Patient safety incident response plan

Effective date: 2nd October 2023

Estimated refresh date: 1st April 2025

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Introduction

This patient safety incident response plan sets out how University Hospitals Derby and Burton (UHDB) intends to respond to patient safety incidents over a period of 12 to 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.

Our services

UHDB is one of the largest hospital providers in the region and nationally, employing 13,000 NHS staff across five hospitals, and at other Derbyshire sites where our staff work. UHDB provides care for over one million patients each year, with an annual budget of over £970 million. Our staff have been working to improve services for local people in South Derbyshire and South and East Staffordshire. This has included investing in more than £50m of infrastructure at Queen's Hospital Burton, expanding our specialist services at Royal Derby Hospital and developing the role of our community hospitals in Lichfield, Tamworth and Derby.

We play a leading role within the healthcare systems across Derbyshire and Staffordshire, especially through the integrated care systems. Along with our partner organisations in the NHS, social care and beyond, our aim is to ensure that all in our communities have the best start in life, live well and age well. These partnerships are the means by which the improvements set out in the Long-term Plan for the NHS will be delivered.

As a university hospital we are a research active Trust and work closely with the National Institute for Health Research and our partner universities in Nottingham, Derby and others. We are also a leading provider of healthcare education from apprenticeships to post graduate qualifications, with our partners at Health Education England (HEE) and with our local higher and further education institutions. Importantly, we are also nationally recognised for volunteering which gives our Trust a warm, friendly, family feel. Our Trust and region are a great place to live, learn and work.

We provide services on five main sites, including the Royal Derby Hospital, which provides general acute and specialist care including complex surgery, radiotherapy, cancer care services and others. Queen's Hospital Burton provides important general hospital services to the communities of Burton and East Staffordshire, including A&E, critical care, inpatient surgical and medical services, paediatrics and maternity care. Queen's Hospital Burton also hosts the Treatment Centre, through which a large proportion of our patients requiring surgery are treated.

We have three community hospitals in Lichfield, Tamworth and Derby providing outpatients services, step-down healthcare of the elderly beds, minor injuries and outpatient services. At the newly renamed Florence Nightingale Community Hospital in Derby we have specialised neuro rehabilitation, at Sir Robert Peel Community Hospital (SRP) there is daycase surgery and endoscopy and at Samuel Johnson Community Hospital (SJ) there is a renal dialysis. We also provide Derbyshire Pathology, an integrated service supporting all NHS organisations including primary care in Derbyshire, delivered in partnership with Chesterfield Royal Hospital.

The Trust has one of the largest planned surgical programmes in the country with the third highest number of elective operations, especially for orthopaedic surgery. The Royal

Derby Hospital is a leading cancer centre and has a world renowned Hand Unit providing specialist care and therapy. In addition, every day our hospitals see more than 4,000 outpatients, nearly 1,000 patients in our busy A&E and Minor Injury Units, and carry out in excess of 400 elective procedures.

The Royal Derby Hospital, incorporating the Derby Medical School and School of Health Sciences, is Derbyshire's only teaching hospital; working in partnership with the University of Derby and the University of Nottingham, educating and training future generations of doctors, nurses and other healthcare professionals. Queen's Hospital Burton also has close links with the University of Wolverhampton and University of Leicester.

Defining our patient safety incident profile

The following describes how the patient safety issues local to UHDB which are included in this response plan were identified.

Our learning having been an early adopter of PSIRF has taught us not to be too broad with the topic chosen. The patient safety incidents described in the local priorities need to be of a specific theme such that thematical analysis is possible.

To identify the patient safety issues for focus within this plan, organisational data for the past 2 years has been reviewed. Our risk management system (datix) was used to identify high level patient safety incident themes, and other intelligence has been used to triangulate and articulate this into a specific problem. The other intelligence that has been drawn on includes learning from complaints, claims, mortality cases, our freedom to speak up guardian and staff survey results.

This triangulation of information was presented at a stakeholder event for multi-disciplinary representatives from each of UHDBs Clinical Divisions: Medicine, Surgery, Cancer Diagnostics and Clinical Support, Women's and Children's Services. Each Division was invited to present their patient safety priorities and describe the rationale for these with qualitative and quantitative data from the past 2-3 years.

