Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan 2024-26

"We are comitted to fostering an environment where all our staff feel empowered to voice concerns and feel supported if they are involved in a patient safety incident."

Contents

Effective from 1st October 24 Review date 31st March 2026.
The Patient Safety Incident Response Plan 2024 – 26 has been reviewed and authorised by the Trust's Quality Committee and Trust Board. The plan has been approved by the Nottingham and Nottinghamshire ICB.

01. Introduction

Foreword from the Executive Leads

"I am proud to present our 2024-2026 Patient Safety Incident Response Plan, which demonstrates our unwavering commitment to learning and improving our services for the community. Our mission is centered on prioritising patient safety and continuously improving the care we provide. This plan embodies our comprehensive approach to understanding and addressing patient safety events, ensuring that every experience contributes to a culture of learning and improvement. I am sincerely thankful to all our patients, staff, and stakeholders for their contributions to the development of this plan. Your collaboration, expertise, and dedication form the foundation of our success. Together, we will continue to promote a just culture, ensuring that our healthcare services are safe, effective, and consistently improving."

Simon Roe
Acting Medical Director

"I am delighted to present our updated Patient Safety Incident Response Plan. This plan outlines our commitment to nurturing a culture of learning and continual improvement throughout the organisation and builds on our achievements following the launch of PSIRF in October 2023. We have recruited 4 Patient Safety Partners to represent the voices of patients, carers, and families and to assist us in emphasising the importance of compassionate engagement with individuals involved in all patient safety events, ensuring they receive the necessary support and are able to contribute to the improvement of our services. It is essential that everyone feels listened to, valued, and secure in voicing their concerns, and we are dedicated to empowering our staff to do so. We will address patient safety events through a variety of approaches, ensuring our responses are customised and effective. Thank you to our patients, staff and stakeholders for being a crucial part of our commitment to patient safety."

Phil Bolton
Executive Chief Nurse

02. Purpose & Scope

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how Sherwood Forest Hospitals NHS Trust will respond to patient safety events during 2024 – 2026.


Mansfield Community Hospital


Newark Hospital


King's Mill Hospital

Scope

This Patient Safety Incident Response Plan (PSIRP) outlines the Trust's strategy for addressing patient safety incidents and should be followed by all staff across the organisation. Whilst the plan sets out our 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.

Who we are

We employ **6,000** people

We have a vibrant community of **400** volunteers

We spend over **£500 million** each year to provide healthcare to our local population

We serve a population of **350,000** people in Mid-Nottinghamshire and beyond

We have over **650** beds

We prepare **630,000** meals for patients every year

We provide **450,000** outpatient appointments every year

We have **190,000** emergency department and urgent care attendances every year

We perform **30,000** scans every year

We deliver **3,500** babies each year at our hospital

We have achieved the UNICEF Baby Friendly **bronze** award

We achieved the Pathway to Excellence designation, a globally recognised nursing excellence framework

We recruited **12** people from our local area through 'Step into the NHS' events held with West Notts College

VETERAN AWARE We achieved the **gold** standard Veterans Aware accreditation

We have planted over **200** fruit trees in our Hope Orchard and more in local community orchards in Warsop and Mansfield

03. Defining our Patient Safety Culture

We remain dedicated to creating an environment that enhances patient safety by promoting a Just Culture approach across the organisation.

A primary objective of the SFH Strategy for 2024-2026 is to foster a culture of learning, empowering our staff to consistently drive and deliver improvements and enhancing this further by co-designing our services with those that use them.

We are committed to creating a culture whereby we adopt innovations and technology, providing opportunities to deliver efficiencies and improvements.

04. Defining our Patient Safety Event Profile

The summary below provides an overview of the analysed data sources within the reporting period from April 2021 – March 2024 and includes incidents reviewed under the Serious Incident Framework and the new Patient Safety Incident Response Framework.

