University Hospitals Birmingham NHS
NHS Foundation Trust

CONTROLLED DOCUMENT

Patient Safety Incident Response Policy and Plan

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PURPOSE	To set out the Trust's response to patient safety incidents.
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Distribution: • **Essential Reading for:** • **Information for:**	 All Managers All Staff

Contents

1. Purpose

1.1 The NHS England Patient Safety Incident Response Framework (PSIRF) advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

1.2 This patient safety incident response policy and plan (referred to as 'the Policy') sets out how University Hospitals Birmingham NHS Foundation Trust (referred to as 'the Trust') will approach the development and maintenance of effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

1.3 It sets out how the Trust intends to respond to patient safety incidents over a period of 24 months. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

1.4 This Policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

1.4.1 Compassionate engagement and involvement of those affected by patient safety incidents;
1.4.2 application of a range of system-based approaches to learning from patient safety incidents;
1.4.3 considered and proportionate responses to patient safety incidents and safety issues; and
1.4.4 supportive oversight focused on strengthening response system functioning and improvement.

1.5 The Policy should be read in conjunction with the Trust's Incident Management Policy and Being Open Policy and associated procedures.

2. Scope

2.1 This Policy applies to:

2.1.1 All Staff

2.1.2 All Patient Safety Incidents ensuring responses are conducted solely for the purpose of system learning and improvement. There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.

2.2 The Policy does not apply to responses for complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, information governance concerns, estates and facilities concerns, safeguarding concerns, Coroner's inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response.

2.3 Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. The Trust's Patient Safety Culture

3.1 The Trust is committed to a restorative Just Culture within the organisation. Involving staff in the investigation of safety incidents is a key priority for the Trust to ensure that a culture of fairness, openness and learning is promoted and supported, empowering all staff to speak up and be part of learning and recommendations. Through the new approaches in how we will respond to safety incidents, wider systemic issues will be considered when learning for improvement, ensuring all staff working with and in our systems can be open and honest in the knowledge investigations are not about individuals, thus removing the fear of blame or retribution.

3.2 The NHS Patient Safety Strategy "sets out what the NHS will do to achieve its vision to continuously improve patient safety". The Strategy was published in 2019 and updated in 2021. Patient safety culture is one of two underpinning foundations of the strategy.

3.3 Members of the Trust Board were provided with an overview of safety culture at a Board Seminar on 7 March 2023. An updated analysis on patient safety culture data[1] will be provided to Clinical Quality and Patient Safety Committee twice per year, and the Patient Safety Strategy action plan updates will be provided in the intervening quarters as part of the National Patient Safety Strategy report. The Trust will utilise this reporting to assess if we are sustaining our ongoing progress in improving our safety culture.

4. Addressing Health Inequalities

4.1 The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

4.2 The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new incident

[1] Includes date/information from our staff survey metrics, patient safety visits Freedom to Speak Up Contacts, Outcomes from Trainee Surveys

management system [2] will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities. This will transform our ability to review incidents against protected characteristics and identify if there are any health inequalities through analysis of incidents, complaints and other patient feedback.

4.3 Where appropriate we will explore further areas highlighted in our recent 2022 staff survey within our Patient Safety Incident Investigations (PSII) such as equality, diversity and inclusion and health inequalities. Any information and learning from these will be included in subsequent response plans.

4.4 Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

5. Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

5.1 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.

5.2 The term engagement describes what the Trust will do to communicate with and involve people affected by a patient safety incident in a learning response. This will include discussion and actively engaging with patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

5.3 Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident. Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

5.4 Patients and families provide a unique and meaningful insight into patient safety incidents and their involvement and contribution to a learning response can help to develop a relationship of openness and trust, leading to respect for how the organisation responds to safety Incidents. All Trust staff should demonstrate compassionate interactions with patients and families following a safety incident.

[2] From Autumn 2023 the Trust is changing providers for the Incident Management System which is to be in place by 31 March 2024.

5.5 Patients/NoK and staff will be communicated with and involved with PSII investigations details on how they will do this are included in accompanying leaflets that will be provided to patients/NoK and staff.

5.6 The Trust has a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team.

5.7 The Trust recognises that there might also be other forms of support that can help those affected by a patient safety incident and will work with staff, patients, families, and carers to signpost to their preferred source for this (see appendix B).

5.8 Being Open and Duty of Candour

5.8.1 Staff should adopt the principles of being open in an honest and timely fashion, with clear communication. Staff must adhere to the Being Open/Duty of Candour Policy and Procedure.

5.8.2 If a patient safety Incident is confirmed as being a notifiable safety Incident then Statutory Duty of Candour (DoC) will apply. This requires us to discharge Verbal and Written DoC as well as share the outcome of the patient safety Incident's learning response. Patients and families will be involved as part of the learning response.

5.8.3 For cases where DoC applies and no investigation is required as part of the response framework, the Trust will complete the DoC requirement through a written response and include the existing improvement plan and provide some information, assurance and explanation on what approach was or was not taken and why. Full details will be within the Trust Being Open Policy.

PATIENT SAFETY RESPONSE PLANNING

6. Resources and Training to Support Patient Safety Incident Response

6.1 The Trust is committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

6.2 All Trust staff are required to complete Patient Safety Syllabus Level 1 – this is currently available as a UHB Moodle package.

6.3 The Trust will ensure that all Patient Safety Incident Investigations (PSIIs) are independently led by a Patient Safety Investigator (part of the Clinical Governance and Patient Safety department) and supported by an independent senior clinician and /or registered nurse/midwife.

6.4 All Patient Safety Investigators will have completed the national training requirements as set out in NHS England's PSIRF guidance and will do a minimum of two PSIIs per year.

6.5 Those in an Oversight Role[3] will complete the national training requirements as set out in NHS England's PSIRF guidance.

