Patient safety incident response plan

Appendix 2 of the Patient Safety Incident Response Policy (to be read in conjunction with the Policy)

Effective date:	28 November 2023
Approval:	NLAG/HUTH Group Executive Team
Estimated refresh date:	Six months post implementation review

Version: 1.0

Contents

Introduction

This patient safety incident response plan sets out how Northern Lincolnshire and Goole NHS Foundation Trust intends to respond to patient safety incidents over a period of the next 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will undertake a post implementation review at 6 months to consider effectiveness and requirements of the Patient Safety Incident Response Framework and the Trust. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Trust is committed to improving patient safety, learning from incidents by understanding the context and taking action to reduce the risk of recurrence. This is linked to the Trusts strategies and specifically to the Strategic Objective 1: To give great care:

- Never compromise on safety
- Give care which works and is clinically proven
- Work on what matters to patients
- Always seek to learn and make improvements

This document should be read in conjunction with the Patient Safety Incident Response Policy.

Our services

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire. The trust has approximately 750 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital at Grimsby in North East Lincolnshire, Scunthorpe General Hospital in North Lincolnshire and Goole and District Hospital (based in the East Riding of Yorkshire).

NLAG provides typical Acute hospital general district hospital specialty services, including Emergency Departments at DPoW in Grimsby and at Scunthorpe General Hospital. Elective surgery is provided on all sites, with a surgical hub recently opened at Goole. NLAG provide Paediatric, Maternity, Gynaecology, Critical Care, ENT, Urology, Colorectal Surgery, Orthopaedics, Breast, Acute Medicine and a range of Medical Specialties, supported by diagnostic services and outpatient services. The Community services are provided in the North Lincolnshire locality.

The Trust is moving into a Group alongside colleagues from Hull University Teaching Hospitals NHS Trust (HUTH), with a recently appointed Group Chief Executive for both organisations, along with an existing joint Chair of the Trust Boards of each

organisation. Following appointment of a single executive team, there will be development of a group operating model with underpinning clinical governance structure.

There are already several shared clinical services with joint leadership teams on delivery of those specialties. In addition, there are some services with historical well-established routes of referral.

While recognising the developing strengthening of relationships with HUTH, NLAG have taken their own PSIRF journey supported by the ICB. While there may be some similar response plan components, the plan is independently produced for NLAG, by NLAG's Patient Safety Incident Response Framework Implementation Group.

Defining our patient safety incident profile

In the development of this response plan, we have taken into consideration a wide range of stakeholders that are impacted on through the change of our approach for investigations. A stakeholder map was developed, identifying colleagues both internal and external to the Trust.

Within NLAG there has been an active implementation group set up to include all clinical divisions, corporate departments and members of existing quality, governance and quality improvement departments. This was intended to assist all relevant departments with the transition from the previous national Serious Incident Framework. It has also enabled contribution from teams in Communications, Human Resources, Training and the senior leadership teams to support the transition. Further to this, a wider membership of clinical and quality governance group members came together to review the patient safety risk profiling work undertaken and refine how it is prioritised and included in this incident response plan.

Externally we have considered the key partnership and participation with the Humber, North Yorkshire Integrated Care Board with particular focus on the localities across northern Lincolnshire and the quality teams who have an existing collaboration arrangement for the management of serious incidents, typical of commissioner and provider. We have particularly appreciated the ICB colleague contribution to our implementation group and support provided with ICB requirements. We have also sought engagement with the Local Maternity and Neonatal System for their agreement of the plan related to those services.

Wider contact with Health and Social Care partners is recognised, as is the relationship with HM Coroner, who have been updated on the changes anticipated as part of Quality Boards for localities or directly through our Head of Legal Service.

In order to create the patient safety risk profile, we have considered a wide range of data held from the past 1 to 5 years and some specific more historical investigations including:

- Incident reports and local manager investigations for past 2 years
- Serious incident and root cause analysis reports, action plans and learning points identified for past 2 years
- Never Event and some specific high profile serious incidents for past 5 years
- Serious Incident Panel meeting notes
- Governance meeting minutes
- Risk Register entries
- Learning from deaths using Structured Judgement Review findings
- Complaints and concerns from patients
- Patient Experience Reports
- Nursing Metrics and Assurance Reports
- Clinical claims
- Inquest case investigations and findings
- Clinical Audit activities with national and local audits
- Current quality priorities, locally identified, as well as national Clinical Quality Innovation (CQUIN) priorities.
- Quality Improvement projects
- Internal Audit report findings
- Inspection reports from the Care Quality Commission

The services covered by our response plan includes all of the clinical services provided by NLAG. The risks identified for Maternity, Neonatal care and Paediatrics have been analysed and themed as a separate activity, due to the need to engage with the LMNS specifically, but also because of the nationally recognised inherent specific Maternity patient safety risk.

