Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Patient safety incident response plan 2023/24

Finalised date: August 2023

Estimated refresh date: March 2024

Version 1.8

Contents

Forward from the Clinical Director for Patient Safety & the Director of Nursing Quality & Governance

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what we currently do, it fundamentally shifts and changes how we as an organisation respond to patient safety incidents. A key change is that under PSIRF there is no distinction between incidents and 'serious incidents. Previous frameworks have described what, when and how to investigate a serious incident, PSIRF focusses on learning and improvement which will compliment other incident response processes (eg Coronial, MBRRACE, Learning from deaths).

In implementing PSIRF, SFHFT will decide which patient safety incidents require more rigorous investigations and which are more suited to an alternative approach. Investigation timescales are also more flexible with the previous 60 days timeframe being replaced with individual PSII timescales agreed in consultation with the patient and/or family. There are a set of principles that we will work to but outside of that, we decide.

When asked "why do we investigate incidents?" the usual response is to learn, but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that.

Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will support our core ambition of working in partnership with patients to improve safety.

We recognise that changing culture is complex and we are committed to being an organisation with a positive safety culture where we continually learn and improve and where people feel safe to speak up.

1. Purpose, scope, aims and objectives

1.1 Purpose.

1.1.1 This Patient Safety Incident Response Plan (PSIRP) sets out how Sherwood Forest Hospitals NHS Trust will respond to patient safety incidents reported by staff and patients, their families and carers as part of work to continually improve the quality and safety of the care we provide

1.2. Scope

1.2.1. There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

1.2.2. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

1.2.3. There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement

1.2.4. Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)

- Patient Safety Reviews (PSRs)

1.2.5. Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

1.2.6. To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

• human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators

• legal teams for clinical negligence claims

• the police for concerns about criminal activity

1.3. Aims and objectives

1.3.1. Table 1 describes the four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based and sets out how these overarching aims will be achieved through specific objectives.

Table 1. Overarching aims and specific objectives of the Patient Safety Incident Response Framework Overarching aims Specific objectives

Overarching Aims	Specific objectives
1. Compassionate engagement and involvement of those affected by patient safety incidents	• Develop a climate that supports a just culture and an effective learning response to patient safety incidents. The Just Culture concept establishes an organization-wide mindset that positively impacts the work environment and work outcomes in several ways. The concept promotes a process where mistakes or errors do not result in automatic punishment, but rather a process to uncover the source of the error. • Respond to patient safety incidents purely from a patient safety perspective • Reduce the number of duplicate PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors • Aggregate and confirm validity of a culture in which people are not punished for actions learning and improvements by basing PSIIs on a small number of similar repeat incidents • Consider the safety issues that contribute to similar types of incident

	• Develop system improvement plans across aggregated incident response data to produce systems-based improvements • Better measurement of improvement initiatives based on learning from incident response
2. Application of a range of system-based approaches to learning from patient safety incident	• Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS. • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting Duty of Candour
3. Considered and proportionate responses to patient safety incidents	Transfer the emphasis from quantity of investigations to a higher quality response to patient safety incidents, and the implementation of actions that lead to demonstrable change and improvement • Develop a local board-led, commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP) assured architecture around response to patient safety incidents, which promotes ownership, accountability, rigour, expertise and efficacy
4. Supportive oversight focused on strengthening response system functioning and improvement	• Act on feedback from staff about their patient safety incidents and investigations. concerns with patient safety incident responses in the NHS. • Further support and involve staff in patient safety incident response.

2. Resource analysis

2.1. Background

2.1.1. There are many ways an organisation can respond to a patient safety incident to learn and improve.

2.1.1. Patient Safety Reviews (PSRs) include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected patient, family or carer.

2.1.2. Different PSR techniques can be adopted depending on the intended aim and required outcome. All PSRs are conducted locally by our organisation.

2.1.3. There are four broad categories of PSRs Patient Safety Review Types for more information): - Incident recovery - Team reviews - Systematic reviews - Monitoring

2.1.4. Patient Safety Incident Investigations (PSIIs) are distinct from PSRs and include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

2.1.5. While most PSIIs will be conducted locally, some will be conducted independently. Independent PSIIs can be funded by our organisation or regionally/nationally.

2.1.6. Some types of patient safety incidents have been identified as national priorities and require a specific response. See Appendix A for a full list of national priorities, and what response is required to them.

2.1.7. All patient safety incidents leading to moderate harm or above and all incidents for which a patient safety incident investigation is undertaken trigger the Duty of Candour.

2.1.8. Understanding our capacity to respond to incidents enables us to be strategic in proactively allocating resources to responding to patient safety incidents that are not included in the list of national priorities.

2.1.9. This section outlines our approach to understanding our available resources, it describes how we are ensuring our resources meet standards required in the National PSII

standards and details how much resource we have available to proactively plan how we will respond to key risks that fall outside national priorities.

2.1.10 How we defined our key risks is outlined in Section 3 - Risk Analysis.

2.1.11 Understanding patient safety incident response activity

2.1.12 A data review of SFHFT Incident Management System (Datix) and other specialist teams information systems e.g. Safeguarding, was conducted for incidents reported between April 2020 and March 2023 to establish the number of investigations that took place within the categories listed below. The data includes events reported as part of the Trust complaints procedure and coroner activity.

Response Type	Category	Average annual number of responses
National priorities requiring patient safety incident investigation	Patient safety incident investigation into Never Events	10
	Mortality Reviews (including Structured Judgement Reviews)	289
	Incidents referred (to HSIB/Regional independent investigation teams (RIITs) for independent PSII	4
	Deaths of persons with learning disabilities	3
	Adult Safeguarding incident reviews Safeguarding Provider Enquiry Reports Independent Enquiry Reports	31 3

	Section 42 enquiry reports	
	Domestic homicide reviews	3
Patient safety incident investigations conducted locally	Coroner initiated patient safety incident investigations	0
	Level 3 Serious Incident investigations (Investigations under the current NHS Serious Incident Framework and reported to StEIS)	92
	Level 2 incident investigations utilising a systems framework for review (divisional investigations)	102
	Level 1 incident investigations utilising a systems framework for review (local investigations)	121

Table 2. Average annual response activity for April 2020 to March 2023

2.2. Patient safety incident response skills - gap analysis

2.2.1 A review of the resource associated with the current Serious Incident Framework for the period 2020 - 2023 has been undertaken to determine how many PSIIs can be supported during 2023/24.

2.2.2 This review has been led by the Director of Nursing, Quality, Governance & Safety with support from the Clinical Director for Patient Safety, involvement from the GSU Team, the Complaints Team

2.2.3. In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

• Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs.

