NHS Somerset NHS Foundation Trust

Patient Safety Incident Response Plan 2023-2024

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Other related documents:

- Patient Safety Incident Response Policy (2023)
- Being Open and Duty of Candour Policy (2022)
- Incident Policy (2021)
- NHS England SEIPS Quick Reference Guide and Work System Explorer (2022)

1.0 INTRODUCTION

The NHS Patient Safety Strategy (July 2019) describes the Patient Safety Incident Response Framework (PSIRF) which will replace the NHS Serious Incident Framework (SIF). This document is the Patient Safety Incident Response Plan (PSIRP), and it outlines how Somerset NHS Foundation Trust (the Trust) will respond to patient safety incidents (PSIs) reported by staff, patients, families, and carers to improve the quality and safety of the care we provide.

The SIF provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is a framework that focuses on learning and improvement with an emphasis on the complex systems and cultures that support continuous improvement in patient safety.

This plan is underpinned by the new Trust Patient Safety Incident Response Policy and will be reviewed every 12-18 months. This plan will enable the Trust to remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and ensure the needs of those affected are met.

2.0 DEFINITIONS

The following terms and abbreviations are used within this policy:

After Action Review (AAR)	An After Action Review 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.
Duty of Candour (DoC)	A regulatory requirement for care providers to be open and transparent with service users and includes situations where things have gone wrong with care or treatment. The requirements span communication, support, truthfulness and an apology (see Guidance: Duty of Candour, 2020 on the GOV.UK website).
Learning Response	Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as after-action reviews, SWARM huddles, multidisciplinary team debriefs and thematic analysis.
Multi-disciplinary Team Review (MDT Review)	An MDT Review involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.
Patient Safety Incident (PSI)	A patient safety incident can be defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare.
Patient Safety Incident Investigation (PSII)	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then 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 then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.
Patient Safety Incident Response Framework (PSIRF)	This is a national framework applicable to all NHS commissioned outside of primary care. 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

Patient Safety Incident Response Plan (PSIRP)	A local plan that sets out how we will carry out the PSIRF locally including our list of local annual priorities.
Swarm Huddle	A Swarm Huddle allows for the rapid review of an incident – staff swarm to a discussion (and where possible the location of an incident) to allow it to be explored on a systematic basis and to support those immediately involved.
Systems Engineering Initiative for Patient Safety (SEIPS)	SEIPS is a framework that can be used in understanding inter-relationships across the structures, processes and outcomes in healthcare. It is used alongside the PSIRF learning response tools to ensure that the system learning is identified.
Thematic Review	A review of a cluster of incidents or investigations that aims to understand common links, themes or issues. The aim of a themed review is to understand key barriers or facilitators to patient safety.

3.0 OUR SERVICES

The Trust is the result of two mergers. The first merger in April 2020, between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, brought together acute services from the Musgrove Park Hospital, community service and mental health and learning disability services. The second merger in April 2023 brought together acute services from both acute hospitals in the county and a large proportion of the county's GP practices.

The Trust delivers care across six clinical service groups supported by additional trust-wide corporate functions such as safeguarding and infection prevention and control. We are an integral part of the Somerset Integrated Care Board and work with NHS, social care and voluntary sector partners in Somerset to plan and deliver services. We care for patients predominantly from Somerset but also from North Somerset, the west of Dorset and north of Devon.

Our Trust's strategic objectives support the achievement of the aims we share with health and social care partners in Somerset. They are to:

1. Improve the health and wellbeing of our population. Enable people to live socially connected healthy, independent lives, promote early intervention and prevent avoidable illness.
2. Provide the best care and support to children and adults. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.
3. Strengthen care and support in local communities. Develop and enhance support in local neighbourhood areas and bring care closer to home.
4. Reduce inequalities. Value all people alike, target our resources and attention where it is most needed, giving equal priority to physical and mental health.
5. Respond well to complex needs. Improve outcomes for children and adults with complex needs through personalised, co-ordinated support.
6. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture.
7. Live within our means and use our resources wisely.
8. Develop a high performing organisation delivering the vision of the trust.

