

Progress against the Patient Safety and Quality Strategy 2024-27

Public Board
30 January 2025

Presented for:	Information
Presented by:	Lucy Atkin, Head of Quality Governance
Author:	Lucy Atkin, Head of Quality Governance
Previous Committees:	Quality Assurance Committee, 19 December 2024

Our Annual Commitments for 2024/25 are:	
Reduce wait for patients	✓
Reduce Healthcare Acquired Infections by 15%	✓
Reduce our carbon footprint through greener care	
Use our existing digital systems to their full potential	
Strengthen participation and growth in research and innovation	✓
Deliver the financial plan	
Be in the top 25% performing Trusts for staff retention	✓

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk				
Operational Risk				
Clinical Risk	✓	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving Towards
Financial Risk				
External Risk	✓	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards

Key points	
1. The Patient Safety and Quality Strategy 2024-2027 was approved by the Trust Board in July 2024. It is aligned to the NHS Patient Safety Strategy and its supporting programme of insight, involvement and improvement	Information
2. This report provides the Committee with an update against each key workstream and draws out highlights from the report as well as key priorities for the next six months.	Discussion
3. The Quality Assurance Committee are asked to note the update against the first 6 months of the Patient Safety and Quality Strategy and be assured on the progress that has been made to deliver the priorities set out in this.	To note

1. Summary

The Patient Safety and Quality Strategy 2024-2027 was approved by the Trust Board in July 2024. It is aligned to the NHS Patient Safety Strategy and its supporting programme of insight, involvement and improvement. This report provides the committee with an update against each work stream.

Key achievements in this period are:

Insight

- The Trust implemented Learning from Patient Safety Events (LFPSE) on 1 July 2024, replacing the National Reporting and Learning System (NRLS).
- The Trust respond to patient safety events in line with Patient Safety Incident Response Framework (PSIRF).
- Patient Safety Specialists have delivered Essentials of Patient Safety for Board patient safety syllabus training to the Trust Board
- Patient Safety Specialists have completed the NHSE Level 3 and 4 Patient Safety Syllabus training.

Involvement

- Since implementation of PSIRF the Trust has enhanced the involvement of patients and the families in patient safety incident investigations (PSII), initial feedback from patients and families is that they have welcomed the openness of the Trust.
- The Trust has appointed and supported Patient Safety Partners who act as the patient voice within these Quality Improvement Collaboratives.
- LTHT participate in the Leeds city-wide Patient Voices Group (PVG), which provides a forum for collaboration on large scale pieces of work and an opportunity to share what we are hearing from our patients and the citizens of Leeds
- LTHT are represented at the Quality and People's Experience (QPEC) Sub-Committee that is co-ordinated and led by the ICB, engaging with partners across the system.

Improvement -

- The Leeds Improvement Method (LIM) underpins all of our organisational strategies. It brings the principles of daily management methods, improvement methodology, respectful behaviours and the removal of waste from processes together.
- The Patient Safety Learning Hub was launched in July 2024 as a hub and spoke model of learning from patient safety events, patient experience and audit whilst remaining flexible to consider any source of information that we can enhance our patient safety and quality from. The Hub, although facilitated by Patient Safety Specialists, has a flat structure to build a culture of openness and equity. The membership is made up of representatives from CSUs, corporate teams and support services with an interest in improving safety culture.
- The Trust continues to lead the WYAAT Patient Safety Shared Learning Group, a well-established network to discuss common challenges relating to quality and safety, focusing on sharing key learning points and themes arising from patient safety incident and Never Event investigations.

Priorities for next 6 months

- **Insight** – Development of a patient safety event review education plan. Building on the national essentials of patient safety levels 1 and 2 to develop staffs' skills in the review of patient safety events, develop their use of review tools and investigation skills. The training will be in modules to allow staff to access the training relevant for the level of investigation they are leading.
- **Involvement** – Roll out of a Trust built digital platform to enable CSUs to self-assess themselves against the CQC Quality Statements.
- **Improvement** - The Quality Improvement Collaboratives, whilst still active, are being reviewed to ensure alignment to the priorities within the Patient Safety Incident Response Plan (PSIRP) and Trust mandatory audit programme.

