Patient safety incident response plan

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# Introduction

The NHS Patient Safety Strategy [available here](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/) was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (2015).

The PSIRF challenges us to think and respond differently when a patient safety incident occurs. PSIRF is best considered as a learning and improvement framework with emphasis placed on the system and culture that support continuous improvement. One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better with a focus on improving quality and safety.

PSIRF recognises the need to ensure we have support structures for patients and staff involved in patient safety incidents. A key part of this is fostering a psychologically safe culture, a ‘Just culture’ where our staff and patients feel confident to speak up when things don’t go as planned.

This document is the Patient Safety Incident Response Plan (PSIRP) for Leeds Community Healthcare Trust (LCH). This version of the PSIRP provides the blueprint of how we intend to respond to patient safety incidents over a period of 15 months (2 Jan 2024 to 31 March 2025). The plan will then be reviewed at least annually and refreshed in line with future fiscal years. This plan details our approach to reviewing incidents in line with nationally defined patient safety priorities and our locally defined safety priorities. The plan will remain a live document and will remain flexible to consider new and emerging patient safety issues.

There is no remit within this PSIRP, or indeed within PSIRF, to apportion blame or determine liability, preventability or cause of death. The responses we will conduct to patient safety incidents are for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resource matters, legal claims and inquests.

# Our services

Leeds Community Healthcare NHS Trust is proud to provide great care to our communities. The Trust provides and/or sub-contracts NHS services that include services from pre-conception to the end of life across many different specialities and professional disciplines. This includes services to promote and maintain health, and to provide care and treatment to manage existing conditions or ill health.

The Trust primarily serves the population of Leeds, in addition to some regional services. Services are delivered within the patient’s home or from a range of sites including health centres, GP practices, hospital sites, schools, police custody suites and HM Prison and secure estate sites.

LCH is commissioned and registered with the Care Quality Commission to provide the following Services:

Table One –Clinical Business Units

|  |  |  |
| --- | --- | --- |
| **Adult Business Unit** | **Childrens Business Unit** | **Specialist Business Unit** |
| * Neighbourhood Teams (Community Nursing and Rehabilitation, HomeWard, Integrated Clinics and Self Management) * Community Discharge and Assessment Team * Continence, urology and colorectal service * End of Life Team * Falls Team * Health Case Management * Neighbourhood Night Service * Recovery Hubs * Tissue Viability * Transfer of Care * Bed Bureau * Wharfdale Recovery Hub | * Integrated Children’s Additional Needs Service (ICAN) * Audiology * MindMate Single Point of Access * MindMate Support Teams * Childrens Community Nursing Service * Children’s Speech and Language Therapy * 0-19 Public Health Integrated Nursing Service * Infant Mental Health * Children’s Community Eye Service * School Aged Immunisations Service * Children and Young People’s Mental Health Service | * Dental * Musculoskeletal * Adult Speech & Swallowing * Podiatry * Wetherby Young Offenders Institute * Adel Beck Secure Childrens Home * Leeds Sexual Health Service * Homeless & Health Inclusion Team * Long COVID Rehab * Gynaecology * Police Custody Suites * Leeds Mental Wellbeing Service * Tuberculosis * Community Stroke Rehabilitation * Community Neurological Rehabilitation * Community Intravenous Antibiotic Service * Diabetes * Liaison and Diversion * Respiratory * Dietetics * Tier 3 Weight Management * Cardiac * Leeds Community Pain Service |

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## **Defining the LCH patient safety incident profile**

## It is recommended that this document be read alongside the Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed: [PSIRF](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/)

To identify our Trust local priorities a review was conducted of the data outlined below within the data section. As part of this we identified incident categories, and then reviewed other data sources against this list. Once all the data had been reviewed, the information was then cross referenced to inform the priorities, identified in Appendix 1.

In accordance with NHS England guidance on developing a PSIRP, we also identified and compared the on-going quality improvement work and quality improvement priorities currently in place for the Trust to inform our decision making on the Trust's local patient safety priorities.

