Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Report on the Patient Safety Incident Response Framework (PSIRF) covering October 2023 to November 2024**

Status:	**For Information**
History:	**Presented at Clinical Governance Committee 20 November 2024 and Trust Management Executive 12 December 2024**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This report provides an organisational overview of the first year of implementation of the Patient Safety Incident Response Framework (PSIRF) It includes how the implementation of framework has evolved over the last year
2. The report will review the implementation of PSIRF to demonstrate how the organisation meets the four key aims of PSIRF which are:
    a. Compassionate engagement and involvement of those affected by patient safety incidents
    b. Application of a range of system-based approaches to learning from patient safety incidents
    c. Considered and proportionate responses to patient safety incidents
    d. Supportive oversight focused on strengthening response system functioning and improvement

Recommendations

3. The Trust Board is asked to:
    - Note the contents of this report
    - Committee members are asked to ensure they have completed their training requirements under the National Patient Safety Strategy

Contents

Report on the Patient Safety Incident Response Framework (PSIRF) covering October 2023 to November 2024

1. Purpose

1.1. The purpose of this paper is to inform the Committee of the progress of PSIRF implementation, embedding and improvement over the first year and review this against the key aims of PSIRF which are:

1.1.1. Compassionate engagement and involvement of those affected by patient safety incidents

1.1.2. Application of a range of system-based approaches to learning from patient safety incidents

1.1.3. Considered and proportionate responses to patient safety incidents

1.1.4. Supportive oversight focused on strengthening response system functioning and improvement.

2. Background

2.1. PSIRF, the national replacement for the Serious Incident Framework (SIF), was launched in the OUH on 2 October 2023. Information on the OUH approach to managing incidents under PSIRF may be found here.

2.2. Under the previous Serious Incident Framework (SIF), approaches to managing patient safety were based on the premise that safety is the absence of harm. This approach, which focuses on identifying root causes of adverse events and outcomes and fixing these to eliminate future adverse events, has been shown to be limited in scope; and the focus on root cause analysis and elimination of serious harm tends to result in ineffective safety actions focused on individual staff members, resulting in a poor safety culture of blame.[1–5]

2.3. PSIRF recognises that healthcare is highly complex. It takes place in constantly evolving environments, termed 'work systems.' These are composed of interacting components including the people (among others the person receiving care, caregivers, professionals), organisations and their processes, procedures, the tasks required, the tools and technology available and the local setting in which the care is taking place. All these components impact on each other and can affect outcomes for people receiving care, staff, and the organisation. PSRIF focuses on understanding how outcomes occur within this complex system of challenging and changing conditions. In PSIRF, safety is understood to be the presence of capacities within the organisation that facilitate safe outcomes.

2.4. Under PSIRF, the OUH aims to become an exemplar in patient safety, reflected through our mature cultures of safety and continuous improvement. It aims to improve safety by increasing the capacity of staff trained and supported to use system-based approaches to learning from safety events, by creating a culture of safety and openness, by bringing the patient perspective and voice into the centre of patient safety and by ensuring that safety is considered a core activity by all.

2.5. This report will describe how the implementation of PSIRF within the OUH reflects the key aims of using systems-based approaches to learning, proportionate responses, engaging and involving those affected by safety events and supportive oversight. The success of PSIRF will be seen in four key areas (see **Error! Reference source not found.**).

Figure 1: Four areas of successful PSIRF implementation

2.1. A comprehensive driver diagram demonstrating how each of these four areas will be assessed has been developed and can be viewed on the PSIRF Intranet site. A high-level summary of the key drivers can be seen in Figure 2.

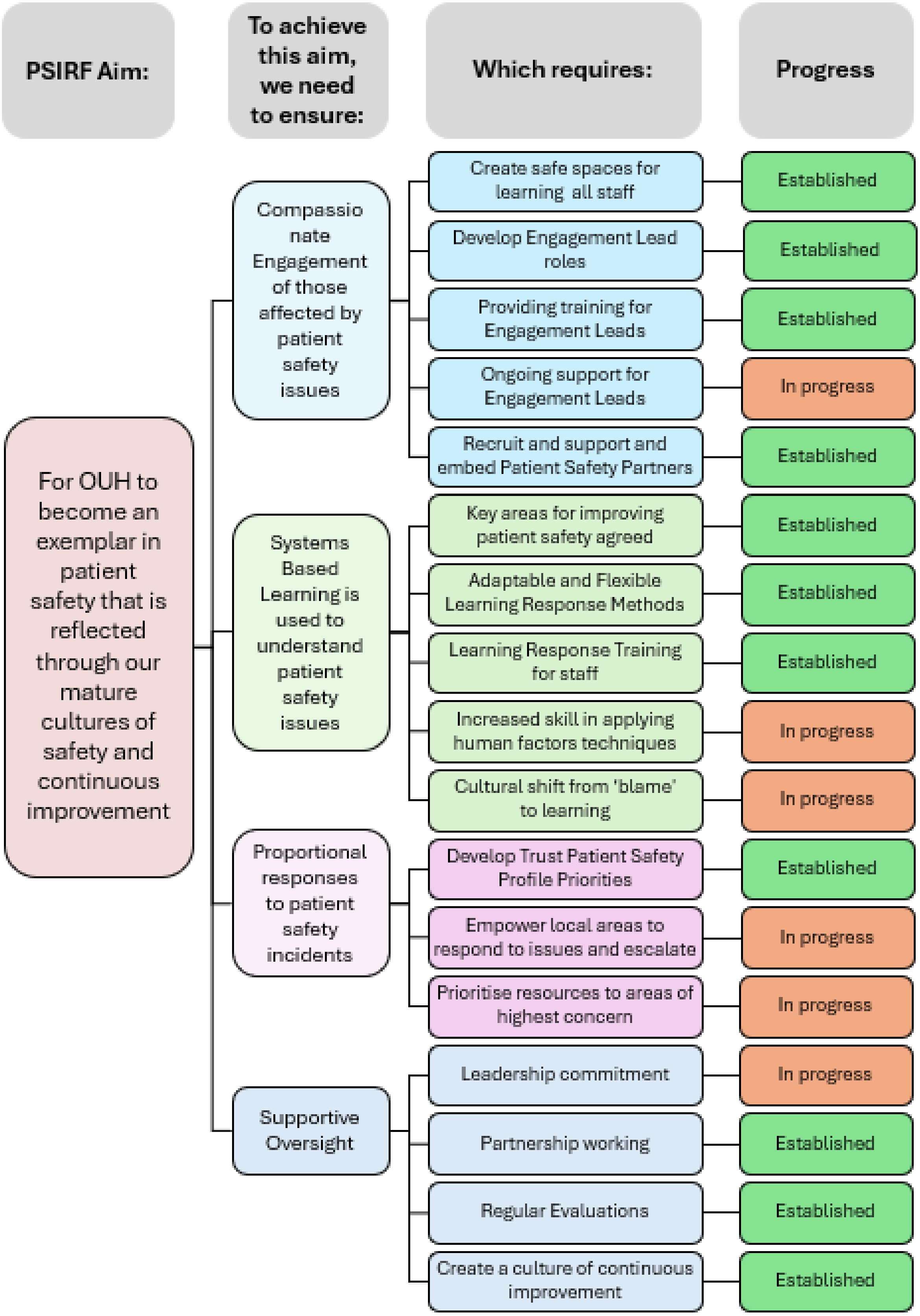

Figure 2: High-level drivers to achieve key aim of PSIRF

3. Compassionate Engagement of those affected by patient safety issues

3.1. PSIRF "promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement and with the aim of learning how to reduce risk and associated harm. PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place."[1]

3.2. To achieve this, OUH will aim to put patients at the centre of patient safety and actively develop and improve our safety culture. To do this we will:

Create safe spaces for learning for all staff - Established

3.3. This has been achieved through the development and implementation of the Safety Learning and Improvement Conversation (SLIC).

3.4. SLIC is a weekly meeting open to all staff where the focus is on learning from safety issues and improvement work and sharing ideas, skills and resources.

3.5. There are 370 staff members on the invitation list for SLIC who represent a range of different roles, grades and levels of seniority within the Trust. Many more staff members have attended SLIC on an ad-hoc basis.

3.5.1. Feedback from participants reflects that this meeting has changed the atmosphere of Safety meetings to be more inclusive, supportive, open and focused on learning. Further evaluation can be found in Appendix I which includes an extract from an HSJ Patient Safety Award application.

3.5.2. A formal survey was conducted in January 2024. Feedback and actions taken are described in Appendix I. This survey will be repeated annually to continuously improve our safety learning meetings and processes.

Develop the Engagement Lead role - Established

3.6. The role of the Engagement Lead was introduced with PSIRF. This refers to anyone who leads on engaging with and involving those affected by a patient safety incident. This may be the Learning Response lead or someone in a role like a family liaison officer. Engagement leads are

[1] Patient Safety Incident Response Framework supporting guidance. Engaging and involving patients, families and staff following a patient safety incident. Version 1, August 2022.

required to undertake a recognised training course and maintain competency by performing this role at least twice per year.

3.6.1. Each division has identified people to act as Engagement Leads. MRC has established a full-time role in the style of a Family Liaison Officer model. NOTSSCaN have appointed someone in a similar capacity. CSS and SuWOn have identified several members of staff who can undertake this role as part of their current role.

3.6.2. Training numbers can be viewed in Appendix II.

3.7. Following feedback from a family about being involved during a Patient Safety Incident Investigation (PSII), and reflecting on OUH processes, it has been agreed that each PSII will have a dedicated Engagement Lead as part of the investigation team. This ensures that the voice of the patient is central to the whole investigation process.

Provide training for Engagement Leads – Established

3.8. Training for Engagement Leads was procured from an external company, who trained 26 members of staff. Some staff members have undertaken the HSSIB online training (details and numbers for these courses are not available for analysis).

Evaluate involvement and engagement following a Patient Safety Event – In progress

3.9. To understand whether this has been achieved, a process for seeking and reviewing feedback from those involved in Patient Safety Incident Investigations (PSII) has been developed.

