Patient safety incident response plan v1

Effective date:

Estimated refresh date:

	NAME	TITLE	DATE
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Contents

Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Salisbury NHS Foundation Trust (SFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The 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.

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

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

The plan is underpinned by our trust policies on adverse reporting available to all staff via our organisation's SALi.

There are five national strategic aims of PSIRF upon which this plan is based, alongside national strategic objectives. The strategic aims and objectives have been aligned with our own Trust values (see table 1), which describe how we will work towards our strategic priorities of:

- Improving the health and well-being of the **Population** we serve
- Working through **Partnerships** to transform and integrate our services
- Supporting our **People** to make Salisbury NHS Foundation Trust the Best Place to Work

Our strategic priorities help us to deliver our vision which is:

'To provide an outstanding experience for our patients, their families and the people who work for and with us'

Table 1: National PSIRF aims, and objectives aligned to SFT's values

SFT Values	PSIRF Strategic Aims	PSIRF Strategic Objectives
Person Centred & Safe Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.	Improve the safety of the care we provide to our patients and improve our patients', their families' and carers' experience.	Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.
Professional We will be open and honest, efficient and act as role models for our teams and our communities. **Friendly** We will be welcoming to all, treat people with respect and dignity and value others as individuals.	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.	Develop a climate that supports a just culture [3] and an effective learning response to patient safety incidents.
Responsive We will be action oriented, and respond positively to feedback.	Improve the experience for patients, their families, and carers wherever a patient safety incident or the need for a PSII is identified	Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to: • make PSIIs more rigorous and, with this, identify causal factors and system-based improvements engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors • develop and implement improvements more effectively • explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally

Progressive We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.	Improve the use of valuable healthcare resources Further develop systems of care to continually improve their quality and efficiency.	Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigor, expertise and efficacy.

Our services

SFT is part of the Bath and North-East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). As part of our Trust strategy, services had previously been mapped, hence there was no need to undertake this activity again for the purposes of developing our PSIRP. Our hospital, Salisbury District Hospital (SDH), delivers a broad range of clinical care and services to approximately 270,000 people in Wiltshire, Dorset and Hampshire including:

- Emergency and planned inpatient services
- Day case services
- Outpatient services
- Women & Newborn and Paediatric services
- Diagnostic and therapeutic services
- Specialist rehabilitation, plastics and burns services - Specialities such as burns, plastic surgery, cleft lip and palate, spinal and our Wessex Rehab unit, extend to a much wider population of more than three million people.

Further information about our organisation can be found on the SFT website. (Add link to SFT website, Comms to do at point of being published)

Defining our patient safety incident profile

The patient safety risk process is a collaborative development. To define the SFT patient safety incidents and responses for 2023/24 the following stakeholders were involved:

- People (Staff) – through the incidents reported on SFT's Datix incident system, as well as data gathered from individual focus groups
- Population (Patient groups) – through a review of the thematic contents of complaints and Patient Advice and Liaison Service (PALS)
- Partnerships (Commissioners/ICS partner organisations) – through partnership working with the ICS patient safety and quality leads and BSW acute Trusts

SFT aims to incorporate wider patient perspective into future patient safety investigation response planning through the introduction of patient safety partners (PSP), in alignment with the National Patient Safety Strategy.

More information on the national PSP programme can be found on the NHS England website: https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

The SFT patient safety incidents were identified through the following data sources:

- Analysis of two years' of Datix incident data 2021-2023
- Detailed thematic analysis of Datix incident data 2021-2023
- Key themes from complaints/PALS/claims/inquests
- Themes from the learning from deaths reviews undertaken in 2021-2023
- Themes for serious incident and clinical reviews 2021-2023

As a result of stakeholder engagement and data source analysis, table 2 identifies our top 10 patient safety incidents.

