Document Reference Number UHN-PL-CR55

Policy/Guideline Title:	Patient Safety Incident Response Plan (PSIRP)		
Executive Summary:	This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at University Hospitals of Northamptonshire (UHN) to prepare for PSIRF.		
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APPROVAL RECORD		
	Committees / Group	Date
Consultation:	Medical Director Chief Nurse, Deputy Medical Director Deputy Chief Nurse, Director of Integrated Governance, Patient Safety Team member, Divisional Head of Nursing/Midwifery and Quality from each clinical Division, Senior Clinical Representative from each clinical division, nominated by each divisional management team, Deputy Chief Pharmacist, (Patient Partnership	31/12/2024

	Representative/Governor)	
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Introduction

The Patient Safety Incident Response Framework (PSIRF) is a new approach to how the NHS will respond and learn from Patient Safety Incidents. This is a new process to investigate incidents and learn from them when they occur; a marked cultural shift in our approach to systems, protocols, and thinking. Working closely with families, patients, and staff this new framework will support us to make changes to ensure incidents that have occurred may be prevented from happening again.

The NHS Patient Safety Strategy was published in July 2019 and describes the PSIRF, a replacement for the NHS Serious Incident Framework (2015). This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at University Hospitals of Northamptonshire (UHN) to prepare for PSIRF.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents. PSIRF promotes a proportionate approach to responding to patient safety incidents.

Under PSIRF framework, each organisation internally determines the type of incidents to be investigated, based upon local risks, trends, and priorities for highest impact.

This Patient Safety Incident Response Plan (PSIRP) sets out how UHN will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve patient safety incident responses, underpinned by the four key PSIRF principles:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Our services

UHN is made up of Kettering General Hospital (KGH) NHS Foundation Trust and Northampton General Hospital (NGH) NHS Trust and was formed in 2020. We deliver acute services from two main sites: Kettering General Hospital and Northampton General Hospital. We also provide diagnostic, outpatient and other non-acute care facilities across Northamptonshire, South Leicestershire, and Rutland

Both our hospitals are acute hospitals providing 24-hour emergency care. We offer a full range of district general hospital care as well as some specialist services: KGH provides emergency cardiac care for the county and NGH provides stroke and some specialist cancer and care for the county, as a centre of excellence. In total we have approximately 1,400 beds with over 600 at KGH and nearly 800 at NGH.

We serve a population of approximately 900,000 people across the county and employ over 9,000 staff, making us one of the largest employers in Northamptonshire.

Defining our patient safety incident profile

We have used a thematic analysis approach to determine which areas of patient safety activity we should focus on, to establish the local priorities.

Our analysis used several data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top patient safety risks from incident reporting and then cross reference these from several other data sources including key stakeholders.

The key priorities were defined from this list based on number of incidents reported, number of Serious Incident investigations conducted and areas where the Trust had existing quality priorities or initiatives in place.

Key stakeholders included:

- Staff from all levels and areas.
- Senior Managers within the Trust.
- Patient Safety Specialists.
- Commissioners.
- Patient Safety Partners.
- Patient Safety teams.

