HMT
HEALTHCARE MANAGEMENT TRUST

PATIENT AND RESIDENT

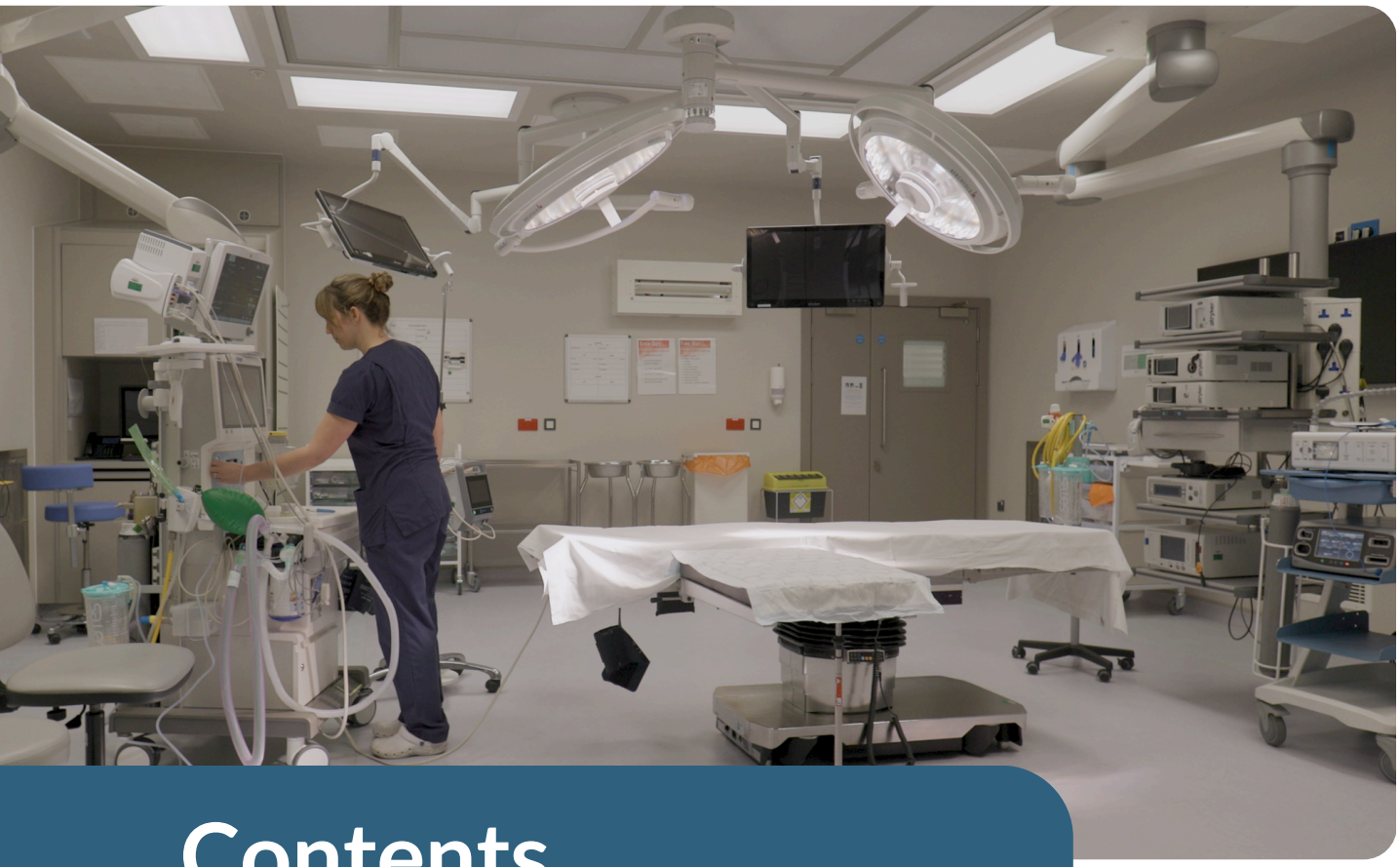
SAFETY INCIDENT RESPONSE PLAN

2025 - 2027

Version 2
March 2025

HMT HOSPITALS

HMT CARE HOMES



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Foreword

From HMT's Executive Team

"It has been a pleasure to work with the Head of Patient Safety and Improvement to develop our Patient and Resident Safety Incident Response Plan as a key component of our commitment to delivering excellence in governance, safety and regulatory standards. This plan is unique in that it encompasses both health and social care. It represents not only our dedication to continuous improvement but also our responsibility to ensure more transparent systems that respond effectively to patient and resident safety incidents. By aligning with national standards and embedding clear processes, we aim to foster a culture of learning, accountability and assurance. This document highlights where we will take action to ensure that we meet and exceed regulatory expectations while building trust with our patients, residents, workforce and stakeholders."

