University Hospitals Coventry and Warwickshire NHS Trust

Patient safety incident response plan

Effective date: 1st December 2023 – 30th June 2025

Estimated refresh date: April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**L. Cummins**	**Director of Quality**		**15/9/2023**
Reviewer	**Mo Hussain**	**Chief Quality Officer**		**1/10/2023**
Authoriser	**UHCW Trust Board**			**7/12/2023**

Contents

Introduction 3
Our services 4
Defining our patient safety incident profile 5
Defining our patient safety improvement profile 8
Our patient safety incident response plan: national requirements 9
Our patient safety incident response plan: local focus 14
Appendix A 16
Appendix B 17
References 18
Glossary 19

Introduction

This patient safety incident response plan sets out how University Hospitals Coventry & Warwickshire NHS Trust, (thereafter UHCW), intends to respond to patient safety incidents over a period of 18 months.

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Patient Safety Incident Response Framework (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected.
- embeds patient safety incident response within a wider system of improvement.
- prompts a significant cultural shift towards systematic patient safety management.
- allows for a proportionate and considered learning response to patient safety incident.

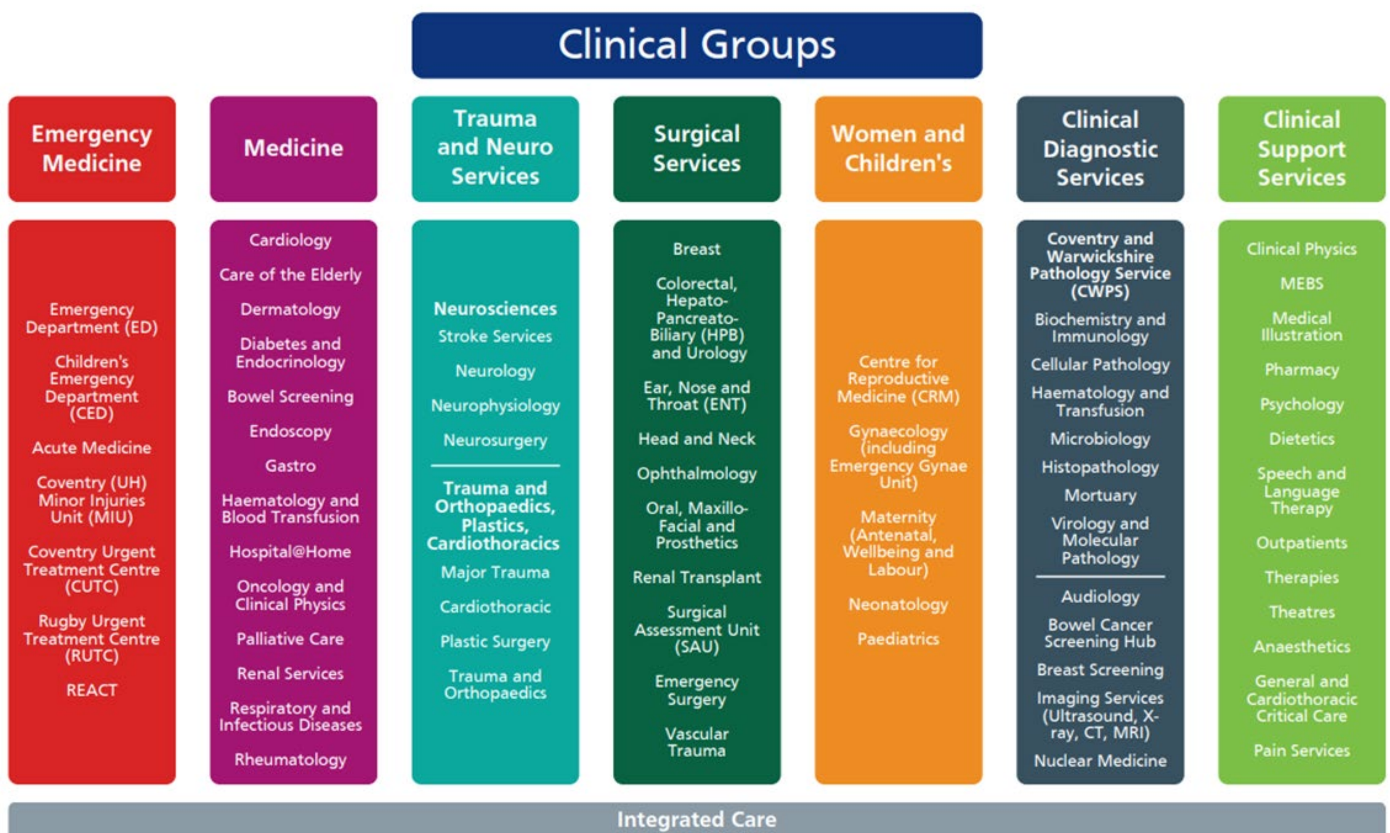
The Trust will review patient safety information regularly through governance and safety meetings, providing updates to the plan as required.