Table 2: SFT's top 10 patient safety incidents

	Incident type	Specialty	Rationale
1	Pressure Ulcers (Workstream 1)	Trust wide	Pressure injuries are one of the top 5 patient safety incidents and an increase has continued to be seen. Some due to the level of harm have met the requirement for SII, others have formed a 'cluster' review. They were also noted in the care theme emerging from complaints and concerns. A new pressure ulcer workstream has been established in view of the increasing number.
2	In-patient Falls (Workstream 2)	Trust wide	Patient falls were the most reported patient safety incident category. Some due to the level of harm have met the requirement for SII. Falls is noted as a trust level risk and as such is included as a current 'breakthrough' objective' in our "Improving Together" programme. They have been noted in the outcome of inquests and are recognised in the care theme emerging from complaints and concerns. There is an established falls workstream which is engaging staff from the clinical areas.
3	Medication	Trust wide	Medication issues have been picked up as a theme through SII reviews. They are also the 3rd most reported patient safety incident; with the administration and errors during the prescribing process being the 2 highest sub-groups. An emerging theme is the recent introduction of an electronic medication management module (ePMA) and the change in practice. Complaints and concerns indicate that medication and pain management is a patient safety theme. There is a medicines safety group, which has good engagement from the Pharmacy Team, who are also looking to engage greater input from the clinical areas.

	Incident type	Specialty	Rationale
4	Clinical assessment (investigations, images and lab tests).	Trust wide	Incidents relating to laboratory investigations is the highest reported sub-group and within that, patient incorrectly identified is the highest reported.
5	Discharge – planning failure	Trust wide	Identified as the 6th highest reported patient safety incident on Datix, with planning failure one of the highest sub-groups. It is a key theme in complaints. External incidents (including safeguarding incidents) raised due to errors in the discharge process. It has been recognised as a contributory factor in investigations.
6	Appointments – failure in referral/booking processes	Trust wide	Failure in referral or booking processes are the highest reported sub-groups around appointments. These have also been identified as themes through complaints and through serious incident investigations, e.g. lost to follow up.
7	Obstetrics	Women and Newborn	Whilst recognising the significant smaller proportion of reported incidents in the maternity department compared to the wider organisation, due to the size of the department, by allocating a figure for relative comparison based on a per 1,000 patient activity (at Division level) this identified the number of incidents reported is comparable to that of the wider organisation. Through the SII process as well as information from National Maternity Services reviews, there is evidence of on-going concerns relating to various areas including CTG interpretation and post-partum haemorrhage.
8	Infection Control- Hospital acquired infection	Trust wide	Throughout the Covid pandemic, SFT witnessed an increase of patients admitted with Covid-19 infections, alongside the rest of the NHS. Aside from this, there is a continuous need to monitor and identify other Healthcare Associated Infections as a matter of course, in order to prevent and reduce the burden of HAIs on our patients and the Trust.
9	Implementation of care (Workstream 4)	Trust wide	Delay or failure to monitor is the second highest reported subgroup of implementation of care. Data has evidenced that suboptimal recognition of the deteriorating patient is due to a failure to monitor in accordance with recognised guidelines. This has also been seen as a significant theme in commissioned serious incident investigations.

	Incident type	Specialty	Rationale
10	Communication (Workstreams 3)	Trust wide	Communication between staff, teams and departments is a highly reported incident across all stages of care. Communication failure outside of the immediate team and inadequate handover of care being the highest reported sub-groups.

Defining our patient safety improvement profile

There are 2 national patient safety improvement programmes in place, as identified in table 3.

Table 3: National patient safety improvement programmes

	***National* patient safety incident improvement plan/scheme title**	**Oversight Forum**
1	Maternity and Neonatal Safety Improvement Program (MatNeoSip)	Patient Safety Steering Group (PSSG)
2	The Medicines Safety Improvement programme (MSIP)	PSSG

Of the top 10 patient safety incidents identified (table 2 above), we were able to classify incident types that already have a local patient safety improvement workstream in place at SFT (see table 4). These workstreams have been commissioned based on learning from previous investigations under the current serious incident investigation framework, datix analysis or emerging themes.