4.0 DEFINING OUR PATIENT SAFETY INCIDENT RESPONSE PROFILE

A thorough understanding of the organisation's patient safety incident profile is critical in preparing the patient safety incident response plan. This process was undertaken between June and October 2023. This process has been a collaborative one involving the following key stakeholders:

- Staff – through the incident reporting process and stakeholder events
- Senior leaders across the Service Groups – through a series of stakeholder events
- Patient groups – through a review of PALS and complaints and engagement with those affected by historical patient safety incidents
- Patient Safety Partners – through direct engagement
- The Somerset Integrated Care Board – through partnership working with the ICB Quality and Safety Leads

Between July 2020 and June 2023, colleagues at Somerset NHS Foundation Trust and its legacy organisations reported 98,826 incidents. Incidents were recorded using two separate incident management systems that collect data in different ways.

A limited extract of the details from each incident across both systems was taken and combined into a minimum incident dataset (MIDS) – this included where and when the incident happened, what the impact of the incident was and how the reporter categorised the incident. The categories from each system were mapped to standardised groups and those groups aligned to existing governance framework topics or other specialist subjects.

From a wider list of the topics, the following priority areas were selected for review based on the volume of incidents occurring across the trust, and their relevance – for example those groups that include patient safety incidents.

- Communication and documentation
- Deteriorating patient (incl. sepsis)
- End of life and treatment escalation planning
- Medical devices (incl. extravasation)
- Medication management
- Pressure ulcers & tissue viability
- Slips, trips & falls
- Suicide, self-harm and ligatures
- Transfer of care (incl. discharge)
- Treatment and care
- Violence and aggression

For each priority area, an initial analysis of incident data was undertaken to describe the number of incidents reported, how this changed over time, where in the organisation they occurred and what level of harm. It also included additional topic specific data that was captured on both incident systems.

The initial analysis was discussed with the topic lead and other subject matter experts knowledgeable about each priority area. A discussion with the leads gave insight into the common types of incidents, current areas of concern, the level of understanding of system factors in relation to these incidents, and any existing quality improvement work in progress.

Additional analytical work was undertaken to further describe the specific areas that could form the trust priorities for patient safety incident investigation. These are subsets of the wider topic that

would benefit from a thorough understanding of the system factors that results in these incidents and could benefit from targeted improvement work. This process included pulling in data from a variety of other relevant sources including, but not limited to:

- Serious Incident Investigations / RCA's
- PALS and Complaints
- Topic Assurance Reports
- Clinical Audits (local and National) and other measurement programmes
- Quality Improvement work
- Claims
- Patient Experience Surveys

The above data was presented to stakeholders in a 'Patient Safety Incident Profile' pack. The current knowledge of sytem factors and existing quality improvement work was also included in the profile. A stakeholder engagement workshop was held to analyse the above profile and agree on the PSIRP priorities for the next 12-18 months. The proposed PSIRP priorities were signed off at Patient Safety Board in November 2023.

5.0 DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

The newly merged Trust is developing its governance processes to ensure it continues to gain insight from patient safety incidents and feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The Patient Safety Board will provide assurance of quality improvement work through the Quality and Governance Assurance Group. The Operational Patient Safety Board will be responsible for oversight of the quality improvement work including the use of quality improvement methodology.

Safety Improvement Workstreams will be required to report their progress with PSIRF priorities to Patient Safety Board to monitor and measure improvement activity across the organisation. Patient Safety Board will also provide assurance of the development of new safety improvement plans following reviews undertaken within PSIRF, to ensure they have followed robust processes during development and are sufficient to enable future improvement in patient safety.

The Trust will focus efforts going forward on the development of safety improvement plans that link to national priorities or the locally determined PSIRF priorities outlined in this plan. Flexibility within this approach will be maintained and emergent risks or patient safety issues will be considered from internal or external insight.

6.0 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 as a direct result of a patient safety incident require a locally led Patient Safety Incident Investigation (PSII) (appendix F). Table 1 below sets out the local or national mandated responses.

