NHS
The Leeds Teaching Hospitals
NHS Trust

Patient Safety Incident Response Plan

2024-26

Patient Safety
LTHT

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The Patient Safety Incident response Plan 2024-26 has been reviewed and authorised by the Quality Assurance Committee and the Trust Board. The Plan has been approved by the Leeds Health and Care Partnership.

For any queries about the plan please contact leedsth-tr.patientsafetyspecialist@nhs.net

Effective date: **1 April 2024** Estimated refresh date: **31 March 2026**

FOREWORD

As an early adopter of the Patient Safety Incident Response Framework (PSIRF) the Trust implemented its first Patient Safety Incident Response Plan (PSIRP) in April 2022. This clearly defined our local priorities, revised methods of review and most importantly the opportunity to not just focus our resources on the level of harm, but the opportunities for learning from a patient safety event.

Since I commenced in post in 2023, we have had time to reflect on the previous plan, engage with the new language and consider what is next for the Trust. We have engaged with our staff, subject matter experts, stakeholders and patients to develop our plan for 2024-26. We have taken time to understand what matters most to our patients, their families and staff involved in a patient safety event and in 2024-26 we will focus on enhancing the support we provide to these individuals and reframing our language further.

In 2023 the Trust also published its 7 Commitments of 2023/24, some of which are being shaped by our revised specialised review processes to reduce the burden on staff undertaking reviews and to maximise patient safety and experience as well as learning opportunities.

I would like to extend my thanks to our patients, staff and stakeholders that have helped us to develop our plan.

Dr Magnus Harrison

Chief Medical Officer and Executive lead for supporting and overseeing implementation of the national Patient Safety Incident Response Framework within the Trust.

1 INTRODUCTION

This Patient Safety Incident Response Plan (PSIRP) sets out how **Leeds Teaching Hospitals NHS Trust (LTHT)** will respond to patient safety events during 2024-2026. Whilst the plan sets out priorities and approach, there may be changes during this period.

We will remain flexible, consider the specific circumstances in which patient safety events occurred, how we can respond to improve our services, and focus on the needs of those affected.

2 OUR SERVICES

Leeds Teaching Hospitals NHS Trust is one of the largest and busiest NHS acute health providers in Europe, a regional and national centre for specialist treatment, a renowned biomedical research facility, and the local hospital for the Leeds community.

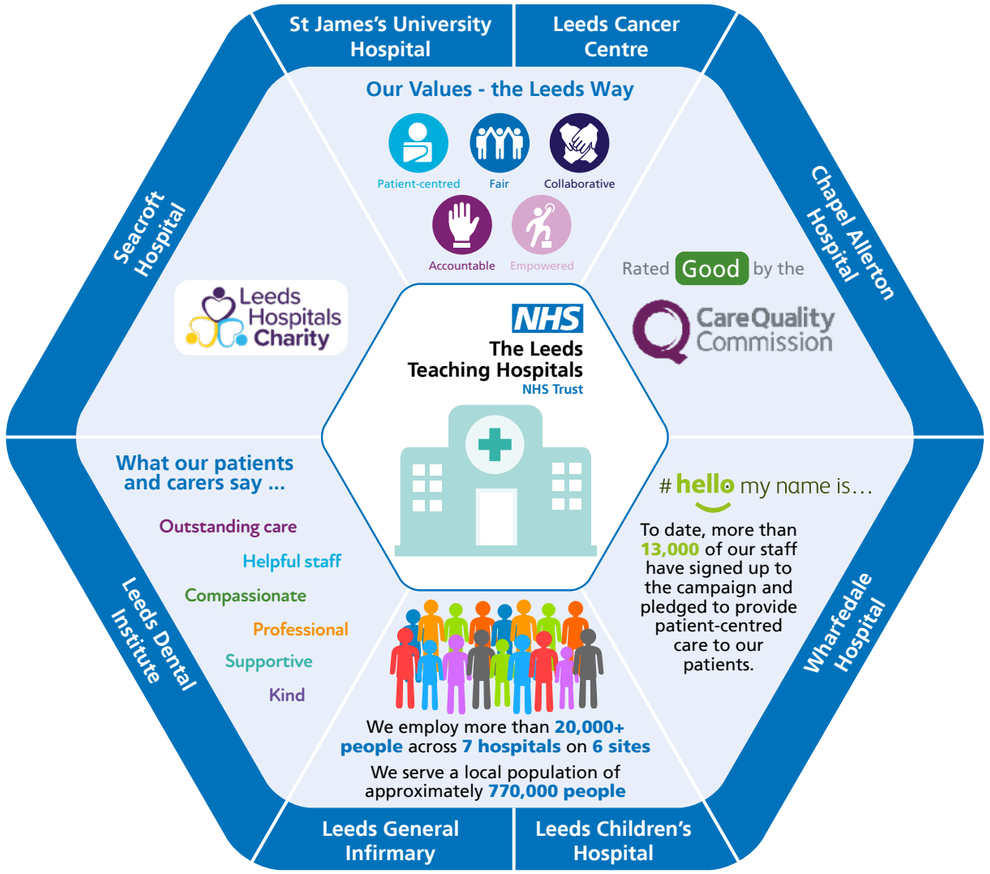
Each year we treat around 1.5 million patients across seven hospital locations:

