South Tees Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan 2023 / 2024

Effective date: 29/01/24

Estimated refresh date: 30/01/25

	NAME	TITLE	SIGNATURE	DATE
Author	**Jenny Simpson**	**Patient Safety Lead**		
Reviewer	**Kate Jones**	**Assistant Director of Patient Safety**		**20th Dec 2023**
Authoriser	**Dr Hilary Lloyd** **Dr Mike Stewart**	**Chief Nurse** **Chief Medical Officer**		**31st Jan 2024**

Contents

Introduction

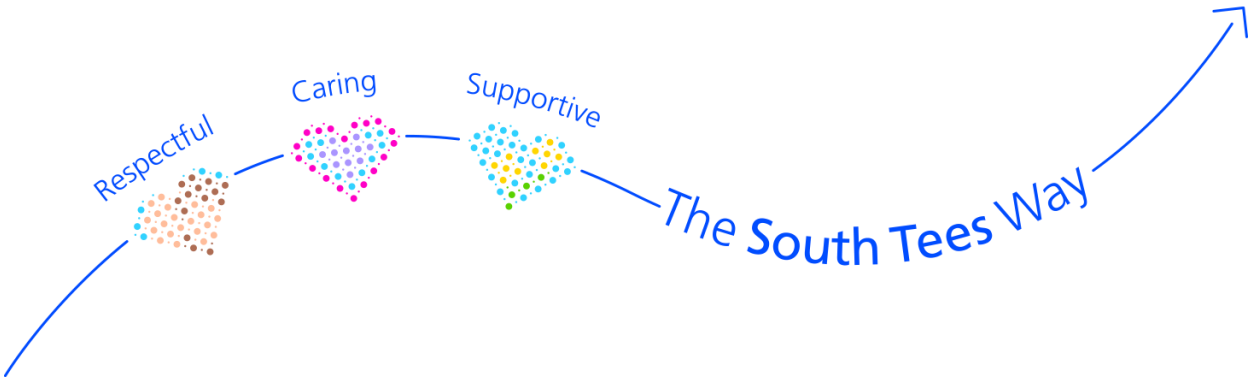
The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework.

This Patient Safety Incident Response Plan (PSIRP) sets out how South Tees Hospitals NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by the Trust's existing policy on reporting, management, review and learning from incidents. The policy is currently being updated to support the introduction of the patient incident response plan.

The plan should be reviewed with the Trust's PSIRF policy which provides further clarity for staff on pathways for escalation, methods of review, safety action development, safety improvement plans and monitoring improvement.

A glossary of terms can be found in appendix A.



Our services

The Trust is an anchor tertiary provider, and our major trauma centre sees half of all trauma cases in the North East and North Cumbria. The Trust has ten clinically led collaboratives, natural care communities of surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support colleagues, which have come together to make their services even better for our patients and service users. At the heart of our collaboratives is our Leadership Improvement and Safety Academy (LISA) which encompasses our patient safety faculty and provides a range of support, including leadership and management training, quality improvement skills, team and service support, coaching and human factors training.

Defining our patient safety incident profile

To define our patient safety response profile, we carried out internal and external stakeholder engagement and reviewed data across the organisation.

Stakeholder Engagement

During the PSIRF implementation phase we undertook engagement with staff, local Integrated Care Boards and those affected by incidents.

Staff engagement was undertaken through Trust patient safety days, ward management away days, relevant meetings and individual consultations.

Patient and family engagement was undertaken through feedback via the Family Liaison Officer Service, and involvement of our Patient Safety Partners throughout the implementation process.

Local Integrated Care Boards have participated in PSIRF implementation meetings. Senior and Board level Trust management have received regular updates and consultation through the Trust's governance processes.

Data sources

Data was collated and triangulated across the following sources;

- Patient safety incidents
- Complaints / PALS concerns
- Safeguarding concerns
- Inquests
- Legal claims
- Freedom to speak up concerns
- Learning from death reviews
- Staff Surveys

Patient safety data reviewed to help determine our patient safety priories is summarised in table 1. Data from our incident reporting system (Datix) and local intelligence was reviewed over a two-year period, 1st April 2021 to 31st March 2023.