3.10. To date, no families have agreed to provide feedback through this method.

3.11. One letter providing reflections on their experience has been received from a family member highlighting areas of excellence and some areas for improving communication. Actions have been taken in response, including:

3.11.1. Reviewing processes to streamline the timelines for PSII completion

3.11.2. Formally including a named Patient Engagement lead as part of the team of PSII

3.11.3. Ensuring that the Engagement Lead feeds back any delay to the investigation process in a timely manner and is clear about the reasons for any delay

Provide ongoing support for Engagement Leads – In progress

3.12. It is recognised that undertaking the Engagement Lead role can be emotionally challenging, and advice has been sought from the Staff Support service for mechanisms to provide psychological support for these members of staff. A peer support community of practice is in development, and Engagement Leads, and their managers are able to contact the Staff Support service if they need additional bespoke support at any time

Recruit, support and embed Patient Safety Partners (PSPs) – Established

3.13. A PSP paper was presented to the Trust Management Executive on 12 September 2024. This included the impact made by the PSPs and their views on supporting the Trust in the safety agenda. This can be found in Appendix III.

3.14. There are currently two PSPs. A third PSP has been recruited and started her induction in late November 2024.These PSPs will sit on Trust safety committees and provide a patient perspective on our processes and ensure that our activity is centred around best patient care.

3.15. The PSPs are developing their education and mentoring programme in collaboration with the Patient Experience Team and the Quality Improvement Team, based on University Hospitals Southampton NHS FT.

3.16. Plans to recruit a total of 14 PSPs by May 2025 are on track.

4. Application of a range of system-based approaches to learning from patient safety incidents

4.1. To achieve this, we are developing a workforce with the skills, tools and support to apply and use a range of appropriate systems-based tools to learn from patient safety events. There are four ways in which this will be supported as summarised below.

Key areas for improving patient safety identified and agreed – Established

4.2. Four Thematic Workstreams were identified in 2023 through analysis of a range of Patient Safety data and stakeholder engagement – see the OUH PSIRF Plan. These are:

4.2.1. Handovers including communication and documentation

4.2.2. Reporting and endorsing radiology and pathology results

4.2.3. Improving cancer multidisciplinary team processes

4.2.4. Supporting people at risk (focus on people with Learning Disabilities)

4.3. See Appendix IV for the latest update included in the September-October 2024 PSIRF bi-monthly paper

4.4. Each Division has elected to develop local PSIRF themes for improvement. These include improving the management and prevention of falls, improving the care of pressure ulcers and loss to follow up.

Adaptable and flexible learning response methods – Established

4.5. A range of learning response methods are available depending on the complexity of the patient safety event and the depth of potential learning. These are described in the OUH PSIRF Policy. A summary of the different types of learning response can be viewed on the PSIRF Intranet site.

4.6. Learning Response reports will be reviewed using the HSSIB/NHS Scotland Learning response review and improvement tool. This tool identifies 8 key features of a high quality report. These are:

4.6.1. The report describes how all people who were affected by the incident are meaningfully engaged and involved. This includes:

4.6.1.1. how their wellbeing and needs were supported

4.6.1.2. how their stories and perspectives contributed to the report

4.6.2. Tools were used to understand how the environments, equipment, tasks and the people involved interacted together to lead to the outcome experienced.

4.6.3. “Human Error” is considered as a symptom of interactions between environments, equipment, tasks and people.

4.6.4. The report does not blame individuals, teams, departments or organisations directly.

4.6.5. The report demonstrates that the author has explored and considered why those involved acted the way they did at the time and not with the benefit of hindsight

4.6.6. The report focuses on understanding what happened and why it happened and does not describe what “could” or “should” have been done.

4.6.7. Safety recommendations should be effective and be developed collaboratively with relevant stakeholders. They should focus on things like equipment, care processes and pathways, and not on individuals.

4.6.8. The language should be clear and easy to read.

4.7. Ten SIRI reports written under the old SIF have been reviewed using this tool, and the findings can be viewed on the PSIRF intranet site. Fully approved PSIIs are being reviewed using this tool as part of the approval process. Once ten reports have been finalised, these will be formally assessed using the tool in 2025 to compare the quality of investigation reports pre- and post- PSIRF implementation.

4.8. One PSII has already been reviewed using this tool by colleagues from partner organisations across the BOB ICB and was rated as excellent.

Training for staff – Established

4.9. Training available for staff includes both patient safety training and role specific training to undertake different learning responses. The training provided to date can be seen in Appendix II.

4.10. Those in Oversight Roles are required to:

4.10.1. Complete the Patient Safety Syllabus courses:

4.10.1.1. Patient Safety Syllabus – Essentials for all staff.

4.10.1.2. Patient Safety Syllabus – For Senior Leaders.

4.10.1.3. Patient Safety Syllabus – Access to practice.

4.10.2. The PSIRF requirements for training for Oversight Roles state: "*Those in system oversight roles (ie provider board PSIRF lead(s)) must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development. Staff in oversight roles must be appropriately trained to support the practical application of PSIRF oversight principles and standards*."

4.10.3. This requires completion of the HSSIB course "Patient Safety Incident Response Framework oversight" or an equivalent course from another provider.

Cultural shift from blame to learning – In progress

4.11. A key feature of a systems-based approach is the shift from actions targeted at individuals, such as reminders, e-learning, repeated training. Instead, the underlying factors that led to the incident should be targeted for a more robust action, such as changes in care pathways, digital support or the introduction of a new role.

4.12. Changing the patient safety culture will take much longer to embed across the whole trust. This is being assessed using:

4.12.1. Answers to relevant questions in the annual NHS Staff Survey (see Appendix V)

4.12.2. Learning response scores using the HSSIB/NHS Scotland Learning response review and improvement tool will improve and reflect excellence in terms of using a systems perspective to focus on learning and avoid blaming individuals or teams.

4.12.3. Staff feedback from events such as the PSIRF summit and regular surveys and discussions with staff relating to various aspects of PSIRF. Staff commitments made to develop PSRIF can be viewed in Appendix VI. This demonstrates staff involved recognise a shift in culture and highlight where future work may be targeted.

4.13. Local areas feeling empowered and motivated to initiate learning responses directly (for example hot debriefs and After-Action Reviews).

5. Considered and proportionate responses to patient safety incidents

Identify key patient safety issues according to the Trust Patient Safety Profile – Established

5.1. Regular monitoring and updates for the four PSIRF Thematic workstreams are provided both at bimonthly reports to SLIC and in bimonthly reports to IAC.

5.2. Ongoing analysis of patient safety data for issues, themes and trends is undertaken through established governance systems (as described in the PSIRF plan) to identify new areas of risk or concern and PSII learning responses initiated where there is the potential for learning to improve patient safety.

5.3. Feedback and suggestions have been sought from multiple stakeholders for future PSIRF thematic workstreams, and the PSIRF plan will be refreshed after 18 months. A full review of all the safety data will be undertaken every four years. Key areas suggested were improving processes around discharge, support for patients with mental health issues (and for staff looking after them), blood conservation and improving how we incorporate the patient voice in safety.

Empower local areas to respond to issues and escalate – In progress

5.4. This will be achieved through the rollout of After Action Reviews (AARs). Staff who have participated in AARs have found these to be a helpful tool to support learning and empower those who participated to own the resulting improvement work (see Appendix VII for feedback from AAR participants).

5.5. AAR training is being rolled out across the Trust to build a community of people trained and enthusiastic about conducting AARs. Training numbers can be viewed in Appendix II.

5.6. Feedback from the AAR Conductor training can be viewed in Appendix VIII and demonstrates the enthusiasm and motivation of those who have participated in the training to use this learning response locally.

5.7. A peer support community of AAR conductors has been established to support those who have been trained to support each other and develop their skills.

Prioritise resources to areas of highest concern – In progress

5.8. The four PSIRF Thematic workstreams were agreed for prioritisation of resources to those issues that impact patient safety across the Trust.

5.9. Incidents reported as moderate harm or greater, and those of concern to the local areas or subject matter experts are reviewed during the daily multidisciplinary Patient Safety Response meeting (PSR) to explore and recommend suitable learning responses.

5.10. The weekly agenda setting meeting for SLIC reviews incidents where learning responses have been agreed and reviews whether an alternative approach may be more appropriate.

6. Supportive oversight focused on strengthening response system functioning and improvement

Leadership commitment – In progress

6.1. PSIRF is supported by strong leadership commitment from the Chief Executive Officer and Chief Medical Officer through the oversight structures within the Trust. There are daily Patient Safety response meetings (PSR) reviewing all incidents graded moderate harm and above or any of concern. The weekly pre-meet for SLIC provides oversight of learning responses and progress. The Deputy Chief Medical Officer chairs SLIC meetings where learning responses are shared, and progress reports provided for comments and suggestions. There are regular, bi-monthly, PSIRF reports to the Clinical Governance Committee and the Trust's Integrated Assurance Committee.

6.2. Leadership demonstrates consistent approach to learning response requests following the guidance provided to those chairing PSR meetings.

6.3. The Patient Safety Team work in partnership with other areas across the Trust including but not limited to, the Quality Improvement Teams, Divisional Governance Teams and other corporate teams.

6.4. Trust Leaders commit to undertaking the required PSIRF training (as outlined in Appendix II).

Partnership working – Established

6.5. The OUH implementation of PSIRF is developing communities of practice and peer support groups to embed partnership working and networking to improve safety skills and knowledge. These include:

6.5.1. Community of Practice for learning response leads to share systems-based approaches

6.5.2. Engagement Leads

6.5.3. Patient Safety Partners

6.5.4. AAR Conductors

6.6. The PSIRF Implementation Group was established to support the transfer from SIF to PSIRF. After the transition, the group continues to meet to oversee the implementation of PSIRF and continually improve its delivery. The terms of reference were updated to reflect the new role and title changed to the PSIRF Improvement Group. This group provides:

6.6.1. A safe space to reflect on, consider and plan adjustments and improvements to how PSIRF is managed within OUH.

6.6.2. A forum for stakeholders across different areas of OUH to join and create a shared vision for PSIRF, including our Patient Safety Partners, Assurance, Quality Improvement, Subject Matter Experts and Divisional Governance teams.

6.7. The weekly SLIC meeting provides an opportunity for improvement work to be shared, and collaborations developed between teams within the OUH and with other organisations who have attended to understand how this meeting supports learning and improvement. See section 3.5 and Appendix I for more detailed information.

6.7.1. From December 2023 to March 2024, colleagues from six per Trusts visited SLIC to witness our processes (OUH adopted PSIRF earlier than most organisations in the country). There were also visits from Health Innovation Oxford & Thames Valley and the South-East Nursing Directorate of NHS England. Feedback was universally positive concerning the meeting’s content and its management; some quotations may be found in Appendix I below.