- Leeds General Infirmary
- St James's University Hospital
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital
- Leeds Children's Hospital
- Leeds Dental Institute

We provide local and specialist services for our immediate population of 770,000 and regional specialist care for up to 5.4 million people.

The Trust spends around £1.34 billion of the NHS budget, treating illness and disease in Leeds and on specialised services for people across Yorkshire, Humber and beyond. The Trust employs more than 20,000 staff, working with academia and industry to play a leading role in education, research and innovation.

The Trust plays an important role in the training and education of staff, including medical, nursing, dental, allied health and medical science students. We are a centre of world-class research, pioneering new treatments.



Our Vision

We provide the highest quality specialist and integrated care

Our Strategic Priorities

- Develop integrated partnership services
- Support and develop our people
- Focus on care quality, effectiveness and patient experience
- Deliver continous innovation and inclusive research
- Ensure financial stability

Our Values

In 2022 our staff came together to share thier views reflect, connect and commit to The Leeds Way. Our newly simplified behaviours better reflect what staff told us was missing. This includes compassion and kindness towards each other, working as one team towards common goals and speaking up to respectfully hold ourselves and each other to account. From this we created ***Living The Leeds Way***

Patient-centred

We act with compassion, empathy and kindness towards those in our care and to each other.

We consistently deliver high quality, safe and dignified care, focusing on individual needs.

Fair

We seek to understand the perspective of others, respecting and embracing our differences.

We champion inclusivity by prioritising fairness & equality.

Collaborative

We are all one team with a common purpose and value the contribution of others.

We work in partnership with our patients, their families and carers, our colleagues and other providers.

Accountable

We keep our promises, agree clear expectations and will speak up to respectfully hold ourselves and each other to account.

We are true to our word and act with integrity and honesty with our patients, colleagues and communities.

Empowered

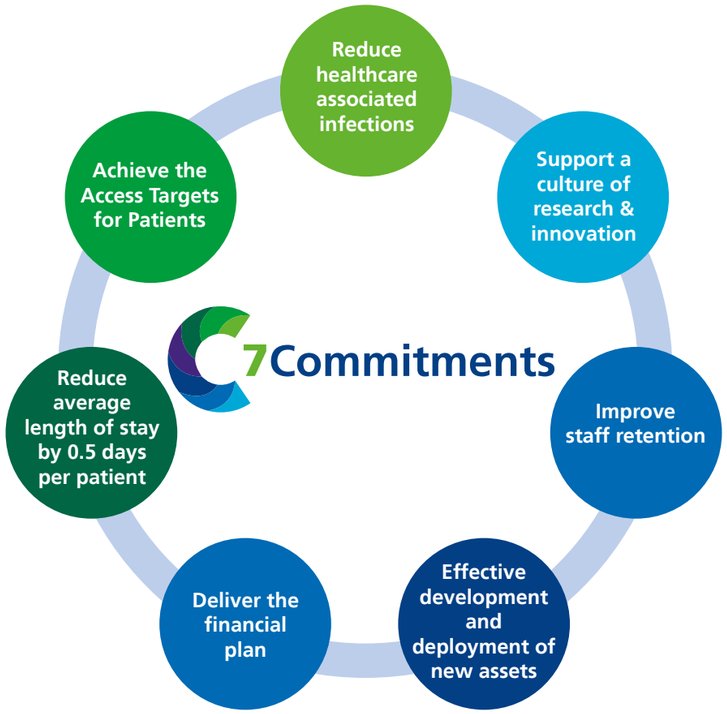
We empower our patients and colleagues to have a voice and make decisions, and are considerate of their choices.

