Patient Safety Incident Response Plan (PSIRP)

30 September 2023

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Patient Safety Incident Response Framework (PSIRF)

Foreword from our Clinical Services Director

"PSIRF is just a new framework" I hear you say. Well let me assure you it is so much more than that. It is more than just a new patient safety framework and new terminology; it represents a once in a generation chance to evolve the safety culture across healthcare - an immense and exciting opportunity!

It is a whole system change to how we think and respond to Patient Safety Incidents (PSIs). It moves away from focussing on mandated investigations, submitted to a precise timescale, concentrating instead on how to prevent the recurrence of a previous incident. It promotes the move to a system where, in accordance with the framework principles, we decide where the most learning can be achieved and which tools and processes to use, ensuring that the focus of any approach is learning and improvement.

Its bedrock is a just culture, where psychological safety is paramount, creating an environment which encourages all employees to feel able to highlight where they believe things could be improved, safe in the knowledge that the focus will be on learning and improving, not on retribution or blame.

As well as equipping employees with training on the new framework and the 'menu' of tools which can be chosen to support learning, we will also be providing them with the necessary skills to have difficult conversations about PSIs with each other and with patients and their families, in order to encourage everyone to be involved in incident responses and developing safety actions. In this way we can truly develop our services to meet the needs of those we care for.

We will also be ensuring emotional support is available to employees who support patients and their families throughout the response and learning processes following an incident, recognising the significant impact this can have on healthcare professionals as well as those directly affected by the incident.

Involving patients and their families centrally in our Quality Governance Team, through the recruitment of Patient Safety Partners is a key component of the new framework, and one of the most exciting. It is entirely supportive of our Nuffield Health values and will increase the patient voice across the organisation.

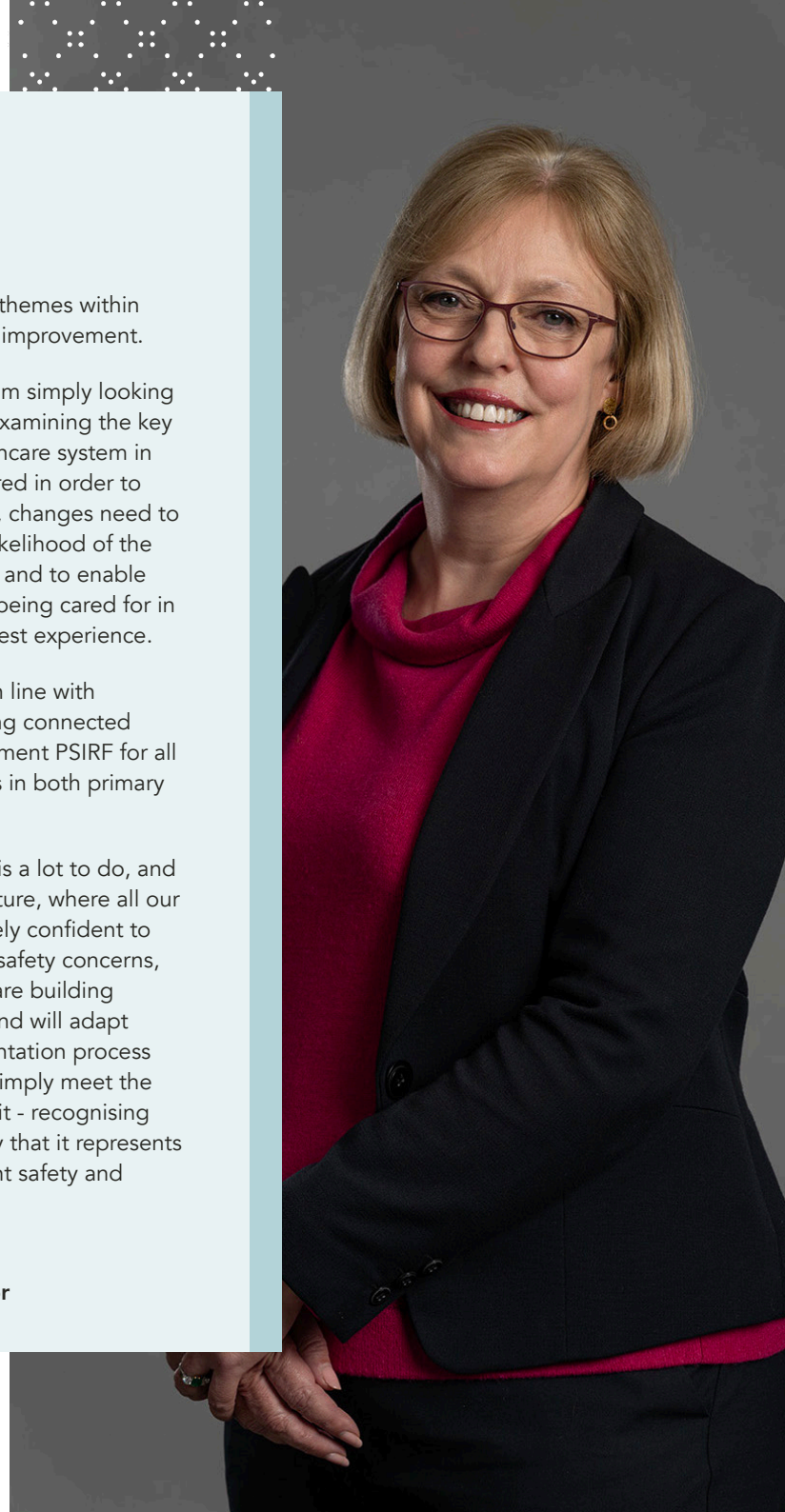
Whilst a key element of quality improvement is investigating individual incidents, so too is looking at repeated incidents of the same nature together and identifying any common themes within these to ensure ongoing improvement.

We will shift the focus from simply looking at what went wrong, to examining the key components of the healthcare system in which the incident occurred in order to identify what, and where, changes need to be made to reduce the likelihood of the incident being repeated, and to enable those both working and being cared for in the system to have the best experience.

Within Nuffield Health, in line with our strategy of developing connected healthcare, we will implement PSIRF for all NHS and private patients in both primary and secondary care.

We recognise that there is a lot to do, and that evolving our just culture, where all our employees feel completely confident to speak out about patient safety concerns, takes time, however we are building on a strong foundation and will adapt throughout the implementation process to ensure that we don't simply meet the requirement but exceed it - recognising PSIRF for the opportunity that it represents to further enhance patient safety and quality across our charity.

Alison McCourt
Clinical Services Director



1.0 Purpose, scope, aims and objectives

1.1 Purpose

1.1.1
This Patient Safety Incident Response Plan (PSIRP) describes how Nuffield Health intends to respond to, and learn from, adverse events involving patients (patient safety incidents – PSIs) reported by employees, patients and families (or carers) across its 37 hospitals over the next 12 to 18 months.

1.1.2
The PSIRP will continuously evolve as Nuffield Health learns from its experience within PSIRF. The Charity will remain flexible and consider the specific circumstances within which patient safety issues and incidents occurred and the needs of those affected by them.

The plan will describe the preparation phases the Charity has gone through in order to meet the transition date of 30 September 2023 including:

- Employee engagement and assessing the current confidence employees have in speaking up about patient safety, known within PSIRF as the 'just culture'.
- Data analysis and triangulation – looking at the types of PSIs which have occurred within the Charity to identify any themes and checking with the employees that these reflect their experience.
- Internal and external communication with employees, consultants, insurers, regulators and those who commission and use our services.
- Governance and quality monitoring and review processes – how we ensure we learn from PSIs and use this knowledge to improve our services and care delivery.
- Training – how we ensure our employees understand PSIRF and have the knowledge and expertise to conduct learning responses (investigations) to truly understand why a PSI has occurred.
- Patient and family engagement – how we ensure we involve anyone who has experienced a PSI, throughout the investigation in a compassionate and sensitive way and how we develop changes to our processes using their experience too.

