East Kent Hospitals University

NHS Foundation Trust

TRUST POLICY

PATIENT SAFETY INCIDENT RESPONSE POLICY

Document properties:	**Detail:**
Version	1.0
Author	Deputy Director of Quality Governance
Policy Owner	Head of Patient Safety and Improvement
Executive Director Responsible for Policy	Chief Nursing and Midwifery Officer
Approving committee	Quality and Safety Committee
Date approved	
Date ratified by Policy Authorisation Group	
Date issued	
Next scheduled review date	December 2024

Applies to:	**Yes/No**
Trust staff (specify groups e.g. clinical/non-clinical)	All EKHUFT Staff with regard to patient safety
Subsidiaries	2gether Support Solutions Ltd. Spencer Private Hospitals East Kent Urgent Treatment Centre Alliance
2gether Support Solutions Ltd. as a service provider (hard and soft facilities services)	Yes

This policy is available in other formats, for example, in large print, Audio and Easy Read on request. Please contact PSIRF (EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST) ekhuft.psirf@nhs.net

Version Control Schedule

Version	Date	Author	Status	Comment
1.0	June 2024	Deputy Director of Quality Governance	Final	New Policy

Policy Reviewers

If policy references children/young people or includes references to medicines policy must be reviewed by the relevant group.

Title and Care Group of Individual	Date Consulted
Head of Patient Safety and Improvement, Quality Governance Directorate	24/03/2024
Director of Quality Governance, Quality Governance Directorate	29/03/2024
Patient Safety Leads	22/02/2024

Name of Committee	Date Reviewed
Quality & Safety Committee	02/04/2024
Policy Authorisation Group April 2022	

Summary of Key Changes from Last Approved Version

New policy

Associated Documentation

Incident Management Policy

Complaints Management Policy

Patient Safety Incident Response Plan

Contents

1. Policy Description

1.1. The aim of this policy is to support the requirements of the Patient Safety Incident Response Framework (PSIRF).

1.2. This document sets out East Kent Hospitals University NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The purpose of which is to ensure learning and improvement in patient safety.

2. Introduction

2.1. The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

2.2. This policy supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

3. Definitions

3.1. **Patient Safety Partner** roles within a Trust are one of many approaches to involving patients, carers, families and the wider public in the development of safer organisations. These voluntary roles will work across the Trust and form part of the Corporate Patient Safety Team. They will be involved in safety at all levels of the Trust.

3.2. **Patient Safety Specialists** are professionals who work within the Trust to ensure that patients receive an excellent standard of care whilst minimising potential risk.

4. Purpose and Scope

4.1. This policy supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents

- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

4.2. This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all areas of this organisation.

4.3. Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Learning responses do not take a 'person-focused' approach where the actions or inactions of people are the focus of an investigation, but where compassionate engagement with the involvement of those affected by an incident can provide learning and supportive oversight.

4.4. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

4.5. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

5. Duties

5.1. **Trust Board** has responsibility to assure themselves that the Patient Safety Incident Response (PSIR) Policy and Plan is being implemented, that learning to address areas of weakness has occurred and improvements are being embedded. Part of this responsibility includes the assurance regarding the Trust's safety culture relating to blame and openness so that a just and learning culture can be achieved and patient engagement is meaningful. Once a quarter, the Trust Board will be provided with an investigation report as part of the assurance process. PSIR progress monitoring will be via the monthly Quality Governance reports reviewed at the Patient Safety Committee and Clinical Executive Management Group, and updates provided via the Quality and Safety Committee onward to the Board.

5.2. **Chief Executive** is responsible for the provision of appropriate policies and procedures to ensure the safety of patients, staff and visitors. They are ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

5.3. **Chief Nursing and Midwifery Officer (CNMO)** has delegated responsibly by the Board for the implementation of PSIRF. The CNMO is responsible for the approval of all Patient Safety Incident

Investigations (PSIIs). The CNMO will be supported closely by the Trust's Patient Safety Specialists (PSS). The Trust will have at least four Patient Safety Specialists.

5.4. **Chief Medical Officer (CMO)** will provide temporary oversight and approval of PSIIs, if the CNMO is not available.

5.5. **Director of Quality Governance** will support the CNMO in the strategic oversight of the implementation of PSIRF.

5.6. **Deputy Director of Quality Governance** will provide leadership in the design and development of new systems and processes to support the effective implementation of PSIRF.

5.7. **Head of Patient Safety and Improvement** will provide leadership to the Corporate Patient Safety Team and wider organisation in the design, development and embedding of the new systems and processes including education and training. As well as identifying where redesign is required to enhance the effectiveness of our learning responses. They also manage the Quality Governance Business Partners (QGBPs) (see 5.11).

5.8. **Patient Safety Specialist** will provide a specialist knowledge and expertise, when required, in response to an incident or theme. They will also take a leading role in the Trust's four key themes providing oversight and leadership in how these are managed and overseen ensuring a robust design methodology and consistent improvement.

5.9. **Deputy Head of Patient Safety and Improvement** is responsible for leadership across the organisation in relation to embedding PSIRF, learning response methodology and the System Engineering Initiative for Patient Safety (SEIPS) framework. Supporting the development and delivery of training for the Trust in relation to both improvement and investigation methodology and tools provided by NHS England for use with PSIRF. This role will provide oversight of the team that provides the day-to-day management of our learning responses as well as the Datix Team, Learning from Deaths Facilitators, Clinical Guidance and Alerts and Patient Safety Leads.

5.10. **Patient Safety Leads** are responsible for providing coaching to the Quality Governance Business Partners (QGBP) on investigation methodologies and techniques, as well as undertaking PSIIs themselves that relate to the four key themes that have been selected for that year.

5.11. **Quality Governance Business Partners (QGBP)** will oversee patient safety activity, supporting and advising the Care Group during the learning response process. They will also take the lead role, supported by the Corporate Patient Safety Team Lead Investigators, for undertaking the PSIIs. These will not usually be within the care group they are aligned to.

The QGBP will have 60% of their working week allocated to Patient Safety and investigation, whilst the remaining 40% of their time will be focusing on the embedding of robust Quality Governance systems and processes within the Care Group to which they are aligned.

5.12. **Corporate Quality Governance Team** will manage the day-to-day Patient Safety functions. There will be close liaison between these roles and the Quality Governance Business Partner roles. These roles will support the new systems and processes designed to embed PSIRF.

5.13. **Care Groups** will be responsible for ensuring that all their incidents are reviewed daily and responded to appropriately, actions placed on the Actions module within the Incident Management System and the incident closed appropriately. Through their governance processes they will ensure that there is timely closure of these incidents as well as proportionate learning responses selected to address the issues identified. The solutions identified, following the completion of the learning response, will be entered onto the Actions module and monitored through their governance processes. They are responsible for promoting an open culture across their Care Group where staff feel comfortable raising concerns and are not fearful when involved in an incident.

5.14. **Medical Examiners** will provide expertise in medicine and contribute to the accurate determination of the cause of death. In addition as part of their role they will be able to provide learning to support the overall aim of PSIRF.

5.15. **Coroner** undertakes investigations into unnatural or unexpected deaths to determine the circumstances surrounding each death as well as the identity of the person, date, place, and cause of death, providing valuable insights that will contribute to the overall improvement of patient safety.

6. Patient Safety Culture

6.1. The Trust has implemented a Trust wide workstream focused on improving the culture, including safety culture, which spans two years. This workstream will identify key areas of focus as well as the most appropriate range of responses with measured improvement. The first six months included data collection and analysis to identify the underlying contributory factors.

6.2. Within our People and Culture team the principles of the Just Culture guide have been applied to both clinical and non-clinical cases that are considered by them. The aim of this work has been to drive down the number of disciplinary investigations for clinical staff who have made a mistake as well as reducing fear for staff and the sense of blame when a mistake is made.

6.3. Further work is planned to review the current approach and build upon the work already completed to fully embed the use of the Just Culture Guide across the Trust. This will be achieved by raising awareness of the tool to all staff, ensuring that it is accessible and providing on line training on how and when to apply it. The training will be monitored centrally as well as data from both the Culture Workstream and the Staff Survey results to demonstrate progress.

6.4. The implementation of the systems approach using a range of tools, such as the Systems Engineering (SEIPS) framework, will also encourage a different approach to understanding how to move away from focusing on individuals who have made an error, to understanding and improving the system within which they work. Close links have been forged to ensure that there is feedback to and from the Freedom to Speak Up (FTSU) team when they identify both positive and improvement needs that relate to our Safety Culture. The FTSU team are being incorporated into the appropriate training sessions so that they are able to influence, advise and raise concern where needed.

During transition, the Trust will move away from simple action plans, as a result of investigations, to Trust wide Improvement Plans (TWIPs) to drive up quality and safety for our staff and patients. This will further embed our improvement methodology as we embed the PSIRF. The Trust will reinforce that statements should not be requested for learning responses as they do not provide the information that is useful for a system-based learning response. However, compassionate, investigative interviews will be undertaken to elicit contextualised, useful information and ensure maximum learning is achieved.

7. Patient Safety Partners

7.1. It is recognised that both patients and carers can provide valuable insights based on their experience, in the development and improvement of safety responses.

7.2. The recruitment of six Patient Safety Partners (PSPs) across the Trust will support this work. There will be two PSPs based at each of the main hospital sites: Queen Elizabeth the Queen Mother Hospital (QEQMH), William Harvey Hospital (WHH) and Kent and Canterbury Hospital (K&CH). The PSPs will cover the entire Trust.