6.6 The Clinical Governance and Patient Safety Department will provide half-day face to face Learning Response and Safety Culture training sessions to staff. This training will cover the following:

6.6.1 Key principles of PSIRF and model in place at UHB
6.6.2 System Engineering Initative for Patient Safety (SEIPS) framework
6.6.3 Learning Response Methods and how to apply them
6.6.4 Safety Culture

7. The Trust's Patient Safety Incident Review Plan (PSIRP)

7.1 <u>Defining our patient safety incident profile</u>

7.1.1 Prior to the implementation of PSIRF the concept of theming and Quality Improvement (QI) for safety issues was in place at the Trust. An initial exercise was conducted in 2019/20 to identify themes from serious incident investigations in order to develop more comprehensive and sustainable solutions to these themes. The top themes identified were established as Corporate Quality Improvement Projects which commenced in the months following that review and a standard QI methodology and reporting through to Trust Board via the Integrated Quality Report was put in place.

[3] At UHB this is the Chair of the Clinical Quality and Patient Safety Committee, Chief Medical Officer and nominated deputy(s), Chief Nurse and nominated deputy(s), Head of Clinical Governance and Patient Safety, Site Medical Directors and Site Directors of Nursing

7.1.2 Through the implementation of PSIRF and the development of this Policy the Trust has completed an even more rigorous analysis detailed below to identify the Patient Safety Priorities.

Stakeholder Engagement

7.1.3 The following groups have all contributed, directly or indirectly to the development of the plan:

a) Members of the PSIRF Project group (Chief Legal Officer, Deputy Medical Director (Quality), Director of Nursing Quality and Innovation, Lead Nurse for Quality and Clinical Assurance, Clinical Risk Lead, Patient Safety Investigations Senior Lead, Head or Clinical Governance and Patient Safety, Deputy Heads of Clinical Governance and Patient Safety and Head of Quality Development)
b) Leads from the Governance Facilitation Team
c) Leads from corporate teams: Falls, Tissue Viability, Infection Prevention and Control
d) Divisional Associate Medical Directors for Governance
e) Divisional Management Teams
f) Patient and family feedback included via the patient feedback data
g) Feedback from Stakeholder engagement events with staff and the Patient Carer Councils
h) Chief Nurse and Chief Medical Officer
i) Committee for Clinical Quality and Patient Safety

7.1.4 Prior to updating the next version of this Policy (18 months following approval) we will conduct staff forums to seek views and assurance on the patient safety response framework and the effectiveness of this Policy. This will ensure our future Policy has further enhanced engagement on the improvement priority areas.

Data sources

7.1.5 Patient safety issues for the Trust have been identified and profiled using the following data sources:

For a three year period 01/10/2019 to 30/09/2022:

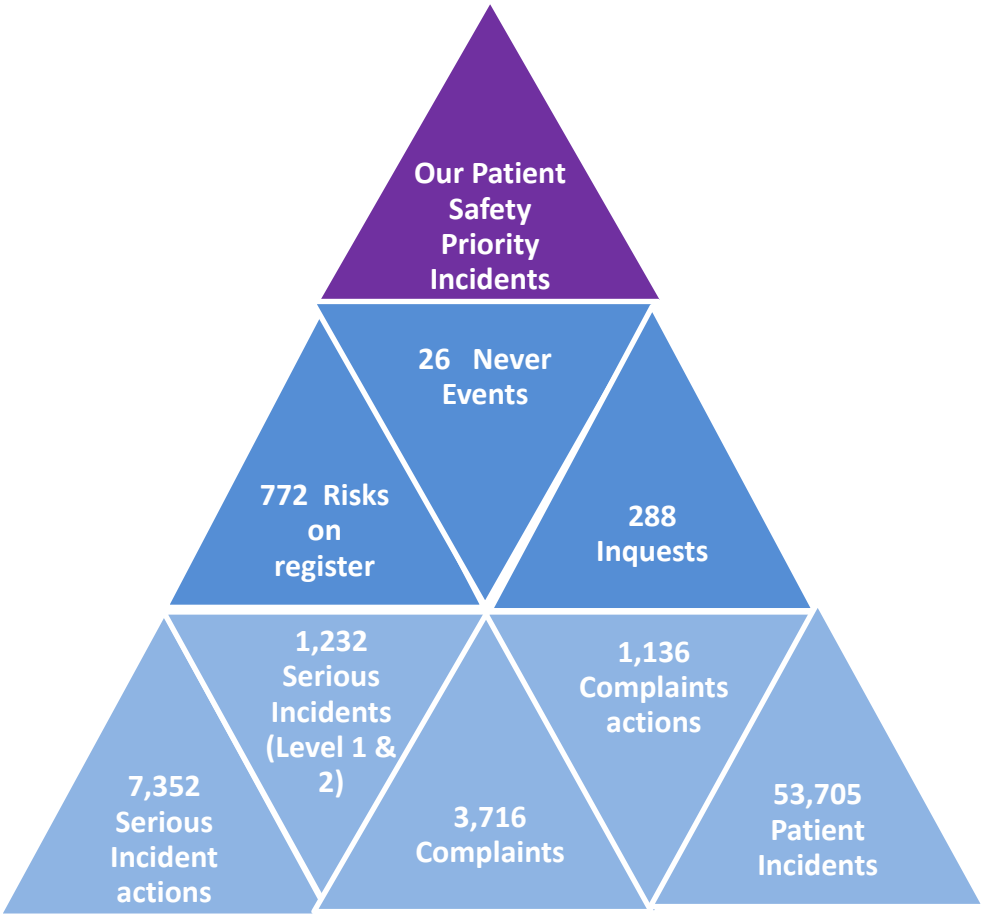
a) Incidents subject to the Clinical and Professional Review of Incidents (CaPRI) process, including Serious Incidents (including HSIB investigations), Never Events, Divisional investigations (previously known as Divisional or Executive RCAs)
b) Complaints

c) Actions arising from the response types above

A further Trust wide review of the following additional data sources which included data up to June 2023 also included:

a) Incident Themes
b) Level 1 SIs (Falls, Infection acquisitions and Pressure Ulcers)
c) Mortality data (HSMR/CUSUM) and Learning from Deaths reviews
d) Claims and Inquests
e) Patient feedback
f) Learning from Excellence
g) CQC enquiries and inspection recommendations and outcomes from other external visits
h) Review of Corporate Risk Register
i) Key themes identified from specialist safety and quality committees (e.g, Falls Steering Group, SMPG)

7.1.6 The diagram below shows the data sources for informing our improvement priorities.



Method

7.1.7 Divisional Review

An analysis was conducted for each Division covering data from 01/10/2019 to 30/09/2022 (3 years). Led by the Governance Facilitation Lead for each division and used inductive thematic analysis. Incidents were assigned a theme and tallied in an iterative process.