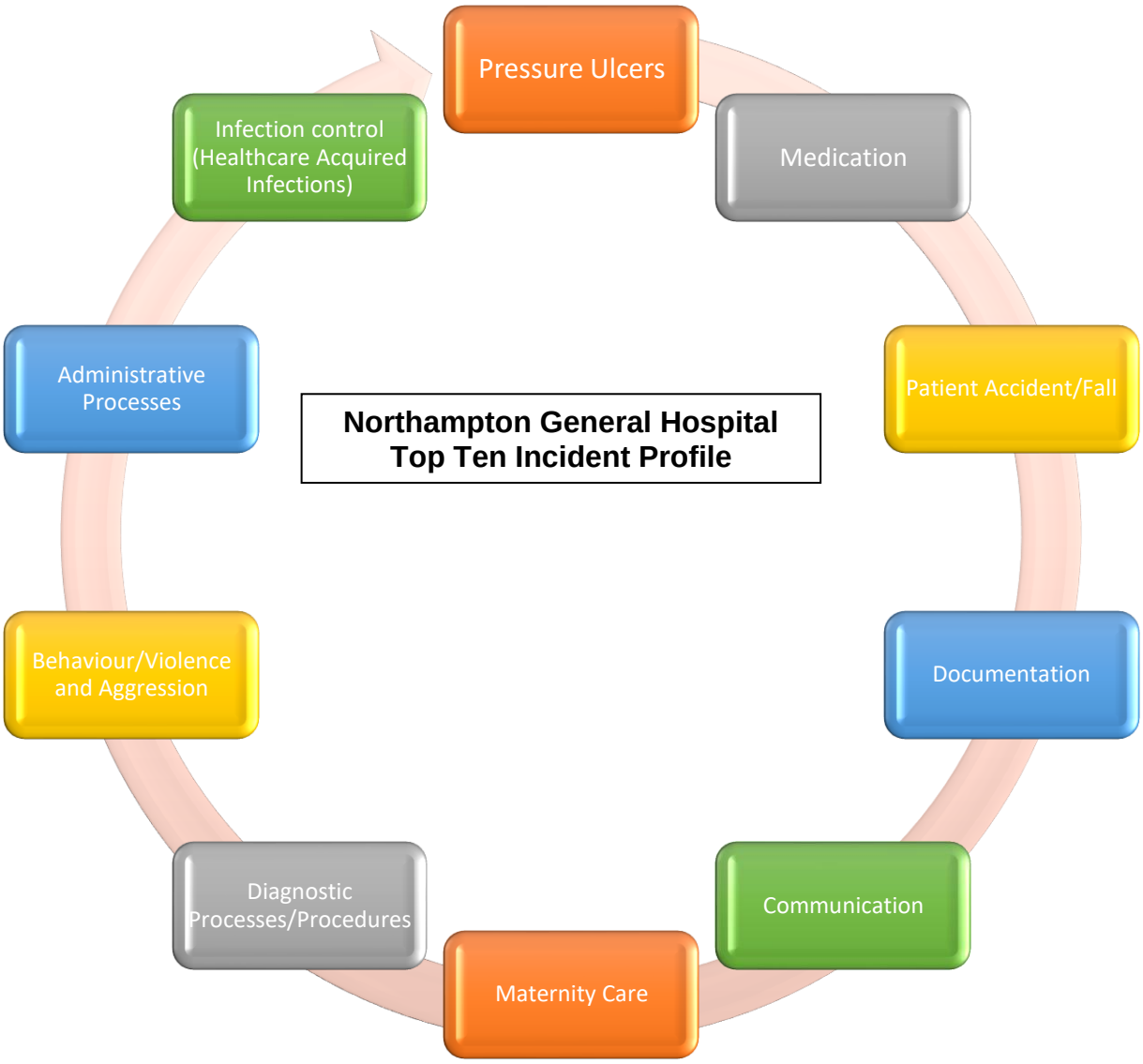
We reviewed three years of data, the sources included:

- Patient safety incident reports.
- Complaints.
- Mortality reviews.
- Claims and outcomes of inquests.
- Trust Risk Register.
- Staff survey on patient safety key priorities.
- Qualitative insight from divisional/directorate level leaders.

Incident Insight

Over the last three-year period, the following are the top 10 categories of incident types reported by each respective trust, through the Datix incident reporting system. Of note, category types differ between both organisations, with differing versions of Datix in use. KGH utilise Datix Web and NGH Datix Cloud.


Kettering General Hospital
Top Ten Incident Profile
Access/Appointment/ Admission
Clinical Care & Treatment
Patient Fall
Clinical Harms from breaches
Pressure Ulcers
Medication (Non-controlled drugs)
Healthcare Associated Infection & Infection Control
Infrastructure
Neonates
Maternity



Common themes surround documentation and communication, specifically in relation to patient movements between wards and services. There is also a link here with staffing levels and staff skill mix on the wards.

Pressure ulcers and falls have a national improvement requirement and have their own specific improvement groups. The trust has engaged with the ICB to look at how these harm types could be addressed across Northamptonshire.

Appointment/Admission/Discharge incidents at KGH, align with Administrative Process incidents at NGH. Specifically with discharge information and referral into services.
A review of 2,672 complaints across both trusts has seen a marked increase in complaints in relation to information provided on discharge.

The top three complaint themes are:

- Communication re. patient care
- Delays in treatment
- Attitude/behaviour of clinicians

Where required, complaints are logged through Datix and clinically reviewed to ascertain if a patient safety review/response is required. Further strengthening of complaints into patient safety/governance will be undertaken as the two trusts look at aligning processes under the UHN banner.

Outside of Maternity claims, missed fractures and missed/misdiagnosis remain as prominent claim's themes, alongside delays in treatment and inaccurate nursing care. As with complaints, a further strengthening of claims with patient safety/governance will be undertaken under the UHN banner.