11
Patient Safety Incident Investigations

90
STEIS

74
Divisional investigations

4
Learning Team

2
After Action Review

6
Category 3 & 4 Pressure Ulcers (Acquired during admission)

2
Thematic Review

7
Never Events

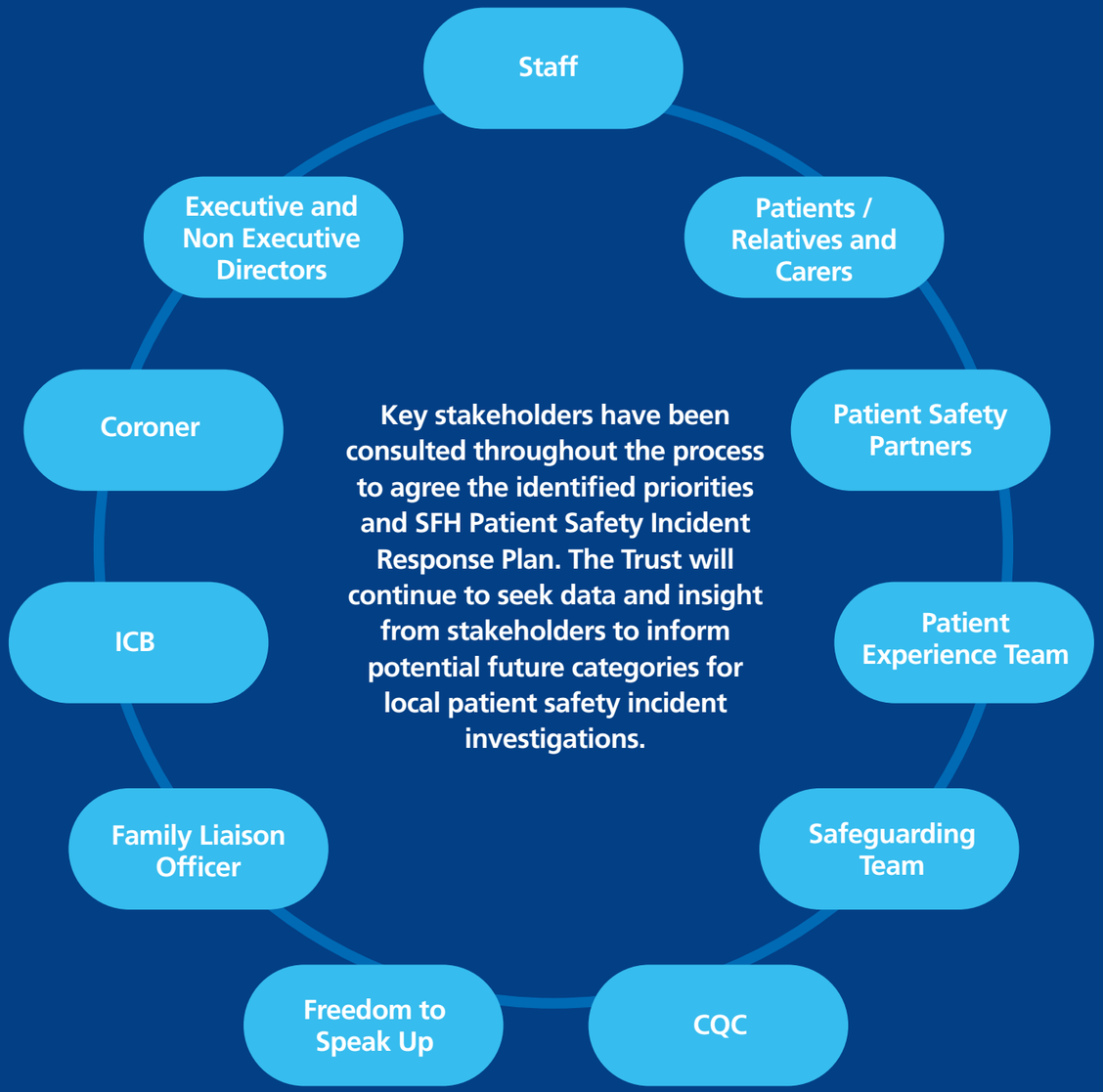
11
LeDeR

7
VTE

595
Healthcare Associated Infections

20
Falls

05. Stakeholder Engagement



Key stakeholders have been consulted throughout the process to agree the identified priorities and SFH Patient Safety Incident Response Plan. The Trust will continue to seek data and insight from stakeholders to inform potential future categories for local patient safety incident investigations.

06. Defining our Patient Safety Improvement Profile

The Trust has established an Improvement Faculty which brings together several existing teams who contribute to improvement across the organisation with the aim of creating a centre of excellence. Teams who are partners in the faculty include:

The aim of the Improvement Faculty is to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and transformation, including implementing improvements/solutions arising from patient safety incident investigations. The Improvement Faculty will offer help, advice, training and, where required, coordinated support.

The Improvement Faculty offers the Quality, Service, Improvement and Redesign (QSIR) quality improvement training programme developed by NHS Improvement. As of June 2024 over 340 staff across the Trust have completed the 5 day QSIR Practitioner training covering:

- Leading improvement
- Measurement for improvement
- Sustainability
- Stakeholders and engagement
- Understanding demand and capacity
- Creativity in improvement
- Process mapping and other tools

07. Our Patient Safety Incident Response Plan: National Requirements

Given the Trust's limited resources for responding to patient safety events, our goal is to maximise improvement through strategic use of these resources.

