University Hospitals of Leicester NHS Trust

Patient Safety Incident Response Plan 2024/26

Author:	Head of Patient Safety
Reviewer:	Patient Safety Committee
Approver:	Trust Board
Effective Date:	1st April 2024
Estimated Refresh Date:	1st April 2026

Table of Contents

Introduction 3

Our services 4

Aims and Objectives of PSIRF at UHL 6

Defining our patient safety incident profile 8

Defining our patient safety improvement profile 12

Our patient safety incident response plan: national requirements 13

Our patient safety incident response plan: local focus 16

Learning responses for other patient safety incidents (not agreed as local priorities for PSII) 18

Appendix A - National Learning Response types 20

Appendix B - Glossary of terms 24

Introduction

This patient safety incident response plan sets out how University Hospitals of NHS Trust (the Trust) 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.

This plan is underpinned by our existing Trust policy on reporting, management, review and learning from incidents (A10/2002) currently in redraft and the new Trust patient safety incident response policy[1].

Our Patient Safety Incident Response Plan (PSIRP) is integral to the implementation of PSIRF and aligns with the UHL vision to be leading in healthcare and trusted in communities and the strategic priorities; high-quality care for all; being a great place to work; partnerships for impact, and research and education excellence.

UHL Strategic priority	PSIRF theme
High quality care for all	The PSIRF is all about improving patient safety and aligning this with quality improvement work, which is an integral part of quality and is at the forefront of everything we do.
Being a great place to work	The PSIRF includes a whole framework for meaningful engagement and involvement of patients, families and staff following a patient safety incident. We will be working on creating a just and restorative learning culture for staff when an incident occurs.
Partnerships for impact	In seeking those in-depth insights into our safety systems across the local healthcare system, PSIRF will help us reduce unwanted variation and feed those insights into continuous improvement work.
Research and education excellence	The essence of PSIRF is about building capability within all staff groups with the provision of the required patient safety training to be able to respond and learn from patient safety incidents. Consideration of research to support further understanding of our local priorities.

[1] UHL is developing a specific PSIRF policy in 2024/25

Our services

Leicester's Hospitals comprises three acute hospitals; the Leicester Royal Infirmary, the Leicester General and Glenfield hospital and a midwifery led birthing unit, St Mary's.

The Emergency Department (ED) at Leicester Royal Infirmary covers the whole area of Leicester, Leicestershire and Rutland and is the only ED in this area. The General provides medical services which include a centre for urology patients, and Glenfield provides a range of services which include medical care services for lung cancer, cardiology, cardiac surgery, renal and breast care.

During 2022/23 Leicester's Hospitals and the Alliance provided and / or sub-contracted in excess of 399 NHS services. These include:

- Inpatient - 77 services (specialties)
- Day Case - 78 services (specialties)
- Emergency - 82 services (specialties)
- Outpatient - 115 services (specialties)
- Emergency Department and Eye Casualty
- Diagnostic Services (Hearing, Imaging, Endoscopy, Sleep and Urodynamics)
- Direct access (Imaging, Pathology, Physiotherapy and Occupational Therapy)
- Critical Care Services in Intensive Therapy Unit (ITU), High Dependency Unit (HDU), Post Anaesthesia Care Unit (PACU), Adult Critical Care Transport Service ACCOTS, Coronary Care Unit (CCU), Paediatric Intensive Care Unit (PICU), Obstetrics HDU, Neonatal Intensive Care Unit (NICU), Extra Corporeal Membrane Oxygenation (ECMO), Special Care Baby Unit (SCBU), Paediatric and Neonatal Transport Services and also Neonatal Outreach Services
- A number of national screening programmes including Retinal Screening (Diabetes), Breast Screening including age extension (Cancer), Bowel Screening (Cancer) and Abdominal Aortic Aneurism (AAA), Cervical screening, foetal anomalies, infectious diseases of the newborn, new born infants' physical

examination, new born blood spot and sickle cell thalassemia
- Covid-19 Vaccination Hospital Hubs and the Covid-19 Medicine Delivery Unit (CMDUs)

Services are also provided at:

