Sheffield Teaching Hospitals
NHS Foundation Trust

Maternity Safety Incident Response Plan 2023 - 2025

Approved by the Quality Committee 18/09/2023
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PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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1. Introduction & Purpose

This maternity patient safety incident response plan (PSIRP) sets out how Sheffield Teaching Hospitals NHS Foundation Trust intends to respond to patient safety incidents in maternity. This includes all patient safety incidents occurring in obstetrics and neonatology. The maternity PSIRP, when read alongside the Trust PSIRP and other associated policies and guidelines describes how the Trust will comply with the national Patient Safety Incident Response Framework (PSIRF) (2022) for the purpose of system and organisational learning to improve safety for women and families. It has been written using national guidance and templates.

2. Scope

Patient safety incidents are any unintended or unexpected occurrences which could or did lead to harm of any level for one or more patients. There are many ways in which patient safety incidents can be responded to and this plan covers responses that are undertaken solely for the purpose of learning and improvement. There is no remit to apportion blame, determine culpability, preventability, or identify cause of death, and responses for purposes other than learning (for example including but not limited to: matters relating to complaints, inquests, claims, competence, and capability) are outside the scope of this plan.

This is not a fixed plan that cannot be changed, it will remain flexible and consider the specific circumstances in which patient safety events and incidents occurred and the needs of those affected.

3. Aims and Objectives

The following table sets out the overarching aims of the national PSIRF and the way in which we will achieve this, in order to make the care provided to women and families at Sheffield Teaching Hospitals NHS Foundation Trust as safe as possible.

