Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
Author	Gill Feerick Tracy Church	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager		V3 15 May 2025
Reviewer	Patient Safety and Harm Group			V3 15 May 2025
Authoriser	Patient Safety and Harm Group			V3 15 May 2025

Introduction

This patient safety incident response plan (PSIRP) sets out how Barnsley Hospital NHS Foundation Trust (BHNFT**)** intends to respond to patient safety incidents over the next 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 PSIRP is underpinned by our Patient Safety Incident Response policy and supporting documents.

Our services

BHNFT is registered with the Care Quality Commission to provide services in the following locations:

- Acorn Rehabilitation Unit
- Barnsley Hospital
- Community Diagnostic Centre

Defining our patient safety incident profile

The following stakeholders were involved in identifying, analysing and defining BHNFT's patient safety incident profile:

- Staff – through incidents reported on the Trust's incident reporting system
- Patients, carers and their loved ones – through review of the thematic contents of complaints and concerns
- Specialist advisors and leads for organisational data in the Trust
- Medical Examiners service, HM Coroner and the Local Maternity and Neonatal System
- Other key external partners

The Trust's patient safety incident profile was developed through review and analysis of the following organisational data:

Clinical incidents reported 01/01/2024 – 31/12/2024
The learning responses declared following the implementation of the PSIRF (1 November 2023 – 31 December 2024)
Escalations to clinical governance, complaints and legal huddle and/or Patient Safety Panel for consideration of patient safety incident investigation (PSII) or other learning response from inquests and claims, complaints, thromboprophylaxis and thrombosis committee, mortality overview group and external partners
Quality improvement (QI) projects recorded as being underway at 31 December 2024

The PSIRP: local focus includes the patient safety incidents BHNFT has identified through stakeholder analysis of the organisational data that present the greatest opportunities for learning and subsequently improving the safety and quality of care our patients receive.

The Trust has used the criteria below when defining our patient safety incident responses:

- Potential for harm and loss of trust in BHNFT's services
- Impact on quality and delivery of BHNFT's services
- Likelihood and persistency of the incident
- Potential to escalate

Defining our patient safety improvement profile

The following QI projects were recorded as being underway at the 31 December 2024. The QI projects have been aligned to a patient safety incident category or subcategory and where the patient safety incident would trigger a learning response under the Trust's 2023-25 PSIRP this is shown below.

Quality improvement project name	Related patient safety incident category/subcategory	Learning response (if triggered) under 2023-25 PSIRP
HIV testing in ED	Diagnosis delay/failure	PSII local priority 1
Improving the quality of clerking for stroke patients	Documentation	PSS local priority 2
Improving the prescribing and administration of Parkinson's meds for inpatients	Medication incident	PSII local priority 1
Switching from IV to oral antibiotics		
Increasing use of nicotine replacement therapy on CDU		
Early prescription of nicotine replacement therapy		
Improving dispensing training		
Measurement of patient outcomes on Acorn Unit	Complication of ill health	
Improving MUST score compliance		
Mouth care		
Low fat diets for patients admitted with gallbladder issues		
Dietetics carb counting nurse education		
Hypokalaemia TAD	Delay/failure to implement care	PSII local priority 1
Management of patients with PEG issues		
Improving correct investigations for community acquired pneumonia on AMU		
Venous blood gas testing in ED		
TAD management of uncomplicated diverticulitis		
Improving care for frail older patients in ED		
Walking boots in paediatric ED		
Resus training compliance		PSII national priority 2
Dysphagia swallow screening		PSII local priority 1/ national priority 2
Therapy for LARS patients		
Avoidance of hospital admissions from ED	Infrastructure	
Increasing use of home management casts in paediatric ED for stable fractures		
Improved management of suspected VTE from ED/MSDEC		PSII local priority 1
Board round review	Extended stay/episode of care	
Reusable PPE	Infection prevention and control	

Reduction of the use of caffeinated products on medical wards	Slips, trips, falls	After action review
Carers attending hospital appointments – buddies system	Access/admission – delay/failure in access to hospital/care	
Reducing inequity in waiting times CBU2		
Increasing maternity services experience for diverse service users		
Endoscopy clinic efficiencies		
SDEC – extend to 12 hours service over 7 days		
Endoscopy clinic efficiencies – staff start times		
Improving efficiency for transferring patients to theatre recovery		
Reducing same-day cancellation of intravitreal injections		
Pelvis health reduction in UTA and DNA rate		
Improving emergency crash trolley stocking	Patient incident/accident	PSII national priority 2
Martha's rule		PSII local priority 1/national priority 2
Introducing mealtime handovers		
Improving the silver trauma experience		
Improving communication between primary and secondary care in relation to alcohol care	Communication failure – outside of immediate team	
Improving communication process with next of kin following child bereavement		PSII local priority 4
Reducing inappropriate referrals to physiotherapy		
Reducing inappropriate referrals to cardiology from AMU		
Increase in referrals to perinatal physio team		
Reducing neonatal admissions	Women and children's	Avoiding term admissions to the neonatal unit
ATAIN maternity compliance		Avoiding term admissions to the neonatal unit
Maternity BAPM7 compliance		
Improvements to Antenatal clinic		

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.

