Sheffield Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan 2023 - 2025

Approved by the Trust Executive Group 12/07/2023
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PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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1. Introduction & Purpose

This patient safety incident response plan (PSIRP) sets out how Sheffield Teaching Hospitals NHS Foundation Trust intends to respond to patient safety incidents. The PSIRP, when read alongside 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 patients. It has been written using national guidance and templates. In line with national guidance a separate plan will be created for Maternity Services.

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 patients at Sheffield Teaching Hospitals NHS Foundation Trust as safe as possible.

Overarching Aims

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

How the Trust will achieve these aims

• Improve the experience for those affected by patient safety incidents, including patients, families and staff by increased support and involvement. • Act on feedback from patients, families, carers and staff relating to any concerns about incident responses. • Work with Patient Safety Partners on the development and ongoing review of the PSIRP.	• Support the development of an open safety culture which promotes a climate of systems-based learning. • Provide the required training and support to ensure staff leading responses to patient safety incidents have the appropriate level of skill and expertise and dedicated time. • Less resource intensive incident responses will release capacity to focus on quality improvements.	• Analyse and understand the Trust's patient safety incident profile. • Reduce the number of duplicate investigations by considering where the greatest impact and most learning can be obtained to ensure effective use of resource. • Identify the patient safety themes that present the greatest opportunity for learning and improvement.	• Develop meaningful and effective improvement programmes resulting in safer patient care. • Support the measurement of improvements to better inform plans year on year. • Promote ownership, accountability, rigour and expertise supported by collaboration with South Yorkshire Integrated Care Board.

Figure 1

4. Our 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. Over 2 million patient contacts are delivered every year by our 19,000 staff through the below services.

Integrated Community Services

As an integrated provider of healthcare services, STH delivers a comprehensive range of adult community and primary healthcare services across the city and within local community hubs to make accessing services more convenient to patients.

The Northern General Hospital

The Northern General Hospital is the home of the city's adult Accident and Emergency Department, which is also one of three Major Trauma Centres for the Yorkshire and Humber region. A number of specialist medical and surgical services are also located at the Northern General Hospital including cardiac, orthopaedics, burns, plastic surgery, spinal injuries and renal.

Royal Hallamshire Hospital

The Royal Hallamshire Hospital has a dedicated regional Neurosciences department including an Intensive Care Unit for patients with head injuries, neurological conditions such as stroke and for patients who have undergone neurosurgery. It also has a large Tropical Medicine and Infectious Disease Unit as well as a specialist Haematology Centre and other medical and surgical services.

Charles Clifford Dental Services

A large dental teaching hospital linked to the University of Sheffield's School of Clinical Dentistry and providing specialist dental services for Sheffield and the surrounding areas. Community & special care dentistry provides dental care in various community settings for patients who do not receive their dental treatment in local dental practices.

Weston Park Cancer Centre

One of only four dedicated cancer hospitals in the country, Weston Park Cancer Centre includes a successful radiotherapy department serving South Yorkshire & Bassetlaw, North Nottinghamshire, and North Derbyshire. It is equipped to support the 6,000 new cases of cancer diagnosed annually in this region, providing outpatient and inpatient care including provision of Chemotherapy and Radiotherapy treatments for patients from across the region.

Networked Services

We are a major tertiary centre for South Yorkshire, Bassetlaw and North Derbyshire and beyond including, Major Trauma, Neurosciences, Stereotactic Radiosurgery, Oncology, Cardiothoracic Surgery, Vascular Surgery and Radiology, Spinal Injuries, Burns, Robotic Surgery, Sarcoma, Ocular Oncology, Hepatitis C, and Plastic Surgery. Complementing the services we provide on our physical estate; we also provide many

services across the broader geography in order that a resilient network of secondary and tertiary services can be delivered as locally as possible for patients.

A fifth of our consultants also work in partnership in local hospitals in particular Barnsley, Chesterfield, Doncaster, Rotherham and Sheffield Children's. Regional networked services include:

- Systemic Anti-Cancer Treatments including chemotherapy and outpatient clinics co-ordinated via Weston Park Cancer Centre
- Neurology
- Cardiology with concentration of Primary Percutaneous Coronary Intervention (PCI), electrophysiology and other complex conditions at the Northern General Hospital and a second complex devices centre based at Rotherham
- On call arrangements for Oral, Maxillofacial Surgery; Ear, Nose and Throat and Ophthalmology services
- Renal dialysis

Jessop Wing

A purpose-built maternity unit that provides a comprehensive range of tertiary maternity services. The Jessop Wing also provides neonatal intensive care and special care facilities for sick and premature babies born in Sheffield and those transferred from other units in the region. It is also home to the Jessop Assisted Conception unit. However as highlighted above, in line with national guidance a separate Patient Safety Incident Response Plan will be created for Maternity Services.

Governance arrangements within the services described 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 the Trust between January 2020 and December 2022 (three calendar years).