- Dialysis units in Leicester General Hospital, Hamilton, Loughborough, Grantham, Skegness, Boston, Kettering, Northampton and Peterborough.
- Spire Hospital. BMI Healthcare, The Health Suite.
- Optical services at Specsavers – Oakham, Corbu, Leicester, Melton, Harvey optical, Simmons Optometrists, Optyco, Opticare, David Austen Optometry, Vision Aid Centre, Narborough Eye Care.
- UHL Pillar Sites Coalville Hospital, Fielding Palmer Hospital, Hinckley & District Hospital, Loughborough Hospital, Melton Mowbray Hospital, Rutland Memorial Hospital and St Luke's Hospital
- The National Centre for Sports and Exercise Medicine at Loughborough University
- Dermatology services provided at ST Peters Health Centre
- UHL at Ashton

UHL has Insourced the following clinical services:

- Elite Emergency
- Nuffield Leicester
- Vascular Europe
- Skin Analytics
- Xyla
- Medinet
- Medacs Healthcare
- KPI-Health
- Your Medical Services
- 187 weeks
- I.D Medical
- SAH Diagnostics

Aims and Objectives of PSIRF at UHL

There are four overarching aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based which support the development and maintenance of an effecting patient safety incident response system. Specific objectives have been set in order to ensure that we meet the overarching aims of PSIRF:

Figure 1. Overarching aims and objectives for PSIRF at UHL

Overarching Aims	Objectives
1. Compassionate engagement and involvement of those affected by patient safety incidents	• Develop a climate that supports a just and restorative learning culture and an effective learning response to patient safety incidents • Respond to patient safety incidents purely from a patient safety perspective • Reduce the number of duplicate PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors • Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents • Consider the safety issues that contribute to similar types of incident • Develop system improvement plans across aggregated incident response data to produce systems-based improvements • Better measurement of improvement initiatives based on learning from incident response
2. Application of a range of system-based approached to learning from patient safety incidents	• Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS. • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting Duty of Candour

3. Considered and proportionate responses to patient safety incidents	• Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement
4. Supportive oversight focused on strengthening response system functioning and improvement	• Support and involve staff in patient safety incident response, for better understanding of the issues and contributory factors

Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into improvement workstreams over a period of years. We have a monthly Executive-led Patient Safety Committee and also an Adverse Events Committee that allows triangulation of themes from serious incidents, learning from death cases, upheld PHSO cases and claims.

In May 2023, we identified the period 1st April 2021 to 31st March 2023 for our thematic data analysis. Over a period of four months, we undertook a comprehensive analysis of our current patient safety risk profile across all services within UHL.

Stakeholder engagement

Internally, a presentation was created to outline the major significant differences between PSIRF and the SI Framework. This was delivered to the Trust Board in December 2022. Since then, all Clinical Management Groups (CMGs) have had this presented at their Quality and Safety Board meetings.

The introduction of the PSIRF creates an opportunity to focus resources on a set of locally agreed UHL safety priorities as part of the PSIR Plan. A collaborative stakeholder workshop was held that involved UHL and integrated care system colleagues in July 2023 to generate our first PSIR plan themes for investigation. The stakeholders presented their data and the top five themes around patient safety, followed by discussion of what could be the agreed themes for our local priorities in the PSIR plan. The following top themes were identified:

Figure 2. Our initial top themes identified

As part of the shortlisting and refining process, a prioritisation decision matrix was used to consider key questions:

1. What is the likelihood of occurrence?
2. What is the potential for harm?
3. Do we have existing in-depth insight about this risk that might mean we de-prioritise this theme in our initial Patient Safety Incident Response Plan?
4. Is there improvement work underway locally, at Integrated Care System level or national level that we are already undertaking to mitigate this risk?

The stakeholder meeting culminated in producing a set of five priority areas which required further discussion and refinement. The next stage of the process was to engage with CMG colleagues to discuss the key risks under each theme and develop the specific areas of focus. This engagement was completed by attendance at key meetings to capture all types of staff groups. The final element of our engagement was the development of a consultation survey to allow staff to feedback their comments on the proposed priorities.

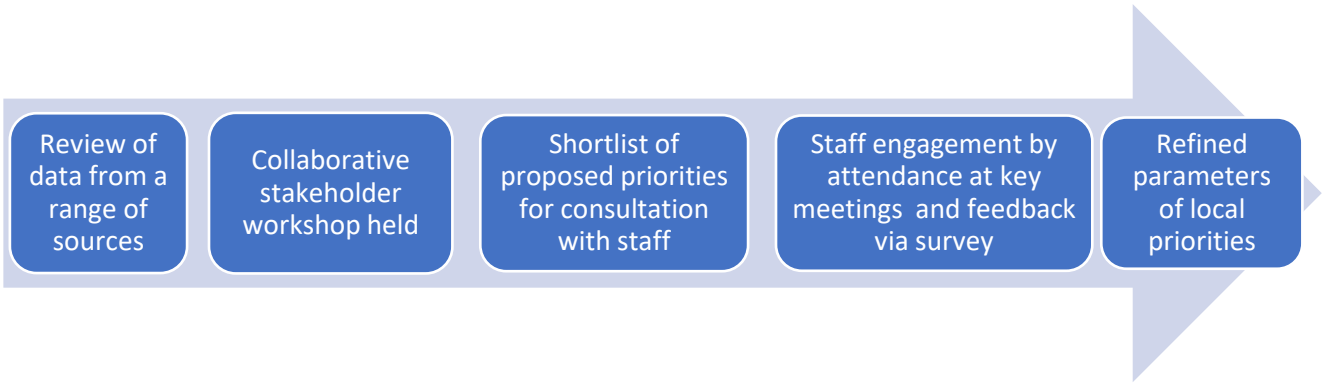

Figure 3. Process for identification of UHL local priorities

Unfortunately, our Patient Safety Partners were not recruited in time to develop our first PSIRP but will play an integral role in patient safety in UHL and in the development of future plans.

Data sources

To define our patient safety response profile, we drew data from a variety of sources. We learned from early adopters that 2-3 years of data seemed to be appropriate to understand patient safety risks and issues. The UHL patient safety risks were identified through the following data sources for 2021-2023:

- Analysis of three years' of Datix incident data (including prevented incidents)
- Detailed thematic analysis of learning from serious incidents
- Key themes from complaints, concerns, claims & inquests
- Key themes identified from specialist safety & quality committees (e.g. deteriorating patient, falls, pressure ulcers)
- Themes from the Learning from Deaths reviews
- Key themes from medication safety incidents
- Key themes from the learning from HSIB maternity investigations and perinatal mortality reviews
- Key themes from risks on the risk register
- Key themes from Infection Prevention incidents
- Key themes from Safeguarding reviews and LeDeR reviews
- Key themes from Freedom to Speak Up concerns
- Key patient safety themes from cancer pathways work

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshop, we also considered any new and

emergent risks relating to operational pressures and changes in demand that the historical data does not reveal.

Defining our patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- Existing Transformation Programme priorities
- Existing Patient Safety Improvement Programme priorities eg safe surgery and invasive procedures
- Trust-wide quality improvement projects
- Trust-wide operational improvement work eg Criteria led discharge
- ICS operational improvement projects eg virtual wards
- National Patient Safety Improvement Programmes eg maternity and neonates improvement programme
- East Midlands Patient Safety Collaborative Programmes

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, 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. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative learning 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 as specific response will be reviewed according to the suggested methods and are detailed in the table below:

Patient Safety Incident Type	Required Learning Response	Lead body for response
Incidents meeting the Never Event criteria	Patient Safety Incident Investigation (PSII)	UHL
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation (PSII)	UHL
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations Special Health Authority (MNSI) (Previously HSIB) criteria.	Refer to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) for independent patient safety incident investigation	MNSI
Death of a person with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death	LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria for PSII.	Child Death Overview Panel/UHL

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)	Patient Safety Incident Investigation (PSII)	UHL
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	UHL
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead via UHL 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	UHL
Hospital acquired infections resulting in harm	Refer to Infection Prevention Team and use of appropriate learning response	UHL
Incidents meeting the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	Refer to the relevant Medical Physics Expert and use of appropriate learning response	UHL
Incidents meeting criteria for reporting to the Human Tissue Authority (HTA)	Refer to designated HTA lead and use of appropriate learning response	UHL
Transfusion incidents meeting criteria for Serious Hazards of Transfusion (SHOT) reporting	Refer to designated Blood Transfusion lead and use of appropriate learning response	UHL

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our data insights, based on the review of incidents and stakeholder engagement process we have determined that the Trust requires 5 patient safety priorities as local focus. We have selected this number due to the breadth of services that the Trust provides. We will undertake a minimum of 5 index case PSII in each of the types of incidents proposed. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors that also featured as broader themes from our analysis work.

We will use the outcomes of PSIIs to inform our patient safety improvement planning and work.

The table below describes how we will respond to patient safety incidents relating to the key patient safety risks identified in our data thematic analysis.

UHL Local Priorities

Theme	Description	Focus	Responses type and identification of cases
Deteriorating patient	Addressing the care of the deteriorating patient to improve early detection and effective treatment	Sepsis	5 PSIIs for adults (not ED) 5 PSIIs for Paediatrics Consider implementation of care bundles and effectiveness
		Postpartum Haemorrhage (PPH) Blood Loss >1500mls	5 PSIIs for PPHs Consider implementation of care bundles and effectiveness
Medication	Addressing the most important causes of severe harm associated with medications	Anticoagulation	5 PSIIs from across 5 different specialities
Transfers of care	Reducing risk and improving experience for transfers of care for non-clinical reasons within the inpatient setting	Ward transfers of care>3 for non-clinical reasons within Medicine	Thematic review of 15 patients moved >3 times for non-clinical reasons in medicine or proactively follow through 15 patients to review cases

Tacking inequalities	Addressing access, experience, and outcomes to achieve equitable delivery of service	Maternity and neonates Outcomes focusing on Black, Asian and ethnic minority	Thematic review of 15 patients
		Cancer pathway Outcomes focusing on Learning disability and autism	Thematic review of 15 patients
Fundamentals of care	Ensuring that people's different fundamental needs are met; physical (nutrition, mobility), psychosocial needs (communication, privacy, dignity), with relational actions (active listening, being empathic)	Care of the Older Person >85yrs	5 PSIIs into care of 5 patients >85yrs

Learning responses for other patient safety incidents (not agreed as local priorities for PSII)

Patient Safety Incident	UHL Planned Response	Oversight of themes & improvement work
Inpatient falls resulting in a bone fracture or haemorrhage	Immediate safety huddle and use of appropriate learning response	Falls Steering Group Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee
Healthcare associated pressure injury	Use of appropriate learning response	Pressure Ulcer Prevention Group Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee
Hospital acquired infections resulting in death	Statutory duty of candour and use of appropriate learning response	Trust Infection Prevention and Control Committee
Maternity or neonatal incident with poor outcome (not meeting HSIB referral criteria)	Rapid review and use of appropriate learning response.	Maternity Assurance Committee Quality Committee
Incident resulting in moderate or severe harm to patient	Statutory duty of candour and use of appropriate learning response	Patient Safety Committee
All other patient safety incidents	Validation of facts at local level by managers review or immediate safety huddle, local action and shared learning	Patient Safety Committee
Identified increase in incidence of subject of theme which has potential for harm	PSII	Patient Safety Committee

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix A - National Learning Response types

Patient Safety Review (PSR) Type	Methods	Objective
Incident recovery Immediate measures taken to: • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carer • Determine the likelihood and severity of an identified risk	Immediate action	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.
	Risk assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'
	Work system scan	A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (ie barriers and facilitators).
Team reviews Post-incident review as a team to: • Identify areas for improvement • Celebrate success • Understand the expectations and	Debrief	An unstructured, moderated discussion The simplest and most informal method to gain understanding and insight soon after an incident (debriefs held

perspectives of all those involved • Agree actions • Enhance teamwork through communication and collaborative problem solving		immediately after an incident are known as ‘hot’ debriefs).
	Immediate Safety Huddle (Swarm huddle)	**Proactive**: a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive**: triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions
	After action review	A ‘cold’ structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?

Systematic reviews To determine: • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient	Multidisciplinary team (MDT) tabletop review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
	Case note review (e.g. Structured Judgement Review)	To determine whether there were any problems with the care provided to a patient by a service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
	Mortality review	A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients

	Specialised reviews	For example, falls, pressure ulcers, IPC reviews
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both)
	Survey	Is the combination of questions, processes and methodologies that analyse data about others. It aims to determine insights about a group of people.
	Appreciative Inquiry	Is a positive-focused approach, which looks at what's going right in order to solve problems

Appendix B - Glossary of terms

PSIRF - Patient Safety Incident Response Framework

This is a national framework applicable to all NHS providers 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.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a collaborative approach with the CMGs and specialist process leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation

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.

AAR – After action review

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 to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review

Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR 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 care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

Immediate Safety Huddle - Used within Healthcare in the UK and US, an immediate collective or SWARM huddle approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis, take any required immediate actions and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf