Bradford Teaching Hospitals
NHS Foundation Trust

Patient safety incident response plan

Effective date:1 December 2023

Estimated refresh date: 1 December 2024

	NAME	TITLE	SIGNATURE	DATE
Author	Leah Richardson Liz Tomlin	Patient Safety Specialist Head of Quality Improvement and Clinical Outcomes		
Reviewed by	Patient Safety Incident Response Framework Implementation Group			
Authoriser	Ray Smith Karen Dawber	Chief Medical Officer Chief Nurse		

Contents

Acknowledgements

The authors would like to thank the following people for their support and feedback in the development of the Patient Safety Incident Response Plan:

- Executive Directors
- Colleagues and staff from across the Trust
- The Yorkshire and Humber Improvement Academy
- Yorkshire Quality and Safety Research (YQSR) group and Patient Panel

Foreword

Judith Connor
Associate Director of Quality

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 safety and care. Unlike previous frameworks PSIRF is not a tweak or adaptation of what came before. It is a whole system change to how we think and respond when a patient safety incident occurs. PSIRF builds on what we have learnt about safety science from other safety critical industries, thinking about systems, human factors and ergonomics, how we interact with the ever-increasing use of technology as well as the emergence of artificial intelligence and virtual services.

In this complex healthcare landscape, it is crucial that we have a comprehensive plan to address any known potential safety concerns as well as set out how we will investigate safety incidents to ensure that we identify learning to make appropriate improvement. By sharing our findings, speaking with those involved, validating decisions made in caring for patients we will be able to facilitate psychological closure for those involved. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

We have made significant progress over the past 2 years in developing and fostering a restorative just culture in which people feel psychologically safe. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak. PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture where people are confident to speak about patient safety events and to simply express their opinion.

One of the challenges we face is to develop an approach to investigation that facilitates thematic insights to inform ongoing improvement. This has required us to think very differently about our approach to addressing some aspects of known safety concerns. As a result, we have also developed a comprehensive improvement plan to support our teams to explore novel ways of improving these aspects.

Our patient safety response plan serves as a roadmap, guiding our teams to respond effectively and efficiently to any unforeseen circumstances or adverse events that may arise. We see patient safety not just as a priority, but a fundamental pillar of how we deliver

care and services. By implementing this response plan, we are taking proactive steps to minimise risks, prevent harm, and continuously improve the quality of care we provide to our patients. This plan is a testament of our commitment to excellence and our unwavering dedication to putting patient well-being at the forefront of everything we do.

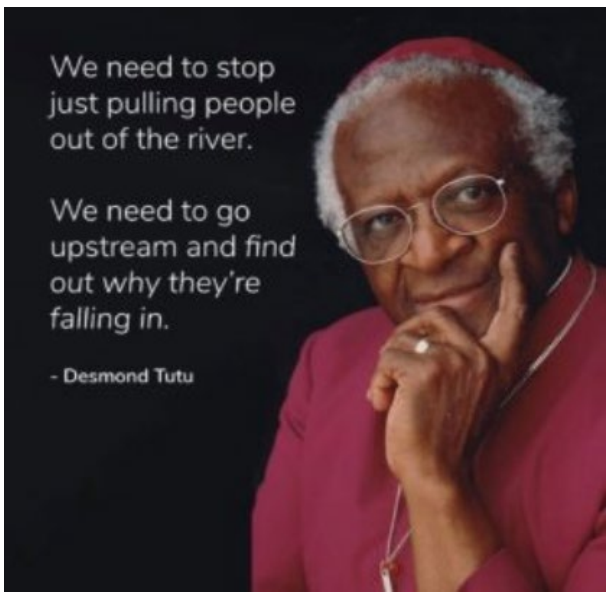
I encourage you to approach this response plan with an open mind and a collaborative spirit. Embrace the opportunity to be creative, think outside the box, and explore new strategies that are innovative and can further enhance patient safety within our teams. We recognise and acknowledge that each member of our team whatever their role plays a vital part in the successful implementation of this plan, and their collective efforts will undoubtedly make a significant impact.

We also see our patients, service users, families and carers as vital partners in this process. They can provide a unique insight into how we deliver care and can help shape solutions to our challenges.

In this ever-evolving healthcare landscape, it will be essential to regularly review and update our response plan to stay ahead of emerging challenges and changing patient needs. By fostering a culture of continuous improvement, we are ensuring that our plan remains relevant, effective, and adaptable to the dynamic nature of healthcare.

