University Hospital Southampton NHS
NHS Foundation Trust

Patient safety incident response plan

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Estimated refresh date:2nd October 2024 with informal review after the first 6 months.

	NAME	TITLE	SIGNATURE	DATE
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Review group	Quality Governance Steering Group	Approved		5/9/23
Review group	Trust Board	Approved		28/9/23
HIOW ICB	Teressa Gallard Helen Eggleton Gemma Seymour	Final Approval from ICB received 5/9/23		22/8/23

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Introduction

This patient safety incident response plan sets out how University Hospital Southampton NHS Foundation Trust (UHS) 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.

As the major university hospital on the south coast, we provide tertiary medical and surgical specialities to over 3.7 million people in central southern England and the Channel Islands. We are a leading research and teaching hospital and a centre of excellence for training the doctors, nurses and other healthcare professionals of the future. We work with the University of Southampton and Solent University to educate and develop staff at all levels, including a large apprenticeship programme, undergraduate and postgraduate education.

This is a large and complex organisation, with about 14,000 employees and a turnover of >£1bm. We work in a dynamic and fast paced environment, where we are always evolving and always improving. We also play an integral role in our Integrated Care System (ICS) and have developed mature and productive relationships with our system partners.

We are recognised as a 'Good' and 'Well-led' trust by the CQC, with a long record of effective financial management. We are also one of NHS England's Digital Exemplars, pioneering the world-class use of digital technologies and information.

Through our long-standing values of *Patients First, Working Together and Always Improving*, we are proud of the care we provide and the outcomes we achieve.

OUR MISSION: TOGETHER WE CARE, INNOVATE AND INSPIRE

OUR VALUES

PATIENTS FIRST

Patients, their families and carers are at the heart of what we do. Their experience of our services will be our measure of success

WORKING TOGETHER

Partnership between clinicians, patients and carers it's critical to achieving our vision, both within hospital teams and extending across organisational boundaries in the NHS, social care and third sector.

ALWAYS IMPROVING

We will ensure we are **always improving** services for patients through research, education, clinical effectiveness and quality improvement. We will continue to incorporate new ideas, technologies and create greater efficiencies in the services we provide.

OUR STRATEGIC FRAMEWORK THEMES

OUTSTANDING PATIENT OUTCOMES, SAFETY AND EXPERIENCE

A national reputation for outstanding patient outcomes, experience and safety, providing high quality care and treatment across an extensive range of services from fetal medicine, through all life stage and conditions, to end of life care.

PIONEERING RESEARCH AND INNOVATION

A leading teaching hospital with a growing, reputable and innovative research and development portfolio that attracts the best staff and efficiently delivers the best possible treatments and care for our patients.

WORLD CLASS PEOPLE

Supporting and nurturing our people through a culture that values diversity and builds knowledge and skills to provide rewarding careers paths within empowered, compassionate, and motivated teams.

INTEGRATED NETWORKS AND COLLABORATION

Delivering our services with partners through clinical networks, collaboration and integration across geographical and organisational boundaries.

FOUNDATIONS FOR THE FUTURE

Making our corporate infrastructure (finance, digital, estate) fit for the future to support a leading university teaching hospital in the 21st century and recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS.

Building on a firm foundation

When shaping an approach to improvement it's important that we build on our assets and what makes us different to other NHS hospitals so that we harness the best of our organisation in helping us move forward.

UHS Asset: Clinical Outcomes

The clinical outcomes that we deliver for our patients are World Class. This gives us the confidence that we are at the leading edge of improvement and helps attract staff, investment and attention for our improvement efforts.

UHS Asset: Our Culture, Our People

We have a really positive culture that compares favourably in our staff survey. At UHS our people are our greatest asset and we are able to attract the top talent to collaborate and innovate to deliver great care. We encourage and celebrate diversity and inclusion across the organisation.

UHS Asset: Patient Safety

We have a positive patient safety culture with people able to report incidents and learn from them. We have senior clinical leadership which gives us a strong foundation for our just and learning culture. We are actively developing patient involvement with patient safety partners and co-design.

UHS Asset: Partnering in Research

UHS is a leading research and teaching hospital working in close partnership with the University of Southampton. Through Covid we have proven our ability to lead national research. We are actively pursuing closer ties with UHS clinical research teams and the University around our Improvement initiatives

UHS Asset: Improvement Approach

Our work on the Always Improving Inpatients programme gave us a clear organisational approach to improvement that trained over 1,000 staff through bootcamps in the high level approach and gave us 18 practitioners of the methodology. This provides a platform for our improvement culture and approach that is recognised in the Trust to build from.

