NHS
North Tees and Hartlepool
NHS Foundation Trust

Patient Safety Event Response Plan (PSERP)
2024 - 25

Contents

Effective date: 29 January 2024

Interim review date: 31 August 2024 (7 months)

Estimated refresh date: 31 March 2025 (14 months)

1. Introduction

This is our first Patient Safety Event Response Plan (subsequently called the plan) and defines how North Tees and Hartlepool NHS Foundation Trust will **deliver safe, high quality and clinically effective care for our population, ensuring a positive experience for those who use or work within our services**.

The plan is supplementary to the Patient Quality Strategy (2023-2026) following adoption of the Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022a). Delivering safe care under the new framework will change how we identify and respond to patient safety events.

The plan has been developed to align to the underpinning philosophy of the Patient Safety Incident Response Framework (NHSE, 2022a) and its four key 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

Throughout this plan we refer to patient safety events rather than incidents. As an organisation we are striving to embed a learning and improvement culture, where our staff, patients, families and carers, and all who engage with us are encouraged to share their stories and their concerns, and to be part of our journey of improvement.

We believe that learning comes from understanding what goes wrong (incidents), what nearly goes wrong but is saved by the actions of those involved (near misses) and also what goes well, despite the daily challenges of healthcare (good care). Collectively we refer to these opportunities for learning as events, and we identify them from numerous sources including incident reporting but also via feedback from patients, families and staff.

The drivers that underpin our plan are Learning and Safety, Quality & Experience, and Improvement and Effectiveness, reflecting the aims of the Patient Safety Strategy (NHSE, 2019) of Insight, Involvement and Improvement. A summary of how we will deliver the plan through the implementation of the framework, the delivery of training, and the engagement of our workforce, is shown in the table on the next page.

This is our first plan which will continue to develop and mature, and we have scheduled a review midway to ensure the decisions we make now about priority areas and types of response remain appropriate and proportionate, and we capture any emerging areas of concern or risk.

This plan has been developed with our staff, patients and partners, and we thank them for their contribution.

Lindsey Robertson

Chief Nurse and Director of Patient Safety and Quality

Aim

To deliver safe, high quality and clinically effective care for our population, ensuring a positive experience for those who use or work within our services.

Drivers

Learning and safety
Maximising the things that go right, minimising the things that go wrong.

Quality and experience
Promote quality through everything we do.

Improvement and effectiveness
Support, encourage and enable improvement.

Deliverables

	Learning and safety	Quality and experience	Improvement and effectiveness
PSIRF	1. Develop, approve and publish the Trust PSERP & policy (Dec 2023). 2. Develop alternate Learning Responses with Task and Finish group (Dec 2023) and include templates on InPhase (Jan 2024). 3. Develop InPhase Events (LFPSE) application and transition to InPhase (Dec 2023) and PSIRF (Jan 2024) and develop the Oversight application for triangulation of data (March 2024).	1. Implement 'Engaging and involving patients, families & staff following a patient safety incident' guidance (Feb 2024) 2. Recruit a minimum of two Patient Safety Partners (Dec 2023) and two Patient Experience Partners (Mar 2024) and establish them within relevant forums & in co-designing safety and QI projects 3. Develop Feedback (Dec 2023) and Policy applications in InPhase (Feb 2024)	1. Develop the Clinical Audit and Actions applications within InPhase (Feb 2024) 2. Develop Event pro formas (data capture) and Improvement Responses with T&F group; include templates on InPhase (Feb 2024) 3. Develop the Oversight application and dashboards for each Oversight group for improved triangulation of data (March 2024)
Training	1. All staff to complete National Patient Safety Syllabus Level 1 (Mar 2024) and identified staff to complete additional levels (Jul 2024). 2. Identified staff to complete PSIRF Learning Response training (Feb 2024) 3. Explore and procure Human Factors 'train the trainer' course (Mar 2024)	1. Identified staff to complete PSIRF Engagement Leads training (Feb 2024) and Family Liaison Officer (FLO) training (Jul 2025) 2. Develop and deliver induction and in-house training programme for Patient Safety Partners / Patient Experience Partners (Mar 2024); collect feedback on the training and the impact of their role.	1. Identified staff to complete PSIRF Oversight training (Feb 2024) 2. Ongoing delivery of the QSIR training across the Trust by the Faculty of Leadership and Improvement and introduction to LifeQI 3. Train those leading / supporting Oversight Groups to use the Action / Board Assurance Framework / oversight applications to develop and monitor their Trustwide Improvement plans
Workforce	1. Involve staff in the development of InPhase Events application to improve user satisfaction and event reporting 2. Increase staff participation in face to face Learning Responses 3. Explore with South Tees their project to train and embed Restorative practice following events and the evaluation	1. Utilise the functionality in InPhase to improve feedback to staff following submission of an Event 2. Promote the variety of avenues available to staff to raise concerns about safety (InPhase Events and Feedback applications, Freedom to Speak Up Guardian, CQC whistleblowing) and monitor use	1. Oversight groups to evidence stakeholder participation in the development of recommendations from Learning Responses 2. Review of each Oversight group including TOR to ensure expert representation to provide knowledge and drive for improvement 3. Develop leadership capacity and capability through participation in programmes such as NTH100 with projects linked to PSERP themes
Outcome Measures	1. 5% improvement in positive responses on NHS Staff survey questions related to incident reporting and feedback (Mar 2025) 2. Establish baseline Event reporting in InPhase & aim for 2% increase month on month (Dec 2024) 3. Evidence of the application of a systems approach within all alternate learning responses and generation of systems based solutions	1. 5% improvement in positive responses on NHS Staff survey questions related to raising concerns. (Mar 2025) 2. 2% improvement in response rate for Friends and Family Test. (Mar 2025) 3. Evidence of co-production and co-design in the development of patient focused improvement projects	1. Evidence that each Trust Oversight group has a dynamic improvement plan which incorporates recommendations from Learning Responses and details the ongoing improvement work 2. A 5% increase in QI projects registered on LifeQI and a 2% increase in the proportion of projects reaching the evaluation stage (Mar 2025)

