Patient Safety Incident Response Plan

Great Ormond Street Hospital for Children
NHS Foundation Trust

2024 - 2025

Patient safety incident response plan

Effective date:

Estimated refresh date: 8th June 2025

	Name	Title	Signature	Date
Author	Shona Little Daniel Mortara	Head of Patient Safety Project Manager – MDO		
Reviewer				
Authoriser	Dr Sanjiv Sharma	Medical Director		The 7th day of February 2024.

Contents

N.B. The PSIRP should be read alongside the Patient Safety Incident Response Framework (PSIRF) guidance[1] and GOSH's Patient Safety Incident Response Policy.

[1] NHS England » Patient Safety Incident Response Framework

Term	Definition
PSIRF	Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned care. To ensure equity and consistency on how GOSH respond to safety events, this framework will apply to all care delivered by GOSH. Building on data collated and learning from best practice across the wider healthcare system, PSIRF is designed to enable a risk-based approach to responding to patient safety events, prioritising support for those affected, effectively analysing events, and sustainably reducing future risk, improve safety culture and work towards minimising avoidable harm.
Patient Safety Event	A patient safety event, which GOSH will use as an alternative to incident. This is an event or circumstance which causes or could have caused harm to a patient.
PSIRP	Patient Safety Incident Response Plan. GOSH has set out a plan determining how we will undertake PSIRF locally, including our list of local priorities. These have been developed through a co-production approach with subject matter experts and supported by analysis of local data.
PSII	Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSII and other learning responses into a similar incident type. Recommendations and improvement plans are then designed to effectively address those system factors and deliver safer care for people who use our services.
AAR	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 a wider group of those affected to identify opportunities to improve and increase to occasions where success occurs.
Safety Huddle	Safety huddles are **short multidisciplinary briefings** designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care.
SERG	Safety Events Review Group.

	A weekly forum where events meeting the local priorities, events of concern and emerging themes are discussed to identify suitable learning responses. This forum will review PSII reports and provide assurance for executive sign off.
OLAF	Organisational Learning and Assurance Forum A monthly forum where learning response coordination will be reviewed to monitor safety actions; develop organisational safety actions and inform quality improvement work to be taken to the Quality Review Group. This forum will be responsible for reviewing all learning response outcomes, identifying how learning will be shared across GOSH and monitoring that learning is embedded and improvements in care.
QSOCC	Quality, Safety, Outcomes and Compliance Committee. QSOCC is a subgroup/committee of the Executive Management Team and is chaired by the Chief Medical Officer or Chief Nursing Officer. It has delegated authority from the Executive Management Team to oversee and monitor all aspects of patient safety and quality and to ensure that the Trust continues to be a learning organisation. The purpose of QSOCC is to monitor and identify quality, safety, outcomes and compliance metrics through the oversight and triangulation of data, insight, and informal signals.
RAG	Risk Action Group A forum where each directorate has a RAG. Some areas may have sub-directorate RAG meetings which report into the directorate board meetings or quality and safety meetings. The purpose of the RAG is to identify and assess risks in the clinical area. The forum also reviews near misses/no harm/low harm events to identify themes and trends to take a proactive approach to improvement and work to manage risks before events happen.

Introduction

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex and dynamic healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients and families are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety events also incur costs through lost time, additional treatment, and litigation. Overall, the majority of events are caused by system design issues, and not by individuals.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety events for the purpose of learning and improving patient safety. It is recognised that there will need to be a shift towards systems-based approaches to a learning culture to allow GOSH to effectively respond to and learn from events, with the purpose of reducing the risk of avoidable harm as low as reasonably possible.

The Serious Incident Framework (SIF) outlines a suggested list of events which require a full investigation, with external oversight and approval. The introduction of PSIRF provides GOSH with more autonomy and flexibility in our approach to patient safety events.

Patient safety events can be defined as

"Any unintended or unexpected incident which could have, or did, lead to harm for one or more patients' receiving healthcare".

Compassionate engagement is a key fundamental of PSIRF. Clear communication with those affected by patient safety events to determine the focus of any review is vital to ensure that the voice of the patient, families/carers, and staff is at the heart of any response and learning. Documentation of clear communication and engagement is vital.

It should be acknowledged that PSIRF is a new framework for the identification and response to patient safety events, however the aims and ethos have been adopted within healthcare for some time. The implementation process will take time to progress and embed and will require regular review to ensure that GOSH can demonstrate positive assurance in improvements and safety. Enhancing data quality and agility will need to be at the heart of the implementation process to ensure continuous progression.

Effective introduction and ongoing development of PSIRF will be achieved through identifying key themes, patterns, and trends from the data, identifying opportunities for learning and ensuring there are organisational improvement plans in place, over the medium and long term. These will be reviewed, by internal and external agencies, to provide assurance that GOSH can demonstrate effective learning, supported by sustainable improvements in the quality and safety of services and improved care for people who use our services.