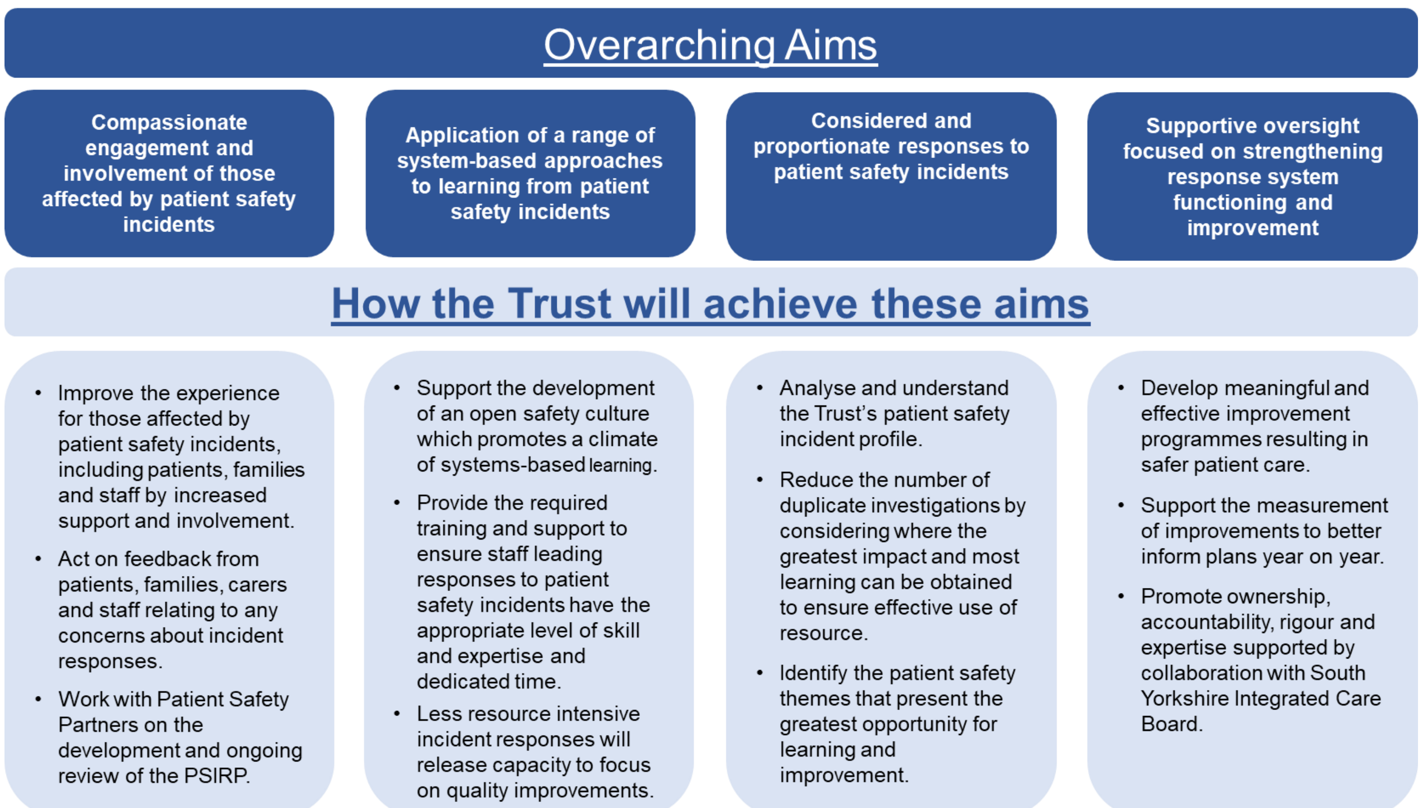


Figure 1

4. Our Maternity Services

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's biggest providers of integrated hospital and community-based healthcare providing a comprehensive range of local and tertiary services to the residents of Sheffield, South Yorkshire, Mid Yorkshire, and North Derbyshire and some highly specialist services to all parts of England.

Maternity care is provided at the Jessop Wing, a purpose-built tertiary referral unit which supports approximately 6000 families a year. The Jessop Wing also provides level 3 neonatal intensive care and special care facilities for sick and premature babies born in Sheffield and those transferred from other units in the region.

Governance arrangements within the Maternity services are in line with the Trust's Quality Governance Policy and Framework, and the Directorate Quality Governance Framework to ensure consistency and effectiveness. This Plan is aimed to compliment and support these frameworks.

5. Defining our patient safety profile

5.1 Situational analysis

A key part of developing the PSIRP is understanding the patient safety profile and related activity. This enables us to plan appropriately and ensure we have the appropriate resources, systems and processes in place to deliver the plan. To provide context the following table details the relevant overarching patient safety data for maternity between January 2020 and December 2022 (three calendar years).

Table 1: Trust patient safety data for maternity (data period: January 2020 to December 2022)

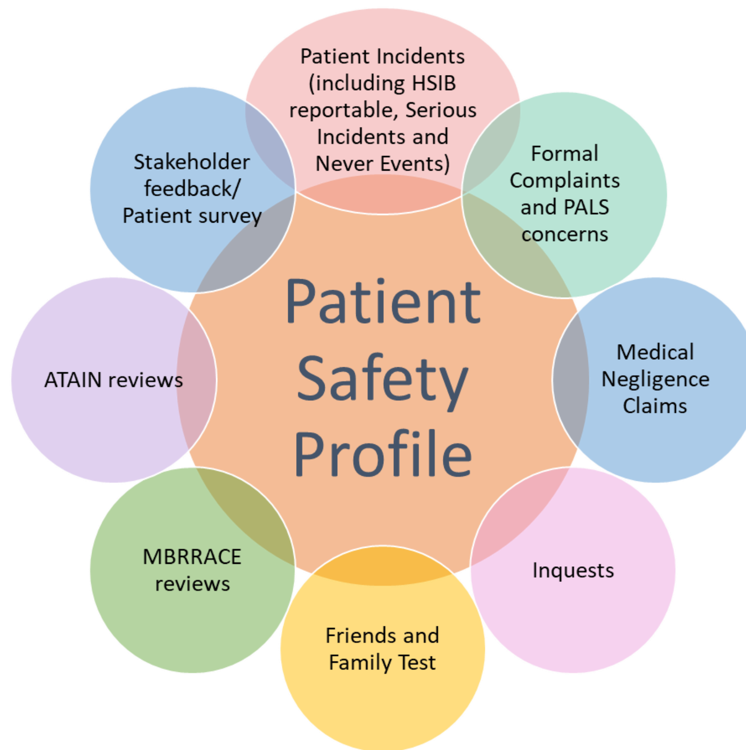
Type of incident	Number of incidents reported
All Patient safety Incidents	4419
Patient safety Incidents resulting in Moderate harm	398
Patient safety Incidents resulting in Severe or Catastrophic harm	45
Patient Safety Incidents reported as a Serious Incident (under SI Framework)	81
Never Events	1

5.2 Thematic Review

5.2.1 Data Sources

A thematic review has been undertaken to understand the incident profile within maternity. Below is a diagram to show the data sources considered as part of the thematic review.

