

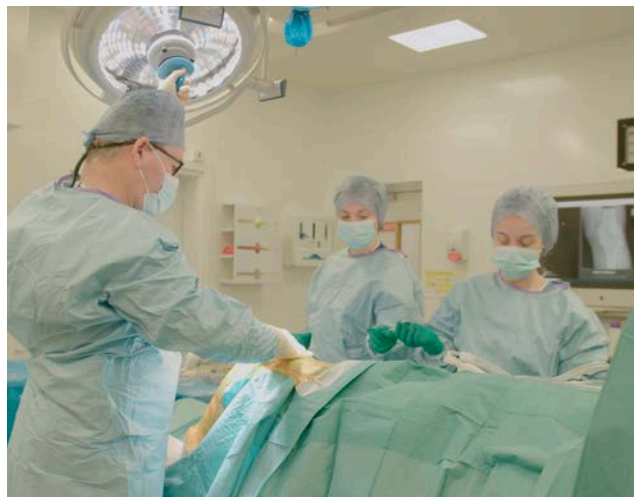


# PATIENT AND RESIDENT

# SAFETY INCIDENT RESPONSE PLAN

2025 - 2027

Version 3



# 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 and innovative 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 that action to ensure that we meet and exceed regulatory expectations while building trust with our patients, residents, staff and stakeholders."

**Andrea Hayward**

Executive Director of Governance,  
Standards and Regulation



"I am proud to introduce our patient and Resident Safety Incident Response Plan - a key step forward in strengthening our commitment to the highest standards of care and safety across all our services. This plan enhances our organisation's ability to respond swiftly and effectively to any patient or resident safety incident, ensuring that learning and improvement remain at the heart of everything we do. By embedding this approach, we continue to build a culture that values accountability and continuous improvement. Every incident becomes an opportunity to reflect and learn to improve the quality of care we provide.

Through this initiative, we reaffirm our mission to deliver safe and high-quality care for every patient and resident, every day - while continually striving for clinical excellence and organisational improvement."

**Nichola Stefanou**

Chief Executive Officer,  
Healthcare Management Trust





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# Introduction

At HMT, we are dedicated to providing exceptional healthcare services to individuals. With a commitment to compassion and excellence, our team works tirelessly to deliver market-leading care solutions, 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 healthcare on communities across England and Wales.

## **Our mission is to provide market-leading care solutions:**

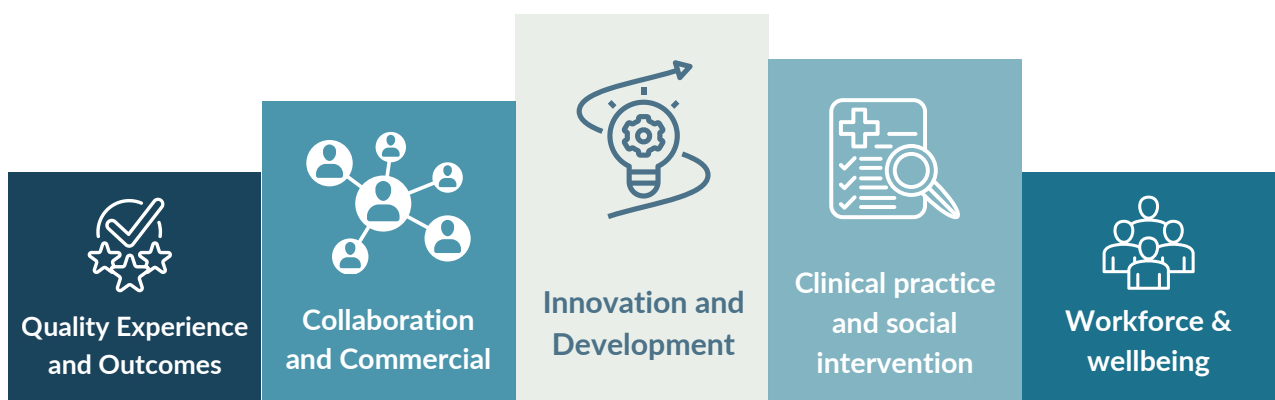
We believe that everyone deserves access to high-quality healthcare. Our mission is to deliver tailored care solutions for individuals with complex needs, ensuring they receive the support they need to live healthier, more fulfilling lives. Through our hospitals and care homes, we aim to create an environment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

## **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 enhancing patient and resident care remains a top priority in HMT's strategic plan for 2025 to 2030. Our Quality Governance Framework weaves itself into all aspects of HMT's strategy.