National priorities for the reporting and referral of patient safety incidents to other bodies for investigation are described in the PSIRF and other national initiatives for the period 2023 to 2024 as follows:

From our incident and resource analysis, we estimate that we will complete approximately 10 PSII reviews where national requirements have been met per annum and 10-15 reviews over a 12-18 month period in line with our local priorities.

	National priority	Response
1	Mental health-related homicide by patient in receipt of specialist mental health services	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. If an independent investigation is not commissioned, then the Trust may commission an internal PSII.
2	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.
	Incident in screening programmes	Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service).
	Child death	Incidents must be referred to Child Death Overview Panels for investigation.
	Death of a person with a learning disability	Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review [LeDeR] programme.
	Safeguarding incidents in which: Babies, child and young people are on a child protection plan;	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

	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.	Partnership (for children) and local Safeguarding Adults Boards.
	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.
	Maternity and neonatal incidents	a. Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Maternity & Newborn Safety Investigations (MNSI) programme for investigation b. All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme c. All perinatal and maternal deaths must be referred to MBRRACE
	Never events that meet the criteria set in the Never Events list 2018	Locally-led PSII
	A death as a direct result of a patient safety incident	Locally-led PSII

7.0 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

PSIRF allows organisations to explore patient safety incidents that are relevant to the organisational context and the populations served. Our analysis of patient safety data has led us to conclude that three patient safety priorities are required to be the local focus for 2023/24. National guidance recommends that 3-6 learning responses per priority are conducted per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from

thematic analysis and learning from excellence. The outcomes of the PSII will be thematically analysed and will inform our patient safety improvement planning and work.

Patient safety priority	Planned response	Anticipated improvement route
Recognition, escalation and response to deterioration of patients within maternity, neonates, paediatrics, acute medical admissions, surgical decisions unit and emergency admissions unit.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.
Involving people who matter (families, friends, carers and loved ones) in patient care.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.
TEP decision making, documentation and communication issues with patients and families that impact on discharge and transfers across SFT locations.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.
The patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.

For any patient safety incident not meeting the PSII criteria, we will use a specific patient safety review tool (including but not limited to After Action Reviews, Swarm Huddles, Multi-Disciplinary Reviews and Thematic Reviews (appendices B-E) to enable a local learning response. These incidents will largely be managed at a local level with ongoing thematic analysis via our existing Trust assurance processes, which may result in new or supplement existing improvement work.

