NHS
Hull University Teaching Hospitals
NHS Trust

Patient Safety Incident Response Plan

Document Control

Document Title:	Patient Safety Incident Response Plan
Reference No:	
Document Purpose:	This patient safety incident response plan sets out how Hull University Teaching Hospitals (referred to as HUTH hereafter) intends to respond to patient safety incidents over a period of 12 to 18 months.
First Published:	March 2023
Current Version Published:	March 2023
Review Date:	September 2023
Version:	1
Ratification Committee(s):	Quality Committee; Trust Board
Lead Director:	Suzanne Rostron, Director of Quality Governance
Date EIA Completed:	
Document Managed by Name:	Donna Pickering
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Consultation Process	
Key words (to aid intranet searching)	Patient safety, PSIRF, PSIRP
Target Audience *(delete as appropriate)*	All staff

Version Control

Date	**Version**	**Author**	**Revision description** *(Provide a brief outline of the changes made to the document)*
March 2023	V1	Head of Patient Safety and Improvement	New document

Contents

Introduction

This patient safety incident response plan sets out how Hull University Teaching Hospitals (referred to as HUTH hereafter) intends to respond to patient safety incidents over a period of 12 to 18 months. The aim of this plan is to continually improve and as such this document will be reviewed after a period of 12 months. HUTH will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The plan is underpinned by the Trust PSIRF and Incidents Policies available to all staff via our organisation's intranet (available to staff only).

The date the Trust will begin the transition to PSIRF is 1 April 2023. This means that all incidents reported after this time would be investigated under the Patient Safety Incident Framework (2022) and that the Serious Incident Framework (2015) would not be applied. The transition will be continually monitored and the PSIRP amended to reflect the journey and learning during the transition period as the Trust adapts to the new approach.

The Trust will continue to declare serious incidents in line with the current 2015 framework until 31 March 2023 and any serious incident investigations open at that date will be concluded; it is expected that all serious incident investigations will be completed by July 2023 in line with 60 working day timescales.

Defining our patient safety incident profile

The patient safety risk process is a collaborative process. To define the HUTH patient safety risks and responses for 2023/24 the following stakeholders were involved.

- Trust staff – through data from incidents reported onto the HUTH Local risk management system (DATIX)
- Senior leaders across the Health Groups – through a series of engagement/briefing sessions
- Patient group – through a review of the thematic content of complaints, patient advice and liaison service (PALs) contacts and litigation claims*
- Commissioners/ICS partner organisations – through partnership working with the ICS patient safety and quality representatives
- ICB attendance at Trust Quality Committee

*HUTH aims to incorporate wider patient perspective in future PSIRF planning through the recruitment of patient safety partners (PSP)

The HUTH patient safety risks were identified through the following data sources:

- Analysis of five years of DATIX incident data 2016-2021
- Analysis of themes arising from the Weekly Patient Safety Summit 2021-2022
- Key themes from complaints/PALS/claims/inquests
- Key themes identified from specialist committees (e.g. falls, pressure ulcers, nutrition, safer medication practice committee)
- Themes form the Learning from deaths Annual Report
- Themes from a review of patient harms (2022)
- Output of stakeholder event discussions

Local patient safety risks related to national priorities have been defined as the list of risks covered by national priorities that HUTH anticipates will require a response in the next 12 months. Table 1 sets out the full of national priorities that require a response.

The local response to patient safety risks have been defined as the list of risks identified through the stakeholder approach and the data analysis described above.

Table 2 lists the top local patient safety risks that represent opportunities for learning and improvement at HUTH.

HUTH patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances or review by, or referral to, another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not to have been due to problems in care (i.e. incidents meeting the learning from deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the national mandated responses.

	National priority	Investigation Response	Learning Response
1	Incidents that meet the criteria set in the Never Events list (2018)	Locally led Never Event including clinical simulation within the SEIPS framework	Full safety action plan with appropriate elements included in other CQI plans
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII utilising the SEIPS framework	Full safety action plan with appropriate elements included in other CQI plans
3	Maternity and neonatal incidents meeting HSIB criteria	Referral to HSIB for independent PSII	
4	Child deaths	Refer for Child Death Overview Panel review.	
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the Panel review	
6	Safeguarding incidents in which: • Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. • Adults (over 18 years old) are in receipt of care and support needs by their Local Authority • The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery &	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and	

	National priority	Investigation Response	Learning Response
	human trafficking or domestic abuse / violence.	local Safeguarding Adults Boards.	