2. Our services

North Tees and Hartlepool NHS Foundation Trust is an integrated hospital and community healthcare organisation serving approximately 400,000 people in Hartlepool, Stockton-on-Tees and parts of County Durham.

During November 2023, board members from both North Tees and Hartlepool and South Tees Hospitals NHS Foundation Trusts met to approve a Joint Partnership Agreement. Whilst both organisations will remain as statutory bodies, the agreement is a formal commitment to work collaboratively for the benefit of our patients, staff and the wider population. This Plan reflects the work within North Tees and Hartlepool NHS Trust but future plans may reflect this partnership.

In setting out the services we provide, we have utilised our current CQC profile and our organisational plans.

Our Trust has two hospitals

- The University Hospital of Hartlepool
- The University Hospital of North Tees (based in Stockton-on-Tees)

We also provide our services in a number of community facilities to support our local population.

Clinical services at the Trust are grouped into three Care Groups to provide integrated care delivery. Our Healthy Lives care group includes services for women and children and our community services such as therapy services and district nursing; Responsive Care includes our urgent and emergency care services, medical specialities and diagnostic services such as radiology and laboratory services; and Collaborative Care includes anaesthetics, theatres and critical care services and all our surgical specialities.

Additionally, we have a corporate directorate delivering finance, performance, workforce, digital, nursing and patient safety services; and our subsidiary company, NTH solutions, providing support services including health and safety, estate services, procurement and supplies, domestic, catering, laundry and portering services.

Our workforce are central to our vision to deliver safe, high quality and clinically effective care. They embody our Trust ‘CARE’ values: Collaborative, Aspirational, Respectful and Empathetic, and every day they deliver high quality, patient-centred care in a challenging and evolving healthcare system. In order to attract, retain and develop our workforce, and to reinforce our dedication to quality and safety, we have established a Faculty of Leadership and Improvement to grow our workforce of the future.

3. Understanding our patient safety event profile

In order to identify the patient safety issues most pertinent to our organisation, and those which require focused work during the life of this plan, we engaged with a range of stakeholders across our Care groups, clinical specialities, non-clinical services, patient experience and patient safety teams. See appendix A)

We held regular stakeholder meetings and met with teams to understand their concerns and the level of risk to patients, staff and the organisation. We drew on various data sources for patient safety events to gain a wider understanding of the issues and potential for learning and improvement.