7.3. The aim is to appoint one PSP who will lead on working within our Maternity Services and up to two that will be attending the Quality and Safety Committee as well as the Patient Safety Committee. A key aspect of their work will be to support the implementation of compassionate and meaningful engagement with our patients and families.

7.4. These staff will be managed by the Patient Safety Leads or the Deputy Head of Clinical Safety and Improvement, within the Corporate Patient Safety Team. Our PSPs will be appointed by June 2024.

8. Addressing Health Inequalities

8.1. There is a requirement under PSIRF to evidence that health inequalities have been taken into consideration when responding to incident reviews. The identification of those patients who may be at a disadvantage in accessing the care they need must be identified as part of our responses as well as consideration in the development of solutions.

8.2. The Trust will apply a more flexible approach and intelligent use of data to help identify any disproportionate risk to patients with specific characteristics and this information will inform our patient safety incident responses.

8.3. The Trust will develop a small working group which will explore how we will respond to issues related to health inequalities as part of the development and maintenance of the Trust's PSIR policy and plan. During the review of our incident responses, and the development of safety actions, health inequalities will be considered. Appropriate prompts will be included on our templates.

8.4. As part of our response to incidents the way in which we engage our patients is important to us. Appropriate consideration must be given to the needs of each patient, their carers and members of staff when planning to communicate with them.

8.5. The Trust will ensure training is available to all staff who will be responsible for undertaking an investigation to ensure that the system-based approach is consistently applied across the Trust. In addition, the Patient Safety Incident Investigation (PSII) Investigators and staff responsible for engaging patients and staff will be provided with coaching support to develop their competence.

8.6. Having fully trained investigators will ensure that not only will the focus be appropriately on the systems within which our staff work rather than their behaviour, it will further promote the development of a Just Culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS.

9. Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

9.1. The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents this includes patients, families, and staff.

9.2. This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

9.3. The principles of engagement:

9.3.1. The Trust requires all staff, who are leading a learning response, to apply compassionate engagement with all those affected by the patient safety incident. This must include staff involved, or otherwise affected, by the incident.

9.3.2. Our approach will be open, kind and sensitive to the needs of those individuals.

9.3.3. Engagement will be focused on their needs as a priority.

9.3.4. The Trust supports openness and transparency in sharing information throughout the investigation with staff, patients and families. This includes sharing information from the investigation at an early stage. This may be both written and verbal.

9.3.5. Staff will be supported by the Trust to ensure they feel confident to share information about work as done.

9.3.6. The investigative process will be collaborative; with the patient, staff and investigators working together to achieve learning that will ensure improvements are made.

9.3.7. The approach towards our staff who have been involved in an incident must be without judgement or blame. After each contact with the investigation team they should leave feeling that they have been treated fairly and not blamed or punished.

9.3.8. Statements (or other written accounts must never be requested following the initiation of a patient safety incident response). Statements are unhelpful and will not promote the new ways of thinking within the principles of PSIRF.

9.3.9. There is an informal agreement between the investigator and staff involved. This agreement is based on the principle that staff share information openly with the investigator and they will not be blamed or punished for making an honest mistake. (An honest mistake is where there was no intention to cause harm and the individual did their best).

9.3.10. Identification of specific communication needs or other needs in relation to Health Inequalities should be considered early in the process.

9.3.11. The Duty of Candour (Professional and Statutory) is a requirement by professional bodies as well as a legal requirement and therefore must always be applied for notifiable safety incidents (CQC 2022). This requirement is not changed by the principles of compassionate engagement.

9.3.12. There will be training for all staff who will be engaging with our patients and staff in response to a patient safety incident. The training will cover: Duty of Candour; how to engage with our patients; families and staff; understanding the process of compassionate engagement; recommended points of contact; how to share information and sign posting.

10. Patient Safety Incident Response Planning

10.1. PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

10.2. **Resources and Training to Support patient Safety Incident Response**

10.2.1. The Trust has recently agreed to transfer all Care Group Governance staff to the Quality Governance Directorate. This has provided the Trust with an opportunity to create a tailored workforce that, with the appropriate training and support, will be able to deliver on the PSIRF requirements as well as the wider quality governance agenda.

10.2.2. Within the new structure which includes the resource from the Care Group governance teams, there will be six full time Band 8 posts, four of which will become the business

partner for each of their Care Groups. The other two posts will remain the governance leads for their respective care groups. These posts will be known as the Quality Governance Business Partners (QGBP). Their roles will be 60% working on Patient Safety and 40% supporting the embedding of Quality Governance within their Care Group. As part of the role they will also be the main resource for undertaking the PSIIs.

10.2.3. In addition to the business partner roles the existing corporate team include two Band 7 Patient Safety Leads and 1.4 WTE Band 8a Deputy Heads of Patient Safety and Improvement. The Deputy Heads of Patient Safety and Improvement will manage the patient safety governance staff that have transferred from the Care Groups.

10.2.4. The Patient Safety Leads will provide oversight of the day-to-day management of the patient safety function and provide coaching and training for the QGBP as well as undertaking PSIIs themselves that relate to the key themes that the Trust is focussing on.

10.2.5. An important aspect of the corporate team roles is to support the development of robust solutions as well as supporting the dissemination and embedding the learning across the Trust for the PSIIs undertaken.

Table 1: The numbers of investigations the Trust has completed in the previous five years as well as the resource demand.

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Total SIs declared	**139**	**210**	**232**	**307**	**240**	**1128**
Total Never Events (sub set of total SIs)	7	4	4	3	7	25
Maternity and Neonatal Safety Investigations (sub set of total SIs)	4	4	4	10	6	28
RCAs and AARs (not SIs)	**80**	**134**	**140**	**124**	**129**	**607**
Total RCA/AAR investigations	**215**	**340**	**368**	**421**	**363**	**1707**
RCA/AAR Investigation hours (55 hrs each)	11825	18700	20240	23155	19965	93885
Total SJRs completed	**16**	**54**	**52**	**29**	**39**	**190**
SJR Investigation hours (1 hour each)	16	54	52	29	39	190
Total Investigation hours (all types)	11841	18754	20292	23184	20004	94075
Investigation time spent in weeks per annum	**316**	**500**	**541**	**618**	**533**	**2509**

The table above shows the increasing number of serious incidents the Trust has undertaken over the past five years as well as the sustained number of other types of investigation responses over the same period. The Trust has calculated the number of hours spent on each investigation, irrespective of the staff members grade or profession, and estimated that there is an average of approximately 55 hours spent per investigation.

This figure is averaged out between serious incident investigations and After-Action Reviews (AAR). There are approximately 553 weeks spent on completing investigations over the previous year and this equates to 12.7 WTE staff.

Table 2. High-level training requirement for key staff across the Trust in accordance with the Patient Safety Incident Response Standards

The Trust has developed a comprehensive training needs analysis. The training plan is under development. Both are available separately.

Role	Training Required
Chief Nursing and Midwifery Officer (Executive Director Responsible for PSIRF) Chief Medical Officer	Level 1 Essentials of Patient Safety for all staff; and for Senior Leadership and Trust Boards Level 2 Access to Practice A systems approach to investigating and learning from Patient Safety Incidents Involving those affected by patient safety incidents in the learning process Patient Safety Incident Response Framework Oversight Continuing Professional Development (CPD) in incident response skills and knowledge
Patient Safety Specialists (Director and Deputy Director of Quality Governance Head and Deputy Heads of Patient Safety and Improvement)	Patient Safety Syllabus Level 1, 2, 3 and 4 Other relevant approved training CPD in incident response skills and knowledge
The Trust Board	Level 1 Essentials of Patient Safety for all staff and for Boards and senior leadership teams Level 2 Access to Practice
Learning Response Leads	Patient Safety Syllabus Level 1 and 2 A systems approach to investigating and learning from patient safety incidents Involving those affected by patient safety incidents in the learning process Be provided with in-house coaching and support when completing learning responses

All Staff	Level 1 Essentials of Patient Safety for all staff (Mandatory Training). Level 2 Access to Practice 1 and 2 (Essential to role)

10.2.6. All staff that undertake PSIIs will have an identified coach from the Corporate Patient Safety Team. The role of the coach is to support the lead investigator's development and expertise in undertaking a high-level investigation. Although the lead investigators may have completed many serious incident investigations previously, the new approach is completely different to Root Cause Analysis, as are the tools and templates.

10.2.7. The coach will provide intensive support initially and gradually withdraw as the investigator gains confidence. The coach will confirm the investigator meets the Patient Safety Incident Response Standards training and competency requirements prior to undertaking an investigation on their own. Competency assessment tools have been developed based on the Patient Safety Incident Response Standards.

10.2.8. In addition to the coaching provided, the investigator will present the investigation to date, to a small audience, so that there can be gentle constructive challenge as a critical friend. This ensures that the investigation is robust and addresses the investigation Terms of Reference.

10.2.9. These sessions are invaluable to ensure that all relevant investigation lines have been identified. With training and coaching provision, the Trust will develop a robust and expert investigation team over the first year. This knowledge and understanding are essential for leaders in patient safety as the skills and knowledge gained in this process can be used in all other aspects of safety.

10.2.10. Regular peer review sessions will also take place once the Trust has transitioned. This is to ensure consistency in approach with the lead investigators and the Corporate Patient Safety Team.