• Provide PSIRF familiarisation sessions for all board members.

• Provide access to update training for current staff who provide the incident investigation oversight function on use of updated analytical tools, use of improvement science approaches and utilization of the national report template.

• Identify an appropriate training provider for training new investigators of PSII's in the Trust to the standard required by PSIRF (e.g. minimum of two days). We will use a targeted approach to identify a number of investigators from a range of professional backgrounds i.e. medical, nursing, AHP.

• Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our website

• Work with senior clinicians, nursing and AHP staff to review the existing tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.

• Negotiate time in job plans for a core group of senior clinical staff to undertake PSII investigations

• Modify existing internal training courses for staff who are required to undertake Patient Safety Reviews to include:

- Application of updated analytical tools
- Principles of PSIRF
- Using QI methodology and improvement science approaches

2.3. Resources for proactive planning

2.3.1 The current structure relies heavily on senior clinicians, nurses and AHP's employed by the trust but independent of the clinical area where the incident occurred, undertaking reviews in their allotted management / administration. GSU do not have any line management

responsibilities with regards investigators and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have executive level sign off.

2.3.2 Resource, restructuring and training is needed to meet the requirements of the patient safety incident investigation standards and the PSIRF.

2.3.3 Planning to address the above is underway and expected to take twelve to 24 months to rollout and fully embed. The planning and restructuring exercise will:

- Enhance patient safety management and leadership support

- Enhance resource and skills to conduct alternative patient safety reviews

- Enhance patient safety investigation with a lead and supporting investigator, subject matter experts, administrative support, patient and family liaison, and executive level oversight and support

- Enable each investigator to:

- receive systems-based patient safety incident investigation training
- be dedicated to no more than two PSII at any time

Table 3. Proactive response planning: overview of estimated resource allocation for patient safety incidents that fall outside national priorities

Response Type	Category	Total number of responses	Hours
PSII	Locally defined PSII	10	Minimum 60 hours per investigation for: • 1 lead investigator • 1 support investigator (QGL) Up to 30 hours per investigation for: • subject matter expertise • family liaison (QGL / divisional DOC lead) Plus Up to 30 hours per investigation for: • investigation oversight and support • administration support • interview and statement time of staff involved in the incident review committee approval and sign off

	Unanticipated incidents	6*	Minimum 60 hours per investigation for: • 1 lead investigator • 1 support investigator (QGL) Up to 30 hours per investigation for: • subject matter expertise • family liaison (QGL / divisional DOC lead) Plus Up to 30 hours per investigation for: • investigation oversight and support • administration support • interview and statement time of staff involved in the incident board committee approval and sign off
Learning from Excellence	All Types	1	Minimum 60 hours per investigation for: Lead by the GSU, Divisional / speciality

* Incidents identified to have significant potential learning will be reviewed and prioritised

3. Risk analysis

3.1. Risk stakeholders and data inputs

3.1.1 The patient safety incident risks for this organisation have been profiled using organisational data between the years 2020 to 2023 from;

- patient safety incident reports
- complaints
- legal claims
- Coroners' findings including prevention of future death notifications and cause for concern notifications
- mortality thematic reviews

FTSU themes

3.1.2 A range of staff, including leads for each of the above data collection systems, were consulted and themes were collated, Appendix B (spider diagram). A prioritised list of incidents for 2023/4 was then collated.

3.1.3 The trust will continue to seek data and insight from stakeholders to inform potential future categories for local patient safety incident investigation and present the 2024/5 plan for approval in Q4 of 2023/4.

3.1.4 Key stakeholders have been consulted throughout the process to agree the identified priorities and SFHFT Patient Safety Incident Response Plan including:

- Commissioners
- Members of staff
- Trust Board and delegated committees

3.2. Local patient safety risk profile

Criteria for defining top local patient safety risks

Potential for harm – considering:

- People: physical, psychological, loss of trust (patients, family, carers)
- Service delivery: impact on quality and delivery of healthcare services; impact on capacity
- Public confidence: including media coverage

Likelihood of occurrence – considering:

- Persistence of the risk
- Frequency
- Potential to escalate

3.2.2 The current local top ten patient safety risks for SFHFT as identified via the analysis described in section 3.1 are presented in table 6 below.

Table 6. Top local patient safety risks

	Incident Type	Description	ciality	Response type
	Falls	Falls that leads to patient injury	All	system wide approach
	Treatment & care	Particularly delays to follow-up	All	**Patient Safety Incident Investigation**
3	Skin damage	All categories of pressure ulcer and tissue damage	All	System wide approach
4	Medication	Relating to wrong dose, omitted/ delayed wrong/ duplicate medication	All	**Patient Safety Incident Investigation**

5	Security / unacceptable behaviour	Violence / aggression towards staff	All	Not included in the scope of this PSIRP
6	Delays in care	Delays to treat the deteriorating patient	All	**Patient Safety Incident Investigation**
7	Appointments, Admission, Transfer & Discharge	Incidents regarding issues with movement of patients/ flow/ capacity	All	**Patient Safety Incident Investigation**
8	Infection	All instances of healthcare acquired infections and issues with infection control procedures	All	HCAI RCA, Outbreak reviews
9	Communication	Consent / Dols / MCA	All	**Patient Safety Incident Investigation** (escalation and care planning)
10	Health Records, Consent & Confidentiality	Incidents relating to health records and consent issues	All	**Patient Safety Incident Investigation**

3.3. Locally defined responses

Table 7 Criteria for selecting risks for PSII response

Criteria	**Considerations**
Potential for learning and improvement	Increased knowledge: potential to generate new information, insights, or bridge a gap in current understanding Likelihood of influencing: healthcare systems, professional practice, safety culture. Feasibility: practicality of conducting an appropriately rigorous PSII Value: extent of overlap with other improvement work; adequacy of past actions
Systemic risk	Complexity of interactions between different parts of the healthcare system

3.3.1 Based on the analysis and selection criteria described above, local priorities for PSII have been set by this organisation for the remainder of the year 2023/4.

3.3.2 The priorities have been agreed with our commissioning organisation, Nottingham and Nottinghamshire ICB. Priorities are listed in table 8 below.

3.3.3 Each PSII will be conducted separately, in full and to a high standard, by a team whose lead investigator is appropriately trained.

3.3.4 Findings from investigations conducted from the same narrowly specified incident type will be analysed for commonalities and opportunities for system improvement.