We celebrate innovation, and we take personal responsibility for our learning.

Our Multi-year Goals

- Deliver a sustainable financial surplus by becoming the most efficient teaching hospital
- Deliver fit for purpose healthcare infrastructure
- Deliver high quality holistic healthcare
- To be a leading academic healthcare institution
- To have an embedded culture of service improvement & innovation
- To have a consistent, high performing and sustainable workforce
- People receive person-centred care in the most appropriate environment and setting

Our Annual Commitments for 2023/24



3 DEFINING OUR PATIENT SAFETY CULTURE

We continue to be committed to promoting an environment that fosters positive patient safety, including supporting a just culture approach through our people priorities.

A key priority within the Trust 7 commitments for 2023/24 is to support a culture of research and innovation. This is a key priority that is closely aligned to PSIRF. Our focus is to encourage an innovative learning environment which will help us to deliver sustainable improvements which will result in better patient outcomes and experience.

We will continue to involve patients in there own safety through engaging them in investigations and patient safety reviews. We will also continue to develop the role of the Patient Safety Partners.

4 DEFINING OUR PATIENT SAFETY EVENT PROFILE

The development of our patient safety event profile has been a collaborative process over three stages; data analysis, engagement and consultation.

What is our data telling us?

In order to define our patient safety event profile and identify our priorities for 2024-2026 we have completed a review and thematic analysis of:

- all incidents in the last three financial years
- all complaints in the last three financial years
- Clinical claims
- a review of Trust reports – Learning from Deaths, Clinical Audit report, Nursing & Midwifery Quality and Safe Staffing Report, Quality and Safety review programme, Annual Integrated Incidents, Inquests and Claims Report.
- a review of national reporting, including: CQC The state of health care and adult social care in England 2022/23, and the annual Medical Examiner report.
- a review of all Care Quality Commission (CQC) enquiries received in the last two years
- Considered our 7 Commitments for 2023/24.

The summary below provides an overview of the scale of the review and the analysed data sources. Where possible the Trust reviewed activity between 01/04/2021 – 31/03/2023

279 National priorities requiring review

93,176 Reported safety events

74 Local priorities requiring review

20 Never events

98 Adult safeguarding incidents

60 Mortality reviews

11 Incidents referred for external review

27 Patient Safety Incident Investigations

61 Patient Safety Learning Review

653 Patient Safety Rapid Review

3254 Patient Safety Reviews

448 Healthcare Associated Infections

169 Falls

164 Pressure ulcers

21 VTE

What are our subject matter experts and staff telling us?

In November 2023 we held an engagement workshop with members of corporate and clinical teams to understand:

- What worries us most?
- Where do we think there are opportunities for learning which are not being addressed through other avenues?
- How should we use our resources to respond proportionately?
- How do we prioritise sharing learning across the organisation?

Following this event, we were able, as a Patient Safety Team, to merge the data and knowledge to identify what patient safety events were in an effective process, or one being established, and consider what our future local priorities should be based upon the data, lived experience and opportunities to learn and improve.

How do our stakeholders view our plan through consultation?

In December 2023 we held an engagement event with our stakeholders to present our draft local priorities. The event was hosted by the Chief Medical Officer and Patient Safety Team and attended by representatives from the Integrated Care Board, HealthWatch, Trust Board, Patient Safety Partners, Get Me Better Champions and patients. The draft plan was also shared with CQC.