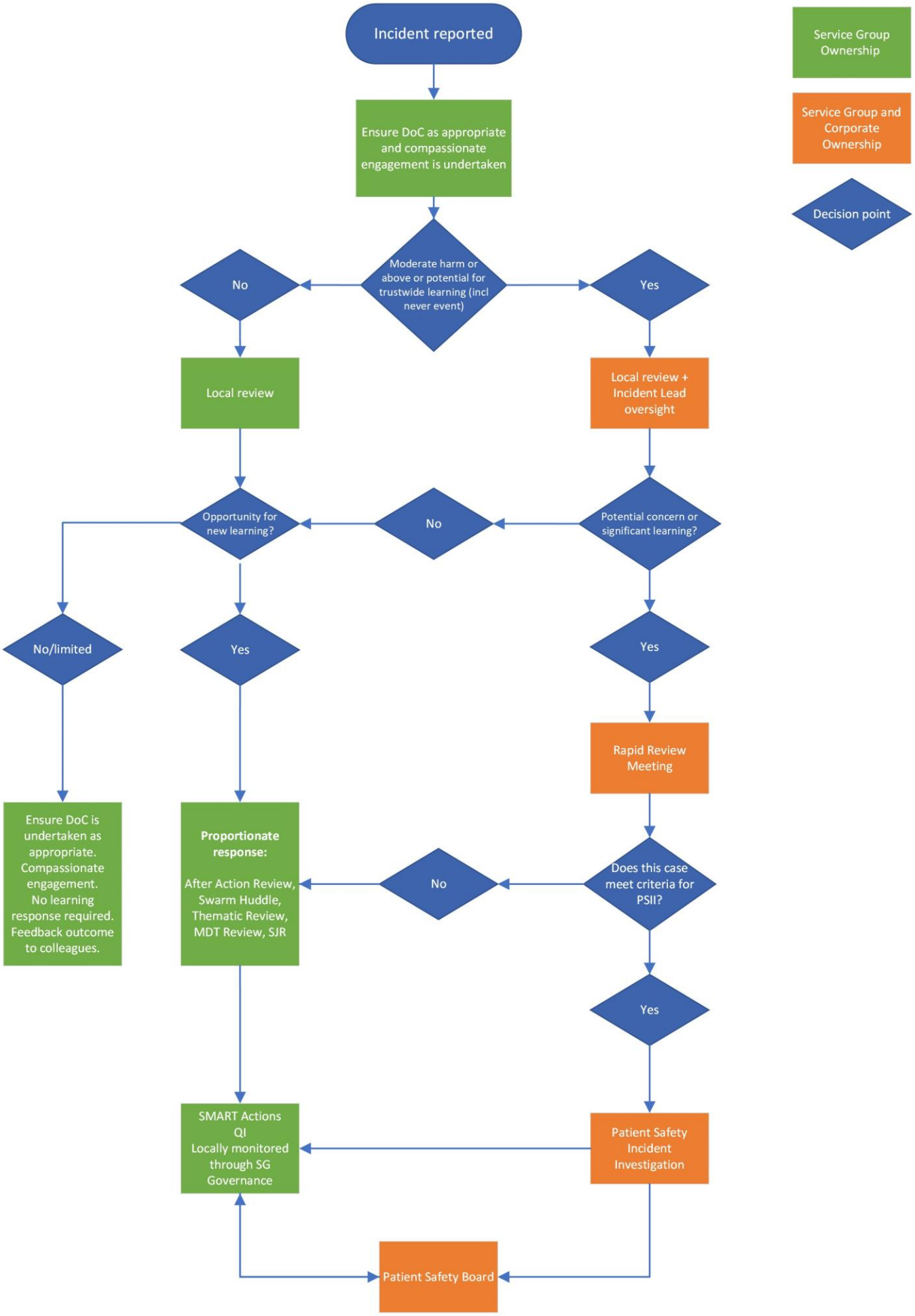
The patient safety priorities will be reviewed 12-18 months following the publication of this plan and the safety incident profile will be updated to reflect the changing patient safety priorities.

8.0 PATIENT SAFETY INCIDENT RESPONSE DECISION MAKING

The PSIRF policy outlines the patient safety incident response decision making process and should be read in conjunction with this PSIRP. The diagram in appendix A outlines the process of

identifying a suitable learning response for patient safety incidents. The PSIRP does not alter the Statutory Duty of Candour requirements. Where Duty of Candour applies this must be carried out according to Trust policy (‘Being Open and Duty of Candour Policy’).

Appendix A – Patient Safety Incident Response Pathway



Appendix B – After Action Review

After Action Review (AAR)

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A structured, facilitated discussion of an event to generate learning and assist improvement. Generates MDT perspectives. Ideallly conducted face to face but can be virtual if needed.

1 APPLICATION

After any patient safety incident where patient care or service was ineffective or compromised, or where events turned out better than expected.

2 TIME COMMITMENT

Around an hour, plus additional administration time to arrange the review/write up the findings.

3 DELIVERY

Led by a trained AAR conductor (internal training will be delivered in SFT early 2024). Senior managers and clinicians will be encouraged to undertake the training.

4 ENGAGEMENT

Staff directly involved in the incident and others connected to them or the patient pathway.
Patient and family engagement occurs before and after the AAR - they may have questions to be answered throughout the AAR.

5 NEXT STEPS

SMART action plan developed (held within service/department).
Summary of AAR is shared with staff members and the patient, outlining lessons learned and what changes have been agreed as a result.