6.8. PSII investigations have implemented a team approach incorporating a human factors lead, a subject matter expert and an Engagement Lead. The sign-off process is also being reviewed, and a panel approach to reviewing the final draft is being trialled to explore whether this is a more collaborative and efficient approach to approving a final draft. The sign off panel will include the investigation team, patient safety team, DCMO, divisional representatives, Patient Safety Partners and other relevant subject matter experts.

Regular Evaluations – Established

6.9. The PSIRF Improvement Group are strengthening the process of PSII and LMDT action plan reviews through SLIC. This will allow better oversight of completion rates and effectiveness. The completion of selected actions and demonstration of their effectiveness has recently been introduced to the Divisional presentations at SLIC and will be captured in the bimonthly SLIC report to PSEC and the PSIRF report to CGC and IAC. Divisions continue to be responsible for ensuring that all actions are completed in line with the action plans and updated in Ulysses.

6.10. All action owners also receive reminder emails through the incident reporting system when actions are due to be completed. Reminders are also sent to the owners of actions that are overdue.

6.11. Any concerns about the ability of the action owner to complete the action will be escalated through the Patient Safety Team for consideration by Head of CG and/ or SLIC Chair.

6.12. A PSII action status report, including the number of actions not started, underway and fully addressed) will be presented each month at the Clinical Governance Committee as a core part of the Divisional reports from December 2024.

6.13. Learning Response pathways are also monitored to ensure timely completion and sign off. See Appendix IX for data around the time taken for learning responses.

Creation of a culture of continuous improvement – Established

6.14. The weekly SLIC meeting has a clear and consistent focus on learning and improvement. This is reflected in the feedback from people who have attended. See Appendix I for further details.

6.15. Integration and collaboration with the Quality Improvement team embeds the model for improvement approach to implementing safety improvements following learning responses.

6.16. Regular review and requests for feedback allow the Trust's management of PSIRF to be updated and evolve according to suggestions and experience of staff.

7. PSIRF first anniversary

7.1. To celebrate the achievements of PSIRF since its launch in October 2023 we bought key stakeholders together to learn about the high and low points of implementing PSIRF and what it has meant to the Trust, Divisions, Directorates and local areas.

7.1.1. The event took place on Friday 18th October. It was attended by around 45 people from OUH, the BOB ICB, Oxfordshire Health watch, PSPs and NHSE.

7.1.2. Presentations included the thematic reviews, progress and achievements so far.

7.1.3. Divisional presentations. What has gone well, what can be improved.

7.1.4. Talk from the patient engagement lead for MRC and the PSPs and what their role has meant for patients and families.

7.2. Feedback from the event included how engaged everyone was. How positive the event felt and how people genuinely wanted to make changes and improve patients' and families' quality of care.

7.3. A Liam Oliver Memorial Patient Safety Poster Award was presented by the widow of Liam Oliver. 15 posters were submitted, and 3 judges awarded this to the work of the Trust's Falls Practitioner. All the posters are available on the PSIRF intranet site.

7.4. Participants of the seminar reflected on the day and wrote commitments to growing PSIRF and the Trust's safety culture on a tree. Responses can be seen in Appendix VII.

PSIRF Internal Audit

7.5. BDO, the Trust's Internal Auditors, completed an audit of PSIRF implementation and management in October 2024. A final report has been published which was presented to TME on 28 November and will be presented to Audit Committee on 26 February. There were two findings regarding:

7.5.1. Support and resources for PSII investigation teams (low risk)

7.5.2. Recording of progress or completion of PSII actions on Ulysses (medium risk)

7.6. The Trust has drawn up actions in response to these findings, including strengthening the monitoring of action plan delivery.

7.7. The auditor’s overall conclusion was that the Trust has Substantial design of controls (the highest rating), and Moderate effectiveness of controls (the medium rating).

8. Future areas of focus

Compassionate Engagement of those affected by patient safety issues

8.1. Engagement leads will be supported through the development of a community of practice peer support group.

8.2. Additional PSPs will be recruited to provide a clear and central patient voice in all patient safety work within the Trust.

Proportionate Responses to Patient Safety Issues: Patient safety risk profile review

8.3. A full and detailed review of the Trust’s Patient Safety Priorities will be undertaken every four years. In the intervening years, stakeholders will be asked to reflect on key safety priorities for the Trust and consider potential new PSII thematic workstreams to replace any that may be reaching closure (see above).

Systems-based learning to understand patient safety issues

8.4. The aim is to continue to grow the PSIRF community of practice to support all those in using system-based analysis and introduce additional tools to their toolboxes. Three bespoke training sessions have been arranged on systems-based analysis and safety action development tools and will continue to be arranged at regular intervals.

8.5. Approved PSII reports will be reviewed using the HSSIB Learning response tool and compared with the baseline SIRI reports. Once ten reports have been completed these will be compared to determine whether there has been an improvement. An improvement is anticipated as the tool is being embedded in the learning response processes and documentation templates. Additional support and information is made available through the community of practice intranet site and during meetings.

Supportive Oversight

8.6. Progress the BDO PSIRF Internal Audit actions which have been designed in response to the two findings (see Section 8 above).

8.7. Integrated Commissioning Board (ICB)

8.7.1. Under PSIRF, commissioners no longer have direct authority to shape the Trust's learning and incident response management as they did under the Serious Incident Framework. However, there is still close working between the two organisations, including a quarterly Safety Review Meeting, at which intelligence is shared on "quality and safety challenges, quality improvement and development of a patient safety culture" (Terms of Reference).

8.7.2. To date, three of these meetings have occurred. There is no formal output from the meetings, but feedback about the implementation of PSIRF and development of safety management practices have been positively received by ICB colleagues.

8.8. The Patient Safety Commissioner has published 7 Patient Safety Principles (see Figure 3: The Patient Safety Commissioner's Patient Safety Principles). The PSIRF team will be exploring how these can be further embedded in Patient Safety activities within the OUH.

Figure 3: The Patient Safety Commissioner's Patient Safety Principles

9. Conclusion

9.1. This report summarises the progress of PSIRF implementation and embedding between October 2023 to November 2024

9.2. This report is for noting and assurance.

10. Recommendations

10.1. The Trust Management Executive is asked to:

- Note the contents of this report
- Committee members are asked to ensure they have completed their training requirements under the National Patient Safety Strategy

11. References

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Appendix I: Extract from the HSJ Award Application for the Safety Learning and Improvement Conversation OUH launched the award-winning Safety Suite in 2019, developing a whole system approach for patient safety. Over the last year, we have built on this success through the development of our PSIRF Plan and Policy in conjunction with patients, external organisations, and trust-wide colleagues. A PSIRF Trust Board seminar enabled the Board to shape the PSIRF Policy and Plan. A key component of the Plan was SLIC, which promotes collaboration across all clinical divisions and key areas of expertise to reduce silo working and duplication of effort. Learning from the meeting is shared trust-wide in a weekly slide for use in safety huddles.

Feedback from a survey of SLIC members provided valuable insight into how participants are perceiving the forum, and whether it is meeting its aims. One comment stated:

> *"SLIC makes it feel like we are one organisation. It is positive and motivating"*

Visitors to the meeting from other organisations are asked to provide feedback, and have commented that SLIC is:

> *"Respectful, kind, positive, supportive feel with very clear focus on learning."*

Another visitor said:

> *"[SLIC] provided an open forum for sharing and discussion as well as healthy challenge."*

A Patient Safety Awareness Week roadshow provided members of the public and staff with an opportunity to feedback on their experience of SLIC. SLIC was seen as "Not scary," and a "Safe space", "Great for collaborating," and "Includes the voice and perspective of the patient experience."

Further to the survey, clinical divisions are actively encouraging all staff to attend SLIC and share the learning with their teams. The format of the Learning Slide has been improved by the Trust's Graphic Design department, to enable the key messages to be easily read and shared.

Spread

OUH has four clinical divisions with their own governance structures. Each week, one division shares their patient safety improvement work. They identify key patient safety issues relevant to their areas to focus improvement efforts on and share this work at SLIC. For example, one division is co-ordinating several projects to improve

the prevention and management of falls. Individual teams have shared improvement projects at SLIC which has provided them with suggestions, advice, offers of assistance, and a forum to share key messages. Local areas have found this approach empowering, and there have been occasions where other departments have been inspired to consider applying the learning ideas in their area. For example, Maternity described a project where chaperoning practices were enhanced using new curtains. This practice was then taken up by radiology.
SLIC has welcomed visitors from other Trusts who wished to learn how this forum is run. One visitor described the forum as being:

> *“Very well structured and organised - I had heard it was a two-hour meeting and was worried about clinician's time but there was a good balance of time vs benefit.”*

Our Patient Safety Partner describes how she feels SLIC demonstrates a valuable forum for listening to concerns from patients:

> *“SLIC is a forum where the patient voice and their wellbeing is, in my opinion, at the forefront of the conversation. As a regular attendee as a Patient Safety Partner (PSP), I have been humbled at times by the honesty of staff regarding a situation that did not go well. This was a surprise to me, and I felt demonstrated a sea change in attitudes from closing ranks to being honest and learning from errors rather than covering up…*
> *As a PSP I have a regular spot at SLIC, feel listened to and valued and actions taken should I raise an issue of concern.*
> *As the Chair of SLIC has noted my voice saying, ‘what about the patent’ is now in his head.”*

Future ambitions are to create opportunities for involvement for even more staff, by providing meetings in different formats and styles to allow even greater participation. By consistently seeking feedback and addressing issues as they arise allows, the forum is evolving. Those working in the patient safety field in OUH are demonstrating the importance of listening to learn and to improve. This is having a positive impact on the Trust’s Patient Safety Culture.

Appendix II: Training records

Type of Course	Course name	Number of staff who have completed	Target audience
Patient Safety Syllabus	Level 1: Essentials for patient safety for all staff	13,697	All staff Number of current members of staff who have completed the training
	Level 1: Essentials for patient safety for senior leaders	201	Trust Board Members and Senior Leadership A request will be made to make this module role specific for appliable staff.
	Level 2: Introduction to systems thinking	310	A request has been made to make this module role-specific for anyone who is a manager.
	Levels 3 & 4 for Patient Safety Specialists	Underway (due to be completed by end December 24)	Patient Safety Specialists (2)
Human Factors training	½ day Virtual Human Factors OxSTaR	542 between April 2023 and March 2024 287 between April 2024 and August 2024	All staff
PSIRF mandated role-specific training	Systems-based approach to incident investigation	12*	Those who will be supporting PSII leads to undertake investigations (CGRPs, Patient Safety Specialists)
	Involving those affected by patient safety incidents in learning process	26*	Training was delivered by an external company, Being Human in Healthcare.
	Patient Safety Incident Response Framework oversight**		Training provided by HSSIB. Further details are below.
Learning Response training	After Action Review Conductor Training – External company (iTS)	43 (Staff must have completed Patient Safety Syllabus Levels 1 & 2 before enrolling)	Those who will conduct After Action Reviews, participants nominated by the Divisions.
	After Action Review Train-the-Trainer	6, but one has subsequently left the Trust	These members of staff will provide further training across the Organisation from July 2024.