The derived themes were shared with the Divisional Management Team and Associate Medical Director Governance to refine the themes and prioritise. Consideration was then given by each division to the themes identified:

a) Are the causes of this safety issue well understood?
b) Is this a high priority safety topic?
c) Would this benefit from the sustained effort provided by the QI method to implement change to reduce the risk?
d) Does this apply to more than one division?

7.1.8 Trust wide review

A 12-month period of the data (up to June 2023) sources listed in 7.1.7 was conducted by the Patient Safety Team. Themes were identified if a topic or contributory factor appeared multiple times and across multiple sources.

The nature of the incident/issue (mode of harm, stage in pathway, task being undertaken) as well as contributory factors have been considered.

The top five incident categories were considered, and potential emerging themes were identified using the following method: each quarter was analysed for the greatest percentage increase in any incident category when compared with the average of the previous three quarters, where the numerical increase is greater than 20.

7.1.9 Consideration was given to the following for Corporate QI projects:
a) Any newly identified themes that map to existing QI projects – does this fit within the current scope? If not should the scope be modified?
b) Any newly identified themes that do not map to an existing project – should this become a new Corporate QI project
c) Are there any existing QI projects that did not map to a theme and could be de-prioritised?

7.2 Defining our Priority Safety Incidents and Patient Safety Improvement Profile

7.2.1 Through the review and thematic analysis of our data (described in section 7.1) we have identified the Trust Patient Safety Incident

Priorities (PSIPs) and Maternity PSIPS and associated Improvement work that the Trust will focus on over the next 24 months as detailed in appendices D and E.

7.2.2 These have been agreed in collaboration with the members from the Group Clinical Quality and Patient Safety Committee and the Trust and ICB Boards.

7.2.3 The QI project groups overseeing the Improvement Work as per appendices D and E will adhere to the following standards:

a) Will be sponsored by the relevant Group Executive Director.
b) Have clearly defined aims.
c) Receive a report at each meeting with relevant performance metrics (including SPC charts) and a report on incident numbers including, severity and trends over time, along with relevant outcomes from the Learning from Deaths cases.
d) Ensure appropriate QI methodology is applied. At the Trust we use the Institute of Health Improvement Model for Improvement
e) Maintain an Improvement Plan – which clearly sets out the lines of improvement the QI group is taking forward so there is full visibility of these.
f) Sites will be kept informed on progress with the QI projects detailed in this document via their site (or where relevant Clinical Delivery Group (CDG)) Quality and Safety meetings by the Clinical Governance and Patient Safety Department or in the Case of Maternity SIPs QI lead midwife.
g) Before the QI Project can stop, a close out report must be presented to the Group Executive Sponsor and the Group Quality & Safety Group setting out the achieved improvement and how ongoing monitoring will be achieved.

7.2.4 The QI project groups listed below will provide a quarterly update on progress to the Group Clinical Quality and Patient Safety Group which will include metrics for improvements and will highlight any barriers or risks to the delivery of the project. This will also be reported to the Group Clinical Quality and Patient Safety Committee and Trust Board via the Integrated Quality Report.

8. Reviewing our patient safety incident response policy and plan

8.1 The Trust's patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. Any updates to the Plan prior to the 24 month review period must be approved by the Chief Nurse (CN) and Chief Medical Officer (CMO) and presented to the Clinical Quality and Patient Safety Committee.

8.2 The Plan will be reviewed every 24 months and approved by the Trust and ICB Boards to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 24 months.

8.3 Updated plans will be published on our website, replacing the previous version.

8.4 Monitoring of progress with regard to safety improvement plans will be reported to the CMO and CN via the Group Quality and Safety Group. Oversight on progress will be provided to the Clinical Quality and Patient Safety Committee and reported to the Trust Board.

9. Responding to Patient Safety Incidents

9.1 <u>Overview</u>

9.1.1 The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement.

9.1.2 In line with the Trust's Incident Management Policy, all staff are responsible for reporting any clinical and non-clinical incidents, including near misses or actual patient safety incidents on the Trust incident reporting system and will record the level of harm they know has been experienced by the person affected (see Appendix A).

