Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Salisbury NHS Foundation Trust (SFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach(1) and the rigorous identification of interconnected causal factors and systems issues
b. focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeated patient safety risks and incidents
c. transferring the emphasis from the quantity to the quality of PSIIs such that it increases

improvement(2) of patient safety through learning from incidents demonstrating the added value from the above approach

The plan is underpinned by our trust policies on adverse reporting available to all staff via our SALi.

There are five national strategic aims of PSIRF upon which this plan is based, alongside national strategic objectives. The strategic aims and objectives have been aligned with our own Trust values (see table 1), which describe how we will work towards our strategic priorities of:

x Improving the health and well-being of the **Population** we s8uc Tm0 g371.83 350.93 Tm0 g0 G[ )]TJ

Table 1: National PSIRF aims,

Progressive We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.	Improve the use of valuable healthcare resources Further develop systems of care to continually improve their quality and efficiency.	Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigor, expertise and efficacy.

Our services

SFT is part of the Bath and North-East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). As part of our Trust strategy, services had previously been mapped, hence there was no need to undertake this activity again for the purposes of developing our PSIRP. Our hospital, Salisbury District Hospital (SDH), delivers a broad range of clinical care and services to approximately 270,000 people in Wiltshire, Dorset and Hampshire including:

- Day case services
- Outpatient services
- Women & Newborn and Paediatric services

- Specialist rehabilitation, plastics and burns services - Specialities such as burns, plastic surgery, cleft lip and palate, spinal and our Wessex Rehab unit, extend to a much wider population of more than three million people.

More information on the national PSP programme can be found on the NHS England website: https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

The SFT patient safety More information on .h1

Table 4

	***Local* patient safety incident improvement plan/scheme title**	**Specialty**	**Oversight Forum**
1	**Workstream 1** Pressure Ulcers	Trust wide	PSSG
2	**Workstream 2** Inpatient Falls	Trust wide	PSSG
3	**Workstream 3** Reducing the loss of clinical information following transfer of care (SBAR)	Trust wide	PSSG
4	**Workstream 4**		

Of the top 10 patient safety incidents identified (table 2 above), those without a current workstream will be addressed through our local Patient Safety Incident Investigation (PSII) or Patient Safety Review (PSR) process, as described later in the plan.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e. incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Incidents requiring other types of investigation and decision-making, which lie outside the scope of PSIRF, will be appropriately referred as follows:

- professional conduct/competence referred to human resources (Organisational Development and People teams)
- establishing liability/avoidability referred to legal team
- cause of death
- criminal referred to the police

Table 5 below sets out the national or local mandated responses.

Based on our analysis of patient safety incidents we have accounted the national mandated criteria.

Table 5: Local and National Mandated PSII responses

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally-led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally-led PSII
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII (see Appendix 3)
4	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required 4(y)-2(ia)7( )]6.51 38 re14 4(y)-2(ia

7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death 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 providers must fully support these investigations where required to do so
9	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
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required

Our patient safety incident response plan: local focus

SFT considers that all of the ten incident types set out in table 2 have relevance for all our inpatient and outpatient services (including maternity). To this end this is an organisation wide (the exception to this being maternity specific incidents as per national requirement).

Patient Safety Incident Investigation (PSII)

In accordance with national guidance, the number of PSII planned in response to each incident type has been restricted to 3 6 to support in depth analysis and identification of common interlinked causal factors. To support the identification of common causal factors, incident types are narrowly defined. This means from a large group of incidents, a smaller subset of incidents (which may be specific to an area, process, and/or presentation of a patient or other characteristic) will be identified.