2. Background

Quality and safety are an integral part of the Trust Strategy 2024-26 and our vision to provide the highest quality specialist and integrated care. We are committed to providing outstanding care for all patients, working collaboratively across the health and social care system to support service development and continuous quality improvement.

In order to achieve our goal of being the best for patient safety, quality and experience we work in partnership with our staff, patients, and their families/carers. We respect individual needs and values to ensure that we treat every patient as an individual, deliver the best clinical outcomes, provide a positive patient experience and one which is free from harm.

3. Improving quality and patient safety

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.

Our Patient Safety and Quality Strategy 2024-27 is aligned to the NHS Patient Safety Strategy and its supporting programme of insight, involvement and improvement. Our strategy describes how we will continuously improve patient safety and sets out our key

workstreams under each program and key deliverables for the next three years. This report provides the committee with an update against each work stream.

3.1 Insight

3.1.1 Learn from Patient Safety Events (LFPSE)

We will utilise Datix to implement the Learn from Patient Safety Events service in 2024.

The Trust implemented LFPSE on 1 July 2024. Promotion and testing of the new LFPSE service was provided to staff ahead of launch within the organisation to prepare for the change within Datix.

We will provide training and support to staff to use Datix to report patient safety incidents to promote a positive reporting culture, enabling us to learn.

Datix training is available by self-enrolment to staff at all levels monthly. The sessions are run via Microsoft Teams and cover all aspects of the Datix system, including how to report patient safety incidents, how to report episodes of good care that can be learned from, how to review incidents and how to pull data/learning from Datix. Further support and guidance are available through our Risk Management intranet pages. Bespoke training sessions are also provided to specialty teams upon request to further support staff and provide knowledge of how to collect trends and themes from specific types of incidents within Datix. By collecting trends and themes we are able to share the learning widely across the organisation and within teams.

We will support staff to raise concerns about patient safety and respond to this.

As an organisation we promote a Just Culture that prioritises safety and is open to learning about risk and safety avoiding inappropriate blame when things don't go well. This supports an environment for psychological safety within teams, which in turn encourages staff to raise concerns. We respond to concerns raised using our Patient Safety Incident Response Framework (PSIRF) to review incidents and the systems and processes that lead to patient safety events.

3.1.2 Patient Safety Incident Response Plan (PSIRP)

We will respond to patient safety events and investigate patient safety incidents in line with our PSIRP.

In April 2024 the potential Patient Safety Incident Investigation (PSII) form was revised to include the local and national priorities published in the PSIRP (see PSIRP on page at appendix 1). Departments report patient safety events that meet one of these criteria to the Weekly Quality Meeting chaired by the Chief Nurse and Chief Medical Officer. The level of investigation is agreed based on the defined response in the PSIRP, where an incident is received and is categorised as an emerging unexpected patient safety incident the group agrees the level of investigation based on the opportunity for improvement and learning.

We will identify safety actions and learning from patient safety incidents and share this with staff across the Trust and link this to our improvement programmes.

At the conclusion of a PSII an improvement plan is developed in collaboration with existing Trust quality improvement frameworks, including the Quality Improvement Steering Group, Kaizen Promotion Office (Trust improvement methodology team) and the Quality Improvement Collaboratives.

The Trust also takes identified or early learning from incidents for discussion at the Patient Safety Learning Hub (described in greater detail in section 3.3.4) where members will discuss if the incident could occur in other areas, potential actions to mitigate the risk and agree the best method of sharing key findings with relevant staff.

We will review patient safety incidents that have been reported to identify emerging themes, to agree actions for improvement.

Themes are identified through a number of methods. A thematic review of all patient safety events was conducted in order to develop the priorities in the patient safety incident response plan. This looked at all incidents and complaints in the last 3 financial years, clinical claims, a review of Trust reports, a review of national reporting, a review of all CQC enquiries from the last 3 years and considered these alongside the Trust 7 Commitments.

Another example of a thematic review generating improvement is the Positive Patient Identification Collaborative, which was established following identification of a theme in both incidents and patient experience and is generating improvement actions engaging both staff and patients.

We will provide training for staff to lead on patient safety incident investigations based on the methods set out in PSIRF and support them in this process

The Quality and Risk Team are developing a patient safety event review education plan. The Education Plan will build on the national training - essentials of patient safety levels 1 and 2 and develop staffs' skills in the reviewing of patient safety events, develop their use of review tools and investigation skills. The training will be in modules to allow staff to access the training relevant for the level of investigation they are leading.