Table 8 Planned Patient Safety Incident Investigation responses for top local patient safety risks

	Incident type	description	Response type	Number of responses (PSII)
1	Treatment & Care to include concerns over appointments, admission, transfer & discharge	Delays to follow-up and to include incidents regarding issues with movement of patients / flow / capacity	PSII	2
2	Medication	Relating to wrong dose, omitted / delayed / wrong / duplicate medication	PSII	2
3	Delays in care	Delays to treat the deteriorating patient	PSII	2
4	Communication	Consent / DoLS / MCA	PSII	2
5	Health Records, Consent & Confidentiality	Incidents relating to health records and consent issues	PSII	2
6	Obstetrics / Maternity	Postpartum Haemorrhage in excess of 1.5L requiring return to theatre or activation of major haemorrhage protocol	Thematic review	2

3.4. Approach to local PSII selection

3.4.1 The SFHFT Datix incident reporting system will be utilised to alert the Governance Support unit to when incidents are recorded matching the types identified for PSII

3.5. Timescales for PSIIs

3.5.1. Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified as meeting the PSII inclusion criteria.

3.5.2. Whilst there is no formal timescale PSIIs should ordinarily be completed within six months of their start date.

3.5.3. In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between the Sherwood Forest Hospitals NHS Trust and the patient/family/carer.

3.5.4. Where the processes of external bodies delay access to 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. Learning from incident responses

4.1. Findings from PSIIs and PSRs provide key insights and learning opportunities.

4.2. Findings will be translated into effective improvement design and implementation.

4.3. Quality Improvement Faculty and specialist working groups will oversee collation and execution of System Improvement Plans (see section 9).

4.4. If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, these actions will be made as soon as possible.

4.5. All other recommendation development will consider collating findings across all or a subset of responses into a single risk.

4.6. Findings from each individual response linked to a specific risk will be collated to identify common contributory factors and any common associations upon which effective improvements can be designed. Recommendations and monitoring arrangements will be summarised in a System Improvement Plan.

4.7. Consideration will be given to the timeframe taken to complete a System Improvement Plan and the impact of extended timescales on those involved in the incident.

4.8. System Improvement Plans will be shared with those involved in the incident including patients, families, carers and staff.

5. Roles and responsibilities

5.1 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

5.2 All Staff

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the GSU pages of the Trust intranet.

5.3 Incident Reviewers

Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required. The reviewer(s) should have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training courses.

5.4 Duty of Candour Leads / Family Liaison Officer

- Responsible for ensuring the organisation's legal duty of candour is discharged for appropriate incidents.
- Identify those affected by patient safety incidents and their support needs by being the single point of contact.
- Provide them with timely and accessible information and advice.
- Facilitate their access to relevant support services.
- Obtain information from review/PSR teams to help set expectations.
- Work with the GSU and other services to prepare and inform the development of different support services.

5.5 Divisional Clinical Triumvirates

Divisional Clinical Triumvirates have a responsibility to:

- Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information.
- Ensure that incidents are reported and managed in line with internal and external requirements.
- Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in reviews/PSIIs.

- Work with GSU and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).

5.6 Patient Safety Partners

As part of our commitment to working with members of the public we will have a partner programme in place. This is where members of the public join our Quality and Safety Improvement work. Their contribution to the PSIRF:

- Partners will undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as other relevant training
- Participate in investigation oversight groups and be active members of the Patient Safety Incident Review Group (PSIRG) and other work streams
- Encourage Patients, Families and Carers to play an active role in their safety.
- Contribute to action plans following investigation, particularly around actions that address the needs of patients.

The support for PSP's is detailed in section 8.

5.7 Governance Support Unit

- The Patient Safety Incident Review group (PSIRG) will meet twice weekly to review incidents and ensure that PSIIs are undertaken for incidents that meet the agreed criteria for this level of response.
- Develop and maintain the local governance management systems and relevant incident reporting systems (including StEIS and its replacement once introduced) to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Lead the development and review of the organisation's PSIRP.
- Oversee procedures to monitor/review PSII progress and the delivery of improvements.
- Work with the executive lead to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents.
- Support and advise staff involved in the patient safety incident response.
- Ensure staff members involved in the management of patient safety incidents have access to the requisite knowledge, skills and tools to undertake patient safety reviews to the required national standards.

5.8 Patient safety incident investigators

- Patient safety incident investigators will have been trained over a minimum of two days in systems-based PSII.
- Ensure that PSIIs are undertaken in-line with the national PSII standards.
- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.

5.9 Clinicians/Specialist Advisors

Incident reviewers may need to involve specialist advisors to assist in their review (e.g. Safeguarding, Health and Safety, Medical Physics, Pharmacy, Radiation Protection Advisor, Clinicians with experience in a particular medical or surgical technique).
Patient safety reviewers are responsible for determining when specialist advice is required and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, review of recommendations.

5.10 Medical Examiner

The medical examiner's key role is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all deaths
- ensure the appropriate direction of deaths to the coroner
- provide an outstanding service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

Whilst medical examiners are NHS employees, they have separate professional accountability and their independence, which is vital to the scrutiny they provide, is overseen by the national medical examiner.

Medical examiners scrutinise all deaths to:

- agree the proposed medical cause of death and ensure the overall accuracy of the medical certification of the cause of death
- identify problems in treatment or care and, as necessary, report to the trust's clinical governance process
- discuss the cause of death with the bereaved and listen to any concerns
- ensure the referral of deaths to the coroner as required by the law; this includes deaths where there are concerns that failure in care contributed to death or where the bereaved raise significant concerns about the care provided to their relative
- liaise with, and assist, the coroner with medical information
- educate and provide advice to other clinicians about death registration and the coronial process

5.11 Patient Safety Committee (PSC)

The Patient Safety Committee (PSC) has responsibility for reviewing completed reports and system improvement plans for effectiveness. The committee should feedback at each meeting on our progress against the PSIRP. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of PSC will seek assurances from the divisions that risks are being adequately addressed. Where there are remaining concerns these will be escalated to the Quality Committee.

5.12 Quality Committee (QC)

The Quality Committee has responsibility to seek and gain assurance that the actions and learning resulting from patient safety incident investigations are appropriate and timely and any challenges to implementation are escalated. The Committee should feedback at each meeting on our progress against this PSIRP.

5.13 Chief Medical Officer / Chief Nurse - Executive leads for supporting and overseeing implementation of the PSIRF

The Chief Medical Officer / Chief Nurse have delegated responsibility for 1) ensuring that there are adequate arrangements in place for patient safety incident investigations and reviews 2) governance of these arrangements. 3) that there is adequate assurance to demonstrate learning is being shared and changes to practice as a result of patient safety incident investigations and reviews are implemented across the Trust.