Patient Safety Activities	Activity	Average Annual
National Requirements	Serious Incidents; Falls Pressure ulcers Covid related	90 20 15 10
	Never Events	6
Local Requirements	Serious Learning Event & Structured Review; Falls Pressure ulcers	72 36 12
	Moderate Harm (inc those investigated above)	300
Total incidents	Low and No Harm	26, 000
	Learning Disabilities Mortality Review (LeDeR)	22
	Perinatal Mortality Reviews (PMRT)	83
	Recommended Trust Mortality Reviews	189

Table 1; Patient Safety Incidents

Incidents reported to Health Services Investigation Branch (HSIB) are reported as serious incidents and included in the above numbers.

Categories for Serious Incidents and Significant Learning Events, excluding pressure ulcers, falls, and infection prevention control incidents over the same two-year period were reviewed. A summary of the review is included in Table 2.

Reported Dates	2021-2022	2022-2023
Admission including internal transfer	4	1
Medication (subcategory total) Adverse reaction (1) Wrong dose (2) Not given (1) Wrong drug (2)	4	6
Anaesthetics / Theatre / Surgery / Recovery Inadequate monitoring (1) Adverse reaction to anaesthesia (1) Wrong body part / site (1) Foreign body left in situ (2) Corrective surgery required conversion to invasive procedure (2) Patient positioning (1)	3	5
Breach /Cancellation of Treatment/Test/Proc Cancel/delay of op or treatment - other reason (4) Lost to follow up (5)	6	3
Cardiac Arrest Specific	3	1
Communication	2	
Death of a Person Unexpected death (11) Death within 24hr not theatre (1)	3	9
Discharge Specific DC arrangements failed (3) DC delayed (1) Pt took own discharge (1)	2	3
Infrastructure		1
Injury to person	1	
Nutrition Related Error with Must (2) Enteral Nutrition (1) Diet / food related (1)	2	2
Obstetrics	11	6
Path Lab Investigations Test Delayed (2) Test Results not acted on appropriately (1)	1	2
Treatment / procedure Foreign body left in situ (6) Adverse reaction (1) Complication of treatment (3) Confirmed DVT / PE (1) Deficiency of treatment (2) Delayed treatment (4) Diagnosis missed / failed (9) Failed treatment / procedure (1) Inappropriate treatment (1) Misplaced line/tube/catheter (1) Omitted treatment, examination, or procedure (1) Wrong body part affected (2)	11	22

Table 2; SI/ SLE categories for the financial years 2021/22, 22/23.

Defining our patient safety improvement profile

The Trust is continually undertaking service improvements to enhance the care and treatment patients receive. The current work being implemented that links to patient safety incidents, as identified through the data review is outlined in table 3. Full details of the Trust's 2022/2023 improvement plan are included in Appendix 2.

Service Improvement	Support for patient safety	Identified Gaps
Outpatient transformation • Patient initiated follow up pathways (PIFU) • Administration review • Waiting list management including outcome codes, validation, clinical prioritisation • Clinic utilisation review • Community location maximisation • Advice and Guidance activity and reporting	Reduction in patients lost to follow up	Lost to follow up main theme of triangulated data. No work relating to missed / delayed diagnosis.
Digital plan • EPMA • Patient journey boards • E- Discharge and assessments • Smartpage • Electronic noting	Reduction in medication errors Opportunities for faster incident reviews and implementing learning	Incidents related to the change to electronic prescribing.
Emergency Care Pathway, Flow and Discharge • Modular discharge lounge • Clinical site management - strengthened staffing model 24/7 providing senior nurse leadership. • Medical and Surgical SDEC opened. • Full Capacity Protocol and Discharge Policy • MDT reviews for long stay patients • Transfer of Care hub with integral social care workforce	Reduction in safeguarding incidents related to discharge. Improved access to treatment and reduced ED queue through improved flow.	Highest number of safeguarding concerns
Nutrition and Hydration • Additional specialist nutrition and hydration lead • Ward based nutrition assistants. • Digitalisation of MUST • Increased resources for patient assessment	Increased knowledge and awareness around patient safety incidents.	