We have also included the national requirements for response plans, applied across the NHS, which links to Healthcare Safety Investigation Branch led investigations, safeguarding investigations through the local authority and the police and guidance on infection control incidents from NHS England.

Defining our patient safety improvement profile

The Trust already has a range of quality improvement priorities including:

- Quality Improvement projects aligned to department teams priorities
    - Maternity and neonatal projects
    - Quality Priority working groups
- Quality Priorities, set through Trust stakeholder engagement activities

    - End of Life care
    - Deteriorating patient in adults
    - Sepsis in adults and children
    - Medication safety – recording of patient weights
    - Mental capacity assessment and best interest decisions
- CQUIN schemes relevant to Acute and community services, with a lead manager and support from the Quality Assurance team.
    - Staff flu vaccinations
    - Supporting patients to drink, eat and mobilise after surgery
    - Compliance with timed diagnostic pathways for cancer services
    - Prompt switching of intravenous to oral antibiotic
    - Identification and response to frailty in emergency departments
    - Timely communication of changes to medicines to community
    - Recording of and response to NEWS2 score for unplanned critical care admissions
    - Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
    - Achieving high quality Shared Decision-Making conversations in specific specialised pathways to support recovery
    - Assessment and documentation of pressure ulcer risk
    - Assessment, diagnosis and treatment of lower leg wounds
- National Audits (See the Trust Quality Account 2022/23 for more detail)
- Local Audits identified by clinicians included in the Clinical Audit Forward Plan
- Strategic priorities and action plans
    - Falls prevention
    - Pressure Ulcer prevention
    - Healthcare associated infection management
    - Safe staffing for nursing and midwifery
    - Learning from deaths

Our patient safety incident response plan: national requirements

The national mandated criteria is provided in the following table. Some elements of the national requirement are included, even though the frequency of occurrence is likely to be rare.

Patient safety incident type	Required response	Anticipated improvement route
Maternity and neonatal incidents meeting Maternity and Neonatal Safety Investigations (MNSI) formerly Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to MNSI or SpHA for independent PSII (If MNSI investigation is declined by family, then local PSII will be required)	Respond to recommendations as required and feed actions into the quality improvement strategy (Determine specific response actions and feed these into the quality improvement strategy)
Late fetal losses at gestation of 22+0-23+6. Antepartum/intrapartum stillbirth. Neonatal death up to 28 days from birth	Perinatal Mortality Review Tool	MBRRACE reports Family Services Quality Improvement & Monitoring Group
Death/Fatality thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Determine specific response actions and feed these into the quality improvement strategy
Incidents meeting the Never Events criteria (2018) or its replacement	PSII	Determine specific response actions and feed these into the quality improvement strategy
Child deaths	Refer for Child Death Overview Panel review PSII (or other response) may be required alongside the panel review if determined necessary and associated to care provided	Child Death Overview Panel Determine specific response actions and feed these into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	LeDeR programme

Patient safety incident type	Required response	Anticipated improvement route
	FPSII (or other response) may be required alongside the LeDeR in circumstances where the incident meets the learning from deaths criteria for patient safety incident investigations (PSIIs))	Determine specific response actions and feed these into the quality improvement strategy
Safeguarding incidents in which: • babies, children, or 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 from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead NLAG must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to the local designated professionals (ICB) for child and adult safeguarding Determine specific response actions and feed these into the quality improvement strategy
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of Trust learning response See: Guidance for managing incidents in NHS screening programmes https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes	Respond to recommendations as required from external experts and create local organisational actions and feed actions into the quality improvement strategy
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 (incidents meeting the learning from deaths criteria)	PSII	Determine specific response actions and feed these into the quality improvement strategy

Patient safety incident type	Required response	Anticipated improvement route
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP
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 or contributed to depending on how NLAG involvement.	As decided by the RIIT

Our patient safety incident response plan: local focus

The following methods of investigation are expected if the national requirements are not applicable. All learning responses are always to be focused on the system learning opportunities, using agreed tools and templates. Quality of adherence to the system focus, rather than person centred will be audited proportionally.