The application of System Engineering Initiative for Patient Safety (SEIPS) methodology, to identify the safety actions that need to be considered, is new within the trust. As such, it is

recognised that those leading on learning responses may benefit from support from either a more experienced practitioner, or a trained peer who has the same level of experience, as a “buddy”. It is possible that this expertise/support may be sought from an external source (e.g., another healthcare provider learning response lead from within North Central London Integrated Care Board (NCL ICB) or GOSH may be requested to provide “buddy” support.

The GOSH profile, however, must be flexible in its approach to risk and learning, and therefore, where there is either significant risk, opportunities for significant new learning, or opportunities to explore systems and processes for the purpose of learning, the Trust will remain flexible and consider specific individual circumstances and/or emerging themes alongside the implementation of this plan. Events for escalation to a PSII will not be graded by severity of harm, but rather the opportunity to understand what happened and the opportunity for learning and improving care.

A Patient Safety Incident Response Plan (PSIRP) is required for all services provided under the NHS Standard contract. This applies to all services provided by GOSH.

This PSIRP sets out how GOSH will respond to patient safety events reported by staff, patients, families, and carers to allow for continuous improvement of the quality and safety of the care we provide. The PSIRP will be reviewed bi-annually following the initial review to be carried out in June 2025

> *The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them.*
>
> Aiden Fowler, National Director of Patient Safety NHS England

Aims

PSIRF has four main aims upon which this plan is based, and the table below sets out how these aims will be achieved through specific objectives.

Patient Safety Incident Response Framework

Compassionate engagement and involvement of those affected by patient safety incidents

- Act on feedback from patients, families, carers and staff about current problems with patient safety incident responses.
- Involve patients, families, carers and staff in patient safety learning responses for better understanding of issues & causal factors.

Application of a range of system based approaches to learning from patient safety incidents

- Identify learning from incidents and areas to improve to allow us to reach our aim of reducing all avoidable harm to zero by 2025; further developing systems of care to continually improve their quality and efficacy.
- Develop clear pathways from learning to Quality Improvement

Supportive oversight focussed on strengthening response system functioning

- Establish a local assurance group, including our commissioners, to uphold efficacy of PSIIs and alternative responses to patient safety incidents which promotes ownership, rigour and expertise and promote organisational learning.
- Develop a climate which supports a just culture (3)

Considered and proportionate responses to patient safety incidents

- Make more effective use of staff resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to develop and implement improvements more effectively.

To meet the requirements for the National Standards for Patient Safety Responses, we will

- Develop a body of expertise within the Patient Safety Team, and the wider organisation, to conduct learning responses which ensure compassionate engagement and involvement for all affected.
- Undertake system-based approaches which support directorate, cross-directorate, and organisational learning, which has a positive impact on providing safer care for patients and families.
- Ensure patients, families/carers and staff affected by patient safety events are compassionately engaged with at the earliest opportunity and are involved, as much as they wish to be, in the review and learning processes to allow for change which reflects the needs of people who use our services.
- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the approval of all PSIIs.
- The Organisational Learning and Assurance Forum, will oversee, manage and provide assurance all learning responses and local improvement across GOSH, sharing and embedding learning.
- Use Quality Improvement (QI) methodology and improvement science approaches to develop learning and implement improvements in care.