I am confident that with our commitment, expertise, and the collaborative spirit of our teams, our patient safety response plan will serve as a beacon of excellence in patient care.

'There comes a point where we need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in.' – Desmond Tutu



Introduction

The Patient Safety Incident Response Framework (PSIRF) sets out NHS England's approach to creating effective systems and processes for responding to patient safety incidents. The aim of this new framework is to improve the safety and experience of care for patients, carers, families, and staff while using our resources effectively. These are aligned to Bradford Teaching Hospitals NHS Foundation Trust (BTHFT, the Trust) overarching corporate strategic objectives (See Figure 1).

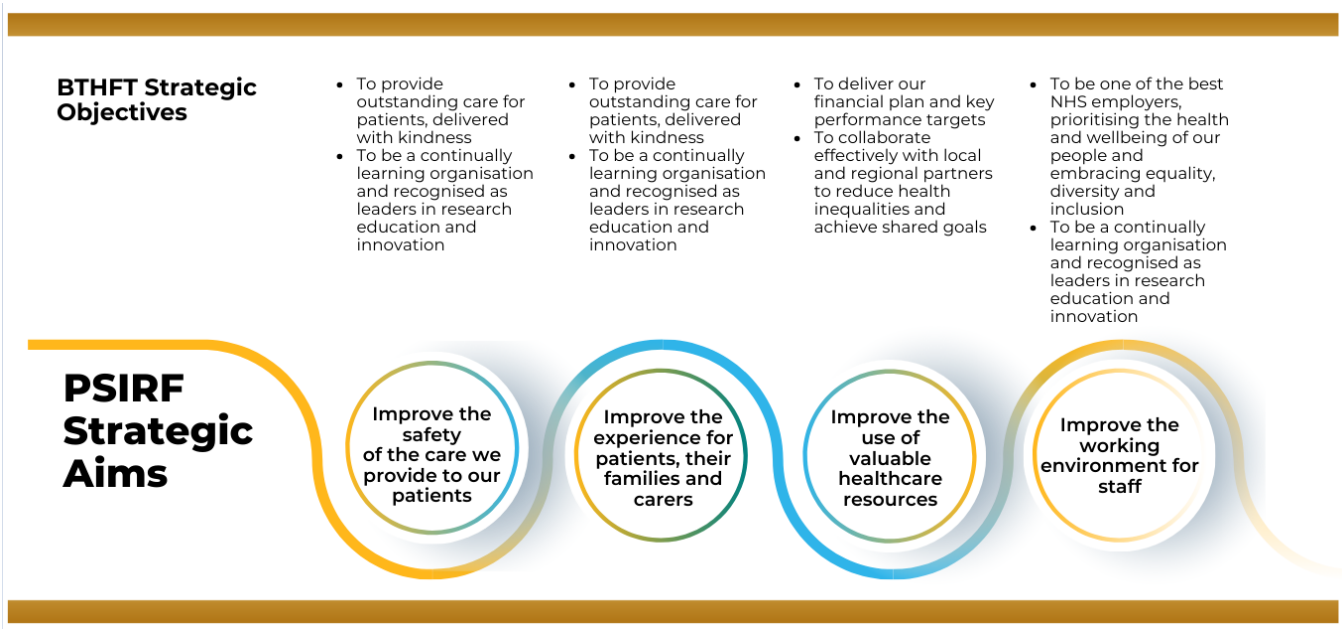


Figure 1 Alignment of PSIRF aims and the Trust's strategic objectives.

This framework will support the Trust to learn from patient safety incidents to help improve patient safety[1]. This means a significant change in the way we respond to incidents and is underpinned by four key principles:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

[1] PSIRF NHS England https://www.england.nhs.uk/patient-safety/incident-response-framework/

One of the main ideas of PSIRF is to do fewer “investigations” but to do them better[1]. This means taking the time to conduct systems-based investigations rather than investigating single events in isolation. This framework gives us the ability to define what we investigate but also how and why. This means that we will continue to investigate individual incidents but also identify and explore themes and trends over time.

In this plan we will describe how we have defined our patient safety incident profile, identified our local focus areas for in-depth investigation and described our approach to our local improvement plan for common patient safety incident types.