Table 4: SFT's local patient safety improvement workstreams in place

	***Local* patient safety incident improvement plan/scheme title**	**Specialty**	**Oversight Forum**
1	**Workstream 1** – Pressure Ulcers	Trust wide	PSSG
2	**Workstream 2** – Inpatient Falls	Trust wide	PSSG
3	**Workstream 3** – Reducing the loss of clinical information following transfer of care (SBAR)	Trust wide	PSSG
4	**Workstream 4** – Reducing harm from unrecognised patient deterioration. There are 6 subgroups to this: • Neurological assessment – Achieve 95% compliance with accurate documentation of ACVPU assessment • Develop a Trust wide education strategy for the early recognition of deterioration (non-medical) • Improve compliance with the use of MEOWS in ED and AMU • Sepsis – Achieve 95% compliance with the prescribing and administration of antibiotics within 60 minutes of diagnosis. • Introduction of PEWS scores in the paediatric population • Improving escalation/response to escalation	Trust wide	PSSG

Of the top 10 patient safety incidents identified (table 2 above), those without a current workstream will be addressed through our local Patient Safety Incident Investigation (PSII) or Patient Safety Review (PSR) process, as described later in the plan.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e. incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Incidents requiring other types of investigation and decision-making, which lie outside the scope of PSIRF, will be appropriately referred as follows:

- professional conduct/competence – referred to human resources (Organisational Development and People teams)
- establishing liability/avoidability – referred to legal team
- cause of death – referred to the coroner's office
- criminal – referred to the police

Table 5 below sets out the national or local mandated responses.

Based on our analysis of patient safety incidents we have accounted for 10 PSII's meeting the national mandated criteria.

Table 5: Local and National Mandated PSII responses

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally-led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally-led PSII
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII (see Appendix 3)
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the Panel review
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the Panel review
6	Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards

7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death 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 providers must fully support these investigations where required to do so
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required

Our patient safety incident response plan: local focus

SFT considers that all of the ten incident types set out in table 2 have relevance for all our inpatient and outpatient services (including maternity). To this end this is an organisation wide PSIRP and there are no separate PSIRP's for individual services (the exception to this being maternity specific incidents as per national requirement).

Patient Safety Incident Investigation (PSII)

PSII's are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents. There is no remit in PSII to apportion blame or determine liability, preventability or cause of death.

Locally defined incidents requiring PSII *(see Appendix 1: Quick guide to locally defined priorities for patient safety investigation)*

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

   Based on our analysis of patient safety incidents we have accounted for 5 PSII's meeting this criterion.

b) **Locally predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII for the period 2023-25 have been identified by SFT through analysis of local data and intelligence from the past two years and agreed with BSW ICB as a local priority (see highlighted in table 6). This has been done in line with the following national guidance relating to criteria for selection of incidents for PSII:

   i. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)
   ii. likelihood of recurrence (including scale, scope and spread)
   iii. potential for learning in terms of:
      - enhanced knowledge and understanding
      - improved efficiency and effectiveness (control potential)
      - opportunity for influence on wider systems improvement.

Any incident type identified as having a local patient safety improvement workstream in place at SFT have been excluded from further PSII (as per national guidance). These incidents will either have a datix response (low harm) or a Patient Safety Review (moderate harm or above) and findings fed into the relevant workstream.

There is no control over when a national PSII may be required but incidents potentially meeting locally-led PSII criteria can be randomly selected over a period of time (as identified in table 6), which will help manage capacity for PSII completion.