3.1.3 Medical Examiner System

We will review all non-coronial deaths to inform where greater scrutiny or patient safety response may be required.

The statutory medical examiner system in England and Wales provides independent scrutiny of all deaths and puts the bereaved family central to the process, offering them a voice and support at what is often a very difficult time. All deaths in any health setting that are not investigated by a coroner will be reviewed by the medical examiner.

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

Medical examiner office is delivered by Leeds Teaching Hospitals and is staffed by a team of medical examiners (ME), supported by medical examiner officers (MEO).

The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local coroner
- identify cases for further review under local mortality arrangements and contribute to other clinical governance processes

We will learn from deaths and share themes emerging from these reviews.

Concerns/themes which are care related will be shared with CSU's directly, or via PALS. We may at times request a further review of the case through local Governance teams.

During the review stage, if any significant issues are identified by the medical examiner, or the family the ME Service alerts the Quality Governance team using the learning from deaths referral pathway. The Quality Governance team will review and action these escalations by requesting a Structured Judgement Review or by escalating to the Risk Management Team to review and advise on most appropriate type of review or investigation required. For more serious concerns risk management or HM Coroner would be notified by the local ME service. These processes ensure that themes and concerns about care are raised and investigated appropriately.

3.1.4 Patient Safety Specialists

We will support the Patient Safety Specialists to develop their profile across the Trust, acting as key leaders within the safety system.

Patient Safety Specialists (PSS) were established within the Trust in November 2020 in response to the NHS Patient Safety Strategy, it is also a requirement within the NHS Standard Contract that each Trust has a minimum of one specialist. The Trust has established an internal network of 14 Patient Safety Specialists who are recognised as key leaders in the safety system and support the Trust's patient safety and quality response. A full list of Patient Safety Specialists can be found in Appendix 2 for information.

Of significance in this period Patient Safety Specialists have delivered Essentials of Patient Safety for Board patient safety syllabus training to the Trust Board.

We will support Patient Safety Specialists to complete the NHS England level 3 and level 4 patient safety training to support the development of their knowledge and skills in this role to support staff in their work.

Eight Patient Safety Specialists are completing the Patient Safety Syllabus level 3 and 4 training being delivered collaboratively between NHS England and Loughborough University. This training is due to be completed by the end of 2024.

3.1.5 Patient Safety Alerts

We will ensure the Patient Safety Alert (PSA) process continues to be implemented, raise awareness amongst staff and clarify the actions that need to be taken by local teams to improve safety.

The Trust has a defined process in place for the management of Patient Safety Alerts in line with the Safety Alert Procedure. All Patient Safety Alerts are managed by a Patient Safety and Quality Manager who leads the Trust response to the alert which includes raising awareness with staff and reporting compliance to the Quality and Safety Assurance Group.

3.1.6 Psychological Safety

We will ensure staff involved in patient safety events are supported.

We are committed to promoting an environment that fosters a positive safety and just culture. The Trust recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place.

Lead investigators of patient safety incident investigations are equipped to signpost staff to support following a patient safety incident and reinforce the principles of just culture and PSIRF during the investigation process. Staff involved with a PSII also receive a copy of the draft report to review and input into.

We will ensure staff are aware of how to raise concerns through Freedom to Speak Up.

The Trust have adopted the national Freedom to Speak Up policy. This is aligned to the NHS People Promise that “we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words”.

In addition to the Trust Freedom to Speak Up Guardian the Trust has a register of over 100 Freedom to Speak Up Champions across all CSUs and corporate services.

The Guardian and champions regularly promote how and when staff should raise concerns through engagement both Trust wide and at local level.

3.2 Involvement

3.2.1 Patient Collaboration and Engagement

We will be open with our patients and their families when a patient safety incident has occurred, keeping them informed about progress and share findings of our investigations.

Since the implementation of the Patient Safety Incident Response Framework (PSIRF) the Trust has enhanced the involvement of patients and the families in patient safety incident investigations (PSII). When a PSII is commenced the lead investigator and the being open lead will liaise with family to invite them to be part of the review process. Lead investigators share the Learn Together Patient and Family Guide produced by National Institute for Health Research with patients and or their families. The level of involvement is set by the patient or their family with the majority wanting to be involved, be consulted on the findings and recommendations and having an opportunity to review and comment on the report before it is finalised. Initial feedback from patients and families is that they have welcomed the openness of the Trust.