9.1.3 When an incident occurs the first action should be to:

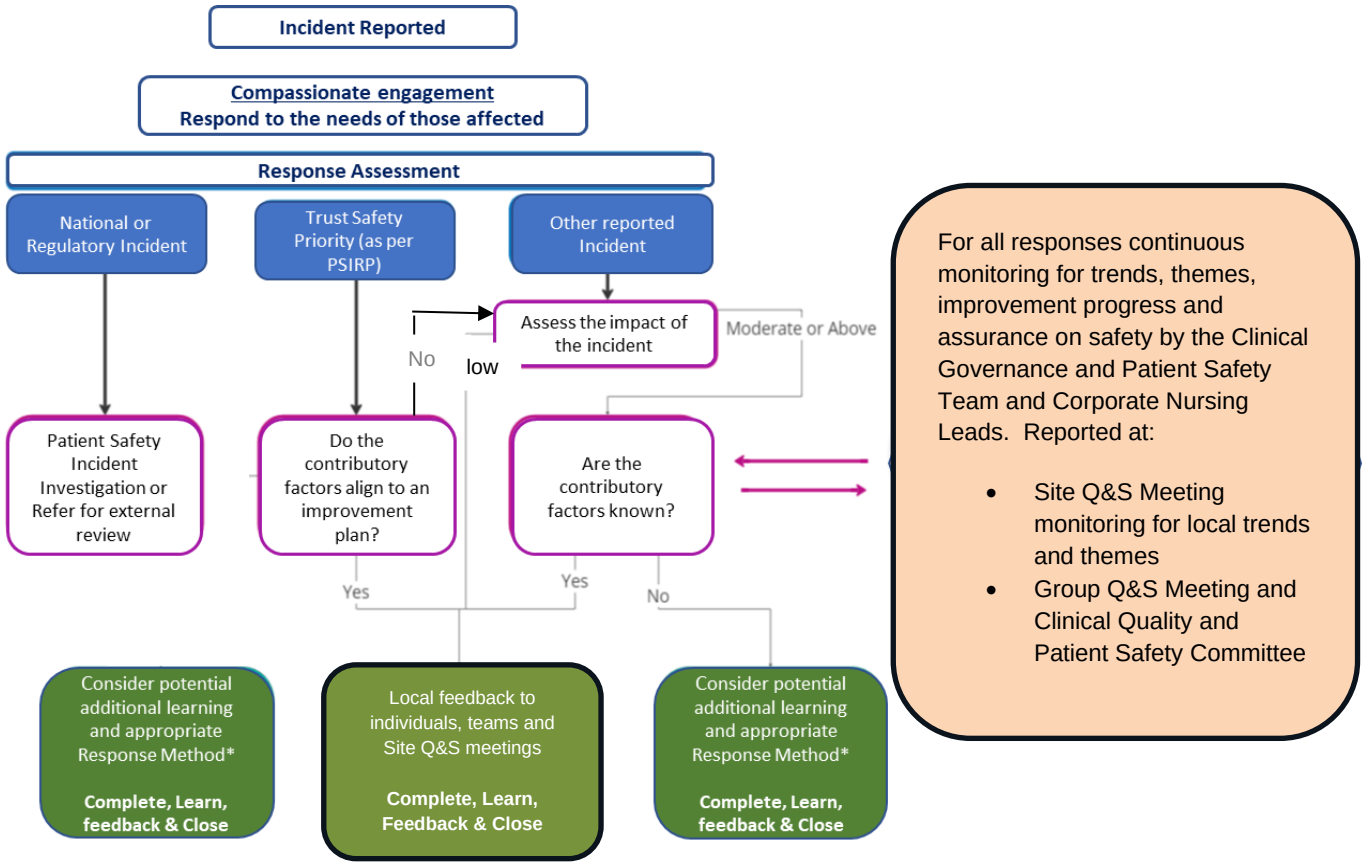
a) make the situation safe;
b) ensure that all practical and reasonable steps are taken to reduce risk and prevent re-occurrence;
c) preserve the scene together with equipment or other items that may be used as evidence in an investigation; and
d) ensure the appropriate senior clinicians/managers are informed, as soon as possible

9.1.4 An incident report must be completed as soon as possible. In addition, where an incident may have contributed to death or serious

injury the staff member's manager/supervisor and the Clinical Governance and Patient Safety team must be notified at the earliest opportunity.

9.1.5 Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these will be assessed in line with the section 9.2.

9.1.6 The chart below outlines the Trust response to reported Incidents occurring within the Trust. Each step and those responsible is described in further detail in section 9.2.



9.2 Patient safety incident response decision-making

9.2.1 Except for PSIIs, PSIRF itself sets no national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work.

9.2.2 Initial incident Review

a) Within seven days of the incident being reported the person who has been identified as the 'Incident Handler' in the Incident Management

System will review the incident and document any immediate actions taken and provide feedback to the person who reported the incident within 28 days.

b) The Clinical Governance and Patient Safety (CG&PS) team will review all incidents reported the following working day to:

- Categorise the incident according to the incident details; and
- As part of the 'Response Assessment' the CG&PS Team will:
    - Assess what learning response is required (see section 9.2.4, 9.2.5 and 9.2.6 below). This assessment will include the appropriate Clinical (including AHPs) and Midwifery leads and discussion with the Site Triumvirate team or nominated deputies (ie CDG medical director).
    - If the detail within the reported incident does not provide adequate information to make the assessment the CG&PS team will obtain further clarity/information about the incident from the reported/incident handler/relevant clinicians
    - Where the incident meets a Trust Safety Priority the CG&PS team may need to liaise with the relevant QI project lead to ensure the issues are being addressed by QI project.
    - Where the incident meets the National Regulatory requirement or there is a need for an alternative Learning Response (see Learning Responses Guide) the CG&PS team will coordinate the preparation of a case assessment for submission to the Patient Safety Incident Review Group (PSIRG).
    - The case assessment will be submitted to PSIRG for the CMO or nominated Deputy to confirm the Learning Response required. If it is agreed to be investigated as a PSII an appropriate clinician/nurse will be identified to support the Patient Safety Investigation Lead.

9.2.3 National or Regulatory Incidents

a) Some patient safety incidents require a specific type of response as set out in national policies or regulations. These responses will include a Patient Safety Incident Investigation or review by or referral to another body or team, depending on the nature of the Incident.

b) The table below sets out the nationally mandated responses for national Incidents:

Incident	Response Action
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII) Reporting to PMRT in accordance with national requirements (All stillbirths of at least 22 weeks gestation and neonatal deaths, and the deaths of babies in the post-neonatal period having received neonatal care)
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations).	
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigation Programme criteria	Refer to MNSI for independent Patient Safety Incident Investigation (PSII)
Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review
Deaths of persons with Learning Disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required
Safeguarding incidents meeting criteria	Refer to local authority safeguarding lead.
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response
Deaths in Custody	Refer to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC).
Domestic Homicide	A domestic homicide is identified by the police
Haemovigilance Incidents: Surveillance covering the entire blood transfusion chain, from the donation and processing of blood and its components, through to their provision and transfusion to patients, and including their follow-up is essential to improving transfusion safety	Recording and reporting of transfusion incidents to Serious Hazards of Transfusion (SHOT) and the Medicines Healthcare products Regulatory Agency (MHRA) remain unchanged. https://www.shotuk.org/reporting/ It is a regulatory and legal requirement to investigate all SAEs and SARs related to the quality and safety of blood and blood components.