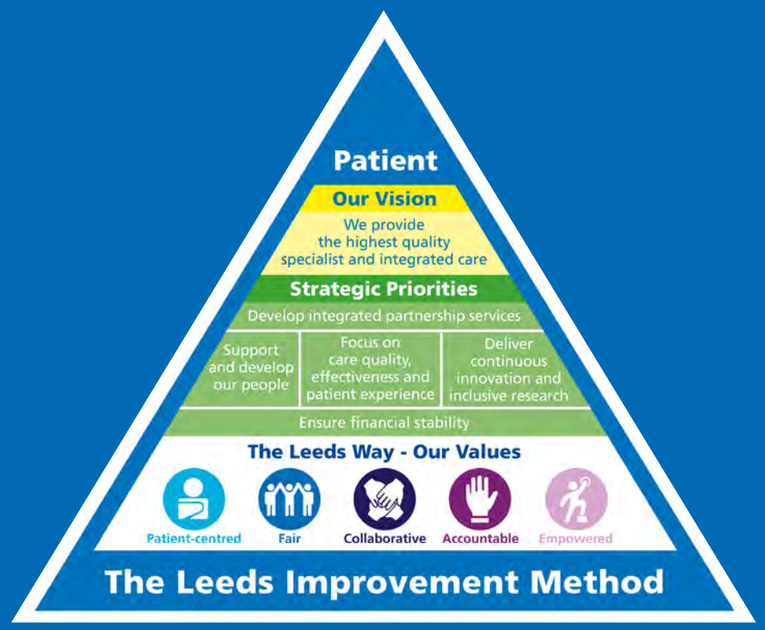
The event gave us the opportunity to ask attendees *'What matters most to them for the people they represent and as potential patients if a patient safety event was to happen'*. This gave us valuable insight in to building on our approach to engaging with patients and their families which will inform our future work.

At the event we also asked attendees to endorse our local priorities prior to us moving forward to a final draft stage. The response was positive and provided us with some key feedback for us to consider in our final plan.

5 DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

The Leeds Improvement Method is integral to the way we do business across the Trust, constantly evaluating our work processes and making changes to improve services for patients and the working environment for staff.

The strategic triangle below shows how our vision, values and goals link together to enable us to provide the best possible care for our patients. All of this is underpinned by the Leeds Improvement Method, spreading a consistent approach to continuous improvement.



Our processes for improvement are described in our Quality Improvement Strategy (2023-2027) and Clinical Quality Strategy (2021-24), Transformational Strategy (2022/27) and Clinical Services Strategy (July 2023). The recommendations from our Patient Safety Incident Investigation and Patient Safety Learning Reviews will flow through these processes linking them indirectly to the Trust's Quality Improvement work.

At the conclusion of a Patient Safety Incident Investigation (PSII) the final report and safety improvement plan will be shared with the responsible CSU, Chief Medical Officer and Chief Nurse and a summary of the key learning points and safety actions included in the report to the Quality Assurance Committee. The improvement plan will be agreed in collaboration with existing Trust quality improvement frameworks or key workstreams. The Trust-wide Lessons Learned Group will also be informed to facilitate sharing of relevant learning across the organisation through the lessons learned bulletin, quality and safety matters bulletins and video.

Improvement plans will be shared with the relevant Quality Improvement Collaborative or Oversight Group to enable delivery of actions, monitoring and evaluation of improvement outcomes. The Quality Improvement Collaboratives will provide reports on progress to the Quality Improvement Steering Group.

The Quality Improvement Steering Group will have oversight and undertake monitoring of all improvement plans created following a PSII. The Quality Improvement Steering Group reports to the Trust Quality and Safety Assurance Group. The group promote a positive culture of continuous learning and improvement using Leeds Improvement Methodology to facilitate Trust-wide learning and improvement.

Monitoring through the use of audit will be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared and implemented with other areas of the organisation and peer organisations.

6 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Given that the Trust has finite resources for patient safety event response, we intend to use those resources to maximise improvement. PSIRF enables us to use this resource to focus on improvement, rather than repeatedly responding to and reviewing patient safety events based on thresholds and definitions of harm that can often be subjective. This is important as reviewing a number of similar events will result in very limited new learning, whereas focusing on improving systems, including those that impact on the wider Trust will bring greater benefits for patients and staff.