**Patient Safety Priorities Profile**

To inform the Trust priorities (Appendix 1) we have assessed a breadth of data from the LCH Incident Management system (RLDatix ®) and other Trust information systems, which included incidents, complaints, inquests, claims and mortality data (see Table Two and Data review summary table). We also considered our learning from incidents, causal and contributory factors from incident reviews, post infection reviews and safeguarding reviews. The soft intelligence gained through our engagement phase has also been used to inform our priorities.

A period of four years (1 April 2019- 31 March 2022) was used to inform our priorities to include one-year pre COVID-19 pandemic in this first Patient Safety Incident Response Plan. The diagram below depicts the data reviewed.

**Infographic one: Overview of data reviewed**

**Table two: Data review summary:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Incidents**: There were 21,353 incidents recorded during the four-year period. This is broken down by annual incidence within the table below. As expected, the data shows an increase in incidents for the 2020/21 period which coincides with the onset and first lockdown of the COVID-19 pandemic.   |  |  | | --- | --- | | **Year** | **No. of incidents** | | 2019/20 | 4779 | | 2020/21 | 6139 | | 2021/22 | 5065 | | 2022/23 | 5370 |   The highest reported category of incidents, annually and in total, in order, was:   * Skin damage * Patient falls * Medication * Access/ admission/ appointment/ transfer/ discharge * Self-harm * Implementation of care.   On further analysis, although medication was the third most frequently reported incident, quarterly analysis by the medicines management team shows these generally occurred because of a preceding incident, for example, a missed visit. These incidents were predominantly no or low harm incidents (99.5%) with the remaining 0.5% of medication incidents resulting in moderate or major harm. During the period analysed only one incident (0.02%) was identified to meet the Serious Incident Framework (2015) criteria. As these incidents are already subject to a quarterly specialist review, they will not be included as a specific priority.  A detailed review was completed of the access/ admission/ appointment/ transfer/ discharge category. Given the breadth of this reporting category the sub-categories were reviewed and individually these were small numbers of incidents with low / no harm. The category will therefore not be included within specific priorities.  Self-harm was the fourth highest category during the total period. Most of these incidents were related to a Tier Three Inpatient CAMHS provision and incidence reduced when that service was transferred to another care provider in April 2021. However, the Trust continues to support children and young people within our Secure Estate provisions of Adel Beck Secure Children’s Home and HMP Wetherby Youth Offending Institute. Whilst most self-harm incidents are low harm, there can be a cumulative psychological effect on these children that results in moderate or major harm. Therefore, self-harm will be captured as a local Trust priority.  Although most of these self-harm incidents occur within the Secure Estate, the Trust also provide other services i.e. Community CAMHS and Leeds Mental Wellbeing Service, where self-harm is a heightened risk. We will therefore consider self-harm within these other services over the initial term of the plan and consider this within future iterations of the PSIRP. There is no data to indicate this is required within this initial plan.  To ensure learning continues to be captured from incidents resulting in moderate or major harm a local priority will be captured to review all moderate or major incidents for consideration of a Patient Safety Investigation and against the legal Duty or Candour regulation. |
| **Serious Incidents**: There were 261 serious incidents reported for the four-year period, and when cross referenced with the above data 112 (42.9%) related to pressure ulcers, 54 (20.6%) to falls, and 20 (7.6%) for self-harm. |
| **Complaints:** There were 542 complaints during the period that have been reviewed |
| **Claims:** On review of the claims profile over the period, 36% (8/22) of claims related to wound care including pressure damage and 9% (2/22) related to self-harm, the remaining 55% varied. |
| **Inquests**: There were 39 inquests registered with the Trust during the period reviewed. The review of this data has supported the local priority around pressure ulcers and informed the priority for deteriorating patients. |
| **Learning from Deaths**: From the Trust learning from death reports, the key themes from mortality review are early identification of the end of life phase for palliative patients, obtaining end of life anticipatory medication, and ensuring people’s wishes are know for their end of life through advanced care planning. |
| **Risk Register:** A review was completed of the Trust wide clinical and operational risks. There were 117 risks that were reviewed to understand our wider risk profile. Our patient safety priorities will be added as risks to the register. |
| **Freedom To Speak Up:** The Freedom to Speak Up Guardian annual report was reviewed. The Freedom to Speak Up Guardian reviewed concerns from the previous four years. Of 374 concerns, 40 were patient safety related. Information held within the overview provided was assessed to be considered within the identified priorities. |
| **Infection Prevention and Control (IPC) Post Infection Reviews:**  MRSA Bacteraemia:  Three years of Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia data was reviewed. Of the 19 reviews for the 2020-2023 period the identified learning was cross system. Although there were no major specific themes for the Trust, there was some learning around deteriorating patient.    The Post Infection Reviews (PIR) will now fall under the PSIRP and are captured within the local priorities below.  MSSA Bacteraemia:  As an emerging trend Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia will be reviewed in LCH in line with discussions across Leeds during the term of this initial PSIRP. Individual learning will be identified, managed and this intelligence will then inform the 2025 PSIRP.  Escherichia coli (E. coli)\*  All E.coli bacteraemia infections are currently reviewed and a PIR is completed if they occur in an LCH inpatient, where the bacteraemia is cited in Part One of a death certificate or where the Infection Prevention Control (IPC) team identify a specific trend in review findings. This approach will continue and the approach is captured within the local priorities below.  Clostridium Difficile  Reviews for Clostridium Difficile (C. Diff)\* over the three year time period has found both an increasing trend (consistent with national trends) and similar learning to the national learning and therefore they will not inform a PSIRP priority at this stage. Reviews will continue within the IPC team as part of the Trust’s contractual requirements.  \*Due to changing processes during the time period reviewed, the dataset cannot be reliably quantified and therefore qualitative data has been used to inform this version of the PSIRP. |