Scope

The purpose of the Patient Safety Incident Response Plan (PSIRP) is:

- To describe how we have developed our patient safety profile.
- To describe how we will respond to patient safety incidents for the purpose of learning and informing improvement.

This plan sets out how the Trust will now respond to patient safety incidents.

This plan will be reviewed and updated on an annual basis with a full review at Year 4.

The annual review will incorporate any new learning, any changes to the organisational risk profile and include a review of linked improvement initiatives.

At Year 4, we will conduct a full review of progress. We anticipate PSIRF will become part of the Trust's wider processes and systems to demonstrate learning, improvement and assurance. This is in order to support the Trusts mission statement "to provide the highest quality healthcare at all times".

This plan covers responses to patient safety incidents for the purpose of system learning and improvement. This plan does not cover the responses needed for the following:

- Professional conduct/ competence
- Establishing liability/ availability
- Cause of death
- Coroner inquests
- Criminal investigations

We recognise the significant impact patient safety incidents can have on patients, their families, and carers. For this plan to be delivered successfully we need to ensure we have support structures for patients and staff involved in patient safety incidents. Getting involvement right with patients, families and staff in how we respond to incidents is crucial, particularly to support improving the services we provide. As part of our new policy framework, we are developing procedures and guidance to support staff in how to discuss incidents with patients and family. We are also developing a framework to support staff involved in patient safety incidents whether this is direct or indirect involvement.

Our services

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. We serve a core population of around 550,000 people and provide specialist services for some 1.1 million.

Our Trust is an integrated Trust that provides acute, community, inpatient and children's health services.

In addition to Bradford Royal Infirmary and St Luke's Hospital, our Trust provides a range of services from community sites at Westbourne Green, Westwood Park, Shipley, Eccleshill, Skipton and the Bradford Macula Centre.

We have approximately 630 acute beds, employ over 6,750 members of staff. In 2022/23 our Trust delivered 5,068 babies, performed 16,872 operations in theatre and handled 446,204 outpatient appointments. We had 141,064 attendances at our Emergency Department.

The organisational structure of the Trust includes Clinical Service Units (CSUs) and corporate support services with oversight and support from the Executive Team and The Board (See Figure 2).