Table 6: SFT's locally identified incidents for PSII

	Incident type	Description	Response type and number to be undertaken	Sampling technique
1	Pressure Ulcers (Workstream 1)	Hospital acquired: • Cat 2 & MASD • Multiple Cat 2, Cat 3 & 4, unstageable, DTI and deterioration of a non-hospital acquired pressure ulcer e.g. 2 to 3, 3 to 4	Datix response PSR (Workstream 1)	
2	Falls (Workstream 2)	In patient falls; • low harm • resulting in a bone fracture or haemorrhage	Datix response PSR (SWARM) (Workstream 2)	
3	**Medication**	Any incident relating to administration of the medication	**PSII 3 – 6** Datix response PSR	• One incident in week 1 of calendar quarter • Aim for a no harm and mixed level of harm
4	**Clinical assessment (investigations, images and laboratory tests)**	Any incident relating to a wrongly identified patient at ward level having a laboratory test	**PSII 3 - 6** Datix response PSR	• One incident in week 2 of calendar quarter • Aim for a no harm and mixed level of harm
5	**Discharge**	Any incident identifying a breakdown in the discharge planning process	**PSII 3 – 6** Datix response PSR	• One incident in week 3 of calendar quarter • Aim for a no harm and mixed level of harm
6	**Appointments**	Any incident identifying a breakdown in the referral process	**PSII 3 – 6** Datix response PSR	• One incident in week 4 of calendar quarter

	Incident type	Description	Response type and number to be undertaken	Sampling technique
				• Aim for a no harm and mixed level of harm
7	**Obstetrics**	Any incident identifying a failure in undertaking a risk assessment	**PSII 3 – 6** PSR	• One incident in week 4 of calendar quarter • Aim for a no harm and mixed level of harm
8	Infection Control- Hospital acquired infection	Hospital acquired infection	Datix response PSR (PSIRF approach work in progress)	
9	Implementation of care (Workstream 4)	Reducing harm from unrecognised patient deterioration	Datix response PSR (Appropriate sub-group of Workstream 4)	
10	Communication	Reducing the loss of clinical information following transfer of care (SBAR)	Datix response PSR (Workstream 3)	

In accordance with national guidance, the number of PSII planned in response to each incident type has been restricted to 3 – 6 to support in depth analysis and identification of common interlinked causal factors. To support the identification of common causal factors, incident types are narrowly defined. This means from a large group of incidents, a smaller subset of incidents (which may be specific to an area, process, and/or presentation of a patient or other characteristic) will be identified.

This process is a valuable and thorough way of accomplishing thematic analysis of PSII findings in a select recent and very similar incidents. The findings from each individual investigation are then collated, compared and contrasted to identify common causal factors and any common interconnections or associations upon which effective improvements can be designed.

Our resource modelling for Learning Response Leads (LRL) allows for 3 PSII's per incident type but the need to be flexible when first transitioning and understanding the new process fully may require more.

Overall, an estimate of annual PSII activity when first transitioning to PSIRF and working to a PSIRP has been identified as 30, broken down to:

- National requirements = 10
- Emerging incidents = 5
- Locally defined = 15

The analysis and the proposed priorities for PSIIs were submitted to the PSIRF Implementation Group and the Clinical Management Board for discussion and agreement, prior to the full plan being completed and circulated for approval and sign-off through internal and external governance processes.

Patient Safety Review (PSR)

Under the term PSR, it is important to move away from the language of 'investigation'. Some patient safety incidents may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used can be found in Appendix 2.

All patient safety incidents which have resulted in moderate harm or above will require a PSR as a minimum to support the statutory Duty of Candour process, thus ensuring we do not breach regulatory requirements (Regulation 20). 'Being open' conversations (see Appendix 2) can support this process. Whilst SFT adopts the PSIRP and becomes familiar with it, a PSR review will be completed and presented at Patient Safety Summit for anything identified in the PSIRP as requiring local PSII. When confidence in the process is established, there may no longer be a requirement for this. We would aim to review this process in the first 6 months of implementation. Significant near miss incidents will also have a PSR. The expectation is that PSRs will be completed in conjunction with the appropriate subject matter experts.

For information purposes, any non-clinical incident where patient safety has not been compromised, but it is still a significant near miss or moderate or above, the ward or department may choose to use one of the tools identified in Appendix 2 to support the Datix response.

For all other low harm patient safety incidents and non-clinical incidents, the response will be managed through validation of facts at a local level i.e. ward/departmental level (unless it meets the PSII criteria outlined in the plan) and findings completed on Datix, as per existing Trust processes around reviewing and closing down Datix incidents.

