Ashford and St. Peter's Hospitals
NHS Foundation Trust

Women's Health & Paediatrics Patient Safety Intelligence Framework

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Executive Summary	Ashford & St Peter's NHS Foundation Trust Women's Health & Paediatrics Department is dedicated to promoting a culture of continuous learning and improvement from safety intelligence, which creates outstanding patient safety insight. The primary purpose of this framework is to create a division where, insofar as is reasonably practicable, risks and adverse events are minimised. At the heart of this framework are the Trust values – our 4Ps – which define what we believe in, how we will behave and the expectations for teams in the delivery of quality care. Every member of staff will know their importance in prevention of hospital associated harm and the difference they make to patient safety.

Table of Contents

1.0. Introduction 4
2.0. Scope 5
3.0. Purpose 5
4.0. Levels within the framework.......... 5
5.0. Sources of safety intelligence data 5
6.0. Sources of safety intelligence are comprehensive, robust, appropriately collected and managed to provide accurate monitoring.......... 8
7.0. Patient Safety Intelligence Pathway.......... 9
8.0. To ensure effective monitoring of actions and effective dissemination of lessons learnt 9
9.0 Training.......... 10
Appendix 1: Safety Intelligence Flowchart.......... 12

1.0. Introduction

1.1 The Ashford & St. Peter's NHS Foundation Trust Women's Health & Paediatrics Division fully endorses the following statement:

"Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line. Information should include: the perspective of patients and their families; measures of harm; measures of the reliability of critical safety processes; information on practices that encourage the monitoring of safety on a day-to-day basis; on the capacity to anticipate safety problems; and on the capacity to respond and learn from safety information" (NAGSPE 2013).

1.2 The division proactively seeks to learn and improve care based on findings from all sources of patient safety intelligence, both internally within the Trust and externally from national reports, regulatory bodies, LMNS and ICB, and the extensive network of peer acute service providers. The findings from publications including HSIB, NICE, MMBRACE, the Kirkup Report (2015), Francis Report (2013) and Ockenden (2022) and the Kirkup East Kent (2022) are embedded within divisional learning, management, and reporting.

1.3 The division aims to do this by gathering patient safety intelligence and ensuring that this intelligence is translated into effective actions that seek to eradicate, or at the very least, minimise the risk of an adverse event occurring or recuring. A patient intelligence reporting framework that is devoted to continual learning and improvement of patient care from floor to board and beyond.

1.4 The Division is committed to embedding the 'For Unit Safety' Framework (THIS Institute, The Health Foundation, 2020). The framework identifies the behaviours and practices that are features of safe care in hospital-based maternity units. It aims to aid reflection and collective learning and to target improvement efforts.

The seven features of safety are:

1. Commitment to safety and improvement at all levels, with everyone involved
2. Technical competence, supported by formal training and informal learning

3. Teamwork, cooperation, and positive working relationships
4. Constant reinforcing of safe, ethical, and respectful behaviours
5. Multiple problem-sensing systems, used as basis of action
6. Systems and processes designed for safety, and regularly reviewed and optimised
7. Effective coordination and ability to mobilise quickly

The safety intelligence framework focusses on multiple problem sensing systems, used as a basis for action.

2.0. Scope

This framework is intended for use by all staff. This document should be read in conjunction with the Trust's Risk Management Strategy, Incident Reporting and Management Policy, the Harm Free Care Strategy, the NHS Patient Safety Strategy, and the divisional investigation policy.

3.0. Purpose

The purpose of this document is:

- To identify sources of safety intelligence data within our division.
- To ensure that those sources of safety intelligence are comprehensive, robust, appropriately collected and managed to provide accurate monitoring.
- To outline the pathway within which our safety intelligence is disseminated to ensure learning from adverse events is shared locally, within the division, the wider Trust, and with colleagues and invested stakeholders external to the Trust.
- To ensure effective monitoring of actions and effective dissemination of lessons learnt.

4.0. Levels within the framework

A flowchart outlining the safety intelligence pathway can be found at Appendix 1. This policy should be read in conjunction with this flowchart.

5.0. Sources of safety intelligence data

Safety intelligence is determined as "any form of data that can provide an indication of safety/risk within a system. This information may exist at both the local, individual organization, as well as at a provincial or national level. The analysis of such data provides a "window on the system", to better understand present gaps and inadequacies" (Yee, Hall, Herlihey, Jeon, Trbovich, Gelmi, 2021). Safety intelligence can also be described as multiple problem sensing systems (The Health Foundation)

Safety intelligence is obtained in real time from a variety of sources including, but not exclusively:

- Datix
- Patient Experience
- Dashboards
- Rotas/Acuity Tool
- Audits/Test of Effectiveness (TOE)
- Staff Feedback
- PMA/PNA/Students
- Safety Checks and real time data capture

5.1. Datix

The division utilises the Trust Datix incident reporting system for the reporting of events. Datix are reviewed daily by the paediatric and perinatal governance teams. These are discussed at the weekly safety summit and themes and learning are shared. Safety actions are documented within Datix. There is an overarching organisational oversight by the Trust central patient safety team.