9.2.4 Trust Patient Safety Priority Incidents

a) Incidents where contributing factors are aligned to the Trust or Maternity PSIPs (see section 7) will follow the table below.:

<table>
<tr><th>Trust Priority Incident (aligned to improvement profile)</th><th>Response Assessment</th><th colspan="2">Response Action</th></tr>
<tr><td rowspan="2">Assess the contributory factors involved in the Incident to identify whether they are well understood and aligned to existing improvement plan.
Consider the potential for learning.</td><td>Contributory factors are well understood and aligned to improvement plan
⇩
Provide local staff and team feedback and close the Incident.

Inform patient/NoK in line with Trust Being Open and Duty of Candour Policies.</td><td>Contributory factors not well understood or not aligned to improvement plan and potential additional learning
⇩
Consider appropriate and proportionate learning and feed results into relevant improvement group and teams within governance structures</td></tr>
<tr><td colspan="2">For all these Incidents there will remain on-going monitoring by the QI group(s) and clinical governance and patient safety team to ensure trends and themes from reported Incidents are tracked and the improvement plan is having an impact.</td></tr>
</table>

9.2.5 Other Reported Incidents

a) Any Incident that is not a national/regulatory response requirement or one of our identified Trust Priority Incidents will be classed as ‘Other Reported Incidents’.

b) Some Incidents may occur that have a high area of future risk to patients, staff and the organisation or have caused moderate harm or above. These may require a proportionate response via an appropriate Learning Response (see above) to understand the contributory factors to identify appropriate actions/learning.

c) Whilst section 7 provides the Trust wide Patient Safety Priority Incidents there will be occasions when single service issues/themes are identified as part of the Trust Learning Response. In this case, services may set up a QI project to address these concerns. If this occurs these projects must adhere to the standards set out in 7.2.

9.2.6 Cross-System Learning Responses

a) Learning responses will generally be managed by local Trusts to facilitate the involvement of people affected and those responsible for delivery of the services. However, if UHB, another Trust or the Birmingham and Solihull Integrated Care Board (BSol ICB) within the Integrated Care System (ICS) identify that a cross learning response is required a shared agreement on the lead and delivery of this response and subsequent improvement will be confirmed with the BSol ICB.

b) The Clinical Governance and Patient Safety department will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's central governance team or equivalent.

c) The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Clinical Governance and Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

9.3 Timeframes for Learning Responses

9.3.1 Timescales for National or Regulatory Incidents

The Trust will adhere to the national timeframes for all National and Regulatory Incidents referred to above.

Patient safety PSII

a) Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

b) The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

c) In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the CMO.

d) In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

9.3.2 Timescales for other forms of Learning Response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than 45 working days to complete.

10. Safety Action Development and Monitoring Improvement

10.1 Safety Action Development

10.1.1 The Trust acknowledges that any form of patient safety learning response will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

10.1.2 The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

a) Agree areas for improvement – specify where improvement is needed, without defining solutions
b) Define the context – this will allow agreement on the approach to be taken to safety action development
c) Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved. The focus will not be on individual feedback and training which are low impact actions.
d) Prioritise safety actions to decide on testing for implementation
e) Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

10.1.3 Safety actions will be clearly written and follow SMART principles and have a designated owner.

10.2 Safety Action Monitoring

Safety actions must continue to be monitored within each site's governance arrangements to ensure that any actions put in place remain impactful and sustainable. Sites will monitor and report on the progress with safety actions via the Site Q&S meetings and in turn this will be included in the Trust Integrated Report to the Group Q&S meeting and Clinical Quality and Patient Safety Committee.

11. Risks of Implementing the Patient Safety Incident Response Plan

11.1 The Patient Safety Incident Response Framework (PSIRF) and our Patient Safety Incident Response Plan (PSIRP) will transform how we respond to incidents in the future. There are however key risks to achieving this that have been discussed and acknowledged as a Trust. The two main risks are listed below and these will be continually monitored and assessed through the quality and safety governance structures:

11.1.1 Resource capacity and engagement from staff to deliver on the improvement plans for all the priority incident areas. Without the focus on the improvement plans the benefit and ethos of the PSIRF model will be not be achieved.

11.1.2 The engagement and understanding from patients and their families on the investigation response types used or the lack of investigation if directly linked to an improvement priority. Patients and families may expect full investigations as with the previous serious incident framework.

12. Oversight roles and responsibilities

12.1 Principles of oversight

One of the aims of PSIRF is for Trusts to focus on improvement and oversight of PSIRF should focus on Trusts demonstrating improvement rather than compliance with centrally mandated measures.

12.2 Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities within PSIRF. In order to meet these responsibilities, the Trust has designated the Chief Nurse (CN) and Chief Medical Officer (CMO) to support PSIRF as the executive leads and will oversee the following standards as set out in the National PSIRF Oversight Document:

12.2.1 Ensuring that the organisation meets the national patient safety standards

a) The CMO and CN will oversee the development, review and approval of this Policy ensuring that they meet the expectations set out in the patient safety incident response standards. The Policy will promote the restorative just working culture that the Trust aspires to.

b) To achieve the development of the Trust Policy and Plan the Trust will be supported by internal resources within the Clinical Governance and Patient Safety team led by the Head of Clinical Governance and Patient Safety.

c) To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight as set out in section 7 (above).

12.2.2 Ensuring that PSIRF is central to overarching safety governance arrangements

a) The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards within the Integrated Quality and Safety Report and via reporting from the Clinical Quality and Patient Safety Committee.

b) The Group Quality and Safety meeting will provide assurance to the Clinical Quality and Patient Safety Committee that PSIRF standards are met, ongoing monitoring of patient safety themes against the Plan and that the improvement workstreams set out in the Plan are effective.

c) Sites must report on the progress and outcome of any site specific quality improvement projects to the Group Q&S meeting via the Site Q&S meeting.