Our Services

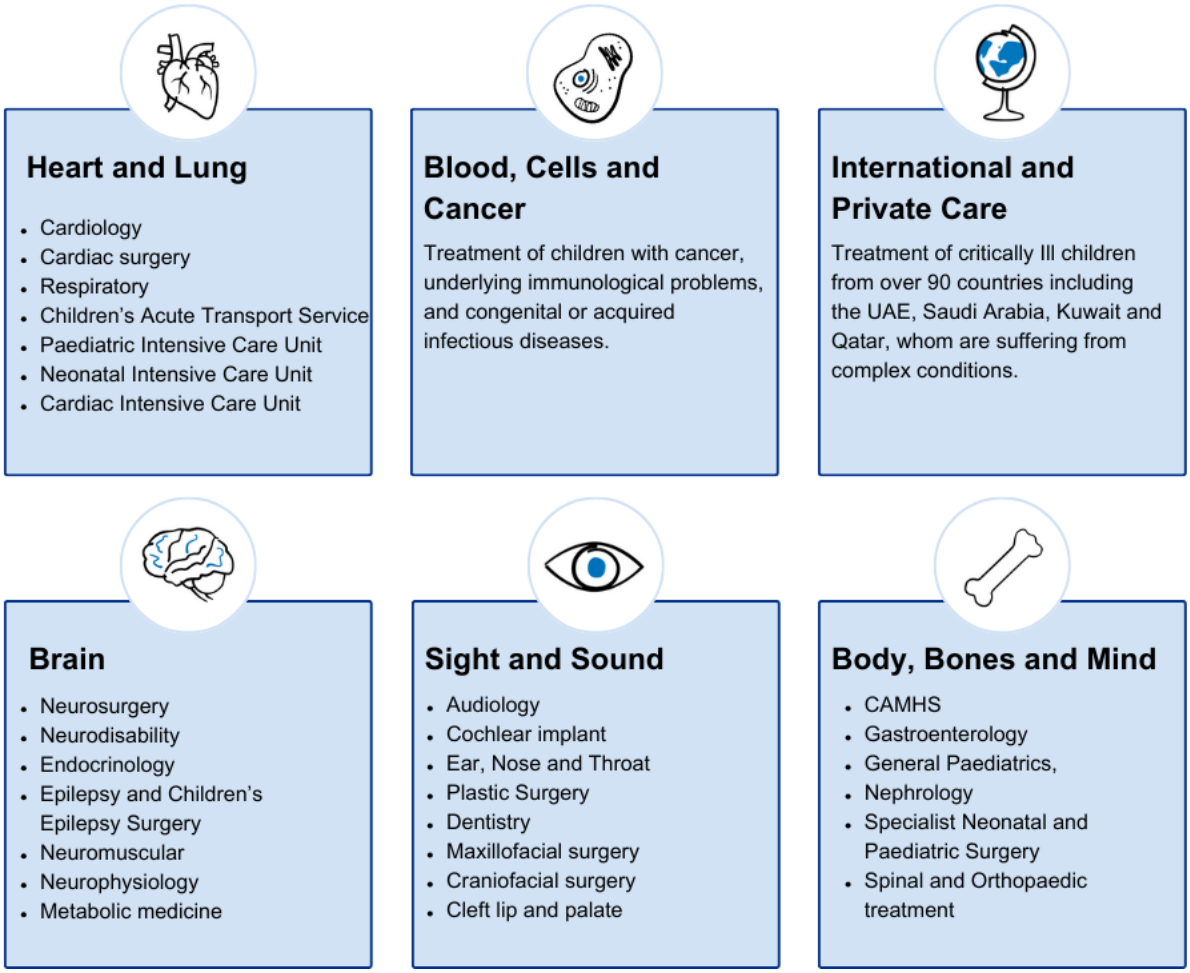
Great Ormond Street Hospital (GOSH) is an international centre of excellence in child healthcare. Since its foundation in 1852, the trust has been dedicated to children's healthcare and to finding new and better ways to treat childhood illnesses.

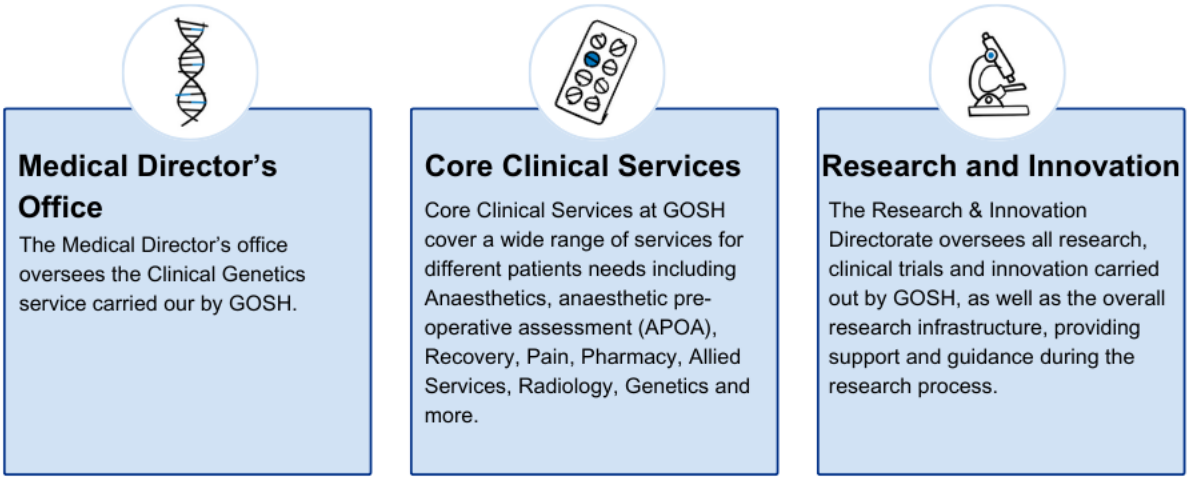
GOSH receives around 242,694 outpatient visits and 42,112 inpatient visits per year, and approximately 750 children and young people per day[2].

There are over 60 clinical specialities across the Trust and GOSH is the largest paediatric centre in the UK for:

- Paediatric Intensive Care.
- Cardiac Surgery.
- Neurosurgery.
- Paediatric cancer services.
- Nephrology and renal transplants.
- Tracheal Surgery.
- Children treated from overseas and privately within our International and Private Care (I&PC) wing.
- Research and Innovation.
- Tier 4 inpatient CAMHS mental health care.

The trust has the following directorates:





Safety Improvement Profile

GOSH has strengthened existing governance processes and will continue to review existing processes to ensure that they meet the PSIRF standards and to deliver the key aims of PSIRF. Patient safety is a key purpose and it essential there is effective learning from incidents.