Table 3; Trust service improvement work

The Trust has outlined its quality priorities for 2023 / 24, work across each of the streams will support ongoing improvements within patient safety and effectiveness (Appendix 3)

Quality Priorities 2023/24

- We will continue to develop a positive safety culture, in which openness, fairness and accountability is the norm.
- We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients.
- We will increase medication safety and optimise the benefits of ePMA.
- We will ensure continuous learning and improved patient care from GIRFT and clinical audits.
- We will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared.
- We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health.
- We will implement the Patient Experience Strategy that has been developed in collaboration with our patients, careers and Healthwatch.
- We will develop and implement shared decision making and goals of care.

Our patient safety incident response plan:

Trust learning responses will be categorised into one of the three areas detailed below, national priorities are predetermined.

Action	Response approach
Patient Safety Review	If the contributory factors to the incident are not understood or if there is no improvement work underway, we will consider one of the following approaches: • Case Note Review • Swarm Huddle • After Action Review (AAR) • Thematic Review • PU/ Fall / IPC review
Local Investigation	• Locally led PSII using a systems-based approach to investigation
National Priority	• PSII undertaken in line with National Priority • Organisation to respond to action plan recommendations following external investigation (e.g. HSSIB / HSIB) • Organisation to support or responds to other external investigations e.g. SHOT

Patient safety reviews cover multiple different learning response methods; incidents within the trust priorities will be reviewed through a weekly Learning Response Panel (LRP) to determine the most appropriate and proportionate learning response to be undertaken.

Local priorities (falls/ Pressure ulcers / IPC) are excluded from the LRP.

National Priorities

<table>
<tr><th rowspan="16">Patient Safety Event Occurs</th><th rowspan="16">National Priorities</th><th>Event</th><th>Approach</th><th>Improvement</th></tr>
<tr><td>Maternal deaths</td><td rowspan="2">Referral to Healthcare Safety Investigation Branch (HSIB)</td><td rowspan="11">Respond to recommendations from external referred agency / organisation as required</td></tr>
<tr><td>Babies who meet HSIB referral criteria: include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:
• intrapartum stillbirth
• early neonatal death
• potential severe brain injury.</td></tr>
<tr><td>Child Death</td><td>Child Death Review process</td></tr>
<tr><td>Deaths of babies meeting PMRT criteria (appendix 4)</td><td>Perinatal Mortality MDT Review Tool (PMRT)</td></tr>
<tr><td>Term readmissions to neonatal unit.</td><td>Avoiding term admissions to neonatal units (ATAIN) MDT process</td></tr>
<tr><td>Death of persons with learning disabilities or autism</td><td>Reported and reviewed by learning disabilities review (LeDeR)</td></tr>
<tr><td>Incidents in screening programmes</td><td>Reported to public Health England</td></tr>
<tr><td>Death of patients in custody / prison / probation</td><td>Reported to Prison and Probation Ombudsman</td></tr>
<tr><td>Mental Health related deaths</td><td>Referral to NHS England Regional Independent Investigation Team</td></tr>
<tr><td>Haemovigilance and transfusion</td><td>Medicines & Healthcare products Regulatory Agency (MHRA)
Serious Hazards of Transfusion (SHOT)</td></tr>
<tr><td>Safeguarding Incidents meeting Section 42 Criteria</td><td>Patient Safety Incident Investigation OR Safeguarding Investigation if PSII not relevant</td><td rowspan="4">Create local organisation recommendations and actions</td></tr>
<tr><td>Incidents meeting Never Event criteria</td><td>PSII</td></tr>
<tr><td>Regulation 28 Requests</td><td rowspan="2">Patient Safety MDT to determine learning response</td></tr>
<tr><td>Death of a person thought more likely than not due to problems in care (learning from deaths criteria)</td></tr>
</table>