**Health Equity**

Health equity is a priority for the Trust and we currently consider patient safety incidents against the equity domains for those incidents. At present we have reporting that includes falls, pressure ulcer, medication and access incidents and mortality reviews and these are considered in relation to deprivation, ethnicity, age, learning difficulty, Autism Spectrum Disorder and communication requirements. This is being prioritised also for incidents of deteriorating patient / sepsis. Whilst implementing reporting changes in response to PSIRF we will aim to deliver the ability to assess equity across all patient safety incidents to allow us to identify groups at risk of poor access, poor experiences or poor outcomes to deliver targeted improvements to reduce health inequalities.

Acknowledging patient safety incidents are experienced unequally with increasing evidence of disparities in healthcare outcomes we are also committed to identifying whether and how current patient safety culture and mechanisms contribute to such health inequalities. Each of the Trust wide improvement plans referred to in Appendix 3 will include dedicated actions to ensure we view health inequalities through the lens of patient safety to generate tangible actions for improvement.

**Stakeholder Engagement**

The identification and agreement of our patient safety profile / priorities was a collaborative process that involved the people described in Appendix 2.

The proposed priorities were shared with our stakeholders for their feedback. Our patient safety specialists sought feedback from their respective areas in teams and with individuals including clinical and non-clinical staff. Colleagues were asked whether the safety priorities felt appropriate and were specifically asked, “do you agree with these priorities and what else would you add?”.

**Patient safety incident response plan: national requirements**

The national requirements and how we will respond to these are detailed in Appendix 3.

**Patient safety incident response plan: local focus**

This part of the plan outlines our local priorities for the period 1 January 2023 to 31 March 2025. These priorities are detailed within Appendix 1 and are based on the review of local data as described above.

In relation to the local safety priorities, the Trust will apply one of three principles in the way we will respond to incidents:

1. Where safety issues are well understood and/or improvement plans are well developed, we will ensure the details of the patient safety incident is added to the improvement project and consider no further investigation, with time and people resource focussing on the improvement activity.
2. Where contributory factors are not well understood and/or where local improvement work is still being developed, we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.
3. Where it is not clear if there is further learning in relation to an improvement plan OR where the incident highlights an area for future learning / improvement we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.

For incidents that are not related to local safety priorities but warrant further review we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning, on a case-by-case basis.

For each local safety priority underpinned by a Trust wide improvement plan, we will assess the quality of the improvement plan ensuring it is systems based e.g. ensuring that all known contributory factors have been addressed, and using appropriate data to measure progress. The plans will be signed off by the relevant committees and executive lead.

Ongoing progress against the plans and tracking of subsequent incident trends will be monitored by the relevant improvement group and overseen by the relevant Trust committee.

The table below defines the criteria the Trust will use to decide which incidents require a Patient Safety Incident Investigation (PSII) to be undertaken.

Table Three – PSII criteria

|  |  |
| --- | --- |
| **Criteria for PSII response** | **Considerations** |
| Potential for learning and improvement | * Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding * Likelihood of influencing healthcare systems, professional practice, safety culture. * Feasibility: practicality of conducting an appropriately rigorous PSII * Value: extent of overlap with other improvement work; adequacy of past actions |
| Systemic risk | * Complexity of interactions between different parts of the healthcare system |

**Appendix 1: Local patient safety priorities**

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| --- | --- | --- | --- |
| **Priority** | **Patient safety incident type or issue** | **Planned response / Sampling technique** | **Improvement route** |
| **1.** | Pressure damage with lapses in care causing moderate, major harm or death | Any incident with themes corresponding to the Trust Pressure Ulcer Improvement Plan will be managed via the associated improvement group.  Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, After Action Review (AAR), SWARM huddle, Multidisciplinary Team (MDT) review. | Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes  PSII actions will be added and monitored through Datix.  A quarterly PSIRF newsletter will be distributed to include learning from each improvement group. |
| **2.** | Patient falls with lapses in care and resulting in moderate, major harm or death | Any incident with themes corresponding to the Trust Falls Improvement Plan will be managed via the associated improvement group.  Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT. | Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes  PSII actions will be added and monitored through Datix.  A quarterly PSIRF newsletter will be distributed to include learning from each improvement group  ABU audit  CBU / SBU investigators share with safety team to cross reference with improvement plans |
| **3.** | Implementing care / deteriorating patient resulting in delayed admission to hospital or death | Thematic review of failure to recognise the deteriorating patient (review of incidents from 12 Dec 2023-12 Feb 2024) to inform a new Trust Improvement Plan which will be managed via the associated Deteriorating Patient Improvement Group.  The  Once established, new incidents will follow the approach of Priority 1 and 2. | Trust improvement plan (based on Model for Improvement) actions, monitored through Quality & Improvement Group (QAIG) and escalations to Quality Committee. Escalations outside of this formal route will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). The DDoNQ will receive minutes from each improvement group minutes and sign off each update report to ensure oversight of duplicated learning themes  PSII actions will be added and monitored through Datix.  A quarterly PSIRF newsletter will be distributed to include learning from each improvement group |
| **4.** | Successive minimal harm, self-harm incidents in children and young people within the Trusts secure estate | After ten consecutive low harm incidents (or less if clinical review suggests repeated incidents equate to moderate harm sooner or continued concerns despite weekly review within secure estate) related to the same young person in a secure estate, a moderate harm incident will be reported for the same young person to assess the longer-term impact on their psychological harm. | All self-harm incidents discussed at the weekly secure estate patient safety panel for initial review. This includes HMP staff and LCH Quality Lead. Where assessed as cumulative moderate harm, case will be escalated to LCH Rapid Review.  Appropriate learning response will be determined at rapid review meeting |
| **5.** | MRSA bacteraemia with care involvement from LCH or other Leeds healthcare partner (amended Feb 2024 post pilot PSII investigation) | A PSII will be completed where a PIR would have been completed | Learning and improvement to be determined by PSII and added to Datix to track actions. These will also be aligned with a Trust Improvement Plan if relevant  Learning will also continue to be shared at IPC Committee with a resultant flash report to QAIG |
| **Additional incident management processes:** | | | |
| **6.** | Moderate and major harm incident relating to the clinical triage process in Neighbourhood Teams. | Service led improvement plan. This is expected to be a short-term (<6 months) local plan. If recurrent themes and trends continue this will be considered for future iterations of the PSIRP. |  |
| **7.** | Moderate and major harm incidents (outside of priority 1, 2 and 3) will be reviewed for Patient Safety Incident Investigation consideration. | Initial service level review / learning to be cross referenced against the Trust Improvement Plans and managed in line with principles described in the PSIRP.  A review of the legal requirement for Duty of Candour will be completed for all. |  |
| **8.** | Moderate and major harm incidents relating to meatal tears | Any incident with themes corresponding to the specialist service (CUCS) Improvement Plan will be managed via the ongoing improvement work.  Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 7 with an appropriate learning response tool e.g. PSII, AAR, SWARM, MDT. |  |
| **9.** | IPC will undertake a review of all E.coli sepsis / bacteraemia cases where the patient has died (Part A of death certificate).  Cases meeting either of the following criteria will come to rapid review:   * LCH inpatient, * IPC Team identify a recurrent trend or significant safety concern | Initial IPC review against the relevant Trust Improvement Plan  Where new learning is identified, further review will be through a Rapid Review.  A review of legal Duty of Candour will be completed for all. |  |
| **10.** | Near miss or no / low harm incidents identified to be high risk by the team or via the Business Unit Quality Lead monthly report | Reviewed for learning through a Rapid Review |  |
| **11.** | Near miss, no and low harm incidents | Service level review and response. |  |

**Appendix 2: Stakeholders**

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| --- | --- |
| Stakeholder | Involvement |
| Trust board | The proposed patient safety incident profile (within the PSIRP) was presented to the Trust board for comment and ratification |
| Quality Committee | The proposed patient safety incident profile (within the PSIRP) was presented to the Quality Committee for comment and approval |
| Patient Safety Strategy Implementation Group (PSSIG) | The proposed patient safety incident profile (within the PSIRP) was presented to the PSSIG for feedback and discussion |
| Clinical Business Unit Senior Leadership Teams | The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment |
| Front line staff | The patient safety specialists shared the patient safety incident profile with front line staff for comment.  Staff feedback was also obtained through conversations at third sector event  Q&A drop in sessions were set up as all user invites |
| Patient safety partners | Patient safety partners were involved via their membership of The Patient Safety Strategy Implementation Group. They were also specifically asked to comment on the safety incident profile and the draft Patient Safety Incident Response Policy and plan. |
| Third Sector Partners | Our proposed local and national safety priorities were shared for comment through our Third Sector Partner Groups and through the LCH engagement champions forum. |
| Healthwatch Leeds / Forum Central | The proposed patient safety incident profile was shared for comment |
| Patients | Our proposed local safety priorities were discussed with patients at engagement activities at both health centres and third sector event |
| Leeds office of the West Yorkshire Integrated Care Board (ICB) | The proposed patient safety incident profiles (within the PSIRP) were presented to the ICB for comment and final approval. |
| Partner Trusts | The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment |

**Appendix 3: National patient safety requirements**

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| --- | --- | --- |
| **Patient safety incident type** | **Response** | **Improvement approach** |
| Incidents meeting the Never Events criteria | Patient Safety Incident Investigation (PSII) | Local organisational actions and feed these into the quality improvement activity |
| Death thought more likely than not to be due to problems in care. This can be identified through an incident and / or the learning from deaths process. | PSII | Local organisational actions and feed these into the quality improvement activity |
| Deaths of person who has lived with a learning disability or autism | Refer to Learning Disability Mortality Review Programme (LeDeR ) for independent review of events leading up to the death LeDeR programme. | Respond to recommendations from LeDeR programme |
| Child death | Refer to Child Death Review process. If incident meets the learning from deaths criteria undertake a PSII. | Respond to recommendations from external programme and feed these into the safeguarding strategy as required. |
| Deaths in custody (e.g. police custody, prison) 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 – carry out independent investigations in to deaths and complaints in police custody) or the Independent Office for Police Conduct (IOPC – police complaints watchdog who investigate the most serious complaints and conduct matters) to carry out the relevant investigations. | Respond to recommendations from PPO or IOPC. |
| 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 LCH designated professionals for child and adult safeguarding.  LCH will 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 from external programme and feed these into the safeguarding strategy as required. |
| 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 from external programme and feed these into the safeguarding strategy as required. |
| Mental health-related homicides | Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII, with consideration of any local learning response | Respond to recommendations from external programme and feed these into the safeguarding strategy as required. |
| Incidents that meet the statutory Duty of Candour threshold (Regulation 20) | Will be reviewed on individual incident basis to determine most appropriate response to undertake to meet regulation 20 |  |