The Specialist review processes being developed to investigate healthcare associated infection also includes a bedside review of the incident, which involves the patient and puts them at the centre of the process and learning.

We will use patient feedback to inform our improvement programmes.

The Trust has appointed Patient Safety Partners as active members of the Quality Improvement Collaborative and the Collaboratives that report to it. The Partners act as the patient voice within these collaboratives.

We also use patient and family feedback provided during patient safety investigations to feed into the improvement collaboratives and the Patient Safety Learning Hub.

The complaints team support CSUs with the co-ordination and progress of responses through the complaints process. A Complaints Improvement Programme was commissioned by the Chief Nurse and commenced in July 2024, involving one CSU that was receiving a high number of complaints relating to the care patients received. There is a Kaizen event booked for November 2024 to help drive improvements in the area forward.

We will use a range of patient surveys, the Friends and Family Test and engage with our patient groups across the city to ensure that opportunity for improvements are identified and action is taken.

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services, should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. Data collected through FFT is provided to all CSU by the Patient Experience Team and used to support the various forums across the organisation with improvement programmes and implement changes to care delivery. The feedback is anonymous and is offered in the following methods:

- Online (ward iPad)
- Digital (QR code / weblink)
- Feedback postcards
- Text Messages and IVMs.

LTHT participates in the four national CQC mandated patient surveys – Adult Inpatient, Maternity, Urgent Care and Children and Young People, results are shared with the relevant teams on publication. Local action plans are developed in response to survey results and are reported and monitored as part of the Patient Experience Assurance Programme at the Patient Experience and Engagement Group which meets monthly.

We will engage with partners, including Healthwatch Leeds and the local authority, to seek feedback from patient groups.

LTHT participate in the Leeds city-wide Patient Voices Group (PVG), which includes involvement and engagement practitioners from all the city's health and social care organisations as well as Healthwatch and local 3rd sector organisations. This provides a forum for collaboration on large scale pieces of work and an opportunity to share what we are hearing from our patients and the citizens of Leeds. Current workstreams LTHT are involved in include, 'The Big Leeds Chat', which goes into local diverse community spaces to find out about what matters to the people of Leeds, and the 'How Does it Feel for me' project which hears from patients with complex care needs about what good 'joined-up' care would feel like for people accessing care from multiple organisations.

LTHT are represented at the Quality and People's Experience (QPEC) Sub-Committee that is co-ordinated and led by the ICB, engaging with partners across the system.

We will listen and act on concerns raised about treatment and care by families, supporting the implementation of Martha's Rule in our hospitals.

As part of NHS England's (NHSE) implementation of Martha's Rule in the NHS, NHSE requested expressions of interest from adult and paediatric acute provider sites who already offer a 24/7 critical care outreach capability. The Trust were successful in being chosen as a pilot site for both adults and paediatric critical care. Each pilot has established a task and finish group in order to deliver the 3 proposed components of Martha's Rule which are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Each service is developing a standard operating procedure for parental/family and staff involvement in escalation of care, including implementation of Martha's Rule.

We will review the impact of patient safety incidents on health inequalities and work with partners and patients to address this.

Within our patient safety response, we directly address if there are any particular factors of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

3.2.2 Patient Safety Partners

We will continue to expand the partner programme to help us deliver patient-centred improvement.

There is on-going work to progress the enabling activities required to test a remunerated partner role. This is a new way of working for the Trust and is in response to NHSE's requirements to offer a payment for involvement.

We will provide training and ongoing support for our Patient Safety Partners to enable them to engage in improvement programmes.

When Patient Safety Partners join LTHT they participate in a structured induction which includes Quality Improvement training. As part of induction, they also complete the National Patient Safety training level 1 and level 2. All partners are offered an identified support person in the groups or meetings they join, this enables the partner to have a point of contact if they need any further information or support with the meeting content. Support and bespoke training is provided as needed and reviewed annually.

3.2.3 Regulation

We will work in partnership with the CQC to implement the single assessment framework, underpinned by quality statements and support our staff in this.

