Patient Safety Incident Response plan

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
1.4	03/10/23	Approved at QEC - First issue please read in full	Simon Brown/Marie Hardacre

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1 INTRODUCTION

This Patient Safety Incident Response plan (PSIRP) sets out how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust intends to respond to patient safety events reported by staff and patients, their families and carers as part of work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of our local patient safety event investigations (PSIIs) by:

a) refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues
b) focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and events
c) transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from events
d) demonstrating the added value from the above approach.

2 OUR SERVICES

As well as being an acute NHS Foundation Trust, hosting one of the busiest emergency services in the county, we are also a teaching hospital operating within the Yorkshire region, working closely with the University of Sheffield and Sheffield Hallam University. As a Trust, we also maintain strong links with Health Education England (HEE), our local Clinical Commissioning Groups in both Doncaster and Bassetlaw, as well as our system partners in South Yorkshire and Bassetlaw. Doncaster and Bassetlaw Hospitals (pre-2017) was one of the first 10 NHS trusts in the country to be awarded 'Foundation Trust' status in 2004. This granted the organisation more freedom to act than a traditional NHS trust, although we are still closely regulated and must comply with the same strict quality standards as a non-foundation trust. We are fully licensed by NHS Improvement and fully registered (without conditions) by the Care Quality Commission (CQC) to provide the following regulated activities and healthcare services:

- Treatment of disease, disorder, or injury
- Nursing care
- Surgical procedures
- Maternity and midwifery services
- Diagnostic and screening procedures
- Family planning
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely.

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We provide the full range of local hospital services, some community services (including family planning and audiology) and some specialist tertiary services including vascular surgery. We serve a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas and run three hospitals and a smaller site at Retford:

Doncaster Royal Infirmary

Doncaster Royal Infirmary is a large acute hospital with over 600 beds, a 24-hour Emergency Department (ED) and trauma unit status. In addition to the full range of district general hospital care, it also provides some specialist services. It has in-patient, day case and outpatient facilities.

Bassetlaw Hospital in Worksop

Bassetlaw Hospital is an acute hospital with over 170 beds, a 24-hour Emergency Department (ED) and the full range of district general hospital services, including a breast care unit. The site has in-patient, day case and out-patient facilities.

Montagu Hospital in Mexborough:

Montagu is a small, non-acute hospital with over 50 in-patient beds for people who need further rehabilitation before they can be discharged. There is a nurse-led Urgent Treatment Centre, open 9am to 9pm. It also has a day surgery unit, renal dialysis, a chronic pain management unit and a wide range of out-patient clinics. Montagu is the site of our Rehabilitation Centre, Clinical Simulation Centre and the base for the Abdominal Aortic Aneurysm screening programme.

3 DEFINING OUR PATIENT SAFETY EVENT PROFILE

3.1 Situational Analysis

A key part of developing the Trusts PSIRP is understanding in detail our Patient Safety Profile and the activity that is associated with it. Identifying and understanding our Patient Safety Profile support us to effectively plan to ensure we have the right processes, systems, and resources in place to deliver our Patient Safety Incident Response plan. The table below details the high-level Patient Safety Data for the Trust between April 1st 2018 and 31st March 2023 (5 financial years).

Note: from this point onwards, we will use the term 'event' rather than 'incident'.

Table 1: Trust Patient Safety Data (1st April 2018 to 31st March 2023)

	Type of event	**Number of events reported**
1	All events	81031
2	All events of which effect a patient	64904
3	Patient safety events resulting in **MODERATE** Harm	745
4	Patient safety events resulting in **SEVERE** or Catastrophic harm	241
5	Patient safety events graded **DEATH**	203
6	Serious Events reported on STEIS	231
7	Never Events	9
8	HSIB	18
9	No. of deaths of person with Learning Disabilities	52
10	Any child deaths	147

3.2 Thematic Review

3.2.1 Data Sources

To understand the Trust's patient safety event profile a thematic review was undertaken using data from a number of sources. The sources are shown in the diagram below.