Defining our patient safety improvement profile

We have set out to deliver high quality care for all the people of Northamptonshire and be a great place to work within our two hospitals. There is strong and ever-growing evidence that the way for us to achieve this and then sustain it, is to foster a continuous improvement culture. There is work underway to align improvement programmes across the group, with specific focus on:

- Deteriorating Patients
- Maternity and Neo-natal services
- Urgent Emergency Care Transformation
- Theatre Transformation
- Digital Transformation

The UHN PSIRP will be ever evolving, as improvement programmes mature to highlight quality improvement and in turn focus on new and emerging issues to be addressed.

The Group has agreed an 'Improving Together' continuous Improvement Strategy for UHN and a clear set of measures. This ambitious plan for 2024-29 sets a clear vision for the Group in developing a vibrant improvement culture and continuous improvement in our teams.

Improving Together goals:

(1) UHN Improving Together
(2) Sharing and Learning
(3) Supportive and Skilled Leaders
(4) A Culture for Improvement
(5) All going in the same direction
(6) Involve patients, carers, and colleagues.
(7) Intelligent Measurement

Measurement

- All UHN colleagues are trained in UHN improving together approach.
- Everyone is empowered to use QI skills to improve their area of work.
- Each year, every department completes at least one QI project that is focussed on what matters most to patients and colleagues in their area.

Established process: Incidents related to the specialist areas below will be monitored and reviewed by the relevant subject matter experts. The specialist teams will be involved in relevant learning responses and have oversight of these. They may steer the appropriate learning response for specific incidents depending on the level of issues identified. Improvement activity will be overseen by the relevant Trust group.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Falls	Improvement review process in place	Harm Free Care Group
Hospital acquired pressure ulcers	Improvement review process in place	Pressure ulcer collaborative work with ICB and Harm Free Care activity.
Healthcare Associated Infections	Improvement review process in place	Harm Free Care Group
IR(ME)R reportable Incidents –	Patient Safety Learning Review	Radiology and Radiotherapy Incidents Ionising Radiation Governance Group
Nutrition related to artificial methods of feeding	Rapid review / learning review for individual cases if moderate or above harm. After Action Review Themed Review Walkthrough Analysis	Patient Safety Committee quarterly reporting
Treatment – delay or cancellation of treatment	Patient safety audit Thematic Review	Patient Safety Committee quarterly reporting
Security – disruptive behaviour, including the use of restrictive interventions	Local Incident review	Violence and Aggression Reduction Group and quarterly reporting

Where an emerging issue is identified that needs a learning response, this will be coordinated in the normal way with the support of the patient safety team and specialist services including the harm free care team for example. Likely response methods would include MDT system reviews, after action reviews and SWARM huddles.

Our patient safety incident response plan: national requirements

	Patient safety incident type or issue	Description	Planned response and anticipated improvement route
	Never Events	Incidents meeting the Never Events criteria	Review by Patient Safety to confirm criteria met & immediate safety actions. PSII. Create local organisational actions and feed these into the quality improvement strategy

National Safety Priorities	Death thought more likely than not due to problems in care	Incident meeting the learning from deaths criteria	Review by Patient Safety to confirm criteria met & immediate safety actions. Structured judgement review triggering PSII. Create local organisational actions and feed these into the quality improvement strategy.
	Incident meeting Each Baby Counts criteria	Incident meeting Each Baby Counts criteria	Refer to MNSI for independent patient safety incident investigation. Refer to NHS Resolution as required. Respond to recommendations as required 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	Review by Patient Safety to confirm criteria met & immediate safety actions & consider Duty of Candour. PSII Create local organisational actions and feed these into the quality improvement strategy
	Mental health-related homicides	Mental health-related homicides	Review by Patient Safety to confirm criteria met & immediate safety actions. Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII.
	Maternity and neonatal incidents	Maternity & Newborn Safety Investigation (MNSI) criteria	Review by MIRF and Patient Safety to confirm criteria met & immediate safety actions & consider Duty of Candour. Refer to MNSI for independent PSII.
	Child deaths	Death of a child	Review by Patient Safety to confirm criteria met & immediate safety actions & consider Duty of Candour

			Refer for Child Death Overview Panel Locally led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.
	Deaths of persons with learning disabilities	Deaths of persons with learning disabilities	Review by Patient Safety to confirm criteria met & immediate safety actions & consider Duty of Candour. Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the LeDeR.
	Safeguarding incidents	Where: 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 safeguarding lead & to local authority lead, as required.
	Incidents in NHS 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