1.1.3
The plan will also improve the Charity's effectiveness when it comes to the investigation of, and learning from, PSIs by:

a. Adopting a broader approach, known as 'systems analysis' to identify the factors which contribute to PSIs, rather than looking for a single point of failure i.e. someone to blame.

b. Focussing improvement activity on those areas which will have the maximum quality and cost benefit for the patients and the Charity.

c. Involving patients, families and employees in the learning response themselves in order to identify and develop meaningful safety improvement actions which reflect their input.

d. Ensuring learning responses and safety improvement actions are shared across the Charity to reduce the likelihood of the recurrence of similar PSIs to as low as reasonably practicable.

1.2 Scope

1.2.1
It should be noted that whilst Nuffield Health provides contracted services to the NHS, PSIRF will apply to any patient treated by the Charity. In addition, although within the NHS PSIRF does not include primary care, Nuffield Health has taken the decision to include their primary care services from the outset, to ensure consistency of approach for all PSIs, and to provide a larger pool of patient safety information from which to learn and improve.

As specified within PSIRF, this plan is charity-wide, covering Nuffield Health's 34 hospitals within England (as well as its one Welsh and two Scottish hospitals), our medical centres, primary care services run from our fitness and wellbeing centres and corporate sites; and our Manchester Institute of Health and Performance combining sports medicines and diagnostics. The hospitals all deliver planned surgery and outpatient services to a broadly similar patient demographic (group) and our primary care services are also broadly similar in nature.

1.2.2
The Charity has collaborated with the Leicester, Leicestershire and Rutland Integrated Care Board (ICB), with the approval of NHS England (NHSE), in order to fulfil the spirit of collaboration that is at the heart of PSIRF.

1.2.3
This plan is underpinned by Nuffield Health's Quality Assurance Framework; policies on adverse event reporting; Radar - the Quality Management System; and a specific PSIR Policy which provides all employees with further clarity on pathways for escalation, proportionate responses to PSIs, safety action development, safety improvement plans and monitoring improvement.

1.0 Purpose, scope, aims and objectives continued

1.3 Strategic aims

1.3.1
PSIRF has at its heart, four strategic aims which correlate with Nuffield Health's core CARE Values, as defined by the Charity's employees. These are illustrated in **Figure 1.**

1.3.2
The primary aim and ambition of this PSIRP is to develop a compassionate, just culture, which provides the psychological safety necessary for any employee member i.e. confidence that they will be heard and thanked, clinical or otherwise, to speak up about patient safety concerns they may have. This will improve their working environment and their experience of any learning responses or investigations.

This will also enable Nuffield Health to move from a position of reacting to PSIs, to one which reduces the likelihood of their occurrence to as low as possible, by modifying the systems within which care is being delivered.

1.3.3
A further aim is to involve the Charity's patients and families/carers in improving patient safety by both asking for their perception of the safety of the care delivered in the patient satisfaction survey they all receive after discharge, as well as involving them in their own incident investigations and associated learning. By engaging Patient Safety Partners (PSPs) to advise the Charity on its approach to, and learning from PSIs, we aim to enhance both the systems within which care is delivered and the experience of those receiving it.

1.3.4
Finally, the Charity wants to ensure that its valuable healthcare resources are used cost effectively and provide the safety and quality of care, its employees wish to deliver, and its patients and families should expect to receive.

Figure 1: Nuffield Health CARE Values and PSIRF Strategic Aims

CARE Values		PSIRF Strategic Aims
C	**Connected** We work together as one Nuffield Health to deliver the best experience to our patients, customers and colleagues	**Improve the safety of the care we provide to our patients**
A	**Aspirational** We inspire individual and collective health and wellbeing	**Improve the use of valuable healthcare resources**
R	**Responsive** We listen, communicate and act in an open, straightforward way	**Improve the experience for patients, their families and carers wherever a PSI or the need for a PSI investigation (PSII) is identified**
E	**Ethical** We demonstrate our commitment to individuals, our communities, society and the environment	**Improve the working environment for employees in relation to their experiences of PSIs and investigations**

1.0 Purpose, scope, aims and objectives continued

1.4 Our PSIRF Strategic objectives

1.4.1
Building a healthier nation is Nuffield Health's overall purpose. The Charity aims to do this by supporting the individuals who need us, and the communities they are part of, to achieve, maintain and recover to the level of wellbeing they aspire to.

The three pillars of the Nuffield Health Quality Assurance framework as shown in **Figure 2**, are key to enabling us to achieve this purpose:

1.4.2
To react positively to feedback from patient's, families and employees about their satisfaction, or otherwise, with any learning responses or PSI investigations within the Charity.

1.4.3
To evolve our just culture, providing the psychological safety and compassionate engagement which encourages employees, patients and their families to express concerns both about potential safety concerns or PSIs in which they have been involved. The objective being to either prevent harm, or to develop more effective learning responses and safety actions where a PSI has occurred.

1.4.4
To maximise the effective use of the resources available to improve safety and quality across the Charity through the use of proportionate responses to PSIs by:

- Recognising that systems analysis in relation to PSIs will produce more robust learning and improve outcomes
- Engaging all those involved in PSIs in their investigation and learning responses in order to truly understand the issues and contributory factors involved
- Developing a robust, data-driven Quality Improvement Programme
- Understanding the optimal way of sharing learning responses and embedding safety actions across the Charity to effect the greatest safety improvement.

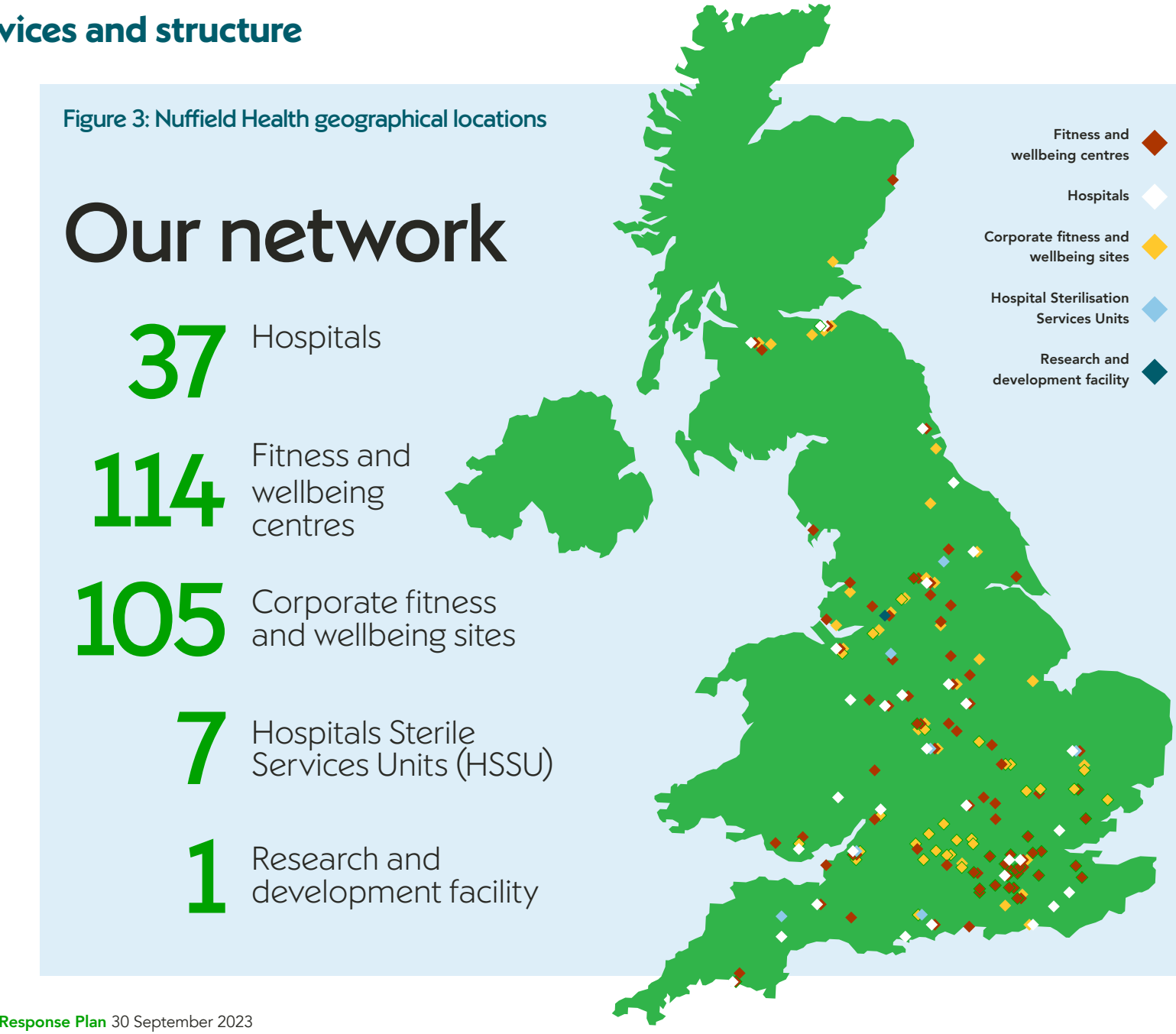
Figure 2:
The three pillars of Nuffield Health's Quality Assurance Framework