10.3. **Our Patient Safety Incident Response Plan**

10.3.1. Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. We will review the Plan and Policy within the first 6 months owing to the level of change required and new approaches it is anticipated that we will need to adapt and amend some aspects. The review of both documents will include the Kent and Medway Integrated Care Board (ICB).

Embed PSIR Plan link once published on Trust extranet

10.4. **Reviewing our Patient safety Incident Response Policy and Plan**

10.4.1. Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan after the initial 6 months and at 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months. Thereafter the policy will be reviewed annually.

10.4.2. The updated plan will be published on our website, replacing the previous version which will be archived.

10.4.3. A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with the ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

11. Responding to Patient Safety Incidents

11.1. Patient Safety Incidents Reporting Arrangements

11.1.1. All incidents will be reported onto the Trust Incident Management System. Where there is a requirement to report externally this will be completed by the appropriate speciality with oversight from QGBP and the Corporate Patient Safety Team.

11.1.2. The Trust Incident Management System was updated in February 2024, to include the Learn from Patient Safety Events (LFPSE) fields that will be automatically uploaded to the LFPSE system. Where there are bounce back errors on specific incident fields, these are corrected on a daily basis to ensure accurate and timely upload of our incidents.

11.1.3. The Trust will, in line with current practice, continue to verbally report to both the ICB and the Care Quality Commission (CQC) incidents that the Trust, ICB and CQC have agreed require direct notification e.g. Never Events. This will be completed by the Director of Quality Governance or the Chief Nursing and Midwifery Officer.

11.1.4. Where there is a system issue identified, the ICB should be informed and the Trust would be required to provide an appropriate and proportionate response.

11.2. Patient Safety Incident Response Decision-Making

11.2.1. One of the requirements of PSIRF is to ensure that we stop undertaking large numbers of investigations, when the contributory factors are known, and that we focus on making the necessary improvements. It is recognised that for the Trust to move away from reporting 240 serious incidents last year, there will need to be a clearly defined and structured approach to incident response decision making, particularly in the first year of transition.

11.2.2. The aim of the Trust's plan has been to provide as much guidance on the potential response, in relation to specific incident types and themes, which we hope will remove the need and desire to respond with an investigation. The Trust will transition to the Incident Response Panel (IRP), from the Serious Incident Declaration Panel, where all appropriate incidents will be discussed and responses agreed. There is an expectation that the incidents will be reviewed, by the local team supported by the Quality Governance Business Partners and Corporate Patient Safety Team, and the appropriate response recommended to the Chair. This decision-making process is supported by a flow chart found in Appendix 2.

11.2.3. Incidents required for review will be identified from the daily review of incidents completed by the Corporate Quality Governance and Patient Safety teams as well as the clinical staff in the Care Groups. The principles used to determine which cases are escalated for consideration at the IRP include, those incidents where there is a significant potential for learning to be gained and therefore the potential for safer care for many other patients. Cases where there is significant risk or concern. Cases that have not been identified for any other response stream. Cases where there has been a near miss with the specific focus to identify why the outcome was not affected. Those cases where there appears to be significant psychological or physical harm as a result of the care provided. Whilst the Trust is moving away from using harm as a factor in the determination of the incident response method, the Trust at this stage, will not exclude its influence entirely. Therefore, although the main influencing and guiding principle will be levels of learning, the Trust will continue to take into consideration the level of both psychological and physical harm caused in the identification of cases to be presented at the IRP.

11.2.4. Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals. The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses. The role of both safeguarding and MCA will be reviewed by the Trust safeguarding team who attend the Trust IRP.

11.2.5. The Trust will undertake a quarterly review of all of patient safety, legal, complaints, clinical audit, mortality, PALS data as well as information from staff and patient engagement session to continue to identify learning. This work will also support the development of the new themes for the following year.

11.3. **Four Key Themes**

11.3.1. The Trust will identify four key themes each year that the Corporate Patient Safety Team will focus on. As per the guidance, they will apply the systems methodology to learning responses undertaken and identify the contributory factors. These will then have an improvement plan developed and the focus of the work will then move away from the

investigation to improvement work. It may be necessary to undertake a number of learning responses to identify the main contributory factors for each theme.

11.4. **Continuous Improvement Approach using the Safety Improvement Plans**

11.4.1. As part of the PSIRF preparation and data review, the Trust identified large numbers of repeat incidents for seven areas that would benefit from the implementation of Trust Wide (safety) Improvement Plans. Across these seven areas there is an opportunity to significantly increase the level of improvement over the coming year. Having identified the seven areas, once the contributory factors have been identified, with support from the Improvement team, a Trust Wide Improvement Plan will be created. For each new case that occurs there will be a desk top review using the work system scan or horizon scanning approach and providing there are no new issues identified, the incident will be closed, the review template saved on the system and the time that would have been spent on the investigation will now be spent working on the improvements to be made.

11.4.2. If there are areas that are new and not identified on the improvement plan, then the response would focus on only those issues and the improvement plan will be updated with the contributory factors and associated improvements to be made.

11.4.3. The levels of improvement will be monitored and, for those areas that have met the targets, the plan would move to business as usual. For those that continue to require improvement there will be consideration of whether these remain as part of the PSIR Plan the following year. There will also be consideration for new themes that have arisen during the previous year to be included in this approach. All improvement plans, and progress against these, will be shared with the ICB.

11.4.4. This approach will be closely monitored through the Fundamentals of Care and other relevant work streams monthly. Relevant meeting agendas and papers will be shared with the ICB and at key points in the year, with prior agreement with the ICB, they will be invited to attend to observe relevant meetings.

11.5. **Individual specialty learning response table**

11.5.1. There are two areas across the Trust this year 2024/2025, that we are in the process of creating a table of appropriate and proportionate learning responses: Maternity Services and Infection Prevention and Control. These will be added to the plan when they have been completed. Each year the Trust will review each of these response plans and update them accordingly. There will also be consideration for the development of new response tables for other specialties with high reporting rates.

11.6. **Responding to Cross-System Incidents/Issues**

11.6.1. Should the Trust be involved in a patient safety incident which has been identified by a system partner or the agency, the Trust will ensure that this is also recorded on the local Incident Management System indicating clearly the lead organisation for the investigation. The Trust will contribute to the response which is led by the partner

organisation and ensure that recommendations for the Trust are clearly defined and communicated across the organisation.

11.6.2. Similarly, should the Trust become aware of an incident that involves a system partner the Patient Safety team, in the partner organisation, would be contacted via their generic email and asked for their collaboration with the learning response. Many of these relationships have been forged over several years and are known to the Trust. Should there be a significant incident, one which either affects many patients or is a very concerning nature, the ICB and CQC will be notified.

11.6.3. Should information need to be shared with other providers within the learning response, information governance standards must be met. Please see more details within the Information Governance Policy. Staff can access this via the Policy Centre and the public can request this by contacting the Freedom of Information Team.

11.7. **Timeframes for Learning Responses**

11.7.1. The response timescales will start on the day the incident has been reported.

11.7.2. These timescales are not rigid and will be determined in collaboration with the patient, family and staff.

11.7.3. Proposed timescales will be discussed and agreed at the Incident Response Panel (IRP) should the incident be reviewed at this meeting.

11.7.4. Guidance and support can be obtained by the Care Groups from the QGBP in relation to timescales.

11.7.5. Consideration also needs to be given to the staff who may also be affected by the incident. It can be stressful for staff as well as patients when investigations are prolonged.

11.7.6. The time needed to conduct the response must be balanced between the impact of long timescales on those affected and the risk that the opportunity for optimum learning and improvement may diminish.

11.7.7. Where there is delay because of external organisations providing information within a reasonable timescale, the Trust will complete the investigation with the information they have. Other, than outlined in the table below, all other responses for significant incidents will be agreed at the time depending on the communication with the patient and/or family.

Table 3. Learning response selected with approximate timescales as guidance

Learning Response	**Timescales**
PSII	3-6 months (as per NHSE guidance)
After Action Review	1–5 weeks
Multidisciplinary Team Review	8 weeks

SWARM	2 weeks

11.8. **Safety Action Development and Monitoring Improvement**

11.8.1. Safety actions will be monitored using the electronic Incident Management System Actions module. All actions will be entered onto the system which will allow monitoring of those that are due and those that have been completed. This data will be reported monthly as part of the Quality Governance Report to the Clinical Executive Management Group (CEMG) and the Quality and Safety Committee.

11.8.2. For PSIIs the Corporate Patient Safety Team will take the lead and support the QGBP in the development of local actions in collaboration with the relevant local teams. The QGBP will be responsible for monitoring the completion of actions for their care group.

11.8.3. The Corporate Patient Safety Team will work with the Quality Improvement Team in relation to improvement work. There will now be a unified register of all improvement plans that will sit with the Quality Improvement Team. For the seven themes that will be using an overarching improvement plan rather than reinvestigating, it has been agreed that the Quality Improvement Team will work with patient safety and key leads to support this work.

11.8.4. During the first year of PSIRF we will be scoping how patient safety and the improvement team will work more closely as the improvement work starts to increase through the implementation of PSIRF.

11.9. **Oversight from the ICB**

11.9.1. NHS Kent and Medway Integrated Care Board (ICB) has a responsibility to provide an oversight role under PSIRF. The ICB has collaborated with East Kent Hospitals University NHS Foundation Trust in the development of this PSIR Policy and will continue to collaborate with them in its maintenance and review. The PSIR Policy will be reviewed by both East Kent Hospitals University NHS Foundation Trust and the ICB at months 6 and 12 following implementation of PSIRF, and will then be reviewed at least annually.