Table 1: National Incident Response Requirements

Our patient safety incident response plan: local focus

	Trust Priority (aligned to local priorities)	Response Assessment	Response Action		Governance Oversight
Local safety priorities	Acting on results (Cancer pathways)	Assess the contributory factors involved in the patient safety event to identify whether they are well understood and aligned to existing improvement plans. Consider the potential for learning.	Contributory factors are well understood and aligned to improvement plan. ⇩ Provide local staff and team feedback and close the incident. Inform patient/NoK in line with Engaging and Involving Patients, Families and staff standards and DoC SoPs.	Contributory factors aligned to improvement plan and potential additional learning. ⇩ Consider appropriate and proportionate learning response method and feed results into the relevant improvement group and teams within existing governance structures	Patient Safety Committee
	Children and Young People Pathways				Children and Young People Oversight Board
	Compassionate Engagement				Deteriorating Patient Oversight Group
	Maternity				Patient Safety Committee

Table 2: Local safety priorities planned response and improvement route.

In line with our PSIRF policy, local responses will conform broadly with the plan outlined above. We will maintain the flexibility to adjust our approach.

The key decision-making that informed both our plan and will inform our ongoing decision making are:

- The views of those affected, including patients and their families.
- Input from local Patient Safety Specialists and Patient Safety Partners.
- Capacity and engagement to undertake a learning response.

- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect/benefit.
- If we as an organisation and our Integrated Care Board (ICB) are satisfied risks are being appropriately managed.

UHN considers that all the incident types detailed in Table 1 and 2 have relevance Group wide. A summary of tools we will use to generate a learning response is summarised in appendix 2.

Appendix 1 – Glossary

Deaths thought more likely than not due to problems in care.
Incidents that meet the 'Learning from Deaths' (LfD) criteria. These are deaths that have been clinically assessed as more likely than not due to problems in care using a recognised method of case note review. These reviews must have been 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.

Never Event
Never Events are defined as incidents that are considered wholly preventable. This is because of the presence of guidance or safety recommendations that provide strong systemic protective barriers, available at a national level that should have been implemented by all healthcare providers.

Patient Safety Incident Response Plan (PSIRP)
Our local plan details how we will achieve the PSIRF locally, including our list of current local priorities. These have been developed through a collaboration with key staff, subject matter experts, stakeholders and patients supported by analysis of local data.

Patient Safety Incident Response Framework (PSIRF)
PSIRF is designed to enable a risk-based approach to responding to patient safety incidents. This framework prioritises support for those affected by incidents (including patients, families, advocates, and staff), effectively analysing incidents, and sustainably reducing future risk.

Perinatal Mortality Review Tool (PMRT)
Developed through a collaboration led by MBRRACEUK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care.

Appendix 2 - Learning response types

After Action Review (AAR)
A method of evaluation that is used when outcomes of an activity or incident have been particularly successful or unsuccessful. It aims to capture learning from these incidents to identify opportunities to improve and increase the instances where success occurs.

Datix Review
A local review documented on Datix which can include specific targeted questions.

Multidisciplinary Team Review
The Multidisciplinary Review (MDT) supports teams to identify learning from multiple patient safety incidents. It allows them to agree, through open discussion, the key contributory factors and system gaps in patient safety incidents, explore a safety theme, pathway or process and gain insight into 'work as done'.

Observational Analysis
A method of evaluation of a pathway, process, or culture. The observer places themselves within the environment to identify opportunities for improvement or learning.

Patient Safety Audit
The monitoring of systems and processes to provide assurance of patient safety and quality of care across the organisation.

Patient Safety Incident Investigations (PSIIs)
An in-depth review of a single Patient Safety Incident or a cluster of incidents to understand what happened and how (replaces SI/RCAs). Must be completed for Never Events and Deaths thought more likely than not due to problems in care (Learning from Deaths criteria).

SEIPS framework (Systems Engineering Initiative for Patient Safety)
A framework that looks at Tools and Technology, Tasks, Person, Organisation, Internal and External Environments. Can be incorporated into the tools below. In line with the philosophy of PSIRF we will flexibly use the approaches outlined above in line with the nature of the incident which is being investigated and how it aligns with our PSIRP. Hybrid approaches mixing learning responses will be used as appropriate.

Specialist Review
Local reviews developed to address specific patient safety incidents e.g. falls / pressure ulcers.