5.14 Chief Executive

The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974). As part of this role the Chief Executive has overall responsibility for ensuring there are effective risk management systems and processes in the Trust to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff and visitors. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

5.15 Trust Board

The Trust Board has a responsibility to ensure that it receives assurance that this plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. This will be achieved through reporting processes as well as receiving assurance via the Quality Committee. The Trust Board receives a bi-monthly report on patient safety incident investigations within the Trust and monitors the lessons learned from these. Where concerns are identified relating to the robustness of lessons learned or actions planned the Trust Board will seek assurances that these concerns are being acted upon.

6. Patient Safety Incident reporting arrangements

6.1 Local reporting of patient safety incidents (PSIs)

6.1.1 The full details of the Patient Safety Incident reporting arrangements are detailed within the Trust Serious Incident Reporting Policy. The procedure provides a structure for reporting incidents at SFHFT.

6.1.2 All staff (including bank, agency, locum and volunteers) have the responsibility to report all incidents and near misses via the Trust electronic incident management system, Datix.

6.1.3 A record of the incident or near miss should be contemporaneously and objectively reported in the patient's clinical records.

6.1.4 All incidents reported as causing moderate, severe, catastrophic harm will be discussed at the Trust twice weekly PSIRG meeting to determine if further information is required and advise on type of investigation required.

6.1.5 Incidents requiring consideration as a potential patient safety incident investigation (PSII) will be reviewed and discussed at the Trusts twice weekly PSIRG meeting to determine type of investigation required. Incidents which meet the criteria for a PSII will be reported onto the Strategic Executive Information System (StEIS) or its replacement system.

6.2 National reporting of patient safety incidents (PSIs)

6.2.1 The trust undertakes its external reporting and notification requirements in line with national guidance will engage with oversight and regulatory bodies as soon as possible to facilitate a joined-up and informed response across the system.

6.2.2 The trust currently reports patient safety incidents to the national reporting and learning system (NRLS) via data uploads.

6.2.3 In line with the PSIRF, reporting incidents previously defined as 'serious incidents' to the national 'StEIS' database will cease at a date to be determined nationally, the replacement system will be used to report and monitor all patient safety incidents including those identified as requiring a patient safety incident investigation.

6.2.4 Management and monitoring of individual investigations, previously the responsibility of the local commissioning organisation, will be the responsibility of the Trust Board.

6.2.5 Reporting PSIs and PSIIs to the new 'learning from patent safety events' system (LFPSE) will follow when this replaces the NRLS and further guidance is issued.

6.2.6 Statutory Care Quality Commission notification requirements will be met by reporting incidents to the national reporting and learning system (NRLS) and its successor system. One notable exception is the death of a patient detained under the Mental Health Act which, in line with national guidance, will be reported directly to the CQC.

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

7.1 Patient and Family Liaison

7.1.1 The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. The Duty of Candour policy sets out the responsibilities of Duty of Candour Leads and the Family liaison Officer

7.1.2 'Duty of Candour Leads' are senior members of the clinical and nursing teams nominated to be the key contact for communication with patients, families and carers during a patient safety incident review.

7.1.3 It is the Duty of Candour Lead / Family Liaison Officer who is responsible for:

- Meeting with patient, families and carers involved in a patient safety incident to explain what has happened, the investigation taking place and provision of contact detail.
- Hearing the patient/family account of the incident from their perspective and gathering any questions they would like the review to answer.
- Ensuring that the patient has been provided with appropriate on-going support.
- Arranging for transfer of care where the patient (and/or carer) requests this.
- Documenting the details of all discussions with the patient (and/or carer), copies of letters relating to the patient safety review ensuring this documentation is uploaded to the relevant incident record on Datix.
- Keeping in close communication with the patient, family and/or carer as per their wishes. Contact will also take place following the conclusion of the investigation to share the findings, lessons learned and actions being taken.

7.1.4 For the Patient Safety Incident Investigations identified in this PSIRP (Table 8) family liaison will be undertaken directly by the PSII team and the Family Liaison Officer. For all other types of Patient Safety Review family liaison it is the responsibility of the nominated Duty of Candour Lead.

7.2 Local support

7.2.1 The Patient Advice and Liaison Service at SFHFT is a free and confidential service to support patients and their families

7.2.2 The PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

7.2.3 The Trust is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, service users, family members or carers. On these occasions the trust aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

7.2.4 Trust staff are empowered to resolve concerns immediately and informally, where this is possible. People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the care team.

7.2.5 Should the care team be unable to resolve the concern then the patient advice and liaison service can provide support and advice to patients, families, carers and friends.

8. Procedures to support staff affected by PSIs

8.1 The national and local arrangements for supporting staff following Patient Safety Incidents

8.1.1 SFHFT is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles into our procedures for the review of incidents. The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. Extending the scope of the response to recognise the needs of the staff and organisation acknowledges the principles of Restorative Just Culture which are captured in Dekker's Restorative Just Culture Checklist RestorativeJustCultureChecklist_MD (safetydifferently.com)

The first three elements of which are:
Who is hurt?
What do they need?
Whose obligation is it to meet the need?

This aligns with work already undertaken within our HR processes based around the model adopted by Mersey Care (https://www.merseycare.nhs.uk/about-us/restorative-just-and-learning-culture)

8.1.2 Governance Support Unit (GSU)- The GSU will advise and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

8.1.3 Professional practice advocates & educational supervisors

8.1.4 The trust continues to roll out the Trauma Risk Management Programme (TRiM) and this PSIRP will be revised in line with this programme.

8.1.5 Occupational Health Service

8.1.6 Schwartz Rounds - Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience or simply listen to their stories.

8.1.7 Freedom To Speak Up Guardian - A confidential service for staff if they have concerns about the organisation's response to a patient safety incident.

8.2 Support from Patient Safety Incident Investigators

8.2.1 All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

8.2.2 Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

8.2.3 All contact with staff will involve the collection of their account of the events and also their views and opinions on how systems can be improved.

8.2.4 CPD- to align with individual investigator feedback and NHSE developments.

9. Mechanisms to develop and support improvements following PSIIs

9.1 The Trust has established an Improvement Faculty which brings together a number of existing teams who contribute to improvement across the organisation with the aim of creating a centre of excellence. Teams who are partners in the faculty include:

- Improvement Team (incl Clinical Audit)
- Transformation Team
- Nursing quality and governance (incl patient safety)
- Research and innovation
- Patient experience
- Organisational development
- Digital transformation
- Library and knowledge services

The aim of the Improvement Faculty is to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and transformation, including implementing improvements/solutions arising from patient safety incident investigations. The Faculty will offer help, advice, training and, where required, coordinated support.