PSIRF allows us to prioritise improvement efforts rather than repeatedly responding to and reviewing events based on often subjective thresholds and definitions of harm. This approach is crucial, as reviewing numerous similar events yields minimal new insights, whereas concentrating on system improvements, especially those affecting the broader Trust, will deliver greater benefits for both patients and staff.

Certain patient safety events, such as Never Events and deaths likely due to care issues, will always necessitate specific responses as outlined by national policies or regulations, including Patient Safety Incident Investigations (PSII), to facilitate learning and improvement. For other types of events affecting specific patient groups, such as children, a nationally defined response is also required. These responses may involve referring events to, or having them reviewed by, external teams or bodies, depending on the event's nature and the individuals involved. The Trust fully supports this approach, as it aligns with our commitment to learning and improving within a just culture.

Event	Action	Lead
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII	The Trust
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	The Trust
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII	The Trust
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RITT) for consideration for an independent PSII. Locally-led PSII may be required	RIIT
Maternity and neonatal incidents meeting the criteria for the Maternity Newborn Safety Investigation (MNSI) programme	Refer to MNSI for independent review	MNSI
Child Deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	LeDeR programme
Safeguarding incidents in which: • babies, children, or young people on a child protection plan; looked after plan or a victim of willful 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 Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery • and human trafficking or domestic abuse/violence	Refer to local authority safeguarding Lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding

Event	Action	Lead
Incidents in NHS screening programmes	As defined by NHSE screening programme	NHS England
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Any death in prison or police custody 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 organisations must fully support these investigations where required to do so	PPO or IOPC
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, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

Coroners' cases

Incidents involving deaths in which there is coronial involvement should be identified at an early stage by the bereavement centre and the clinical team. Allocation of learning responses should take into consideration issues raised with the Coroner (eg in the referral to the Coroner) and the potential for learning which may prevent future deaths. It is irrelevant whether potential lapses in care identified in the incident contributed to this specific death. Reports should be suitable for submission by the legal team in anticipation of any potential inquest.

08. Our Local Priorities

Based on our analysis and engagement with key stakeholders, the Trust has identified six key patient safety priorities. These will guide the Trust's Patient Safety activities between October 2024 – March 2026. These patient safety priorities will serve as the basis for how the Trust conducts Patient Safety Incident Investigations (PSII) and other relevant patient safety reviews. The detailed Patient Safety Priorities are as follows.

	Incident type	Description	Response type
01	Treatment & Care to include concerns over appointments, admission, transfer & discharge	Delays to follow-up and to include incidents regarding issues with movement of patients / flow / capacity	PSII
02	Medication	Relating to wrong dose, omitted / delayed / wrong / duplicate medication	PSII
03	Delays in care	Delays to treat the deteriorating patient	PSII
04	Communication	Consent / DoLS / MCA	PSII
05	Health Records, Consent & Confidentiality	Incidents relating to health records and consent issues	PSII
06	Obstetrics / Maternity	Postpartum Haemorrhage in excess of 1.5L requiring return to theatre or activation of major haemorrhage protocol	Thematic review

All initiated Patient Safety Incident Investigations should have clearly defined terms of reference, agreed upon in collaboration with the patient, their family, and carers affected by the patient safety event.