Some patient safety events, such as Never Events and deaths thought more likely than not to be due to problems in care, will always require a specific type of response as defined by national policies or regulations, such as a Patient Safety Incident Investigation (PSII), to learn and improve. For other types of events which may affect certain groups of patients, for example children, a nationally defined response will also be required. These responses may include events being referred to, or reviewed by, a team or body outside of the organisation, depending on the nature of the event and the people involved. The Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

Table 1: National Incident Response Requirements

Incident	Action requires	Lead Body for response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII	The Trust
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)	Locally-led PSII	The Trust
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII	The Trust
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	RIIT
Maternity and neonatal incidents meeting the criteria for the Maternity Newborn Safety Investigation (MNSI) programme	Refer to MNSI for independent review	MNSI
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	Child Death Overview 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	LeDeR programme

Incident	Action requires	Lead Body for response
Safeguarding incidents in which: • **babies, children, or young people are on a child protection plan; looked after plan or a victim of willful 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 Female Genital Mutilation (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	Refer to local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	As defined by NHSE screening programme	NHS England
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	PPO or IOPC
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	CSP

7 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

In line with our PSIRF policy local responses will conform broadly with the plan outlined below. We will maintain the flexibility to adjust our approach. The key decision-making assumptions that have informed both our plan and will inform our ongoing decision making are:

- The views of those affected, including patients and their families.
- Capacity available to undertake a learning response.
- What is known about the factors that lead to the event(s)
- Whether improvement work is underway to address the identified contributory factors
- Whether there is evidence that improvement work is having the intended effect/benefit
- If we as an organisation and our Integrated Care Board (ICB) are satisfied risks are being appropriately managed.

LTHT considers that all of the event types detailed in Table 1 and 2 have relevance Trust wide. Because of this, this document is an organisation wide PSIRP and there are no separate plans for individual Clinical Service Units.

A summary of tools we will use to generate a learning response is summarised in appendix 2.

Local priority along with planned response and improvement route

These patient safety priorities form the foundation for how the Trust will decide to conduct Incident Investigation (PSII) or another appropriate patient safety review. The Patient Safety Priorities are detailed in table 2 below.

Table 2: Local priority along with planned response and improvement route

Patient safety event type or issue	Planned response	Anticipated improvement route
Failure to recognise, escalate or respond to a deteriorating patient or patient with sepsis	PSII (4 per year selected on opportunity to learn) Thematic review 10 events including 4 PSIIs focusing on collating findings, areas for improvement and action effectiveness	Deteriorating Patient Collaborative Sepsis Improvement Group
Insulin /management of diabetics. Omission of long acting insulin when patients are on a sliding scale within surgical wards	PSII (four per year selected on opportunity to learn) Thematic review of 10 events omitting long acting insulin on surgical wards	E.G. inform ongoing improvement efforts
Anticoagulation. Omission of enoxaparin prophylaxis doses resulting in patient developing a blood clot	Thematic review of 10 events to be repeated in 2026	Medicines Safety Group Thrombosis Steering Group
Impact of birth traumas on patient experience and the person's perception of their labour	Women's CSU - thematic review selected on opportunity to learn and improve patient experience	Once only review using multiple sources of information and patient input Women's CSU Improvement
Any emerging unexpected patient safety event signifying an extreme level of risk and where the potential for new learning and improvement is so great or the consequences of the event may be significant that it warrants a comprehensive PSII response. Any other patient safety event with significant opportunity for improvement or learning including near misses	To be agreed based on the best method to generate timely learning and response	To be agreed on agreement of method of review

Table 3: Planned response to priority patient safety events with potential for improvement

Established process: Events related to the specialist areas below will be monitored and reviewed by the relevant subject matter experts. The specialist teams will be involved in relevant learning responses and have oversight of these. They may steer the appropriate learning response for specific events depending on the level of issues identified. Improvement activity will be overseen by the relevant Trust group.