A review of all Patient Safety events, Complaints and Concerns logged on Datix between April 1st 2018 and 31st March 2023 was undertaken. The review looked at Categories, Sub-Categories, Event Details and Summary Root Causes to develop themes e.g. Communication, Appropriate Management/Transfer, Delay or Omission in prescribing.

In addition to this Quantitative Data we also engaged with colleagues across the organisation via a number of online workshops, engagement sessions and meetings to understand their views on what the priorities were, asking them to consider and feedback what they encounter and think about in their everyday work.

3.2.2 Data Assumptions and Limitations

When reviewing and analysing the data described above a number of assumptions had to be made, and/or points should be noted, including but not limited to;

- When an event is reported on Datix, there can be a degree of inconsistency around how events are categorised and described as a result of individual interpretation of the system fields.

- There are a significant number of sub-categories that an event can be assigned too and there is a degree of overlap between some of the categories.
- We do not routinely collect data on all protected characteristics, however as part of the engagement process we have engaged with relevant staff forums to consider how the protected characteristics influence health inequalities to ensure these are reflected in the priorities set.

3.2.3 Engagement with Stakeholders

As described in section 4.2.1 to validate the themes and ensure we captured the safety concerns of our stakeholders, we undertook consultation via a number of methods and forums, collating their feedback and triangulating with the themes already identified after reviewing the data. Below is a list of those consulted with.

- Clinical Governance Leads
- Divisional Nursing Teams Bands 2 to 7
- Divisional Leadership Triumvirates
- Medical Staffing at all grades
- Divisional Nurse
- Integrated Care Board
- Patients

4 DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

To define the Trust patient safety profile, the views of our stakeholders were collated together with the quantitative data and qualitative data sources, alongside this Patient safety improvement projects already underway were considered. The following themes were identified as the most common themes across all areas;

Table 2: Patient Safety Priorities

Patient Safety Theme	Description
Access, Admission, Assessment and Transfer of care	Where there are significant/extreme contributing factors relating to Access, Admission, Assessment and Transfer of care internally and externally, such as initial clinical assessment or discharge, initiating pathways and follow up.
Communication and Documentation	Where there are significant/extreme contributing factors relating the communication and documentation that impacts on patient outcomes.
Assessing and responding to and escalating the deteriorating patient	Where there are significant/extreme contributing factors relating to the recognition, monitoring or response to a clinically deteriorating patient in line with policy.
Medication	Where there are significant/extreme contributing factors relating to the administration, prescribing, and dispensing of medication, or where the medicines improvement panel that further investigation is needed.
Recognising and responding to behaviours of concern	Where there are significant/extreme contributing factors relating to the application of the legal frameworks e.g., Mental Capacity Act, Deprivation of Liberty, Mental Health Act. The application of restrictive practices, or where there has a been an escalation of behaviours of concern which continue to cause risk.
Falls	Where there are significant/extreme contributing factors, or it is identified by the falls improvement panel that further investigation is needed.
Pressure Ulcers	Where there are significant/extreme contributing factors, or it is identified by the SIT improvement panel that further investigation is needed.
Infection Prevention and Control (IPC)	Where there are significant/extreme contributing factors, or it is identified by the IPC improvement panel that further investigation is needed.

PSIRF promotes a range of system-based approaches for learning from patient safety events including but not limited to Patient Safety Event Investigations (PSII's), After Action Reviews and SWARM huddles. Organisations are encouraged to use national tools and guides which have been developed in collaboration with human factors experts and the Healthcare Safety Investigation Branch who lead the way in modern healthcare safety investigation methodology. These will be available in a Trust learning response toolkit, and a

training programme in these techniques will be developed. The below table describes the possible response types that could be used, although is not an exhaustive list.