The Faculty offers the Quality, Service, Improvement and Redesign (QSIR) quality improvement training programme developed by NHS Improvement. As of May 2023 over 160 staff across the Trust who have completed the 5 day QSIR Practitioner training covering:

- Leading improvement
- Measurement for improvement
- Sustainability
- Stakeholders and engagement
- Understanding demand and capacity
- Creativity in improvement
- Process mapping and other tools

A further cohort of staff have undertaken QSIR Fundamentals or other introduction to QI training covering basic tools to get started on an improvement project. Additional training is also available to increase knowledge in human factors and project management

10. Evaluating and monitoring outcomes of PSIIs, Reviews

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

10.2 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.

10.3 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.

10.4 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.

11. Complaints and appeals

Local arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are detailed within the Trusts Complaints, Concerns, and Compliments Policy

12. National priorities requiring a response

12.1 National priorities are set by the PSIRF, these priorities require a PSII to be conducted by the organisation.

12.2 The three categories of national priorities requiring local PSII: incidents that meet the criteria set in the Never Events list (2018); incidents that meet Learning from Death criteria; and Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Incidents that meet the criteria set in the Never Events list 2018

12.3 Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Incidents that meet the 'Learning from Deaths' criteria;

12.4 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.

12.5 Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care

12.6 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

12.7 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

12.8 Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Examples include 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.

12.2 National priorities to be referred to another team

12.2.1. 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 as follows, further details are provided below:

- Maternity and neonatal incidents
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes
- Deaths of patients in custody, in prison or on probation

Maternity and neonatal incidents:

12.2.2. 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/)

12.2.3. 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

12.2.4. All perinatal and maternal deaths must be referred to MBRRACE

Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge

12.2.5. These must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

Child deaths
12.2.6. For further information, see: *Child death review statutory and operational guidance*

12.2.7. Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities

12.2.8. Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

12.2.9. Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

Incidents in screening programmes

12.2.10. Incidents must be reported to the regional Screening Quality Assurance Service (SQAS) and commissioners of the service.

Deaths of patients in custody, in prison or on probation

12.2.11. 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.

Coroners' cases

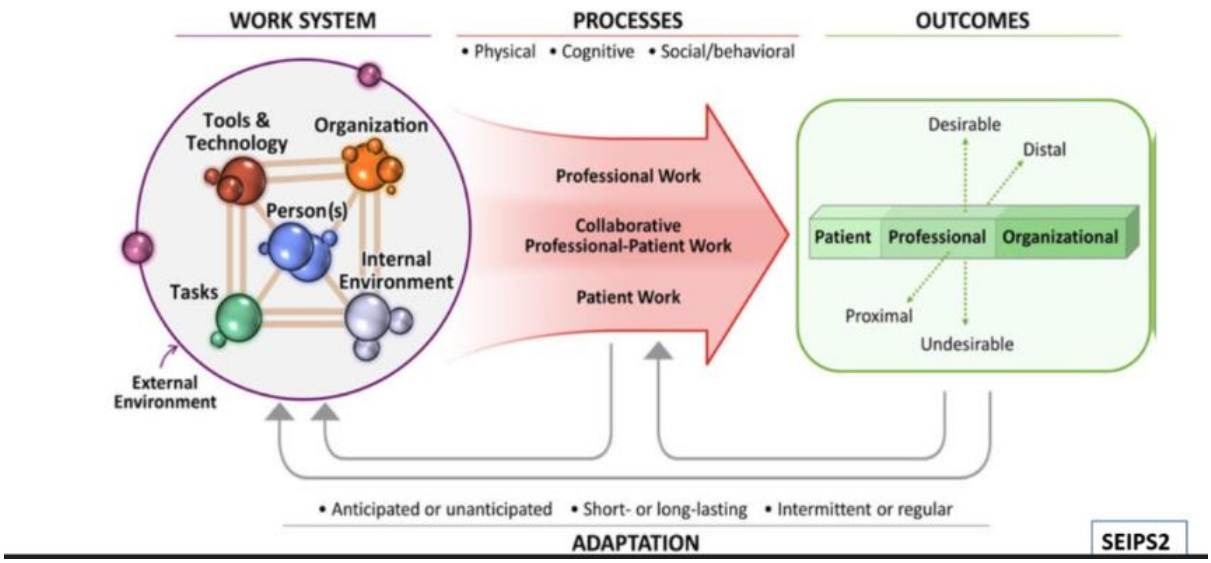
Incidents involving deaths in which there is coronial involvement should be identified at an early stage by the bereavement centre and the clinical team. Allocation of learning responses should take into consideration issues raised with the coroner (eg in the referral to the Coroner) and the

potential for learning which may prevent future deaths. It is irrelevant whether potential lapses in care identified in the incident contributed to this specific death. reports/ output should be suitable for submission by the legal team in anticipation of any potential inquest

