Gateshead Health NHS Foundation Trust

Patient Safety Incident Response Plan

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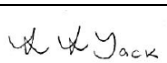
Author	**Ashleigh Jack**	**Patient Safety Lead**		**June 2023**
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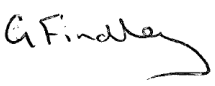
Authoriser	**Gill Findley**	**Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/ Deputy Chief Executive**		**August 2023**

Foreword

"*The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen - including the factors which contribute to them.*" (Aidan Fowler, National Director of Patient Safety, NHS England)

The Patient Safety Incident Response Framework (PSIRF) does not mandate investigation as the only method for learning from patient safety incidents; nor does it prescribe what to investigate. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

On this basis the Trust will explore patient safety incidents relevant to our context and the populations we serve rather than exploring only those that meet a certain nationally defined threshold. We will embrace the cultural shift to evidence we are *continually* learning and improving by balancing those individual responses where we feel we need to learn more to direct improvement, with working on meaningful improvement in areas we feel we have already learned a lot. Our plan will be a live document that will evolve and keep being developed in response to new insights, on a never ending journey in pursuit of keeping our patients safe.

PSIRF asks us to consider how we engage meaningfully with our patients, families and carers to ensure that their voice is equal to that of our staff in any of our patient safety learning responses, on the basis that their perspectives are crucial to our full understanding. Our Patient Safety Partners will help us to redress this balance, and ensure that the patient voice is present in all of our patient safety systems, processes and activities.

Our Trust's journey towards a restorative and just culture underpins how we will approach our incident responses, including a culture whereby people feel psychologically safe enough to highlight incidents or concerns without fear of retribution, and to speak freely about the work as it is done by those who do it. We will engage, listen and empower our people to make meaningful change as experts in their fields.

Contents

Introduction

This Patient Safety Incident Response Plan sets out how Gateshead Health NHS Foundation Trust (hereafter referred to as GHFT) 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, in response to new or evolving insights. 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 will be underpinned by our Patient Safety Incident Response Policy, which is currently being drafted in line with the Patient Safety Incident Response Framework and will be published alongside the plan on the Trust's website when the approval and ratification process is complete.

Our services

GHFT provide services in the hospital, the community and at people's homes, and is registered with the Care Quality Commission to provide services at the following locations, all of which are in the Gateshead area.

- Queen Elizabeth Hospital (including inpatient beds, outpatient and screening services, emergency care centre, pathology centre of excellence and surgery centre)
- Blaydon Primary Care Centre (walk-in appointments and care for minor injuries and ailments, as well as emergency contraception)
- Bensham Hospital (community services available at this hospital include occupational therapy, Rapid Response Service, Speech and Language Therapy and Podiatry)
- Cleadon Park Primary Care Centre (Breast screening and Acute Aortic Aneurysm (AAA) screening)
- Grindon Lane Primary Care Centre (Breast screening and AAA screening)
- Breast Screening Unit at Sunderland Royal Hospital

Further information about our organisation can be found on the GHFT website: Gateshead Health NHS Foundation Trust

Defining our patient safety incident profile

Stakeholder Engagement

In order to identify the patient safety issues most prevalent and pertinent to our organisation, the Patient Safety Team have engaged with stakeholders to define our incident profile as well as triangulate with the following sources of insight; some of which have been reported to us by our staff and our patients, families and carers.

- Incidents: 2020 – 2023 (reported by staff)
- Complaints: last 12 months (reported by patients, families and carers)
- Claims: 2012 - 2022 (reported by patients, families and carers)
- Risks
- Mortality (including Medical Examiner Service)
- Getting it Right First Time (GIRFT)
- Clinical Audit
- Quality Accounts

The Trust will incorporate wider patient perspectives into our future patient safety incident response planning through the introduction of our Patient Safety Partners and through meaningful engagement with our patients, families and carers involved in patient safety incident responses over the next 12 - 18 months. More information regarding the framework for involving patients in patient safety can be found here: NHS England » Framework for involving patients in patient safety

Defining our Profile

The above activities, together with an exercise to define our patient safety improvement profile (page 8 and Appendix A) have allowed us to distinguish between learning required to inform improvement and improvement based on existing learning, and where individual assessment would be required to determine our required response. Our local profile is detailed on pages 13 – 16. The nationally mandated learning response profile is outlined on pages 9 – 12.

Learning to inform improvement: where an incident type is a recognised significant issue for the organisation but contributory factors are not well understood and local improvement work is minimal, a Patient Safety Incident Investigation (PSII) is required to fully understand the context and underlying factors that influenced the outcome.

Learning from these individual reviews would inform existing or future quality improvement workstreams and the evolvement of our Patient Safety Incident Response Plan (PSIRP).

Improvement based on learning: where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

Assessment to determine required response: for issues or incidents where it is not clear whether a learning response is required. All incidents where there is potential for *new* learning or significant concern would be presented to the Trust's Safety Triangulation Group (STG) for discussion and consideration of whether an individual learning response is required to better understand the contributory factors, and the most appropriate tool to do this. This group will also consider the allocation of Family Liaison Officer resource where appropriate.

Duty of Candour requirements remain the same in relation to levels of harm, regardless of whether an individual learning response will be undertaken. Views of the patient/family/carers should always be taken into account as part of this assessment.

Defining our patient safety improvement profile

Our patient safety improvement profile has been identified and agreed via insights from our patient safety incident profile, alongside a scoping exercise undertaken to consolidate a list of all improvement and service transformation work with an impact on patient safety underway or planned across the organisation; this list is not exhaustive however and it is acknowledged that a large proportion of quality improvement activity that is undertaken in our services is not formalised or identified on a centralised record (see below and Appendix A). The Trust's latest Quality Account has also been taken into account as part of this exercise (Appendix B).