Following publication, the Trust has developed a self-assessment for CSUs, corporate teams and Trust wide to support the introduction of the single assessment framework. The Quality Team have developed a digitalised version of this self-assessment which is currently in the pilot phase. The digital platform will allow the Quality Team to look at self-assessed rating across the Trust and by core service and make assessments of areas for improvement, transferrable learning or risks.

We will engage with the CQC through our monthly meetings with the Relationship Owner (RO).

The Trust meet regularly with the CQC Relationship Owner and Operational Manager. These meetings had moved to quarterly in line with the CQC restructure to a single assessment framework and system wide team. At the meeting in October 2024 the Trust requested that the meeting frequency revert back to monthly in order to ensure effective communication is maintained from both parties. The meeting frequency was changed to monthly from November 2024.

The Quality Team have a well established and open relationship with CQC. CQC are notified when the Trust has a significant case, potential for media attention or declaration of a never event.

We will support our staff to meet the fundamental standards and prepare for inspections.

Building on established presentations of the fundamental standards at Quality Governance Forums, CSU Team meetings, preceptorship sessions etc the Quality Team are developing a suite of resources to support staff in understanding the CQC domains and prepare for inspection.

3.3 Improvement

3.3.1 Improvement Strategy

We will support and promote a culture of continuous quality improvement involving all of our staff.

The Trust Improvement Strategy 2023-27 set out the Trust goals and ambitions to continually improve the quality of care and services at Leeds Teaching Hospitals through improvement priorities determined by organisational intelligence of patient safety issues and continual growth and development of improvement skills and capabilities throughout our workforce.

This is being delivered through education and training being available and accessible to all, coaching in improvement being available to any member of staff and each CSU having their own “Improvement Specialist”.

We will use the Leeds Improvement Method to improve the quality and safety of the services we provide for our patients

The Leeds Improvement Method (LIM) is our philosophy of continuous improvement that underpins all of our organisational strategies. It brings the principles of daily management methods, improvement methodology, respectful behaviours and the removal of waste from processes together. The LIM philosophy and principles are at the forefront of this improvement strategy, which is underpinned by our quality improvement principles.

The Quality Improvement Collaboratives, whilst still active, are being reviewed to ensure alignment to the priorities within the PSIRP and Trust mandatory audit programme.

3.3.2 PSIRF Improvement Actions

We will use the Quality Improvement Steering Group to monitor improvement actions and use these to inform our Collaborative programmes.

The Quality Improvement Steering Group meets quarterly to provide senior engagement, leadership and accountability for the Trust’s Quality Improvement Strategy and programmes of work. The Group receive a patient safety incident report, which includes the findings and recommendations of patient safety investigations to consider if any of the action should be considered Trust wide and factored into the collaboratives programme of work. An example of this is the establishment of the Positive Patient Identification collaborative, which arose from a theme being identified within patient safety events related to identification of patients.

3.3.3 Measuring improvement

We will measure quality and safety through national and local qualitative and quantitative data analysis.

The Trust measures quality and safety through data from ward to board through ward metrics, clinical audit and reporting on national and local data sets. The Trust uses SPC charts to track progress overtime.

The Leeds Improvement Method is an integral part of the Trust, constantly evaluating our work processes and making changes to improve services for patients and the working environment for staff. Our vision, values and goals enable us to provide the best possible care for our patients which is underpinned by the Leeds Improvement Method, spreading a consistent approach to continuous improvement.

3.3.4 Sharing Learning

We will be innovative in our approach to share learning to reach staff to improve safety.

The Patient Safety Learning Hub was launched in July 2024. The Learning Hub has established a hub and spoke model of learning from patient safety events, patient experience and audit whilst remaining flexible to consider any source of information that we can enhance our patient safety and quality from. The Hub, although facilitated by Patient Safety Specialists, has a flat structure to build a culture of openness and equity. The membership is made up of representatives from CSUs, corporate teams and support services with an interest improving safety culture. The key ask of members when we review sources of learning and work through required improvements is “who needs to know this and how do we share it?”.

The Trust are also building a network of Patient Safety Ambassadors. The aims of the network are to help make patient safety everyone’s business, share key patient safety messages and start a conversation in the work area. The Network meetings are informal, virtual and open to all members of LTHT staff.

We will engage with partners through the WYAAT shared learning network to identify emerging themes to improve quality and safety.