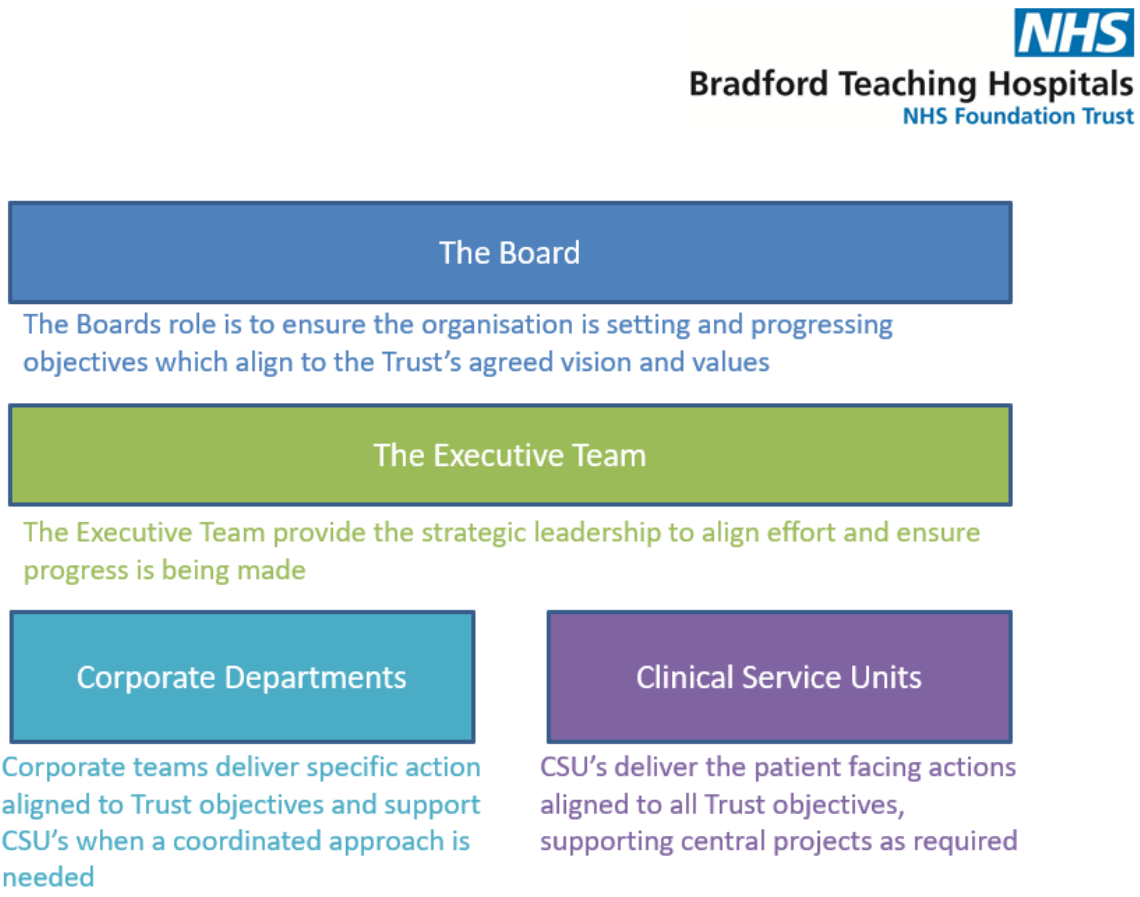


Figure 2 Operational Performance & Accountability Framework at BTHFT

Quality Governance

The quality governance framework seeks to ensure that CSUs can perform effectively, enabling clear information flow, escalation and accountability up and down from ward to Board. This includes, a standardised approach to CSU Quality and Safety monthly meetings that are chaired by the Clinical Director, a set agenda covering all five 5 domains within the Care Quality Commissions regulatory framework.

Our patient safety incident response plan will drive our patient safety agenda as described in our patient safety incident response policy.

Defining our patient safety incident profile

A patient safety incident profile is a list of all the patient safety concerns and issues related to a specific organisation.

The profile will enable us to describe our responses to patient safety events by defining our:

- Patient safety incident local priorities
- Patient safety incident improvement responses
- Our response to national patient safety priorities

At BTHFT a systematic process was used to identify and agree the most important patient safety issues for the Trust (See Figure 2). This process involved:

1. Data collection:

Primary data: All reported patient safety incidents from the Trust's incident reporting and patient safety management system from 1 January 2019 to 31 December 2022

Secondary data: Patient experience (Friends and Family Test (FFT), complaints, compliments, Patient Advisory Liaison Service (PALS), Claims and Litigation, Learning from Deaths from 1 January 2019 – 31 December 2022.

2. Analysis of Data

Primary data: We used a thematic analysis approach to identify patient safety themes. This involved, a health care researcher reading and becoming familiar with the data, identifying codes that related to reported incidents and areas for learning. The codes were then gathered into higher level themes and sub-themes.

The themes were then reviewed against our secondary data sources to check for any similarities and differences at stakeholder engagement events. This was to ensure we had fully explored the organisations safety incident profile, not missed any key issues that had not been captured through the reporting process and to sense check the trustworthiness and validity of the analysis.

3. Stakeholder engagement

We held a range of events to discuss the findings from the analysis. This included;

- Senior Leaders, clinical staff, non-clinical staff, patients, family, and carers
- Staff and public facing information stand within the Trust
- Face to face facilitated meetings
- All wards and departments were visited during the PSIRF roadshow
- Presenting at Trust Board, Consultant Development, Nursing conference, CSU Quality and safety meeting, undergraduate trainee programme, regional PSIRF group