This event was hosted by the Medical Director for Quality and Safety, also in attendance was the Director of Nursing, Deputy Medical Director, Head of Patient Safety, Head of Clinical Governance, multi-disciplinary representation from across our Clinical Divisions, members of our corporate clinical governance team and those in specialist interest roles such as tissue viability and falls.

To plan our transition from an early adopter of PSIRF to the now National, version 1 of the framework, we have created a 'PSIRF implementation team' with relevant subject matter experts and representatives from our clinical divisions. This team have reviewed this document prior to publication.

Incident Profile

The following table gives an overview of the historic response activity and is reflective that as an organisation UHDB transitioned from the Serious Incident Framework to an earlier adopter of the Patient Safety Incident Response Framework in November 2020.

	2020	2021	2022
Total Patient Safety Incidents Reported	23,540	25,736	28,307
Report Style			
Serious Incident (SI) investigations (excluding falls and pressure ulcers)	57	4	1
High Level Investigations (HLI) (excluding falls and pressure ulcers)	32		
Falls SI and HLI	44		
Pressure ulcer post harm reviews (Including SI & HLI)	56		
SI framework totals	189	4	1
Patient Safety Incident Investigations (PSII) Local	5	14	14
Patient Safety Incident Investigations (PSII) National	1	20	17
Patient Safety Reviews (PSR)	14	80	53
Total Patient Safety Incident Plans (PSIP) - PSIP Falls - PSIP Pressure ulcers	70 32 29	277 84 192	264 116 152
Early Adopter PSIRF Framework totals	90	391	348
Never Events	2	7	4
Incidents referred to HSIB for independent PSII	7	11	3
IRMER	4	3	0

Data Sources

To understand the patient safety profile across the organisation, themes from across the incidents, complaints and claims modules of the datix system were triangulated using 2 different methods. Datix is a risk management information system which is the platform used to collect and manage data on adverse events. Quarterly data was analysed from quarter 1 2020-2021 to quarter 2 2022-23. This covered April 2020 to September 2022, 2 years and 5 months.

Both methods of analysis resulted in identifying the same 5 top themes:

1. Verbal communication
2. Falls
3. Treatment delays
4. Diagnostic issues
5. Failure to provide adequate care

These identified themes from the datix system, and the presentation of patient safety priorities at the stakeholder event as described, concluded in the exploration of the following themes:

Falls

The UHDB Falls Group have done further work to understand the patient safety incident profile within the theme of 'falls'. The incidents module on datix was used to do this and data was analysed between the periods of April 2021 and February 2023, 22 months. The incident profile is described by whether the fall was witnessed, the location and any activities which were ongoing at the time of the fall (for example activities of daily living), presence of cognitive impairment, supervision underway at the time of the fall, history of falls and describes the actions from the falls care plan.

At UHDB, we use an assessment tool to determine what level of supervision is required for a patient. This tool considers multiple risks which includes but is not exclusive to falls.

Our incident profile indicates that despite identifying patients as requiring 1:1 supervision, patients do still fall. What we do not currently understand, is why.

National guidance is to ensure that there is a multifactual assessment and personalised intervention plan which aims to reduce the risk of falls and may include 1:1 supervision. However, the use of 1:1 care may not always be the most effective option available.

Failure to provide adequate care: Sepsis

Our monthly sepsis audit describes compliance with screening and the subsequent actions that have been taken (the sepsis 6 bundle) for both adults and paediatrics.

At UHDB, we have a sepsis screening tool to identify those who are at risk of sepsis (a red flag).

Despite this, our incident profile describes an emerging theme that patients with sepsis may not get antibiotics prescribed within an hour of this flag (which is the expected standard as per the nationally recognised sepsis 6 bundle).

Giving antibiotics is the most impactful aspect of the sepsis 6 bundle for improving patient outcomes. A prescription is the first step to enable delivery of antibiotics.

Resuscitation

An issue that can be found within multiple categories when analysing themes is that of futile resuscitation. This patient safety issue has been highlighted through a review of the data from our medical examiners office, and our Medical Director for Quality and Safety.