11.9.2. East Kent Hospitals University NHS Foundation Trust is requested to invite their named ICB PSIRF Partner (or a suitable representative) to attend core internal meetings. The purpose of the ICB representative at these meetings is to observe interactions between staff (in terms of culture and psychological safety) and to ensure that they are following the PSIR Policy and Plan. These meetings may have different names within each provider, but their functions are described within this policy. Where additional meetings take place, the ICB requests an invite to also attend these meetings.

- Incident review/declaration meetings, i.e., where incidents are discussed, and type of learning response is determined.
- Investigation review/closure meetings, i.e., where the completed learning response is reviewed.

The ICB PSIRF Partner will feed into the monthly ICB PSIRF Partners System meeting. The purpose of this meeting is to ensure and support learning across the wider system.

11.9.3. The ICB will be listed on all relevant Terms of Reference and be invited to attend any relevant meetings.

12. Quality Review

12.1. During the transition, of both the care group quality governance teams joining the Quality Governance Directorate and the Trust transition to the PSIRF, there will be a peer review process implemented, at all levels, to ensure consistency in approach and style in relation to undertaking and reviewing all incident learning responses.

13. Complaints and Appeals

13.1. The PSIRF provides a very different approach to how we will manage patient safety incidents in the future. If you would like more information or to offer suggestions or feedback on this policy, please email the Patient Safety Team at ekhuft.psirf@nhs.net

13.2. If you have a concern and you would like to make a complaint, please can you use the Trusts complaints process (https://www.ekhuft.nhs.uk/contact-us/giving-feedback/pals/making-a-complaint/)

13.3. To make a complaint you can:

Call us: 01227 783145

Email us: ekh-tr.pals@nhs.net

Write to us at:

The Complaints Team
East Kent Hospitals University NHS Foundation Trust
Trust Offices
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG

14. Policy Development, Approval and Authorisation

14.1. This policy will be approved by the Quality and Safety Committee.

14.2. This policy will be ratified by the Policy Authorisation Group.

15. Review and Revision Arrangements

15.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

15.2. It will be reviewed/ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with the policy for the Development and Management of Trust Policies.

16. Policy Implementation

16.1. Refer to Appendix 5.

17. Document Control including Archiving Arrangements

17.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

17.2. This policy will be uploaded to the Trust's policy management system.

18. Monitoring and Assurance

18.1. The following table outlines the monitoring arrangements in place for this policy.

Policy Objectives	**Monitoring methods**	**Assurance**
To ensure a safe and smooth transition from the Serious Incident Framework to the implementation of PSIRF	Via the Patient Safety Committee (PSC) and the Quality and Safety Committee (QSC)	Monthly agreed metric reporting including improvement plans
To provide clear guidance on how the Trust will manage patient safety incidents in the future and to provide a framework by which the Trust will be able to identify key areas for improvement that relate to patient safety	Via the Patient Safety Committee (PSC) and the Quality and Safety Committee (QSC)	Monthly agreed metric reporting including improvement plans

19.References

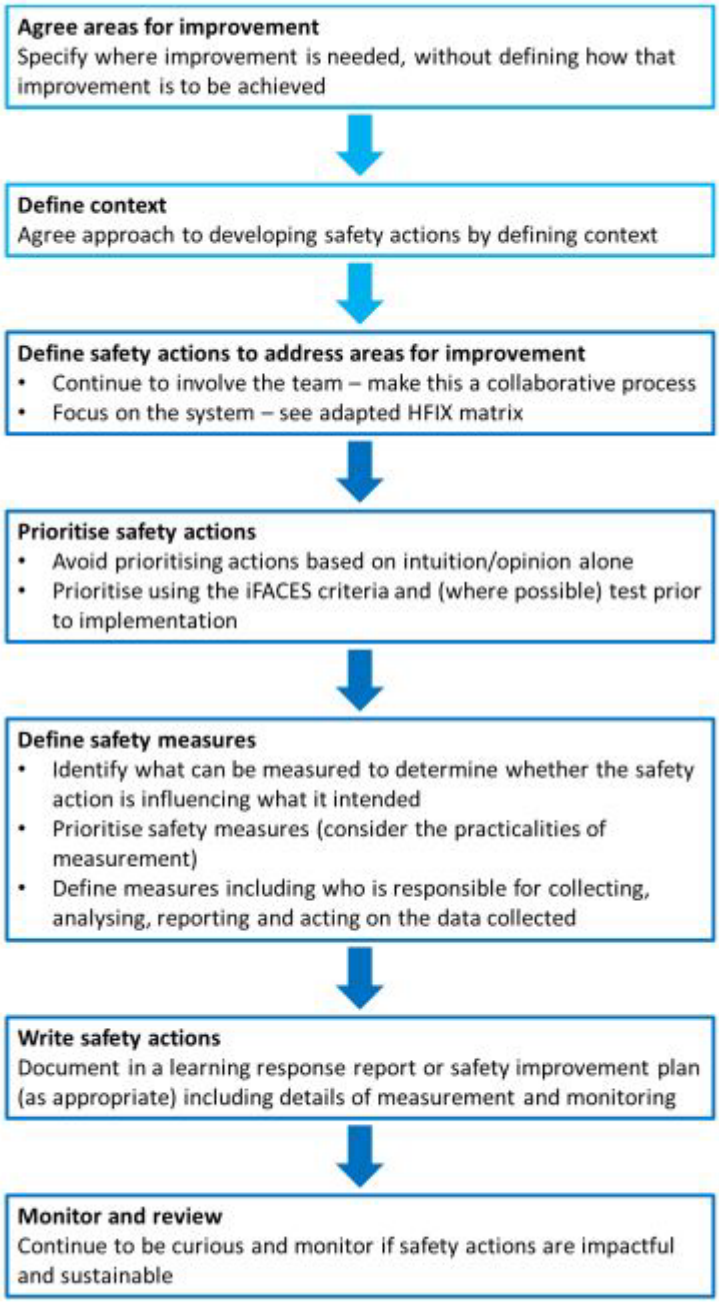
Academy of Medical Royal Colleges. (2022) Patient Safety Syllabus. Version 2.1. London.

NHS England. (2022) *Patient Safety Incident Response Framework.* London

NHS England. (2022) Safety Action Development Guide. London

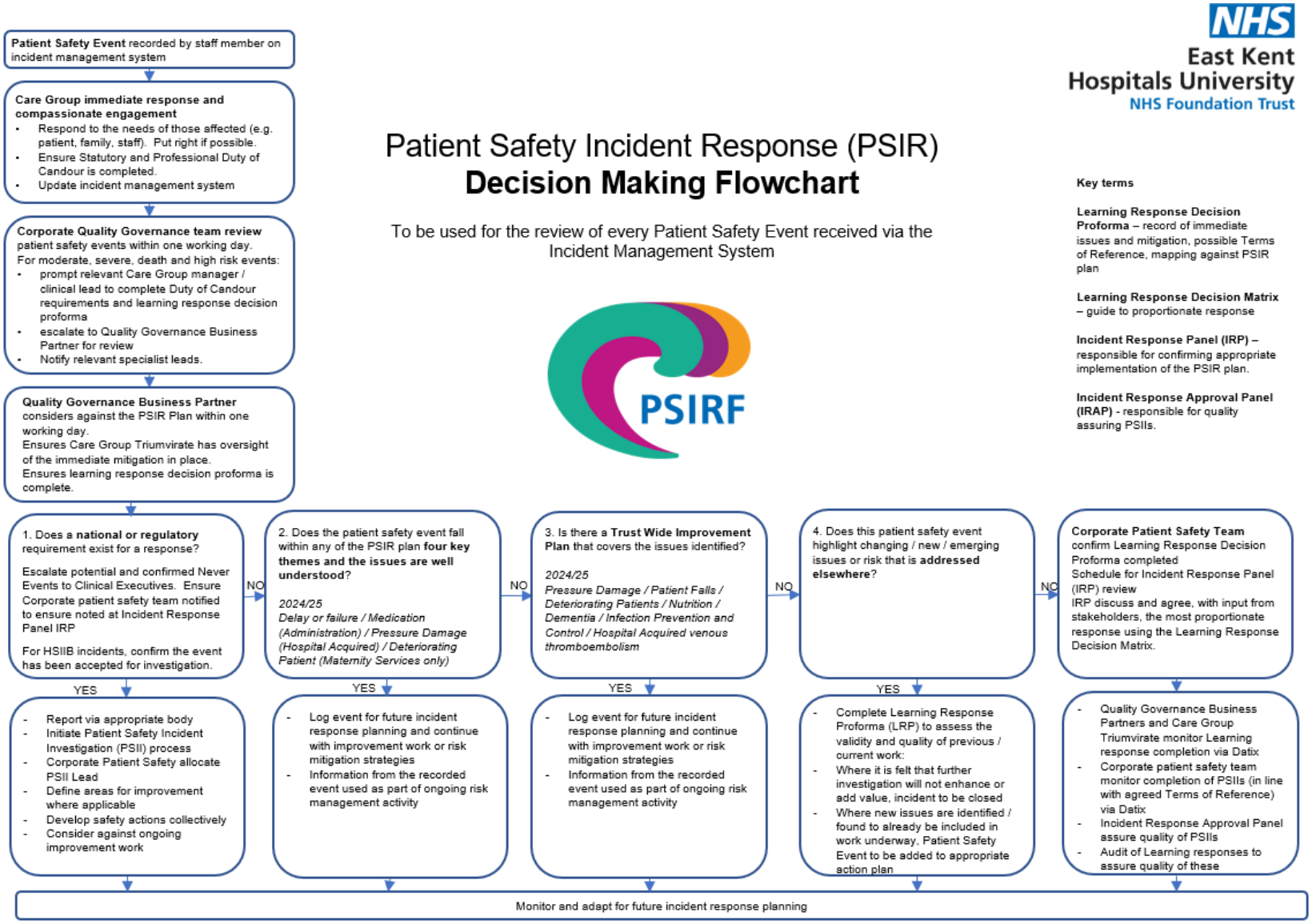
Appendix 1: Safety Action Development Process