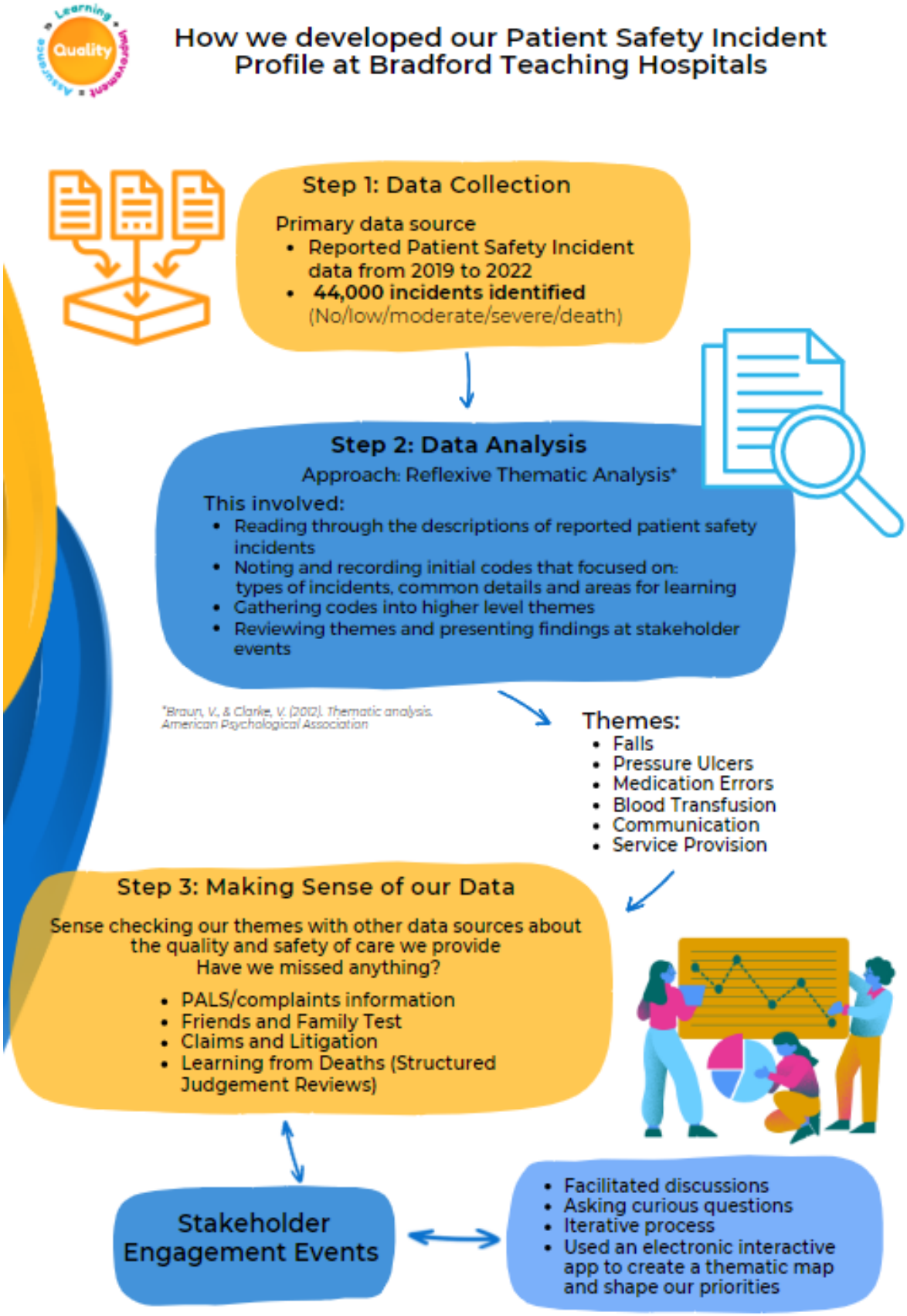


Figure 2 Steps taken to develop and describe BTHFT's Patient Safety Incident Profile

Our patient safety incident response plan: local focus

Following the review of incidents and our stakeholder engagement we have identified two patient safety priorities as our local focus. The principal of PSIRF is about doing less but better, therefore focussing on two key areas will allow us to carry out in-depth investigation responses that are meaningful to our services and people. These are called Patient Safety Incident Investigations (PSII).

Our priority areas are:

1. People (adults & children) admitted in a mental health crisis with medical or surgical needs

2. Safe internal hospital movement of patients

As this is a new framework, we will also consider any emerging patient safety themes where learning and improvement can be gained. Whilst these priorities have been agreed with our stakeholders they are not fixed and are open to review.

Learning response methods (see glossary appendix 1) have been aligned to each of the priority areas. We will use these tools to investigate our priority areas in order to inform our learning and to improve patient safety. These are set out in Table 1 below.