2.0 Nuffield Health services and structure

2.1 Nuffield Health network

Geographically, as **Figure 3** demonstrates, Nuffield Health has sites delivering broadly similar services throughout England, as well as in Scotland and Wales. The sites outside England will adopt the PSIRF principles as well as ensuring that they meet the requirements of their own regulatory bodies.

Figure 3: Nuffield Health geographical locations



2.0 Nuffield Health services and structure continued

2.2 Employee and service provision

2.2.1
Nuffield Health's purpose is to build a healthier nation. The Charity's experts have been working together for more than 60 years to make the nation fitter, healthier, happier and stronger. Nuffield Health believes that the best healthcare should help prevent illness by looking after mind and body. That's why its connected health and wellbeing offering spans physical and mental health.

2.2.2
The Charity employs 17,000 employees all working together to build a healthier nation. In 2022, it delivered more than 233,000 episodes of hospital care through self pay, private medical insurance and NHS referrals, and delivered services to 75,000 NHS funded patients.

2.2.3
Nuffield Health's service provision (**Figure 4**) was reviewed to ensure clarity existed with regard to those employees who are involved in patient safety activities across the Charity, as well as the systems and processes, which exist to support patient safety.

Figure 4: Nuffield Health's connected health and wellbeing services

Nuffield Health is the only major health and wellbeing provider to operate fitness and wellbeing centres, medical clinics, and hospitals, allowing us to provide a wide range of healthcare services. Our connected healthcare model joins together our network of experts, facilities and services, both face-to-face and online. From prevention and keeping well, through to diagnosis, treatment, rehabilitation and recovery, we can help. By offering connected healthcare, we aim to improve the experience and outcomes for our beneficiaries.

Figure 5: Nuffield Health's service lines overview

Our 37 hospitals

We have **1,500** nurses and work with **5,200** consultants

Services offered:

- Diagnostics
- Pathology
- Physiotherapy
- Outpatients
- Elective surgery

100% of our hospitals rated Good or Outstanding by national regulators

2.2.4
Despite the fact that PSIRF will currently only apply initially to secondary care services within the NHS, Nuffield Health made an early decision that not only would it apply PSIRF to all its patients, regardless of funding source, but it would also apply it across its primary care services in order to ensure continuity in the management and investigation of, and learning from, PSIs across the Charity.

2.2.5
The services which have, therefore, participated in the development of this plan include all the hospitals, Health Assessment Clinics, Fitness & Wellbeing Centres (Gyms), Mental Health Services including cognitive behavioural therapy, counselling and general psychological therapies.

2.2.6
The 37 hospitals all deliver broadly similar planned, elective surgery across a range of specialties including, but not limited to, general surgery, gynaecology, orthopaedics, ophthalmology, spinal, urology etc., so their PSI profile is also broadly similar. Some of our larger sites provide specialist services such as Cardiac surgery and critical care.

Figure 5 demonstrates how these services are supported.

2.0 Nuffield Health services and structure continued

2.3 Quality and safety governance

2.3.1

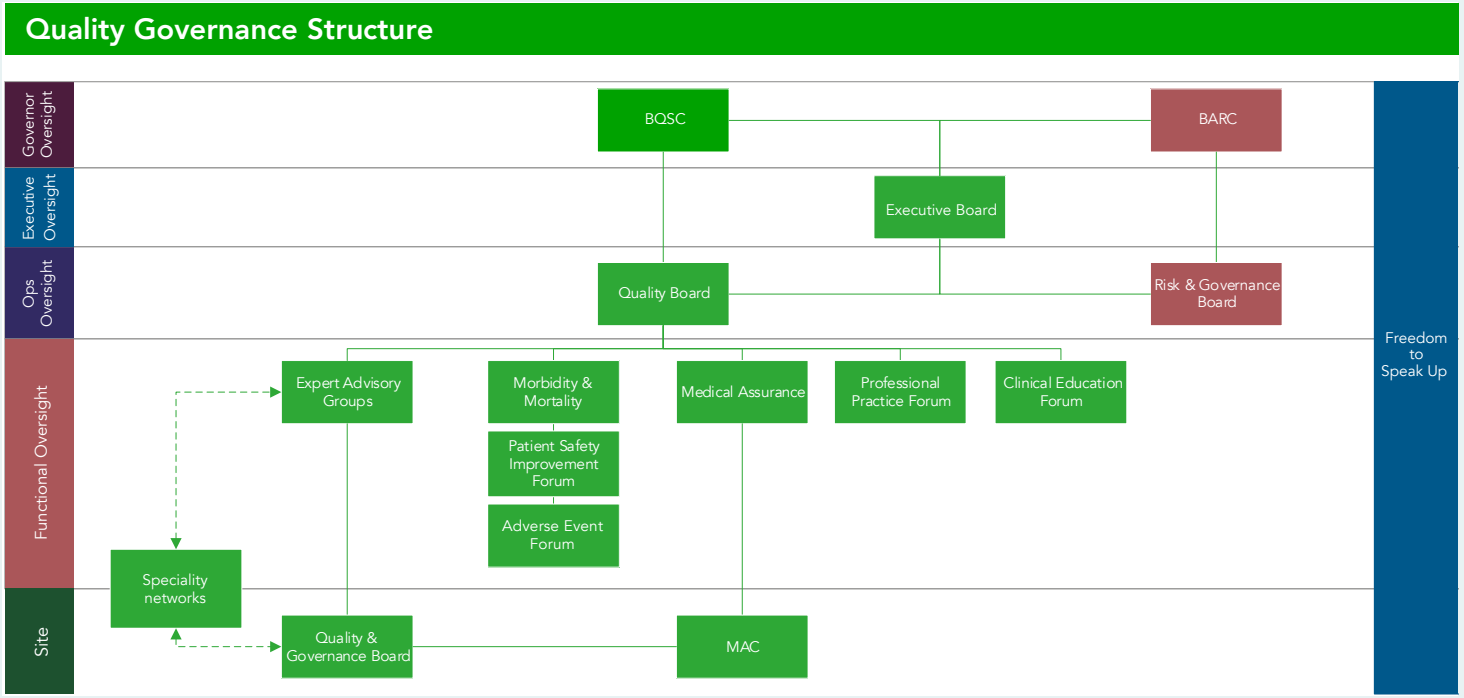
To achieve Nuffield Health's Strategic Objective requires a robust Quality and Safety Governance structure as illustrated in **Figure 6**.

This structure is supported by a series of committees, Expert Advisory Groups (EAGs) and networks. The EAGs and Networks include representatives from the hospital and primary care locations, as well as members from the central quality governance team to ensure effective oversight across the Charity. External Subject Matter Experts (SMEs) are also called upon to provide specific independent expertise when necessary.