## HMT's Strategic Priority Pillars:



HMT's Quality Governance Framework outlines the essential structures for ensuring quality governance. The care delivered by HMT will be of high quality if it is Safe, Effective and provides a positive Patient Experience. Above all, patient and resident safety is our top priority.

At the Healthcare Management Trust (HMT), we have fully embraced the NHS Patient Safety Strategy established in 2019 across all our operational sites. This outlines our commitment to continuously enhancing patient safety by building on a foundation of a proactive safety culture and robust systems designed to mitigate risks. We aim to learn from what works, as well as what needs to improve.

What sets HMT apart is our role in the implementation of this strategy, particularly as we adapt and apply its principles within Wales and 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 safety. Our approach involves engaging with staff at all levels, utilising data to identify areas for improvement and fostering a psychologically safe culture that encourages open communication and learning from experiences. With our initiative, we are striving not only to meet safety standards but to exceed them, ensuring that the care we provide is consistently safe and effective for all.

The Patient Safety Incident Response Framework (PSIRF) forms part of this strategy and sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents. It is a fundamental cultural safety change in the way we think, report and investigate incidents. Previous frameworks have described when and how to investigate incidents. PSIRF focuses on maximising learning and improvement. It does not mandate investigation as the only method of learning nor does it prescribe what to investigate.

Our Patient and Resident Safety Incident Response Plan outlines which patient and resident safety incidents should be reviewed and investigated and which approach should be applied in different scenarios.

Based on this, we will look into patient and resident safety incidents that are key to us and the people we serve. This approach will enable us to direct resources to focus on meaningful continuous learning and improvement, allowing us to focus on areas for meaningful improvement. Our response plan will adapt as we gain new insights, in the pursuit of maintaining the safety of patients and residents.

PSIRF highlights the importance of engaging with patients, residents, families and carers. Their input is as valuable as that of our staff in informing our learning responses and improvements. Our Patient and Resident Safety Partners will help us to ensure the patient/resident voice is included 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 learn from both successes and areas of improvement, fostering a fair culture where everyone feels safe to speak up. This is supported by NHS England's Being Fair Tool, and 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 we may need to make changes as insights evolve. 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 public website for everyone to access.

# Our services

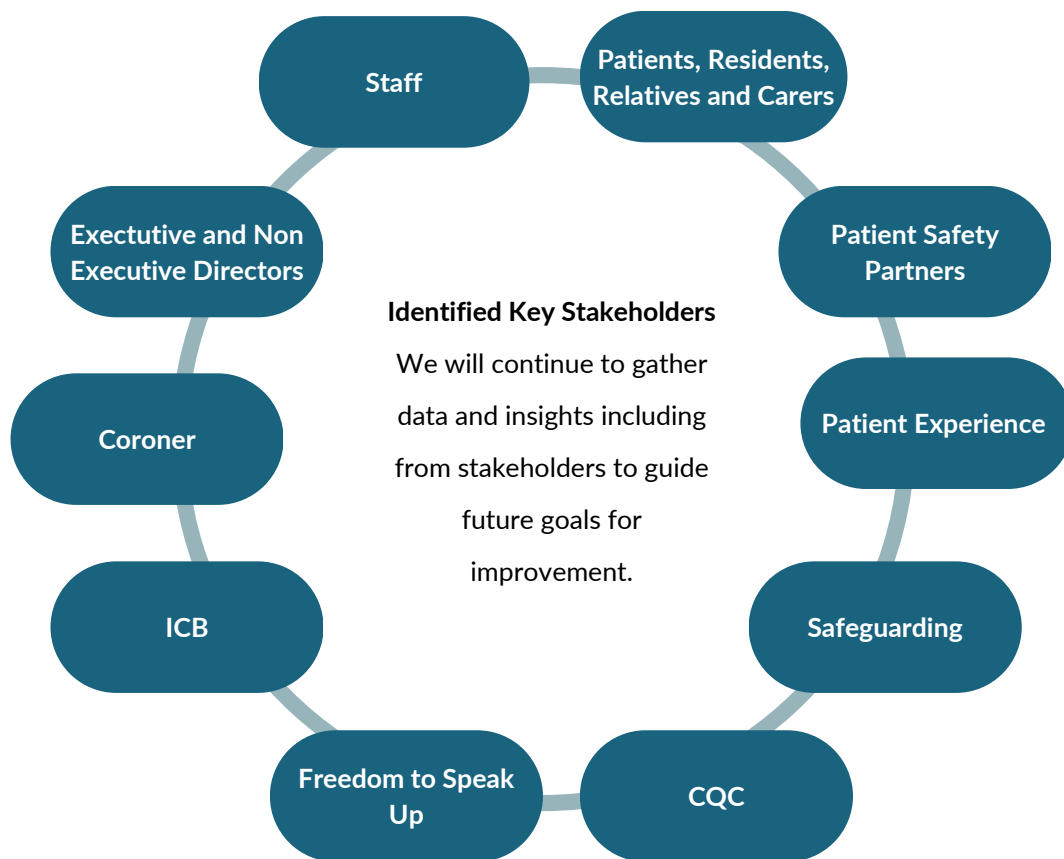
HMT is a registered charity that provides not-for-profit health and social care services across England and Wales at the following locations. Our operations include two independent surgical, outpatient and diagnostic hospitals, as well as homes for the elderly. We collaborate closely with local authorities, 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, 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 continue to seek data and insight from the above stakeholders to inform our Patient and Resident Safety Improvement Profile and Local Priorities.