Known areas of risk to the Trust	National requirements and Trust compliance	Local insight and improvement
Identified on the Board Assurance Framework and grading	National Event Response Requirements	Local audits and Trust compliance
A current risk on the risk register and highest grading	National guidance and Trust compliance	Event profile (incidents, complaints and claims)
Can demonstrate that causative factors are understood and controls are in place	National audits and Trust compliance	Serious incidents and never events
Inspection reports, recommendations and work underway to address gaps	Performance measures and CQUINs	Current or planned improvement work and progress
Trust Committee or Council in place to oversee learning/improvement responses		Stakeholder engagement

4. Defining our patient safety learning and improvement profile

The review identified ten potential themes for focused learning and improvement work:

- Maternity and neonatal
- Deaths in our care
- Vulnerable people
- Management of deteriorating patients
- Medication
- Delays in diagnosis and treatment
- Transfers of care
- Infrastructure and resources
- Inpatient falls
- Skin integrity

Of these ten themes, a number of them have well established and embedded processes for learning and improvement, for example a Trust Oversight group, Assurance Framework or Improvement plan, and processes for audit, monitoring and review of themes and trends.

They have also had no serious incidents reported over the last two years (skin integrity) or no significant new learning from the serious incidents reported during this period (inpatient falls; delays in diagnosis and treatment).

The maternity and neonatal and deaths in our care themes have both had a number of serious incidents reported over the last two years, but similar incidents in the future will meet the nationally mandated criteria, and be investigated via an external or internal Patient Safety Incident Investigation (see table overleaf). In addition, specific event types within maternity and neonatal including post partum haemorrhage, readmission of babies under 28 days old, and unexpected term admissions to a neonatal unit/special care baby unit, have established processes for monitoring, review and escalation.

The theme of infrastructure and resources included digital, devices and workforce, and whilst these may be contributory to other incident types, there have been very few serious incidents directly related to these issues, and the work to manage and develop these areas is covered within other strategies.

The remaining themes - vulnerable people, management of deteriorating patients, medication, and transfers of care - were further explored with stakeholders. We looked for specific issues that underpinned or were causative across a range of incidents and events; where the issues may not be well understood, and where a focused and resourced plan of work had the potential to impact on patient safety during the life of this plan.

These were agreed as our local priorities, and together with the nationally mandated learning responses, form our Trust Patient Safety Event Profile (overleaf).

How we will respond to Patient Safety Events

	Event	Learning Response	Improvement response
National priorities	Maternity and neonatal events meeting Maternity & Newborn Safety Investigations (MNSI) criteria	Refer to MNSI for external PSII	Relevant Trust Oversight group(s) to respond to recommendations from external investigation and report and develop action plan with stakeholders
	Deaths of persons with learning disabilities [or autism]	Refer to Learning Disability Mortality Review (LeDeR) +/- Trust led response	
	Child deaths	Refer to Child Death Overview Panel (CDOP) +/- Trust led response	
	Safeguarding event	Refer to local authority safeguarding lead and contribute to review	
	Incidents in NHS screening programmes	Refer to local screening quality assurance service (SQAS) +/- Trust led response	
	Deaths meeting the learning from deaths criteria	Trust led PSII and recommendations	Relevant Trust Oversight group(s) to respond to recommendations from the PSII and develop action plan with stakeholders
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, and meeting the learning from deaths criteria		
	Never events		
Local priorities	Child not brought for appointment	Trust local learning response	Relevant Trust Oversight group(s) to collate learning from responses, undertake thematic reviews where indicated, and develop actions which support the Trust improvement plan
	Delayed recognition and management of the sick child (including neonates)		
	Management of diabetes		
	Quality of discharge information		
Other events	All other events	Event Response Form on InPhase	Relevant Trust Oversight group(s) / Care Group to monitor for emerging trends
	Any event with moderate harm or above	Duty of Candour to be applied	

5. Our patient safety event response plan: national requirements

The Guide to Responding Proportionately to Patient Safety Incidents (NHSE, 2022b) identifies events that have a nationally defined response as set out in policies or regulations. The responses are defined by NHSE or the appropriate body and the Trust will undertake and/or contribute to the investigation or response as defined in the relevant policy, regulation or guidance.

Through our internal processes, we will ensure the learning from these events is shared and acted upon, and contributes to our learning and improvement.

6. Our patient safety event response plan: local focus

Aside from the nationally required responses, the Guide to Responding Proportionately to Patient Safety Incidents (NHSE, 2022b) defines three types of response to events: learning, improvement and assessment. See below application of patient safety event response activity according to key objectives (adapted from NHSE, 2022b, pg.12).