Learning response methods, tools and descriptions are provided in the table below:

Learning response methods and tools	**Description**
Patient Safety Incident Investigation (PSII) *Target timeframe: 3 months, but no longer than 6 months.*	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. It is a detailed investigation that will require involvement of the patient or their family, gaining information from relevant parties involved to understand the contextual work system. Learning response lead will be independent from the service being investigated. They will work with subject matter experts to provide clinical or specialist advice and contribute to the investigation. PSII can be used for individual incidents or thematic investigations of similar groups of incidents using other learning responses if available. The aim is to thoroughly investigate and produce a detailed analysis and identify system learning opportunities.
After Action Review (AAR) *Target timeframe: Within 2 weeks of the reporting of the incident*	Facilitated approach, AAR is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future, with a duration of 1 hour for the session.
Swarm Huddle *Target timeframe: On the day or as soon after incident is reported*	Facilitated approach, immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.
Multidisciplinary team review *Target timeframe: Within 2-4 weeks of the reporting of the incident*	Table-top review with a multidisciplinary team, applying systems focused analysis, using available clinical records. Can be helpful when the incident is historic and unlikely to have a specific recall of the event.
Local Manager investigation or review *Target timeframe: 1 week*	Department Management team would review and identify learning, themes, trends to contribute to their oversight of their department and share within their governance arrangements.
Post Infection Review (PIR)	Infection prevention and control specific MDT review, with a systems focused output. IPC led activity for alert organism acquisition and cross infection cases.

Learning response methods and tools	Description
Structured Judgement Reviews *Targeted timeframe of 6 weeks from request*	This is a process for reviewing concerns or triggers for review raised by the Medical Examiner or when concerns are raised about care when a patient has died, yet do not appear to have caused the death. Clinical review of care from records, systematically identifying the quality of care. Poor care outcomes result in a second review and reporting to Learning response considerations and potentially PSII if determination that the death was more likely than not to be caused the quality of care provided.
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). This may contribute to a PSII or other learning response
Observation	Observation of work as done in practice, which can contribute to a PSII or other learning response

Duty of Candour

Duty of Candour applies formally for all moderate or greater harm. It is noteworthy, that when reviews are undertaken within the 10 working days timeframe for formal duty of candour, the outcome can be provided in the same communication cycle, including when no lapses in care identified or when the risk is known and features as part of the strategic action plan for that type of incident of initiative.

Learning Response Panel

Supporting the allocation of investigation methods, the Trust will introduce a Learning Response Panel, made up of Patient Safety team, specialists, clinicians, divisional governance and clinical leaders. This meeting will take place weekly as part of implementation. They will also review the quality of PSII and other learning responses to promote systems-based learning.

Monitoring, review and audit processes

With patient safety incident reporting, there are triggers for reporting that feed in to monitoring and audit process, that require a review through a relevant process, such as Cardiac Arrest calls, that are reviewed and feed into the National Cardiac Arrest Audit. Where a review through another process identifies a patient safety concern, this should be escalated through governance arrangements, which may include the Learning Response Panel.

Planned responses

The following table integrates all services and anticipate responses. If there are themes or patterns of reporting not included, they will be expected to follow local manager investigation for all no harm and low harm cases. Moderate and greater harm cases will be reported through the Learning Response Panel for decision making on proportional investigation. This process in turn will help shape the response plan over time, as will other quality governance activities.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Blood transfusion or sampling incidents	Moderate or greater harm impact/ significant near miss: SWARM huddle or AAR No/Low harm – local manager investigation	Hospital Transfusion Committee
Delays in treatment causing harm due to waiting beyond standard	Moderate or greater harm impact/ significant near miss: SWARM huddle or AAR Low harm – local manager investigation	To feed into further analysis.
Digital system design/change that raises concerns resulting on patient care	Moderate or greater harm impact/ significant near miss/ multiple patients affected: AAR No/Low harm – local manager investigation Consideration of a lookback exercise if multiple patients are likely to be affected.	Chief Nurse Information Officer/ Chief Medical Information Officer
Handover of care • Inpatient admission and assessment pathway through departments • Discharge • Between shifts of clinical teams	Moderate or greater harm impact or significant near miss: SWARM huddle or AAR No/Low harm – local manager investigation	To feed into further analysis. 4 active QI projects Discharge working groups
Hospital Acquired alert organism infections that are part of national targets or cross-infection	PIR investigation	Infection Prevention and Control Committee
Ionising radiation incidents impacting on patients	Moderate or greater harm impact/ significant near miss/ multiple patients affected: AAR/MDT review No/Low harm – local manager investigation	Medical Exposures Committee External reporting as thresholds dictate