Incident themes and trends will be reviewed at directorate Risk Action Groups (RAGs). The purpose of this forum is to review all safety events, with an emphasis on incidents across the directorate, or sub-directorate, to identify patterns. This allows for local learning and improvement to take place with the aim of minimising events and preventing avoidable harm. Patterns and events of concern can be escalated to the SERG for review by members of the senior leadership team.

The Safety Events Review Group (SERG) will continue to review incidents which:

1. Meet the national or Trust priorities.
2. Where there are identified patient safety themes.
3. Emerging themes which impact on patient safety.
4. Provide a forum for review and sign off of PSIIs.

Learning from events, PSII and learning responses will be undertaken in the Organisational Learning and Assurance Forum (OLAF) where there will be consideration for directorate, organisational and system-wide learning. PSII safety actions, themes from learning responses and local learning initiatives will be reviewed by this forum with recommendations for sharing learning and assurance that learning is being embedded.

OLAF will work collaboratively with the Quality Review Group (QRG) to identify and commission specific quality improvement projects to address learning from events. The QRG will ensure that clinical and corporate directorates provide robust assurance on quality improvement, in accordance with the Trust Quality Strategy.

Findings from individual PSII and other PSIRF learning responses will be collated and compared to identify themes in modifiable factors upon which quality improvement initiatives can be developed to support organisational learning.

The trust will apply the principles of patient safety science and improvement methodology to identify:

- What improvements are recommended and prioritisation of quality improvements.
- Plans for implementation and involving stakeholders.
- Measuring the impact of the changes or identifying alternative changes where the desired impact is not achieved.
- Engage QI teams to ensure services have the resource to embed and sustain improvement.
- Hospital-wide Safety Transformation Programme.

The trust has the following safety improvement plans underway:

- Deteriorating patients Working Group
- Complex Patient Working Group
- Medicines Safety Committee
- Total Parenteral Nutrition (TPN) Improvement Group

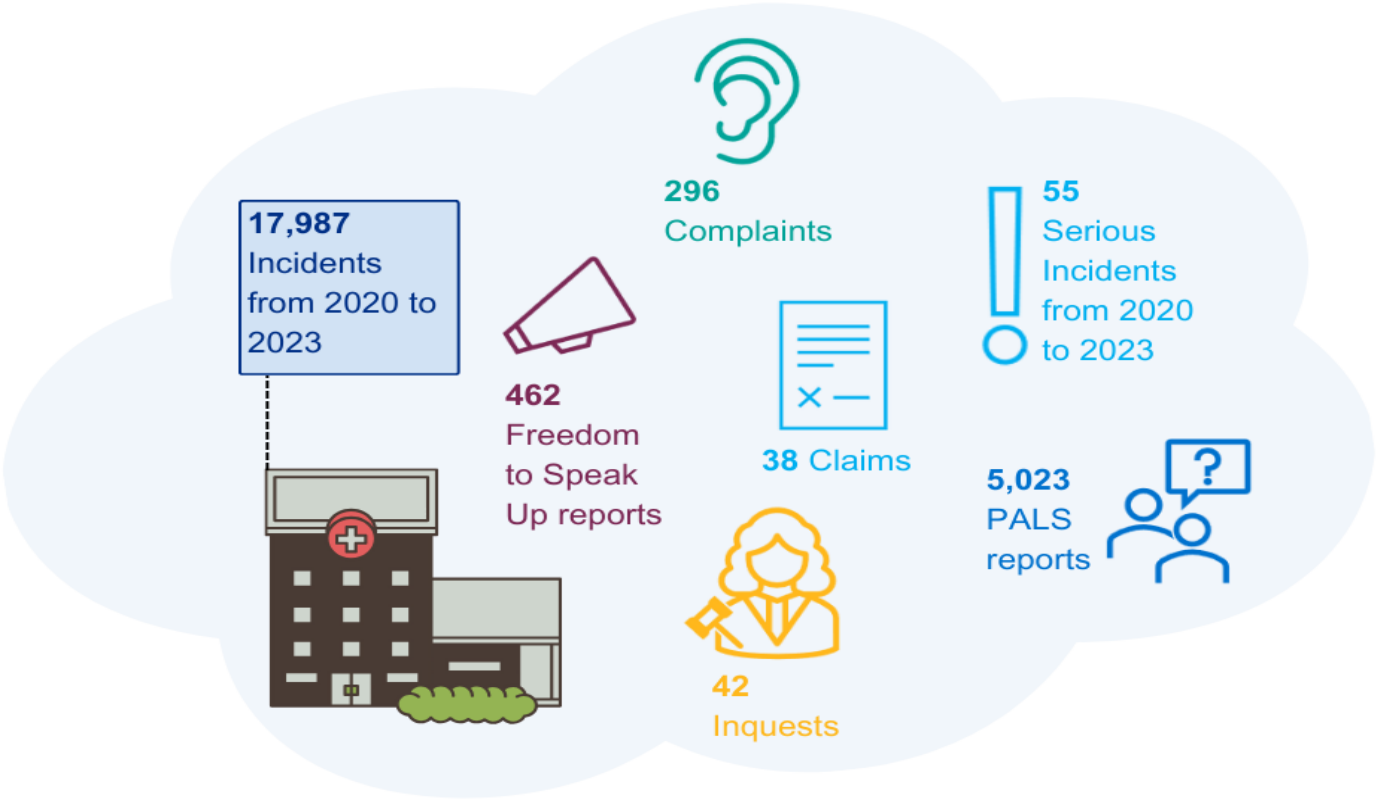
Clinical effectiveness processes such as clinical audits, Horizon Scanning and Learning from Death data will continue to be monitored to ensure any new patient safety trends and risks are identified and acted upon in a timely manner. This data will also be used to inform the Trust's patient safety event risk profile.
All forums listed above will report to the Quality, Safety, Outcomes and Compliance Committee (QSOCC).

