University Hospitals Bristol and Weston NHS Foundation Trust

Patient Safety Incident Response Plan

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Introduction

We are delighted to present our first Patient Safety Incident Response Plan for University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

This plan sets out how we intend to respond to patient safety incidents over a period of 18 to 24 months in line with the national Patient Safety Strategy for England (2019) and the new Patient Safety Incident Response Framework (PSIRF) **Figure 1**. This plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Figure 1.

The Patient Safety Incident Response Framework (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- **advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected**
- **embeds patient safety incident response within a wider system of improvement**
- **prompts a significant cultural shift towards systematic patient safety management.**
- **allows for a proportionate and considered learning response to patient safety incidents**

Our Patient Safety Incident Response Plan (PSIRP) is integral to the implementation of PSIRF and aligns with UHBW strategic priorities.

1. PSIRF fits with our new continuous improvement journey in UHBW called Patient First.

Patient First is a whole organisation focus on improvement work which will see us move from trying to do too many things to working together on fewer improvement goals and doing them well - with the patient at the heart of everything we do. It will help us to do this collaboratively in a way that sticks. It will:

- Create a shared vision and destination for the Trust - our True North.
- Adopt a new way of working for all staff who will be trained and empowered to resolve problems and issues at a local level.
- Reduce the number of priorities and objectives, so that we can all focus on moving in the right direction together.

Similarly, PSIRF both requires and enables us to focus on our key patient safety risks and seek an in-depth understanding of the complexity of our safety systems that underpin these risks. It also enables more supportive engagement of patients, families and staff and inclusivity by considering multiple perspectives. It's about understanding and learning together "doing with, rather than doing to". Insights obtained from our PSIRP will feed into future continuous improvement work.

2. PSIRF also aligned with the strategic priorities set out in our Quality Strategy 2021-2025 **Figure 2.**

Figure 2.

UHBW strategic Quality Priority (Trust Quality Strategy 2021-2025)	**PSIRF theme**
To make quality the first priority for every member of staff – the 'why' that's behind everything we do	By definition, PSIRF is all about patient safety, which is an integral part of quality and is at the forefront of everything we do.
To reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement	In seeking those in-depth insights into our safety systems, PSIRF will help us reduce unwanted variation and feed those insights into continuous improvement work
To work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care	PSIRF includes a whole framework for engaging and involving patients, families and staff following a patient safety incident
To be recognised by our patients, staff and regulators for delivering consistently outstanding patient care	The essence of PSIRF is about enabling the delivery of safer care in a highly complex healthcare system which supports our ambition towards providing consistently outstanding care.

We have been working hard for the past 18 months to develop our structure, processes, organisational approach and culture ready for a better way to respond to

and learn from patient safety incidents that comes with PSIRF. Our Patient Safety Incident Response Plan is one of these elements. We are on a journey of discovery and we may not get it right first time, but we will learn and improve for the future.

Our plan has been approved by our Board of Directors and is accompanied by a new Patient Safety Incident Response Policy and associated documents.

Our services

1. Services at UHBW

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) delivers over 100 different clinical services across 10 different sites serving a core population of more than 500,000 people.

With services from the neonatal intensive care unit to care of the elderly, we provide care to the people of Bristol, Weston and the south west from the very beginning of life to its later stages.

Our staff provide general diagnostic, medical and surgical services to the populations of central Bristol, south Bristol and North Somerset. These services are delivered from our Bristol city centre campus and Weston General Hospital with some services delivered in community settings such as South Bristol Community Hospital.

We also provide specialist services such as children's services including tertiary paediatric trauma, cardiac and cancer services, and other smaller specialist services that are nationally commissioned, to a wider population throughout the south west and beyond.

Our services are delivered through five clinical divisions across Bristol and Weston campuses supported by a management team at Weston General Hospital and a sixth division providing support and infrastructure for service delivery.

2. Patient Safety at UHBW

UHBW has operated a hub and spoke model for responding to patient safety incidents with a small central team setting standards and the strategic direction for patient safety, whilst providing practical support, training and advice on the full range of patient safety activity. The central patient safety team manage the serious incident process in accordance with the current Serious Incident Framework 2015, but the work of managing patient safety incidents and risks is currently held within our operational divisions.