5.2. Patient Experience

Feedback from patients and their families is received either directly within the division through a variety of mechanisms (e.g., instant feedback, viewpoint system), or via the Trust central patient experience team (both Complaints and PALS). Issues are either resolved locally with the patient and their families, or via the Trust complaints process if a more formal response is necessitated. The division actively engages in patient partner groups, using feedback constructively to improve the safety and quality of services. There is an active Maternity Voices Partnership[1] with regular 15 steps walkabouts. The neonatal unit has a model of family integrated care and several families actively involved in the Little Roo Neonatal Fund charity to improve care. The bereavement service gathers and shares feedback on a yearly basis. Patients involved in adverse incidents are supported to share their experience if they feel they want to with the Trust Board and to contribute to Trust learning events.

[1] An NHS working group consisting of a team of women and their families, commissioners and providers, working together to review and contribute to the development of local maternity care www.nationalmaternityvoices.org.uk

5.3. Dashboards and data collection

Data from the dashboard is collated through a variety of sources, including maternity Badgernet and Neonatal Badgernet. In addition, workforce and training data are captured. SPC charting is used to identify outcomes/measures that require further scrutiny. The dashboards are also reviewed each month in their respective departmental governance meetings, identifying any themes/trends, inviting a deep dive if necessary. The Maternity dashboard is also shared through the Perinatal Quality Surveillance (PQS) tool, which is then disseminated as per the safety intelligence framework flowchart (Appendix 1) The division will ensure compliance against any KPIs and regional or national safety indicators.

5.4. Acuity Tool and Workforce Rota's

These are utilised to track workforce and safe staffing. The tools highlight skill mix and gaps within the rotas. Daily departmental staffing huddles review and action safe staffing and report centrally via the daily Trust CAT meetings.

The Acuity Tool is completed by the Maternity operational coordinator (MOC) or the labour ward Shift leader and captures a variety of safety indicators such as staffing, capacity, OPEL status and red flag events as per CNST guidance. Red flag events are captured through the dashboard and follows the intelligence flow within the framework (appendix 1). The Paediatric Wards and Neonatal Intensive Care Unit also utilise an OPEL scoring tool to capture safety indicators such as staffing and capacity. This is discussed at a daily Children and Neonatal Matrons meeting. Subsequently all acuity intelligence is fed into the Trust daily CAT meetings.

5.5. Audits/Test of Effectiveness (TOE)

Local audits require registration onto the Trust's clinical effectiveness monitoring programme. This is monitored via Trust CENARG committee and attended by the Perinatal Governance lead and the Paediatric Governance Lead. National audits required are monitored, collated, and overseen by the Trust central clinical effectiveness team in collaboration with the division.
The Division has an active programme of quality improvement workstreams which undertake data collection and audits as part of the PDSA cycle.

Effectiveness of actions resulting from serious incidents will be tested (if appropriate) to ensure that the action has achieved its purpose in reducing or eliminating the care/service delivery issue related to the incident. TOE's will be SMART in nature. The TOE for all HSIB and SI action plans are reviewed and agreed by the LMNS SI panel.

5.6. Staff Feedback

Staff feedback is gathered both formally, via annual staff survey, and informally via appraisal and staff team meetings. There is a monthly maternity unit meeting, in person, on Teams and streamed on Facebook. There are high levels of engagement and staff feedback. The Exec and Non-Exec safety champions undertake regular drop in listening events. The Trust has a Freedom to Speak up Guardian. A divisional action plan based on formal feedback from staff surveys is monitored through safety champion meetings and the Trust Quality of Care Committee.

5.7. PMA/PNA/Students

The role of a Professional Midwifery or Nursing Advocate (PMA/PNA) is to support and guide midwives/nurses so that they can deliver consistent, high quality, safe maternity care. Their feedback is an imperative source of patient safety intelligence. The division actively advocates these roles and support staff to undertake them within each clinical area.

Students are actively supported by a learning and support midwife who is based within the CPE team but is available to students during their clinical placements. Any safety issues raised by students will be addressed via this learning support and formally raised at a formalised CPE/governance meeting which takes place monthly.

5.8. Safety Checks

The division utilises a QR code system to give real-time data concerning safety checks within all appropriate clinical areas. The compliance of the adult crash trolley safety check is captured and reported within the Quality Effectiveness Warning System (QEWS) dashboard. Clinical matrons are responsible for identifying and reporting any issues with safety checks, usually through local level processes, most often through weekly safety summits.

6.0. Sources of safety intelligence are comprehensive, robust, appropriately collected and managed to provide accurate monitoring.

The division collates safety intelligence from a variety of established electronic systems, both divisionally and Trust-wide. The division, and the Trust, provides training for all staff for effective utilisation of these electronic systems to ensure comprehensive and robust data is inputted. Softer intelligence is also collated from the informal feedback mechanisms already identified within section 5.0. Safety intelligence is triangulated within departmental governance meetings to ensure the division is identifying any themes or trends.