Identifying the Trust Safety Incident Profile

The Trust completed a thematic analysis approach to determine our patient safety priorities. Thematic analysis is a method of identifying, analysing, and reporting patterns (themes) within data.

The data sources used to define the trust profile are outlined below. The analysis of data was undertaken by subject matter experts for each area to provide expert knowledge of trends and priorities and inform how the trust will respond to events. The review period was between 01 April 2020 to 31 March 2023 to ensure that the data was reflective of pre- and post-COVID data. This included careful consideration of safety improvement opportunities and plans/interventions already in place.

To determine the focus and priorities for PSII, engagement sessions to agree and finalise the Trust priorities were undertaken. This plan has also been reviewed by our Patient Safety Partners (PSPs).



We have determined **six patient safety priorities** that will be the focus for the next 18 months. These patient safety priorities have been developed from a review of the data listed above, and where the specified level of harm, or negative impact has occurred, will be subject to a Patient Safety Incident Investigation (PSII) using system-based methodology. Root Cause Analysis (RCA) methodology is not recommended for safety investigations.

Trust priorities

Admissions, Discharge and Transfers

- Delays in admission or transfer from external hospitals for time critical transfers which lead to a negative outcome for patients, i.e., life changing outcomes or death.
- Unsafe or delayed transfer between specialty teams which result in life changing outcomes, or death.
- Delay in transition between CAMHS and AMHS which result in psychiatric deterioration resulting in use of the MCA; MHA or a review of placement to locked environment.

Medication

- Errors where ten-fold of the prescribed dose has been prescribed and/or administered causing life-changing injury or increased length of stay >14 days.
- Total Parenteral Nutrition (TPN) wrongly connected; or lipid rate over infusing causing significant harm or increased length of stay for patients >14 days.
- Errors occurring during the prescribing, preparation and administration of medication which results in patient harm lasting more than 14 days, i.e., delayed stay in hospital, treatment required to prevent life-changing harm.

Communication

- Communication failures between teams which result in significant harm to patients, resulting in life changing injury; increased length of stay over 14 days and/or reputational risk to the Trust.
- Communication failures relating to treatment between teams and parents which result in readmission/reattendance of patient within 14 days of discharge.

Access to Clinical Services

- Delay in treatment or follow up/imaging incidents which results in a patient not accessing the correct clinical pathway, and harm has been identified on the clinical harm review.
- If indicated, we will collaborate with local services where clinical deterioration resulting in life-changing or catastrophic harm for patients waiting or receiving care under the Gender Identity Dysphoria Service (GIDS)

Responding to deteriorating patients

- No/delayed response to identification of deteriorating patient, as defined in the deteriorating patient pathway which results in harm

Invasive procedure problems

- Invasive Procedure Problems, including injury during or following surgery which results in significant harm to patient(s) resulting in life changing or catastrophic harm, where care and/or service delivery problems have been identified

For events which do not meet the threshold for a PSII as outlined in the six priorities, an alternative, proportionate learning response will be identified and undertaken, involving staff, patients, families/carers, and where identified, a patient's wider support network.

PSII, and other learning responses, are completed for the purpose of learning to and gain an understanding of system contributors about events. This will allow for improvements to be made to systems to make care safer for people who use services.

The selection of patient safety incidents investigations will be selected based on:

- Actual and/or potential impact of the incident outcome on harm to people, service quality, reputation of the Trust etc.
- Likelihood of recurrence
- High potential for new learning regarding:
    - Incident causing factors
    - Improving system efficiency and effectiveness
    - Opportunities to greatly influence wider system improvement.

How we will Respond to Safety Events

A full outline of national defined priorities which require referral for review by another agency or requiring a PSII can be found in the Patient Safety Incident Response Policy and Appendix A.

The table outlined below will guide how we will respond to the identified priorities and local investigations, including the governance arrangements to ensure we have meaningful learning which can be implemented across the Trust with the aim of reducing avoidable harm.

Timescales for Patient Safety Incident Investigations

PSII should ordinarily be completed within 3 months of their start date. The expected date of completion, including executive member sign off should be agreed at the commissioning of the investigation; patient and/or family and/or carer involvement, unless expressed otherwise, should be involved in determining completion dates. Once a date has been agreed with all involved, all efforts should be made to ensure completion of PSIIs are undertaken within this timeframe.