Table 3: Possible Response Types

Response Type	Description
Patient Safety Event Investigation (PSII)	A patient safety event investigation (PSII) is undertaken when an event or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation.
Rapid Review/Hot Debrief	An interactive, structured team dialogues that takes place either immediately or very shortly after a clinical case.
After Action Review	An After Action Review (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.
Being Open Discussion	To provide the opportunity for a verbal discussion about the event (what happened) and respond to any concerns
Event Timeline	An event timeline is a complete real-time record of an event

5 NATIONALLY DEFINED EVENTS

In addition to local priorities there are several patient safety events that fall within the national priority areas. The table below lists those relating to secondary acute care providers (adult services) where it is a mandatory requirement that a PSII will be undertaken. The PSII may be carried out by the Trust or an external body and this is described below.

Event Type	**Required response/ approach**
Deaths thought more likely than not due to problems in care (events meeting the learning from deaths criteria for PSII)	PSII led by the Trust
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 (events meeting the learning from deaths criteria)	PSII led by the Trust
Events meeting the Never Events criteria 2018, or its replacement.	PSII led by the Trust
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
Maternity and neonatal events meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII
Child deaths	Child Death Overview Panel review. PSII may also be required following discussion and agreement with Child Death Overview Panel.
Deaths of persons with learning disabilities	Learning Disability Mortality Review (LeDeR) panel. PSII may also be required following discussion and agreement with LeDeR panel.
Safeguarding events in which:	Refer to local authority safeguarding lead

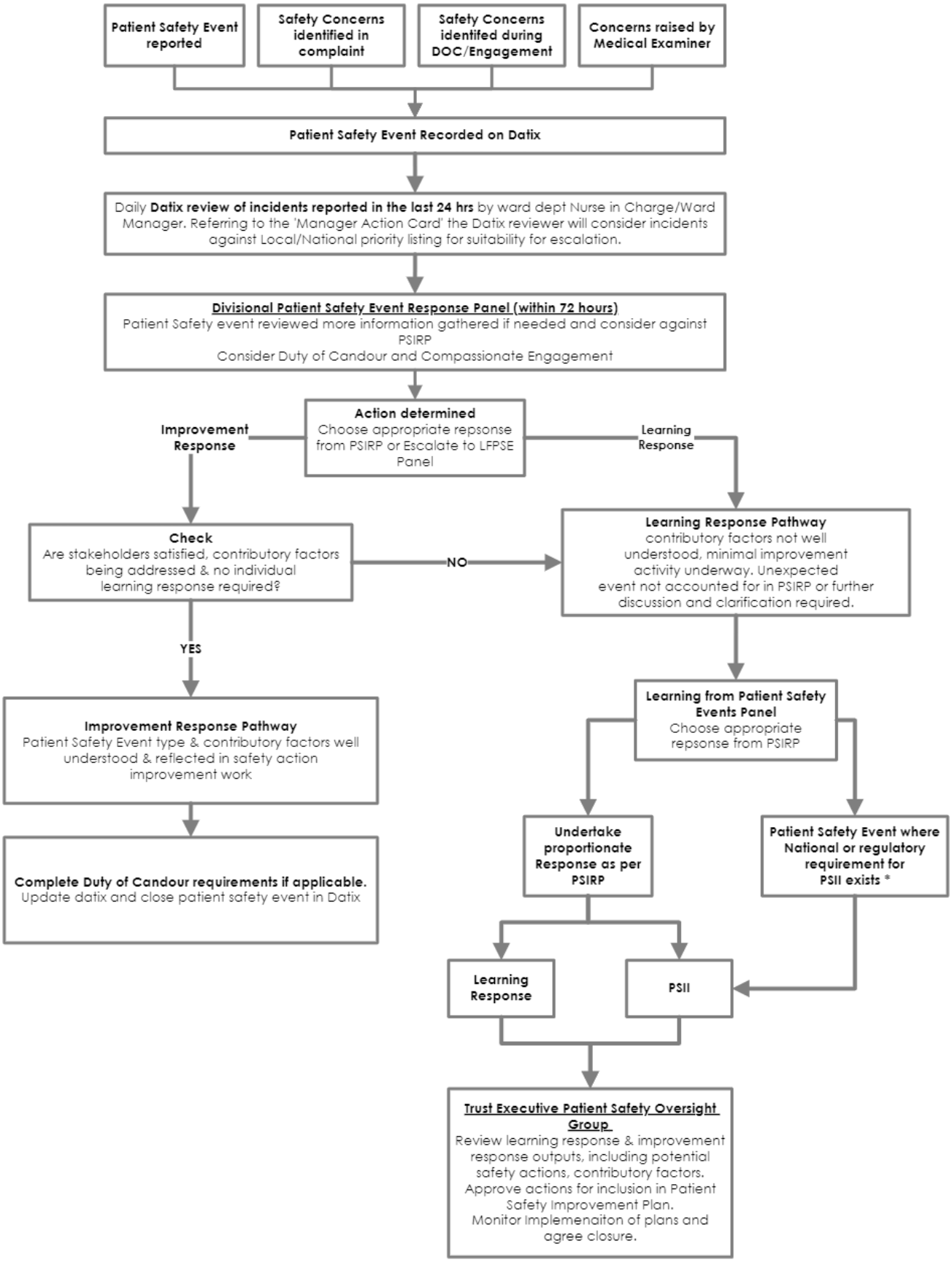
• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the event relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Healthcare organisations 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
Patient Safety events in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody 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 Trust to provide input where required
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.