"I am delighted to introduce the Patient and Resident Safety Incident Response Plan, which directly supports our commitment to delivering high-quality clinical care across our services. This plan strengthens our ability to respond swiftly and comprehensively to patient and resident safety incidents, prioritising learning and improvement to safeguard the care we provide. It compliments our clinical care model by ensuring that every incident is an opportunity to enhance our practices, support our teams and improve outcomes for patients and residents. Through this plan, we demonstrate our mission to provide safe, compassionate care while continuously raising the standards of clinical excellence."

Andrea Hayward
Executive Director of Governance, Standards and Regulation

Andrew Willcocks
Executive Director of Clinical Care and Acute Services

Introduction

At HMT, we are dedicated to providing exceptional health and social care services to individuals. With a commitment to compassion and excellence, our team works tirelessly to deliver market-leading care, particularly within marginalised and deprived communities. As a not-for-profit organisation, our mission, vision and values guide us as we strive to make a positive impact in health and social care on communities across England and Wales.

Our mission is to provide market-leading care solutions:
We believe that everyone deserves access to high-quality health and social care. Our mission is to deliver tailored care solutions for individuals with complex needs, ensuring they receive the support they need to live healthier, more fulfilling lives. Through our hospitals and care homes, we aim to create an environment where patients and residents feel valued and respected.

Our vision is to be the most innovative and best quality provider:
We aspire to lead in the healthcare sector by being the most innovative and best-quality provider of niche health and social care services. Our commitment to continuous improvement drives us to embrace new ideas, technologies and approaches that enhance our care delivery and patient experience.

Quality and safe care is central to our operations and continuous improvement of patient and resident care is a top priority in HMT's strategic plan for 2025 to 2030. Our Quality Governance Framework underpins this approach.

At the Healthcare Management Trust (HMT), we have fully embraced the NHS Patient Safety Strategy (2019) across all our sites. This outlines our commitment to understand our safety culture and to take a proactive approach, focusing on safer systems. It is about learning from what works, not just what does not.

What sets HMT apart is our commitment to the implementation of this approach within our services throughout Wales and also in social care settings. We recognise the unique challenges these environments present and we are dedicated to leading the way in developing innovative practices that prioritise patient and resident safety.

The Patient Safety Incident Response Framework (PSIRF) forms part of this approach. It supports a response to incidents that maximises learning and improvement. It is a fundamental cultural safety change in the way we think, report and investigate incidents. It does not mandate investigation as the only method of learning nor does it prescribe what to investigate.

We will focus on patient and resident safety incidents that are key to our organisation and the people we serve. This approach will enable us to direct resources to focus on meaningful continuous learning and improvement. Our response plan will adapt and evolve as we gain new insights, in the never ending pursuit of maintaining the safety of patients and residents.

PSIRF highlights the importance of meaningful engagement with patients, residents, families and carers. Their input and voice is as valuable as that of our staff in informing our learning responses and areas for improvements. Their perspectives are crucial to inform our full understanding. Our Patient and Resident Safety Partners will ensure that their voices are represented in all our safety systems, processes and activities.

Our commitment to a restorative and Just Culture shapes how we approach our learning responses to incidents. We want everyone to feel safe reporting issues and encourage open discussions, creating a psychologically safe culture. We will empower staff to describe the way in which work is carried out day to day and encourage them to make meaningful changes, as experts in their fields. We learn from both successes and areas of improvement, fostering a Just Culture where everyone feels safe to speak up. This is supported by HMT's Freedom to Speak Up Plan for 2025 to 2027 and the appointment of a Freedom to Speak Up Guardian and Champions.