It is recognised that PSR's bring some new methodologies that SFT staff may not be familiar with. The use of a new methodology e.g. After Action Review (AAR), will not be utilised until the appropriate training has been provided and we are in a position to adopt effectively. We would plan to procure (if required) any training required within 6 – 9 months of going live with our PSIRP.

Maternity Specific

The Guide to responding proportionately to patient safety incidents states that organisations with maternity services should include in their PSIRP how they intend to respond to the different types of non-HSIB referred maternity patient safety incidents and, as with other services, use the guidance and processes outlined in the PSIRF and its supporting documents to do so.

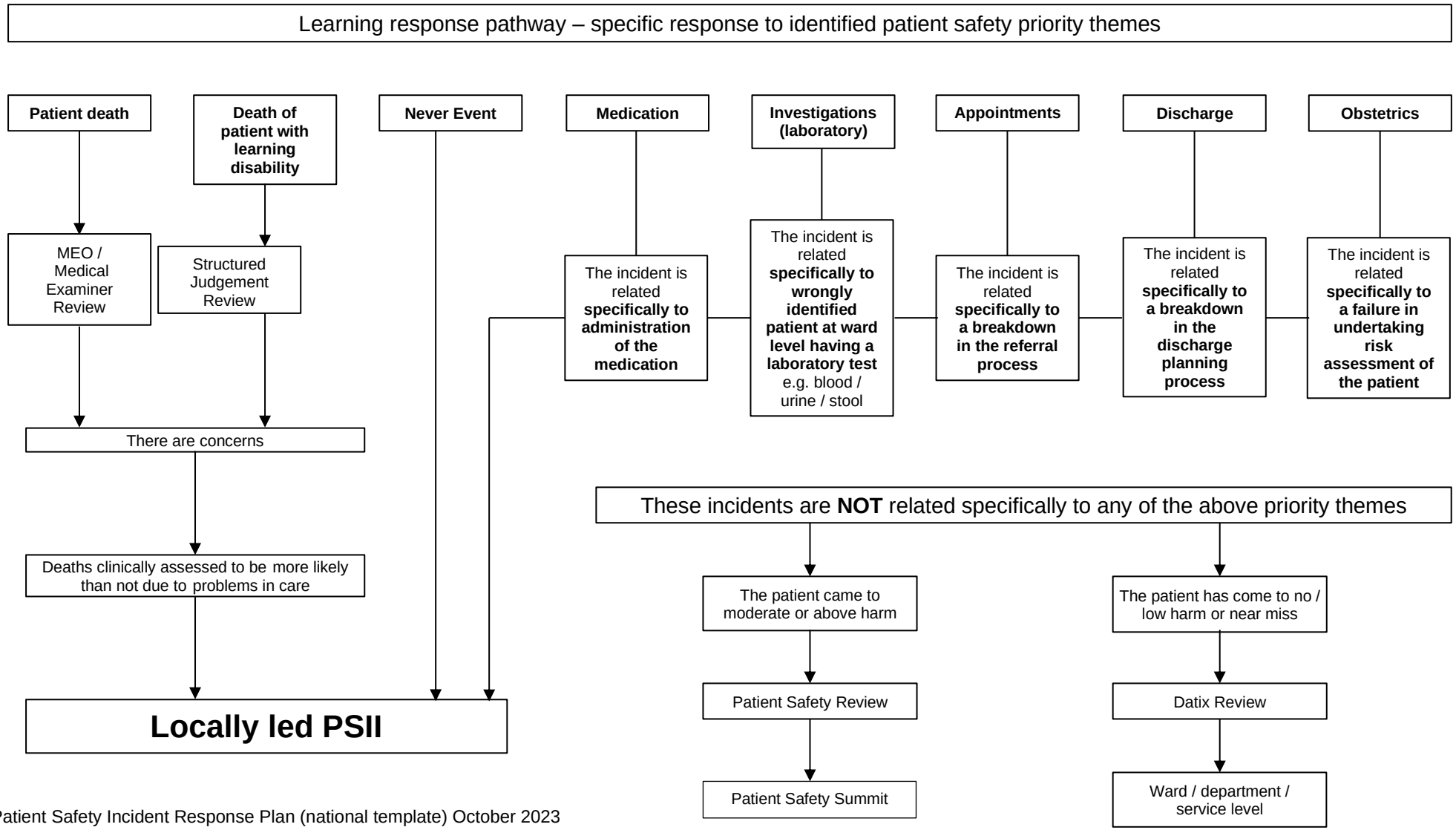
Table 8: Maternity specific PSR process

Maternity Triggers	Proposed PSR methodology
Maternal death	HSIB (in line with national guidance) or a local PSII
Maternal admission to ITU (unplanned)	PSR template for Patient Safety Summit (PSS)
Maternal collapse e.g. eclampsia, anaphylaxis, cardiac arrest	PSR template for PSS
Massive Obstetric Haemorrhage - Blood loss >1500ml	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Significant event e.g. hysterectomy, uterine rupture, bladder trauma	PSR template for PSS
Lost clinical material e.g. swab or instrument	PSR template for PSS PSII (if retained foreign object as would meet never event criteria)
Anaesthetic complication e.g. dural tap, nerve injury, failed intubation	PSR template for PSS
Transfer in from home birth or Birth out of hospital	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Third or fourth degree tear - case review if no episiotomy	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Shoulder dystocia - case review if any harm to baby	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Attempted instrumental delivery leading to CS	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Maternal readmission	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Venous thromboembolism in pregnancy or <6/52 postnatal	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Delay in treatment >24hrs – IOL or Elective LSCS	Continuous case by case audit PSR template for PSS if findings identify omissions in care
Non-attendance by Consultant (as per local agreement)	Datix response PSR template for PSS if findings identify omissions in care

Neonatal Triggers	