A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to information for longer than six months, a PSII can be completed and subsequently reviewed when the information becomes available; a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Duty of Candour

Once an incident has been identified that meets the Statutory Duty of Candour threshold, which the trust outlines are moderate harm and above, then the legal duties as outlined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 will be carried out in full.
Duty of Candour is regulated by the Care Quality Commission (CQC).

A culture of openness is crucial to improving the safety of patients, families, and staff; thus improving the quality of healthcare. Duty of candour involves apologising and explaining what happened to patients who have been harmed as a result of their care or treatment.

An overview of duty of candour can be outlined in 3 steps:

1. **Conversation**: Apologise in person as soon as we become aware that something has gone wrong.
2. **Candour Letter**: Send a letter with a summary of the conversation and outline plans as to how GOSH will respond to this patient safety event (within 10 working days).
3. **Completion**: Arrange for the learning from the response and if there are areas where GOSH will work to improve care and systems will be shared with those affected once this response has been completed.

Learning Responses Which Support Engagement and Learning

All patient safety events will have a learning response, however, often engagement and learning are best achieved through a proportionate learning response.

Many patient safety events will not require PSII but may benefit from a different type of response to gain further insight or address queries from the patient, family, carers, or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

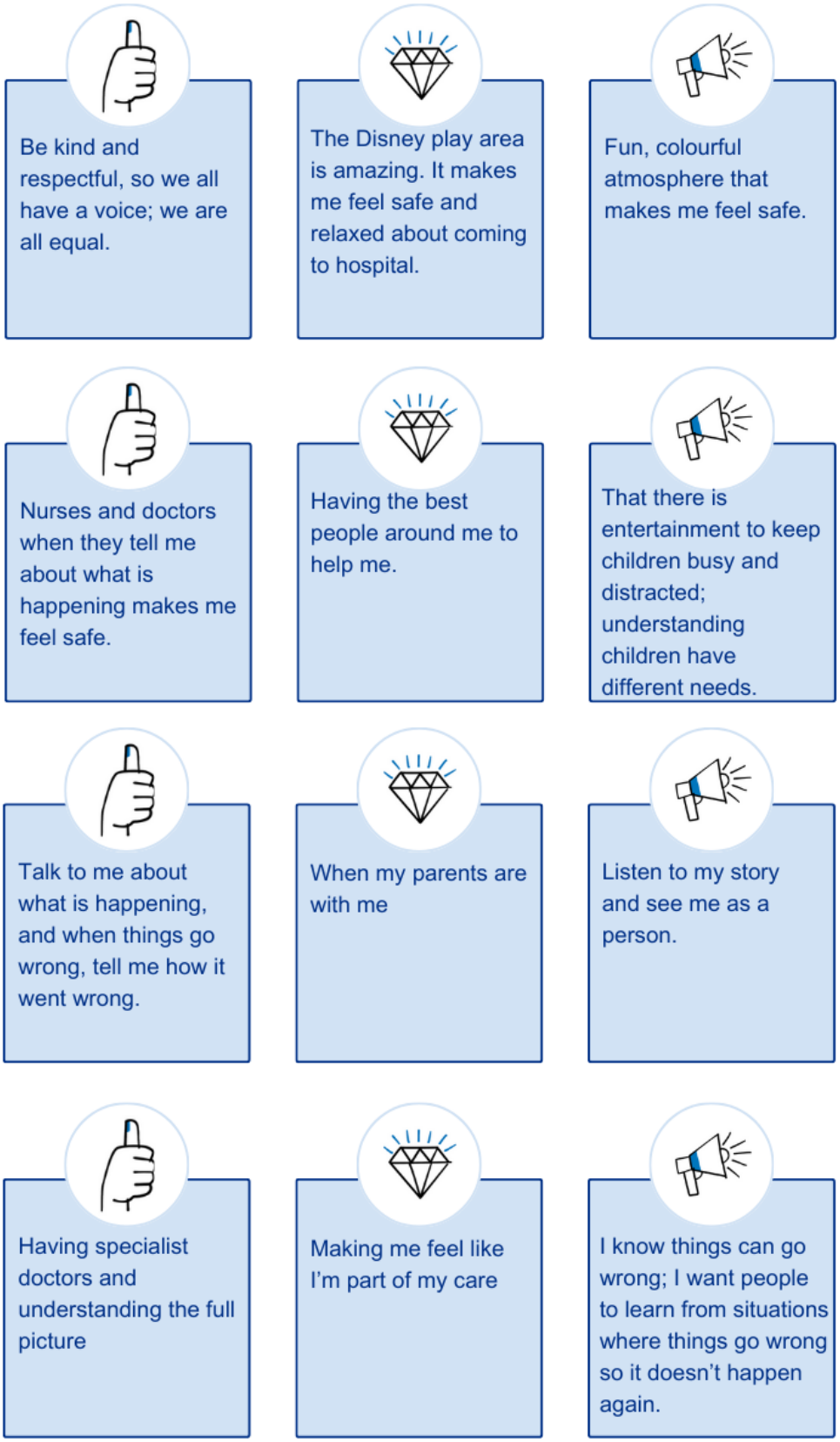
Different response techniques can be adopted, depending on the intended aim, and required outcome to identify learning.