6 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

There are a wide range of responses that can be deployed when a patient safety event occurs and Table 3 describes possible response types. The decision on the appropriate response for each event, will be informed by this plan, will consider whether the contributory factors are understood and whether it meets local safety priorities in table 2 or national priorities in table 4.

This plan will be supported by a number several resources including a workbook that will guide staff through how PSIRF will operate within DBTH.

The diagram below illustrates our decision-making process


Patient Safety Event reported
Safety Concerns identified in complaint
Safety Concerns identifed during DOC/Engagement
Concerns raised by Medical Examiner
Patient Safety Event Recorded on Datix
Daily Datix review of incidents reported in the last 24 hrs by ward dept Nurse in Charge/Ward Manager. Referring to the 'Manager Action Card' the Datix reviewer will consider incidents against Local/National priority listing for suitability for escalation.
Divisional Patient Safety Event Response Panel (within 72 hours)
Patient Safety event reviewed more information gathered if needed and consider against PSIRP
Consider Duty of Candour and Compassionate Engagement
Action determined
Choose appropriate repsonse from PSIRP or Escalate to LFPSE Panel
Improvement Response
Learning Response
Check
Are stakeholders satisfied, contributory factors being addressed & no individual learning response required?
NO
YES
Learning Response Pathway
contributory factors not well understood, minimal improvement activity underway. Unexpected event not accounted for in PSIRP or further discussion and clarification required.
Improvement Response Pathway
Patient Safety Event type & contributory factors well understood & reflected in safety action improvement work
Learning from Patient Safety Events Panel
Choose appropriate repsonse from PSIRP
Complete Duty of Candour requirements if applicable.
Update datix and close patient safety event in Datix
Undertake proportionate Response as per PSIRP
Patient Safety Event where National or regulatory requirement for PSII exists *
Learning Response
PSII
Trust Executive Patient Safety Oversight Group
Review learning response & improvement response outputs, including potential safety actions, contributory factors.
Approve actions for inclusion in Patient Safety Improvement Plan.
Monitor Implemenaiton of plans and agree closure.

*In line with PSIRF it is important that no arbitrary timescale is applied to the time in which it will take to complete a PSII. However, for the benefit of those affected by the event every effort will be made for all PSII's to be completed within 60 working days and unless there are exceptional circumstance no PSII will take more than six months to complete. .