2.3.2

PSIRF required the organisation to think hard about how it could gain the most benefits from organisational learning and also retain oversight of PSIs, when responsibility for choosing proportionate response tools was devolved to the 37 individual hospitals (as well as primary care services).

Figure 6: Quality Governance Structure



On a daily basis the Directors of Clinical Services at hospital sites, together with their Governance Leads, review any PSIs recorded on the previous day. Any requiring a learning response are highlighted to the Regional Directors of Quality (three across the Charity) and these are then discussed at a weekly Incident Review Meeting.

Finally, a new Forum which was created during the PSIRF implementation process, the Patient Safety Improvement Forum, looks at emerging themes or individual PSIs of specific concern which then become a focus for patient safety improvement activities.

Within Primary Care Services, there are fewer PSIs which are generally less severe in nature, than within the acute services, so these are overseen by the Quality Care Partner for Primary Care and the National Service Leads.

3.0 The implementation process

3.1 Initial planning

3.1.1

Between October and December 2022 the Charity followed the steps in the NHSE PSIRF Preparation Guide (August 2022). **Figure 7** shows the Implementation Team that was established, which included representatives from all parts of the organisation and across all service lines.

Figure 7: PSIRF Implementation Team

Role	Responsibility	NH role equivalent
1. Senior Responsible Officer (SRO)	• Chair and Lead the PSIRF Implementation	Clinical Services Director
2. Deputy SRO	• Support the above	Head of Clinical Governance
3. Patient Safety Lead	Expertise in: • Patient safety, • Patient safety incident response, • Human factors	Quality Lead – Patient Safety
4. Quality Improvement Lead	• Thematic Reviews to shape PSIR plan	Head of Secondary Care
5. Medical Assurance Lead	• Consultant engagement	Medical Assurance Lead/Chief Medical Officer
6. Clinical Safety Specialist	• Consultant Engagement/Patient Safety Expertise	Associate Medical Lead – Patient Safety
7. Risk Management Lead	• Expert in Risk Management	Head of Clinical Governance
8. Clinical and Quality Governance Lead	• Develop the PSIR Plan and roll-out • PSIR Policy – rewrite/amalgamation of GOV 04/GOV 13 etc • Identify Toolkit for learning responses	Clinical Effectiveness Lead
9. Operations lead	• Recognise and communicate Business Impact to Exec. Board.	Operational Support Lead
10. Academy Lead	Training for: • Learning response leads • Engagement leads • Those in PSIRF oversight roles • Recruit patient safety partners (PSPs)	Professional Education Lead
11. Customer Experience Lead	• Complaint Management – thematic reviews • Patient and family involvement plan/standard	Head of Customer Relations Customer Experience/propositions
12. Legal Team Lead	• Ensure learning responses meet legal requirements	Senior Legal Counsel
13. Head of Safety Culture	• Compassionate engagement • Just culture	Head of Safety Culture
14. Internal and External Comms Leads	• Stakeholder list and engagement plan e.g. for Organisational Comms; Integrated Care Board Comms support; Patient Safety Collaborative Comms; NHSE; CQC. • Identify key messages and methodology for sharing	Internal Communications Manager Corporate Affairs Manager
15. Data analyst	• Thematic reviews • Ongoing monitoring and triangulation of data	Clinical Outcomes and Performance Lead Clinical Insights (Research) team
16. Human resources	• Recruitment of PSPs • Training regarding engagement with employees involved in serious incidents	Senior HR Business Partner
17. Representatives from different clinical services, different employee grades	• To represent different service lines (primary and secondary care • To ensure PSIRP and Policy are relevant and actionable for end users	Primary Care Lead; health Assessment lead; Mental Health Lead; Head of non-clinical Assurance; Site Governance Leads; Site Employees Representatives

3.0 The implementation process

3.1.2
The inaugural meeting, held in January 2023, brought all these individuals together to discuss the PSIRF vision for the Charity and a series of workstreams were established to address each of the elements which emerged during the reading and reflection phase. **Figure 8** illustrates these workstreams and the broad tasks they were assigned.

Each workstream included employees from all levels of the organisation and all disciplines, both clinical and non-clinical. Anyone at site level who expressed an interest to their Director of Clinical Services (DCS) could participate.

3.1.3
A business case was submitted which provided funding for a Project Manager and Project Analyst, the role-specific training defined within PSIRF, and the finances associated with Patient Safety Partners (PSPs). This was all approved by the Executive Team.

3.1.4
Links with both internal and external communications teams were established, and it was agreed that this function was so important it would have its own workstream.

A communications strategy was developed, and an empathy mapping exercise undertaken to inform the communications plan and messaging.

Figure 8: PSIRF Implementation Workstreams

Employee Engagement and 'Just Culture'

- **PSIRF champions: Exec +non/Board/SLT/Site Level**
- **Media – Senior leaders (clinical and non-clinical) endorsing PSIRF**
- **Site visits to demonstrate commitment to 'Just' culture and FTSU**
- **Baseline employee survey on current NH Safety Culture**
- **FTSU/'Just' culture roll-out**
- **Psychological safety**

Data Analysis and Triangulation

- Identify/agree data sources
- Thematic reviews to identify Patient Safety Priorities
- Sense-checking of priorities with employees.
- Dashboard development
- Improvement monitoring
- Ongoing identification of future Patient Safety Priorities.

Internal & External Comms

- External communication strategy and materials for ICBs, CQC, insurers, employees, consultants etc
- Listening to leaders and employees
- Internal communications Charity wide awareness campaign
- Targeted comms to teams needing to adopt PSIRF
- Leader led and Champion led comms to teams, supported by consistent messaging and comms tools and materials

Governance

- Finance
- Adapt all NHSE documents and templates for NH
- Understand and embed SEIPs (Systems Model)
- Agreeing patient safety priorities
- Involvement of employees groups in 'testing' processes
- PSIR Policy and PlanSign off of PSIR Plan with all local ICBs
- Agree tools and templates
- Establish oversight process
- Quality Improvement Programme
- Legal and coronial

Training

- Provider selection
- Training Needs Analysis
- Training package development
- Investigator Training
- Engagement Training
- Oversight Training
- Learning response and improvement report training
- Levels 1&2 e-lfh Pt safety syllabus
- Delivery of training for After Action Reviews/ Swarm Huddle etc

Patient/Family Engagement

- Gap analysis against current activity.
- Creation of a pt./family engagement standard.
- Review and link to DoC Process
- Establish model for, and cost of, PSPs
- Recruitment process for PSPs.
- Training needs for PSPs
- Review NHSE. Framework for involving patients in patient safety (IPIPS)