Figure 1: Overview of safety action development process



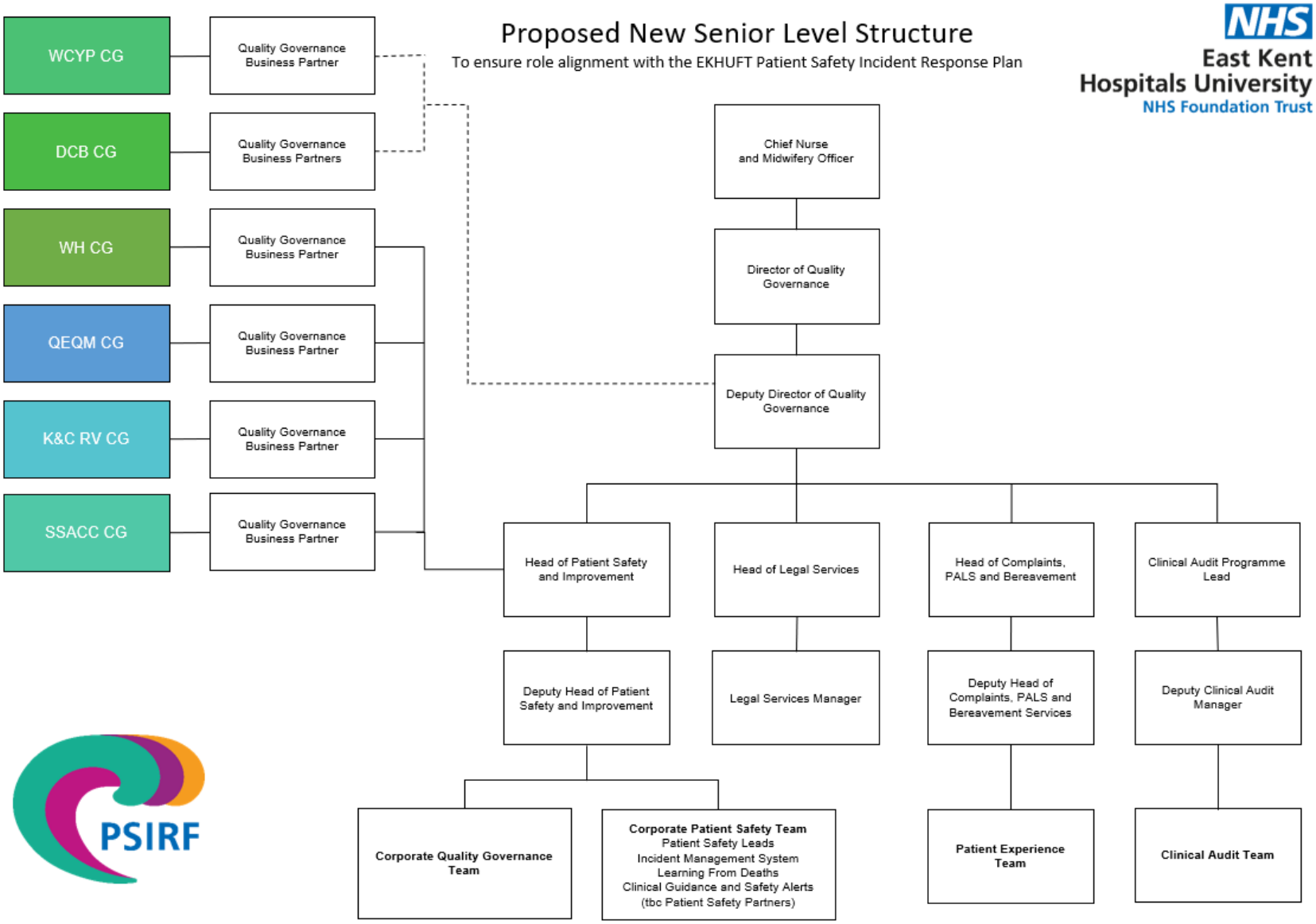
NHS England, Safety Action Development Guide, August 2022

Appendix 2: Incident Response Decision Making Flowchart



Appendix 3: Quality Governance Structure Chart

24/52 – Appendix 1



Appendix 4: Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis

Job title: Deputy Director of Quality Governance

Care Group/Department: Quality Governance Directorate

Date completed: 05 April 2024

Who will be impacted by this policy

[x] Staff (Trust)

[x] Staff (Other)

[x] Clients

[x] Carers

[x] Patients

[x] Relatives

Assess the impact of the policy on people with different protected characteristics

When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.

Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
Age	All	Neutral
Disability	All	Positive
Gender reassignment	All	Positive
Marriage and civil partnership	All	Neutral
Pregnancy and maternity	All	Positive
Race	All	Positive
Religion or belief	All	Positive

Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
Sex	All	Positive
Sexual orientation	All	Positive

If there is insufficient evidence to decide about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.

Has there been specific consultation on this policy?

N/A

Did the consultation analysis reveal any difference in views across the protected characteristics?

No

Mitigating negative impact:

(Where any negative impact has been identified, outline the measures taken to mitigate against it.)

None

Conclusion:

(Advise on the overall equality implications that should be considered by the policy approving committee.)

The are many positive implications to the implementation of this policy. There is a specific focus within PSIRF for the Trust to address health inequalities as well as a much greater emphasis on the engagement of all parties that would be affected by an incident occurring.

Appendix 5: Policy Implementation Plan

Policy Title: Patient Safety Incident Response Policy

Implementation Lead: Deputy Director of Quality Governance in partnership with the Head of Patient Safety and Improvement

Staff Groups affected by policy: All staff

Subsidiary Companies affected by policy:

2gether Support Solutions Ltd.

Spencer Private Hospitals

East Kent Urgent Treatment Centre Alliance

Detail changes to current processes or practice:

- Our response to incidents, method of investigations and level of engagement of those affected is changing.
- Greater involvement of staff and patients and their families in the incident investigation.
- Higher standards of the role of the investigator and investigation to be applied.
- Oversight from the ICB will adapt to becoming a collaborative approach to provide assurance.

Specify any training requirements:

- Refer to Table 2 in section 10.2.5

How will policy changes be communicated to staff groups/ subsidiary companies?

- Via the Patient Safety Communication (Comm) plans
- Information sessions to staff

East Kent Hospitals University NHS Foundation Trust

Patient safety incident response plan

Effective date: June 2024

Interim Review and Update: December 2024

Estimated refresh date: March 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Samantha Gradwell**	**Deputy Director of Quality Governance**		**14/05/2024**
Reviewer	**Melinda Brewer**	**Head of Clinical Safety and Improvement**		**14/05/2024**
Authoriser	**Sarah Hayes**	**Chief Nursing Officer**		**14/05/2024**
Authoriser	**Des Holden**	**Chief Medical Officer**		**14/05/2024**

Contents

Foreword

I am delighted to introduce our new Patient Safety Incident Response (PSIR) Plan for East Kent Hospitals University NHS Foundation Trust (EKHUFT).

I am very thankful for the input from all staff, for their dedication and commitment to the new Patient Safety Incident Response Framework (PSIRF) planning and implementation in our Trust. Particularly our clinical staff and their commitment to delivering high quality patient safety for our patients, their families and carers.

We aspire to deliver compassionate, safe, effective and high-quality care to all our patients, families and carers; this will remain our highest priority. We strive to provide excellent care to ensure that any harm to patients is minimised. We aim to achieve this in all areas of our Trust.

This plan aligns with the National Patient Safety Incident Response Framework (PSIRF) and will continue to develop as we work together to provide the best outcome and experience for every patient.

It is our hope that as the implementation progresses and becomes embedded over the coming years, the value of this transformation will be visible not only to our staff but all of our stakeholders.

Sarah Hayes

Chief Nursing and Midwifery Officer

Introduction

This Patient Safety Incident Response (PSIR) Plan sets out how East Kent Hospitals University NHS Foundation Trust (EKHUFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule and we can adapt the plan accordingly with any learning during this period. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Prior to further updates to this plan, we will conduct staff and patient forums/surveys to seek views and assurance on those updates and on the effectiveness of our proposed plan. We will also use patient feedback and data sources, to inform those updates.

With the inception of the Serious Incident Framework, NHS Trusts were required to report to their commissioners, and investigate, increasing numbers of serious incidents that met the thresholds. Over the past seventeen years the NHS has matured and developed its understanding and the application of patient safety and risk in the delivery of patient care and minimising harm. During this time the types of incidents that have been investigated has also evolved with a significant increase in numbers of serious incident investigations. This has resulted in the NHS creating the need for a significant resource required to complete these investigations rather than focusing on continuous improvement. This emphasis is about to undergo a dramatic change with the introduction of the PSIRF. The new framework will transform how patient safety is understood and practiced across the NHS at all levels.