UHS Asset: System Partnership

We have mature relationships with our system partners and the Covid-19 has supported us to work closer and progress the integration agenda. A core part of our Improvement framework is to focus on system transformation.

Successfully unlocking the value and potential will require a coherent, collaborative and coordinated approach which is supported widely within the Trust and by its key partners.

Our services

UHS is registered with the Care Quality Commission (CQC) to provide services in the following locations:

Southampton General Hospital is the Trust's largest location, with a great number of specialist services based here, ranging from neurosciences and oncology to pathology and cardiology. Emergency and critical care is provided in the hospital's special intensive care units, operating theatres, acute medicine unit and emergency department (A&E), as well as the dedicated eye casualty. Southampton General also hosts outpatient clinics, diagnostic and treatment work, surgery, research, education and training, as well as providing day beds and longer stay wards for hundreds of patients.

Princess Anne Hospital - Is a centre of excellence for maternity care, providing a comprehensive service, including home birth, for about 5,000 women each year from around Southampton. We are also a regional centre for fetal and maternal medicine, providing specialist care for women with medical problems during pregnancy, and for those whose baby needs extra care before or around birth. Other services provided at the Princess Anne Hospital include genetics and breast screening.

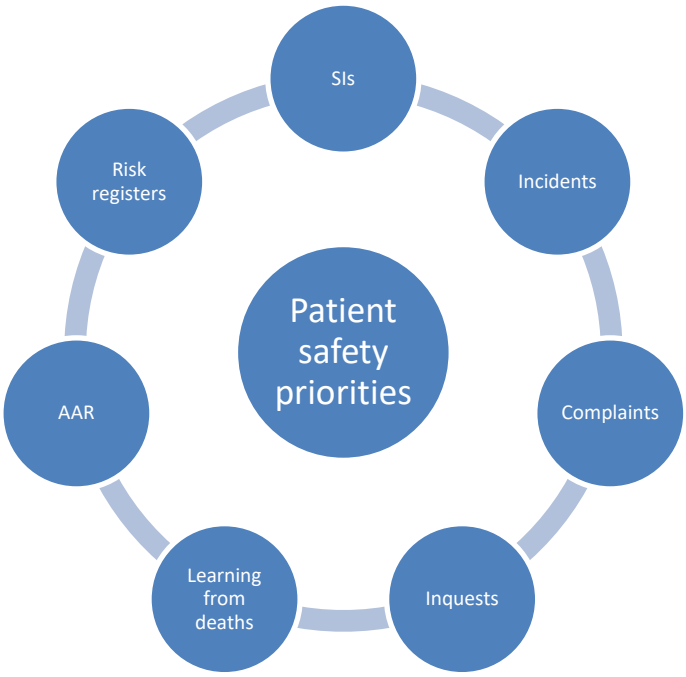
Lymington Hospital - Lymington New Forest Hospital is a community hospital located in Lymington and managed by Southern Health NHS Foundation Trust. UHS manages the surgical services at the hospital.

Royal South Hants Hospital - The Royal South Hants Hospital is located near the centre of Southampton and is managed by NHS Property Services Ltd. A small number of UHS services are provided here including dermatology.

Helicopter Emergency Medical Service - Hampshire and Isle of Wight Air Ambulance (HIOWAA) brings an advanced critical care team to sick and injured people in emergency situations across the area. On 1 November 2018, a partnership was formalised between UHS as the major trauma centre for the southern region, HIOWAA and South Central Ambulance Service NHS Foundation Trust (SCAS). The air ambulance charity is fully responsible for funding the service, while UHS manages and provides clinical governance for the critical care teams of doctors and paramedics. SCAS continues as the dispatch authority.

New Forest Birthing Centre - Run by experienced UHS midwives and support staff, the New Forest Birth Centre offers a safe, friendly environment for mothers and babies . The birth centre also provides antenatal support in preparation for parenthood, private spaces and ongoing support including breastfeeding support groups.