We will improve our response to patient and resident safety incidents by increasing input from patients and residents. This will be supported by introducing our 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

## Defining our Profile

The below information has helped us create 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 improvement 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 because we have investigated similar past incidents thoroughly and identified learning, our resources will focus on making improvements instead of investigating the same issues again. We will only investigate again if there is a chance for new learning to be identified or if the event is so significant or concerning.

## Learning to Inform Improvement:

A patient safety learning response may be required to be carried out to fully understand contributory factors, local rationality and context that influenced the outcome of incidents. This response helps us understand what happened and why. Any new areas for improvement we find will be included in and 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. We will always consider the views of the patient, resident, and their families or caregivers in this assessment. A structured Debrief tool may be used as part of this assessment.

## Learning Responses:

Several system-based learning response methods will be used to respond to a patient or resident safety incident or cluster of incidents, where contributory factors are not well understood and the current local improvement work is minimal. At present those used within the organisation include, but are not limited to:

<b>Patient Safety Incident Investigation</b>	<p>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.</p> <p>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.</p> <p>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.</p>
<b>After Action Review</b>	<p>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 insights from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as negative.</p> <p>It is based around 4 questions:</p> <ul style="list-style-type: none"><li>• What was the expected outcome/expected to happen?</li><li>• What was the actual outcome/what actually happened?</li><li>• What was the difference between the expected outcome and the event?</li><li>• What is the learning?</li></ul>