Patient safety incident type or issue	Planned response	Anticipated improvement route
Management of DKA and fluid management/potassium / Insulin	MDT review/ SWARM huddle or AAR	QI project on DKA management
Medication – prescribing related to actual weight	MDT review/ SWARM huddle or AAR	Chief Pharmacist for all weight related Quality Priority focus on processes to mitigate patient harm
Medication prescribing/ administration/ monitoring	Moderate or greater harm impact/ significant near miss: SWARM huddle or AAR No/Low harm – local manager investigation	Safer Medication Group Chief Pharmacist for all controlled drug related incidents
Mental Capacity Assessment process related	Moderate or greater harm impact/ significant near miss: SWARM huddle or AAR No/Low harm – local manager investigation	Quality Priority lead, Named Nurse for Mental Capacity and the working group
Nutrition and hydration, including enteral NG/PEG/RIG and parental feeding	Moderate or greater harm impact/ significant near miss: SWARM huddle or AAR No/Low harm – local manager investigation	Nutrition steering group CQUIN on Drink Eat and Mobilise for relevant post operative care issues. To feed into further analysis
Patient deterioration management/ lack of recognition or delayed escalation (Any harm or significant near miss)	SWARM huddle or AAR or MDT review	Deteriorating patient and sepsis group Quality priority
Patient falls with moderate or greater harm	Moderate or greater harm or Multiple falls occasions: SWARM huddle or AAR No/Low harm – Local manager investigation	Falls improvement plan

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure Ulcers acquired (excludes damage present on admission)	Cat 3 or 4: SWARM huddle or AAR Cat 1/2 – Local manager investigation	Pressure Ulcer improvement plan, led by: • Lead Nurse for Patient Safety for inpatients • Head of Nursing for Community cases CQUIN lead link for assessment and documentation of pressure ulcer risk
Radiological missed clinical findings (satisfaction of search)	Moderate or greater harm impact/ significant near miss/ multiple patients affected: MDT review (includes findings of Discrepancy Meetings) No/Low harm – local manager investigation	Radiology clinical governance
Sepsis screening, assessment or response (Any harm or significant near miss)	SWARM huddle or AAR or MDT review	Deteriorating patient and sepsis group Quality priority
Test/investigation result not acted on correctly	Moderate or greater harm impact or significant near miss - MDT review/ SWARM huddle or AAR No/Low harm – local manager investigation	To feed into further analysis. Digital results acknowledgement project for inpatients. MDT pathway management for relevant division or Cancer Lead as identified Maternity specific cases to Maternity Governance Group.

Maternity and Neonates specific planned responses

In addition to the section and table above and the national requirements for MNSI investigations, the following elements are specific to Maternity and Neonatal patient safety incidents.

There are a range of monitoring and review processes that are used to assess the risks to patient safety for a number of events that are specific to Maternity and Neonates, with Multi-disciplinary team reviews taking place including:

- Post-Partum Haemorrhage (PPH) reviews.
- Avoiding Term Admissions Into Neonatal-units (ATAIN) reviews.
- Births at <27 weeks gestation, using regional off-pathway review tool.

The outcome from these reviews will determine if there is the potential to provide learning and so lead to systems-based learning response or be a part of a strategic improvement plan.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Maternity service women who are significantly compromised or experience significant deterioration/ critical care requirement or cardiac arrest (Any harm or significant near miss)	SWARM huddle or AAR or MDT review or PSII for Maternal Cardiac Arrest	Family Services Quality Improvement & Monitoring Group
All antepartum stillbirths and neonatal deaths outside of MNSI (formerly HSIB) criteria	Urgent clinical reviews through MDT (Perinatal Mortality Review Tool, reported through MBRRACE)	Family Services Quality Improvement & Monitoring Group
Lack of recognition or inaction when there is need to escalate to obstetric team (Any harm or significant near miss)	SWARM huddle or AAR or MDT review	Family Services Quality Improvement & Monitoring Group
Emerging patient safety risk/themes	Thematic review	Family Services Quality Improvement & Monitoring Group