Commissioned and allocated at service level or Rapid Review Meeting

Opportunities for use (not extensive list)

Unexpected death (not due to PSI)
Unexpected ITU admission
Fall resulting in fracture
PSI resulting in significant harm

Duty of Candour requirements remain unchanged and are supported by the AAR model

S STRENGTHS

Learning is the primary focus
Highly adaptable
Psychological safety is actively created
Provides a safe, reflective, supportive environment, reducing isolation and rumination
Group learning process supports team performance

W WEAKNESSES

Sharing collated learning can be challenging in complex organisation
Staff attendance can be difficult to manage due to shift patterns
Tracking the outcome of actions locally can reduce trust-wide assurance

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Appendix C – Swarm Huddle

Swarm Huddle

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Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened, how it happened and decide if further action is needed to reduce risk.

1 APPLICATION

After any patient safety incident where patient care or service was ineffective or compromised, or where events turned out better than expected.

2 TIME COMMITMENT

No more than 30 minutes.

3 DELIVERY

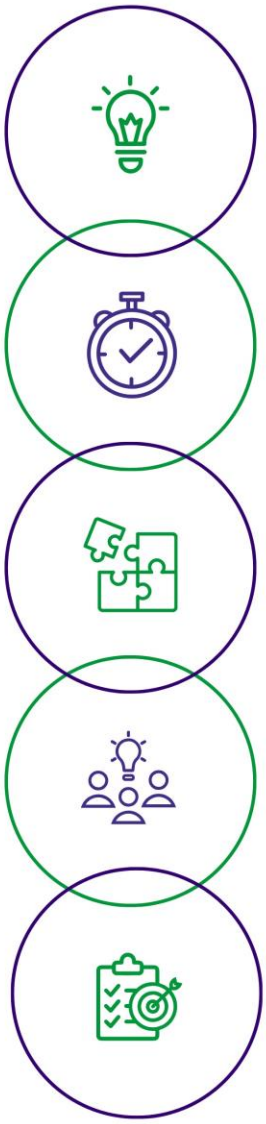
Normally facilitated by a senior lead (Doctor, Charge Nurse, Labour Ward Co-ordinator, Service Lead) who was not directly involved in the incident.

4 ENGAGEMENT

Staff directly involved in the incident will be encouraged to attend.
The findings and actions from a swarm huddle may be shared with the patient. Duty of candour requirements remain unchanged.

5 NEXT STEPS

Immediate learning occurs with early actions identified (where applicable). Actions held at service/departmental level.



Should be completed within 48 hours of the patient safety incident

Opportunities for use (not extensive list)

Major haemorrhage
Obstetric emergency
Post cardiac arrest
Traumatic fall
Medication overdose
Patient absconding from MH unit

SEIPS framework is used to ensure system factors are considered

S STRENGTHS

Immediate learning occurs with early actions identified
Connecting immediately after event may reduce stress for staff
Quick and easy to undertake so increases likelihood of being done
Reduces key information being lost by its immediacy

W WEAKNESSES

Scope of learning is narrow
Learning is focused on a single event rather than the interactions in the system
Psychological safety is assumed to be present so full participation may not be achieved.
Weak governance arrangements for tracking actions and collating learning

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Appendix D – Thematic Review

Thematic review

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A themed review can be useful in understanding common links, themes or issues within a cluster of incidents or investigations. The aim of a themed review is to understand key barriers or facilitators to patient safety.

1 APPLICATION

Grouped, or clusters of incidents, such as pressure ulcers, falls or deteriorating patients, will benefit from a thematic analysis.

2 TIME COMMITMENT

Widely variable depending on the data to be analysed, but anticipated to be upwards of 10 hours.

3 DELIVERY

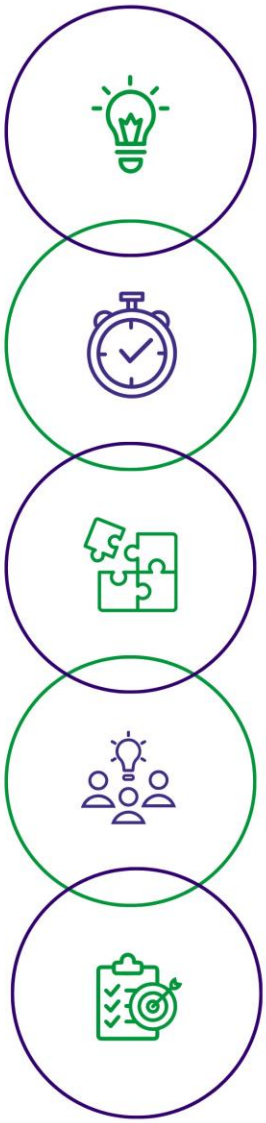
Facilitated by an individual who has completed training or has experience in thematic review.

