Patient safety incident response plan

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Approved by West Suffolk Foundation Trust Improvement Committee March 2024.

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Introduction

This patient safety incident response plan (PSIRP) sets out how the West Suffolk NHS Foundation Trust (hereafter referred to as WSFT) 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. We 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 our trust policies on incident reporting and investigation available to all staff via our organisation's intranet (available to staff only).

Our services

The WSFT is registered with the Care Quality Commission to provide services in the following locations:

- West Suffolk Hospital (Inpatient acute beds)
- Newmarket Hospital and Kings Suite (inpatient community beds)
- Community services for adults (West Suffolk)
- Community services for children and young people (Suffolk-wide)
- Glemsford GP surgery (General practice)

Further information about our organisation can be found on the WSFT website.

Defining our patient safety incident profile

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

- Staff – through the incidents reported on the WSFT Datix incident system
- Senior leaders across the divisions – through a series of stakeholder events
- Patient groups – through a review of the thematic contents of complaints and Patient advice and liaison service (PALS) contacts[1]
- Commissioners/ICS partner organisations – through partnership working with the ICS patient safety and quality leads

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

- Detailed thematic analysis of Datix incident data 2022/23
- Key themes from complaints/PALS/claims/inquests
- Key themes identified from specialist safety & quality committees (e.g. deteriorating patient, falls, pressure ulcers)
- Output of stakeholder event discussions
- Themes from the Learning from deaths reviews
- Pharmacy / Drugs & Therapeutics group (D&T) review of frequently occurring medication incidents

[1] The WSFT aims to incorporate wider patient perspective into future PSIR planning through the introduction of patient safety partners (PSPs). More information on the national PSP programme can be found on the NHS England website https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

National patient safety risks are defined as the list of risks covered by national priorities. Table 1 sets out the full list of these priorities that require a response.

The top local patient safety risks have been defined as the list of risks identified through the risk stakeholder approach and the data mining described above. These local identified risks represent opportunities for learning and improvement in the WSFT health system. Table 2 lists these top local patient safety risks.

The criteria WSFT have used for defining the top local patient safety risks is as follows:

- Potential for harm
    - People: physical, psychological, loss of trust (patients, family, caregivers)
    - Service delivery: impact on quality and delivery of healthcare services; impact on capacity
    - Public confidence: including political attention and media coverage
- Likelihood of occurrence
    - Persistence of the risk
    - Frequency
    - Potential to escalate

Our 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 may include 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 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 local or national mandated responses. As WSFT does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types (6 to 11).

	National priority	**Response**
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII by WSFT (ref. 7C)
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by WSFT (ref. 8C)
3	Maternity and neonatal incidents meeting MNSI[2] criteria	Refer to MNSI for independent PSII
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the Panel review

[2] Maternity and Newborn Safety Investigations programme (MNSI) from October 2023

	National priority	Response
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 & human trafficking or domestic abuse / violence.	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 local Safeguarding Adults Boards.
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
9	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)	Locally led PSII by the provider in which the event occurred with WSFT participation if required
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and WSFT participation if required

	National priority	Response
11	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, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

Our patient safety incident response plan: local focus

The WSFT considers that all of the six incident types set out in Table 2 have relevance for all our inpatient services (including maternity), our community teams and our general practice services. To this end this is an organisation-wide PSIRP and there are no separate PSIRPs plans for individual services. The letter (c) in parentheses indicates these are our third year PSIRP subjects

	Incident type	Description	Response
1C	Discharge / readmissions	Barriers to effective discharge due to issues in coordination of system elements *(e.g. transport not appropriate for patient needs/arriving home and essential equipment not available so returned to hospital/issues with timing of transport/community carer visit so patient spends night in hospital for non-clinical reason)*	PSII
2C	Diabetes	Problems with the clinical care / management of diabetic patients when diabetes is not the primary reason for admission to service / hospital	PSII
3C	End of life pathways	Patient on an end-of-life pathway receiving unnecessary / inappropriate clinical interventions	PSII
4C	Inclusivity	Barriers to effective inclusivity *(e.g. using modified assessments for patient with additional needs / effective LD care plan implementation for treatments or investigations / effective pain assessment and relief for patients with dementia)*	PSII
5C	Staffing	Potential for adverse impact on staff wellbeing where fundamentals of care cannot be provided due to staffing challenges	PSII
6C	Unexpected PSII	Identified increase in incidence of subject of theme which has potential for harm	PSII

The letter (C) indicates these are our third year PSIRP subjects to enable future identification.

<u>Patient safety incidents which meet criteria for harm or potential harm not included in the subjects above</u>

Where an incident does not fall into any of the categories 1 – 6; an investigation and/or review method described in Annex 1 may be used by the local team **except** PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

Other methods such as the national PMRT and SJR tools and/or structured local proformas may be used. The completion of a narrative response on the Datix incident module is also appropriate.

Annex 1 - Glossary

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are 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 divisions and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Further information on the framework can be found using the QR link or on the NHS England website

https://www.england.nhs.uk/patient-safety/incident-response-framework/

AAR – After action review

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 to identify the opportunities to improve and increase to occasions where success occurs.

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;

https://www.npeu.ox.ac.uk/pmrt

SJR - Structured judgement review

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

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

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.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Deaths thought more likely than not 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)