The aim of our plan is to minimise the resource dependency for investigations and redirect it to undertaking continuous improvement work, as a result of fewer, higher quality investigations that delve deeper into the contributory factors. The aim is that we develop specific and targeted solutions which result in demonstrable improvements in care. We now have the opportunity and freedom to respond in a proportionate way to all of our incidents by utilising both current and new responses in order to establish and implement learning. EKHUFT is in a unique position as we are also in the process of centralising our Care Group governance support, which will allow us the opportunity to re-design whilst standardising and ensuring consistency of approach to all aspects of the new framework.

Our Services

We are a large hospital Trust, with five hospitals and several community clinics serving around 700,000 people in east Kent. We also provide specialist services for a wider population of over a million. We provide several services in the local community including home dialysis, community paediatrics and the Hospital at Home Team.

As a teaching Trust, we play a vital role in the education and training of doctors, nurses, and other healthcare professionals, and are working in partnership with the new Kent and Medway Medical School. We will continue to work with our long-term partner, King's College University in London and with St George's Medical School. We value participating in clinical research studies and we consistently recruit high numbers of patients into research trials. Kent and Medway's Clinical Trials Unit, which opened in 2022, is based in the Queen Elizabeth the Queen Mother Hospital, Margate.

Our Hospitals

Kent and Canterbury Hospital Canterbury, provides a range of surgical and medical services. It is a central base for many specialist services in east Kent such as elective orthopaedics, renal, vascular, interventional radiology, urology, dermatology, neurology, stroke and haemophilia services.

Queen Elizabeth The Queen Mother Hospital Margate, provides a range of emergency and elective services including comprehensive trauma, obstetrics, general surgery, and paediatric services. It has a specialist centre for gynaecological cancer and modern operating theatres, intensive care facilities, children's inpatient/outpatient facilities, and a Cardiac Catheter Laboratory.

The William Harvey Hospital Ashford, provides a range of emergency and elective services including a trauma unit, as well as comprehensive maternity, paediatric and neonatal intensive care services. The hospital has a renal satellite service and a specialist cardiology unit undertaking angiography and angioplasty.

The Royal Victoria Hospital Folkestone, provides a range of local services including an urgent care centre, a thriving outpatients department, the Derry Unit offering specialist gynaecological and urological outpatient procedures and diagnostic services.

Buckland Hospital Dover, provides a range of local services. Its facilities include a minor injuries walk-in centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services, ophthalmology surgery and a community diagnostic centre.

Further information on the services provided by each of our hospitals can be found on our Trust Website.

Our Trust Structure is accessible here.

Our Values

We are committed to improving how it feels to be a patient being cared for in our Trust, and how it feels to work here.

Our values were developed using feedback from staff, patients and stakeholders to support us to deliver “great healthcare from great people” and the culture we aspire to. They apply to every one of us, irrespective of role, seniority or base.

Our Vision

We want local people to have the best, most effective, hospital care when they need it - with more care, treatment and support out of hospital when they don’t. Our mission is improving health and wellbeing and our vision is to deliver great healthcare from great people.

We want our Trust to be a centre of excellence - where specialist teams have the equipment and staff they need to provide excellent patient care and where local people have faster access to hospital treatment because people who no longer need hospital care are receiving appropriate treatment closer to home instead.

Defining our Patient Safety Incident Profile

Our Approach

Two complete years, 2021/2022 and 2022/2023, of patient safety incidents were reviewed. This included all incidents including near misses and low and no harm. As our Trust experiences high reporting numbers we were assured that there would be an adequate number of incidents to review for the purposes of identifying our main themes. The Trust reports approximately 20 - 25 thousand incidents per year.

An analysis of our incident data within our Datix incident management system revealed where our highest number were reported. Table 1 shows the incident types in relation to our higher reporting rates.

Table 1. Incident Types with greater reporting rates over the previous two years

Patient Safety Incident Type	2021/2022	2022/2023	Total
Delay / Failure	7699	4109	11808
Tissue viability (including Pressure Damage)	4624	5184	9808
Care and Treatment	2556	2496	5052
Medication	1897	2115	4012
Patient Falls	1818	2066	3884
Infection Control	1387	596	1983

Our Four Key Quality and Safety Themes for Improvement

The following four themes will be the focus of the patient safety workstreams over the coming year. All four themes will also include our Maternity Services however the fourth theme 'Deteriorating Patient (Maternal and Neonatal)' is specifically for our Maternity Services.

Delay/Failure

One of our highest reported incident types was Delay/Failure. Further analysis showed that within this incident type a variety of issues were identified. These included the deteriorating patient, delays in diagnosis, delays in treatment, delays or failure in follow up (all of these included cancer patients), inappropriate or delayed transfer. Also work that had been scoped earlier in 2023 showed that there were issues within our electronic patient systems which created risks in terms of follow up, test results (including radiology results) going to the appropriate doctor and many more issues. These all feed into the category of Delay/Failure. As this affects almost every specialty across the organisation the potential improvement in patient safety is significant. Complaints and the Patient Advice and Liaison Services (PALS) data confirmed this is a common theme across the Trust. Legal data showed that there have been claims that have included allegations around delays.

Further scoping is being undertaken through detailed analysis of the intelligence available. It is anticipated that the principles of undertaking a themed review using a combination of inductive and deductive approaches will be applied to further interrogate the data available. It is acknowledged that to do this well requires time and thus the planned dates for commencement of improvement will be determined accordingly.

Medication Safety

The data shows that there have been a total of 1679 administration incidents over the two years as well as 1135 prescribing incidents. Medication incidents remain within the top 5 highest reported incidents over the previous two years. Although the levels of harm are mostly low or no harm the Trust has experienced 23 incidents where our patients have experienced moderate harm and above including three deaths. In April 2023 a new electronic prescribing software programme was introduced which was hoped to have an impact on incident rates for both prescribing and administration errors however the data does not demonstrate this.

Medication Safety, in particular medication administration, has been selected as our second key theme where there is a need for focused work, informed by Patient Safety Incident Investigation and other learning responses to identify what the Trust needs to achieve in order to improve patient safety in relation to medication administration.

Pressure Damage

With 9808 Tissue Viability incidents reported over a two-year period this theme features consistently in the top 5 categories. Within this theme there are other tissue viability issues. Focusing solely on both ‘hospital acquired’ and ‘admitted with’ pressure damage the figures are as follows:

Table 2. Hospital Acquired Pressure Damage rates for the previous two years.

Pressure Damage	2021-2022	2022-2023	Totals
Category 1	122	187	309
Category 2	305	323	628
Category 3	7	10	17
Category 4	4	2	6
Unstageable	80	104	184
Total category 3 and above	91	116	207
Total	518	626	1144

Table 3. Admitted with Pressure Damage rates for the previous two years.

Pressure Damage	2021-2022	2022-2023	Totals
Category 1	326	359	685
Category 2	1538	1687	3225
Category 3	224	222	446
Category 4	116	74	190
Unstageable	254	327	581

Total category 3 and above	1365	623	1988
Total	3229	2669	5898

It is clear from the data that the hospital acquired pressure damage is significantly lower in numbers compared to the number of patients who are admitted with this condition. The level of care and nursing time with additional days in hospital to manage and treat the more serious cases has been shown to impact on patient's experience, often incurring extra treatment and requiring a higher level of dependency. There is an improvement programme that has been underway over the previous few years, addressing the issues in relation to hospital acquired care. This workstream has had some impact however with this new approach it is hoped that the level of improvement will be greater. This programme identified that if they were to address/prevent all cases of hospital acquired pressure damage this would save 16 extra bed days per day across the Trust.

For the first year it has been agreed that hospital acquired pressure damage cases will be the focus of our third theme whilst also working with the Integrated Care Board (ICB) and Primary Care GP practices to look at initiating a project to launch in our second year of PSIRF. This will focus on the 'admitted with' cases with a view to reducing these numbers as they are significantly greater and therefore the solutions may have a greater impact on improvement within the Trust. This is a system wide project and will need the support of the ICB however it will provide a potential for learning across the region and potentially impact on improving the safety for many of our patients both in hospital and in the community.

Maternity Services – Deteriorating Patient

The deteriorating patient within the maternity services has been noted as a theme. Further improvement work is required specifically in Maternity Services to address this issue and the theme will include both maternal and neonatal deterioration. There was an initial review of the data over the previous two years. The main theme included delays in care and treatment. Within that theme the following sub themes were identified: difficulty using the NEWS tool in terms of completion of the tool as well as not escalating when appropriate. These cases specifically related to mothers who had experienced post-partum haemorrhage, poor bladder care, septicaemia and pre-eclampsia. On review of the data it also included difficulty in completion of the NEWS2 tool for neonates with incidents relating to hypothermia and hypoglycaemia. With this information it was agreed that the theme would need to include all of these incident types and therefore it was agreed to use the broader theme of the deteriorating patient which included both maternal and neonate.

It has been agreed that this would be a stand-alone theme owing to the need to be a specific focus on Maternity. The deteriorating patient theme Trust wide has been

picked up as part of our Continuous Improvement Approach where this is one of seven themes. As maternity continue to experience these incidents and as they are more specialised, it has been agreed that our maternity services will have an opportunity to identify a theme specific to themselves. This approach will provide in depth analysis and intensive support leading to improvement over the coming year.