			One trained member of staff has now left the organisation.
	In-house AAR Conductor training	10 new staff members trained	The first in-house training day was held in July, with five more sessions booked in 2024.
Community of Practice	Peer to peer advice and discussions for patient safety investigations and improvement work	4 meetings have taken place, and three bespoke training sessions planned.	

*These courses are run by HSSIB and have an external booking system. The PSIRF team are reliant on staff informing the team when the course has been completed, therefore the number of staff trained may be greater than the number presented.

** Patient Safety Incident Response Framework oversight:

This live course is provided by HSSIB and covers the mindset and the culture underpinning effective oversight, as well as the theory and practice of measurement and monitoring of patient safety. This course is designed to introduce the principles of patient safety incident response oversight.

This is a seven hour course, delivered in two sessions of 3.5 hours each, with a gap of about a week between the sessions. As this course is CPD certified, you can record 7 CPD points upon completion.

This course covers:

- NHS PSIRF and associated documents
- Effective oversight and supporting processes
- Maintaining an open, transparent and improvement focused culture
- PSII commissioning and planning

It is required for those in PSIRF Oversight roles. Enrolment opens on Monday 9 December 2024 at 10am.

Appendix III: Report on the Patient Safety Partner role at OUH

Cover Sheet

Clinical Governance Committee: Thursday 12 September 2024

Insert Paper Number

Title:	**Patient Safety Partners**

Status:	**For Information**
History:	**First report**
Board Lead:	**Chief Nursing Officer**
Author:	**Dr Rustam Rea, Director of Patient Safety**
	Caroline Heason, Head of Patient Experience
Confidential:	**No**
Key Purpose:	Assurance, Performance.

Executive Summary

1. The paper aims to update on the role of Patient Safety Partners (PSPs), outline the committees they are part of, and discuss the current recruitment strategy.
2. The recruitment and engagement of PSPs are integral to the NHS Patient Safety Strategy and detailed in Part B of the Framework for Involving Patients in Patient Safety. This initiative aims to improve organizational safety through patient involvement in governance and management processes.
3. PSPs are promoted nationally by NHS England to foster openness, understand patient perspectives, identify risks, support risk prioritization, assist in action plans, and create patient information. Trusts are encouraged to engage PSPs in various activities such as safety committees, improvement projects, board work, staff training, recruitment, and investigation oversight.
4. Since March 2023, PSPs have been involved in the Trust's patient safety agenda. Currently, the Trust has two PSPs, with a third being onboarded, and aims to recruit a total of 14 PSPs including two for the Clinical Governance Committee by 31 March 2024. These PSPs are registered Trust volunteers with DBS checks and have signed a code of conduct based on the Trust's Governors code of conduct. They have significant experience in healthcare and volunteering, enabling them to act as trusted critical friends.
5. PSPs meet monthly with the Director of Patient Safety and the Head of Patient Experience to review past activities and plan future contributions to enhance the safety culture. Additionally, they present in the weekly Safety Learning and Improvement Conversation (SLIC) meetings, where they actively participate and contribute to improvements.
6. A Patient Safety Partner (PSP) has described the impact of the post, and they expressed feeling valued and supported within the Trust, highlighting their involvement in various projects. Over 16 months, they have contributed to patient care and staff perspectives by participating in policy reviews, interviewing staff, reviewing Duty of Candour letters, suggesting website improvements, and setting up a forum for young people and carers. They are also involved in Patient Safety Investigations and several committees, including Safety Learning and Improvement Conversation [SLIC] and Patient Safety and Effective Committee [PSEC]
7. The Trust has partnered with University Hospitals Southampton (UHS) NHS FT to benchmark the involvement of Patient Safety Partners (PSPs) in patient safety and QI. The Trust plans to adopt UHS's structured approach to involving PSPs in QI as it recruits more PSPs during the autumn. This approach will be led by the Interim Head of Integrated Quality Improvement and Head of Patient Experience and will be co-produced with the PSPs.

8. The Trust's Quality Priority: involving patients in safety, includes six actions to enhance engagement with patients, families, and carers following a patient safety incident.

9. **Conclusion:** The paper describes the role of the Patient Safety Partners, highlights the committees of which they are members, and outlines their projects and the impact of their involvement. The paper has also described the partnership with University Hospitals Southampton NHS FT and the current recruitment plan. The Trust is very grateful to the PSPs for their contribution given on a voluntary basis to the Trust's patient safety culture.

10. **Recommendation:** The Trust Management Executive (TME) is asked to note the contents of the report.

Contents

Patient Safety Partners

1. Purpose

1.1. The purpose of the paper is to describe the role of the Patient Safety Partners, advise on the committees of which they are members and the current recruitment plan.

2. Background

2.1. The recruitment and involvement of Patient Safety Partners (PSP) is embedded within the NHS Patient Safety Strategy[1] and detailed in Part B of Framework for Involving Patients in Patient Safety[2]; aiming to enhance organizational safety by involving them in governance and management processes.

2.2. The national development of PSPs led by NHS England has been designed to promote openness, help understand patient perspectives, identify risks, support risk prioritization, assist in action plans, and create patient information.

2.3. Trusts are encouraged to engage PSPs in safety committees, improvement projects, board work, staff training, recruitment, and investigation oversight.

3. The Trust's Patient Safety Partners

3.1. PSPs have been engaged in the Trust's patient safety agenda since March 2023. One PSP worked with the Trust between March 2023 until March 2024.

3.2. The Trust has two PSPs and currently onboarding a third with the ambition of recruiting 14. They are registered Trust volunteers with DBS (Disclosure and Barring Service) checks in place[3] and have signed a PSP code of conduct which is based on the Trust's Governors code of conduct.

3.3. The PSPs have significant combined experience within Children's and Adults' healthcare, third sector and healthcare volunteering which has facilitated them in adopting the role of a trusted critical friend.

3.4. The PSPs meet monthly with Director of Patient Safety and Head of Patient Experience to review the previous month's activity and plan the next with particular emphasis on the contribution and the impact the PSPs can make in increasing safety and strengthening the safety culture within the Trust.

3.5. The reflections and reviews of Patient Safety Partners (PSPs) are a regular agenda item at weekly Safety Learning and Improvement Conversation (SLIC) meetings. PSPs actively participate in the various committees, contributing questions and suggestions for practice improvements. The PSPs have demonstrated the adoption of Trust values as working practice, which has led to their acceptance as critical friends. Their significant communication skills,

[1] Report template - NHSI website (england.nhs.uk)
[2] Framework for involving patients in patient safety (england.nhs.uk)
[3] Quick_Guide_to_DBS_Checks.pdf (publishing.service.gov.uk)

and aptitude has led to them being highly valued for their involvement in reviewing complex and serious incidents and the subsequent changes in practice.

3.6. The Trust PSPs are involved in three Trust committees, with opportunity to speak and offer critique at each and 17 projects / programmes. Appendix 1 itemises the committees and projects in which the PSPS are / have been involved.

4. Impact of PSPs

4.1. The PSPs have demonstrated considerable impact in their work with the Trust, including internal, external and international presentations, membership of Trusts committees and service changes. This is itemised in Appendix 1.

4.2. A PSP has recently described

"I have been treated as a valued member at every meeting I attend and feel that my questions are answered, my input acted upon when necessary, and valued. I feel that the trust placed in me and the role I have as a PSP demonstrates a very open and supportive culture within the Trust".

4.3. They have also described the impact of being involved in Trust projects.

"During the past 16 months as a Patient Safety Partner (PSP) I believe I have made both a practical difference to patient care and to staff thinking regarding patients. Examples of this are as follows.

- I have been actively involved in the cannulation policy review and asked to comment on venepuncture policy rewrite.
- I was invited to interview the MRC Patient engagement Lead, with the Divisional Nurse, Complaints and Patient Services Manager and the clinical governance and Risk Practitioner.
- I was asked to review Duty of Candour letters within two divisions. This took the form of reading Duty of Candour letters and having frank discussions with staff regarding the content.
- I have suggested that the OUH website is simplified to show where patient information is situated. It is now at the beginning of the website, so much easier for patients to access.
- I am involved in setting up a young person and carers forum to better support young people and carers moving from child to adult services.
- I am currently involved in PSII (Patient Safety Incident Investigations) improvement with the team Patient Safety Team.

I am involved in several committees including SLIC (Safety Learning and Improvement Conversation) where I have a place on the agenda and PSEC

(Patient Safety and Effectiveness Committee). I also dip in and out of meetings as invited and relevant to my role".

5. Partnership with University Hospitals Southampton (UHS) NHS FT

5.1. The Trust has partnered with UHS to provide external benchmarking and mutual support in the embedding of PSP into Quality Improvement (QI). UHS started recruiting PSPs in autumn 2021 and currently have 12 in total. They have developed these posts to encompass both safety and quality improvement. UHS's PSPs are also registered volunteers and they follow a similar recruitment process to the Trust.

5.2. UHS have a structured approach to involvement in QI which the Trust will adopt as more PSP are recruited during the autumn. The UHS approach includes co-produced training, project role cards which describe and scope the QI project, giving the detail of the contribution required, PSP mentors and project buddies.

5.3. The Trust's PSPs have more opportunity than the UHS PSPs to openly discuss and critique practice in committees and speak with / work alongside clinicians and leaders to improve healthcare practice. The PSPs, Director of Patient Safety and Head of Patient Experience are keen to maintain this approach as it contributes to role modelling a positive safety culture, enabling and empowering all to speak about safety.

5.4. This benchmarking with UHS has been insightful as it has endorsed the Trust's recruitment PSP process and PSP inclusion in identifying patient safety concerns and involvement in QI.

6. Next stage of Recruitment and extending the PSP role to include QI.

6.1. The recruitment process will continue in collaboration with the Trust's Voluntary Services Team until 14 are recruited. This includes recruitment of two PSP to attend the Trust's Clinical Governance Committee (CGC) and this plan will be confirmed at the monthly PSP meeting on 16th September 2024.