Core patient safety activities undertaken at UHBW include:

- Implementing the NHS Patient Safety Strategy
- Delivering a Patient Safety Improvement Programme
- Participating in local and national improvement programmes e.g. maternity, medicines safety
- Developing our patient safety culture
- Preparing for the Patient Safety Incident Response Framework

- Recruiting and supporting our Patient Safety Partners
- Providing a range of patient safety training
- Supporting compliance with statutory duty of candour
- Involving patients and families in keeping themselves safe
- Identifying and supporting mitigation of new patient safety risks
- Implementing actions in response to patient safety alerts

Other activities within the Trust that provide insights to patient safety include:

- Leaning from Deaths Mortality Reviews (Structured Judgement Reviews) for adult patients
- Child Death Reviews and Peri-natal Mortality Reviews
- Learning from Disabilities Mortality Reviews (LeDeR)
- Routine quality surveillance
- Freedom to Speak Up
- Safeguarding concerns, complaints and patient feedback and inquests

3. Developing our approach and capacity to respond to patient safety incidents

With the publication of the original (2019) and subsequent (2022) Patient Safety Incident Response Standards by NHS England it became clear that the current UHBW hub and spoke model for divisions conducting their own in-depth patient safety incident investigations was unsustainable. Specifically, the new standards recommend a higher seniority of lead investigator, dedicated time for learning responses and engagement/support of patients, families and staff. In addition, more advanced training is required and competencies for investigators have been introduced. The aim of these new standards within PSIRF is to:

a) Conduct fewer high-quality investigations to identify wider systems and organisational learning
b) Focus on our highest patient safety risks
c) Enable more agile local learning from incidents

In preparation for transfer to PSIRF we have invested in:

a) A small central expert team to lead patient safety incident investigations
b) A Head of Human Factors role to transform and embed human factors and systems thinking into all patient safety activities across UHBW

The Head of Human Factors role will take a lead in building capacity and capability for a variety of learning responses to patient safety incidents through training and development activities.

4. Capacity for conducting patient safety learning responses

Historically UHBW has completed 70-80 detailed patient safety investigations a year as part of the Serious Incident Framework, with additional local investigations and local learning responses undertaken by divisions. It has been challenging to ensure timeliness and a consistent quality of investigation as investigation leads have had varied training and experience and have needed to prioritise clinical and operational work. This can sometimes leave patients, families without answers for considerable periods and feeling let down by our processes.

The enhanced central patient safety team comprises 2.6 WTE expert investigators supported by an Incident Response Lead, an administrator and some allocated time of the Head of Human Factors. It is estimated this will provide capacity to lead 20 patient safety investigations or thematic reviews per year that meet the standards for PSIRF.

a) Seven investigations each full-time investigator x 2
b) Four investigations part-time investigator
c) Two investigations Head of Human Factors

As PSIRF is a new way of responding to incidents and uses new investigation models for in-depth investigations; and it is new for UHBW to have a dedicated team to conduct investigations, the conclusion of capacity to undertake 20 patient safety investigations or thematic reviews per year is a best estimate based on experiences of early adopter acute trusts. This will need to be reviewed in the life of this plan should the situation prove otherwise.

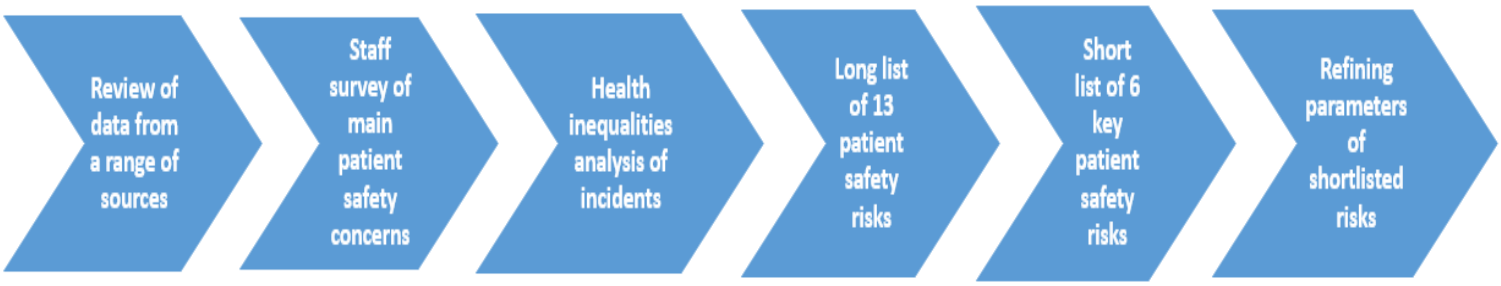
Colleagues in divisions will continue to participate in patient safety incident investigations in the form of clinical or subject matter experts as members of investigation teams.