Patient safety event type or issue	Planned response	Anticipated improvement route
Falls	Specialised improvement review process in place	Falls Collaborative and Steering Group Quarterly reporting to the Quality and Safety Assurance Group
Hospital acquired pressure ulcers	Improvement review process in place	Pressure ulcer Collaborative and Steering Group Quarterly reporting to the Quality and Safety Assurance Group
Healthcare Associated Infections	Specialised review process being developed	Infection Prevention Steering Group
VTE risk assessment and prophylaxis	Specialised review process being developed	Clinical Effectiveness and Outcomes Group
IR(ME)R reportable Events – Radiology and Radiotherapy Events	Patient Safety Learning Review	Ionising Radiation Governance Group
Nutrition related to artificial methods of feeding	Rapid review / learning review for individual cases if moderate or above harm. After Action Review Themed Review Walkthrough Analysis Patient Safety Audit	Nutrition Steering Group
Treatment – delay or cancellation of treatment	Patient safety audit Thematic Review Specialist questions on datix	Quality and Safety Assurance Group
Security – disruptive behaviour, including the use of restrictive interventions	Local Event review	De-escalate collaborative

APPENDIX 1: Glossary of terms

Deaths thought more likely than not due to problems in care

Events that meet the 'Learning from Deaths' (LfD) criteria. These are deaths that have been clinically assessed as more likely than not due to problems in care using a recognised method of case note review. These reviews must have been 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.

Never Event

Never Events are defined as events that are considered wholly preventable. This is because of the presence of guidance or safety recommendations that provide strong systemic protective barriers, available at a national level that should have been implemented by all healthcare providers.

Patient Safety Incident Response Plan (PSIRP)

Our local plan details how we will achieve the PSIRF locally, including our list of current local priorities. These have been developed through a collaboration with key staff, subject matter experts, stakeholders and patients supported by analysis of local data.

Patient Safety Incident Response Framework (PSIRF)

PSIRF is designed to enable a risk-based approach to responding to patient safety events. This framework prioritises support for those affected by events (including patients, families, advocates, and staff), effectively analysing events, and sustainably reducing future risk.

Perinatal Mortality Review Tool (PMRT)

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.

APPENDIX 2:
Learning response types

After Action Review (AAR)

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 events to identify opportunities to improve and increase the instances where success occurs.

Datix Review

A local review documented on Datix which can include specific targeted questions.

Multidisciplinary Team Review

The Multidisciplinary Review (MDT) supports teams to identify learning from multiple patient safety events. It allows them to agree, through open discussion, the key contributory factors and system gaps in patient safety events, explore a safety theme, pathway or process and gain insight into 'work as done'.

Observational Analysis

A method of evaluation of a pathway, process or culture. The observer places themselves within the environment to identify opportunities for improvement or learning.

Patient Safety Audit

The monitoring of systems and processes to provide assurance of patient safety and quality of care across the organisation.

Patient Safety Incident Investigations (PSIIs)

An in-depth review of a single Patient Safety Event or a cluster of events to understand what happened and how (replaces SI/RCAs). Must be completed for Never Events and Deaths thought more likely than not due to problems in care (Learning from Deaths criteria).

Patient Safety Learning Review (PSLR)

A local template that replaced the previous level 2 investigation and incorporates the Yorkshire Contributory Framework.

Patient Safety Rapid Review

Local template which replaced the previous level 1 investigation and uses an SBAR format.

SEIPS framework (Systems Engineering Initiative for Patient Safety)

A framework that looks at Tools and Technology, Tasks, Person, Organisation, Internal and External Environments. Can be incorporated into the tools below.

In line with the philosophy of PSIRF we will flexibly use the approaches outlined above in line with the nature of the event which is being investigated and how it aligns with our PSIRP. Hybrid approaches mixing learning responses will be used as appropriate.

Specialist Review

Local reviews developed to address specific patient safety events e.g. falls / pressure ulcers.

Structured Judgement Review (SJR)

SJR is a systematic, evidence-based mortality review programme that can help drive improvement in the quality and safety of patient care. SJR was developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths and 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, and score, care for each phase.

SWARM

Swarm-based huddles are designed to start as soon as possible after a patient safety event occurs to identify learning. Immediately after an event, staff 'swarm' to the site to quickly analyse what happened, how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning

Thematic systems review

Learning from multiple sources of insight into a patient safety issue.

Walkthrough analysis

Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (eg designing a new protocol).

Yorkshire Contributory Factors Framework (YCFF)

A framework, developed by the Improvement Academy, to consider the contributory factors involved in a patient safety event – used as a basis for reviews within LTHT.

Further information

For further information on Leeds Teaching Hospitals NHS Trust approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety please see our Patient Safety Incident Response Policy.

The Leeds Teaching Hospitals NHS Trust

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