6.2. Following the benchmarking with UHS, the Trust is planning to adopt their approach to involving PSP into QI delivering the co-produced training, implementing project role cards as described above, PSP mentors drawn from senior multidisciplinary clinical leaders and individual QI project buddies.

6.3. This will be ratified by the Patient Safety Improvement Group and implemented during the autumn led by the Interim Head of Integrated Quality Improvement and Head of Patient Experience and coproduced with the PSPs.

7. Quality Priority: Involving patients in Safety

7.1. This Quality Priority has six actions and has been developed to improve the compassionate engagement of patients, families and carers following a patient safety incident and is based on the NHSE / HSIB / Learn Together document principles of Engaging and involving patients, families and staff.

7.2. The tools to capture patient experience and improve our understanding of this part of the patient's journey are being co-produced with PSPs. To date one action is complete.

7.3. The PSP are reviewing the Quality priority on 16th September with the Director of Patient Safety, Head of Patient Experience and the PSIRF Implementation Lead to form a coproduced and detailed action plan and which will be reviewed at the PSIRF Improvement Group on 9th October 2024.

8. Conclusion

8.1. The paper has described the role of the Patient Safety Partners, explained on the committees of which they are members, their projects and the impact of their involvement. The paper has also described the partnership with University Hospitals Southampton NHS FT and the current recruitment plan.

8.2. The Trust is very grateful to the PSPs for their contribution given on a voluntary basis to the Trust's patient safety culture.

9. Recommendation

9.1. The Trust Management Executive (TME) is asked to note the contents of the report.

Appendix 1.

Committee	Project/ Programme
Weekly Safety Learning and Improvement Conversation (SLIC).	Review of Duty of Candour Letters in MRC with Clinical Risk and Governance Practitioner and Patient Engagement Lead.
Monthly Patient Safety and Effectiveness Committee (PSEC).	Trust website and relocation of patient information making it easier for patients to access.
Previous attendance at the Clinical Improvement Committee (CIC). PSPs are not currently represented at this committee. The feedback has been that this is a very technical committee which to a lay person is complex to understand and contribute.	Co-producing and co-chairing the Young People and Family / Carer Group supporting the Moving to Adult Services / Healthcare Transition Programme.
Monthly Patient Safety and Improvement Group (PSIG).	Review of Patient Safety Investigations and Improvement (PSII) with the PSIRF Implementation Lead.
	Observing and reviewing the Falls Teaching Programme led by the Lead Falls Practitioner.
	Recruiting MRC Patient Engagement Lead with MRC Divisional Director of Nursing, Clinical Risk and Governance Practitioner and PALS and Complaints Manager.
	Review of the Trust Cannulation Policy with the Clinical Policy and Safety Standards Practitioner.
	Review of the Venipuncture Policy with the Clinical Practice Educator, Practice Development and Education.

Committee	Project/ Programme
	Working with the Deputy Director of Nursing for NOTSSCaN to ensure Staff name badges placed so they can be easily read by patients.
	Presentation with the Head of Patient Experience about the PSP role to the national Patient Safety Commissioner on 16th February 2024.
	Joint presentation with the PSPs from the University Hospitals Southampton NHS FT on the learning from working with PSPs at the International Health Improvement Conference on 10th April 2024.
	Presentation with the Head of Patient Experience about the PSP role at the International Learning Collaborative on 8th June 2024.
	Presentation to the Oxfordshire Health Overview and Scrutiny Committee on 15th July 2024.
	Correct location of Trust DVT clinics publicised to Oxfordshire GPs.
	Member of the Trust's Moving to Adult Services / Healthcare Transition Steering Group.
	"What Matters to You?" And QI Voices – strengthening the reflections and learning from patients, relatives and staff working with the Quality Improvement Team and Patient Experience Team.
	Reviewing the Reasonable Adjustment Flag internal education programme with the Reasonable Adjustment Flag Steering Group.

Appendix IV: Update from the PSIRF Thematic Workstreams

Updates on each of the Trust's 4 PSII thematic reviews from the Patient Safety Profile are summarised below. Workstreams were started in October 2023, except for Handover and Communication which was started in response to a specific incident earlier in 2023.

Handovers including communication and documentation

The task-and-finish group exploring the issues around clinical handovers includes representatives from medical, nursing teams, Divisional governance teams, PSIRF Implementation team, Quality Improvement, Operational team, Divisional digital leads, and Patient Safety partners. Key actions arising from this workstream are summarised in Table 1.

Key Performance Indicators for this Workstream:

1. Reduction in time between decision to transfer and actual transfer time – this time efficiency between decision to admit/transfer and actual transfer time of patient to an allocated bed will be measured via Capman, ED performance
2. Reduction in the number of patient safety related incidents directly related to the handover of patients between ED/EAU and the onward ward and between ward-to-ward transfers and the level of impact. Measured by direct incident reporting and search for 'handover' on all incidents from ED/EAU over a specified period.
3. Increased compliance against the risk assessment that is required prior to the transfer of patients from one clinical area to another - measured through incident reporting, audit of risk assessments being completed and feedback from portering staff on use of the risk assessment tool
4. Increased use of electronic transfer document - audit of transfer document being used in ED/EAU and being read by ward staff in advance of patients being transferred to the wards.

Table 1: Actions to address key issues relating to clinical handover and communication

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
Reviewing and updating the Transport and Escort Policy	Update policy to improve clarity around roles and responsibilities. Reduce size of policy. Create short summary on a page.	Divisional Director of Nursing (DDoN) CSS Previous work by Emerging Leaders Group	A policy that is reduced in size, clear and easy to follow Compliance against the policy. Risk assessments being used. Improved experience for the portering staff. Better patient experience during transfer. Reduction in Ulysses related to moderate and above harm.	Process mapping completed October 2024 New policy update January 2025

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
A disconnect between documentation in emergency areas and other clinical areas in the Trust. Lack of clarity on digital handover documentation	Improving outlier practice QIP to improve communication between teams through accurate record keeping, to identify patient safety concerns and to improve efficiencies in time	Clinical Operational Manager	See below as this work has been incorporated in digital workstream	See below
	Alignment of digital documentation process between emergency areas to the rest of the Trust Creation of a digital handover document for the whole Trust	Divisional Informatics Lead, MRC and Interim Deputy DDoN, SUWON	A digital EPR handover template that can be used by staff receiving a patient from ED or EAU without the need for a verbal handover - this will facilitate an effective clinical handover This will become the standard template across the Trust (ICUs already have an agreed template) Safer handovers where preventative measures are in place that will reduce patient harm.	Presentation of EPR transfer note at PSIRF anniversary forum and at SLIC in October 2024 Went live 11 November 2024 Evaluation of impact for the wards December 2024

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
			Efficient handover demonstrating a reduction in time wasted.	
Review the role of porters and how they are supported and engaged when transferring patients	Meeting with Head of Portering to identify key issues and next steps. Patient Safety Partner to work alongside portering team to understand their role and challenges particularly in relation to transferring patients from one clinical area to another.	DDON for MRC and Trust Patient Safety Partner	Wider understanding of the impact that transferring patients from one clinical area to another has on our portering staff and to make sure that the Transfer and Escort Policy supports them in this role Risk assessments being used and available for porters prior to transfer. Improved experience for the portering staff. Better patient experience during transfer.	Visit still to be organised with Trust Patient Safety Partner but Head of Portering attends Transfer & Policy Group, and once the new policy is in place will be a key stakeholder in its evaluation

Reporting and endorsement of results

The stakeholder group membership includes digital, clinical, radiology and pathology and patient safety representatives. Key actions arising from this workstream are summarised in Table 2.

There are several key performance indicators connected with this thematic PSII, performance against which is shown in the graphs below. Overall, Trust-level results endorsement performance is shown below. These KPIs are reviewed at Trust and Divisional level at monthly theme meetings. Significant improvement has been seen in some areas, eg Cardiology (work presented at SLIC in August 2024).

The greatest risk to patient safety for results that are not endorsed or endorsed and not actioned are radiological and histopathological results. Work to address this is ongoing between the CD for Radiology and the theme lead. The number of incidents leading to a delay to diagnosis due to non-endorsed or endorsed but not actioned results will be tracked.

Table 2: Actions to address key issues identified around results endorsement

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
Reviewing and updating the management of results for staff who leave the Trust	Review Leaver form and update to include metrics required to set up a TIE auto-forward to proxy	Director of Clinical Informatics (DCI)	Automate the redirecting of results to avoid missed results in a leaver's inbox where a proxy has not been manually set up	February 2024 (delayed from October by resource constraint)
	Develop a training video to circulate to all clinical teams via a safety message on how to give and take proxies. as well as other functions in message centre	Director of Clinical Informatics (DCI)	Improve digital literacy of staff to ensure results are not missed in dormant inboxes	Completed. Videos created; Safety Message submitted which included the tutorials and videos regarding message centre and results endorsement. The videos have also been circulated with

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
				the PSIRF safety slides.
Some results being automatically removed after 30 days, meaning some clinicians have not had a chance to endorse in time	Increasing the length of time results remain within an inbox to 60 days	Director of Clinical Informatics	Reduction of risk of results being missed by clinicians where they have not been endorsed within 30 days	Complete - April 2024
Large numbers of results for review, and therefore the noise to signal ratio leads to increased risk of error when endorsing	Benchmark with other Oracle Health trusts what they auto-endorse and review local auto-endorsed results list. A task-and-finish group has been set up to assess locally with lab teams, this in turn will be presented to the DCMO, and then presented at CGC for sign-off.	Director of Clinical Informatics Divisional Medical Informatics Leads Laboratories	To lower the present risk caused by the large number of normal results that need endorsement. Consultants report the challenge of the noise-to-signal ratio in results endorsement which makes the few results that need action hard to spot among the bulk.	April 2025 (Needs to be after the South 4 LIMS Go-Live)
Results that have been forwarded or auto-endorsed still appear on the performance report for individual clinicians as unendorsed	The data and analytics team are developing programmatic logic to identify forwarded and auto-endorsed results and re-assign to the appropriate consultant.	Data and Analytics team	Improvement in the accuracy of reported data on results endorsement	Ongoing