Trust Priorities

Patient Safety Event Occurs	Trust Priorities	Event	Description	Approach
		Treatment / Procedure	Lost to follow up Harm or potential for physical and/ or psychological harm of moderate or above and/or significant opportunities for learning	Patient Safety Review
			Missed Diagnosis /Treatment Delayed Diagnosis / Treatment Harm or potential for physical and/ or psychological harm of moderate or above and/or significant opportunities for learning	Patient Safety Review
		Medication	Thromboprophylaxis	Coagulation team AAR/thematic review
			Critical Medications related incidents Harm or potential for physical and/ or psychological harm of moderate or above and /or significant opportunities for learning	Patient Safety Review
		Admission/ Transfer / Discharge	Harm or potential for physical and / or psychological harm of severe or above and /or significant opportunities for learning as a result of gaps / delays in transfers of care or discharge.	PSII
		Care and treatment	Harm or potential for physical and/ or psychological harm of moderate or above and / or significant opportunities for learning as a result of gaps in coordination of care between multiple stakeholders in ongoing patient treatment.	Patient Safety Review
			Harm or potential for physical and/ or psychological harm of moderate and /or potential for significant learning attributable to health inequalities or mental health.	PSII
		Maternity	Maternal postnatal readmissions.	Thematic review
		Mortality Review	Patient safety incidents identified as part of the Trusts Mortality review process and significant opportunities for learning.	Patient Safety Review /PSII
		Harm	Incidents graded as fatal that do NOT fall into any alternative category.	Patient Safety Review
			Incidents graded as moderate or above for physical and / or psychological harm and do NOT fall into any alternative category	Duty of Candour process

The number of Patient Safety Incident Investigations (PSII) undertaken within the Trust per year will be dependent upon the capacity of the learning response leads and this will be reviewed within 12-18 months.

Local learning response

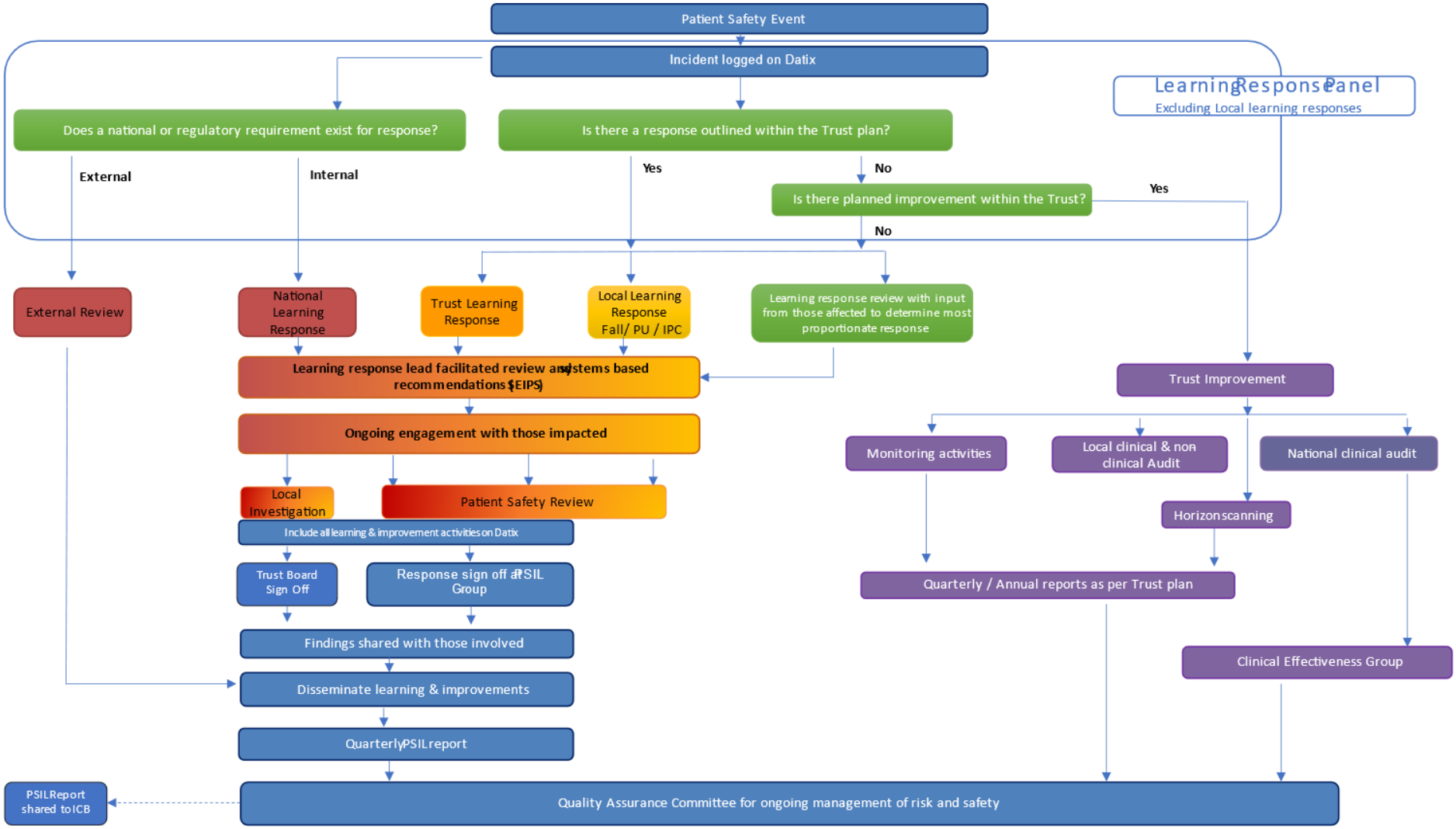
Patient Safety Event Occurs	Trust Priorities	Event	Description	Approach
		Falls	All inpatient falls Inpatient fall resulting in severe harm	NAIF Reviews
		Pressure Ulcers	Acute Deteriorating category 2 pressure ulcers (selected wards) Category 3 and 4 pressure ulcers developed in our care.	PU Safety Review
			Community	PU Safety Review
		Infection Prevention Control	Trust apportioned MRSA and Clostridiodies difficile	IPC Review
			Trust apportioned MSSA, GMBSI, Covid deaths Infection outbreaks	IPC Review