3.0 The implementation process continued

3.1 Initial planning continued

3.1.5

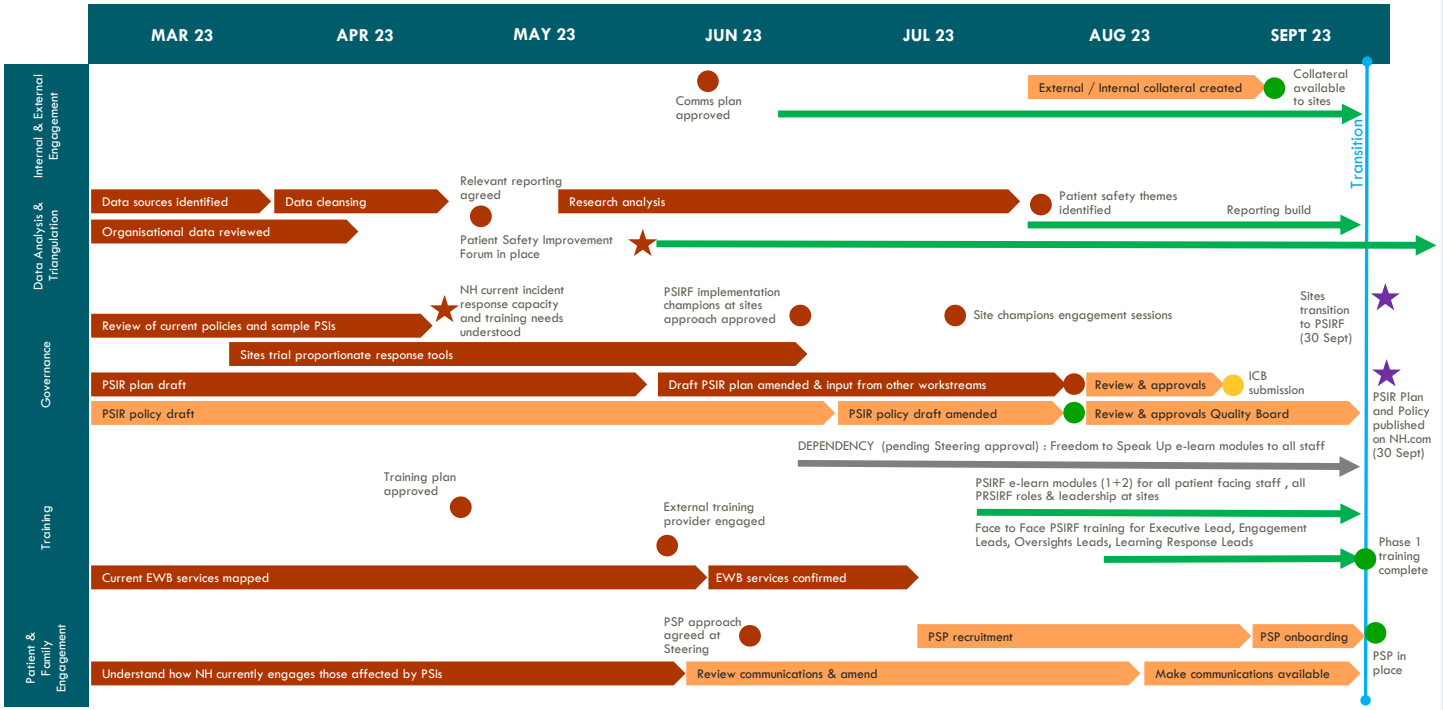
Challenges existed with identifying one ICB for PSIRF collaboration across such a large geographical spread. This was not seen as a barrier to success, but it was recognised that informing all the ICBs of the Charity's commitment to PSIRF would be an important element of the work undertaken in order to meet oversight requirements. These initial communications were sent in January and April 2023.

In June 2023, with the support of NHSE, the NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB), agreed to provide support with the PSIR Plan collaboration and invited members of the Nuffield Health Implementation Team to attend their ongoing PSIRF Implementation meetings.

3.1.6

The organisation's PSIRF ambition was defined, and the Project Management Team maintained a risk register throughout the process. A Steering Committee was formed which was updated weekly on the Project's progress and met fortnightly to discuss key escalations and risks, and any approvals needed for changes to policy or processes.

Figure 9: PSIRF Project plan on a page



3.1.7

Formal, weekly Project Team Meetings were held with all Workstream Leads to ensure progress and the achievement of key performance indicators (KPIs) and milestones was closely monitored and any challenges to these identified. **Figure 9** shows the PSIRF project plan on a page.

3.0 The implementation process continued

3.2 Educating the Charity and involving the key internal stakeholders

3.2.1
Aside from reading the NHSE documentation, opportunities were taken to attend webinars by the following organisations:

- Patient Safety Managers Network (PSMN)
- Independent Health Providers Network (IHPN)
- Healthcare Safety Investigation Bureau (HSIB)
- Clinical Audit Support Centre
- NHSE.

3.2.2
Utilising all this knowledge, numerous presentations were made accessible to leaders at all levels of the organisation to ensure inclusivity across all services and the opportunity to promote discussion, particularly around the psychological safety, just culture and proportionate response tools. This included:

- Executive Board
- Board of Governors
- Senior Leadership Community
- Quality Team (including all Subject Matter Experts and the Medical Assurance Team)
- Health System Directors
- Directors of Quality for Secondary Care
- Quality Care Partner – Primary Care
- Directors of Clinical Services
- Senior Management Teams at sites (including all Heads of Department, clinical and non-clinical).

The Chief Executive Officer included his commitment (and that of the Executive) to PSIRF in his monthly update video for all employees, emphasising the importance to the organisation of employees speaking out where they had concerns about the potential for PSIs to occur.

3.2.3
A Patient Safety Culture Survey was undertaken within the secondary care teams in early June 2023 to establish how safe and supported the employees felt about speaking up about safety issues. **See Figure 10.**

Figure 10: Patient Safety Culture survey results

617 employees responded, and the following results were obtained:

89% of respondents were extremely confident to report a patient safety risk or incident to their line manager

85% would report rude or discourteous behaviour

61% of those who had reported a PSI reported being offered further support, including emotional wellbeing but of those only **6.5%** decided to access this

76% reported feeling safe to say exactly why they thought a PSI had occurred, **69%** felt supported by their team and **72%** by their line manager

74% reported being involved in the investigation and **54%** involved with the team in planning how to prevent another incident of a similar nature happening again

These results have given the Charity a benchmark from which to develop its existing Safety Culture Strategy further.

3.0 The implementation process continued

3.2 Educating the Charity and involving the key internal stakeholders continued

3.2.4

Nuffield Health's PSIRF Training Plan has been created in collaboration with both in-house and third-party Subject Matter Experts (SMEs) and has been based on embedding a 'just culture' across the organisation. To achieve this, training for PSIRF has been aligned with the training requirements for Freedom To Speak Up (FTSU), working in partnership with the Charity's Head of Safety Culture.

A training needs analysis has been completed to better understand the current capabilities and knowledge gaps within the workforce, allowing appropriate learning resources to be made available to specific target audiences.

A blended learning approach utilising both online modules and live, interactive, virtual classrooms has been used to ensure the learning programme is both accessible and sustainable.

The training programme includes the online Patient Safety modules from e-Learning for healthcare (elfh), which will be made accessible to all employees in a patient facing role. This will be accompanied by training in Systems Approach to PSIs, People Engagement and Involvement, Oversight and a specific Just Culture Module. These have been made available to bespoke audiences as detailed in **Figure 11**.

Collaboration with the Charity's Communications Team has been vital to the success of the learning and development plan, promoting the availability of the learning resources and driving engagement across a variety of communication channels and forums.

Figure 11: Training Needs Analysis (TNA) for PSIRF roles by employee group

What is the training?	How is it delivered?	Duration	Who needs to do the training?
FTSU – Speak Up	e-learn	25 mins	All hospital employees
FTSU – Listen Up	e-learn	30 mins	Hospital Line Managers
FTSU – Follow Up	e-learn	30 mins	HSDs, Exec Board, Board of Governors
Essentials of patient safety for all employees	e-learn	30 mins	All Hospital employees; All non-Hospital Physiotherapists; All non-Hospital Physiologists; GPs and Health assessment doctors; Clinic Managers; All EWB employees; All MSGMs/GMs; ICSMs; SMEs
Essentials of patient safety for boards and senior leadership teams	e-learn	45 mins	HSDs DCSs; All Hospital HODs; Exec Board; SMEs
PSIRF – Systems Approach to Patient Safety Incident Investigations	Virtual Classroom	2 days	HSDs DCSs; key Hospital HODs; Exec Board; SMEs; Clinical Services Director; Chief Operating Officer – Quality and Operations
PSIRF - People Engagement and Involvement	Virtual Classroom	1 day	Clinical Services Director; Chief Operating Officer – Quality and Operations; Directors of Quality; Patient Safety and Clinical Effectiveness Leads; Associate Medical Lead for Safety; All DCSs, Site Governance Leads, x 2 Clinical HODs (priority to Theatre and Ward HoDs); Head of Clinical and Nursing Practice; Head of Non-Clinical Assurance; SMEs
PSIRF - Oversight	Virtual Classroom	1 day	Clinical Services Director; Chief Operating Officer – Quality and Operations; Patient Safety and Clinical Effectiveness Leads; Associate Medical Lead for Safety; Directors of Quality; All DCSs and Site Governance Leads; Head of Clinical and Nursing Practice; Head of Non-Clinical Assurance; SMEs
Creating a Just and Learning Culture	e-learn	25 mins	Medical Director; Charity and Medical Director; Heads of Primary and Secondary CareGovernor; EODs; HSDs

3.2.5

An Empathy Mapping exercise was undertaken for the key internal stakeholders in order to recognise the competing priorities for each employee group who will be impacted by PSIRF and develop a communications strategy accordingly.