Defining our patient safety incident profile



We used a thematic analysis approach to determine which areas represented our patient safety priorities. To do this review we utilised a variety of data sources including:

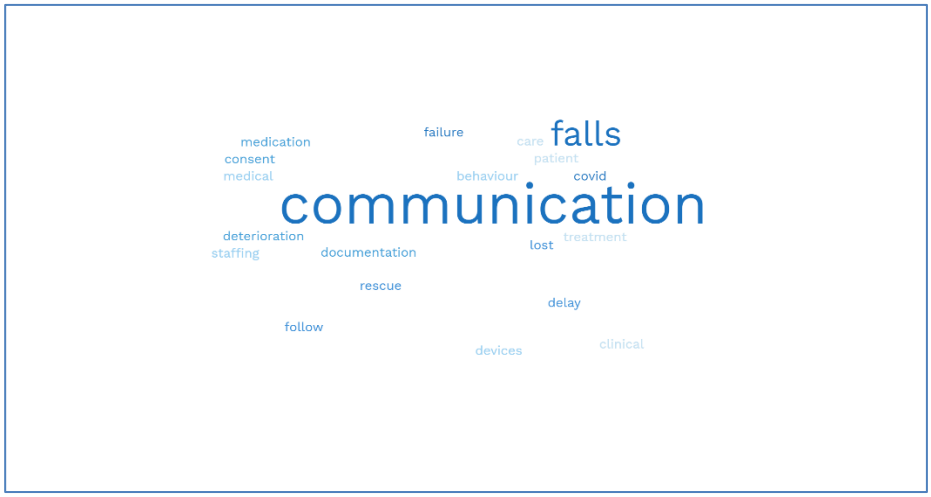
- Serious Incidents (SI's) recorded on STEIS including falls and pressure ulcers.
- Patient safety incidents reported through our local management system including all levels of reported harm.
- Risk registers
- Review of After-action reviews completed during first three months of pilot
- Learning from deaths data
- Inquests
- Complaints and concerns

Key findings of the thematic analysis were

- Average number of SI's for last 3 financial years was 98 (60 when falls/PU and VTE excluded). These include SI's reported where patients have either died from a hospital acquired Covid 19 infection or those who have come to severe harm due to delays caused by the covid pandemic.
- Our top themes during the last 3 years include:
    - Covid (infections and harm secondary to waits caused by Covid)

    - Failure to rescue[1]
    - Lost/ Delay to follow up
- Average number of inquests for the last three years is 249 per year
- Inquests highlighted the following themes
    - Documentation
    - Communication
    - Falls
    - Deterioration
    - Consent
- Further analysis of the failure to rescue using the Yorkshire Framework identified Communication as the most common theme.
- Medication and falls were the highest reported incident each year. Categories for number 3 slot were Medical devices 20/21, Staffing 21/22 and Behaviour 22/23. All reflective of the focus and workload of the organisation for those years.
- Complaints from 22/23 identify the top themes as:
    - Clinical treatment
    - Communication
    - Patient care

Word cloud to summarise themes highlighted



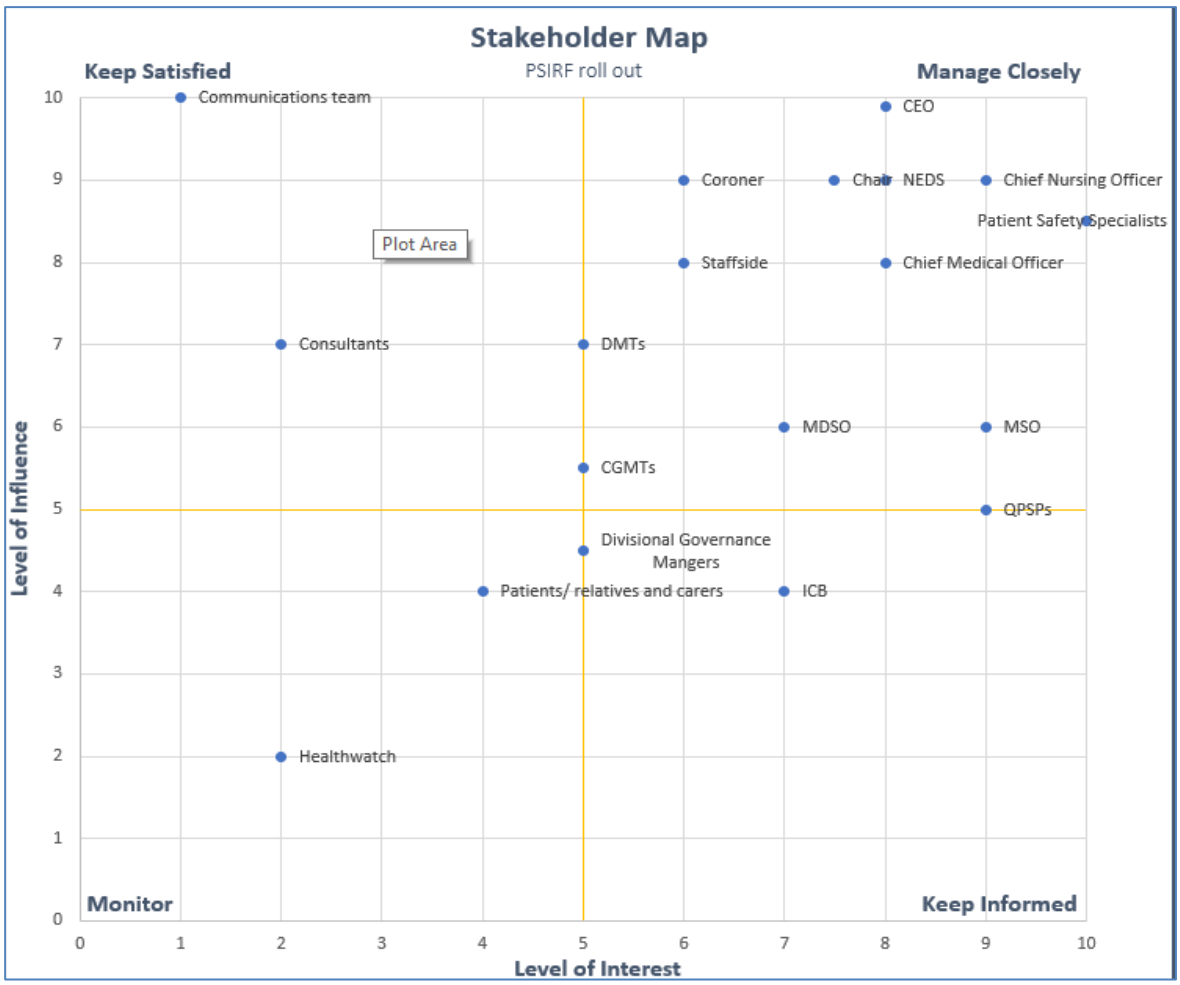
Stakeholder engagement:

To support the Plan's development with consulted with a range of stakeholders including Commissioners/ Hampshire and IOW Integrated Care Board (ICB)

- Members of staff through a number of workshops/ engagement events
- Trust Board executives and non-executives and delegated committees
- Trust governors
- Quality and patient safety partners
- Governance teams

[1] Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention

- Medication Safety Officer
- Coroner
- Healthwatch



Defining our patient safety improvement profile

UHS have a centralised Transformation team, hosted in THQ, with staff embedded into subgroups working within each division. There are four corporate programmes of specific focus agreed for 2023/24, all of which will have an impact on elements of patient safety. These are:

- Outpatients
- Patient Flow
- Improving Operating Services
- Continuous Improvement (to include local and individual projects)

Progress against each of these is robustly monitored and reviewed by the Transformation Oversight group and owned jointly with care groups up to divisional board level.

We offer a variety of modular education opportunities in improvement science and techniques. These will be further developed to ensure all staff are equipped to solve the problems they see, empowered to be part of our improvement vision and inspired to develop their skills and learning within a culture of continuous improvement. Examples are:

- Induction seminars
- One day introduction to improvement
- Bite sized learning opportunities on specific tools and techniques
- 5-day Improvement Practitioner training (NHSE Improvement teaching programme)

We are working with teams to maximise engagement and further support learning in improvement tools and techniques and will be identifying local champions across the organisation.

The NHS Delivery and Continuous Improvement Review has just been published and offers guidance on ways to improve quality in the short, medium and longer term, with aims to support a whole system focus on improving healthcare outcomes. We are reviewing our Always Improving Strategy against these principles and ensuring it aligns with those from other UHS departments such as Patient Safety, Organisational Development, Research and Clinical Effectiveness.

Staff will have easy access to an online Always Improving hub, containing examples of successful projects, good practice and useful information to support improvement across UHS.

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.

Table 1 below sets out the local or national mandated responses. As UHS does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types (8 to 11)

	Patient safety incident type	**Required response**
1	Incidents meeting the Never Events criteria or its replacement	UHS led Patient Safety Incident Investigation (PSII)
2	Death thought more likely than not due to problems in care	UHS led PSII
3	Maternity and neonatal incidents meeting the HSIB (or its replacement)	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation
4	Child deaths* * please see local priorities and PSIRF policy for greater detail	See local priorities for how we will decide level of investigation
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Local LeDeR panel review
6	Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful 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 FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

	Patient safety incident type	Required response
7	Incidents in the NHS screening programme	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Managing safety 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 Mental Health Act (1983) or where 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)	PSII – likely to include other organisations
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 with mental health provider as lead and UHS participation if required
11	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, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide review