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
	Opportunities are being explored with Oracle Health to improve the system to improve the process for clinicians and for reporting.			
Radiological results which have a new cancer finding are missed or they are endorsed and not acted upon appropriately	Setting up a governance process for new cancer findings that have not been acted upon to be reviewed in departmental or morbidity and mortality meetings.	Deputy Chief Medical Officer Clinical Director of Radiology & Imaging Director of Clinical Informatics	To reduce the number of patients who have a delayed cancer referral or appropriate action from first suspicious imaging.	May 2025

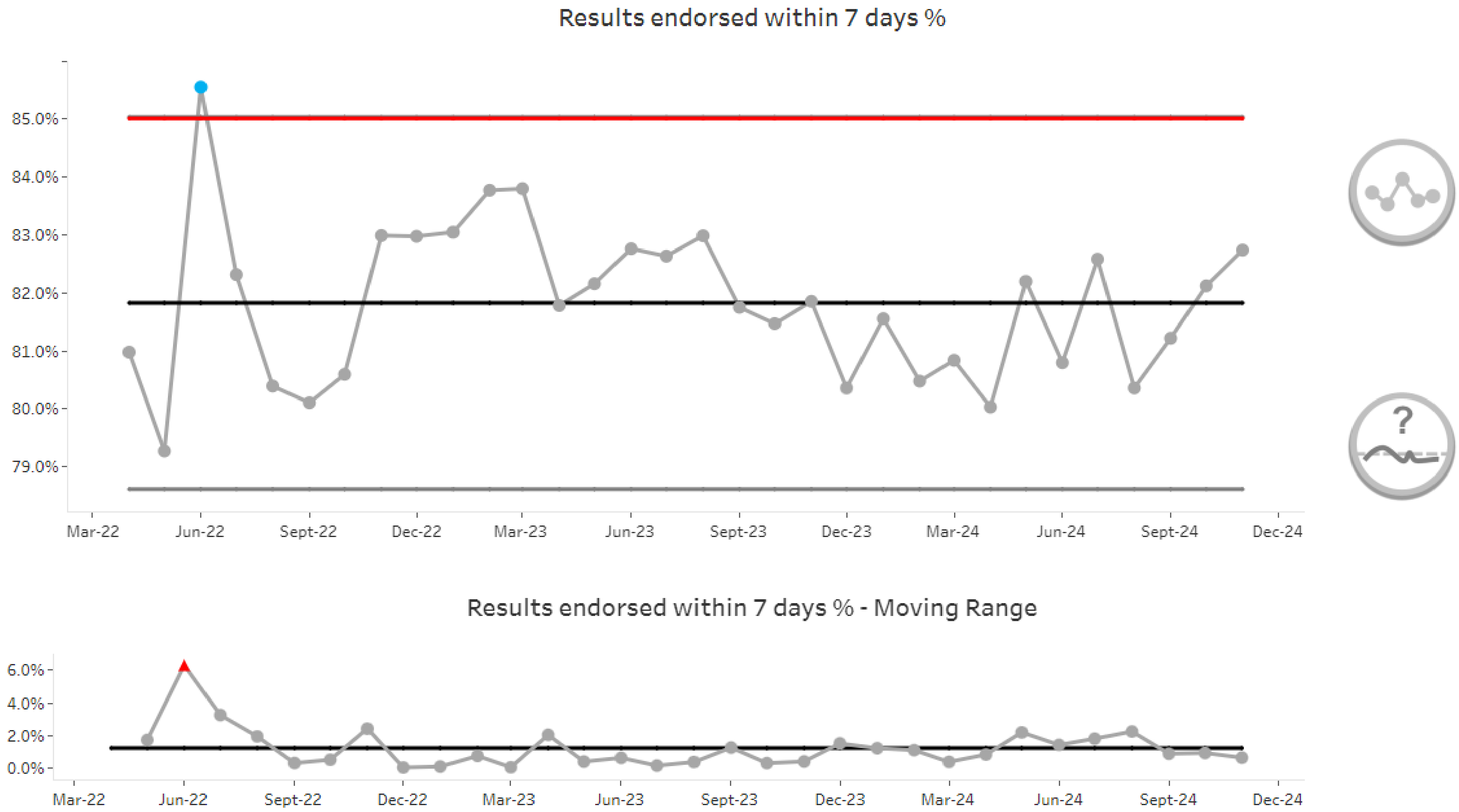
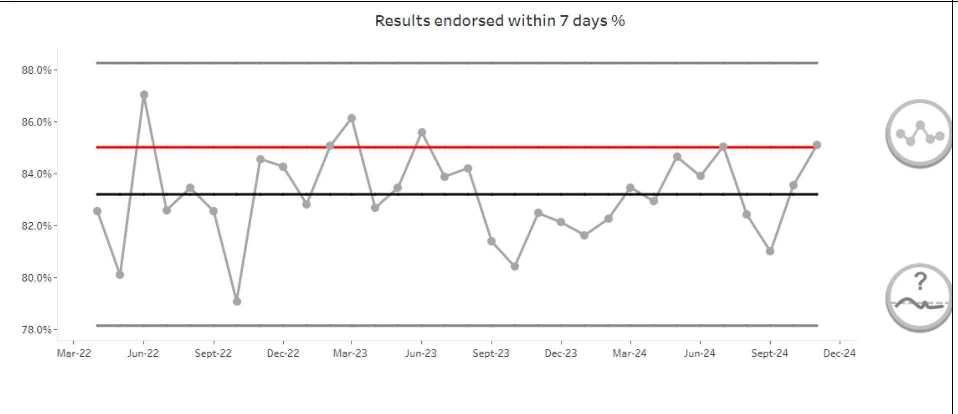
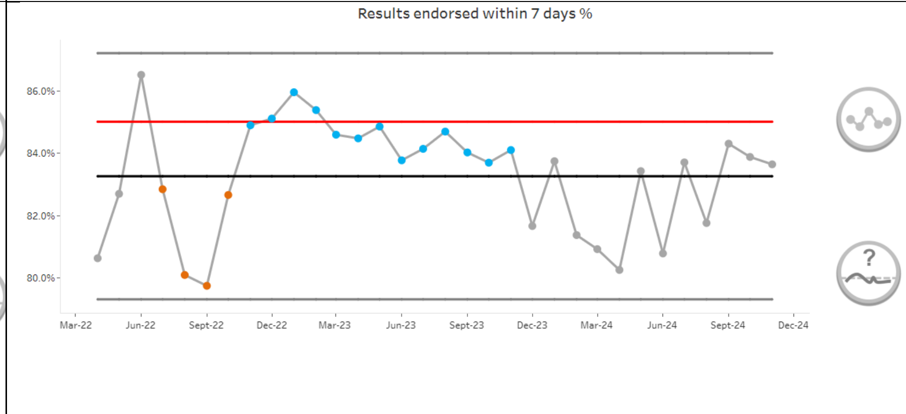


Figure 4: Trust-wide performance

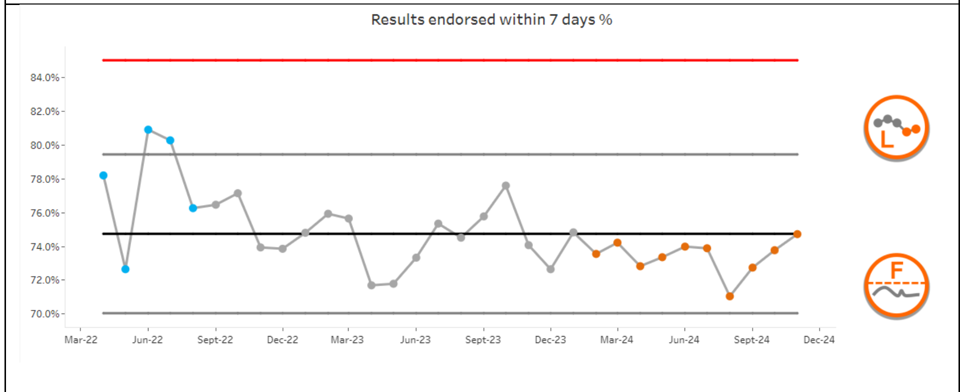
Graph 3a: Divisional performance MRC



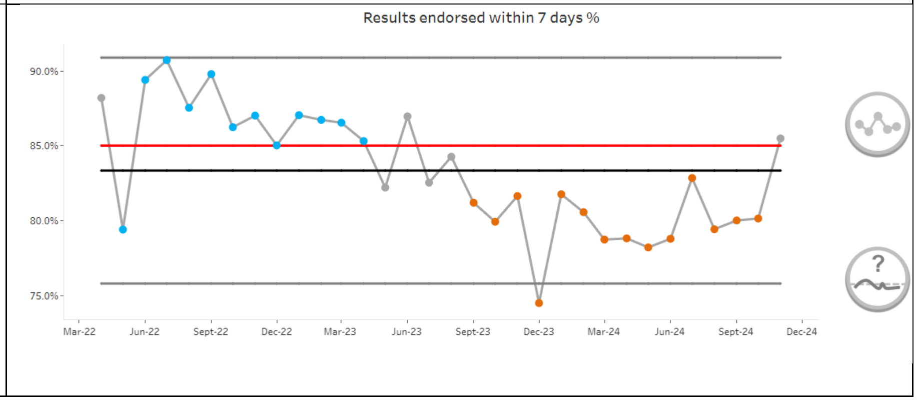
Graph 3b: Divisional performance SUWON



Graph 3c: Divisional performance NOTSSCaN



Graph 3d: Divisional performance CSS



Referral and MDT processes and pathways

The Cancer Management Team and stakeholder group have focussed on 3 themes, as detailed in Table 3.

KPIs have been agreed as

a. That 100% of MDTs are provided with the MDT-to-MDT SOP, and the number of MDT business meetings where Cancer Management Team members have attended and have highlighted and discussed the SOP.

b. The number of MDT coordinators present at the training meeting and from which tumour site, ensuring those not present are seen and trained. Recording training via a training log by the coordinator team leaders to ensure all tumour sites are covered.

c. The monitoring of referrals (MDT-to-MDT) by month and the number of incidents where an unavoidable delay has occurred by MDT, by month. Inform the MDT coordinator and MDT lead if incidents of noncompliance occur, and apply learning.

Progress against these may be seen below in Table 4.