Purpose and scope

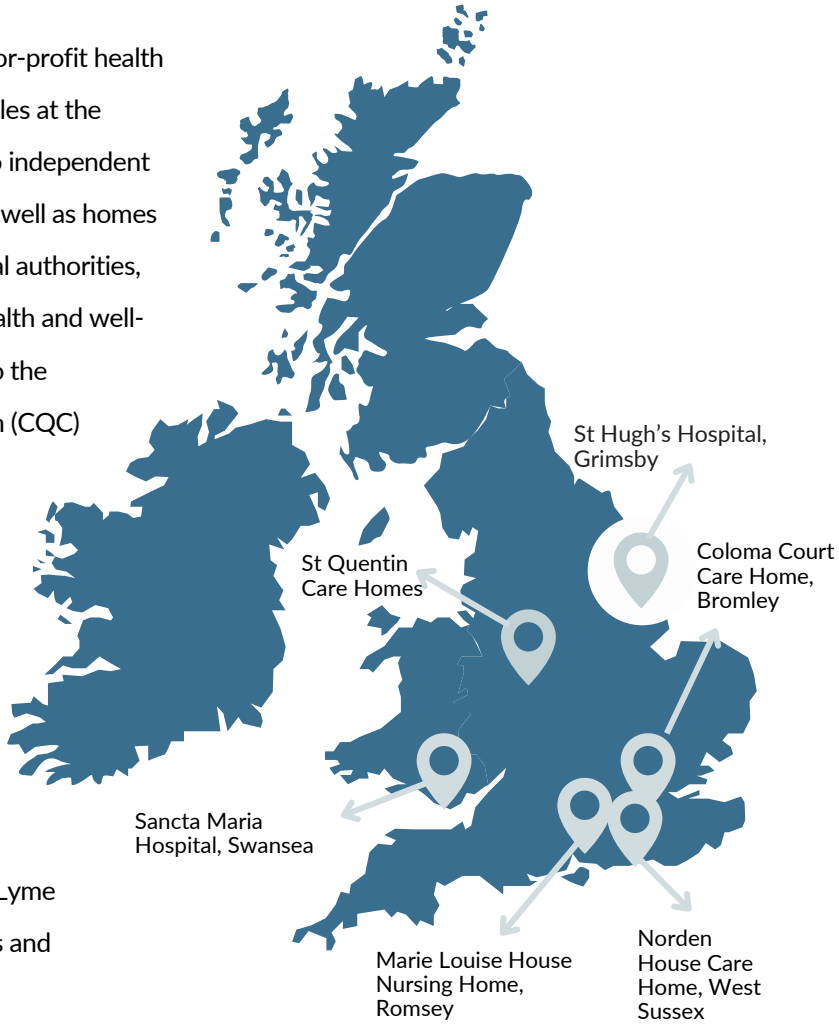
This Patient and Resident Safety Incident Response Plan explains how HMT will respond to safety incidents over the next 12 to 24 months. The plan outlines our key goals and methods, but will evolve and adapt to new insights. We will stay flexible and consider the specific circumstances of each incident and patient or resident safety issue to improve our services and address the needs of those impacted.

This plan is supported by our Patient and Resident Safety Incident Response Policy. Both the plan and the policy will be available on HMT's website for everyone to access.

Our services

HMT is a registered charity that provides not-for-profit health and social care services across England and Wales at the following locations. Our operations include two independent surgical, outpatient and diagnostic hospitals, as well as homes for the elderly. We collaborate closely with local authorities, the NHS and other charities to enhance the health and well-being of the communities we serve, adhering to the regulations set by the Care Quality Commission (CQC) and Health Inspectorate Wales (HIW).

- St Hugh's Hospital (SHH), Grimsby
- Sancta Maria Hospital (SMH), Swansea
- Coloma Court Care Home, West Wickham
- Marie-Louise House, Romsey
- Norden House, Littlehampton
- St Quentin Care Homes, Newcastle under Lyme (which includes St Quentin, The Hawthorns and Langley House)



Defining our patient safety incident profile

Stakeholder Engagement

To identify the key patient and resident safety issues pertinent to HMT, the Head of Patient Safety and Improvement has engaged with stakeholders, gathered and triangulated insights . This includes feedback reported by our staff, as well as input from patients, residents, families and carers.

We will incorporate wider patient and resident perspectives and increase their involvement. This will be supported by the introduction and support of Patient and Resident Safety Partners and by actively and meaningfully engaging with patients, residents, families, and caregivers over the next 12 to 24 months.

Defining our patient safety incident profile

The below information has helped us define our local safety improvement profile. Safety understanding and intelligence relies not only on numbers and data but also on the knowledge and expertise of our stakeholders. Together these aspects will continue to inform and develop our Patient and Resident Safety Plan.

Incidents:
2021 – 2024
(where available)
(reported by staff)

Complaints:
last 12 months
(reported by patients, families and carers)

Claims:
last 12 months
(reported by patients, families and carers)

Risk Register

Improvement projects underway and planned

Regulatory feedback

We are alive to and acknowledge identified weaknesses and gaps in our quality improvements systems, processes and activities. We will focus on these areas to ensure they are strengthened, particularly ensuring required improvement work is carried out and appropriately formalised and recorded to evidence learning and improvement.

Improvement Based on Learning:

When a safety issue or incident is well understood, usually due to the investigation of similar past incidents resulting in improvement plans having been implemented and monitored, our resources will focus on making improvements instead of investigating the same issue again. We will only carry our further investigations if there is a chance for new learning to be identified or if the event is significant.

Learning to Inform Improvement:

A patient safety learning response may be required to fully understand contributory factors, the context and underlying factors that influenced the outcome. Any new areas for improvement identified will inform our current and future improvement plans and activities.

Assessment to Determine Required Response:

In all safety issues and incidents where it is identified there is potential for new learning or that raise significant concerns, consideration will be given as to whether an individual learning response is required. Thought will be given to the most appropriate learning response tool. We will always consider the views of the patient, resident, and their families or caregivers in this assessment.

Learning Responses:

Several system-based learning response tools and methods will be used to respond to a patient or resident safety incident or cluster of incidents,. At present those used within the organisation include, but are not limited to:

Patient Safety Incident Investigation (PSII)	A PSII is undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. It offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. Investigations explore decisions or actions as they relate to the situation and the goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.
After Action Review (AAR)	AAR is a structured, facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around 4 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?

Case/Peer Review	The Case/Peer Review is based on the PSII, but a condensed version. For use when there is an opportunity for new learning, from a single incident/event. It is usually undertaken by one learning response lead/peer reviewer and often includes review of clinical and other related records as well as discussion with those involved.
SWARM Huddle	The SWARM huddle is designed to be initiated as soon as possible after an event, such as a fall, and involves a MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
Learning Team Review (Multi Disciplinary Team (MDT) Review)	A Learning Team is an MDT review of a systemic safety issue (theme/recurring issue) or a complex problem. The intention is to understand what needs to happen for it to go well/as intended, and what gets in the way of that sometimes (barriers), to direct improvement work in the right places but also identify what we can learn from good practice/excellence and everyday work (known as Safety II). The Learning Team uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to support a human factors approach. The Learning Team focuses on the 'work as done', as opposed to the work as we imagine it to be, how it is prescribed in policies or as it's disclosed to us following an incident.
Thematic analysis	A thematic analysis may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.

These tools and methods continue to be developed/expanded.

The most appropriate type of learning response to a patient or resident incident will be decided on a case-by-case basis and determined and agreed collaboratively. In some circumstances, outlined further below, the type of learning response will be mandated by policy and regulation.

Statutory Duty of Candour and Being Open Requirements:

The requirements for the Statutory Duty of Candour and Being Open principles remain the same, regardless of whether an individual learning response is undertaken.

Our Patient/Resident Safety Improvement Plan: National Requirements

Certain Patient and Resident Safety events, depending on the nature of of incident and circumstances surrounding them, will necessitate a specific type of response. Such responses include a mandatory Patient Safety Incident Investigation (PSII) or a review by, or referral to, another body or team. Table 1 summarises the guidance on nationally mandated responses to certain categories of event which apply to activity carried out by HMT.

Whilst this national guidance only relates to NHS activity provided at St Hugh's Hospital (SHH), under the NHS England Standard Contract, the same principles will be applied across the organisation, on the basis of good practice and standardisation. This aligns to our commitment to learning and improving within a Just Culture.

Table 1

	National Priority	Response	Improvement
1	Incidents that meet the criteria set out in the Never Events list 2018	Locally led PSII by HMT's Patient Safety Specialist (PSS)	Respond to recommendations as required and feed actions into a system improvement plan
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by HMT's Patient Safety Specialist (PSS)	
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). This may need to be undertaken by an external party for HMT. Locally led PSII (or other response) may be required alongside the LeDeR review if clinically assessed as more likely than not due to problems in care.	Respond to recommendations as required and feed actions into a system improvement plan
6	Safeguarding incidents in which: Babies, children 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 slavery & 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.	Respond to recommendations as required and feed actions into a system improvement plan
9	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 by HMT's Patient Safety Specialist (PSS)	Respond to recommendations as required and feed actions into the system improvement plan

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 HMT participation if required	Respond to recommendations from external referred agency/ organisation as required and feed actions into the system improvement plan.
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 reviews.	

Our Patient Safety Incident Response Plan: local focus

Based on our analysis and engagement with key stakeholders, the local priorities for HMT's Hospitals and Care Homes have been identified and are set out in Table 2. These will guide HMT's patient and resident safety activities between 2025 and 2027. Table 2 also details how we will respond to patient and resident safety incidents that fall within the identified priority descriptions.