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

Type of incident	Number of incidents reported
All Patient safety Incidents	78,792
Patient safety Incidents resulting in Moderate harm	2432
Patient safety Incidents resulting in Severe or Catastrophic harm	738
Patient Safety Incidents reported as a Serious Incident (under SI Framework)	239
Never Events	18
Maternity / Neonatal cases meeting HSIB reporting criteria	28
Deaths more likely than not due to problems in care (incidents meeting the learning from deaths criteria)	8
Deaths of persons with learning disabilities	214

Death of patients detained under Mental Health Act	0
Any child deaths	121
Safeguarding incidents meeting the Serious Incident criteria	1

5.2 Thematic Review

5.2.1 Data Sources

A thematic review has been undertaken to understand the Trust's incident profile. Below is a diagram to show the data sources used as part of the thematic review.

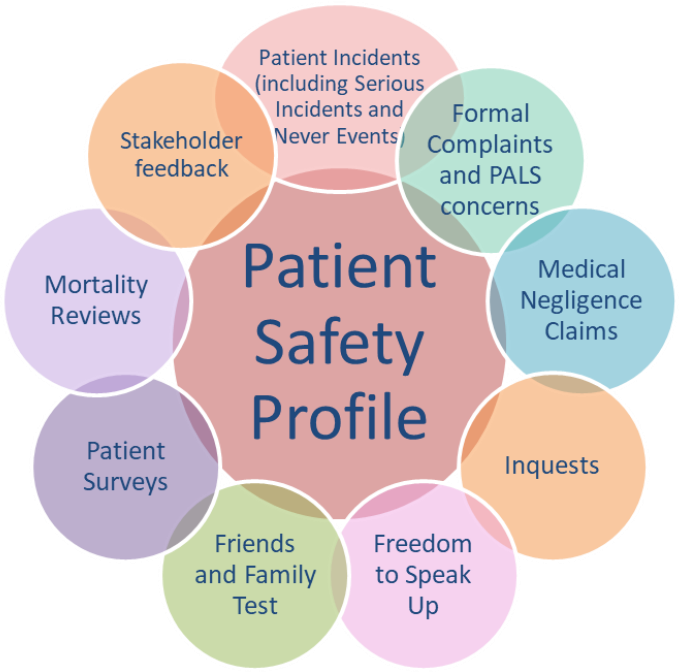


Figure 2

A review of the Trust's Incident Management System (Datix) including looking at subject categories and sub-categories for incidents, complaints, inquests and claims 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, patient surveys, mortality reviews, Freedom to Speak Up data 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, including but not limited to;

- When an incident is reported on Datix, we acknowledge there will be reporter bias in terms of how the incident is described and categorised. There are 378 sub-categories an incident can be assigned to with a degree of overlap between some of the categories.

- The sub-categories for incidents do not neatly align with the sub-category options for other modules on Datix (Complaints, inquests, and medical negligence claims). A pragmatic approach was taken as to which categories aligned appropriately across the modules.
- Friends and Family Test data is broken down into themes, however these are very broad and do not align with the sub-categories on Datix. As such, the top negative themes, and negative words for each area (A&E, Inpatients, Outpatients and Community) were included in the review process.
- We do not routinely collect data on all protected characteristics, however as part of the engagement process, we have engaged with relevant staff forums to consider how the protected characteristics influence health inequalities to ensure these are reflected in the priorities set.

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. 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, we consulted with the following groups.

- Safety and Risk Forum members which has Trust wide representation.
- Medical Quality Leads
- Nurse Directors
- Clinical Directors
- 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 our patients and their families, and wider stakeholders including the Integrated Care Board. For this plan, a review of formal complaints, PALS concerns, patient surveys 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. In addition, there will be an increased focus on health inequalities and the consideration of patient safety incidents that affect some groups more than others.

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 and where the greatest opportunities for learning and improvement lie. The following themes were identified as common themes across all areas.

Table 2: Patient safety priorities

Patient safety theme	Description
Medication related	Time sensitive medications delay
Communication	Sharing of critical information during handovers or patients cared for on shared pathways
Appointment issues	Delay in Outpatient appointment due to process issue

Infection Control	Control measures not followed
Medical Records	Data entry or transcript error
Discharge	Inadequate or missing information
Delay in treatment	Delay in treatment caused by process error
Diagnostic result issue	Delayed result or result not available
Issue with Specimen	Specimen processed incorrectly, or mislabelled by ward
Admissions	Patient crowding in Emergency Department
Falls	Where the contributory factors are unknown *(to be identified by the Inpatient and Community Falls Review Meeting process)*
Pressure Ulcer and Skin Damage	Where the contributory factors are unknown *(to be identified by the Pressure Ulcer Review Group meeting process)*

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 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

Response types	Description
Patient Safety Incident Investigation (PSII)	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. 10-15 incidents will be selected from the themes in table 3 a PSII over 1 year by the Patient Safety Incident Response Group *(current SIG - name to be confirmed). Those selected for a PSII would be where there was felt to be significant learning; where there already is effective improvement work, eg falls, it would only be considered for a PSII if requested by the Falls Group.*
SWARM huddle	A huddle that occurs immediately or as soon as possible after an incident with those involved to encourage open discussion in a blame fee environment to identify learning and prevent recurrence.
After Action Review	A structured approach to evaluating an incident by a facilitated discussion meeting.
Multidisciplinary (MDT) team review	An in-depth process of review which aims to identify learning from a number of incidents to explore a theme, pathway or process.
Inpatient and Community Falls Review Meeting process	A review of individual cases by subject matter experts.
Pressure Ulcer Review Group meeting process	A review of individual cases by subject matter experts for those not selected for a PSII.