The whole plan will be reviewed every 18 months to ensure that it remains contemporaneous and reflects the patient safety issues with the greatest potential for learning and improvement. This review of the plan will involve re-engagement with stakeholders to discuss and agree any changes and will be published as a new version of the plan

Our services

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest teaching Trusts responsible for managing two major hospitals in Coventry and Rugby, which between them serve a population of over a million people; every year we provide more than 800,000 episodes of care to patients from across Coventry, Warwickshire and beyond.

The Trust provides a range of services which are aligned to 7 Clinical Groups further supported by a range of corporate services. The Groups are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies, and procedures. The Groups are made up of a number of specialties and are led by a Group triumvirate comprising Clinical Directors, Associate Group Directors of Nursing and Group Directors of Operations.



Defining our patient safety incident profile

A key part of the development of our Patient Safety Incident Response Profile was to understand the key issues that arise that lead to risks for patient safety at UHCW.

Stakeholder engagement

An outline of the requirements and approaches to be taken in the preparation of the policy and plan was presented the Chief Officers Forum (Trust Senior Leaders) in November 2022. This led to the development of a dedicated PSIRF task and finish group which was established to lead the PSIRF development and a number of key stakeholders in the organisation have contributed to the policy and plan.

- Chief Quality Officer
- Deputy Chief Medical Officer (DCMO) Patient Safety
- Associate Director of Nursing (Safety & Quality)
- Associate Director of Quality (Safety & Risk)
- Head of Patient Safety
- Patient Safety Manager(s)
- Associate Director of Quality (Patient Experience & Involvement)
- Associate Director of Quality (Effectiveness & Assurance)

Additionally, a series of multi-agency forums at System (ICB) involving ICB leads, and partner organisations were held over a 12-month period to facilitate shared learning which have helped to shape our Patient Safety Profile and cross-system organisational responses.

Data sources

To define our patient safety profile, data was taken from a variety of sources including data held within our Datix system (Incident, complaints, risks) and relevant assurance reports.

The Trust collated and observed data over a three-year period (1/4/2020 – 31/3/2023) recognising the variations in data observed arising from the COVID-19 pandemic.

To understand the patient safety incident profile a number of sources of information about risks to patient safety were reviewed and evaluated and the process for developing our patient safety incident profile is described below.

In the previous 3 years (01/04/20 to 31/03/23) 56,991 patient safety incidents have been reported, (all types, all grades), of which 381 (0.6%) were investigated under the Serious Investigation Framework (NHSE, 2015)

A large proportion of the patient safety investigation resource is currently aligned to the investigation of serious incidents, which can be considerably time consuming and this approach to investigation can limit the potential learning opportunities that may arise from

other patient safety incidents that, whilst not meeting the current serious incident (SI) reporting threshold, present opportunities for thematic review, learning and improvement.

A key part of developing the new national approach is to understand the amount of patient safety activity the trust has undertaken over the last three years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach. The patient safety PSIRF related activity undertaken prior to PSIRF can be broken down as follows:

Patient Safety Activity	Activity	Definition	2020-2021	2021-2022	2022-2023
National Priorities	Never Events	Incident meeting criteria for never events framework and reported to Strategic Executive Information System (StEIS) as a Serious Incident (SI)	2	7	5
	Incidents meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation.	6	8	13
Local Patient Safety Activities	Serious incidents	Serious Incident requiring investigation and reported to Strategic Executive Information System (StEIS) as a Serious Incident (SI)	97	133	151
	Patient Safety Incidents reviews (triaged by PSR)	Including moderate harm incidents meeting the requirement for Duty of Candour, not meeting SI criteria for reporting on StEIS	346	854	962

To identify our patient safety priorities, we took a thematic approach to identify which aspects of patient safety activity we would identify as our patient safety priorities.