Where an incident type is well understood, resources may be better directed at improvement rather than repeated investigation (or other type of learning response). Associated safety/quality improvement activities and initiatives will be planned, undertaken and monitored for effectiveness.

Table 2

Patient safety incident type or issue	Planned response	Anticipated improvement route
Hospitals		
Surgical site infections	Local review by IPC Lead and site Patient Safety weekly meeting to identify if an individual learning response may be required (where there is potential for new learning or significant concern).	When a learning response is undertaken, areas for improvement to be shared at site and Group Quality Governance meetings for discussion and informing of quality improvement activities.
Cancellations	Local review by site Patient Safety weekly meeting to identify if an individual learning response may be required (where there is potential for new learning or significant concern).	
Venous Thromboembolism (VTE)		
Documentation (inc Consent)		
Unexpected incidents that are so significant in nature/pose such a risk to patient safety/the organisation, including unexpected death.	Locally led PSII by HMT's Patient Safety Specialist (PSS)	

Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern	Local review by site Patient Safety weekly meeting to identify if an individual learning response may be required (where there is potential for new learning or significant concern).	
Care homes		
Falls (care homes)	Site to identify if an individual learning response may be required (where there is potential for new learning or significant concern), with support from Head of Patient Safety and/or Executive Director of Clinical Care & Acute Services.	When a learning response is undertaken, areas for improvement to be shared at site and Group Quality Governance meetings for discussion and informing of quality improvement activities.

Development of safety actions

Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. We will look to move from simply identifying the learning to improving implementation of it via the creation of safety actions. An integrated process for designing, implementing, and monitoring safety actions, reduces risk and limits potential for harm. The development of safety actions will be guided by NHS England's Safety Action Development Guide.

The core principles on which safety actions will be developed will be in collaboration with and through empowerment of those who do the work (Work as Done). We will seek to embrace ambiguity and challenge inherent biases to achieve the best possible outcomes for our patients, residents and staff.

An improvement plan for each identified organisational safety priority will be developed to monitor quality improvement activities, including their effectiveness.

Actions from all types of learning responses, out with, the priorities will be monitored to inform potential development of the Patient and Resident Safety Incident Response Plan in the future or added to an existing improvement plan if relevant.

Below is an overview of the safety action development process. While the process is depicted as linear, monitoring and review should be repetitive, in the form of Plan, Do, Study, Act (PDSA).

Agree areas for improvement
Specify where improvement is needed, without defining how that improvement is to be achieved.

Define context
Agree approach to developing safety actions by defining context.

Define safety measures
- Identify what can be measured to determine whether the safety action is influencing what it intended.
- Prioritise safety measures (cosnider the practicalities of measurement)
- Define measures including who is responsible for collecting, analysing, reporting and acting on the data collected.

Write safety actions
Document in a learning response report or safety improvement plan (as appropriate) including details of measurement and monitoring.

Monitor and review
Continue to be curious and monitor if safety actions are impactful and sustainable.

Define safety actions to address areas for improvement

- Continue to involve the team - make this a collaborative process
- Focus on the system - to ensure our safety actions are system-related and not focused on our staff/individuals, we will utilise the adapted Human Factors Intervention Matrix (HFIX)

Prioritising of safety actions

The number of safety actions for implementation is often high. Monitoring their implementation and tracking the resulting changes can be onerous. We will decide which safety action or set of safety actions to test for implementation, using the iFACES tool to help quantify the potential value of each identified action. This uses six criteria: inequality, feasibility, acceptability, cost/benefit, effectiveness and sustainability, with a priority matrix.

Writing safety actions

Safety actions will be drafted to follow the SMART principles of specific, measurable, achievable, relevant and time-bound.

Measuring safety actions

Measures associated with safety actions should be clearly defined to allow for effective monitoring and in order to ensure the actions are adding the value that was intended.

The definition should include the following:

- A description of what is being measured
- The purpose of the measure (i.e. what it is intended to manage and who it is intended to inform)
- The units of measurement and any formula for its calculation
- Who is responsible for collecting, validating, analysing, reporting and acting on the measure (these may be different people in different parts of the organisation)
- Where or how the data should be collected
- The frequency of collecting, analysing and reporting
- If appropriate, the target value, goal, tolerances and statistical tests that can be applied
- Potential actions for when the measure deviates from the accepted tolerances, including when the deviation should be escalated.

HMT
HEALTHCARE MANAGEMENT TRUST

HMT HOSPITALS

HMT CARE HOMES

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