Learning response:

Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.

Improvement response:

Where a safety issue or event type is well understood (for example, because previous events of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

Assessment:

For issues or events where it is not clear whether a learning response is required.

The Trust has worked with key stakeholders (clinical leads, teams, patients and partners) to identify the most appropriate and proportionate responses to gain the most learning for our organisation. We have reviewed the suggested learning and improvement response tools, and adapted them to suit our local needs and governance structures (Appendix D). In addition, where a defined issue or emerging trend is identified, a selection of events meeting the criteria will be subject to a thematic review.

As there are various types of response to an event we will, together with all those involved and with consideration to the circumstances in which the event occurred, identify an appropriate, proportionate and timely response to each event.

6. Our patient safety event response plan: local focus

All our responses are underpinned by a systems-based approach. A systems-based approach examines all the elements of the 'system' in which the event occurred, such as the equipment involved (the tools and technology and how they are used and maintained), the environment (such as lighting, noise, layout, and accessibility), the task that was being undertaken (how complex it was or whether it was completed correctly), the impact of the organisational structures and processes (including policies, training, work schedules), any relevant external factors (such as national policies and regulations), and the people who were involved in the event (including factors individual to both the patient and the staff).

All the elements of the system and their interdependencies (i.e. how they influence and impact on each other) are explored, in order to understand how they may have contributed to the event. All staff undertaking a learning response will have training in systems-based approaches, human factors and quality improvement, in order to identify where changes need to be made, how best to achieve this and how to monitor the impact.

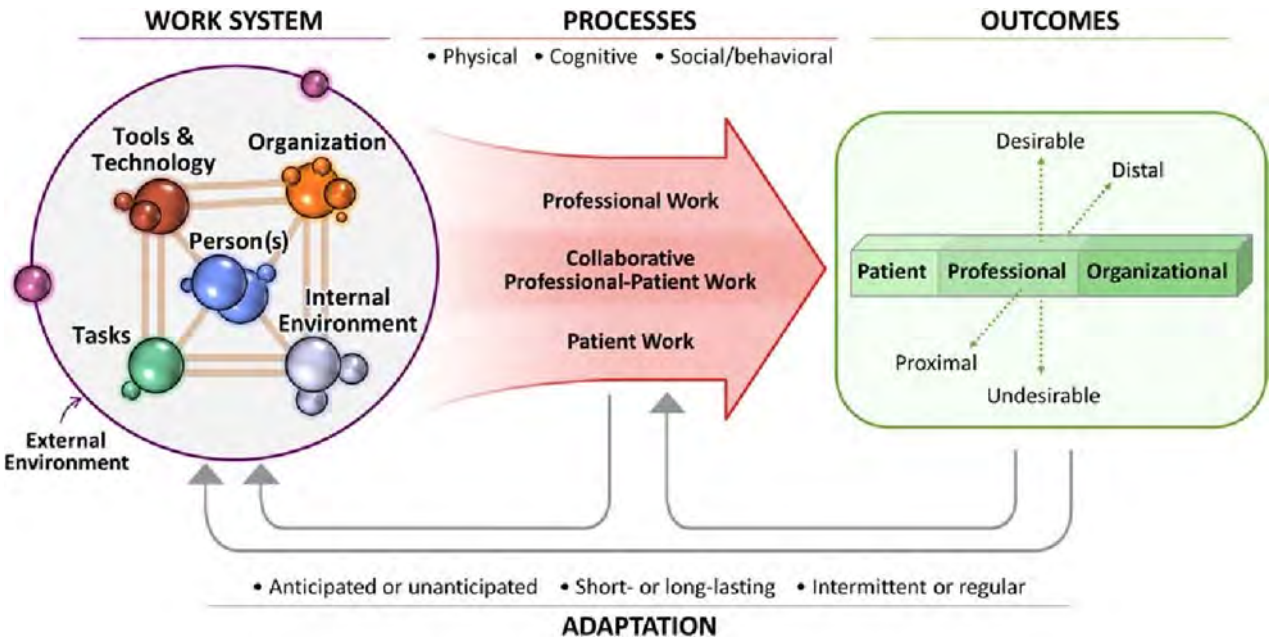

Fig. 6.1 Systems Engineering Initiative for Patient Safety (SEIPS) (Holden et al, 2013)

7. References

Holden, R.J., Carayon, P., Gurses, A.P., Hoonaller, P. et al (2013) SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics, 56 (11) doi:10.1080/00140139.2013.838643

NHSE (2022a) Patient Safety Incident Response Framework

B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

NHSE (2022b) Guide to Responding Proportionately to Patient Safety Incidents v1.