Table 3: Actions to address key issues identified around referrals and MDT processes

Issue	Planned Action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
Internal Cancer MDT to Cancer MDT referrals	Revisit process, write a SOP with focus on: • Understanding of referrers/ MDT responsibility • Clear definition of when transfer of care is required • Communication of outcome and responsibility for action • Provide clear process for internal clinician to clinician referral	Thematic PSII Lead Lead Cancer Nurse Cancer Management Governance Support	To improve internal understanding of and the processes relating to cancer MDTs, to reduce likelihood of delays to planning and treatment for cancer patients	Completed. April 2024 SOP written and presented to the Cancer Management Group and MDT Leads. Agreed May 2024. Sign-off by Divisions at the August Cancer Improvement Group meeting
	• Launch SOP and policy on a page via email to all MDT leads and MDT coordinators for distribution to all core and extended	Cancer Management Governance Support	To improve internal understanding and agree practices to reduce likelihood of delays for patients	SOP and policy on a page signed off August 2024 Launch 20 September

Issue	Planned Action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
	members of cancer MDTs • One member of the cancer management team to attend MDT business meetings to promote SOP	Cancer Management team (Cancer Clinical Director, Lead Nurse and Cancer Manager)		2024 - Completed
Internal referral to cancer MDTs, MDT coordinator responsibilities	• Simplify, and provide a template for all MDTs for consistency and ease of referrer via EPR • Review intranet MDT pages regarding how to guide and ensure information is up to date • Define process and responsibilities for cancer pathway coordinators – process SOP, on a page document • Launch MDT coordinators	Cancer Manager Cancer service manager, Cancer Management Governance Support	Reduction in errors related to referrals to cancer MDTs Reduce, improve timeframes to diagnosis and treatment for patients	Roles and responsibilities within the SOP agreed May 2024- completed Intranet pages for each MDT referral form completed August 2024 Documents completed 4 July 2024 Trialled July/August 2024

Issue	Planned Action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
	process documents at team meeting (training)			Completed August 2024, documents in use
Management of incidental findings identified at MDTs	• Establish current practice (completed April) • Revisit incidental findings SOP • Working party to determine SOP - Trustwide comms	Thematic PSII Lead	Provide a clear process for clinicians to act upon incidental findings indicative of a cancer diagnosis. Ultimately to reduce timeframe to diagnosis and treatment if cancer confirmed.	This has been incorporated into work led by the Director of Clinical Informatics Meeting will take place on 26 September between CD for Radiology and DCI to agree work plan

Table 4: Progress against KPIs

KPI	Planned action	monitoring	Plans / completion
All Cancer MDTs to receive SOP and distribute to all cancer core members.	SOP ready for distribution to 23 cancer MDTs		Completed

Cancer management representation at MDT business meetings	Ongoing programme over each year		
Number of MDT coordinators receiving training	Training completed Total 20 staff required training including team leaders	Training completed for 16 pathways team staff on 6 August 2024 Training confirmed for final 4 staff 22 August 2024 Training to be included into MDT coordinator new starter pack	Completed all relevant staff trained Documents available to team on Sharepoint
Number of referrals (MDT To MDT)	Awaiting response from Infoflex system manager for monitoring worklist At present reviewing Ulysses where MDT process is highlighted	Awaiting response time for infoflex build No specific MDT-to-MDT Ulysses incidents reported	Ongoing

Patients at risk (people with learning or intellectual disabilities, safeguarding, and mental health issues).

The work to date has been led by the Lead Learning disability Liaison nurse and a working group has not been established. A Trust wide Learning Disability Steering group is in the process of being established. The group will be chaired by the CSS Divisional Director of Nursing and membership is being considered. Draft ToR have been developed.

Table 5: Actions to address key issues identified around patients at risk

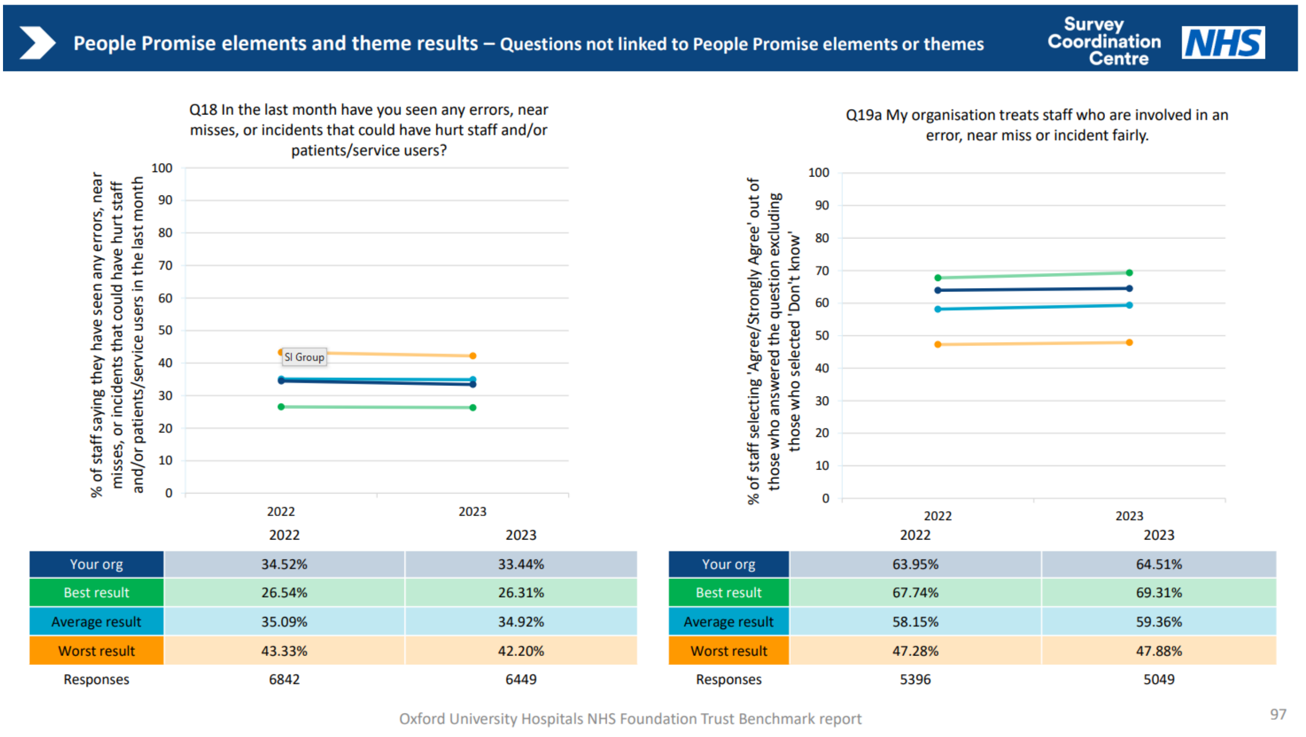
Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
1. Provision of timely investigations and treatments. Patients are not waiting too long on waiting lists (coming to harm)	• Create a list of patients with a learning disability to cross reference in the Electronic Pathway Manager. This will enable people with a learning disability on waiting lists to be identified. • Compare Learning disability data with that of the general population for length of time waiting and proportion of people on multiple lists. Identify key targets and aims in relation to waiting times for	Head of Patient Experience and Director of Data and Analytics	Reduce risk of harm. Reduce waiting time for patients with learning disabilities.	December 2024 Currently exploring options available that will provide a reliable list of patients with a learning disability.

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
	patients with learning disabilities.			
2. Provision of timely investigations and treatments People with learning disabilities/autism can have examinations, bloods and scans carried out under sedation/GA as required	• Ongoing discussions with anaesthetists and general medical consultant for creation of a pathway. Escalation pathway in place for raising concerns as new patients with need for sedation are referred.	Lead Learning Disability Nurse	Improve health of people with learning disabilities Reduce clinicians time and stress spent organising procedures Reduction in delays to treatment	December 2024 (delays due to availability of clinicians) Planning meeting to be held in January 2025; date awaiting confirmation.
3. Provision of timely investigations and treatments To reduce occurrence of missed fractures	On hold due to limited capacity			
4. Person-centred care provided: a. Improve ability to meet additional needs in ED	• Rollout of Oliver McGowan Training • Review of Healthcare Passports and increase	Deputy to Associate Chief Nurse Thematic PSII lead	Increase staff knowledge. KPI - increase % of staff trained. Revised passport to increase useability, improve care	July 2025

Issue	Planned action	Action owner job title(s)	Expected improvement outcome	Expected timeframe
b. Increase staff knowledge and skills to meet needs of patients and carers.	numbers of patients with electronically held passports. • Autism/LD focus ED project • Implementation of the Reasonable Adjustment Flag • Variety of ward-based QI projects increasing resources and knowledge.	Matron, ED & EAU Head of Patient Experience Various Head of Patient Experience	KPI - increased number of electronically held passports Increase awareness of patient's needs KPI - number of patients with a Reasonable Adjustment Flag (Significant national delay in flag roll out – not for inclusion in KPIs at the moment)	February 2026
c. Improved discharge plans	Project in development funded by Better Care Funding			
d. Reduction in hospital acquired pressure sores	On hold			
Reduction in medication errors	On hold			

Appendix V: Staff Survey results highlighting Organisational Safety Culture

The results of the 2023 Staff Survey showed improvements in key areas of a strong safety culture, however changes relating directly to PSIRF are anticipated to take several years to become apparent in this data set. The images below demonstrate current results in the 2023 Staff Survey.



	2022	2023
Your org	34.52%	33.44%
Best result	26.54%	26.31%
Average result	35.09%	34.92%
Worst result	43.33%	42.20%
Responses	6842	6449

	2022	2023
Your org	63.95%	64.51%
Best result	67.74%	69.31%
Average result	58.15%	59.36%
Worst result	47.28%	47.88%
Responses	5396	5049

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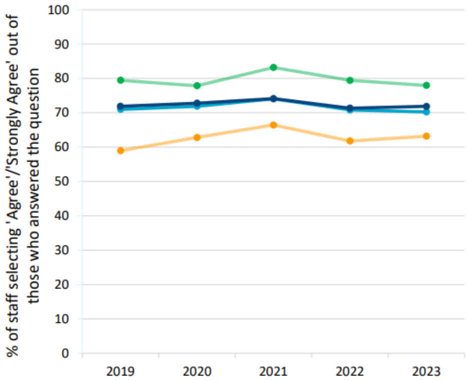
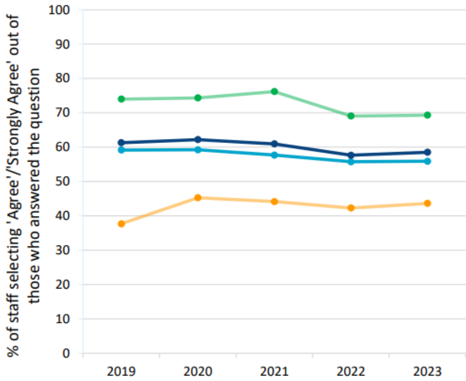
Q20a I would feel secure raising concerns about unsafe clinical practice.