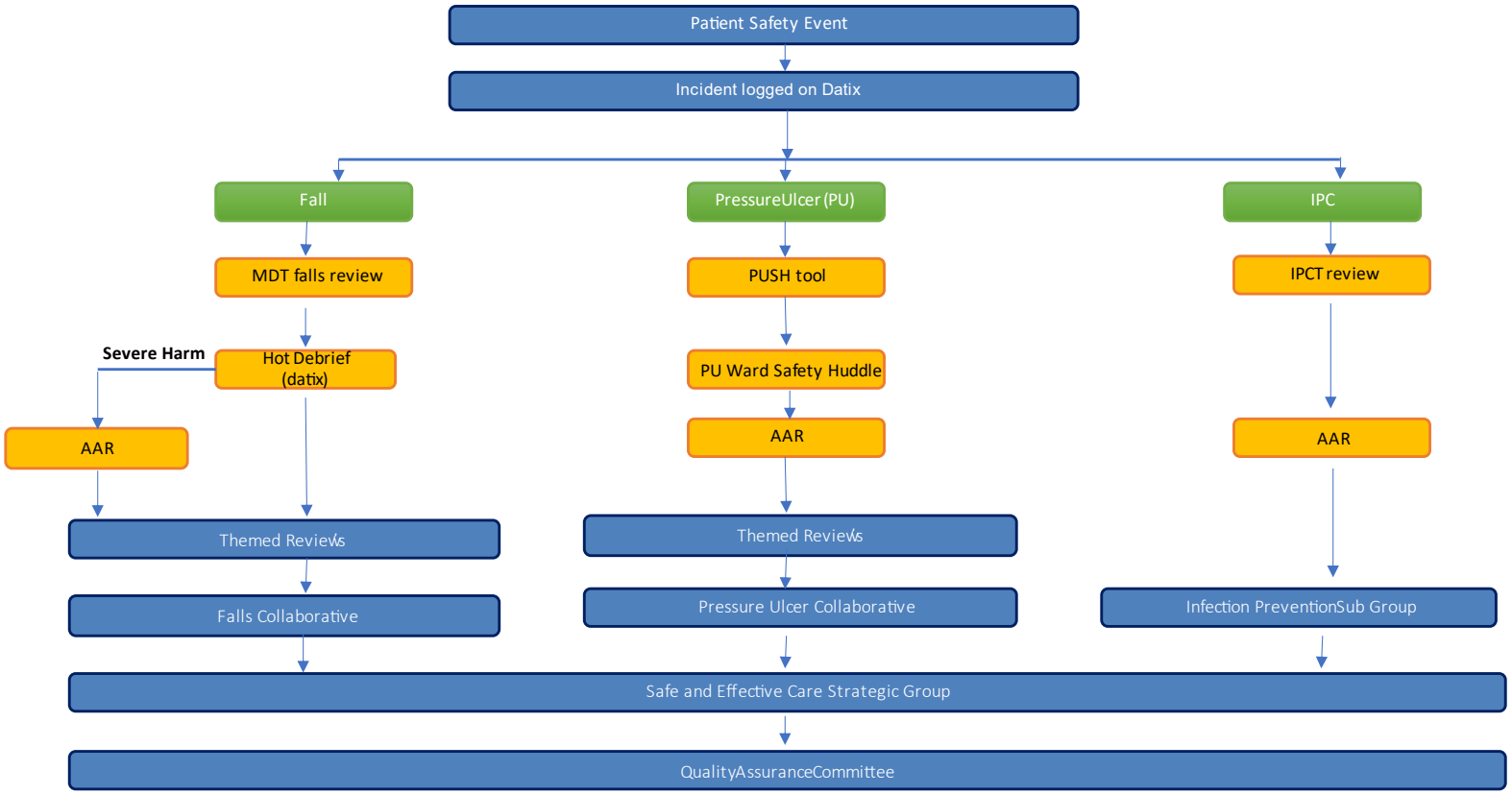
Local level learning responses are supported by Trust wide improvement programmes. Improvement programmes are continually reviewed and updated.