B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1-FINAL.pdf (england.nhs.uk)

8. Appendix A - List of stakeholders

Chief Nurse and Director of Patient Safety and Quality

Director of Nursing & Midwifery, NENC ICB

Associate Dean NENC NHS England Workforce Training and Education

Lead Medical Examiner

Consultant Palliative Medicine and Trust Lead for Mortality and Learning from Deaths.

Consultant Physician and Trust Lead for Mortality and Learning from Deaths

Associate Director of Nursing and Patient Safety

Associate Director of Nursing, Clinical Safety

Associate Director of Nursing Experience and Improvement

Associate Director Effectiveness and Clinical Standards

Associate Director of Risk Management

Assistant Director of Procurement and Supply Chain Management (LLP)

Deputy Director of Infection, Prevention and Control

Patient Safety Specialist and PSIRF Implementation Lead

Project Manager

Patient Safety Operational Lead

Patient Safety Lead - Responsive Care

Patient Safety Lead – Women and Children's services

Patient Safety Lead – Out of Hospital Care

Governance and Experience Manager

Head of Culture, Leadership, Education and Development

Workforce Development Lead

Organisation Development Lead

Deputy Clinical Lead of Faculty of Learning, Leadership and Improvement

Clinical Lead for Quality Improvement

Quality, Safety and Innovation Lead - Collaborative Care

Quality, Safety and Innovation Lead – Maternity, Paediatric and Pharmacy

Quality, Safety and Innovation Lead – Out of Hospital Care

Quality, Safety and Innovation Lead - Responsive Care

Quality Improvement Facilitator

Chair of Audit and Clinical Effectiveness Committee

Clinical Effectiveness Manager

Named Nurse Children's Safeguarding

Named Nurse Safeguarding Adults

Senior Tissue Viability Nurses

Tissue Viability Nurse

Trust Falls Lead

Senior Clinical Matron ICU/Chair Deteriorating Patients Group

Head of Patient Flow Services

Head of Pathology

Pathology Quality Manager

Resuscitation and Simulation Lead

Outpatient Implementation manager/Chair of Keeping People Safe Group

Unit Matron Special Care Baby Unit

Paediatric Nurse Lead

Associate Director of Midwifery

Safety, Quality and Governance Lead Midwife

Improvement Consultant Midwife

Senior Business Lead – Healthy Lives

Senior Clinical Matron / Community Nursing Lead

Specialised Services Manager

Senior Project Support Officer

Medicines Safety Officer

Medical Devices Safety Officer

9. Appendix B - Learning and Improvement Responses

Trust learning response methods

Rapid Learning Response (RLR)

The purpose of the Rapid Learning Response is to understand why the outcome may have differed from what was expected and identify learning from an event. The purpose is not to assign blame or hold people to account, and those leading the huddle should aim to create an environment which supports everyone to contribute without fear of blame or retribution.

Where possible, the Rapid Learning Response should be completed following a huddle with those involved in the event (consider including patients and families) so that a wide range of viewpoints can be explored. The huddle should take place as soon as practical after the event and ideally within the same shift; the report should be completed within 48-72 hours of the event, this ensures:

- Knowledge about the event is captured before it is lost (for example, equipment removed or disposed of, peoples recollections of events etc)
- Rapid safety actions can be identified and actioned promptly to ensure patients are safe
- Further recommendations for improvement that need to be undertaken locally (where the event occurred) and/ or in other areas across the organisation or system, can be identified

Intermediate Learning Response (Single) (ILRS)

The Intermediate Learning Response for a single events (ILRS), is a structured, facilitated review of a single but complex event, where a more in depth analysis is required, which is beyond the scope of an Event Response Checklist or a Rapid Learning Response (RLR). It is based on the After Action Review technique, but the terminology has been adapted for the Trust to reflect how the technique will be deployed:

- For single (complex) events
- At an intermediate time frame (this should be discussed and agreed with those involved but is recommended to be completed within 4-6 weeks)
- With a focus on learning and improvement

The ILRS should include as many of those involved in the event as possible (multidisciplinary, clinical and non-clinical staff where relevant) so that a wide range of viewpoints can be explored. It may be appropriate to invite contributions from patients and families, representatives from other organisations involved in the patient pathway, and subject matter experts who were not involved in the event. The review should take around 90 minutes and will require planning to compile information and coordinate availability of attendees.