7.0. Patient Safety Intelligence Pathway

7.1 There are a variety of local meetings and forums where patient safety intelligence is collated and discussed. From these meetings and forums, any areas of concern are escalated to the specialty governance meetings (of which there are five). Each specialty governance meeting has a set of standing agenda items and capacity for additional ad-hoc governance issues if required. Exception reporting to divisional governance meetings is used for any patient safety issues not resolved at a specialty governance level.

7.2. Escalation and exception reporting to Trust board occurs via the Quality of Care Committee which occurs bi-monthly. The Trust Board will be informed of all new serious incident investigations and HSIB referrals as well as be provided with copies of completed reports via this committee.

7.3. In addition, there is a direct reporting mechanism to Trust Board via the safety champion process, where the Executive Safety Champion presents the Perinatal Quality Surveillance tool which contains a variety of statutory metrics, alongside any exceptional safety issues discussed via the safety champion meetings.

7.4. Patient Safety Intelligence, and any additional statutory required metrics, are shared externally with the Local Maternity and Neonatal System (LMNS) to facilitate effective oversight in accordance with national requirements. This reporting then follows a local and nationally dictated process, via the Integrated Care Board (ICB) and regional pathways.

7.5. The flow of patient safety intelligence within, and outside of the organisation, is intended to be bi-directional - allowing floor to board involvement, oversight and feedback.

8.0. To ensure effective monitoring of actions and effective dissemination of lessons learnt

8.1. Lessons learned from incidents, complaints, claims and near misses are reported to the specialty governance meetings and disseminated via learning slides developed by the Patient Safety Midwives & Nurses. The CPE team work in close collaboration with the Quality and Safety team and learning from incidents is a key part of the annual training programme. There is a Clinical lead for simulation in maternity and NICU who work closely with the safety team. Learning is incorporated into multi-professional obstetric training (PROMPT), regular in situ simulation scenarios, departmental induction days

for new staff and maternity update days, which are mandatory for all midwives and maternity support workers within maternity. Annual mandatory training for paediatric and neonatal nurses will incorporate learning from adverse incidents. Lessons learned from individual incidents will be fed back to the patient, or patient's representative, and staff involved. Feedback mechanisms for staff include theme of the week email and poster, daily team safety briefings at handovers, labour ward forum, unit and team meetings, and safety whiteboards in all areas and learning slides. In addition, multi-professional Quality and Safety meetings are held every 2 months with learning from excellence and adverse incidents.

8.2. Monitoring of action plans as a result of incidents or safety intelligence is managed by Datix with oversight by Perinatal and Divisional governance and the Quality-of-Care committee. Incident reports and action plans are reviewed and shared with the LMNS Quality and Safety Forum and the LMNS Serious Investigations Panel. Both forums include representation from the Local Integrated Care Board (ICB) and key members of staff from local trusts within the Local Integrated Care System (ICS) and external representation. As detailed previously the test of effectiveness for all HSIB and SI action plans are reviewed and agreed by the LMNS SI panel.

8.3 Safety intelligence feedback is provided directly to the division through varying statutory and voluntary external organisations, for example: Healthcare Safety Investigations Bureau (HSIB), Mothers and Babies Reducing Risk Audits Confidential Enquiries (MBRRACE), Local ICB, Maternal Voices Partnerships etc. This feedback can take various formats, both formal and informal, and can flow into the organisation via multiple routes. All feedback received from external organisations will be managed via the local specialty governance meetings and will then follow the framework pathway through the organisation to Trust Board where required (Appendix 1). Additionally, the division can hold an extraordinary meeting in response of the receipt of any patient safety intelligence that requires an immediate divisional response.

9.0 Training

There is no specific training required for the implementation of this framework.

10.0 Approval and Ratification

The final policy must be approved by each speciality governance meeting, followed by divisional governance for final ratification.

11.0 Dissemination and Implementation

The policy will be uploaded on Trust Net via the relevant Trust processes. Divisional Directors, management teams, ward managers and heads of department are responsible for ensuring that all relevant staff under their management (including bank, agency, contracted, locum and volunteers) are made aware of this policy.

12.0 Review and Revision Arrangements

The guideline will be reviewed every 3 years or earlier if national guideline or guidance changes are required to be considered. The review will then be subject to review and re-ratification.

13.0 Document Control and Archiving

The Clinical Effectiveness team is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management: NHS Code of Practice, 2009.

14.0 Monitoring compliance with this Policy

Monitoring will take place via Divisional Boards.

15.0 Supporting References / Evidence Base

Kirkup Report, 2022

Ockenden Report, 2021 and 2022

A promise to learn – a commitment to act, National Advisory Group on the Safety of Patients in England, 2013

Focusing the safety spotlight: How safety intelligence can inform systemic patient safety initiatives, 2021

Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation, Dixon Woods et al BMJ Safety and Quality 2020

THIS.Institute/The Health Foundation 2020 7 features of safety in maternity units

Appendix 1: Safety Intelligence Flowchart