This thematic approach included:

- Analysis of incidents reported onto Datix in the period 1/4/2020 – 31/3/2023 inclusive.
- Analysis of the incidents reported onto StEIS in the period 1/2/2020 – 31/3/2023 –
- Thematic review of the incident types not reported onto StEIS (including low harm/no harm and near miss) incidents.
- Complaints and concerns received relating to clinical care and treatment.
- Trust level risks pertaining to patient safety.

Defining our patient safety improvement profile

There are many Trust-wide and locally initiated quality improvement projects ongoing throughout the Trust; these are shared routinely via Rapid Improvement Report Out activities and the Trust UHCWi “stand up” events. Some of the ongoing work includes:

- Emergency Department Majors (Value Stream Project)
- Community Diagnostic Centres (Value Stream Project)
- Robotic assisted Radical Prostatectomy (Value Stream Project)
- Violence and Aggression – Staff Support Response
- Orthopaedics Pathway Improvement
- Pathway and flow improvement (Site management)

The PSIRF approach supports an improvement approach to patient safety investigation and, whilst we will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our internal or external surveillance, where an incident type is well understood, resources may be better directed at improvement rather than an investigation.

As part of our PSIRF response our insights to support improvement activity will be further strengthened through the creation of the Safety Learning and Improvement (SLI) Group (Appendix A). The Safety and Learning Group (SLI) will receive and synthesise data and intelligence from a number of sources, (National and local), to drive improvement projects aligned to our learning from patient safety.

The Trust has also launched a new style patient safety and quality dashboard reporting framework which will bring together a number of sources of information that we will use to support systems analysis, (quality, safety, risk, effectiveness and experience).

The Safety Learning and Improvement Group (SLI) will maximise learning opportunities and will seek to further develop and mature this approach through evaluation and feedback.

We plan to develop safety improvement plans across our most significant incident types whilst also remaining flexible and being responsive to emerging themes that may arise e.g., cluster of patient safety incidents of a similar type or theme.

The further areas that we have identified for improvement are:

- Falls (led by Falls Forum)
- Pressure Ulcer (led by Pressure Ulcer forum)

These local priorities will seek to mature the specialised review piloted during the PSIRF transition period to enable systematic data collection to inform wider improvement work.

Our patient safety incident response plan: national requirements

The Trust has finite resources for patient safety incident response; therefore, we intend to use those resources to maximise improvement. PSIRF allows us to do this; rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care, will always require a Patient Safety Incident investigation (PSII) to learn and improve and to act as a record of the event.

For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been mandated nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the Table 1. below.

Table 1.

Event	Response required	Anticipated improvement route
Deaths thought, more likely than not, due to problems in care (incidents meeting the learning from deaths criteria for PSII)[1]	PSII	Create local organisational actions to be received by the Incident review group and shared with the Safety Learning and Improvement Group (SLI)
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)	PSII	Create local organisational actions to be received by the Incident review group and shared with the Safety Learning and Improvement Group (SLI)
Incident meeting the Never Events Criteria (or its replacement)	PSII	Create local organisational actions and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSSIB/MNSI) criteria	Refer to HSSIB/MSNI for independent PSII – see also **Appendix B**	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)

[1] Unless the death falls under another more specific category (Appendix A), in which case that response must be followed.

Event	Response required	Anticipated improvement route
Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR.	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)
Safeguarding incidents in which: • 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 local authority safeguarding lead. 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	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI) (via the Trust Safeguarding Committee)

Event	Response required	Anticipated improvement route
Incidents in NHS screening programmes[2]	Refer to local screening quality assurance service for consideration of locally-led learning response (refer also to relevant guidance)	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)
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, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI) (via the Trust Safeguarding Committee)
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally-led PSII may be required	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)

[2] Guidance for managing incidents in NHS screening programmes https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes?msclkid=3ed7eeecbbe011eca69e287393777fd1

Event	Response required	Anticipated improvement route
Deaths in custody (e.g. 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. Healthcare organisations must fully support these investigations where required to do so	Respond to recommendations as required and share learning through weekly Incident review group and the Safety Learning and Improvement Group (SLI)

Our patient safety incident response plan: local focus

Our learning responses will adopt a system-based approach and our responses will be considered and proportionate with supportive oversight.