The purpose of the ILRS is to understand why the outcome may have differed from what was expected and identify learning from the event. The facilitator should not have been involved in the event or line manage those who were involved; they should be trained to undertake a Learning Response including knowledge of systems approaches, and be able to create an environment which supports everyone to contribute without fear of blame or retribution.

Patient Safety Incident Investigation (PSII)

A PSII offers an in-depth review of a single patient safety event or cluster of events to understand what happened and how.

A PSII will be led by someone who has completed the PSIRF Learning Response training and who has expertise in investigating events; they will be supported by a team including subject matter experts. The lead will not have been involved in the event and will not line manage those who were involved.

A PSII is a formal investigation process and should include the setting of Terms of Reference, and with sufficient time allocated to the collection and review of information. As with the other response methods, the investigation will be underpinned by a systems approach.

Patients and families should be invited to contribute or participate in the investigation and should be supported by an Engagement Lead / Family Liaison Officer. The timescale for completion of the investigation and development of the report should be agreed with the patient/family.

Intermediate Learning Response (Themed) (ILRT)

The Intermediate Learning Response for an identified theme, trend or cluster of events (ILRT), is a structured, facilitated multidisciplinary review to understand common links, themes or issues within a group of events or across a safety theme or pathway. This technique can be used:

- For multiple safety events (including events where multiple patients were harmed or where there are multiple similar events)
- To identify key contributory factors and system gaps, through an open discussion, and where it may be difficult to collect staff recollections of events because of the passage of time or staff availability
- To explore a safety theme, pathway or process (examples could include delayed recognition of deteriorating patients, admission or discharge-related safety events, etc.)
- To gain insight into 'work as done' in a health and social care system

It is based on the NHSE (2022) MDT Review guidance and the Themed Review Template (Dr Samantha Machen), but the terminology has been adapted for the Trust to reflect how the technique will be deployed:

- For multiple events
- At an intermediate time frame following the reference case or where a theme is identified over a period of time
- With a focus on learning and improvement

The ILRT should be facilitated by someone with appropriate training, and include a wide range of stakeholders including frontline staff who can describe 'work as done' within the pathway of care (consider both clinical and non-clinical roles) as well as subject matter experts. The review should take the form of a workshop, the purpose of which is to gain insight into the real world issues in delivering care, and identify systems gaps and areas for improvement.

The purpose of a themed review is to take a group of events which have the same or similar safety concerns or occur along the same pathway of care, and identify different aspects of the work system and variability across the pathway(s) of care that may have or could contribute to the outcome. The themed approach can include cases where there has been a negative outcome (an event with or without harm), a near miss (an event which was prevented), or where there has been a positive outcome (i.e. no event), as this gives insight into the differences (or similarities) in cases with different outcomes.

A themed review should be viewed as a diagnostic tool which can highlight barriers and challenges within a pathway (or multiple pathways) of care and therefore should be linked to the relevant oversight group and incorporated into their overarching Improvement Plan for ongoing monitoring.

Trust tools to respond to broad patient safety issues (Improvement responses)

Event response checklist

The Trust will utilise nationally recognised or locally developed checklists / pro formas to review selected event types. This will provide immediate information on the events and be utilised to provide feedback to the patient and family.

The checklists / pro formas will be audited at a pre-determined frequency (monthly or quarterly as appropriate) and analysed for trends. Where a defined issue or emerging trend is identified, a selection of events meeting the criteria may be subject to a thematic review utilising the ILRT tool.

Intermediate learning response (themed) (ILRT)

See Trust learning response methods points above.

An ILRT can be used as a Learning Response or as an Improvement Response to explore a theme, pathway or process, where there has been no specific event but the aim is to identify further opportunities for improvements to patient care.

Horizon scanning

The horizon scanning tool supports health and social care teams to take a forward look at potential or current safety themes and issues. It can be used to proactively identify safety risks.

Adapted from Guide to responding proportionately to Patient Safety Events (NHSE, 2022b, pg.16)