12.2.3 Quality assuring learning response outputs

a) Prior to finalising the PSII investigation the draft document will be reviewed as follows:
   - The Patient Safety Investigation Lead will discuss the draft findings with the patient/or nominated representative prior to be presented to PSIRG.
   - The Draft report will be reviewed at the Trusts IQAM meeting by the relevant Site Management team members and service leads.

b) The Trust's Patient Safety Incident Review Group, Chaired by the CMO will review and sign-off all final PSIIs, ensuring they are conducted to the highest standards.

c) A summary of all completed PSIIs along with a copy of the report will be shared to each Clinical Quality and Patient Safety Committee. The summary will also be shared at each Trust Board meeting.

Appendix A: Definitions of harm

Level of Harm

In summary harm is defined as follows

No harm This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a ‘near miss’.

No harm (impact not prevented) - Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care

Low harm - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm - Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death – Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix B: Patient Advice

- **National guidance for NHS trusts engaging with bereaved families https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf**

- **Learning from deaths – Information for families https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/** explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

- **Help is at Hand – for those bereaved by suicide https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf** specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

- **Mental Health Homicide support https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/** for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

- **Child death support https://www.childbereavementuk.org/grieving-for-a-child-of-any-age https://www.lullabytrust.org.uk/bereavement-support/**

- **Complaint's advocacy https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy** The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

- **Healthwatch https://www.healthwatch.co.uk/** Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site **https://www.healthwatch.co.uk/your-local-healthwatch/list**

- **Parliamentary and Health Service Ombudsman https://www.ombudsman.org.uk/** makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

- **Citizens Advice Bureau https://www.citizensadvice.org.uk/** provides UK citizens with information about healthcare rights, including how to make a complaint about care received

Appendix C: Definitions

Term	Acronym	Glossary Definition
Investigation		To examine, study or inquire into an incident, event or process systematically. Any investigation undertaken at UHB has the aim of examining the system and not individuals. This includes what works well and where there are potential safety gaps to a system or process.
Just Culture		A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts. NHS Just Culture Guide: https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf
National and Regulatory Incident		Are patient safety Incidents that require a specific type of response as set out in national policies or regulations. These responses will include a PSII, internal PSII or referral to another body or team, depending on the nature of the Incident.
Patient Safety Incident Investigation	**PSII**	A patient safety incident investigation (PSII) is an in-depth investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. A PSII investigation uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to understand outcomes within complex systems and which can be applied to support the analysis of incidents and safety issues more broadly. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. PSII's look at work as done and include safety I and safety II.
Patient Safety Incident		Are any unintended or unexpected Incident which could have, or did, lead to harm for one or more patients receiving healthcare
Never Event	**NE**	Are incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all

		healthcare providers. Full details of each Never Event can be accessed via NHS England Website.
Patient Safety Incident Priority	**PSIP**	Are patient safety Incidents that are aligned to our improvement priorities and which have a robust improvement plan.
Site		For the purpose of the document Site will mean Solihull, Good Hope, Birmingham Heartlands and Queen Elizabeth Hospital and CDG11 support services, and Women and Children's Services

Appendix D: Trust Patient Safety Incident Priorities

Trust Safety Priority	Rationale	Improvement Committee/Group
Vulnerable Patients – Particular focus is on: a) Processes for patients lacking in capacity and the completion/ documentation of mental capacity assessments and best interests decisions b) patients absconding and those leaving clinical areas prematurely including: • Mental Health patients • Drug or alcohol dependency	The trust wide review of the data highlighted a significant increase in these incidents with 431 reported in Q1 2023/24. The Trust also received a regulation 28 prevent future deaths notice associated with patients absconding in 2023.	Close monitoring through Trust Safeguarding Board : for any patients who Abscond/or go missing Report MCA Assessments for patients with a diagnosis Dementia, LD/ASD through the Vulnerabilities Steering group There is a Trust process for the completion of MCA and BIM/ meeting which is available via PIC s: Audit and Reporting via the Mental Health Group.

Trust Safety Priority	Rationale	Improvement Committee/Group
Nutrition and hydration related incidents including: • Inadequate provision of hydration and nutrition • poor monitoring of weight nutritional status • inappropriate food/fluids provided	Identified as an ongoing theme via: • Incident reporting • Complaints • Inquests linked to Serious incident investigations and RCA's • Audits • Clinical dashboard and CDRG. • Learning from deaths reviews. Patient Care including Nutrition/Hydration continue to be in one of the top 5 themes from complaints Nutrition and hydration are key components of effective, safe care. They have been highlighted through incidents and audit as requiring focus to ensure best practice and promote recovery and wellbeing of our patients. Weight is also a key measure for the safe prescribing and administration of many medications. April data showed only 55.21% of patients requiring to be weighed being weighed.	Nutrition and Hydration Steering Group and associated QI sub-groups
Management of Deteriorating patient: • Delayed or incomplete observations • Reliance/emphasis on NEWS2 score • Recognition of Sepsis • Recognition of bleeding • Escalation for Senior review	20% of the incidents reported in the last 3 years related to non-adherence to standards which includes a sub-category of incidents relating to deteriorating patient. As of June 2023 it is one of the top five incident category which resulted in moderate, severe or catastrophic/death harm. Of the incidents reviewed as part of the divisional review, incidents associated with the management of a deteriorating patient were 10%. Over 10 serious incidents per year in the previous three years related to this topic.	Sepsis and Deteriorating Patient QI Group

Trust Safety Priority	Rationale	Improvement Committee/Group
End of life care: • Failure to follow DNACPR procedure • Delayed recognition of the dying patient; • excess tests and treatments • Poor pain/symptom relief	Whilst there have been incidents associated with this topic it has been a consistent theme over the last 12months from the Learning from Deaths (LfD) reviews. Every month cases from the LfD reviews have identified areas for improvement regarding end of life care.	End of Life / DNACPR QI Group
Management of Patient treatment pathway including associated Booking Processes • Patients lost to follow up before or after the MDM process • Outpatient booking processes (including partial booking and surveillance) • Referral processes (external & Internal) specifically internal 2ww referrals being missed.	In quarter 1 2022/23 'diagnosis delayed or failed (misdiagnosis)' incident was the top five incident reported as moderate, severe catastrophic deaths. Over the last 3 years there have been a number of Serious Incidents (on average 9 per year) and a number of associated local investigations relating to this.	Cancer MDM QI Group Booking QI Group
Urgent or critical radiology results not acted upon	Previously identified safety topic. Incidents reduced but still occurring including those causing severe harm	RadAlert QI project