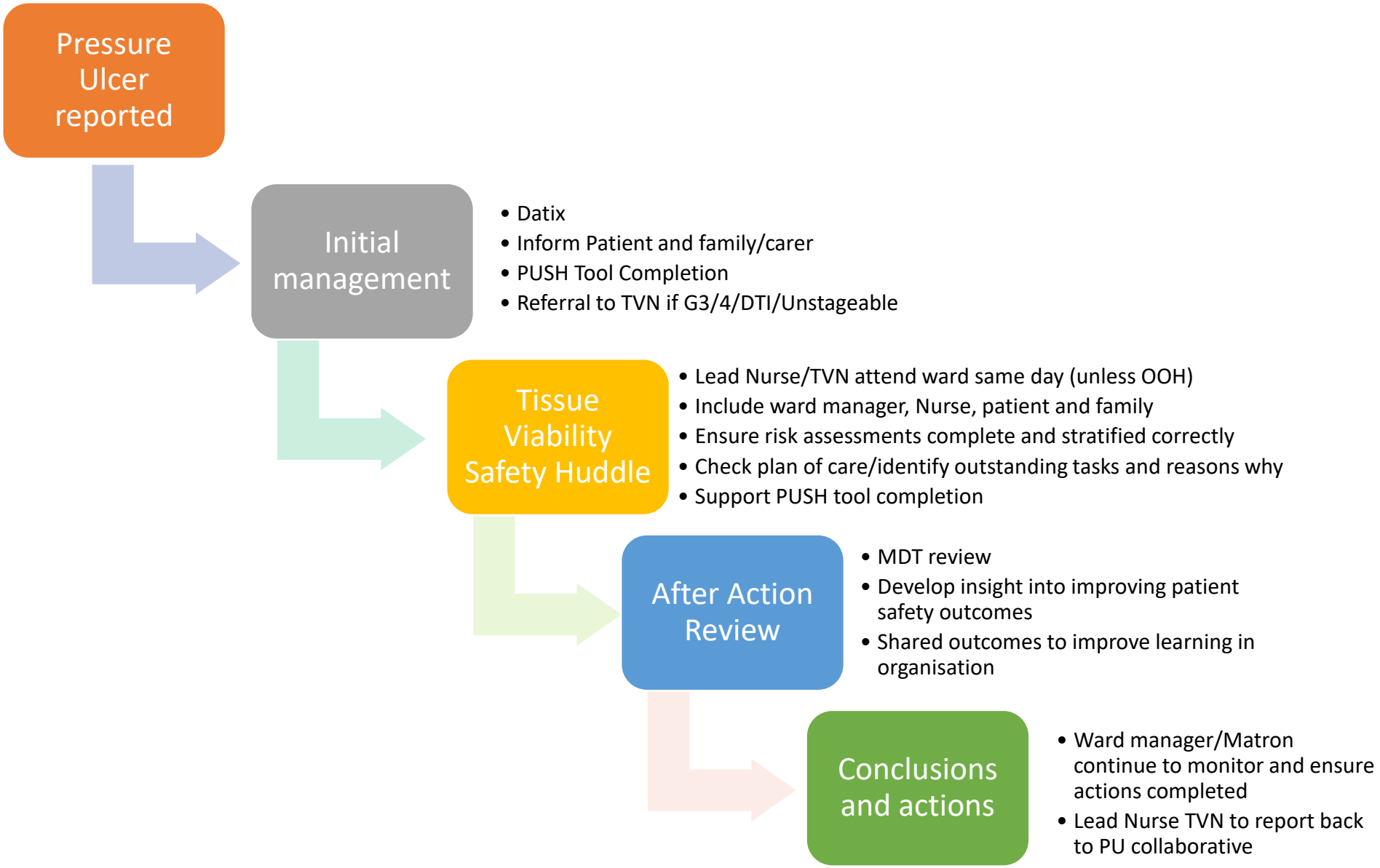
PSIRF promotes a range of system-based approaches for learning from patient safety incidents, the Trust will utilise these tools to ensure it maximise the opportunities to introduce system-based learning and improvement from incidents or a cluster of incidents. As PSIRF and the PSIRP are new ways of working within the Trust, the chosen learning responses may be amended as the Trust learns and PSIRF becomes embedded.