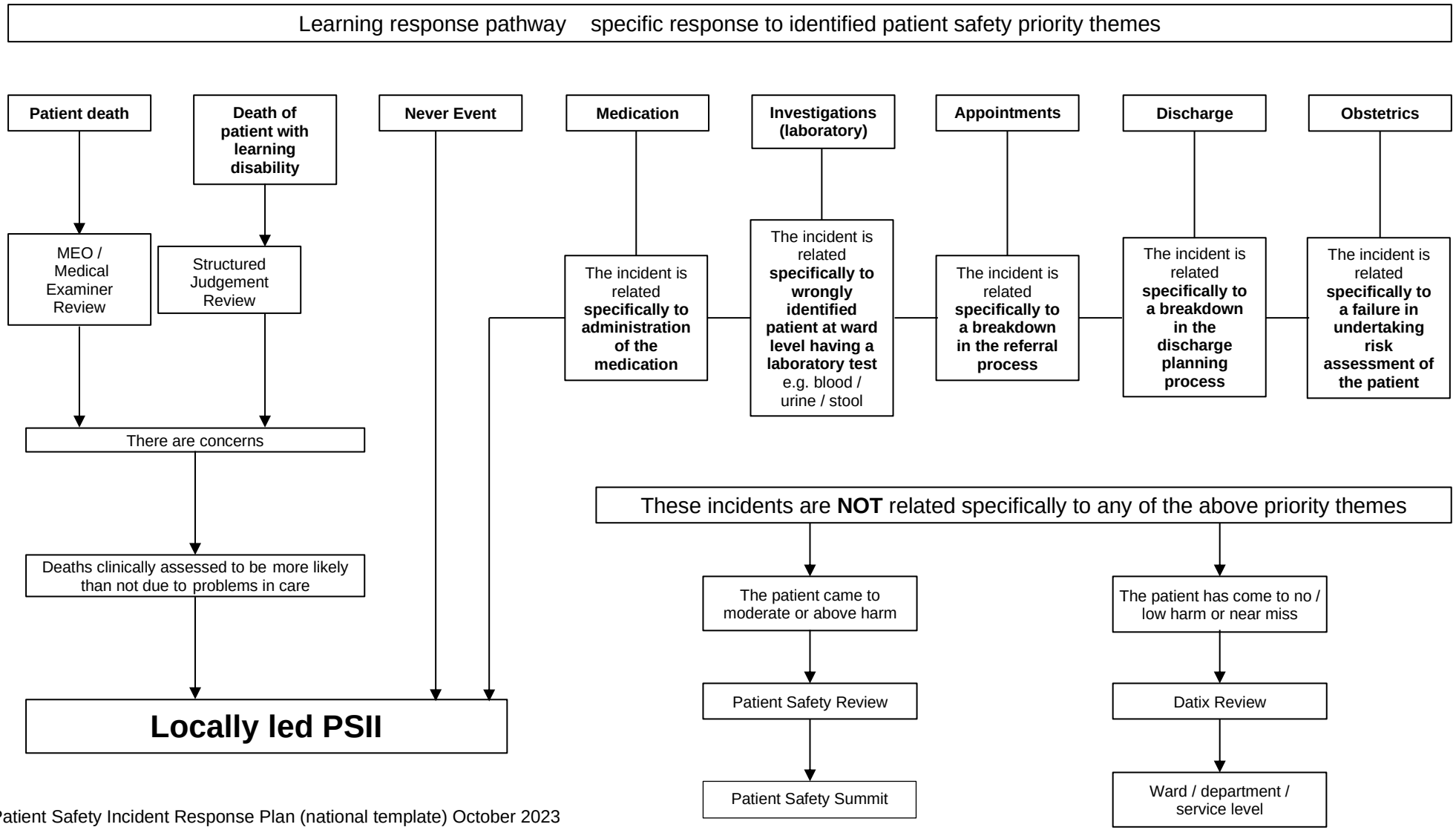
This process is a valuable and thorough way of accomplishing thematic analysis of PSII findings in a select recent and very similar incidents. The findings from each individual investigation are then collated, compared

Maternity Specific

The Guide to responding proportionately to patient safety incidents states that organisations with maternity services should include in their PSIRP how they intend to respond to the different types of non-HSIB referred maternity patient safety incidents and, as with other

Earlier in the plan, Table 4 identified current improvement workstreams in progress at SFT. Moving forward with PSIRF, how we will use learning from PSIIs and PSRs to inform improvement 08871 0 595.32smprovemenr8BT/F1 11.52 Tf1 0 Tf1 0 0 1 99.864 164.9 Tm0 g0 G[(Mo)4

Appendix 1: Quick guide to locally defined priorities for Patient Safety Investigation (PSII)



Appendix 2 PSR Methodologies

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: x improve situational awareness of safety concerns x focus on the patients most at risk x priorities x agree actions x enhance teamwork through communication and collaborative problem-solving x celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a _____.
After-action review	Team review	A structured, facilitated discussion on an incident or and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	To review the care of a person with a learning disability (recommended alongside a case note review).

Technique	Method	Objective
Perinatal mortality review tool	Specialist	

Potential severe brain injury

Potential severe brain injury diagnosed in the first seven days of life, when the baby:

- x Was diagnosed with moderate or severe (grade III) hypoxic ischaemic encephalopathy (HIE). This is brain injury caused by the baby's brain not getting enough oxygen.
- x temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- x Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

HSIB no longer routinely investigate cases involving therapeutically cooled babies where there is no apparent ongoing neurological injury following cooling therapy. This would usually mean a brain MRI showing no hypoxic damage (a type of brain injury that occurs when there is a disruption in supply of oxygen to the brain) and the baby demonstrating no ongoing neurological
should continue to refer cases to HSIB. HSIB decide which investigations proceed based on ust.

Maternal deaths

HSIB investigate direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

Acronym	Meaning
MEOWS	Maternity Early Obstetric Warning Score
M&M	Mortality and Morbidity (multidisciplinary meeting)
NICU	Neonatal Intensive Care Unit
PEWS	Paediatric Early Warning Score
PMRT	Perinatal Maternity Review Tool
PSIRF	Patient Safety Incident Response Framework
PSIRP	