Our patient safety incident response plan: local focus

- Following the review of our data and consultation UHS considers these our top incident types which have relevance to all our services including maternity
- These have been agreed with our local commissioning organisation, Hampshire and Isle of Wight Integrated Care Board
- These are the priorities set by UHS for 2nd October 2023 to 1st October 2024
- These apply to adults and children and both in and outpatients unless specified
- Each PSII will be conducted separately, in full and to a high standard by a team whose lead investigator is appropriately trained.
- Whilst communication was a reoccurring theme it was predominantly a secondary cause and hasn't been identified as a theme on its own.
- Decisions regarding type of response will be documented on the Safeguard System
- Guidance on management of cases not going through a full PSII is provided in the UHS PSIRF Policy.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Hospital acquired category 3/4 or unstageable pressure ulcer	After action review (AAR)	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and pressure ulcer steering group
Falls within hospital leading to an injury (consider if it is a non-accidental injury (NAI) e.g. infant or adult who is tetraplegic)	After action review (AAR) If NAI – consider safeguarding	Local safety actions to be identified and quarterly thematic analysis through patient safety steering group and Trust falls steering group
Child deaths that are unexplained with UHS paediatric involvement within 12 months <18 years (excluding neonates)	All reviewed by CDAD panel to determine investigation type for e.g. Concerns regarding care – PSII On a child protection plan or safeguarding concerns refer to local authority	Local safety actions to be identified. Learning shared through Children's hospital governance group To contribute to trust wide learning from deaths learning.

Patient safety incident type or issue	Planned response	Anticipated improvement route
	safeguarding lead via UHS safeguarding Other child deaths consider Local learning response e.g. M&M	
Interruptions to clinical services leading to temporary closure / service diverts lasting >24 hours	Has this service previously experienced this issue? Yes – review previous incident(s) if no new learning complete a harm review tool. PSII if new learning identified No - PSII	Local safety actions to be identified. Learning shared through divisional governance and Quality Governance Steering Group
Infections	Healthcare associated C/Difficile - Initial IPT case review followed by an AAR if there a concerns about practice Hospital associated MRSA and Gram negative blood stream infections - initial review with Senior IPN and Lead IP consultant to determine if more detailed IPT case review required followed by an AAR if there are concerns about practice Infection outbreaks/ incidents leading to bed closures. IPT/ Operational review of impact. Is there new learning? Yes – PSII No – Revisit previous actions	Local safety actions to be identified. Learning shared through divisional governance and Infection Prevention Committee.

Patient safety incident type or issue	Planned response	Anticipated improvement route
	Single infection incident e.g. Hospital acquired legionella or case of CJD – PSII	
Incidents relating to failure to rescue (Failure or delay in recognizing and responding to a hospitalized patient experiencing complications from a disease process or medical intervention).	Do we understand all the contributing factors? Yes – Review at M&M No - PSII	Local safety actions to be identified. Thematic reviews of incidents at Deteriorating Patient Group Learning shared via Patient Safety Steering Group
Maternal or neonatal death not meeting the HSIB criteria I.e. maternal suicide	PSII	Local safety actions to be identified.
Maternal/ Neonatal cases that are externally reportable i.e. PMRT/EMBRACE/ATTAIN	All cases would be triaged when externally reported. PSII will be completed if significant learning identified.	Local safety actions to be identified.
Interruptions to supply of medication or equipment leading to disruption to patient care	PSII – If within UHS sphere of control Consider MHRA yellow card (in discussion with MDSO or MSO) If not significant learning or has been seen previously – local learning response Outside UHS sphere of control - ensure Duty of Candour has been completed and consideration of any mitigations required and escalate appropriately.	

Patient safety incident type or issue	Planned response	Anticipated improvement route
Incidents where patients care has been impacted by delays to treatment and or appointments and or investigations	Are the reasons for the delay understood e.g. Covid – harm review tool If not understood - PSII	
Medication safety	Does the incident identify system based learning? – Yes PSII No use of appropriate tool to identify local learning e.g. AAR	Review of individual and thematic learning through the Medication Safety Group. Trust wide learning escalated via Quality Governance Steering Group
Incidents where patient care has been impacted on due to flow through the hospital E.g. ED long waits[2], ICU bed capacity, patients no longer meeting the criteria to reside	Is there significant systems based learning? Yes – PSII No – Local M&M / Case note review Align with improvement workstreams	Local safety actions to be identified.

[2] This is not defined by time but based on the clinical condition of the patient