Please note that any event that is not considered to meet any of the above criteria but is felt significant enough to warrant escalation to the Learning from Patient Safety Events Group can still be discussed with the Patient Safety Team and the most appropriate route of escalation will be advised. This may include a PSII if the Patient Safety Events Group consider doing so would result in significant learning.

7 ROLES AND RESPONSIBILITIES

This organisation describes clear roles and responsibilities in relation to its response to patient safety events, including investigator responsibilities and upholding national standards relating to patient safety events.

Chief executive

- Overall responsibility for the effective management of all patient safety events, including contribution to cross-system/multi-agency reviewed and/or investigations where required.
- With the executive and non-executive team, models behaviours that support the development of patient safety reporting, learning and improvement system.
- Ensure that systems and processes are adequately resourced including; funding, management time, equipment and training.

The **Chief Nurse**, supported by the **Executive Medical Director**, is the executive lead responsible for supporting and overseeing implementation of the Patient Safety Incident Response Framework (PSIRF) and includes;

- Ensuring processes are in place to support an appropriate response to patient safety events (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Oversee development and review of the organisations PSIRP.
- Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families and carers where required.
- Ensures the organisation complies with the national patient safety investigation standards.
- Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards.
- Develops professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety event management.

Patient Safety Team

- Undertake Patient Safety Incident Investigations as directed by the Learning from Patient Safety Events Group.
- Develops and maintains local risk management systems and relevant event reporting systems to support the recording and sharing of patient safety events and monitoring of event response processes.
- Ensures the organisation has procedures that support the management of patient safety events in line with the organisation's PSIRP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).
- Established procedures to monitor/ review investigation progress and the delivery of improvements.
- Works with executive lead to address identified weaknesses/areas for improvement in the organisations response to patient safety events including gaps in resource including skills and training.
- Supports and advises staff involved in the patient safety event response

Investigation leads

- Ensure that investigations are undertaken in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

Investigators

- Under the direction of investigation lead undertake investigations in line with the patient safety investigation standards.
- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.
- Undertake patient safety investigations and patient safety investigation related duties in line with latest national guidance and training.

Named contact for patients, families and carers

- Identify those patients, families and carers affected by patient safety events and provide them with timely and accessible information and advice
- Ensure they are provided with an opportunity to access relevant support services
- Act as liaison between patients, families and carers and investigation teams to help manage expectations.

All named contacts for patients, families and carers must have;

- Received appropriate training in communication of patient safety events including 'being open' and Duty of Candour.
- Sufficient time to undertake their role; that is they should be staff dedicated to the role or with dedicated time for this role.

More information can be found in the Trust's Being Open (Duty of candour) Policy.

Named contacts for staff

- Provide advice and support throughout the investigation process to staff affected by a patient safety event.
- Facilitate their access to additional support services as required.
- Act as liaison between these staff and investigation team as required.

Department Leads/Managers

- Encourage reporting of all patient safety events including near misses and ensure all staff in their area is competent in using the Datix reporting system and are provided sufficient time to record events and share information.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in investigations as required.
- Liaise with the patient safety team and others to ensure those affected by patient safety events have access to the support they need.
- Support development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

All Staff

- Understand their responsibilities in relation to the organisations PSIRP.
- Know how to access help and support in relation to patient safety event response process.

8 SUMMARY

By following this plan, it is anticipated that the Trust will undertake a PSII into around 20 patient safety events per year. This will be made up of events selected as part of the locally defined criteria in table 2, events from those in the nationally defined criteria described in table 4 and a small number of events where the Learning from Patient Safety Events Group determined significant learning could be gained. In addition to the PSIIs we will also undertake Learning Responses to selected events where contributing factors are not understood, the response types will be selected from the approaches we have chosen to adopt as outlined in Table 3.

This plan will be reviewed in Quarter 4 of 2024/2025, unless it is identified that a review is required sooner.