BHNFT is required to carry out PSII for incidents meeting the NHS England never events criteria 2018 (updated February 2021) and deaths clinically assessed as more likely than not due to problems in care.

The table below sets out the events that a national mandated response is required for. It is more likely that the Trust will contribute to, rather than lead the investigations for the events numbered six to eleven.

	National priority	**BHNFT response**
1.	Incidents meeting the never events criteria	BHNFT led PSII
2.	Deaths clinically assessed as more likely than not due to problems in care	BHNFT led PSII
3.	Incidents in NHS screening programmes	BHNFT led PSII in line with guidance for managing safety incidents in NHS screening programmes
4.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) in line with BHNFT learning from deaths policy
5.	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 (BHNFT learning from deaths policy)	BHNFT led PSII in line with BHNFT learning from deaths policy
6.	Maternity and neonatal incidents meeting the Maternity and Newborn Safety Investigations (MNSI) criteria	Refer to the MNSI for an independent PSII
7.	Safeguarding incidents in which: • babies, child and 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 by their Local Authority • the incident relates to FGM, Prevent (radicalisation to terrorism); modern	Refer to local authority safeguarding lead. BHNFT 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.

	slavery & human trafficking or domestic abuse / violence.	
8.	Child deaths	Refer to child death overview panel for review
9.	Mental health related homicide	Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration of an independent PSII
10.	Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigation
11.	Domestic homicide	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

Our patient safety incident response plan: local focus

BHNFT considers that the incident types set out below are key to delivering high quality, person centred care. The PSIRP aims to support and embed the Trust's ongoing quality improvement (QI) work.

Incident type	Description	Learning response
Patient harm (excluding a fatal outcome)	Incidents resulting in patient harm (excluding a fatal outcome) as a consequence of missed/delayed recognition or escalation of diagnosis or treatment where new system based learning is identified	Patient safety incident investigation (PSII)
Digital systems	Incidents as a result of the use of BHNFT's digital systems that have the potential for harm, loss of trust or an impact on quality and delivery of services where new system based learning is identified	PSII
Incident that meets the criteria for an after action review (AAR) that has resulted in a fatal outcome	Where an incident that resulted in a fatal outcome that meets the criteria for an AAR a swarm huddle will be undertaken and the incident will be discussed at the Trust's next Patient Safety Panel for consideration of a PSII.	PSII
Patient involvement	Where patients or their loved ones questions would not be fully answered by the proposed learning method or other Trust process* (e.g. complaint, litigation, subject access request etc.)	PSII
Repeated incident identified	A source* (e.g. corporate lead, group, committee,	Multidisciplinary team (MDT) review

	complaints, incidents litigation, inquests, maternity dashboard etc.) identify the same issues in three investigation/responses when improvement work is known to have been implemented	

*not an exhaustive list

All proposed PSII will be escalated for discussion and agreement at the Trust's weekly Patient Safety Panel chaired by the Medical Director/Director of Nursing, Midwifery and AHPs.

Where a patient safety incident does not fall into any of the above categories a learning response will be undertaken in line with the relevant Trust policy/SOP. Links to the relevant SOPs are included in appendix 2.

Where there is no Trust policy/SOP that sets out a learning response a narrative response should be updated on the incident report following a local investigation or one of the learning responses included in appendix 1.

Appendix 1 – learning response methods

Learning response method	Description
Patient safety incident investigation (PSII) Suggested duration – 20 to 80 hours over several weeks Undertaken by a trained patient safety investigator Report generated	An in depth review of a single incident or cluster of incidents to understand what happened and how
Multidisciplinary team review (MDT) No suggested duration Led by a clinical governance facilitator/investigation officer	Supports teams to learn from multiple incidents or a safety theme that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Uses an open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle Suggested duration – 30 minutes Chaired by a senior lead Report generated	A meeting initiated as soon as possible after an incident. Staff 'swarm' to the site to gather information about what happened, why it happened and decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR) Suggested duration – 45 – 90 minutes Led by an appropriate facilitator Lessons learnt log generated	A structured facilitated discussion of an incident that gives individuals involved in the incident understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

Appendix 2 – Trust policies/SOPs relating to learning responses

Procedure for reporting and managing patient safety incidents

Womens services quality, safety and governance

Learning from deaths policy

Surgical site infection RCA process (appendix 4 in procedure for managing patient safety incidents)

Falls prevention policy

Pressure ulcer prevention policy

VTE prevention policy

Clostridioides difficile policy

Hospital onset covid-19 infection SOP

Management of healthcare associated infections SOP

Procedure for after action review (AAR)

Procedure for multidisciplinary team (MDT) review

Procedure for a patient safety incident investigation (PSII)

Procedure for swarm huddle

Patient safety incident response policy