Trust Safety Priority	Rationale	Improvement Committee/Group
Discharge planning and Communication Key issues: • Failure to update patient/family on plans of care • Incomplete or inadequate discharge summary/letter • Handover/documentation of care process - including post operative instructions • Readmissions following presentation in acute pathway (mis-diagnosis or failed discharge)	High readmission rate compared with National average. Theme identified in quarterly IQR analysis and from Safeguarding and concerns raised directly to the CQC, who have highlighted this as an emerging concern. Identified in • Learning from Deaths • Coronial Inquests • Common theme in complaints, with an average of 96 complaints per year relating to discharge • *Serious Incidents* – Issues relate to failed discharges i.e. patients returning to hospital in a deteriorated clinical condition after being discharged.	Write to me QI Project Discharge project
Iatrogenic harm		
Preventable Falls	Over the last 12 months, 6,648 patient fall related incidents were reported, representing 10% of the overall trust-wide patient related incidents. Patient falls are within the top 5 most common harmful (moderate, severe, catastrophic) incident categories; with 69 SIs commissioned in the last 12 months.	Falls Steering group
Preventable Pressure Ulcers	Over the last 12 months, 6,376 Trust acquired pressure ulcers related incidents were reported, representing 10% of the overall trust-wide patientrelated incidents. With 44 SIs, reported in the last 12 months, the incidence of reported trust acquired pressure ulcers remains high.	Tissue Viability Steering Group
Preventable hospital acquired infections	Over the last 12 months, there were 203 SI reported in relation to Trust acquired infections; representing the highest number of Serious Incidents reported by the Trust.	IPCC Group

Trust Safety Priority	Rationale	Improvement Committee/Group
Operative Management relating to Safety checks	Over the last 12 months, there were 13 Never Events reported, of which 11 related to surgical/invasive procedures.	LocSSIPS QI Group Theatre Standards Group (WHO Checklist)
High Risk Medications: Omitted and delayed medicines for high risk drugs (insulin and anticoagulants). Wrong dose for high risk medicines (insulin, and anticoagulants)	Medication related incidents represent 5% of the total of incidents reported. Whilst less than 1% have led to moderate or significant harm, we have identified a continued trend of incidents reported resulting in omitted doses of insulin and anticoagulation medications and they do have high potential to cause harm. We have had some 'must do' actions associated with anticoagulation medication from previous CQC inspections. Continued performance issues on clinical dashboard.	VTE QI group and Thrombosis Committee Diabetes (DKA and hypoglycaemia) QI Group

Appendix E: Maternity Patient Safety Incident Priorities

Maternity PSIPs	Rationale	Improvement Committee/Group
Diabetes Management in Pregnant Patients Identified themes: • GDM screening at correct intervals and where growth increases • Pre-conception care • Urgent GTT's for third trimester • Rebooking of GTT after DNA • Visibility and review of blood glucose readings taken by the patient • Recording of CGB for self administration • Delivery plans • Joint obstetrician and diabetic reviews • Consistent cross site practice for management of gestational diabetes • Diabetes in Pregnancy Guideline in place and embedded • Inpatient management of diabetes • Management of Pre-existing diabetes in pregnancy	Saving Babies Lives Version 3 recognises that women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. Analysis of the incident data highlighted diabetes management as a theme from incidents reported and in actions identified from investigations, including HSIB and Executive and Divisional RCA's. There were 19 non-adherence to standards incidents reported from June 2022 to May 2023 coded as diabetes management in pregnant patients. The management of diabetes in pregnancy is also on the Maternity Risk Register. A review of the CNST Claims scorecard from August 2022 also identified diabetes as a cause in some cases.	O&G Diabetes improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group

Fetal Monitoring
Identified themes:
• Telemetric CTG / CTG traces being lost
• Use of Oxycotin
• Categorisation
• Interpretation in relation to decision making
• Timing / repeats of CTG
• Intermittent auscultation
• Partograms
• Correct use of CTG – Dawes Redman and conventional
• CTG training
• Documentation:
  • Fresh eyes
  • Escalation
  • Action plans
  • Classification
	Saving Babies Lives 3 Element 4 relates to Fetal Monitoring.
	Maternity providers are encouraged to focus improvement in the following areas:
	a) Risk assessment of the woman/fetus at the beginning and regularly during labour.
	b) Interpretation and escalation of concerns over fetal wellbeing in labour.
	
	Analysis of the incident data highlighted fetal monitoring as a theme from incidents reported and in actions identified from investigations, including HSIB and Executive and Divisional RCA's.
	
	Updated NICE Guidance has been published - NG229 Fetal monitoring in labour. There are some areas of non –compliance, which need to actioned.
	
	A review of the CNST Claims scorecard from August 2022 also identified CTG interpretation as a cause in some cases.
		Fetal Monitoring improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group

Management of deteriorating patient
Identified themes:
Sepsis and MEWS:
• MEWS scoring and documentation:
  ○ Fully completed MEWs chart
  ○ Correct score assessment
  ○ Appropriate management as per triggers
• Use of sepsis tool
• Antibiotics for maternal sepsis in labour and coexisting GBS
• Episodes of raised temperature
• Fluid balance
 	
Identification / escalation of:
• AKI
• HELLP syndrome
• Hypertension/PET
 	
Escalation and Consultant Review:
• SBAR handovers
• Triggers for formal MDT review
• Escalation to consultant
Escalation of acuity
	Analysis of the incident data highlighted management of the deteriorating patient as a theme from incidents and in actions identified from investigations, including HSIB, Serious Incident, Executive and Divisional RCA's and local M&M reviews.
	
	The CQC report of Maternity Services in June 2023 identified that compliance with MEOWS could not be assured as records were not audited, therefore learning or areas for improvement were not being identified. In addition, medical handovers did not use the SBAR format to its full capacity.
	