4 STAGES OF REVIEW

1: Description of the reference cases
2: Description of the safety system
3: Relevant context to each reference case and key problems
4: Common themes across the reference cases – narrative analysis
5: Safety recommendations and future work

5 NEXT STEPS

A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and the diagnosis should always result in quality improvement work.



Thematic reviews primarly examines qualitative data

Opportunities for use (not extensive list)

Analysing a patient safety incident or safety theme

Informing or assessing the impact of patient safety improvement plan

SEIPS framework is used to ensure system factors are considered

S STRENGTHS

Flexibility of approach can support changes in the terms of reference
Suitable for reviewing complex data
Multiple people can support a thematic review
Can help direct quality improvement work

W WEAKNESSES

Can be time consuming and requires skill to identify representative themes
Validity can be influenced by reviewer bias
Interpretation/Subjectivity can be an issue
Poorly performed reviews may produce low quality results

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Appendix E – MDT Review

MDT Review

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An in-depth process of review with input from different disciplines to identify learning from multiple PSI's and build an understanding of how patient care is delivered in the real world. Focuses on system gaps and contributory factors that impact on the safe delivery of care.

1 APPLICATION

After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability.

2 TIME COMMITMENT

No defined time allocated. Likely to include a workshop lasting 2 to 3 hours.

3 DELIVERY

Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme.

4 ENGAGEMENT

Those directly involved in these events from the MDT, plus patient safety experts and other senior clinicians.

5 NEXT STEPS

Triangulation of the data with other sources may be required.
Findings of the MDT review are shared to inform patient safety improvement work.

Primary aim of an MDT review is for reporting and recommending

An MDT review is ideal for understanding work as done versus work as imagined. An MDT review may be commissioned for emerging themes under PSIRF.

Commissioned at a service group level or through Rapid Review Meeting

S STRENGTHS

The participation of the MDT without the spotlight on a single event enables a broad and deep discussion to take place and a system view to be gathered

Incorporates the systems engineering initiative for patient safety (SEIPS) framework to structure the review

W WEAKNESSES

The MDT committee is often determined by the individual arranging the review which may the sphere of influence

Resource intensive to undertake and ensure full MDT representation is available

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Appendix F – Patient Safety Incident Investigation

Patient Safety Incident Investigation

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An in-depth review of a single patient safety incident or cluster of events undertaken by trained Patient Safety Incident Investigators.

1 APPLICATION

To investigate an incident that meets one of the Trust PSIRF priorities (max 3/yr per priority) ***or*** a never event ***or*** a death thought to be as a direct result of a patient safety incident.

2 TIME COMMITMENT

Depending on complexity, one to two weeks.

3 DELIVERY

Undertaken by two trained patient safety incident investigators who review records, collate data, conduct interviews, undertake analysis and write the patient safety incident report including recommendations.

4 ENGAGEMENT

People directly involved in the incident (staff, patients and families), senior clinicians and subject matter experts. Patients, carers and family members may be heavily involved in a PSII, depending on their wishes.

5 NEXT STEPS

SMART action plan developed and owned by service group(s).
PSII signed off at Patient Safety Board.
System factors addressed through quality improvement workstream.

Commissioned and allocated through Rapid Review Meeting

PSII's are designed to identify as many causes of a patient safety incident as possible, analysing the risks of reoccurence. They are most suitable for the complex,recurring and serious patient safety events.

Compassionate engagement is led by the trained patient safety investigators

S STRENGTHS

Well established approach based on extensive research
Thorough analysis of an event
Responsibility for the investigation and completion of related actions is clearly articulated in governance processes.

W WEAKNESSES

Time-consuming
Investigative interview process can be stressful for staff
Actions arising in the PSII report can take many months to complete

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