HUTH patient safety incident response plan: local focus

HUTH considers that all of the incident types set out in Table 2 have relevance for all our inpatient services. This is an organisation-wide PSIRP however there are separate PSIRP plans for individual services (e.g. maternity) set out at appendix II.

All incident types below will have a PSII undertaken by staff who have received specialist training required to undertake a PSII.

Table 2 sets out local responses

	Incident Type	Investigation Response	Learning Response
1	Administration of wrong medication, omission or wrong dose resulting in major or catastrophic harm	PSII	Full safety action plan with appropriate elements included in other CQI plans
2	Deterioration of a patient waiting for handover from ambulance crew for ≥1hr to a NEWS score of 5+ resulting in major or catastrophic harm	PSII	Full safety action plan with appropriate elements included in other CQI plans
3	Deaths of patients who have taken their own lives	PSII	Full safety action plan with appropriate elements included in other CQI plans

Where an incident does not fall into any of the categories above; an investigation and/or review method described in appendix I may be used by the team at ward level and where required facilitated by a member of the Patient Safety team

Local methods such as the national PMRT and SJR tools and/or structured local proformas (e.g. falls and pressure ulcers) may be used. The completion of a narrative response on the Datix incident module is also appropriate.

Table 3 sets out patient safety themes and investigation options

	Incident Type	Incident Response method Options	Learning Response
1	Harms identified in the Quality Strategy • Inpatient falls • Hospital acquired pressure ulcers • Catheter associated UTI • Avoidable VTE • Hospital acquired infections • Medication errors	AAR PSA MDT review, Walkthrough analysis Observational analysis Quarterly thematic review	One page learning response template Update on Quality Strategy improvement programme for that theme
2	Incidents linked to established working groups e.g. • Nutrition • End of life care • Dementia • Mental Health	AAR PSA MDT review, Walkthrough analysis	One page learning response template Update on improvement programme for that theme Quarterly thematic review
3	Risk to patient safety themes e.g. • Deteriorating patient/Sepsis • Ambulance handovers • Overcrowding • Access to treatment	AAR SWARM huddle MDT review Clinical simulation	One page learning response template Improvement plan Quarterly thematic review
4	ReSPECT/Advanced Plans not identified	AAR PSA	Quarterly thematic review and improvement plan
5	Service level determined reviews e.g. • Failed intubation (regardless of outcome) • Failed grafts	AAR SWARM huddle MDT review Clinical simulation	One page learning response template Improvement plan Quarterly thematic review
6	Moderate and above harms	AAR SWARM huddle MDT YCFF Walkthrough analysis Observational analysis Link analysis	One page learning response
7	Cluster of near miss, no harm and / or low harm	Thematic review	Thematic review report and improvement plan

	Incident Type	Incident Response method Options	Learning Response
8	Emerging patient safety risks / themes - identified at the weekly patient safety summit	Thematic review	Thematic review report and improvement plan
9	Learning from Excellence/things that go well (Safety II)	AAR Thematic reviews	One page learning response template Quarterly thematic review

Appendix I – Maternity PSIRP

Maternity Patient Safety Incident Response Plan

Within the maternity services at HUTH a range of system based approaches will be utilised in order to respond to and learn from patient safety incidents. This approach is central to improving perinatal quality surveillance therefore improving outcomes for the women and their families. With maternity patient safety incidents like all aspects of incident responses under the Framework, the Board are accountable for the quality of incident responses and fundamentally for reducing the reoccurrence and risk as a result of incidents. This is particularly relevant to Hull University Teaching Hospitals Board-level Maternity Safety Champions and the Non-Executive Director appointed to work alongside the champions as set out in the Maternity safety and culture policy.