The shift to fewer patient safety incident investigations will lead to an increase in the use of more agile local learning responses recognised in PSIRF such as: After Action Reviews, local multidisciplinary team reviews (MDT reviews) and swarm huddles **(Appendix 1).** This will lead to a change for divisional patient safety teams as a result with more time spent leading these local responses. The central patient safety team will support divisions to undertake local learning responses.

Defining our patient safety risk profile

Over a period of five months, we undertook a comprehensive situational analysis of our current patient safety risk profile across all services within UHBW. There is an in-depth supporting document that holds the detail of the first three steps of the process and their outputs. An overview of the process followed is outlined below **Figure 3:**

Figure 3.



1. Stakeholder engagement

We have been thinking hard about our key patient safety risks and how we respond to and learn from patient safety incidents over the past 18 months through a series of monthly patient safety workshops and discussions in several committees and groups. Most recently, in January 2023, the Clinical Quality Group agreed the short list of patient safety risks within this Patient Safety Incident Response Plan and the Board sub-committee for quality, the Quality and Outcomes Committee, received the draft of the plan for comment.

We have also linked in with partners in Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS) and the West of England Patient Safety Collaborative.

Unfortunately, our Patient Safety Partners were not recruited in time to develop our first PSIRP but will play an integral role in patient safety in UHBW and in the development of future plans.

2. Review of data from a range of sources

Our data analysis took place before the revised version of the Patient Safety Incident Response Framework was published by NHS England in August 2022 and as such, we were very grateful for the learning shared by PSIRF early adopters through national and local networks. In May 2022, we identified the period 1st April 2018 to 31st March 2022 for our thematic data analysis. We learned from early adopters that 2-3 years of data seemed to be about right to understand patient safety risks and issues. We were conscious of two significant changes in the period 2020/21 that could have an influence on the UHBW data which might be unrepresentative of a “normal” year.

a) The merger of University Hospitals Bristol NHS Foundation Trust and Weston Area Health Trust to form University Hospitals Bristol and Weston NHS Foundation Trust in April 2020.
b) The COVID-19 pandemic in 2020/21 during which we had observed an increase in incidents relating to COVID-19 infections and the operational adjustments necessary to manage the impact of the pandemic and a decrease in other types of incidents due to changes in healthcare activity.

The impact of the merger on our analysis was mitigated by including legacy incident and serious incident data from the former Weston Area Health Trust in our analysis. The impact of the COVID-19 pandemic was mitigated by extending the analysis back a further year to April 2018, four years in total.

The data analysed was taken from a number of sources:

a) Our local risk management system, Datix, which holds our incident, complaints, claims, inquest data and current risk registers
b) NHS England's Strategic Executive Information System which holds serious incident data
c) Patient feedback data from UHBW patient surveys (monthly postal surveys)

The range and volume of data analysed is shown in **Figure 4** below.

Figure 4.

3. Staff survey of main patient safety concerns

We were keen to involve our staff as key stakeholders in identifying our key patient safety risks and issues. A patient safety staff survey ran from 6th July to 15th August 2022. Staff were asked to tell us about their main patient safety concerns. This was a ranking survey, with 20 randomised choices identified from data themes. Staff were asked to choose their top five from the 20 options available and there was a free text field for staff to add anything else.

4. Further health inequalities incident data analysis

Using the original patient safety incident data, we made a first attempt to understand whether patients experienced incidents and harm disproportionately in relation to protected characteristics. From the information available to us, we used age, gender and ethnicity taken from our Care flow Electronic Patient Record (inpatients only) and postcodes were used as a proxy for Indices of Multiple Deprivation Decile. There were some gaps in data for protected characteristics and the outputs were not subject to statistical significance analysis so initial indications would need future in-depth data validation and analysis.