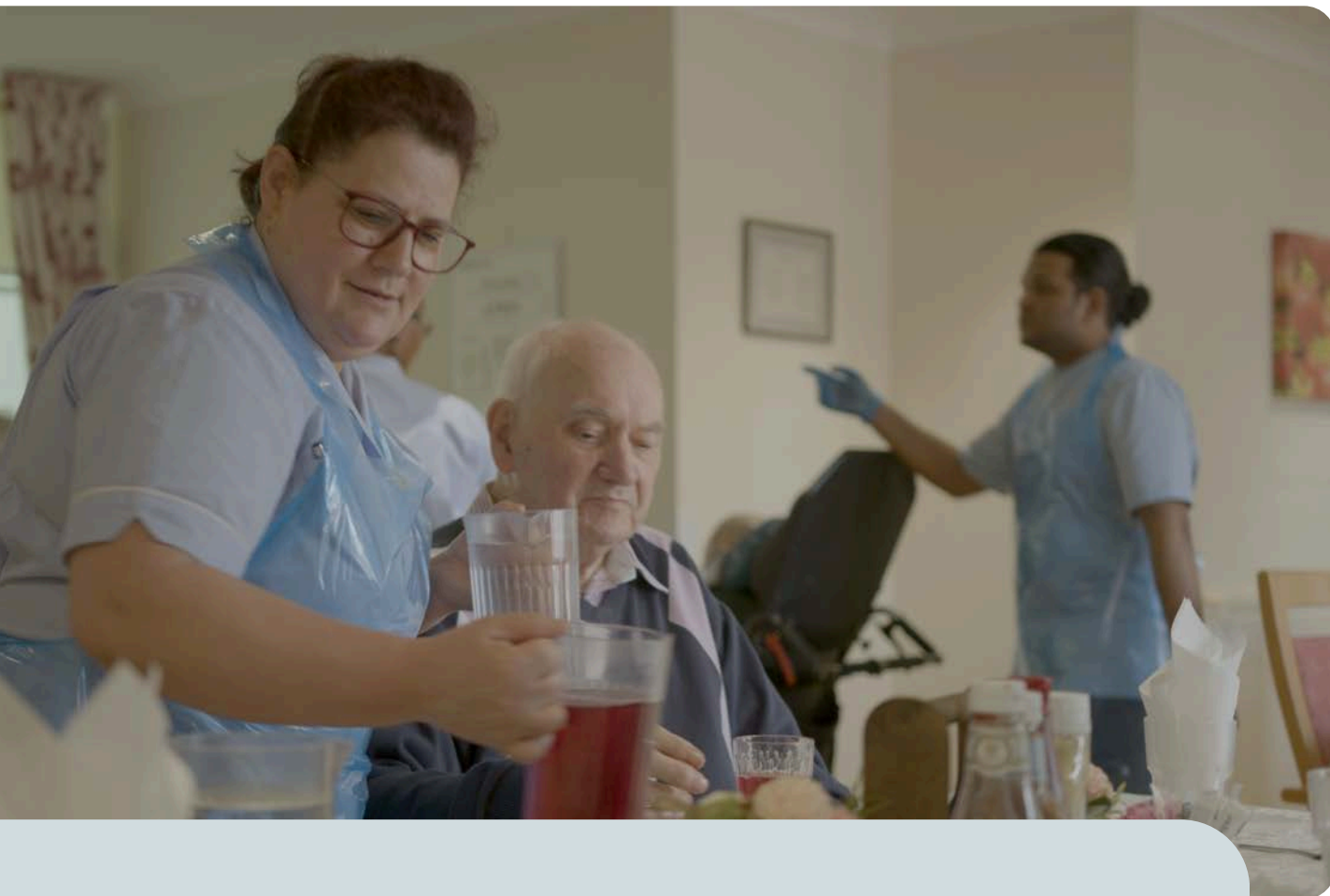
Case Review	A case review is a condensed version of the PSII, that can also be used for peer review of an event to identify learning.
SWARM Huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Also known as a Hot Debrief or Cold Debrief (depending on amount of time lapsed since event). Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insights gathered from other sources wherever possible) decide what action may need to be taken to reduce the risk of the same thing happening in future.
Learning Team (Multi-disciplinary review)	The aim is, through open discussion (and other approaches such as observation and walk through-talk through undertaken in advance of the review meeting), to agree the key contributory factors/system issues that impact on safe patient care. This approach aims to understand what happens when it goes well, and what gets in the way (barriers), from subject matter experts, doing 'the work'.
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 and/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 Legal Duty of Candour and Being Open 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 and/or circumstance 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 are applicable to activity carried out by HMT.

Whilst at HMT, this national guidance only relates to NHS activity provided at St Hugh's Hospital (SHH), the same principles will be applied across the organisation, on the basis of good practice and standardisation. This aligns to our commitment to a learning and improvement culture, based on NHS England's principles of Being Fair.

## Table 1 - National Priorities

	National Priority	Response	Improvement
1	Incidents that meet the criteria set out in the Never Events list 2018	Locally led learning response by HMT's Patient Safety Specialist (PSS) (as of September 2025, no longer mandated PSII)	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	<p>Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII.</p> <p>Locally led PSII may be required with mental health provider as lead and HMT participation if required.</p>	Respond to recommendations from external referred agency/ organisation as required and feed actions into the system improvement plan.
11	Domestic Homicide	<p>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.</p>	

# Our Patient Safety Incident Response Plan: local focus

Based on our analysis of available data 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 because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness, resources may be better directed at improvement rather than repeat 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
<b>Hospitals</b>		
<b>Surgical site infections</b>	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).	Safety/quality improvement plan to be developed to include existing learning, and further developed as and when new insights are identified.
<b>Informed Consent (documented)</b>	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).	
<b>Pre-assessment/pre-op escalation</b>		
<b>Unexpected incidents that are so significant in nature/pose such a risk to patient safety/the organisation, including in relation to unexpected death.</b>	Locally led PSII by HMT's Patient Safety Specialist (PSS)	

<p><b>Incidents of any harm level or category not listed above where potential for new learning is identified or significant concern</b></p>	<p>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).</p>	
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**Care homes**

<p><b>Falls</b></p>	<p>Identify if an individual learning response may be required (where there is potential for new learning or significant concern).</p>	<p>Safety/quality improvement plan to be developed to include existing learning, and further developed as and when new insights are identified.</p>
<p><b>Restrictive practices</b></p>		

# 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 develop moving from 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.

Thematic actions from all types of learning response, out with the priorities, will be considered in future iterations of the PSIRP and/or added to an existing improvement plan if relevant.

Below is an overview of the safety action development process that follows the identification of areas for improvement. 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 (consider 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.



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