In order to ensure a collaborative and collective approach, the Regional and Local Maternity Neonatal systems (LMNS) as well as the Maternity voices partnership have been involved in the development of this Maternity Patient Safety Incident Response Plan.

Maternity patient safety incidents requiring referral to HSIB

In line with the National mandated responses set out in table 1 of the HUTH PSIRP, patient safety incidents meeting the 'Each Baby Counts' and Maternal Death criteria listed below meet the requirements for a patient safety incident investigation (PSII). As such, they must be referred to the Healthcare Safety Investigation Branch (HSIB) or Special Healthcare Authority when in place, through the web portal provided to all trusts, for an independent PSII, and incidents will be referred to HSIB.

Babies who meet the criteria to be referred to HSIB for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:

- Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.
- Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).
- Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic ischaemic encephalopathy; or was
- Therapeutically cooled (active cooling only); or had decreased central tone, was comatose

Maternal deaths that meet the criteria to be referred to HSIB:

Deaths of women while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

Maternity patient safety incidents not referred to HSIB: local focus

Table 1 below sets out how HUTH Maternity service intend to response to different maternity incidents. As with all patient safety incident responses under the PSIRF, the focus is on examining and understanding how to reduce the risk of future incidents.

Table 1

	Incident Type	incident response method Options	Learning Response
1	Postpartum haemorrhage 500mls to 1499mls	PSA	One page learning response template Quarterly thematic review
2	Avoidable Term admission to NICU	MDT review PSA	One page learning response template Quarterly thematic review
3	Maternity incidents resulting in moderate harm or above when a consultant on call not attending is a factor	AAR SWARM huddle MDT Walkthrough analysis Observational analysis	Thematic review report Update to improvement plan relating to theme
4	Early pregnancy loss which do not meet the perinatal mortality review criteria	AAR SWARM huddle MDT Walkthrough analysis Observational analysis	Thematic review report Update to pre term birth improvement plan
5	• Massive obstetric haemorrhage cases over 1.5 Litres systematically reviewed • Severe pre-eclampsia/eclampsia • Any woman requiring ICC care • Maternal or fetal morbidity following spontaneous vaginal birth, shoulder dystocia or operative delivery • Transfer to ICU • Ruptured uterus • Neonatal low cord gases • Severe Sepsis • Cord prolapse • Third and fourth degree tears • Postnatal readmission	MDT review PSA	One page learning response template Quarterly thematic review

	Incident Type	incident response method Options	Learning Response
6	All perinatal deaths from 22+0 days gestation until 28 days after birth*; (*excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known);*	Case MDT Review	Thematic review report and improvement plan if outcome of review is graded below C Local PSII if outcome of care review is graded A or B
7	Undiagnosed foetal abnormality	MDT SWARM huddle	Thematic review
8	Failed ventouse/forceps delivery leading to LSCS	AAR SWARM huddle MDT Observational analysis	Thematic review report and improvement plan
9	Delayed recognition of a deteriorating women	AAR	One page learning response template Quarterly thematic review

Appendix II – Glossary

AAR – After action review

AAR is a structured facilitated discussion following an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.

Deaths thought more likely than not to have been due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

MDT – Multidisciplinary team (MDT) review

An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walkthroughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Never Events list 2018 (updated February 2021)

Observational analysis

Observations help us move closer to an understanding of how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as disclosed).

PSA – Patient safety audit

A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guideline).

PMRT - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

PSII - Patient Safety Incident Investigation

PSIIs offer an in-depth review of a single patient safety incident or cluster of incidents to understand any system factors that contributed to the incident. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the health groups and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the strategy.

SJR - Structured judgement review

Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

SWARM – SWARM Huddle

The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

Walkthrough analysis

Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (e.g. designing a new protocol).

The tool is used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support human performance.

YCFF – Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework is a tool which has an evidence base of 16 domains for optimising learning and addressing causes of patient safety incidents by helping staff identify contributory factors of patient safety incidents. The underlying aim of this tool is not to ignore individual accountability for unsafe care, but to try to develop a more sophisticated understanding of the factors that cause incidents. These factors can then be addressed through changes in systems, structures and local working conditions.