Structured Judgement Review (SJR)
SJR is a systematic, evidence-based mortality review programme that can help drive improvement in the quality and safety of patient care. SJR was developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths and 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, and score, care for each phase.

SWARM

Swarm-based huddles are designed to start as soon as possible after a patient safety incident occurs to identify learning. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened, 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.

Thematic systems review

Learning from multiple sources of insight into a patient safety issue.

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).

Equality Impact Assessment (EQIA) – Initial Assessment			
1.Division	Corporate	2. Department	Patient Safety and Governance Services
3. Person(s) completing this form	Elaine Dolden	4. Contact Information	Elaine.dolden2@nhs.net
5. Others involved		6. Start date of this assessment	December 2024
7. What is being assessed (please tick)	New Procedural Doc ☒ Existing Procedural Doc ☐ New Service or Function ☐ Existing Service or Function ☐	8. Implementation/ effective date	December 2024
9. Name of Policy	UHN Patient Safety Incident Response Plan		
10. What are the aims / objectives of policy this service?	This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at University Hospitals of Northamptonshire (UHN) to prepare for PSIRF.		
11. Who will be impacted by policy / service (please tick)	Patients ☒ Carers ☒ Public ☒ Staff ☐ Other ☐	11a. If staff are impacted, how many individuals / Which Groups of Staff are likely to be affected?	N/A
12. Who has been involved in the policy / service development (please tick)	Patients ☒ Carers ☒ Public ☒ Staff ☐ Other ☐	12a. If yes, who have you involved and how have they been involved	National Implementation Plan alongside NHSE
13. What further consultation method(s), if any, are you proposing?	N/A	14. How are any changes / amendments to the policy / service to be communicated?	N/A

Equality Impact Assessment – Initial Assessment Outcome			
15. As part of the completing the above have you or a member of the group conducting EQIA identified any issues relating to the specific service/policy/plan in relation to gender, race, age, religion/belief, disability, sexual orientation, gender reassignment, marriage & civil partnership or pregnancy & maternity?	No	☒	EQIA Complete - If relating to a procedural document submit as part of the ratification process - If not relating to procedural documents please send completed EQIA to - KGH - kgh-tr.diversity@nhs.net

			- NGH - ngh-tr.edi@nhs.net
	Yes	☐	Requires EQIA Full Assessment to be completed – see below.

Equality Impact Assessment – Full Assessment

Review of any previous EQIA actions

What actions did you plan last time? (List them from the previous EQIA)	**What improved as a result?** What outcomes have these actions achieved?	**What <u>further</u> actions do you need to take?** (add these to the Action plan below)

Review of information, equality analysis and potential actions

Protected characteristics groups from the Equality Act 2010	**What do you know?** Summary of data about your service-users and/or staff	**What do people tell you?** Summary of service-user and/or staff feedback	**What does this mean?** **Positive** / **Neutral** / **Negative** Impact identified from data and feedback (actual and potential)	**What can you do?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Age				
Disability				
Gender reassignment				
Pregnancy and maternity				
Race/ethnicity Including migrants, refugees and asylum seekers				
Religion or belief				

Protected characteristics groups from the Equality Act 2010	**What do you know?** Summary of data about your service-users and/or staff	**What do people tell you?** Summary of service-user and/or staff feedback	**What does this mean?** **Positive** / **Neutral** / **Negative** Impact identified from data and feedback (actual and potential)	**What can you do?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Sex/Gender				
Sexual orientation				
Marriage and civil partnership				
Other relevant groups (e.g. carers)				

Equality Impact Assessment – Full Assessment Outcome

Assessment of overall impacts and recommendations	

Equality Impact Assessment – Detailed list of data/community feedback that informed your EQIA

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps: who else do you need to engage with?** (add these to the Action Plan below, with a timeframe)

Equality Impact Assessment – Prioritised Action Plan[1]

Impact identified and group(s) affected	Action planned	Expected outcome	Measure of success	Timeframe

[1] These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.

Equality Impact Assessment – Final Assessment Outcome

As part of the completing the above have all the issues identified been addressed as part of EQIA assessment	No	☐	Please speak to Head of Organisational Development and Inclusion
	Yes	☐	EQIA Complete - If relating to a procedural document submit as part of the ratification process - If not relating to procedural documents please send completed EQIA to - KGH - kgh-tr.diversity@nhs.net - NGH - ngh-tr.edi@nhs.net