Table 1 Patient Safety Incident Local Priorities

Patient safety Priority area (PSII)	**How we will learn**	**How we will Improve**
People (adults & children) admitted in a mental health crisis with medical or surgical needs.	Individual patient safety incident level we will use an After Action Review (AAR) approach. A thematic approach will look at all of the AAR's to gather system wide learning.	We will use our Quality governance framework to monitor and manage learning generated from our PSII 1 and 2 We will use a range of improvement tools and techniques We will collaborate with our local partner organisations across our system. We will use patient safety audit to monitor systems and
Safe Internal hospital movement of patients	Low and no harm - individual patient safety events we will use a local level investigation Moderate, harm and above	

	- individual patient safety events multidisciplinary Team Review. A thematic approach will look at all the local investigation responses and Multidisciplinary Team (MDT) reviews to gather system wide learning.	processes to provide assurance of patient safety.
Emerging patient safety themes where learning and improvement can be gained	Locally lead PSII	

Defining our patient safety improvement profile

Following the review of incidents with our stakeholders we have identified our patient safety improvement profile. This includes:

1. Pressure ulcers
2. Patient falls
3. Medicines safety
4. Blood transfusion process.

These four incident types have been thoroughly investigated in the past three years. Therefore, we understand the contributory factors and now need to work on our local improvement plans to make sustainable change.

This approach is underpinned by the PSIRF aim of doing less but doing it better. We hope to achieve this by directing our resources towards improvement efforts rather than repeating investigations. Our planned responses for our patient safety improvement profile are described below in table 2.

Table 2 Patient Safety Incident Improvement Response

Patient safety incident theme	Planned learning response	Service improvement work underway or planned
Pressure ulcers	Exploring everyday work - Observations in clinical areas - Conducting interviews with staff and patients	Build a case for improvement plan managed through the Pressure Ulcer Improvement group reporting into the Patient Safety Group
	Daily horizon scanning by the tissue viability team to identify new themes and trends.	Themes and trends reported into Safety Event Group weekly to identify need for a formal Patient Safety Review
	For category 2 and above pressure ulcers ward / department complete local after action review learning response tool.	Ward Level data used to inform local level improvement programmes which will report into the Pressure Ulcer Improvement group to inform insight involvement and improvement.
Falls	Exploring everyday work - Observations in clinical areas - Conducting interviews with staff and patients	Build a case for improvement plan managed through the Falls Improvement group reporting into the Patient Safety Group

	Daily horizon scanning by the falls lead to identify new themes. All falls ward / department completed hot debrief tool. Where further learning is identified a after action review learning response tool will be completed.	Themes and trends reported into Safety Event Group weekly to identify need for a formal Patient Safety Review. Ward Level data used to inform local level improvement programmes which will report into the Falls Improvement group to inform insight involvement and improvement.
Medication Safety	Continued monitoring of patient safety incident records to determine any emerging risks/issues.	Build a case for improvement plan managed through the Medicines Safety group reporting into the Patient Safety Group Themes and trends reported into SEG weekly to identify need for a formal Patient Safety Review
Blood Transfusion	Continued monitoring of patient safety incident records to determine any emerging risks/issues. Transfusion practitioner team work with areas with high safety events to establish the cause and work on an action plan.	Review incident reporting data following the Scan for Safety Implementation Monthly reporting to the hospital transfusion team (HTT) meetings observing open incidents, progress and reviewing themes and trends.

Our patient safety incident response plan: national requirements

Some patient safety incidents will need a specific type of response as set out in other national policies and regulations (See Table 3).

Table 3 National event response requirements

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality 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)		
Incidents meeting the Never Events criteria 2018, or its replacement.		
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 from external referred agency/organisation as required and feed actions into the
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	
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	
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 –	

	organisations should liaise with this	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	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	
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	
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	

Glossary

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.

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.

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Human Factors and Ergonomics

Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings

https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

Multidisciplinary Team (MDT)

An in depth process of review, with input from different disciplines to identify learning from multiple patient safety incidents and to explore a safety theme, pathway or process. To understand how care is delivered in the real world i.e., work as done.

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

PMRT - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;

Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

Pressure Ulcer

A pressure ulcer is damage to the skin and the deeper layer of tissue under the skin. This happens when pressure is applied to the same area of skin for a period of time and cuts off its blood supply. It is more likely if a person has to stay in a bed or chair for a long time. Pressure ulcers are sometimes called 'bedsores' or 'pressure sores'.

Without care, pressure ulcers can become very serious. They may cause pain or mean a longer stay in hospital. Severe pressure ulcers can badly damage the muscle or bone underneath the skin and can take a very long time to heal.

What is a pressure ulcer? | Information for the public | Pressure ulcers: prevention and management | Guidance | NICE

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).

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 to help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response Profile

A patient safety incident profile is a list of all the patient safety concerns and issues related to a specific organisation.

Restorative and Just Culture

Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.

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.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)