GOSH will use the following response methods:

Learning Response Method	Objective
Immediate safety actions	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	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	To determine whether there were any problems with the care provided to a patient by a particular service.
Safety huddle	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses, and areas for improvement. This usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, which can then be shared locally, organisationally and system wide.

Engaging and Involving those Affected by Patient Safety Events

As part of World Patient Safety Day 2023, we engaged patients, families/carers, and staff about what makes them feel safe.

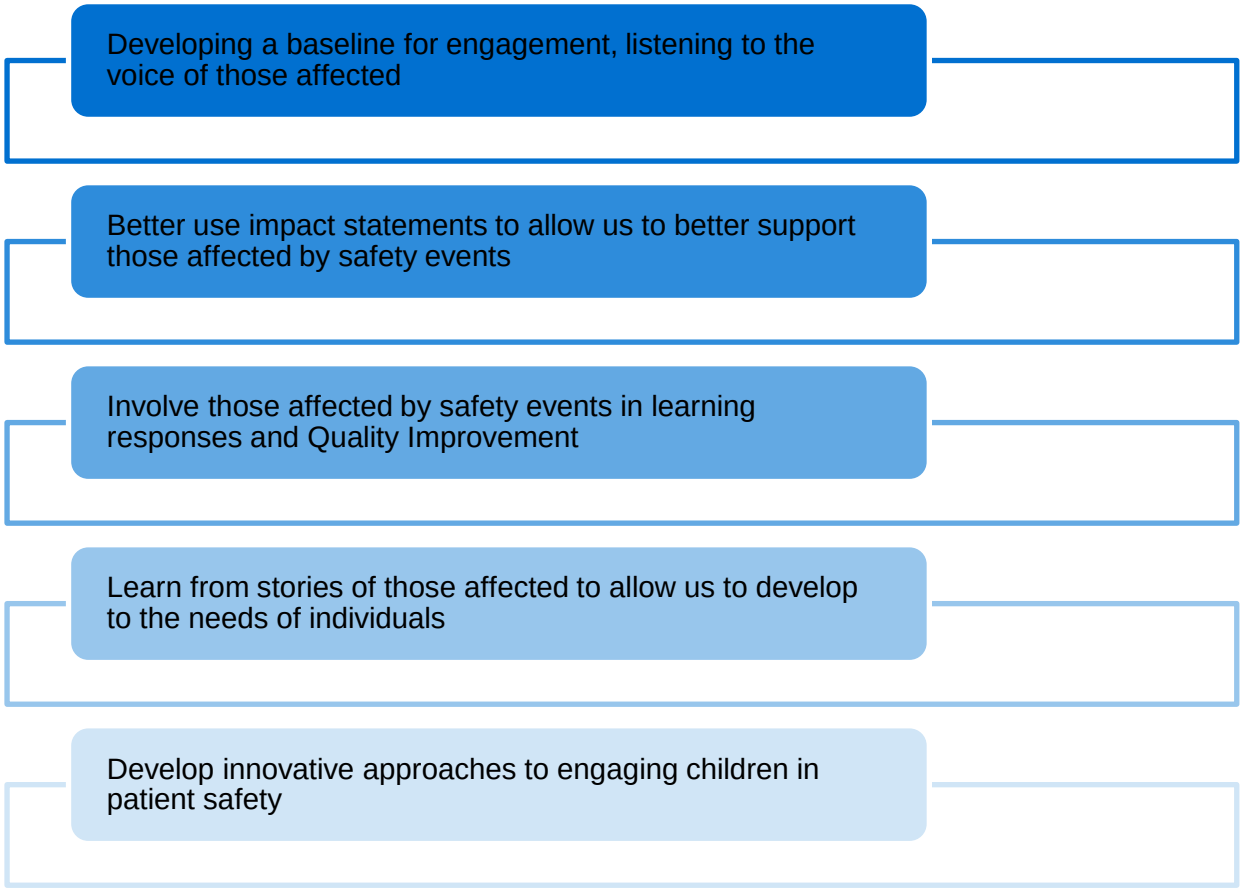


The Patient Safety Incident Response Framework (PSIRF) recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. A Restorative Just and Learning Culture is essential when reviewing or investigating incidents, and there is a need to ensure psychological safety to encourage openness and transparency to support colleagues reflect upon processes and actions taken during care delivery to allow for learning and improvement and facilitate closure for those affected.

GOSH recognises the significant impact patient safety events can have on patients, their families and carers, and our staff.

Getting the right level of involvement from those affected and listening to the voice of people is crucial in developing systems for meaningful learning.