Figure 2



A review of the Trust's Incident Management System (Datix) including looking at subject categories and sub-categories for incidents, complaints, inquests and claims including the CNST claims scorecard reported between January 2020 and December 2022 was undertaken. This enabled themes to be developed (e.g. 'drug related incident' or 'communication issue') and a scoring system weighting issues relating to likelihood and consequence was applied.

As it is important not to rely on quantitative data alone, this data was therefore triangulated with additional qualitative data sources, including Friends and Family Test feedback, and feedback from our stakeholders.

5.2.2. Data assumptions and limitations

When analysing the data sources described above several assumptions regarding the data have had to be made, these have been described in the Trust PSIRF plan. [Link to STH plan to be embedded]

To overcome the data assumptions made during the thematic review, we have included a wide range of patient safety data to help understand the Trust's incident profile. In developing the maternity PSIRP We have also sought feedback from a variety of stakeholders to supplement and provide further information on what the data is showing.

5.2.3 Engagement with Stakeholders

To understand the patient safety concerns of our stakeholders within maternity, we consulted with the following groups.

- Maternity Voices Partnership
- Obstetric anaesthetists
- The maternity triumvirate
- Maternity Quality and Safety team
- Senior Midwifery leadership team
- Race, Equality and Inclusion Network
- SthAbility Group
- PROUDER Network

For future plans, when more time allows, there will be a stronger focus on engaging with women and families and an analysis of incidents stratified by ethnicity, recognising that 28% of women accessing care At Sheffield Teaching Hospitals are non-white British. MBRRACE-UK analysis demonstrates the impact of both deprivation and ethnicity on perinatal and maternal mortality. Improving access to services and tailoring services around the needs of the local population in an inclusive way is part of ongoing work both locally and regionally to reduce inequalities in health.

As we move forward with PSIRF we will be reviewing themes around incidents and ethnicity so we can ensure this is reflected when we review the PSIRP. And workstreams to enable further analysis has commenced.

For this plan, a review of formal complaints, PALS concerns, and Friends and Family Test feedback received by the Trust has been included in the thematic review to ensure inclusion of the views of patients and their families.

6. Defining our patient safety improvement profile

In order to define the Trust patient safety profile, the views of our stakeholders were collated together with the quantitative data and qualitative data sources. Consideration was also given to patient safety improvement projects already underway and the effectiveness of these.
The following themes have been agreed areas with the greatest opportunities for learning and improvement lie. The following themes were identified as common themes across all areas within the Maternity services.

Table 2: Patient safety priorities

Patient safety theme	Description
Unplanned Admission to NNU	All unplanned Term admissions to Neonatal Unit
Failure to follow protocol/ escalate	Failure to escalate fetal monitoring concerns and deteriorating patient
Category 1 caesarean section	Delay greater than 30 minutes for Category 1 Caesarean section
Communication issue	Communication failure within team
Stillbirth/Neonatal Death	Stillbirth/neonatal death occurring in the Jessop Wing

Drug related incident	Omitted drug, wrong dose or frequency
Massive Obstetric Haemorrhage	Antenatal or postpartum haemorrhage over 1500mls
Birthing Injury/ Complication	Perineal trauma with Obstetric Anal Sphincter Injury
Delay in treatment	Delay in acting on Cardiotocograph (CTG)
Missed small for gestational age	Baby born below the 3rd centile when growth issue not identified in pregnancy

PSIRF promotes a range of system-based approaches for learning from patient safety incidents including but not limited to Patient Safety Incident Investigations (PSII's), After Action Reviews and SWARM huddles. Organisations are encouraged to use national tools and guides which have been developed in collaboration with human factors experts and the Healthcare Safety Investigation Branch (HSIB) who lead the way in modern healthcare safety investigation methodology. These will be available in a Trust learning response toolkit, and a training programme in these techniques will be developed. The below table describes the possible response types that could be enacted, although is not an exhaustive list.

Table 3: Possible Response Types

<table>
<tr><th>Response types</th><th colspan="2">Description</th></tr>
<tr><td>Patient Safety Incident Investigation (PSII)</td><td colspan="2">The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks, and work processes involved.</td></tr>
<tr><td>SWARM huddle</td><td colspan="2">A huddle that occurs immediately or as soon as possible after an incident with those involved to encourage open discussion in a blame free environment to identify learning and prevent recurrence.</td></tr>
<tr><td>After Action Review</td><td colspan="2">A structured approach to evaluating an incident by a facilitated discussion meeting.</td></tr>
<tr><td rowspan="3">Multidisciplinary (MDT) team review</td><td colspan="2">An in-depth process of review which aims to identify learning from a number of incidents to explore a theme, pathway or process. And it could be one of these following established forums:</td></tr>
<tr><td>Avoiding Term Admission to Neonatal Unit. (ATAIN)</td><td>A structured MDT review of all term admissions to the Neonatal Unit. Themes identified and action plans are shared quarterly at maternity safety champions meeting and Directorate quality and safety.</td></tr>
<tr><td>Massive Obstetric Haemorrhage (MOH)</td><td>An MDT review of MOH cases to identify learning and themes.</td></tr>
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7. Nationally defined incidents

In addition to local priorities there are a number of patient safety events that fall within the national priority areas. For maternity the national requirements for responding to patient safety incidents in maternity are

detailed below. All late fetal losses, stillbirths and neonatal deaths are reported through the MBRRACE Perinatal Mortality Review Tool.

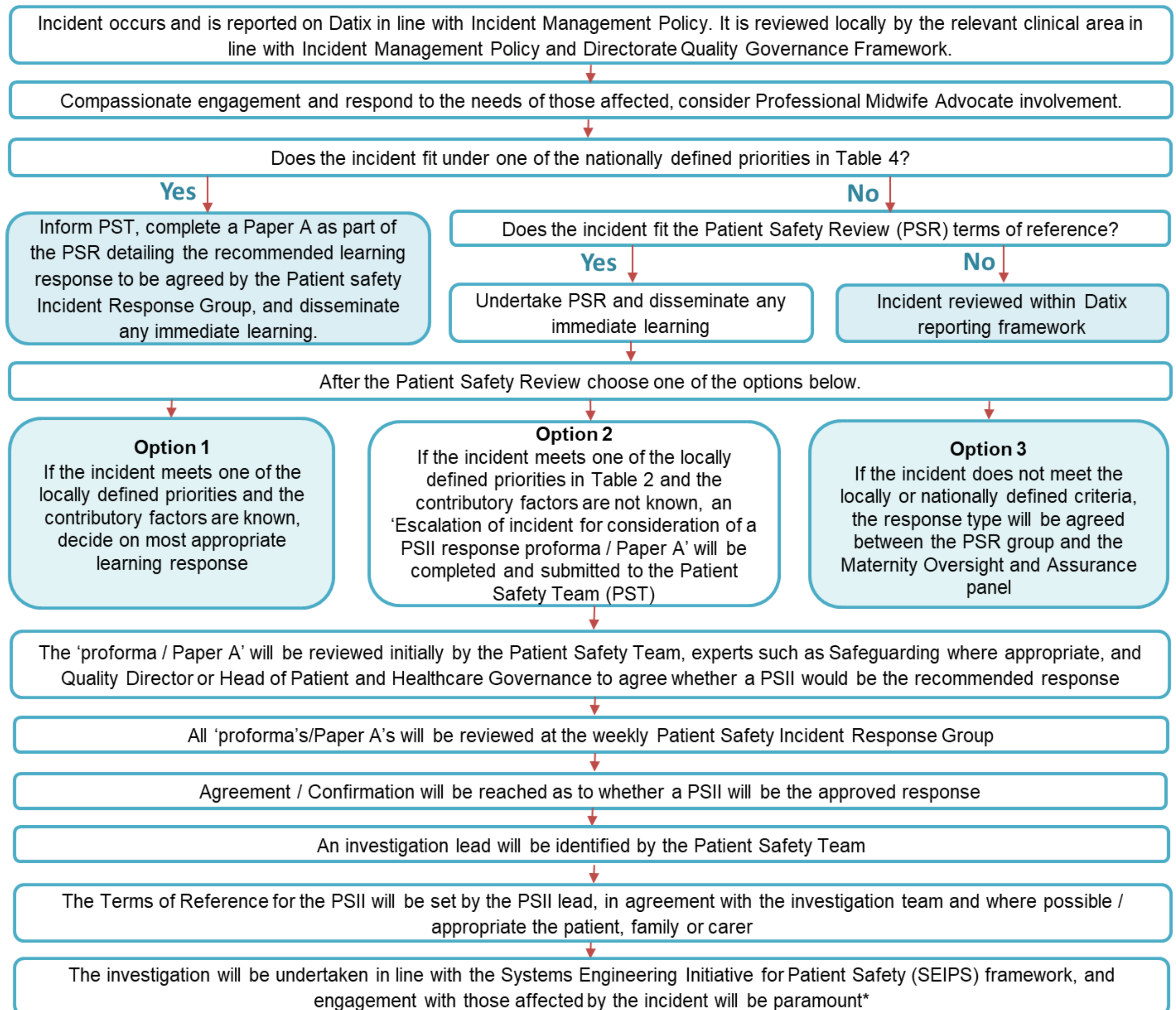
Table 4: Response type for national priorities