Incidents identified that meet the Trust priorities will be escalated to the weekly Learning Response Panel (LRP). The LRP will review the suitability of the incident for further review and identify the most appropriate learning response. Learning response leads will be allocated, when indicated.

Our Governance and Oversight




Patient Safety Event
Incident logged on Datix
Fall
PressureUlcer(PU)
IPC
MDT falls review
PUSH tool
IPCT review
Severe Harm
Hot Debrief (datix)
PU Ward Safety Huddle
AAR
AAR
AAR
Themed Reviews
Themed Reviews
Falls Collaborative
Pressure Ulcer Collaborative
Infection PreventionSub Group
Safe and Effective Care Strategic Group
QualityAssuranceCommittee


Pressure Ulcer reported
Initial management
• Datix
• Inform Patient and family/carer
• PUSH Tool Completion
• Referral to TVN if G3/4/DTI/Unstageable
Tissue Viability Safety Huddle
• Lead Nurse/TVN attend ward same day (unless OOH)
• Include ward manager, Nurse, patient and family
• Ensure risk assessments complete and stratified correctly
• Check plan of care/identify outstanding tasks and reasons why
• Support PUSH tool completion
After Action Review
• MDT review
• Develop insight into improving patient safety outcomes
• Shared outcomes to improve learning in organisation
Conclusions and actions
• Ward manager/Matron continue to monitor and ensure actions completed
• Lead Nurse TVN to report back to PU collaborative

Appendix 1

Glossary of Terms

Patient Safety Incident Investigation (PSII)

An in-depth review of a single patient safety incident or cluster of events to understand what happened and how. PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified.

After Action Review (AAR)

AAR is a structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and generates learning to assist improvement.

Thematic Review

A process to understand common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g. individual datix incidents or previous investigations)

Swarm Huddle

A facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

PSIL - Patient Safey, Improvement and Learning

Appendix 2 – 2022/23 Improvement Plan

2022/23 STH Improvement Plan

Appendix 3 – 2023/24 Quality Priorities

2023-2024 STH Quality Priorities .pd

Appendix 4 – PMRT Criteria

Microsoft Word - 3 Contributory Factors Classification Framework.doc (ox.ac.uk)