At GOSH, we are in the process of developing an engagement framework for those affected by patient safety events which will focus on the areas below:



GOSH offer support for staff affected by patient safety events through the following channels:

- Access to Employee Assistance and Wellbeing services (Care First).
- Debrief services via PEERS
- Trauma Risk Management Services (TRiM)

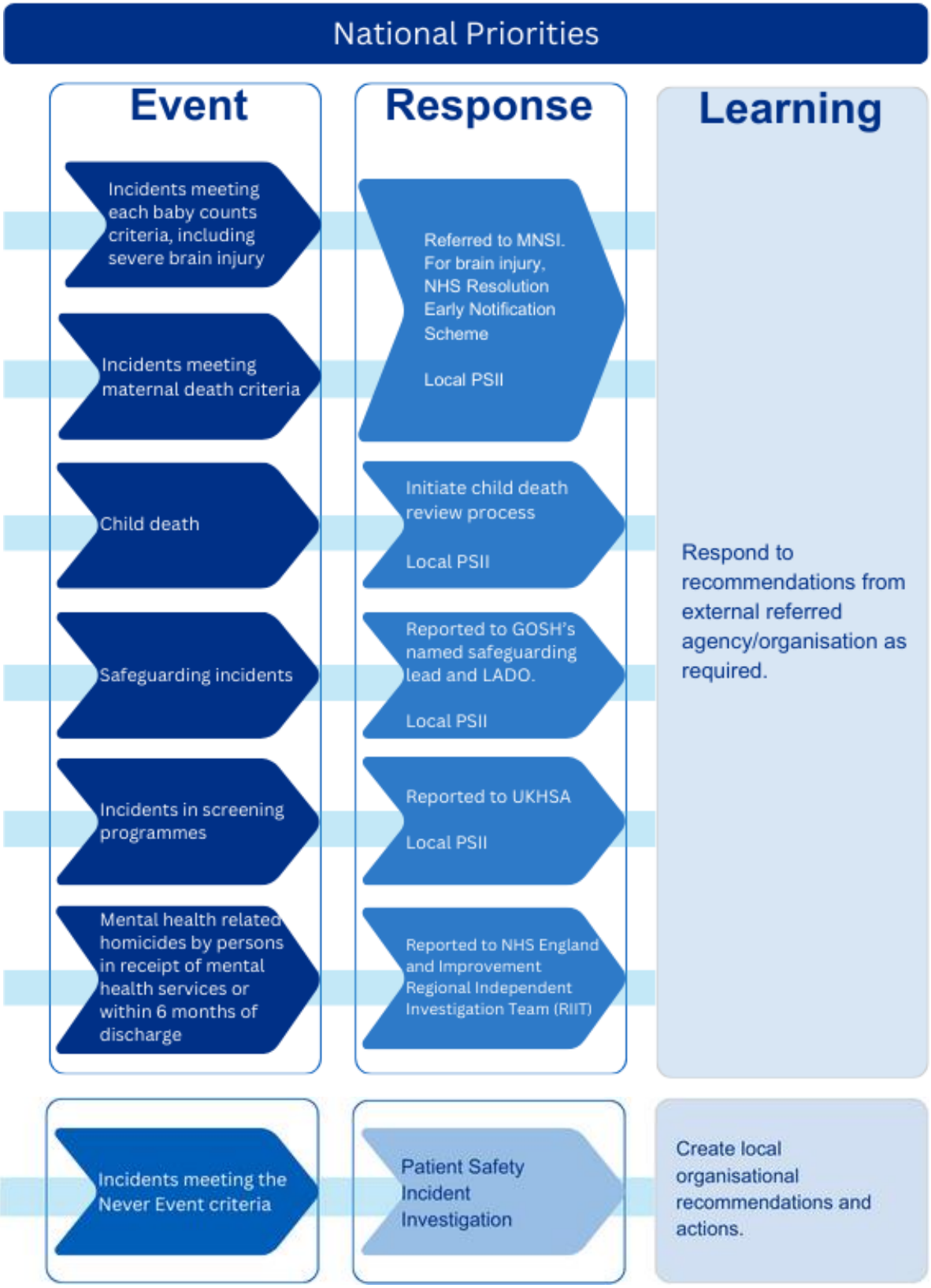
Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation.

Incidents in screening programmes

For further information see incidents in screening programme.

Appendix A


National Priorities
Event
Response
Learning
Incidents meeting each baby counts criteria, including severe brain injury
Incidents meeting maternal death criteria
Child death
Safeguarding incidents
Incidents in screening programmes
Mental health related homicides by persons in receipt of mental health services or within 6 months of discharge
Referred to MNSI. For brain injury, NHS Resolution Early Notification Scheme
Local PSII
Initiate child death review process
Local PSII
Reported to GOSH's named safeguarding lead and LADO.
Local PSII
Reported to UKHSA
Local PSII
Reported to NHS England and Improvement Regional Independent Investigation Team (RIIT)
Respond to recommendations from external referred agency/organisation as required.
Incidents meeting the Never Event criteria
Patient Safety Incident Investigation
Create local organisational recommendations and actions.

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
020 7405 9200
gosh.nhs.uk

Thank you to every member of staff involved in the production.

Thank you to the Patient Safety Partners for their support and review of this document.

The Patient Safety Incident Response Plan is available to view at gosh.nhs.uk.

Head of Patient Safety
Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH