

# Patient safety incident response plan

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## Introduction

This patient safety incident response plan sets out how Gloucestershire Health and Care NHS Foundation Trust (GHC) intends to **respond** to patient safety incidents over 12–18 months. The plan is not permanent: we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our Trust policies on incident reporting and investigation available to all staff via our organisation's intranet (available to staff only).

## Our services

GHC provides joined-up mental health, physical health and learning disability services to people of all ages across Gloucestershire. We do this in our hospitals, in community buildings and in people's own homes.

Further information about our organisation can be found at [www.ghc.nhs.uk](http://www.ghc.nhs.uk).

## Defining our patient safety incident profile

The patient safety risk process is a collaborative process. The following stakeholders were involved in defining the GHC patient safety risks and responses for 2023/24:

- staff, through the incidents reported on the GHC Datix incident system
- senior leaders across the services, through a series of briefings and a task and finish group
- patient groups, through a review of the thematic contents of complaints and Patient Advice and Liaison Service (PALS) contacts\*
- commissioners/ICS partner organisations, through partnership working with the ICS patient safety and quality leads

More information on the national PSP programme can be found on the NHS England website:

[www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/](http://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/)

The GHC patient safety risks were identified using:

- analysis of 3 years of Datix incident data, 2019–2022
- detailed thematic analysis of Datix incident data, 2021
- key themes from complaints/PALS/claims/inquests
- key themes identified from specialist safety & quality committees (e.g. deteriorating patient, falls, pressure ulcers)
- output of stakeholder event discussions
- themes from the Learning from Deaths reviews undertaken in 2021/2022
- a review of the Trust corporate risk register.
- a review of 10 years of claims and litigation managed by GHC's legal team and NHS Resolution

Local patient safety risks relating to **national priorities** have been defined as the list of risks covered by national priorities that GHC anticipates will require a response in the next 12 months. Table 1 sets out the full list of national priorities that require a response.

The top **local patient safety risks** have been defined as the list of risks identified through the risk stakeholder approach and the data mining described above. These local identified risks represent opportunities for learning and improvement in the GHC health system. Table 2 lists these top local patient safety risks.

The criteria GHC have used for defining the top local patient safety risks are:

- **potential for harm** – people: physical, psychological, loss of trust (patients, family, caregivers); service delivery: impact on quality and delivery of healthcare services; impact on capacity, public confidence: including political attention and media coverage
- **likelihood of occurrence** – persistence of the risk, frequency and potential to escalate.

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\*GHC aims to incorporate wider patient perspective into future PSIR planning through the introduction of patient safety partners (PSPs).

## 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 thought more likely than not due to problems in care (i.e. incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 sets out the national mandated responses.

Table 1 Nationally mandated responses.

National priority		Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care including the death of a person in receipt of care by serious self-harm	Locally led Care Review Tool
3	Child deaths	Refer for Child Death Overview Panel review Locally led PSII (or other response) may be required alongside the Panel review
4	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review
5	Safeguarding incidents in which: babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. adults (over 18 years old) are in receipt of care and support needs by their Local Authority the incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

6	Incidents in NHS screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: <a href="#">Guidance for managing incidents in NHS screening programmes</a>
7	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provider in which the event occurred with GHC participation if required
8	Mental health-related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead if required
9	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. <i>The Domestic Violence, Crime and Victims Act 2004</i> , sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

## Our patient safety incident response plan: local focus

GHC considers that all of the incident types set out in Table 2 have relevance for all of our patient services. This is an organisation-wide PSIRP and there are no separate PSIRPs for individual services.

Incident type		Description	Response
1	Clinical care	An incident involving sub optimal care of the deteriorating patient	AAR
2	Waiting list for CAMHS services	An incident or severe harm to a young person related to the delay in start of treatment following referral for children and adolescent mental health service (CAMHS) with a moderate or severe mental health condition	PSII
3	Validation of results	Potential for patient harm as a consequence of non-communication and action of diagnostic results	AAR
4	Digital systems	Emerging risks identified as a result of the use of our digital systems	PSII
5	Clinical care	Category 3 and above or unstageable pressure ulcers developed in the community while the person was receiving care from both community nurses and another care provider	AAR
6	Falls	Unwitnessed falls with harm resulting in fracture or haemorrhage requiring secondary care intervention for patients over 80 years of age admitted to our inpatient wards	AAR
7	Medication	An incident involving the misuse or unsafe management of medications leading to moderate harm. For example, opioids, all time critical medications, e.g. Parkinson's medications, anticonvulsants, all antimicrobials, Clozapine and medicines used in the management of diabetes and thromboprophylaxis	AAR
8	Unexpected PSI	Identified increase in incidence of subject or theme which has potential for harm	AAR with PSII
9	Other	Patient safety incidents which meet criteria for harm or potential harm not included in the subjects above	See below

Where an incident does not fall into any of these categories, an investigation and/or review method such as a huddle or AAR may be used by the local team **except** PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

The completion of a narrative response on the Datix incident module is also appropriate.

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## Annex 1: Glossary

**PSII, patient safety incident investigation:** 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.

**PSIRP, patient safety incident response plan:** sets out how we will carry out the PSIRF locally, and includes our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

**PSIRF, patient safety incident response framework:** builds on evidence gathered and wider industry best practice 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.

**AAR, after action review:** method of evaluation 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.

**Care Review Tool:** devised with reference to the questions raised in the NCISSH and guides the reviewer to respond to the parameters most often encountered in death by serious self-harm of a person in receipt of mental health care at the time of their death. The review ensures that all such deaths are reviewed, and the family and staff are involved in the review process.

**PSA, patient safety audit:** a review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline).

**SJR, structured judgement review:** developed by the Royal College of Physicians as part of the national quality board national guidance on learning from deaths; 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 <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

**Never event:** patient safety incident 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](https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf)

**Deaths thought more likely than not due to problems in care:** incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care – using a recognised method of case note review, 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.