Incident type	Required response / additional information
Maternity and neonatal incidents meeting HSIB criteria. This includes: Term babies with the following outcomes-intrapartum stillbirth, early neonatal death, potential severe brain injury unless health issues or congenital conditions (something that is present before or at birth) have led to the outcome for the baby. Maternal deaths-direct and indirect maternal deaths while pregnant or within 42 days of birth unless suicide.	PSII led by HSIB or successor organisation.
Deaths that meet MBRRACE-UK perinatal surveillance. This includes: All late fetal loses and stillbirths (excluding medical termination) and neonatal deaths	Completion of Perinatal Mortality Review Tool within mandated timeframe. Identify and disseminate learning. Where issues in care have contributed to the outcome consider PSII led by the Trust
Incidents meeting the Never Event criteria	PSII led by the Trust.
Deaths more likely than not due to problems in care (incidents meeting the learning from deaths criteria)	PSII led by the Trust.
Deaths of persons with learning disabilities	Learning Disability Mortality Review (LeDeR) panel. PSII may also be required following discussion and agreement with LeDeR panel.
Death of patients detained under Mental Health Act	PSII led by the Trust.
Any child deaths	Child Death Overview Panel review. PSII may also be required following discussion and agreement with Child Death Overview Panel.
Safeguarding incidents	Refer to Local Authority Safeguarding Lead.
Incidents in NHS screening programmes	PSII led by the Trust.
Deaths in custody	Prison and Probation Ombudsman (PPO) or Independent Office for Police Conduct (IOPC). Trust to provide input where required.

In line with the criteria used by the Each Baby Counts programme, all cases of severe brain injury will also be referred to NHS Resolution

8. How we are going to respond to incidents

There are a wide range of responses that can be deployed when a patient safety incident occurs and table 3 describes possible response types. The decision on the appropriate response for each incident, will be informed by this plan, will consider whether the contributory factors are understood and whether it meets local safety priorities in table 2 or national priorities in table 4.



*In line with PSIRF it is important that no arbitrary timescale is applied to the time in which it will take to complete a PSII. However, for the benefit of those affected by the incident every effort will be made for all PSII's to be completed within 60 working days and no PSII will take more than six months to complete.

Please note that any incident that is not considered to meet any of the above criteria but is felt significant enough to warrant escalation to the Patient Safety Incident Response Group can still be discussed with the

Patient Safety Team and the most appropriate route of escalation will be advised. This may include a PSII if the Patient Safety Incident Response Group consider doing so would result in significant learning.

9. Summary

By following this plan, it is anticipated that the Trust will undertake a PSII into 5-10 Maternity incidents per year. This will be made up of incidents selected as part of the locally defined criteria in table 2 or where the Patient Safety Incident Response Group determined significant learning could be gained. This does not include incidents that will be subject to a PSII by HSIB or due to other nationally defined criteria.

This plan will be reviewed in Quarter 4 of 2024/2025, unless it is identified that a review is required sooner.