12.3 Local Patient Safety Reviews

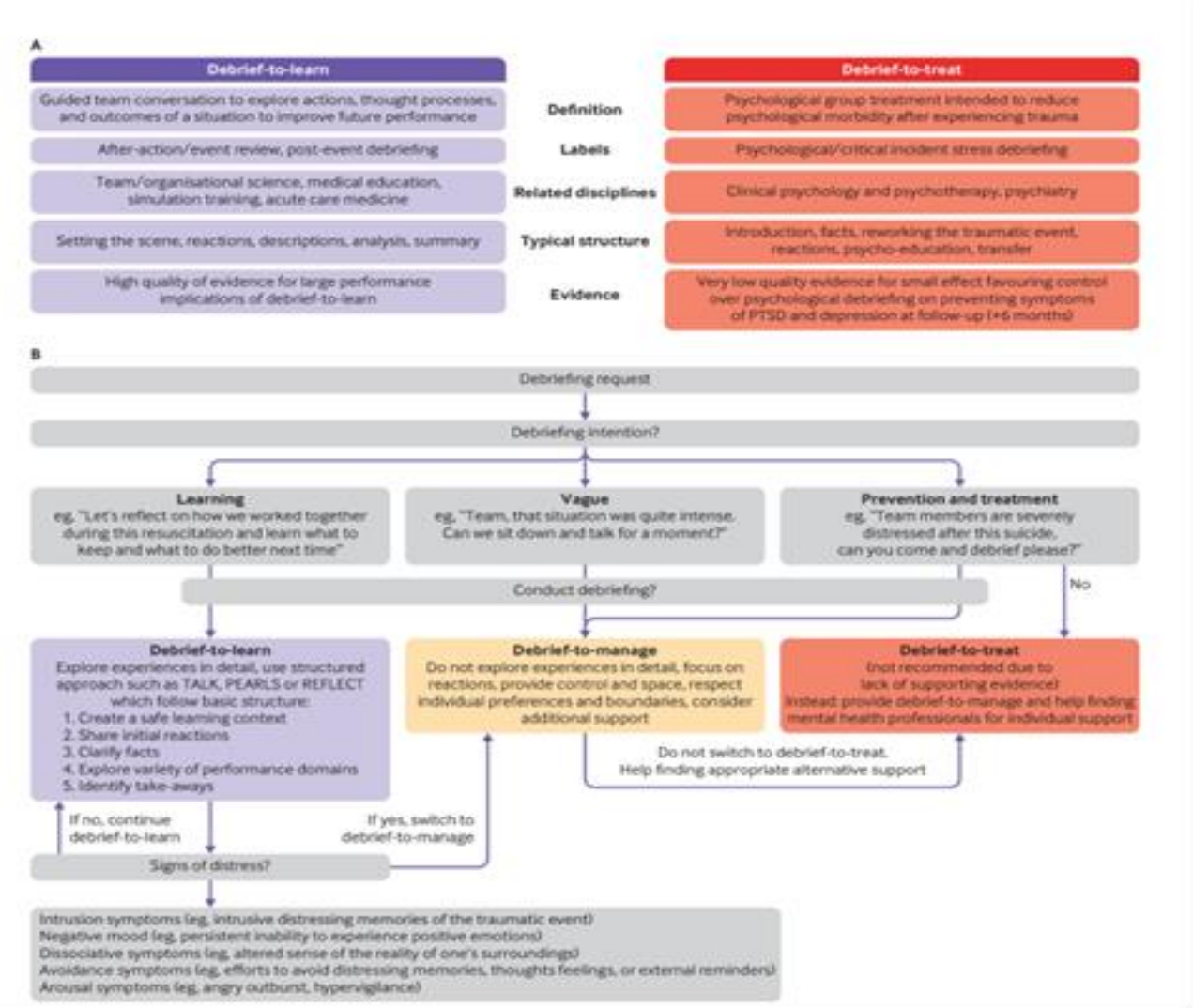
Much of the emphasis of PSIRF is on learning and improvement. This PSIRP has described how we have identified those areas we believe to have the most potential for learning and how we intend to use our resources proactively to investigate and learn from these priority areas and other areas which are identified in the future.
Patient safety events will continue to occur and this section describes the approaches which are available to respond to those incidents.

SEIPS underpins much of the PSIRF philosophy and, with reference to this, the response to a patient safety event should seek to address outcomes for patients (including relatives and carers), professionals and organisations in both the short and long terms. This approach supports the principles of Restorative Just Culture as outlines in Section 8.



SEIPS 101 and seven simple SEIPS tools | BMJ Quality & Safety

Balancing these priorities can be challenging as outlined in the figure below taken from a recent paper from the British Medical Journal (BMJ 2021;374:n2042 | doi: 10.1136/bmj.n2042)



12.3.1 Immediate response- incident recovery.

Objective	Methods
Ongoing Patient care • Address discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carers	Treatment as guided by agreed best practice. Escalate as required. Communicate according to Trust and professional standards. An apology is not an admission of liability.
Professional wellbeing • Signpost staff to appropriate support • Protect vulnerable staff from further harm	**Debrief** An unstructured, moderated discussion The simplest and most informal method to gain understanding and insight soon after

Service continuity To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied	an incident. Debriefs held immediately after an incident are known as 'hot' debriefs. If a debrief does not take place rationale and alternative arrangements should be captured.
Learning To provide a detailed, contemporary documentary account of what happened. This may form the entirety of the incident response or the basis for further action.	**Documentation** The details of the debrief conversation should be summarised, agreed and documented ideally in real time. Capture of multiple perspectives is important. We are not looking for a "single version of the truth" **Datix** Details of the incident, immediate outcomes, responses and ongoing safety issues should be captured on Datix as soon as reasonably possible.

12.3.2 Ongoing responses- follow-up and investigation

Objective	
Ongoing patient care • Address discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or care	**Duty of Candour** **The Family liaison Officer** (FLO) will provide support to patients & their families throughout the patient safety incident investigation and complaints processes, ensuring that they are treated with compassion, ensuring openness and transparency as equal partners
Professional wellbeing • Signpost staff to appropriate support • Protect vulnerable staff from further harm	Following initial normal stress response most people will recover. Some may already be showing signs of requiring further support and in others the incident follow-up may trigger recurrence of the stress response. Colleagues should be signposted to mental health first aiders, Trust wellbeing offers, TrIM practitioners, educational supervisors, professional practice advocates or other more formal psychological interventions.
	Some staff may want to be involved personally in the incident response others may not but they should be supported and offered the opportunity to review reports

	relevant to their involvement in the case before finalisation.
Learning **Systematic reviews** To determine • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient	Case record/ note review (eg RCP structured judgement review, falls, pressure ulcers, IPC reviews) A review conducted by a single or small number of trained reviewers according to an approved methodology (RCP SJR methodology was conceived for mortality review but is easily applicable to any clinical episode) to determine whether there were any problems with the care provided to a patient by a service. **Case series review** A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group. This methodology is used particularly in relation to deceased patients identified through mortality metrics.
Learning **Team reviews** • Identify areas for improvement • Celebrate success • Understand the expectations and perspectives of all those involved • Agree actions • Enhance teamwork through communication • **and collaborative** • **problem solving**	**Safety Huddle** A planned team gathering triggered by an event. An unstructured moderated discussion for those involved in the incident to regroup and talk about the event. Focussed on process-orientated reflection to propose actionable solutions. **After Action review (Learning Team)** A 'cold' structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt? This may or may not include people directly involved in an incident depending on the case. Representatives at this meeting should have familiarity with the case and the working environment. Expert opinions

	or further information may be required as determined by the discussion. This might require a second follow-up meeting to finalise the findings and agree recommendations.

12.3.4 Monitoring- Audit and proactive data collection

In addition to external (often regulatory) measure and metrics all services should have agreed programmes of audit, monitoring and metrics with associated reporting structures. Performance against these targets should contribute to our future PSIRPs this is a real-world example of the transition from Safety I (learning from what goes wrong) to Safety II (learning from all work). Rather than taking it for granted we should apply the same rigor to understanding success or positive deviance as we do to failure or negative deviance.