The Trust continues to lead the WYAAT Patient Safety Shared Learning Group. This is a well-established network to discuss common challenges relating to quality and safety, focusing on sharing key learning points and themes arising from patient safety incident and Never Event investigations, reporting to the WYAAT Medical Directors and Chief Nurse Group.

4. Financial Implications

There are no financial implications within this paper.

5. Risk

The Quality Assurance Committee provides assurance oversight of the Trust’s most significant risks, which cover the Level 1 risk categories clinical and regulatory risks. Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

6. Communication and Involvement

Given the parliamentary elections the Trust strategy and its core strategies, of which the Patient Safety and Quality Strategy is one, did not have an official launch. However, the Patient Safety and Quality Strategy 2024 -27 has been presented at the Quality Governance Forum and Staff Forums and shared through the Operational Bulletin and a screensaver on week commencing 30 September 2024.

7. Equality Analysis

The strategy has been assessed for accessibility and meets the Trust standard.

8. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000

9. Recommendation

The Quality Assurance Committee are asked to note the update against the first 6 months of the Patient Safety and Quality Strategy and be assured on the progress that has been made to deliver the priorities set out in this.

10. Supporting Information

The following papers make up this report:

Appendix 1 – Patient Safety Incident Response Plan 2024-2026 priorities

Appendix 2 – Patient Safety Specialist contact details

Lucy Atkin
Head of Quality Governance
December 2024

Appendix 1



Patient Safety Incident Response Plan (PSIRP) 2024-26

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.

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.

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

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.

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 a range of data sources, listened to what subject matter experts are telling us and shared our plans with stakeholders.



National Incident Response Requirement
Deaths thought more likely than not due to problems in care
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 Never Events criteria 2018, or its replacement
Mental health-related or domestic homicides
Maternity and neonatal incidents meeting the criteria for the Maternity Newborn Safety Investigation (MNSI) programme
Child deaths to be referred to the local Child Death Overview Panel
Deaths of persons with learning disabilities to be referred to the local LeDeR reviewer
Safeguarding incidents to be referred to local safeguarding lead
Incidents in screening programmes to be referred to the local Screening Quality Assurance Team
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS

Local Incident Priority
Failure to recognise, escalate or respond to a deteriorating patient or patient with sepsis
Insulin /management of diabetics. Omission of long acting insulin when patients are on a sliding scale within surgical wards
Anticoagulation. Omission of enoxaparin prophylaxis doses resulting in patient developing a blood clot
Impact of birth traumas on patient experience and the person's perception of their labour
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

Scan or click to view the full PSIRP



Scan or click for further information about patient safety at LTHT



Appendix 2**Leeds Teaching Hospitals Trust Patient Safety Specialists as of 1 October 2024**

Name	Designation	Contact details
John Adams	Medical Director (Governance & Ris	John.adams1@nhs.net
Lucy Atkin	Head of Quality Governance	Lucy.atkin6@nhs.net
Craig Brigg	Director of Quality	Craig.Brigg@nhs.net
April Daniel	Governance and Quality Lead (Maternity Safety)	April.Daniel2@nhs.net
Diane Holden	Patient Safety & Quality Manager	Diane.Holden@nhs.net
Lorna Johnson	Deputy Chief Nurse	Lorna.Johnson2@nhs.net
James Meehan	Patient Safety Incident Response Manager	James.Meehan1@nhs.net
Julie Metcalfe	Patient Safety & Quality Manager	juliemetcalfe@nhs.net
Shona Michael	Head of Clinical Engineering	Shona.Michael@nhs.net
Sharon Morrison	Patient Safety & Quality Manager	Sharon.morrison2@nhs.net
Elaine Robinson	Associate Medical Director (Quality Improvement)	Elaine.Robinson24@nhs.net
Marianne Taylor	Medication Safety Officer	Marianne.Taylor4@nhs.net
Dr Anna Winfield	Specialist Doctor (Quality Improvement)	Anna.winnfield@nhs.net
		Currently on maternity leave
Emma Wright	Patient Safety & Quality Manager	Emma1.Wright@nhs.net

Appendix 3 Patient Safety and Quality Strategy 2024-2027

[Patient Safety and Quality Strategy 2024-2027 – Leeds Teaching Hospitals NHS Trust \(leedsth.nhs.uk\)](https://leedsth.nhs.uk)