An area on the Charity's internal network was identified to hold all PSIRF resources, including presentations, training tools, links to learning response and investigation templates and guides for ease of access by employees.

3.3 Safety Governance Review

3.3.1

A Quality Lead for Patient Safety was appointed in January 2023 and has worked with the PSIRF Implementation Lead to consider the approach needed to bring together all the Charity's patient safety initiatives under one umbrella, which will be articulated as part of the Patient Safety Strategy that is under development and anticipated by the end of 2024.

3.3.2

This PSIR Plan and the accompanying PSIR Policy will be part of the Strategy as will the proportionate response tools to be utilised when investigating PSIs.

3.0 The implementation process continued

3.4 Patient and family engagement

3.4.1

As emphasised in *'The Framework for involving patients in patient safety' (NHSE, 2021)*, Nuffield Health recognises the importance of patients and their families being 'partners' in their personal safety as well as the contribution they can make to the safety of the organisation.

The Charity gains valuable insight from patients and their families, through a Patient Satisfaction Survey, the Friends and Family Test and, in some sites, successful patient forums. The aim of these is to understand and learn from what patients thought about the care they received during their treatment, and any areas that they felt could be improved upon, in order to maximise the learning from both good practice and PSIs.

Engaging with patients, in terms of listening to their concerns and responding to them, is an absolute priority for the Charity, particularly to enable improvements in the quality and safety of the services we provide to our patients and their families.

3.4.2

Patient Safety Partners (PSPs) are a new concept for the Charity which we recognise will complement and further enhance our Quality Assurance Framework.

Nuffield Health is in a unique position as a Charity, with a cohort of 70+ Charity Members who have an established understanding of its purpose and have prior experience of using a variety of Nuffield Health Services. Recruitment to the PSP roles from this Member Group was explored and agreed to be appropriate.

Nuffield Health will also look in the future to engage with a wide range of individuals who have previously been patients to be recruited into the Patient Safety Partner (PSP) role.

The Charity's initial intention is that PSPs will join the relevant Boards/committees that have a patient safety remit. Their role is to reflect the voice of the patients who use Nuffield Health services and combine this with their leadership and decision-making experience. It is our intention that Patient Safety Partners within Nuffield Health will be actively involved in the design of safer healthcare systems across the Charity.

It is likely that the role will evolve over time and involve PSPs visiting individual Nuffield Health sites, meeting patients and asking them about their experience of safety within our facilities.

3.4.3

Thematic analysis of feedback from patients provided insight into their experience of service provision, specifically regarding their perception of feeling safe whilst receiving care from the Charity. This also highlighted where work will need to be done to ensure that the factors they identified become consistently part of the employee's safety approach and care delivery. This improved our understanding of our patients' perceptions and also complemented our existing patient safety initiatives.

To further encourage patients and families to ask questions regarding their safety, a *'What does patient safety mean to you?'* leaflet has been developed, which details simple steps that patients can take to keep themselves safe in our care but, most importantly, encourages patients and families to speak out and communicate safety concerns to their healthcare team.

3.4.4

The Patient and Family Workstream identified that there has not always been a consistent approach across the organisation when engaging with, and learning from, patients and families when something has gone wrong resulting in a PSI.

A Gap Analysis was undertaken to establish existing practices at individual sites, identifying areas where engagement could be improved whilst acknowledging examples of good practice and learning opportunities nationally.

This exercise helped inform the development of a *'Patient and Family Information Booklet'* which has been produced to support these individuals through an investigation process, informing them of what to expect, the value of their engagement, their choice in the level of involvement in the process and the production and publication of the subsequent report.

3.4.5

The Legal Duty to fulfil Statutory Duty of Candour, as described by the three nations in which the Charity has hospitals, must be fulfilled as part of PSIRF with the emphasis being on openness, honesty and compassion.

In order to reflect PSIRF expectations The Nuffield Health Duty of Candour and Being Open Policy has been rewritten and is now called *'Duty of candour and engaging with those affected by a patient safety incident'*.

It includes Standard Operating Procedures (SOPs) for both professional and statutory Duty of Candour and the provision of template Duty of Candour (statutory or otherwise) letters, both at the beginning and end of the process to reflect the compassionate engagement and involvement embodied in the spirit of PSIRF.

4.0 Defining our Patient Safety Incident Profile

4.1 Data analysis

4.1.1
Nuffield Health continues to improve its 'data-led decision making' across all areas of the Charity. This principle was fundamental to our implementation of PSIRF and, as such, a full review of the Charity's patient safety data was conducted.

4.1.2
The Data Analysis and Triangulation Workstream was led by the Clinical Outcomes and Performance Lead, with data analysis conducted by Nuffield Health's in-house research team.

4.2 Data sources

4.2.1
Adverse Event (Datix/Radar) Analysis: The review started with an analysis of incident data spanning five years (2018-2022 inclusive). This analysis included, but was not limited to, an analysis of:

- Types of PSIs
- Frequency of PSIs
- Severity of their impact (harm level).

Figure 12: Radar modules implemented

Adverse events	Doctor concerns	Risk registers
Complaints – Stage 1	Erasures	Safeguarding events
Complaints – Stage 2	Field safety Notices (FSN) Bulletins	Safety Alerts
Complaints – Stage 3	Freedom to Speak Up (FTSU)	Subject Access Requests (SARS)
Concerns	GMC complaints	

4.2.2
This initial analysis allowed the Research Team to develop Nuffield Health's 'Patient Safety Incident Profile' which used data to help determine the likelihood and severity of certain PSIs. From this data we were able to determine the specific PSIs that were affecting patients most frequently.

4.2.3
Other data sources: These include the last two years of complaints, claims, mortality reviews, whistleblowing incidents, employee allegations, conduct investigations and safeguarding reviews. Nuffield Health Annual Reports and the Charity's NHS Quality Accounts provide significant historical data and analysis, including actions taken, and can be viewed at How we are governed | Nuffield Health

4.2.4
Significant investment has been made into moving to a new data management system, Radar, where the Charity has the ability to collate safety data across a broad range of topics, as demonstrated in **Figure 12**.

Still to come, later in 2023 will be Document Management modules for Policies and Standard Operating procedures (SoPs), as well as the creation of investigation forms for specific events such as Venous Thrombo-Embolism (VTE). These will all enable the Charity to further enhance its data capture and analysis.

4.3 Stakeholder engagement

4.3.1
Once the results of the incident analysis had been received, an employee survey was conducted which allowed the Charity to validate the themes identified in the data with the views of clinical employees. The employee survey took a 'deep dive' into the identified themes with a view to further understanding how:

- Well Nuffield Health learnt from previous PSIs of this nature
- Well the employees understood the contributory factors
- Effective the Charity is at implementing plans to minimise the same types of incidents happening in the future.

4.3.2
This data allowed Nuffield Health to not only identify areas where incidents were impacting patients the most, but also where the Charity had the most to gain in terms of understanding, learning from and preventing such events recurring in the future.

4.0 Defining our Patient Safety Incident Profile continued

4.3 Stakeholder engagement continued

4.3.3
A combination of the outputs from each data stream (reported incidents, patient survey and employee survey) were thematically reviewed by senior leaders across Nuffield Health who were part of the 'Data Analysis and Triangulation' workstream. This thematic review then formed the basis for the identification of the patient safety themes discussed in our Improvement Profile.

Both the Incident and Improvement Profiles were then presented to the PSIRF Steering Committee and Quality Board for final approval.