Stakeholder Engagement

The following stakeholders were included in the development and/or agreement of these the safety incident profile:

- Our Corporate Patient Safety Team including the Trust Patient Safety Specialists
- Care Group Governance Business Partners
- Head of Risk
- Legal Services
- Complaints and PALS Services
- Governors
- Trust Board
- ICB Lead for PSIRF
- Head of Transformation (leads the Quality Improvement Team)

Data Sources

Data sources for this work included:

- Datix Incident Management System
- Complaints and PALS data
- Legal services data
- Themes from Freedom to Speak Up
- Discussions with key speciality leads for each of the key themes selected.

The feedback from these groups included:

- the need to make the plan more explicit in terms of how we would respond to all incidents for our staff.
- the suggestion that the Trust should allocate an annual budget specifically for solution developed from the new approach.
- concern regarding this level of change for the NHS.
- there was incredible enthusiasm from all of the groups that have been presented to and included in this engagement.

Where possible the changes have been made to the plan and policy. Within the first six months the Plan will be reviewed and again at 12 months. Following this it will be reviewed annually. These reviews will include the ICB and consideration of the issue around having a specific budget for PSIRF solutions. Overall the feedback was very positive.

Defining our Patient Safety Improvement Profile

Below is a list of key workstreams that are relevant to determine the Trust's patient safety response.

Improvement Projects Underway Across the Trust	
These projects are led by local staff with the support and of the Quality Improvement Team	
Project Name	**Details**
Reducing Hospital Acquired Pressure Damage	These projects are in a number of areas across the Trust and tailored to individual wards.
Improving the documentation of Fluid Balance charts for patients	These projects are in a number of areas across the Trust and tailored to individual wards.
Reducing Surgical Site Infection rates	Trust Wide Improvement Plan which focusses on pre-operative, peri-operative and post-operative care of patients attending for elective orthopaedic surgeries and neck of femur fractures.
Improving Infection Prevention and Control (IPC) compliance	There is currently a campaign 'CLEAN' that is being implemented Trust wide promoting essential standards of infection control to all staff.
Improving Cannula Care	This is focusing on Visual Infusion Phlebitis tool across specific areas of the Trust.
Releasing time to Care	Focusing on the reduction in sourcing equipment.
Improving VTE Assessments	Focusing on the completion of the risk assessment tool.
Releasing time to Care	Focusing on the reduction of waste on drug rounds.
Catheter Care	Including fluid balance and reduction of dehydration.
Improving the Nutrition scores and plans	Focusing on prevention of the deterioration of our patients.

Quality Improvement Projects led by Junior Doctors	
Improvements in advanced care plans for patients who are approaching the end of life.	This links in with the Quality Priority for this year and the coming year for the deteriorating patient workstream.
Improvements in the administration of time critical medication e.g. insulin, anti-epileptics and Parkinson's medications.	Reducing iatrogenic (healthcare related) harm to our patients.
A reduction in the number of inpatient falls by having a walking aid within easy reach for those that had an aid prior to admission.	Reducing Harm to patients.
Improvement in the skills of doctors with regards to the Pleural Ultrasound Scan Procedure.	This will offer safer care to these patients in the acute medical departments, Same Day Emergency Care (SDEC) and respiratory wards during the on-call hours at the WHH site.
Improvement in timely administration of a nerve block for patients presenting in the emergency department with multiple rib fractures.	This will offer safer care to these patients in the acute medical departments and emergency departments.
Use of qFIT (test for blood in the stool) in the Colorectal Cancer Pathway.	This has increased by 250% whilst also reducing the rejection rates from 8.4% to 2.4%. This approach is supporting the endoscopy service and enables them capacity to meet their 62-day Cancer targets.
Evaluation of the physiotherapy treatment for complex spinal patients across the Trust.	Ensuring patients received the most effective care for their needs.
Improve accessibility to secondary care therapy services for newly diagnosed patients with early onset Parkinson's disease.	Ensuring patients received the most effective care for their needs.

Quality Priorities for 2023/2024 There are workstreams / improvement programmes for each of the patient safety areas below.
• Deteriorating Patient Improvement Work • Embedding Governance Processes within the Care Groups • Implementation of the National Patient Safety Strategy • Maternity Services • Timely Access to Services
The Quality Priorities for 2024/2025 Work will continue with these priorities, some of which were also a focus for the previous year, however there will be a different emphasis.
• Implementation of the Patient Safety Incident Response Framework. • Maternity Services • Timely Access to Services • Deteriorating Patient • NICE Guidance

Our Patient Safety Incident Response Plan: National Requirements

Introduction

The areas below have either a national or a statutory requirement to be reported and therefore there is little flexibility in the Trust's response. When we do not investigate, we will ensure that the Trust still captures the learning which will inform our improvement work.

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Never Events	Patient Safety Incident Investigation (PSII)	• EKHUFT will be taking a proactive approach to Never Events by way of an annual audit programme that has been created for each relevant Never Event. • The audit will identify where actions arising from the Alerts and previous Safety Incidents have identified learning to ensure that they are both in place and effective. • Targeted work will be undertaken proactively to ensure that areas of improvement are addressed. There has also been focused work in Main Theatres to address any areas for improvement within our standards of practice. This work commenced with the aim of reducing the number of reported Never Events in the coming years. We aim to significantly reduce the rate of Never Events over the next two years. *It is noted that NHSE are currently reviewing the Never Events List. When this is published the work that is underway may be adapted to meet the requirements from this review.*

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Deaths of persons living with a learning disability.	Refer for Learning Disability Mortality Review (LeDeR). Consideration for additional learning response at the Incident Response Panel.	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.
Deaths where a Structured Judgement Review has determined that the care likely contributed to the patient's death.	Consideration for additional learning response at the Incident Response Panel. Patient Safety Incident Investigation (PSII)	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.
Safeguarding Incidents	Refer to Local Authority Safeguarding leads. Where appropriate the Trust will collaborate with the Local Authority to promote system learning. *Also detailed in our local plan.*	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.
Child Deaths	Refer for Child Death Overview Panel review. A local response may also be required which will be determined at the Incident Response Panel.	• Develop safety actions or improvement plans to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Maternity and Neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) reporting criteria. (Including maternal deaths)	• Refer to Maternity and Newborn Safety Investigation (MNSI) process for independent Patient Safety Incident Investigation. • Provide required information to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE). • Undertake local investigation if the maternal death is not accepted by Maternity and Newborn Safety Investigation (MNSI) programme. After Action Review (AAR) or a Patient Safety Incident Investigation (PSII) depending on the circumstances of the incident.	• Develop safety actions or improvements to address new insight and/or emerging safety issues. • Where improvement plans are already in place, incorporate the learning.
Incidents in NHS Screening Programmes	Refer to local screening quality assurance service for consideration of locally-led learning response.	• Develop safety actions or improvements to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where this is reason to think that the death may be linked to problems in care.	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration of an independent PSII.	• Relevant learning from these investigations will be identified for the Trust and implemented appropriately through either entry onto an existing Improvement plan or as a result of safety actions.
Deaths in Custody, where health provision is provided by the NHS.	In prison and Police custody, any death 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. The Trust will support these investigations as required.	• Relevant learning from these investigations will be identified for the Trust and implemented appropriately through either the continuous improvement or as a result of actions arising out of investigations.
Accidental or unintended exposure to Ionising Radiation	Refer to Ionising Radiation (Medical Exposure) Regulation (IRMER). Review at the Incident Response Panel for consideration for the most appropriate local response.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.

Patient Safety Incident Type	Required Investigation Response	Anticipate Improvement Route
Haemovigilance	Relevant incidents should be reported to Serious Hazards of Transfusion (SHOT). A local response will be considered at the Incident Response Panel.	• Develop safety actions or improvement to address new insight and/or emerging safety issues identified. • Where improvement plans are already in place, incorporate the learning.

Our Patient Safety Incident Response Plan: Local Focus

Introduction

As this is such a significant change in approach, we have considered three main categories:

1. **Trust Key Themes**: include themes that have come out of the patient safety incident profiling, of which there are four.
2. **Continuous Improvement Approach**: include incidents where there are clear incident types together with high numbers of repeat incidents.
3. **Another Improvement Workstream across the Trust**: those incidents that fit under a workstream that is part another significant improvement workstream across the organisation.
4. **Uncategorised Incidents:** include those incidents that do not fit into any of the above, (the national requirements or category 1, 2 or 3). This also includes those key areas within the Continuous Improvement Approach that have not yet had their trustwide improvement plans signed off. As the Trust progresses through the first six months of the plan, it is anticipated that further learning will emerge on areas within the plan which will then be updated.

There may be occasions when the Trust must undertake investigative work with other organisations that have not developed the systems approach outlined within PSIRF. In these circumstances the Trust will either offer to support the investigation using the new approach or to provide the required information to the relevant organisation using an appropriate methodology in line with PSIRF Learning Responses. This is to ensure that the learning specific to the Trust is maximised. These incidents will also be recorded on our Incident management system. All learning from the incident must be managed in the same way we managed learning from internal incidents.

Any of the outputs (including thematic reviews) from this process may be shared with our commissioners to provide assurance that the Trust is able to identify our themes accurately, understand the associated contributory factors and develop the learning solutions required to demonstrate improvements. This will be undertaken upon discussion with our commissioners using a collaborative approach. Please refer to the PSIR Policy for managing joint investigations and sharing information.

Should the Trust become aware of an incident that involves a system partner the Patient Safety team, in the partner organisation, would be contacted via their generic email and asked for their collaboration with the learning response. Many of these relationships have been forged over several years and are known to the Trust. Should there be a significant incident, one which either affects many patients or is a very concerning nature, the ICB and Care Quality Commission (CQC) will be notified.