12.3.5 Themes and trends

12.3.6 Report Taxonomy

It is important that we continue to be able to identify themes and trends in real time. Whatever the method used to respond to an incident the output/ report should go beyond a simple description of the outcome and identify the processes and work systems that contributed:

Specific types of problem

1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)

2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)

3. Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)

4. Problem with infection control

5. Problem related to operation/invasive procedure (other than infection control)

6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)

7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))

8. Problem of any other type not fitting the categories above

Adapted from NMCRR guide England_0.pdf (rcplondon.ac.uk)

For each problem identified (there may be more than one of each type) analysis should identify **contributing factors** according to the SEIPS model People, Environments, Tools and Tasks (PETT) scan

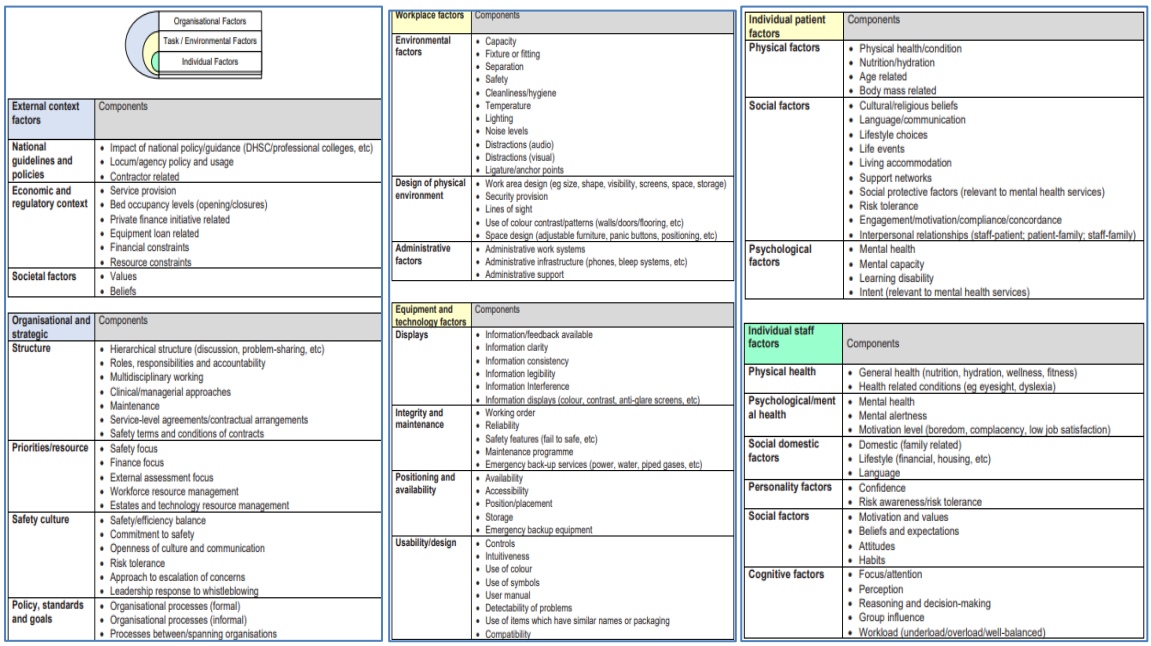
An example is shown below from [SEIPS 101 and seven simple SEIPS tools (bmj.com)]

Table 1 Examples of PETT scan

	Example: patient work **System factors associated with transitions and rehospitalisations among patients discharged following abdominal surgery***		Example: clinician work **System factors associated with tele-ICU nurses' job performance†**		Example: collaborative work **System factors associated with family engagement in the paediatric hospital bedside rounding process‡**	
Work system factors	**Barriers**	**Facilitators**	**Barriers**	**Facilitators**	**Barriers**	**Facilitators**
People ○ Patients ○ Healthcare professionals ○ Others	Poor understanding of what would be needed once back at home			Sharing nursing knowledge with bedside ICU nurses	Lack of communication skills of clinicians Parent fatigue	Parent knowledge of their child's condition
Environments ○ Physical ○ Socio-organisational ○ External		Collaboration from clinician: follow-up call after discharge to help patient with recovery at home	Lack of acceptance of tele-ICU by ICU staff	Positive teamwork and collaboration between tele-ICU and ICU Quiet work environment	Interruptions and noise affecting team communication	
Tools	Too many educational materials		Too many logins in multiple health information systems	Access to comprehensive information on patient	Computer as a physical barrier to communication	Use of computer to present and share visual information such as X-ray
Tasks	Receiving inadequate or incomplete instructions about patient care at home		Missing direct patient care in the ICU	Challenging and interesting job content because dealing with various ICU patient problems		Introduction of all team members and their roles
Interactions between people, environments, tools and tasks	Negative interaction in the discharge process: patients receiving insufficient instructions (*tasks*) in a hurried manner (*environments*), therefore not understanding what will be needed for home recovery (*people*)			Positive interaction between tele-ICU and ICU (*organisational environment*) facilitates communication and sharing of information (*tasks*)	High clinician workload (*environments*) may limit their availability and participation in bedside rounding, therefore affecting information exchange and communication (*tasks*)	

*Adapted from Acher *et al*'s study of system factors contributing to readmissions of surgical patients.[22]
†Adapted from Hoonakker *et al*'s study of tele-ICU nurses.[24]
‡Adapted from Carayon *et al*'s study of family engagement in bedside rounds in a paediatric hospital.[23]
ICU, intensive care unit; ;PETT, people, environments, tools and technologies.

Use of this taxonomy will allow us to establish themes across a range of sources of safety information. This taxonomy should be reflected in the next iteration of our Datix incident management platform. A comprehensive list of contributory (and mitigation) factors recommended by NHSE can be found at [https://www.england.nhs.uk/wp-content/uploads/2020/08/PSII_Contributory_and_Mitigation_Factors_Classification.pdf]. A representative extract is shown in the figure below.