4.3.4
Following the internal approval, the PSIR Plan was presented to the Leicester, Leicestershire and Rutland Integrated Care Board (ICB), as part of a 'check and challenge' process under the following headings – **Insight, Involvement and Improvement** in order to ensure external stakeholder approval.

5.0 Defining our Patient Safety Improvement Profile

5.1 Quality Improvement Plan (QIP)

5.1.1

Currently within Nuffield Health's Quality Assurance Framework there is the Quality Improvement Plan (QIP). The QIP is used to identify quality improvement initiatives which the Charity has identified as being key to ensuring patient safety.

Nuffield Health prioritise initiatives into those which are strategic and those which are key quality initiatives.

The Quality Board approve the QIP and monitor progress against each of the initiatives.

5.1.2

Strategic initiatives include those which are needed in response to:

- Regulatory change
- A significant threat to clinical quality if the issue is not addressed
- High impact strategic patient safety oportunities.

5.1.3

Key quality initiatives are those which are in response to:

- Significant opportunity to enhance clinical quality
- Opportunity to mitigate and manage threats to patient safety, clinical effectiveness and/or beneficiary experience.

Figure 13: Quality improvement plan for 2023

1 Launch of new Quality Management System	2 Patient Safety Incident Response Framework	3 Launch of Secondary Care Professional Leadership: Assurance Network	4 Enhanced assurance across our hospitals
What we plan to do • Procurement and implementation of a new Quality Management system, Radar, which is compliant with NHS England's 'Learn from Patient Safety Events' (LFPSE) framework • Consolidate a number of collection tools as Radar modules, including Adverse Events; Risk Management; Complaint Management; Safety Alerts; Subject Access requests/ Erasure requests; Document Management Repository • Streamline our Quality Management processes, and ensure we are complying with the latest regulations and best practices • Identify areas for improvement and make data-driven decisions, using the Initiative System to provide real-time data and analytics • Drive data quality for safety incidents and near misses, by educating and standardising reporting to support learning.	**What we plan to do** • Establish Executive Lead responsible for PSIRF and focus on leadership role model initiatives • Establish a Quality Lead for Patient Safety • Create a working group to facilitate the achievement of key elements of PSIRF: a data-driven safety culture; a clear policy and plan, with well understood learning responses to prevent and react to patient safety incidents (PSIs); a standard for engaging and involving those who experience PSIs, and strong safety leadership • Develop a Patient Safety Strategy to articulate our approach to patient safety across all service lines • Provide educational support for staff involved in patient-facing roles, including those in investigatory, engagement and involvement roles • To include Health Education England's Patient Safety Syllabus • Establish robust oversight structure and process to allow for local engagement and empowerment.	**What we plan to do** • Ensure appointees are highly experienced and capable of overseeing Quality Assurance in their specialism centrally, and at hospital sites • Ensure appointees work within a professional role on site each week, maintaining clinical expertise and credibility within their specialism • Ensure appointees deliver clinical development and change within the hospitals, inspiring the clinical teams directly involved in patient care • Ensure appointees chair and co-chair Expert Advisory Groups within the organisation, motivating the clinical talent of the MDT within the specialty • Ensure appointees are capable of engaging with peers and colleagues across the NHS and the independent healthcare sector, influencing policy and development of national guidelines • Ensure appointees are members of key professional organisational boards, keeping Nuffield Health at the forefront of strategic development within the specialism.	**What we plan to do** • The Hospital Quality Review (HQR) audit tool will continue to be enhanced to integrate the Specialist Quality Assurance Review tools to aid triangulation, and improve efficiency to lessen operational impact • Simultaneous safety surveillance data will be used consistently to proportionately assess risk and inform the future targeted programme of integrated reviews • Reviews will include key areas within the patient pathways, and any other areas identified through proportionate risk assessment • In line with the planned introduction of the CQC's new approach to inspections, we will include themed visits or reviews which may include a particular focus on a clinical specialty or care process • The outcomes of 2022 site HQR will drive 2023 quality initiatives of audit and action plans, clinical documentation completion, incident management processes, duty of candour management, and risk assessment consistency.

Figure 13 provides examples of 2023 QIP Activity prior to PSIRF transition.

5.1.4

Individual sites can also identify and launch local quality initiatives in line with locally identified quality improvement requirements.

6.0 Our Patient Safety Incident Response Plan

6.1 Proportionate responses to Patient Safety Incidents (PSI)

6.1.1
PSIRF allows more flexibility in the methods which can be used in responding to a PSI depending on the nature of the incident, its severity, the frequency of it occurring and the type of learning which needs to be achieved.

6.1.2
Regardless of the proportionate response method chosen for a specific incident, the aims are the same. To:

- Respond to concerns raised by any patient, their family or a staff member
- Understand what contributed to the incident happening in the first place
- Identify areas for improvement
- Improve safety for future patients
- Reduce the risk of incident recurrence.

6.1.3
Figure 14 summarises the methods which can be employed when responding to a PSI and the objectives of each type of response. Some of these are already in use across the Charity but some will be introduced as part of PSIRF.

Figure 14: Proportionate response types and objectives

Proportionate Response Type	Method	Objectives
Incident recovery Immediate measures taken to: • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient/family, or staff member • Determine the severity of an identified risk and likelihood of recurrence.	Immediate actions	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.
	Risk assessment	To assess the severity of identified hazards and likelihood of recurrence so that risks can be determined, prioritised, and control measures applied. To provide a detailed documentary account of what happened in the style of a 'chronology'.
Team reviews Post-incident review as a team to: • 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.	Debrief	An unstructured, moderated discussion. The simplest and most informal method to gain understanding and insight soon after an incident (debriefs held immediately after an incident are known as 'hot' debriefs).
	SWARM huddle	A facilitated 'hot' structured debrief, held immediately or within 24hrs of an incident. All those involved in the event gather to quickly analyse what happened, how it happened and what needs to be done next to reduce the risks of a repeat event occurring. Enables insights and reflections to generate prompt learning.
	After Action review (AAR)	A facilitated 'cold' structured debrief, held within 3 – 5 days of an incident. The review endeavours to: 1. create a common understanding of the event 2. reflect on successes and failures 3. identify specific recommendations and agree group safety actions 4. how lessons will be shared more widely across each hospital and the Charity as a whole.

6.0 Our Patient Safety Incident Response Plan continued

Figure 14: Proportionate response types and objectives continued

Proportionate Response Type	Method	Objectives
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.	Patient Safety Incident Investigation (PSII)	• To build a detailed narrative from information gathered from all those involved in the incident • To understand why the actions or decisions relating to care were deemed appropriate at the time by those involved in the incident • To develop safety actions based on the findings in order to reduce the likelihood of an incident happening again to as low as reasonably practicable.
	Structured Judgement Review (SJR) (Mortality review)	• To make safety and quality judgements about each phase of care delivered to a patient • To make explicit written comments about each phase of care • To 'score' care for each phase • To arrive at a 'judgement' as to whether there were any deficits in care • To develop meaningful and tangible actions that impact on care delivery for the benefit of future patients.
Themed Patient Safety Improvement Projects: • Analysis of recurring patient safety incidents within Radar e.g. VTE events, surgical site infections over a specified time frame, 3, 6 or 9 months • Allows for pattern analysis and continues to analyse newly occurring events within the project timeframe to see if any new information arises • Summarises, findings, conclusions and recommendations for changes to care processes in the future.	Thematic reviews	• To understand common links, themes and/or issues within a cluster of events or incidents • Seeks to understand key barriers or enablers for safety using reference cases e.g. individual Radar incidents or previous investigations • To develop Charity-wide improvement plans for patient safety.
Other available methods: • Analysis of multiple PSIs where harm occurred or where the incidents were of a similar type • Allows for identification of system gaps or key contributory factors.	Audit	• To establish whether care is being provided in line with agreed policies/standards etc. • To enable quality improvement to take place where it will be most helpful in improving clinical outcomes/ safety for patients.
	Multi-disciplinary team meetings	• To identify learning from multiple incidents • To 'look back' over historical incidents using open discussion rather than staff recollection • To explore a safety theme, pathway or process • To gain insight into 'work as done' (i.e., what actually happened) and compare it to 'work as prescribed' (i.e. what a policy or SOP prescribes should be done) and establish why there are differences and whether system changes are needed.