All Neonatal death	HSIB (in line with national guidance). For congenital abnormality PSR template for PSS
Antepartum or Intrapartum Stillbirth. Any fetal loss (except planned TOP)	PSR template for PSS (followed by PMRT) (and HSIB as per criteria if indicated)
Unexpected transfer of neonate to tertiary care	Datix response PSR template for PSS if findings identify omissions in care (followed by M&M-Perinatal)
Term admission to NICU	ATAIN (case note review) PSR template for PSS if findings identify omissions in care.
Birth trauma e.g. laceration, fracture, nerve injury	PSR template for PSS
Undiagnosed fetal anomaly	PSR template for PSS
Neonatal Neurological issue e.g. seizures, HIE, intraventricular haemorrhage	PSR template for PSS (and HSIB as per criteria if indicated)
Severe neonatal respiratory issue e.g. pneumothorax, ventilation >48hrs	PSR template for PSS
Arterial cord gas pH<7.0 BE-10.0	PSR template for PSS
Apgars less than 7 @ 5 mins	PSR template for PSS
Severe neonatal infection (e.g. line infection, necrotising enterocolitis, missed GBS, meningitis, HSV)	PSR template for PSS
Pathological jaundice (e.g. ABO (blood groups) incompatibility, antibodies)	PSR template for PSS
Trust Triggers	
Patient fall or injury	Note: as these are some of the Trust triggers for reporting, these will be addressed in accordance with the wider PSIRP.
Equipment unavailable or failure	
Staffing or acuity problem-	
Data protection or security issue	
Blood transfusion reaction, wasted blood, issues with crossmatch	
Pressure ulcer	
Medication error	
Staff injury e.g.: Needlestick injury	
Patient or visitor injury	
Violence or aggression from patient or visitor	

Earlier in the plan, Table 4 identified current improvement workstreams in progress at SFT. Moving forward with PSIRF, how we will use learning from PSIIs and PSRs to inform improvement and decisions about how the improvement will be commissioned and delivered, will be addressed in the 'Safety action development and monitoring improvement' and 'Safety improvement plans' sections of our Patient safety incident response policy. This policy will also detail the governance and quality monitoring arrangements around PSIRF and our PSIRP.

Appendix 1: Quick guide to locally defined priorities for Patient Safety Investigation (PSII)



Appendix 2 PSR Methodologies

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	To review the care of a person with a learning disability (recommended alongside a case note review).

