is there evidence of improvement?

# 4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1 PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.1.2 There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

4.1.3 There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

4.2 Selection of patient safety incidents for PSII

4.2.1 In view of the above, the selection of incidents for PSII is based on the:

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

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

c. potential for new learning in terms of:

* enhanced knowledge and understanding of the underlying factors
* improved efficiency and effectiveness (control potential)
* opportunity to influence wider system improvement.

4.3 Timescales for patient safety PSII

4.3.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

4.3.2 PSIIs should ordinarily be completed within one to three months of their start date.

4.3.3 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

4.3.4 No local PSII should take longer than six months. A balance must 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.)

4.4 Nationally-defined priorities to be referred for PSII or review by another team

4.4.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are:

* 1. **maternity and neonatal incidents:**
* incidents which meet the ‘Each Baby Counts’ and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (<https://www.hsib.org.uk/maternity/>)
* all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution’s [Early Notification Scheme](https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/)
* all perinatal and maternal deaths must be referred to [MBRRACE](https://www.npeu.ox.ac.uk/mbrrace-uk/faqs)
1. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)
2. **child deaths** ([*Child death review statutory and operational guidance*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf)):
* incidents must be referred to child death panels for investigation
1. **deaths of persons with learning disabilities:**
* incidents must be reported and reviewed in line with the [Learning Disabilities Mortality Review (LeDeR) programme](http://www.bristol.ac.uk/sps/leder/notify-a-death/)

g. **safeguarding incidents:**

* incidents must be reported to the local organisation’s named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation
1. [**incidents in screening programmes**](http://www.screening.nhs.uk/incidents)**:**
* incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE’s regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

h. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

* incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally-defined incidents requiring local PSII

4.5.1 Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

* 1. **incidents that meet the criteria set in the** [Never Events list 2018](https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018)
	2. **incidents that meet** [**the** ‘Learning from Deaths’ criteria](https://improvement.nhs.uk/resources/learning-deaths-nhs/); that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient’s care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:
		1. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist’s** [mortality review tool](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/care-review-tool-for-mental-health-trusts) and which have been determined by case record review to be more likely than not due to problems in care
		2. **deaths of persons with learning disabilities** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
		3. **deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS
	3. **suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.**

4.6 Locally-defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation for the period **[…..]**.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. **Locally-predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

* **Criteria for selection of incidents for PSII:**
1. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
2. likelihood of recurrence (including scale, scope and spread)
3. potential for learning in terms of:
	* enhanced knowledge and understanding
	* improved efficiency and effectiveness (control potential)
	* opportunity for influence on wider systems improvement.

For the period **[…..]** local priorities for PSII have been agreed as follows:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Incident type and specific description** | **Specialty** | **Quantity** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

4.7 Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents

* + 1. A valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.
		2. The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.
		3. Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

4.8 Patient safety improvement plans underway

* + 1. National, or locally designed patient safety improvement plans underway. This relates to full plans, rather than individual actions, designed and prescribed to address previous PSII, review, audit or risk assessment findings (eg national suicide prevention plan).

|  |  |  |  |
| --- | --- | --- | --- |
|  | ***National* patient safety incident improvement plan/scheme title** | **Specialty** | **Improvement plan review date** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | ***Local* patient safety incident** **improvement plan/scheme title** | **Specialty** | **Improvement plan review date** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

# 5. Selection of incidents for review

5.1 Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

5.2 A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

5.3 Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

| **Technique** | **Method** | **Objective** |
| --- | --- | --- |
| **Immediate safety actions** | Incident recovery | To take urgent measures to address serious and imminent:1. discomfort, injury, or threat to life
2. damage to equipment or the environment.
 |
| **‘**[**Being open’**](https://webarchive.nationalarchives.gov.uk/20171030124348/http%3A/www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) **conversations** | Open disclosure  | To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.  |
| [**Case record/note review**](https://improvementacademy.org/documents/Projects/avoidable_mortality/Case%20Note%20Review%20Guide%20FULL.pdf)  | Clinical documentation review  | To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.) |
| **Hot debrief** | Debriefing | To conduct a post-incident review as a team by discussing and answering a series of questions. |
| [**Safety huddle**](https://www.england.nhs.uk/atlas_case_study/improving-patient-safety-by-introducing-a-daily-emergency-call-safety-huddle/) | Briefing | A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to:* improve situational awareness of safety concerns
* focus on the patients most at risk
* share understanding of the day’s focus and priorities
* agree actions
* enhance teamwork through communication and collaborative problem-solving
* celebrate success in reducing harm.
 |
| **Incident timeline** | Incident review  | To provide a detailed documentary account of an incident (what happened) in the style of a ‘[chronology’](https://study.com/academy/lesson/what-is-chronological-order-definition-example.html). |
| [**After-action review**](https://improvement.nhs.uk/documents/2087/after-action-review.pdf) | Team review | A structured, facilitated discussion on an incident or event to identify a group’s strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. |
| **LeDeR (Learning Disabilities Mortality Review)** | Specialist Review | [To review the care of a person with a learning disability](http://www.bristol.ac.uk/sps/leder/) (recommended alongside a case note review). |
| [**Perinatal mortality review tool**](https://www.npeu.ox.ac.uk/mbrrace-uk/pmrt)  | Specialist review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Mortality review** | Specialist Review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Transaction audit** | Audit | To check a trail of activity through a department, etc, from input to output. |
| **Process audit** | Audit  | To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended |
| **Outcome audit** | Audit | To systematically determine the outcome of an intervention and whether this was as expected/intended |
| [**Clinical audit**](https://www.hqip.org.uk/wp-content/uploads/2018/02/developing-clinical-audit-patient-panels.pdf) | Outcome audit | A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes. |
| **[Risk assessment](http://www.mtpinnacle.com/pdfs/Healthcare_Risk_Assess.pdf)** | Proactive hazard identification and risk analysis | To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business). |