External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information Interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

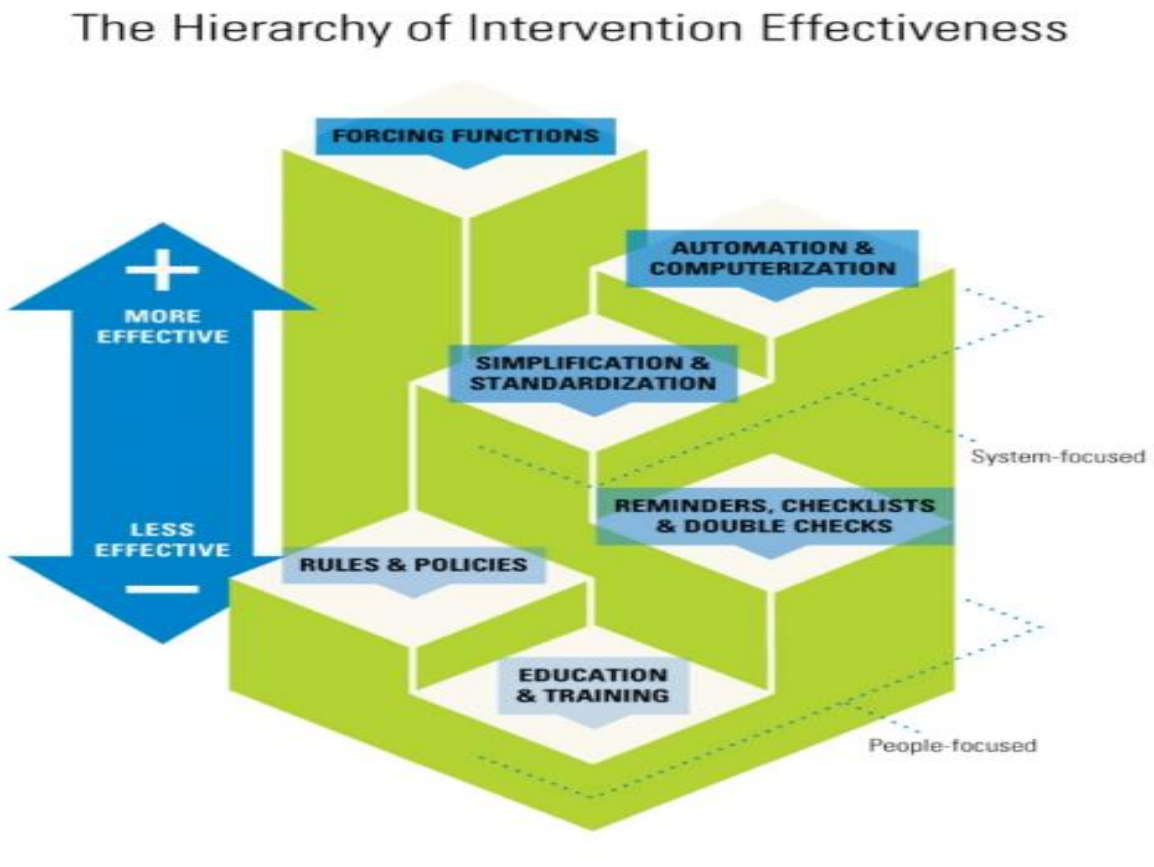
Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

12.3.7 Recommendations, Action planning and Monitoring

Establishing an agreed taxonomy to describe care and service delivery problems and their contributing factors also has relevance to the drafting of recommendations and the formation of action planning. If we are to move beyond the much-criticised “name, blame, shame, retrain” paradigm of responding to safety incidents we must understand that different problems may require different solutions depending on the context. Some interventions are easy to implement but have limit effectiveness- as described in the hierarchy below (The Hierarchy of Intervention

Effectiveness – patientsafe (wordpress.com)



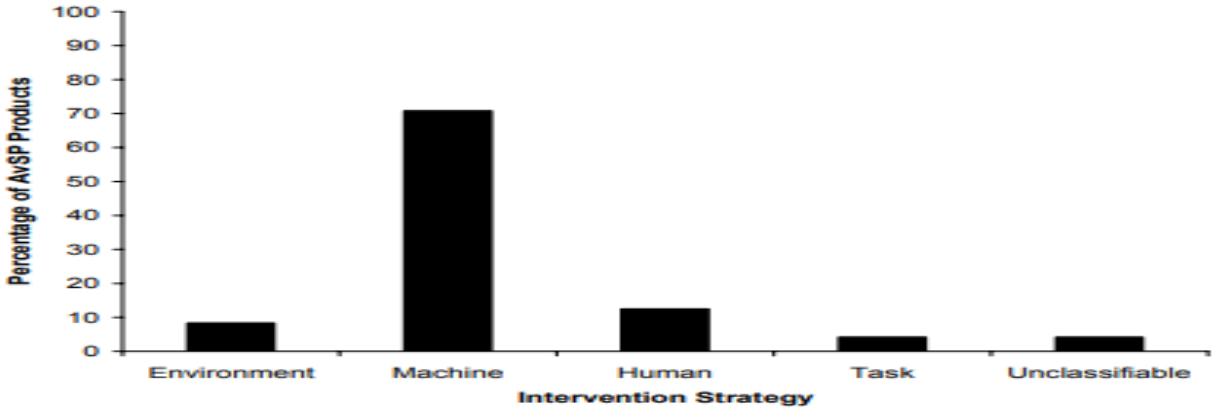
Whilst some interventions are not appropriate at all as described by Michie et. al (From Theory to Intervention: Mapping Theoretically Derived Behavioural Determinants to Behaviour Change Techniques Applied Psychology Vol 57 Issue 4 October 2008 p 660-80)

Technique for behaviour change	Techniques judged to be effective in changing each construct domain										
	1	2	3	4	5	6	7	8	9	10	11
Goal/target specified: behaviour or outcome											
Monitoring											
Self-monitoring											
Contract											
Rewards; incentives (inc. self-evaluation)											
Graded task, starting with easy tasks											
Increasing skills: problem-solving, decision-making, goal-setting											
Stress management											
Coping skills											
Rehearsal of relevant skills											
Role-play											
Planning, implementation											
Prompts, triggers, cues											
Environmental changes (e.g. objects to facilitate behaviour)											
Social processes of encouragement, pressure, support											
Persuasive communication											
Information regarding behaviour, outcome											
Personalised message											
Modelling/demonstration of behaviour by others											
Homework											
Personal experiments, data collection (other than self-monitoring of behaviour)											
Experiential: tasks to gain experiences to change motivation											
Feedback											

	Agreed use
	Uncertain
	Disagreement
	Agreed non-use

1	Social/Professional role and identity
2	Knowledge
3	Skills
4	Beliefs about capabilities
5	Beliefs about consequences
6	Motivation and goals
7	Memory, attention, decision processes
8	Environmental context and resources
9	Social influences
10	Emotion
11	Action planning

In turn it should be possible to track our responses across the system in terms of which techniques and interventions have been used and have been effective as has been proposed in more mature safety management systems. The figure below from Shappell and Weigmann's paper (Proceedings of the Human Factors and Ergonomics Society Annual Meeting 1071-1813 http://dx.doi.org/10.1080/10508410902983904) illustrates the distribution of interventions (products) from NASA's aviation safety programme (AvSP).



This broadly follows the PETT model, although with slightly different terminology.

13. Appendix B: Themes from Trust wide engagement sessions