Technique	Method	Objective
Perinatal mortality review tool	Specialist review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Mortality review	Specialist review	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 a specific patient group, particularly in relation to deceased patients.
Transaction audit	Audit	To check a trail of activity through a department, etc, from input to output.
Process audit	Audit	To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended
Outcome audit	Audit	To systematically determine the outcome of an intervention and whether this was as expected/intended
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (e.g. clinical, safety, business).

Appendix 3 HSIB referral criteria

The HSIB maternity programme investigates cases of:

- early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England
- maternal death in England.

Babies

Babies who meet our criteria to be referred to us by NHS trusts for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:

- intrapartum stillbirth
- early neonatal death
- potential severe brain injury

HSIB do not investigate cases where health issues or congenital conditions (something that is present before or at birth) have led to the outcome for the baby.

The definition of labour used by HSIB includes:

- Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation.
- When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking).
- Induction of labour (when labour is started artificially).
- When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

This means that for HSIB to investigate a maternity incident under the HSIB criteria, the mother must have been in term labour as defined by these conditions.

HSIB do not investigate neonatal cases where the mother has not gone into labour. For example, when a caesarean section was performed before the mother had started having contractions or ruptured her membranes.

Intrapartum stillbirth

Where the baby was thought to be alive at the start of labour and was born with no signs of life.

Early neonatal death

When the baby died within the first week of life (0-6 days) of any cause.

Potential severe brain injury

Potential severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
- Was therapeutically cooled (active cooling only). This is where the baby's body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

HSIB no longer routinely investigate cases involving therapeutically cooled babies where there is no apparent ongoing neurological injury following cooling therapy. This would usually mean a brain MRI showing no hypoxic damage (a type of brain injury that occurs when there is a disruption in supply of oxygen to the brain) and the baby demonstrating no ongoing neurological signs or symptoms. However, this remains as one of HSIB's criteria. NHS trusts should continue to refer cases to HSIB. HSIB decide which investigations proceed based on an individual baby's clinical outcome, after discussion with the family and the NHS trust.

Maternal deaths

HSIB investigate direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

HSIB may investigate some maternal deaths which do not entirely fit within these two categories.

HSIB do not investigate cases where suicide is the cause of death.

Direct deaths

Direct deaths include those resulting from obstetric complications of the pregnant state (pregnancy, labour and after the birth), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

Indirect deaths

Indirect deaths include those from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes but was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

Definitions

(1) page 2: The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.

(2) page 2: "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) https://www.health.org.uk/publications/improvement-science.

(3) page 4: A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture

Glossary

Acronym	Meaning
ACVPU	Alert Conscious Voice Pupils Unresponsive
AMU	Acute Medical Unit
ATAIN	Avoiding Term Admissions Into Neonatal units
BSW ICB/ICS	BANES, Swindon and Wiltshire Integrated Care Board/Integrated Care System
Cat	Category
CTG	Cardiotocograph
DTI	Deep Tissue Injury
DoC	Duty of Candour
ED	Emergency Department
FGM	Female Genital Mutilation
GBS	Group B Streptococcus
HAI	Hospital Acquired Infection
HSIB	Healthcare Safety Investigation Branch
HSV	Herpes Simplex Virus
IOL	Induction of Labour
ITU	Intensive Therapy Unit
LRL	Learning Response Leads
MASD	Moisture Associated Skin Damage

Acronym	Meaning
MEOWS	Maternity Early Obstetric Warning Score
M&M	Mortality and Morbidity (multidisciplinary meeting)
NICU	Neonatal Intensive Care Unit
PEWS	Paediatric Early Warning Score
PMRT	Perinatal Maternity Review Tool
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSII	Patient Safety Incident Investigation
PSP	Patient Safety Partners
PSR	Patient Safety Review
PSSG	Patient Safety Steering Group
SALi	Staff-Access-Learning-Information (formerly intranet)
SBAR	Situation Background Assessment Recommendations
SII	Serious Incident Investigation
TOP	Termination of Pregnancy