5.4 Priorities for ‘being open’ conversations and Duty of Candour include:

* all patient safety incidents leading to moderate harm or above
* all incidents for which an investigation is undertaken.

5.5 Key subject suggestions for patient safety reviews:

|  | **Incident type**  | **Specialty** | **Year** |
| --- | --- | --- | --- |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

5.6 Key subject suggestions for patient safety audits:

|  | **Incident type**  | **Specialty** | **Audit type** | **Year** |
| --- | --- | --- | --- | --- |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

5.7 Key subject suggestions for patient safety risk assessments:

|  | **Incident type**  | **Specialty** | **Review type** | **Year** |
| --- | --- | --- | --- | --- |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

# 6. Roles and responsibilities

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents. **[More generic examples are given in Appendix 2 of the PSIRF.]**

# 7. Patient Safety Incident reporting arrangements

This section will include internal and external notification requirements for the reporting of patient safety-related incidents. **[Generic guidance on national reporting requirements is given in Part B, step 2 and Appendix 6 of the PSIRF.]**

# 8. Procedures to support patients, families and carers affected by PSIs

The national and local arrangements for supporting patients, families and carers following Patient Safety Incidents are: **[National sources of support are given in Appendix 1 of the PSIRF].**

# 9. Procedures to support staff affected by PSIs

The national and local arrangements for supporting staff following Patient Safety Incidents are: **[National sources of support are given in Appendix 3 of the PSIRF]**.

# 10. Mechanisms to develop and support improvements following PSIIs

The national and local mechanisms to develop and support improvements are: **[Generic guidance is given in Part B, step 4 of the PSIRF and generic programmes are signposted in Part A: Continuous improvement]**.

# 11. Evaluating and monitoring outcomes of PSIIs, Reviews etc

11.1 Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

11.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

11.3 Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

11.4 Reports to the board will be monthly and will include aggregated data on:

* patient safety incident reporting
* audit and review findings
* findings from PSIIs
* progress against the PSIRP
* results from monitoring of improvement plans from an implementation and an efficacy point of view
* results of surveys and/or feedback from patients/families/carers on their experiences of the organisation’s response to patient safety incidents
* results of surveys and/or feedback from staff on their experiences of the organisation’s response to patient safety incidents.

# 12. Complaints and appeals

12.1 Local and national arrangements for complaints and appeals relating to the organisation’s response to patient safety incidents are: **[insert details and/or link(s)]**.

**Contact us:**

|  |  |
| --- | --- |
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This publication can be made available in a number of other formats on request.

**Publication approval reference: 000682**

1. The approach is broken down into units to make it easier to understand the complexity, [interactive](http://www.businessdictionary.com/definition/interactive.html) nature and [interdependence](http://www.businessdictionary.com/definition/interdependence.html) of the various external and [internal factors](http://www.businessdictionary.com/definition/internal-factors.html). [↑](#footnote-ref-1)
2. “Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement.” Health Foundation (2011) <https://www.health.org.uk/publications/improvement-science>. [↑](#footnote-ref-2)
3. A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) [Just culture](https://www.eurocontrol.int/articles/just-culture). [↑](#footnote-ref-3)
4. Health and Safety Executive (2014) [Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals](https://www.hse.gov.uk/pubns/books/hsg245.htm). [↑](#footnote-ref-4)
5. Vincent C, Adams S, Chapman A et al (1999) [*A protocol for the investigation and analysis of clinical incidents*](http://www.patientsafety.ucl.ac.uk/CRU-ALARMprotocol.pdf)*.* [↑](#footnote-ref-5)
6. Public Administration Select Committee (2015) [*Investigating clinical incidents in the NHS. Sixth report of session 2014–15*](https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf). [↑](#footnote-ref-6)
7. Parliamentary and Health Service Ombudsman (2015) [*A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*](http://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has). [↑](#footnote-ref-7)
8. Care Quality Commission (2016) [*Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*](https://www.cqc.org.uk/news/stories/care-quality-commission-reviews-how-nhs-acute-trusts-are-learning-serious-incidents). [↑](#footnote-ref-8)
9. NHS Improvement (2018) [*The future of NHS patient safety investigation*](https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/). [↑](#footnote-ref-9)
10. NHS Improvement (2018) [*The future of NHS patient safety investigation: engagement feedback*](https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/). [↑](#footnote-ref-10)