The learning responses we will adopt are outlined below:

- **SWARM** - 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 and how it happened and decide what needs to be done to reduce risk. At UHCW this will be the methodology utilised within the established Patient Safety Review (PSR).
- **After Action Review (AAR)** - 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.
- **Multi-disciplinary review (MDT)** - An MDT review supports health teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.
- **Themed reviews** - A themed review may be useful in understanding common links, themes or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g., individual Datix incidents or previous investigations).
- **PSII** - A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation.

Where incident types have been seen to reoccur, there will be a preference for learning response approaches that seek to elicit the discovery and learning at pace to facilitate improvements and/or themed review approaches that seek to maximise the learning from cluster events.

Our local priorities (Table 2.) are broad, but the scope for our terms of reference will be developed and approved through the Incident Review Group (IRG) to provide clarity through the development of key lines of enquiry and objectives.

Table2.

Patient safety incident type or issue	Planned response	Anticipated improvement route
1. Medicines safety (prescribing and administration)	Thematic review	Review of reoccurring areas for improvement to inform ongoing improvement efforts
2. Patient safety incidents involving patients with a mental health presentation	Thematic review	Review of reoccurring areas to inform ongoing improvement efforts
3. Adverse events and outcomes associated with childbirth and pregnancy (not including those Nationally mandated) – see Table 1. and Appendix B)	Incidents with the potential for learning and improvement will be identified through routine SWARM (PSR) and where required will be subject to further learning response.	Review of reoccurring areas to inform ongoing improvement efforts

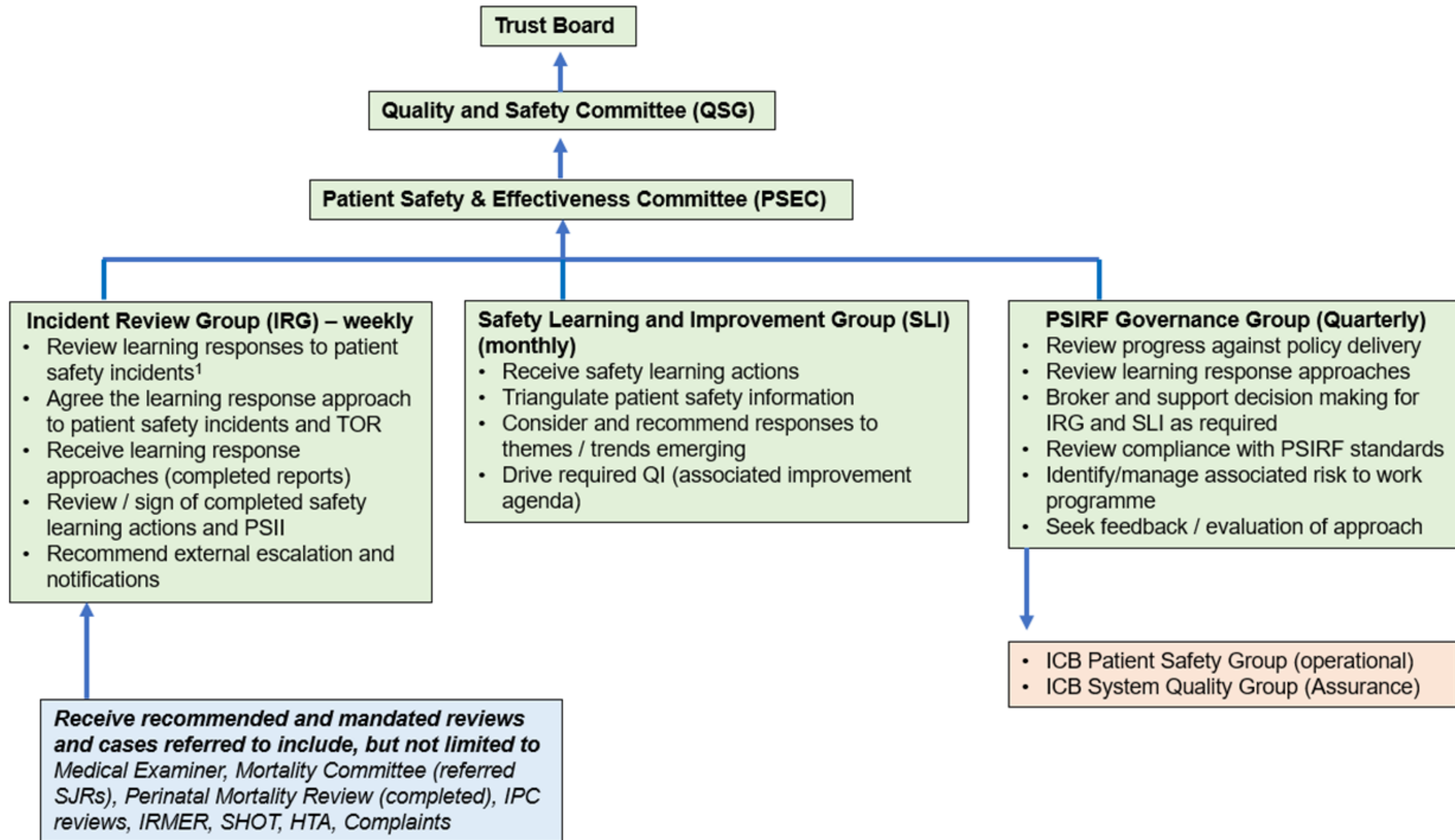
Infection prevention and control incidents will be reviewed routinely using the Midlands: Infection Prevention and Control (IPC) – Patient Safety Incident Response Framework (PSIRF) Matrix; (currently under development).