7. Nationally defined incidents

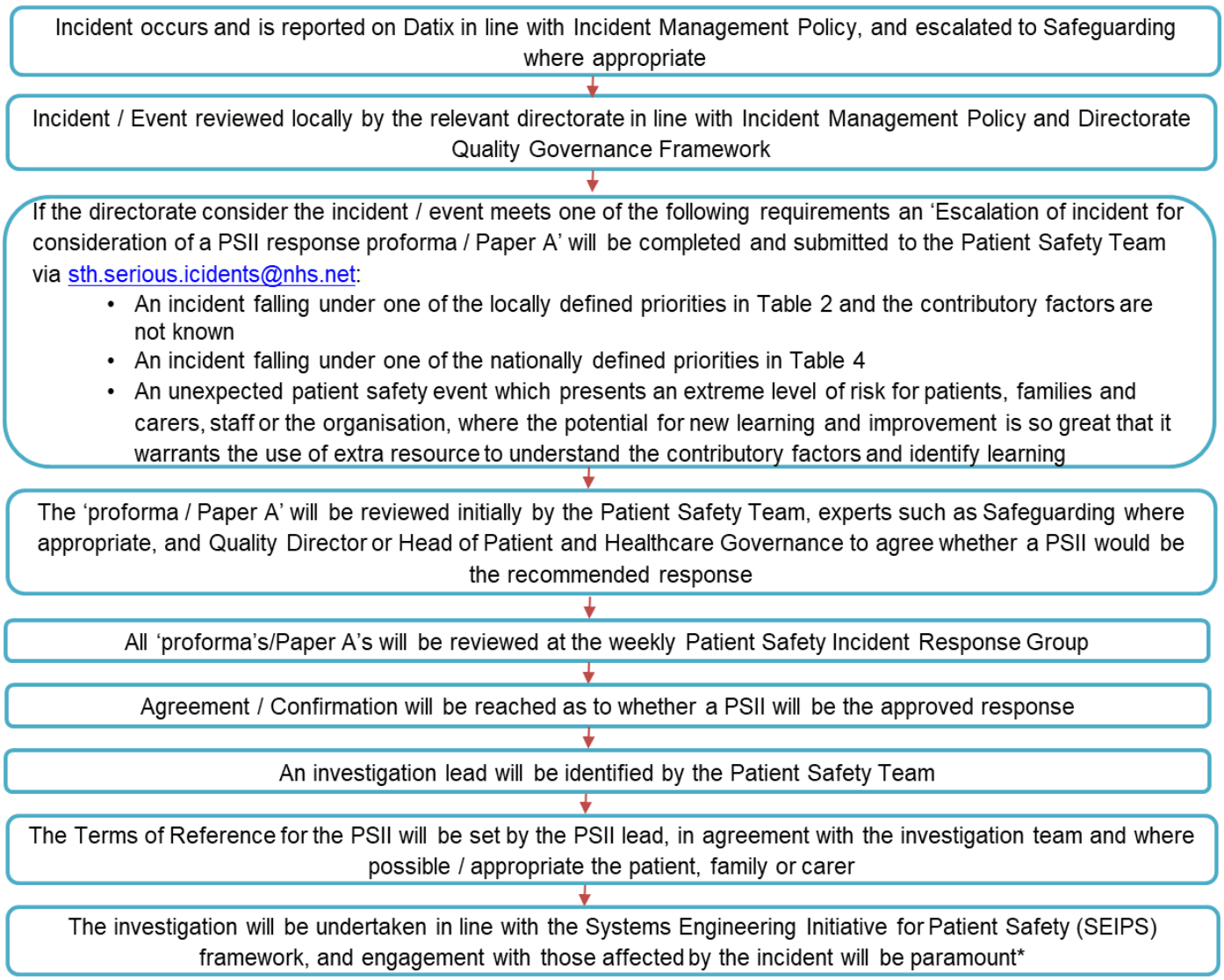
In addition to local priorities there are a number of patient safety events that fall within the national priority areas. The table below lists those relating to secondary acute care providers (adult services) for which it is mandated that a PSII will be completed. The PSII may be carried out by the Trust or an external body and this is described below.

Table 4: Response type for national priorities

Incident type	Required response / additional information
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.
Maternity and neonatal incidents meeting HSIB criteria	PSII led HSIB or successor organisation.
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.

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 20-30 incidents per year. This will be made up of 10-15 from those incidents selected as part of the locally defined criteria in table 2, an anticipated 5-10 incidents from those in the nationally defined criteria described in table 4 and a possible further 5 where the Patient Safety Incident Response Group determined significant learning could be gained.

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