A review of the profile at UHDB has shown that, particularly for our Queens Hospital Burton site, the most pertinent patient safety issue is that a ReSPECT discussion would have been appropriate but did not take place. The ReSPECT form details a conversation between the patient and the healthcare provider. It details what is important to the patient and the treatments they would want in an emergency.

The Resuscitation Group audit of resuscitation team calls at UHDB, and the National Cardiac Arrest Audit, triangulates this information and benchmarks UHDB against our peers nationally.

Our finding that these discussions do not take place, was also a finding in the NCEPOD report "Time to Intervene" which was published in 2012. What as an organisation we do not currently understand, is what prevents these discussions with patients and their relatives taking place, such that when end of life is recognised, this is acted upon.

Defining our patient safety improvement profile

At the time of reviewing the patient safety incident profile to inform this plan, the Learning Review Group, chaired by the Medical Director for Quality and Safety, described the patient safety improvement profile at UHDB. In addition to our monthly Clinical Divisional updates, the following list of groups also attend to update quarterly with a triangulation of themes and trends to provide an overview of the linked improvement activity.

- Diabetes Safety Group
- Point of Care Testing
- Oxygen Safety Group
- Radiation Protection Group
- Sedation Group
- Hospital Out of Hours Patient Safety Issues
- Deteriorating Patient Group
- Sepsis Steering Group
- Transfusion Group
- Thrombosis Group
- Medicines Safety Group
- Discharge Summary Group
- Acute Kidney Injury Group
- Tissue Viability
- Human Factors Strategy Group
- Resuscitation Group
- Screening Group
- Drugs and Therapeutics Group
- Safeguarding and Vulnerable People
- Clinical Guidelines Group
- Tobacco Dependency
- Falls Group
- Patient Experience
- Learning from Deaths

These groups are Trust-wide and reflect patient safety improvement across all of our Clinical Divisions.

UHDB has been working with the Good Governance Institute and from Spring 2023, the governance structure has changed. Patient safety improvement groups now report upwardly into Quality Assurance Committee via the following 'tier 3' groups:

- Clinical Effectiveness Group
- Patient Experience, Engagement and Insight Group
- Infection Prevention and Control Group
- Maternity Improvement Group
- Patient Safety Group
- Children and Young People Group
- Safeguarding and Vulnerable People Group

Reviews from the Health and Care Safety Investigations Branch and NHS England Maternity Support Team have reaffirmed that our patient safety priorities within our maternity services include to ensure compliance against important safety measures. A maternity improvement programme has been commissioned to co-ordinate the workstreams, this is supported with a dedicated project lead and is clinically overseen by an associate clinical director. This improvement work and accompanying improvement plan will be shared and overseen externally to UHDB through the Integrated Care Board.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and feed these into the quality improvement strategy
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
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	Create local organisational actions and feed these into the quality improvement strategy
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	Create local organisational actions and feed these into the quality improvement strategy
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	Create local organisational actions and feed these into the quality improvement strategy
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	Create local organisational actions and feed these into the quality improvement strategy

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	Create local organisational actions and feed these into the quality improvement strategy
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	Create local organisational actions and feed these into the quality improvement strategy
Deaths in custody (eg 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	Create local organisational actions and feed these into the quality improvement strategy
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	Create local organisational actions and feed these into the quality improvement strategy

	and commissioners of health services in relation to DHRs	
Incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
A patient falls who had been identified as requiring 1:1 supervision prior to falling	**Swarm**, to identify learning immediately after the incident and take action to reduce the risk of reoccurrence	Thematical analysis will understand if 1:1 supervision was provided in these cases, and if not, why not. Actions will be developed to understand whether 1:1 supervision is the most impactful action to reduce the risk of falling for this cohort of patients
A red flag for sepsis has been raised, but antibiotics did not get prescribed within the hour	**After action review**, to understand the work as is planned compared to the work as it was done	Understanding work as it is done compared with the available clinical guidelines will identify actions to test to improve compliance with Sepsis 6 bundle and subsequently improve patient outcomes
A do not resuscitate discussion was absent when one would have been in the best interest of the patient	**PSII**, to explore decisions and actions	Actions will be identified and tested so that there is a reduction in the number of patients who experience futile resuscitation following a cardiac arrest. The outcomes following cardiac arrest will improve