5. Longlisting, shortlisting, refining

The longlist was derived from the top categories from each of the data sources and reviewed alongside the patient safety concerns from the staff survey results to identify the most common themes across all data sources. This resulted in 13 themes in a long list.

Shortlisting involved presenting the data analysis and resulting long list to a range of stakeholder groups alongside identified existing programmes of improvement work as outlined in the next section to identify where we should focus our in-depth insight resource to best effect. The outputs of this process are described in the next section.

Defining our patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- Our new Patient First Programme which has identified the areas of focus for organisation-wide improvement.
- Existing Transformation Programme priorities
- Existing Patient Safety Improvement Programme priorities
- Trust-wide quality improvement projects
- Trust-wide operational improvement work
- ICS operational improvement projects
- National Patient Safety Improvement Programmes
- West of England Patient Safety Collaborative Programme

The detailed consolidated list can be found in **Appendix 2**.

As part of the shortlisting and refining process described in the previous section, we considered two key questions:

a) Do we have existing in-depth insight about this risk that might mean we de-prioritise this theme in our initial Patient Safety Incident Response Plan?
b) Is there improvement work underway locally, at Integrated Care System level or national level that we are already undertaking to mitigate this risk?

The outcome of this consideration is shown in **Figure 5** below.

Figure 5.

Longlisted theme from situational analysis	Existing improvement work	Shortlisted as key patient safety risk for PSIRP	Rationale
Communication (information sharing between staff, staff/patients and family)	No. A Trust-wide approach is needed.	Yes	Focus on staff/staff communication at transfer of care is seen as a contributory factor in many reported incidents.
Operational delays (e.g.12-hour trolley breaches, front door delays)	Yes. ICS partnership work on improving flow, UHBW Every Minute Matters.	No	Cause of front door delays well understood nationally and locally. Significant improvement work underway

Longlisted theme from situational analysis	Existing improvement work	Shortlisted as key patient safety risk for PSIRP	Rationale
Patient falls	Yes. Refreshed falls prevention QI work at system and local level. Risk enhanced by staffing challenges.	No	Refreshed approach incorporated broader understanding of contributory factors and system wide improvement work.
Deteriorating patient	Yes. Recently refreshed existing programme. Patient First priority.	No	Detailed systems-based diagnostic conducted for refreshed programme. Systemic contributory factors well understood and a comprehensive programme of improvement work underway.
Safe discharge	Yes, but focus is mainly on expediting discharge of medically fit patients.	Yes	Most frequently reported incidents relating to UHBW from primary care. Focus on systems to enable review of clinical information prior to discharge.
Treatment delay/failure	Yes, significant work on restoration and reducing backlogs in planned care.	Yes	Focus on understanding internal/clinical causes of inpatient delays
Medication	Yes, national medicines safety programme, but improvement focus does not cover recurrent incidents seen in UHBW.	Yes	Consistently one of the highest reported incident categories. Careflow Medicines Management digital system will mitigate a number of medicines safety risks. Focus on delayed and not-

Longlisted theme from situational analysis	Existing improvement work	Shortlisted as key patient safety risk for PSIRP	Rationale
			administered high-risk medicines.
Staffing	Numerous Trust wide workstreams underway in line with UHBW People Strategy	No	Risk already well understood locally and nationally, and comprehensive actions being taken to mitigate within UHBW
Maternity/perinatal (clinical care)	Yes, national maternity safety programme in place.	Yes	More in-depth insight required of local areas for improvement to mitigate risk.
Infection Prevention and Control (IPC)	Yes, national IPC improvement workstreams in place	No	Embedded local and system processes for learning from healthcare associated infections (Post Infection Reviews)
Tissue viability	Yes, refreshed tissue viability improvement plan in place.	No	Refreshed approach incorporated broader understanding of contributory factors.
Patients needing specialist mental health admission	Yes	No	National work underway to improve access to mental health services.
Equipment	No	Yes	More in-depth insight required of local areas for improvement to mitigate risk. Focus on availability of functional equipment: CSSD and medical equipment.

Our patient safety incident response plan: national requirements

Figure 6 below describes how we will respond to patient safety incidents that meet the national event response requirements set out in PSIRF. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feeds into future patient safety improvement plans.