Local priority incidents (as outlined in Table 2.) identified through triage, as potentially requiring further individual incident investigation, will be referred to the Incident Review Group who will determine the level of investigation required based on a number of factors including:

- Incident complexity
- Level of risk to future care
- View of those affected by the patient safety incident.

Where individual incidents are found to meet the National responses criteria (as outlined in Table 1) then the learning response adopted will reflect the National recommendations.

Appendix A



Appendix B

Requirements for maternity services

Patient safety incidents meeting the ‘Each Baby Counts’ and maternal deaths criteria listed below are national requirements for PSII. As such they must be referred to the MNSI through the web portal provided to all trusts, for an independent PSII.

HSIB investigates the following maternity patient safety incidents:

- 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 therapeutically cooled (active cooling only); or – had decreased central tone, was 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).

Where such an investigation is undertaken, **a separate local patient safety learning response is not required**. However, organisations should complete Duty of Candour requirements (ahead of handover to MNSI for further involvement of patients/families in the investigation) and report on the relevant incident reporting system(s).

Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.

In relevant cases, the organisation should also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of MNSI) as it works through its independent investigation).

References

NHSE, (2015). Serious Incident Framework

NHSE, (2019). NHS patient safety strategy

NHSE, (2022). Patient Safety Incident Response Framework

Glossary

AAR	**After Action Reviews** (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.
CDOP	A **Child Death Review** meeting is held to review all the information to understand why the child died. They review and identify any learning points from services involved with the child leading up to their death
CSP	**Community Safety Partnership** are statutory partnerships that bring together local organisations with the shared goals of reducing crime and the fear of crime, anti-social behaviour, alcohol and drug misuse and reducing re-offending.
DHR	**Domestic Homicide Reviews** are carried out so that agencies such as the police, social services and the health service can examine how they handled a murder case and if there are any ways they might work better together in the future.
Each Baby Counts	**Each Baby Counts** was the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.
HSSIB	The **Health Service Safety Investigations Body** is an independent body that conducts major safety investigations into the most serious risks to NHS patients in England.
HTA	The **Human Tissue Authority** is an independent regulator of organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public
ICB	An **Integrated Care Board** (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area
IOPC	The **Independent Office for Police Conduct (IOPC)** investigate the most serious complaints and conduct matters involving the police
IPC	Infection Prevention and Control
IRMER	Ionising Radiation (Medical Exposure) Regulations
LeDeR	The **Learning Disability Mortality Review** (LeDeR) programme was commissioned to improve the standard and quality of care for people with a learning disability
MSNI	The **Maternity and Newborn Safety Investigations** (MNSI) programme hosted by the Care Quality Commission (CQC)
PALS	Patient Advice and Liaison Service
PMRT	Perinatal Mortality Review Tool
PPO	Prison and Probation Ombudsman (PPO)
PSII	A **PSII** is a patient safety incident investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
PSIRF	The **Patient Safety Incident Response Framework** (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety

PSIRP	The **Patient Safety Incident Response Plan** sets out how organisations respond to patient safety incidents
RIIT	NHS England Regional Independent Investigation Team
SEIPS	Systems Engineering Initiative for Patient Safety
SHOT	Serious Hazards of Transfusion
SJR	**Structured Judgement Review** is a method that allows trained reviewers to identify and describe the quality of care received
SME	Subject Matter Expert
SWARM	**SWARM**- 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 and how it happened and decide what needs to be done to reduce risk.