If information needs to be shared with other providers within the learning response, information governance standards must be met. Please see more details within the Information Governance Policy. Staff can access this via the Policy Centre and the public can request this by contacting the Freedom of Information Team.

Four Key Themes as a focus for Improvement over the next 12 months		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
1. Delay / Failure	A selection of learning responses to provide appropriate analysis, to ensure that the contributory factors have been fully identified/validated. When sufficient system learning has been identified and or the improvement work is effectively focused / measurably improving and this has been agreed by stakeholders the investigative response will cease and improvement will become the focus. Develop the improvement plan with associated metrics for assessing progress.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed.
2. Medication (Administration)	A selection of learning responses to provide appropriate analysis, to ensure that the contributory factors have been fully identified/validated. Develop the improvement plan with associated metrics for assessing progress.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed.

Patient safety incident type or issue	Planned response	Anticipated improvement route
3. Pressure Damage (Hospital Acquired)	A selection of learning responses to provide appropriate analysis to ensure that the contributory factors have been fully identified/validated. Develop the improvement plan with associated metrics for assessing progress. After six months work will be initiated to start to consider the programme for the next year in collaboration with the ICB.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed.
4. Deteriorating Patient to include both Maternal and Neonatal Deterioration (Maternity Services only)	A selection of learning responses to provide appropriate analysis to ensure that the contributory factors have been fully identified/validated. Develop the improvement plan with associated metrics for assessing progress.	Within six months demonstration that the improvements have started to impact on the safety of our patients. Specific measures will be developed.

Continuous Improvement workstreams – Trust Wide Improvement Plans
Repeated Patient Safety Incident themes will be managed by an overarching improvement plan for each theme (see Appendix 1). These will be overseen by the ICB as well as through the Trust governance processes. Pressure Damage and Inpatient Falls progressed initially and prior to the 01 April 2024. This is owing to there already being an improvement plan in place. IPC will be transitioning in the second quarter and Nutrition and Dementia in the third quarter. For those themes that will not be transitioning until after the PSIR plan transition date, the learning responses to their incidents will be aligned with the plan. Serious Incident reporting will cease, for all incidents related to the continuous improvement workstreams, on the date of transition to this plan.

Patient safety incident type or issue	Planned response	Anticipated improvement route
1. Pressure Damage	Validation of the contributory factors via PSII or learning response tools depending on the current level of knowledge. Review and update the improvement plan and redirect resource to focus on the implementation of the plan. See Appendix 1, this is a defined process which moves away from investigating high numbers of similar incidents and focuses on the improvement work. As this is one of our key four key themes work will start immediately however following further PSIIs the Improvement plan will be updated with further learning.	• An improvement plan is already in place once validated add additional learning from PSIIs or other learning responses. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.
2. Patient Falls	Validation of the Contributory Factors via PSII or SEIPS tools depending on the current level of knowledge. Review and update their improvement plan and redirect resource to focus on the implementation of the plan (see Appendix 1).	• An improvement plan is already in place once validated add additional learning from the PSII or other learning responses. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and/or learning responses.

Patient safety incident type or issue	Planned response	Anticipated improvement route
3. Deteriorating Patients Transitioning during Quarter 2: July – September 2024	Validation of the contributory factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan (see Appendix 1).	• An improvement plan is already in place once validated add additional learning from the PSII or learning response tools. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.
4. Nutrition Transitioning from Quarter 3: October 2024	Validation of the contributory factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan (see Appendix 1).	• An improvement plan is already in place once validated add additional learning from the PSII or learning response tools. • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.

Patient safety incident type or issue	Planned response	Anticipated improvement route
5. Dementia Transitioning from Quarter 3: October 2024	Validation of the contributory factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan (see Appendix 1).	• An improvement plan is already in place once validated add additional learning from the PSII (approx. 1 - 2 will be required). • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.
6. Infection Prevention and Control (IPC) Transitioning by the end of Quarter 2: 01 September 2024. IPC are also developing their own response plan which will be finalised by 1 July 2024.	Validation of the contributory factors via PSII or learning response tools depending on the current level of knowledge. Create an improvement plan and redirect resource to focus on the implementation of the plan (see Appendix 1).	• An improvement plan is already in place once validated add additional learning from the PSII (Approx. 1 - 2 will be required) • Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.

Patient safety incident type or issue	Planned response	Anticipated improvement route
7. Hospital Acquired Venous Thromboembolism (VTE) Transitioning by the beginning of Quarter 4: January 2025	There is a plan towards the end of the year to use the defined process for repeat incidents using an Improvement Plan approach (see Appendix 1). Until this has been completed each case will be assessed and a proportionate response will be undertaken. There may be targeted reviews which may include Multidisciplinary Team Review and AAR. For low and no harm incidents there will be a Case Note review undertaken which will be benchmarked again best practice standards.	• Agree improvement targets and ensure accurate data collection to demonstrate improvement. • Where there is poor progress consider further review and learning responses.

Incidents that do not have a national requirement to investigate, are contained within the four key themes and do not have a continuous improvement approach in place (Trust wide improvement plan)		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Safeguarding Incidents	During the previous year the Trust undertook two thematic reviews. As a result of these reviews Trust Wide Improvement Plans are now in place to drive up the quality of care for our patients. For all new incidents that are not addressed by the thematic review a proportionate response using either a SWARM, AAR or a PSII should be considered.	Sustained progress within Safeguarding against the key themes that were identified during the 2023/2024. Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals. The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses. The role of both safeguarding and MCA will be reviewed by the Trust safeguarding team who attend the Trust IRP.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Maternal and Neonatal incidents that do not meet the threshold for national reporting/investigation. Maternity are developing their own learning response plan which will be finalised by 1 July 2024.	These will be assessed on a case by case basis to ensure that a proportionate response has been agreed that ensures that the learning has been gained. The response can include, AAR, SWARM, Multidisciplinary Team Review, PSII.	Actions arising from the incident response will be added to relevant Maternity local Improvement plans.
Incidents that are not included either within our four key themes or our improvement plan approach, where there is concern, should be reviewed at the Incident Response Panel and a proportionate response agreed that will maximise the learning potential. All moderate and above harm incidents will be reviewed and consideration given to the appropriateness of bringing it to the Incident Response Panel for discussion.	For a list of possible responses please see Appendix 2.	

Appendix 1: Process for managing repeat incidents using an continuous improvement approach

Phase 1

1. Identify those incidents where there are a high number of repeated incidents every month.
2. Identify key staff/teams that lead on the subject matter areas of focus.
3. Identify if there are already learning/Quality Improvement projects in place to address these issues.
4. Evaluate if further learning is needed or if assurance evidence can be taken with the current improvement process in place.

Phase 2

1. If assurance has not been gained regarding the identification of contributory factors, we will investigate further incidents using the PSII or learning response methodology. Statutory Duty of Candour will be completed for notifiable safety incidents (CQC 2022).
2. Add the learning to the overarching Trust Wide Improvement Plan.
3. Every subsequent incident that occurs will have a desk top exercise (e.g. Work Systems Scan) undertaken looking to identify if there were any new contributory factors / issues identified. If this is confirmed then those issues will be investigated, not the entire incident, and added to the overarching improvement plan.
4. If no new contributory factors have been identified no further review or investigation is necessary. The resource that would have been spent on the investigation will now be redirected to spend time on developing and implementing the improvement plan. A response will still be required to the patient for the purposes of the Statutory Duty of Candour. This can be in the form of a letter with an attached summary of the project being undertaken together with achievements and areas of continued work.

Phase 3

1. The desk top review process will be documented on a short template to provide evidence of a review and assurance that the issues are being addressed.
2. A detailed summary of the improvement plan and progress will be developed to use this as a response to incidents that require the Duty of Candour and therefore a response to specific incidents.
3. Close monitoring of the pre-determined areas for improvement will be completed monthly.
4. Where progress is slow further review and/or learning responses will be undertaken to understand why and the learning will be added to the current improvement plan.

Appendix 2: Types of Incident Responses open to the Trust

Types of Incident Responses open to the Trust. (This list is not exhaustive)

- **Patient Safety Incident Investigation**, is a structed process aimed at thoroughly examining patient safety incidents within Healthcare. The Trust will use a system approach using the SEIPs tool as its preferred methodology.
- **After Action Review**, is a rapid process used to evaluate and learn from an incident. It is a structure review with key questions. These questions will lead to the identification of contributory factors and their areas for improvement.
- **Multidisciplinary Team Review** is a forum where relevant disciplines are included in the discussion of the incident. The outcome would be to identify areas for improvement.
- **Structured Judgement Review** is a process designed for a rapid review of deceased patients care by a doctor to establish if there is learning and an opportunity to improve patient care.
- **Clinical Audit** is a systematic process used to assess and improve the quality and outcomes of patient care within Healthcare.
- **Risk Assessment/New Risk** on the Risk Register
- **Observation Guide** – Observing care as delivered rather than described.
- **Walkthrough Guide** – structure process to collecting and analysing information regarding a task or process.
- **Link Analysis Guide** supports the identification of the frequency of interactions in a specific location or environment.
- **Interview Guide** will support the use of the cognitive interview.
- **Timeline Mapping** is describing what occurred in chronological order
- **Work System Scan** is a checklist and documentation tool to ensure the breadth or work system that is considered.
- **Thematic Reviews** is the identification of common themes from a series of similar incidents where learning can be obtained.
- **Undertaking Research**
- **Obtaining Medical / Nursing** Opinion