Figure 6.

Patient safety incident type	Required response	Lead body for response
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	UHBW
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	UHBW
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place.	Refer to Healthcare Safety Investigation Branch for independent patient safety incident investigation	HSIB
Deaths of persons with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death	LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria for PSII.	Child Death Overview Panel/UHBW
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	PSII	UHBW

meeting the learning from deaths criteria)		
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally led PSII may be required	As decided by the RIIT
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	UHBW
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	CSP

	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 commissioners of health services in relation to DHRs	
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 Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC

Our patient safety incident response plan: local focus

Figure 7 below describes how we will respond to patient safety incidents relating to the key patient safety risks identified in our situational analysis. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feeds into future patient safety improvement plans.

Figure 7.

Patient safety incident or issue	UHBW planned response
Staff/staff communication at transfer of care	PSII or thematic review
Safe discharge. Focus on systems to enable review of clinical information prior to discharge.	PSII or thematic review
Treatment delay/failure-internal/clinical causes of inpatient delays	PSII or thematic review
Medication-delayed or non-administration of high-risk medicines	PSII or thematic review
Maternity/perinatal (clinical care)-lack of recognition of maternal or child intra-partum deterioration	PSII or thematic review
Equipment-lack of functioning CSSD/medical equipment	PSII or thematic review
Patient falls	Swarm huddle
Healthcare associated pressure injury	After Action Review
Incidents meeting trigger for rapid incident review taking into account: • the views of those affected, including patients and their families	Local review: MDT review, After Action Review

• capacity available to undertake a learning response • what is known about the factors that lead to the incident(s) • whether improvement work is underway to address the identified contributory factors • whether there is evidence that improvement work is having the intended effect/benefit • if UHBW and/or BNSSG ICB are satisfied risks are being appropriately managed.	
All other patient safety incidents	Managers review or swarm huddle, local action and shared learning

Indicative allocation of resource for PSIIs for our Patient Safety Incident Response Plan in Year 1 with available capacity to conduct 20 PSIIs or thematic reviews a year:

Patient safety incident or issue	Indicative capacity
Incident meeting never events criteria	Two PSIIs or thematic reviews
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	Six PSIIs or thematic reviews
Local focus in Patient Safety Incident Response Plan	Ten PSIIs or thematic reviews
Contingency for emerging risks	Two PSIIs or thematic reviews

A summary of how this Patient Safety Incident Response Plan will work in practice is provided at Appendix 3.

Appendix 1

National learning response methods

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	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(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is 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 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?

Appendix 2

Consolidated list of patient safety improvement work relevant to key patient safety risks identified in "long list"

Source of Improvement work	Relevant improvement Project/Programme	Focus
Patient First Programme (in preparation phase)	Quality and Patient Safety	Deteriorating patient (see below)
	Experience of care	Person centred, inclusive care
	Our people	Improving staff experience and retention
	Timely access to care	Eliminating delays in patient care
Patient Safety Improvement Programme	Deteriorating Patient	Advanced care planning and early recognition and treatment of deteriorating patients
	Venous Thrombo-embolism (VTE)	Prevention of VTE. Links with Careflow Medicines Management (electronic prescribing) work stream.
Patient Safety Improvement work	Falls prevention – planned improvement work	Improving assessment and recording of Multi-Factorial Risk Assessment for patients. Embedding Personalisation, Prediction, Prevention and Participation in falls prevention and management across the Trust. Improving mobilisation and preventing deconditioning in hospitals.
	Tissue Viability - improvement work plan	Pressure injury prevention
	Implementing National Safety Standards for Invasive Procedures 2 (NatSSIPs 2)	Reducing risk of invasive procedure related never events
Trust-wide operational improvement work	Every Minute Matters	Timely patient pathways and discharge

ICS operational improvement projects	Care Traffic Control	
	Care Hotel	
	Virtual Wards	
National Patient Safety Improvement Programmes	Maternity Improvement Programme	
	Medicines Safety	Reducing harm from opioid prescribing
	Patient Deterioration	(see above)
West of England Patient Safety Collaborative Programme (Acute Trusts)	As for national programmes.	

Summary of how the Patient Safety Incident Response Plan will work in practice **Appendix 3**