- Rapid Process Improvement Work (RPIW) as follows:
  - Urgent and Emergency Care pathways
  - ICE test results (Pathology)
  - Medication rounds
  - Stop Smoking
  - Cancer waiting lists
  - Nursing Professional Development
  - Physiotherapy equipment
  - Audiology service pathways and capacity/demand
  - Well organised hospital
- 'Supervisory band 7' project
- Quality Account (Appendix B)

Gaps have been identified where strengthening of existing workstreams/improvement work is required, as well as identification of where there is no current workstream/improvement work underway and establishment will be required based on learning from our local patient safety incident profile and qualitative intelligence from those involved in patient safety investigation over the last 3 years and beyond.

Our Patient Safety Improvement Plan: national requirements

Some events in healthcare require a specific type of response as set out in policies or regulations. These responses include mandatory PSII in some circumstances or review by, or referral to, another body or team, depending on the nature of the event. The below table summarises the guidance on nationally mandated responses to certain categories of event and sets out whether that mandated response needs to be a PSII or some other response type, including referring the event to another organisation to manage.

For clarity, incidents meeting the Never Events criteria (2018) or its replacement, 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 by GHFT. (More information relating to national event response requirements can be found here: Guide to responding proportionately to patient safety incidents).

	National Priority	**Response**	**Improvement**
1	Incidents that meet the criteria set out in the Never Events list 2018	Locally led PSII by GHFT	Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by GHFT as well as Mortality Council review	
3	Maternity and neonatal incidents meeting HSIB criteria as follows. • 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 25 | Guide to responding proportionately to patient safety incidents therapeutically cooled (active cooling only); or – had decreased central tone, was	Refer to HSIB for independent PSII. Local learning response is not required, however any immediate actions will be identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant cases, the organisation will also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSIB as it works through its independent investigation).	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy

	comatose and had seizures of any kind. • Maternal deaths: death 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).		
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the Panel review if clinically assessed as more likely than not due to problems in care. These are also reviewed by the Mortality Council.	
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 if clinically assessed as more likely than not due to problems in care. These are also reviewed by the Mortality Council.	
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.	Respond to recommendations as required and feed actions into a system improvement plan/quality improvement strategy

		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.	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy
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. These are also reviewed by the Mortality Council.	Respond to recommendations as required and feed actions into the system improvement plan/quality improvement strategy
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 GHFT participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the system improvement plan/quality improvement strategy
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

Several system-based learning response methods are available for the Trust to respond to a patient safety incident or cluster of incidents (see Appendix C). We propose that these are applied where contributory factors are not well understood and local improvement work is minimal - that is, there is the greatest potential for new learning and improvement, as outlined in the table below.

Where an incident type is well understood - for example falls, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness - resources may be better directed at improvement rather than repeat investigation (or other type of learning response).

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Falls	Falls triage tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for discussion. Falls learning response tool to be used where indicated.	Create local safety actions and feed these into the falls workstream/quality improvement strategy
Pressure damage	Pressure damage triage tool to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and tool to be used.	Create local safety actions and feed these into a tissue viability workstream/quality improvement strategy

Medication incidents	Local review by Business Unit/Medicines Management Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into the medicines workstream/quality improvement strategy
Maternity incidents	Local review by Maternity Safety Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into the Maternity workstream/quality improvement strategy Local workstream will link to regional PS learning network and MatNeo SIP network
Infection Prevention & Control	Local review by Business Unit/IPC Team to identify if an individual learning response may be required (where there is potential for new learning or significant concern). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review,	Create local safety actions and feed these into a IPC workstream/quality improvement strategy

	Learning Team, Thematic Review)	
Digital/IT inc pathology/radiology and sample/reporting issues and medication issues and consenting procedures	Local review by Business Units to identify if an individual learning response may be required (where there is potential for new learning). When it is indicated, to Safety Triangulation Group (STG) for a decision and agreement on tool to be used (After Action Review (AAR), Case/Peer Review, Learning Team, Thematic Review)	Create local safety actions and feed these into a digital/IT workstream/quality improvement strategy
Diagnosis/treatment delay	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to this incident category to inform PSIRP, or existing workstreams where applicable (e.g. digital)
Admission/transfer/discharge issues resulting in deterioration	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to this incident category to inform PSIRP, or existing workstreams where applicable (e.g. digital)
Maternity incidents that occur in theatre	PSII to understand contributory factors	Create local safety actions and feed these into a PSII SIP related to incident type to inform PSIRP, or existing Maternity workstream
Unexpected incidents that are so significant in nature/pose such a risk to patient safety/the organisation	PSII	Create local safety actions and feed these into PSIRP insights, or existing workstreams where applicable (e.g. digital)

Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern	AAR, Case/Peer Review, Thematic Review, Learning Team	Create local safety actions and feed these into PSIRP insights, or existing workstreams where applicable (e.g. digital)

Development of safety actions

The Trust will follow an integrated process for developing, implementing, and monitoring safety actions. We will seek to reduce duplicative and/or disconnected safety actions, for example, by maintaining a wider safety improvement plan for each workstream and PSII category type and not adding what is already there. Actions will be taken from all other types of learning responses and will feed into any relevant existing system improvement plan; any actions that sit outside of these plans will be collated onto a separate system improvement plan to inform future development of the PSIRP.

Appendices

Appendix A: Safety Improvement Profile

Appendix A - Improvement Plan.d

Appendix B: Trust Quality Account 2023-24

Quality Account 22-23 - final.docx

Appendix C: Learning Response Methods/Tools

After Action Review.docx


Case Review.docx


Patient Safety
Learning Team Templ


PSII-Report-Template
-v1.1.docx


Themed review
template Aug 2022.dc


Falls Review Tool
V4.2.docx