09. Appendix

9.1 Roles and Responsibilities

Role	Responsibility
Chief Executive Officer	The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974). As part of this role the Chief Executive has overall responsibility for ensuring there are effective risk management systems and processes in the Trust to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff and visitors. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.
Medical Director / Chief Nurse	The Medical Director / Chief Nurse have delegated responsibility for 1) ensuring that there are adequate arrangements in place for patient safety incident investigations and reviews 2) governance of these arrangements. 3) that there is adequate assurance to demonstrate learning is being shared and changes to practice as a result of patient safety incident investigations and reviews are implemented across the Trust.
All other Executives and Non Executives	All Directors on the Trust Board, whether Executive or Non-Executive, are responsible for adhering to, championing, and supporting the implementation of this patient safety plan within their respective portfolios.
Patient Safety Partners	Our patient safety partners will participate in investigation oversight groups and be active members of the Patient Safety Incident Review Group (PSIRG) and other work streams. They will encourage patients, families, and carers to play an active role in their safety and contribute to action plans following investigations, particularly focusing on actions that address the needs of patients.
Director of Nursing Quality and Governance	The Director of Governance will support the Chief Nursing Officer in all aspects of their patient safety portfolio. As the lead manager for the Trust's patient safety function, the Director of Governance holds overall responsibility and will provide strategic direction for the implementation of this plan.
All Staff	All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the GSU pages of the Trust intranet.
Family Liaison Officer (FLO)	The FLO will ensure the organisation's legal duty of candour is met for relevant incidents. They will support those affected by patient safety incidents, address their support needs, and act as their single point of contact. This role includes providing timely and accessible information and advice, facilitating access to relevant support services, gathering information from review teams to set expectations, and collaborating with the Governance Support Unit and other services to develop various support services.
Incident Reviewers	Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required. The reviewer(s) should have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training courses.
Divisional Leadership Teams	Divisional Leadership Teams are responsible for encouraging the reporting of all patient safety incidents and ensuring staff are proficient in using reporting systems and have time to record and share information. They must ensure incidents are managed according to internal and external requirements and periodically review the PSIRF and PSIRP to ensure expectations are understood. Additionally, they should provide protected time for training in patient safety and for participation in reviews and PSIIs.
Governance Support Unit (GSU)	The GSU will facilitate the Patient Safety Incident Review group (PSIRG) meetings twice weekly to review incidents and ensure appropriate investigations are conducted. They develop and maintain local governance and national incident reporting systems to record and share incidents. PSIRG leads the development and review of the organisation's PSIRP, oversees PSII progress monitoring, and ensures improvements are delivered. They collaborate with executive leadership to address identified areas of improvement in patient safety incident responses, support and advise staff involved in incident response, and ensure staff have necessary skills and tools for patient safety reviews at national standards.
Medical Examiner	The Medical Examiner's responsibilities include ensuring thorough scrutiny of all deaths, directing appropriate cases to the Coroner, and offering bereaved families a platform to raise concerns independently. They aim to enhance death certification and improve mortality data quality. Despite being NHS employees, medical examiners maintain professional accountability separate from their employer, overseen by the national Medical Examiner to safeguard their independence. They scrutinise deaths to verify medical causes, identify care-related issues, report to clinical governance processes, engage with bereaved families, refer cases to the coroner as needed by law, assist coroners with medical information, and educate clinicians on death registration and coronial procedures.
Patient Safety Specialist	Our Patient Safety Specialist is a key patient safety expert who will provide dynamic and visible leadership to support the patient safety agenda.

Committee responsibility

Role	Responsibility
Patient Safety Committee (PSC)	The Patient Safety Committee (PSC) has responsibility for reviewing and monitoring PSIRF activity and outcomes from the themes and trends identified at PSIRG. The committee should feedback at each meeting on our progress against the PSIRP. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of PSC will seek assurances from the divisions that risks are being adequately addressed. Where there are remaining concerns these will be escalated to the Quality Committee.
Quality Committee	The Quality Committee has responsibility to seek and gain assurance that the actions and learning resulting from patient safety incident investigations are appropriate and timely and any challenges to implementation are escalated. The Committee should feedback at each meeting on our progress against this PSIRP.
PSIRF Oversight Group	The Oversight Group is responsible for ensuring that the Trust is meeting the national patient safety incident response standards. It will seek assurance that improvements have been made within divisions in response to patient safety incidents, supporting to emphasise the focus on engagement and empowerment. The Oversight Group will report directly to the Quality Commitee who will seek assurance that these standards are met.
Trust Board	The Trust Board has a responsibility to ensure that it receives assurance that this plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. This will be achieved through reporting processes as well as receiving assurance via the Quality Committee. The Trust Board receives a bi-monthly report on patient safety incident investigations within the Trust and monitors the lessons learned from these. Where concerns are identified relating to the robustness of lessons learned or actions planned the Trust Board will seek assurances that these concerns are being acted upon.
ICB	The Integrated Care Board (ICB) is tasked with approving and ensuring the collaborative implementation of this plan across the local integrated care system (ICS). It acts as a crucial stakeholder, offering oversight and support to the Trust throughout the process. A representative from the ICB will participate in the Trust's PSIRG to supervise and uphold the quality of investigations conducted by the Trust.

9.2 Glossary

Patient Safety Incident Investigation (PSII)

A Patient Safety Incident Investigation (PSII) is a comprehensive investigation which will utilise the System Engineering Initiative for Patient Safety (SEIPS) framework. These investigations may be initiated when it is felt a patient safety event meets the criteria to be defined as a national or local priority.

After Action Review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these events to identify opportunities to improve and increase the instances where success occurs.

Learning Team Reviews

- Identify areas for improvement
- Celebrate success
- Understand the expectations and perspectives of all those involved
- Agree actions
- Enhance teamwork through communication and collaborative problem solving

Safety Huddle

A planned team gathering triggered by an event. An unstructured moderated discussion for those involved in the incident to regroup and talk about the event. Focussed on process-orientated reflection to propose actionable solutions.

Thematic Review

Learning from multiple sources of insight into a patient safety issue.