	2019	2020	2021	2022	2023
Your org	71.91%	72.80%	74.11%	71.34%	71.86%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	5766	6707	7499	6941	6527

Q20b I am confident that my organisation would address my concern.



	2019	2020	2021	2022	2023
Your org	61.27%	62.18%	60.93%	57.63%	58.50%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	5760	6713	7501	6940	6513

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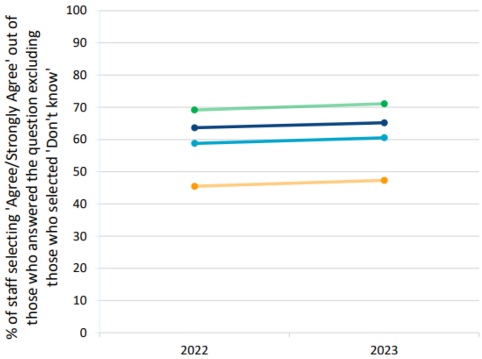
People Promise elements and theme results – Questions not linked to People Promise elements or themes

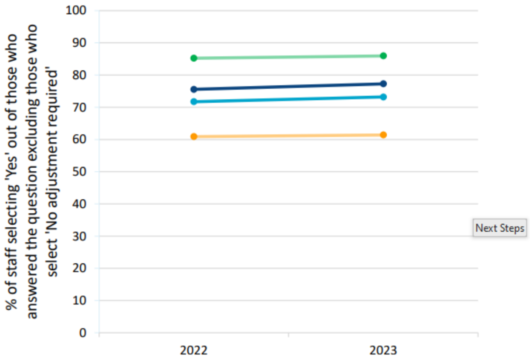
Survey Coordination Centre NHS

Q19d We are given feedback about changes made in response to reported errors, near misses and incidents.



	2022	2023
Your org	63.63%	65.17%
Best result	69.13%	71.09%
Average result	58.78%	60.53%
Worst result	45.47%	47.31%
Responses	6250	5878

Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work?



	2022	2023
Your org	75.55%	77.26%
Best result	85.20%	85.95%
Average result	71.72%	73.19%
Worst result	60.88%	61.41%
Responses	777	780

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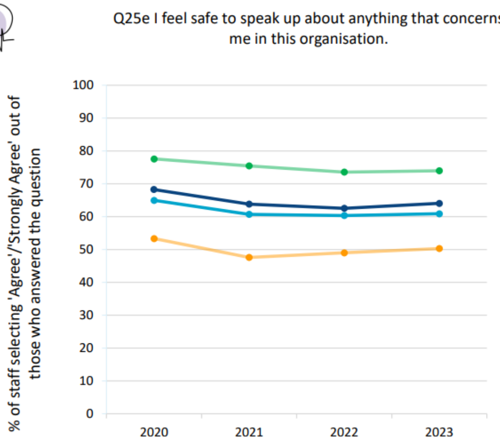
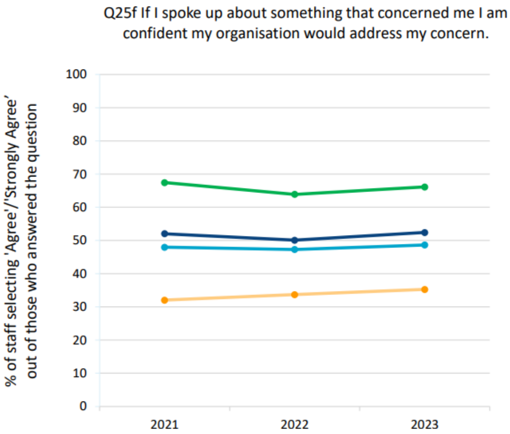
People Promise elements and theme results – We each have a voice that counts: Raising concerns

Survey Coordination Centre NHS



	2020	2021	2022	2023
Your org	68.25%	63.84%	62.56%	64.07%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	6683	7460	6942	6538



	2021	2022	2023
Your org	52.02%	50.10%	52.41%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	7457	6940	6529

Appendix VI: Feedback from the PSIRF one year anniversary seminar

Participants at the PSIRF One Year Anniversary seminar committed the following to help grow PSIRF within the Organisation and build the Trust's Safety Culture.

Appendix VII: Feedback from staff following an AAR participation

A survey has been developed to obtain feedback from staff following participation in an AAR. To date, only seven members of staff have provided feedback, however the tool is being rolled out and encouraged for use after every AAR.

Initial feedback demonstrates:

- Average rating of 4.71 out of 5 for the quality of the AAR
- 100% of respondents agree that AARs were a valuable use of time
- Key learning was how to understand why decisions made sense at the time, understand other people's perspectives, identify ways to prevent similar events in the future and identify how to share learning to the wider team.
- Feedback highlighted challenges of scheduling AARs to ensure all relevant staff can attend.

AAR feedback…

Positive experiences	Challenges	Future plans
"Being part of some great conversations and knowing it can make a difference."	"The AAR is not the right format for resolving conflict where participants have a lot of emotional investment. Sometimes their expectation is too high in this regard."	Develop peer support and buddying opportunities.
"So much potential for improving services and teamwork and the AARs are such good tools to model the principle of learning as a team."	"Controlling difficult situations with strong personalities. Not having admin support and writing up AAR's."	Continue to roll out training
"Seeing the want to improve and how AAR's can be a positive meeting that generate on the ground changes."	"Ensuring all the rules are understood and followed during the meeting, especially the time allocation, ensuring hierarchy is left outside."	Community of practice open to all

Figure 5: Feedback and plans for After Action Reviews

Appendix VIII: Feedback from staff following AAR Conductor Training

Feedback from 12 staff who attended in-house AAR Conductor Training has been positive, with:

- 83.3% of attendees felt they learnt more than they expected to
- 91.7% felt the pace was right
- 100% would recommend the training to others
- 83.3% felt ready to conduct their first AAR

Attendees described learning:

1. Understanding AAR:
    a. what an After Action Review (AAR) is, its importance, and when to use it. They emphasize the significance of preparation and understanding the structure and process of conducting an AAR.
2. Conducting AARs:
    a. Practical aspects of conducting an AAR including
        i. questions to ask,
        ii. maintaining psychological safety.
    b. Confidence and preparedness of individuals to undertake their first AAR.

Figure 6: Word cloud developed from participant feedback for AAR Conductor training

Appendix IX: Timelines to Learning Response completion

Data is collected against AARs[2] and LMDTRs submitted to PST each month to identify how many calendar days it takes to complete learning responses from the incident date, and to write and submit the final report. The current Incident Reporting Investigation and Learning Procedure (v1.3, July 2024) specifies desired timeframes to conduct meetings:

- AAR 14 calendar days after the incident was reported
- LMDTR 42 calendar days after the incident was reported

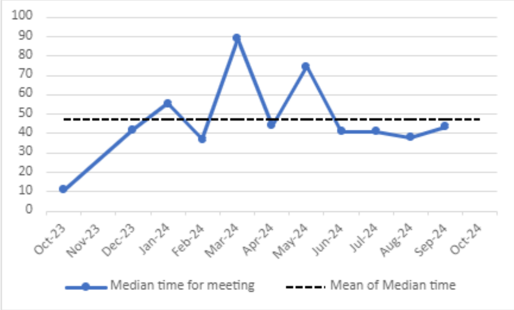
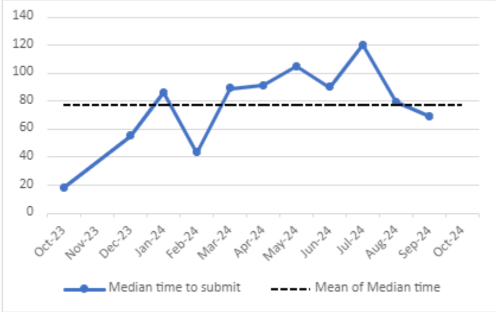
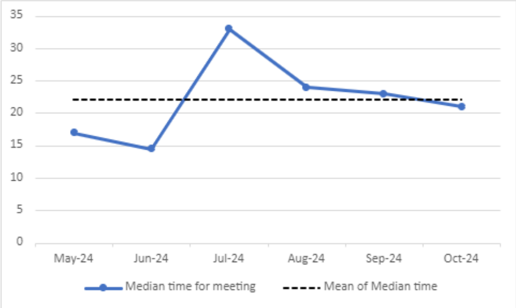
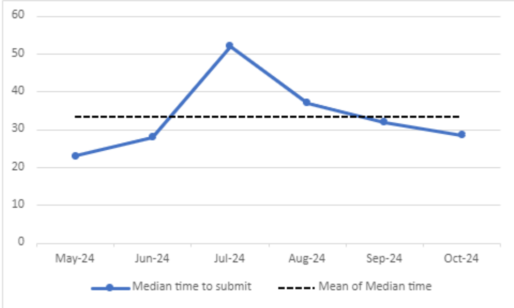
Tracking of completed AARs began on 1 May 2024, but data from LMDTRs goes back to the Trust's adoption of PSIRF in October 2023.

The data shows the median times to AAR meetings to be above the desired timeframes, whilst the median time to LMDTR meetings has been within the target for 3 of the past 4 months where there is data. A small group of staff have been trained to deliver AAR/LMDT training, and to date 4 training sessions have been delivered.

Where is it proving difficult to gather everyone together who was involved in the incident in a timely manner, existing meetings such as Directorate governance meetings are being used to review cases and identify learning. This ensures timely review while at the same time providing a route for other teams to add their expertise into the response.

In addition, we will benchmark with other BOB ICB trusts to ascertain their guidance timeframes for learning response, and their success rate to date in a discussion scheduled for the ICB's January 2025 Patient Safety & Improvement meeting. The OUH approach will then be discussed and reviewed in a future PSIRF Improvement Group meeting.

[2] For the purposes of this process, reviews of falls and pressure damage undertaken under the harm-free assurance process are considered to be AAR equivalents

Graph 5a: Days until LMDTR meetings	*Graph 5b: Days until LMDTR report submission*
	
Graph 5c: Days until AAR meetings	*Graph 5d: Days until AAR report submission*
	

NB There were no LMDTRs tabled at SLIC during November 2023 or October 2024