6.0 Our Patient Safety Incident Response Plan continued

6.2 Nationally defined priorities to be referred for PSII or review by another Team

6.2.1

The national priorities for referral to other bodies or teams for review or PSII (described in PSIRF) for the period 2023 to 2024 are shown in **Figure 15**.

Figure 15: National priorities

Patient safety incident type	Required response
Child Deaths	Referred to child death panels for investigation. See guidance available at: Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)
Death of a person with Learning Disabilities	Incident to be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme. See guidance available at: LeDeR - Home
Safeguarding Incidents	These must be reported to Nuffield Health's National Safeguarding Lead and Clinical Services Director for review and multi-professional investigation

6.3 Nationally defined incidents requiring local PSII

6.3.1

The national priorities which will require a PSII for the period 2023 to 2024 are shown in **Figure 16**, together with the intended improvement routes.

Figure 16: Nationally defined incidents requiring PSII

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria. Guidance available at: NHS England » Revised Never Events policy and framework	PSII	• Review at Patient Safety Improvement Forum • Create local organisational actions and share these at Monthly Director of Clinical Services Meeting • Monitor implementation of actions monthly by Regional Directors of Quality
Incidents that meet the 'Learning from Deaths' criteria i.e. deaths thought more likely than not due to problems in care. Available at: NHS England » Learning from deaths in the NHS	PSII	• Review at monthly Morbidity and Mortality Committee • Create local organisational actions and share these at Monthly Director of Clinical Services Meeting • Monitor implementation of actions monthly by Regional Directors of Quality

7.0 Our Patient Safety Incident Response Plan: local focus

7.1

In order to define our local priorities, Nuffield Health looked at the following data sources:

- PSIs reported into our Incident Management System for the last **five years**
- Complaints relating to deficits in patient care for the last **two years**
- Claims relating to deficits in patient care for the last **two years**
- Patient SHR investigations into employment concerns (including whistleblowing) for the last **two years**
- Coroners inquests for the last **two years**.

7.2

An employee survey was then created from the data analysis results from the Adverse Event Management System to see whether employees agreed with the findings or whether they had any other safety concerns which did not feature in the data analysis results. The summary of the findings can be seen in **Figure 17**.

7.3

Following the data analysis and triangulation exercises, the results were presented to the Quality Board for agreement of the Nuffield Health Local Patient Safety Response Plan for 2023/2024, which includes the response types that can be selected depending on the specific incident and level of harm and the anticipated improvement routes. **Figure 17** shows the table demonstrating these.

7.4

Other incidents which have resulted in moderate to severe harm or a near miss where there is a potential for wider learning will also need to have a proportionate response. The options for these will be based on the level of harm and are as follows:

- Duty of Candour (Statutory or Professional
- Patient Safety Incident Investigation (PSII)
- After Action Review or SWARM huddle
- Systematic Themed Review
- Audit
- Multi-disciplinary Team Review
- Notes Review.

Depending on the nature of the incident will depend on the improvement route followed but will be largely similar to those defined in the Local Focus Plan in **Figure 18**.

7.5

The following are not described in this plan but are contained in the Charity's Patient Safety Incident Response Policy:

- Our patient safety culture
- The role of Patient Safety Partners
- Patient/family and employee engagement following a PSI
- Employee roles and responsibilities within PSIRF for:
  - all employees
  - engagement and involvement leads
  - PSI investigators
  - learning response leads
  - oversight/executive leads
  - governors
- Safety Action development and monitoring
- Plans for shared learning.

7.0 Our Patient Safety Incident Response Plan: local focus continued

Figure 17: Summary of findings from adverse event data analysis and employee triangulation survey

Incident data

Excluding incidents relating to COVID-19 and patient choice, all low and moderate harm incidents across a five-year period were analysed. Using the data, both the probability of an incident occurring and the likely severity were used to create an overall risk profile for each incident category. The 10 categories of the highest risk profile were then analysed by sub-category to determine the specific areas of interest.

Analysing >15,000 incident reports told us...

i Incidents having the biggest impact on patient safety were related to **unexpected medical events, unplanned transfers, infections, readmissions** and **cancelled surgeries**.

ii Of these areas, cancelled surgeries and unplanned readmissions showed poor data quality and were subsequently discounted from the list of specific areas of interest. To extract intelligent inside across these key areas, Nuffield Health needs to **improve data quality**, specifically consistency and accuracy of reporting both of categorisation and harm.

iii Further analysis of the categories with the biggest risk profile identified that incidents relating to **VTEs, unplanned transfers, surgical site infections** and **medication** impact patient safety the most. These are the proposed **key areas of review** within the initial PSIRF project.

Employee survey

A survey was sent to all hospitals to gather feedback from front-line employees. The survey aimed to establish what they felt impacted patient safety the most and where Nuffield Health had the most to gain in relation to improving our understanding and learning from patient safety events.

Of 221 hospital employees surveyed, they told us...

i They felt that incidents relating to **staffing issues** and **medication** impact patient safety the most

ii Patients feel **cancelled surgeries, delayed test results** and **staffing issues** impact patient safety the most

iii Nuffield Health has effective plans, learns from previous incidents and understands the factors that contribute to **VTEs, infections** and **slips, trips and falls**

iv The areas most noted where Nuffield show less learning, understanding and effective action plans *are in relation* **equipment issues, staffing issues** and **cancelled surgeries**.

7.0 Our Patient Safety Incident Response Plan: local focus continued

Figure 18: The local focus for the Nuffield Health Incident Response Plan

Patient safety incident type or issue	Planned response options	Anticipated improvement route
Venous Thrombo-embolism	Duty of Candour To be determined by level of Harm: • After Action Review • PSII • Central PSII (Thematic Review)	**1.** Patient Safety Improvement Forum (PSIF) **2.** PSIF considers new learning from local safety actions to enhance development of national safety development plan **3.** Monthly Director of Clinical Service (DoCS) Meeting and bi-monthly Clinical Effectiveness Network (CEN)
Medicines Administration / Omission errors (non-cancer)	Duty of Candour To be determined by level of Harm: • Site Audit • After Action Review	**1.** Medicines Management Expert Advisory Group (EAG) **2.** EAG considers new learning from local safety actions to enhance development of national safety development plan **3.** EAG reports recommendations to PSIF **4.** Monthly DoCS Meeting and bi-monthly CEN
Medication and Medicines Management (Cancer Services)	Duty of Candour To be determined by level of Harm: • SWARM • After Action Review • MDT Review • Central PSII (Thematic Review)	**1.** Cancer Services EAG **2.** EAG considers new learning from local safety actions to enhance development of national safety development plan **3.** EAG reports recommendations to PSIF **4.** DoCS and Governance leads at sites delivering Cancer Services
Unplanned Transfers to another healthcare provider • **Cardiac events** • **Unexpected medical problems**	Duty of Candour To be determined by level of Harm: • After Action Review • PSII • MDT Review • Audit	1. Resus and Critical Care EAG 2. EAG considers new learning from local safety actions to enhance development of national safety development plan 3. EAG reports recommendations to PSIF 4. DoCS Meeting and bi-monthly CEN
Post-discharge Surgical Site Infections	Duty of Candour To be determined by level of Harm: • After Action Review • PSII • MDT Review • Central PSII (Thematic Review)	1. Infection Prevention EAG 2. EAG considers new learning from local safety actions to enhance development of national safety development plan 3. EAG reports recommendations to PSIF 4. DoCS Meeting and bi-monthly CEN
Returns to theatre	Duty of Candour To be determined by level of Harm: • SWARM • After Action Review • PSII • Audit	1. Theatre EAG 2. EAG considers new learning from local safety actions to enhance development of national safety development plan 3. EAG reports recommendations to PSIF 4. DoCS Meeting and bi-monthly CEN

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