	Health Education England junior doctors survey identified support needed for junior doctors in relation to when to escalate clinical concerns.
	
	A review of the CNST Claims scorecard from August 2022 also identified management of deteriorating patient as a cause is some cases
		Deteriorating patient improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group
Delays in maternity triage (PAER): Identified themes: • Completion of RAG Rating / initial observations and initial assessment • Documentation of CTGs • Delays due to high activity / bed availability • Appropriate risk assessment, use of RFM checklist, timely USS • Booking system for follow up appointments at PAER • Implementation of BSOTS • Comprehensive reviews, history taking including drug history and formulation of a differential diagnosis • Medical staffing	Analysis of the incident data highlighted delays in maternity triage or reviews of women in PAER as a theme from incidents and in actions identified from investigations, including HSIB, Serious Incident, Executive and Divisional RCA's and local M&M reviews The CQC inspection of Maternity Services in 2023 highlighted a serious patient safety issue due to the time taken to review women in PAER and CQC issued a Section 29a Warning Notice in Feb 2023 that there was insufficient medical staff to provide safe care and treatment, to support the triage/Pregnancy Assessment Emergency Room (PAER) effectively. Risk of patient harm in delay of patient assessment and diagnosis in PAER at BHH due to lack of capacity is also on the Maternity risk register. The lack of space has led to delays and made it difficult to implement BSOTS, a standardised risk assessment tool for maternity triage. PAER was relocated in 2023 to the HTC and now has more beds, medical cover has been increased and there are ongoing audits of triage.	Bronze meeting and MIP estates programme and job planning work PAER improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group

Risk assessment in ANC
Identified themes:
• Risk assessment at booking and every appointment which prompts history taking, management plan and risk assessment at each visit
• Review of all relevant information and results (bloods/urinalysis)
• Review of place of birth
• Review of COVID risks
• Named consultant
• Documentation and correct use of Badgernet ANC forms
• Assignment to correct pathways based on risk, including:
  ○ Hypertension
  ○ VTE risk assessment
  ○ Risk of PPH
	Analysis of the incident data highlighted risk assessment in antenatal management as a theme from incidents and in actions identified from investigations, including HSIB, Serious Incident, Executive and Divisional RCA's and local M&M reviews.
	
	The immediate and essential actions (IEA) from the first Ockenden Report outline requirements related to ongoing antenatal risk assessment and management planning:
	
	IEA 5 of Ockenden 7 requires that all women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional and ongoing review of intended place of birth. Personal Care and Support plans should be in place.
	
	IEA 4 of Ockenden 7 Managing Complex Care requires that referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians.
	
	A review of the CNST Claims scorecard from August 2022 also identified risk assessment as a cause in some cases.
		Antenatal Improvement group

Maternity PSIPs	Rationale	Improvement Committee/Group

Fetal Growth
Identified themes:
• Scanning:
  ○ Independent review and audit of scan images
  ○ Timing and appropriateness of growth scans according to risk factors
  ○ Electronic USS requesting & tracking to ensure a streamlined and auditable process is in place for both routine and urgent USS requests
• Missed FGR
• CO monitoring
• Hypertension and SGA guideline
• Discussion with women regarding care pathways options
• Growth scans and GTT/GDM
• Documentation of symphyiso fundal height
• Referrals to Fetal Medicine
	Analysis of the incident data highlighted management of fetal growth as a theme from incidents in actions identified from investigations, including HSIB, Serious Incident and Divisional RCA's.
	
	Umbilical artery Doppler is recommended as part of Saving Babies Lives 3 element 2 in women whose pregnancies are at high risk of fetal growth restriction. This is on the Maternity risk register as it is not currently implemented and this resulted in Maternity Services not achieving all 10 CNST Safety Actions in 2023. A plan is in place to implement for 2024.
	
	A review of the CNST Claims scorecard from August 2022 also identified management of fetal growth as a cause is some cases.
		Fetal Growth Improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group

Consent / birth choices
Identified themes:
• Birth choices regarding:
  ○ mode of delivery
  ○ care options
  ○ place of delivery
• Documentation of discussions / plan
Resources and training for staff
	There are a number of documents that highlight legal, ethical and professional responsibilities around supporting informed choice for the women, including:
	- The Lanarkshire v Montgomery ruling
	- The Ockenden report recommendations around informed consent
	- The Birthrights information on consenting to treatment/ Human rights (In particular Article 8)
	- The NMC professional code of conduct
	- The GMC Good medical practice guidance
	- The Trust consent policy
	
	Analysis of the incident data highlighted consent as a theme from incidents presented in actions identified from investigations, including HSIB and Divisional RCA's.
		Birth Choices Improvement Group

Maternity PSIPs	Rationale	Improvement Committee/Group
Interpreters and Translators The appropriate use of interpreting and translation services is directly related to ensuring women can provide informed consent. • Inappropriate use of family members • Use of and compliance with the Trust Interpreting/Translating services • Staff training and access Clarity required around the language demographics to be used for our patient population	Analysis of the incident data highlighted use of interpreters as a theme from incidents and in actions identified from investigations. Inconsistent use of Trust translating and interpreting services, resulting in inability of patients to make informed decisions is on the Maternity Risk Register. There is some audit work taking place regarding use of interpretation services. The PMRT Q2 2022/23 Report also identified learning and actions related to the ensuring effective and robust communication using available interpreting services. The CQC Inspection in June 2023 stated that interpreting services were available but there were inconsistencies across clinical areas in the use of interpreting services and availability of information in different languages. Ward staff regularly used telephone translation services, however face to face translation services tended to be used more by the specialist midwifes.	Part of MNIP improvement work
Did Not Attend (DNA) Identified themes: • Support to vulnerable families to access care • Identification DNAs, including community appointments. • Follow up of DNA's • Documentation of DNA's • Documenting decision making process following a DNA • Consultation and escalation following DNA. • DNA management for late bookers • Compliance with DNA Standard Operating Procedure	Analysis of the incident data highlighted DNA as a theme from incidents and in actions identified from investigations including HSIB and SI investigations.	ANC work (see above)