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NHS Foundation Trust

Frimley Health Patient Safety Incident Response Plan 2024-2025

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1.0 Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP) and sets out how Frimley Health NHS Trust will respond to patient safety incidents. This will be read alongside the national guidance as well as our Trust Patient Safety Incident Response Policy and Learning from Deaths Policy.

PSIRF is designed to promote learning and improvement using a systems-based approach, moving away from the previous Serious Incident Framework which focussed more on process than emphasising a culture of continuous improvement in patient safety.

Purpose

This patient safety incident response plan (PSIRP) sets out how Frimley Health NHS Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of all our local patient safety incident investigations (PSIIs) and any investigation led by the patient safety team by:

- Refocusing PSII towards a systems approach and the rigorous identification of interconnected casual factors and systems issues
- Focusing on addressing these casual factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents
- Demonstrating the added value from the above approach

Scope

There are many ways to respond to an incident. This document covers responses conducted solely for the purposes of systems-based learning and improvement. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.

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 types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims, and inquests.

Vision

There are four key aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based:

- 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.

2.0 Our Services

Frimley Health NHS Foundation Trust provides services NHS hospital services for around 900,000 people across Berkshire, Hampshire, Surrey and South Buckinghamshire. The Trust has three main hospitals, Frimley Park and Wexham Park Hospital, Heatherwood and provides community services. The Trust is made up of 9 directorates:

- Emergency and Acute medicine
- Critical Care, Anaesthetics and Theatres
- Medicine
- Surgery
- Orthopaedics
- Specialist Surgery
- Obstetrics and Gynaecology
- Paediatrics
- Community Services and Older People's Medicine

3.0 Defining our patient safety incident profile

Frimley Health NHs Trust patient safety incident profile has been built by analysing data from the following sources from January 2019 to June 2022.

- Serious Incident and Round Table Reviews
- Themes from Mortality and Morbidity Reviews (Structured Judgement Reviews)
- Lower harm incidents reported on the Trust Incident Reporting system (RL)
- Themes from Coroners Inquests and Litigation
- Themes from Complaints

In addition, stakeholder engagement was undertaken to seek views in further understanding our incident profile. This included Trust Board, Non-executive directors, Head of Nursing and Therapies, Chief of Service, complaints and legal team and coroners.

4.0 Defining our patient safety improvement profile

PSIRF requires a systems-based approach to generating areas for improvement and safety actions, in addition to a systems-based approach being the basis for investigation.

Significant learning has been identified from previous investigations into common types of patient safety incidents and it is important to have an integrated process to embed and monitor safety actions. In order to support the Trust's transition to PSIRF, choosing an improvement response rather than a learning response, Trust wide improvement plans have been developed for the following types of common patient safety incidents:

- Falls
- Pressure Ulcers

- Deteriorating patient and Sepsis
- Mental Health

The implementation of these improvement programmes is being led by subject matter experts and monitored through a range of methods such as FAB audits, share governance and data sources. The improvement plans will be monitored through Patient Safety Steering group and report to Care Governance Committee.

Frimley Excellence (FX) is the Trust's improvement methodology. The FX Way combines established Lean and A3 Thinking theory with the applied experience of the FX team to create a methodology that is evidence based and understands the complexity of healthcare. FX Way gives us a shared language and framework for all staff to play their part in delivering improvements, no matter what our role, the improvement we are working on or where in the organisation we fit.
Through improvement projects and delivering training to individuals (as well as the Frimley Excellence Improvement System, an applied programme that guides teams through adopting The FX Way in their local work environment) staff are skilled and supported to use the FX way. These projects also include those identified through the patient safety processes and governance in the organisation. By clear understanding of problems using data, teams, services and the organisation then use recognised tools and techniques to drill down to the root cause of the issue and develop countermeasures to these. These are then tested and improved as needed (using 'plan, do study, act' cycles) to drive further improvement.

5.0 Developing our approach to responding to patient safety incidents

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1. The table below sets out the national mandated responses.

	National priority	**Response**	**Anticipated Improvement Route**
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII	Create local organisational actions and feed these into the patient safety steering group/SIRG
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII	Create local organisational actions and feed these into the improvement workstreams/ SIRG
3	Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria	Refer to HSIB for independent PSII	Respond to recommendations as required and feed actions into the

			Maternity Governance
4	Child Deaths	Refer for Child Death Overview Panel review. Locally led-PSII (or other response) may be required alongside the Panel review - organisations should liaise with the panel	Respond to recommendations as required and feed actions into the Paediatric Governance/SIRG
5	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR review	Respond to recommendations as required and feed actions into improvement workstream/SIRG
6	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards	Respond to recommendations as required feed actions into improvement workstream
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration or locally led learning response See: Guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)	Respond to recommendations as required
8	Deaths in custody (e.g. police custody, in prison, etc) where heath provision is delivered 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. Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations as required
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may	Locally led PSII	Respond to recommendations as required and feed actions into PSSG/SIRG

	be linked to problems in care (incidents meeting the Learning from Deaths criteria)		
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and FHFT participation	Respond to recommendations as required and feed actions into PSSG/SIRG
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	Respond to recommendations as required

Table 2: The table below sets out the patient safety response plan (PSIRP) for Frimley Health:

Incident Type	**Planned Response**	**Anticipate Improvement Route**
Failure to identify or escalate care of the deteriorating in-patient.	AAR/PSII is significant concern or systemic issue	Current improvement workstream
Delayed diagnosis	MDT Review/PSII	Actions to SIRG
Delayed treatment	AAR/MDT Review/PSII	Actions to SIRG
Falls with serious injury or death where new learning is identified	Local Review and detailed DOC	Current Improvement Workstream
Hospital acquired pressure injuries Grade 3 & 4 where new learning is identified	Local Review and detailed DOC	Current Improvement Workstream
Medication errors	Local review and detailed DOC/PSII for significant learning/systemic concerns	Medication Safety Workstream/SIRG

Surgical or procedural complications	Local M+M review or PSII for significant learning / systemic concerns	Actions to SIRG
Mental health / mental capacity / patient behaviour related incidents	PSII	Current Improvement Workstream/SIRG
New unexpected PSII with high risk and potential for new learning	PSII	Actions to SIRG
HCAI related patient safety incidents	MDT Review	Current Improvement Workstream/SIRG

Due to the complexity of Maternity Services across Frimley Health, an incident response plan has been developed separately (see Appendix 1).

6.0 How we will respond to patient safety incidents

The above table outlines the incident type based on the analysis undertaken and the appropriate response allocated to the incident. For unexpected new incidents for PSII will be declared using the following criteria:

- Potential for learning in terms of:
    - Enhanced knowledge and understanding
    - Improved efficiency and effectiveness
    - Opportunity for influence on wider systems improvement
    - Where learning crosses between multiple specialties or areas of the Trust requiring a coordinated review
- Actual and potential impact of outcome of the incident (harm to people, service quality, public)
- Likelihood of recurrence (including scale, scope and spread)

A twice weekly meeting (PSIRG) will discuss potential PSII's and confirm the learning response as outlined above. Where a PSII is declared a 72 hour report will be completed to establish the facts, immediate actions to be taken and mitigate immediate risks.

Some patient safety incidents will not require PSII but will benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. Different review techniques can be adopted, depending on the intended aim, and required outcome.

The patient safety team will continue to liaise with patients and families to inform them of the investigation, gather their concerns, questions and agree level on involvement and agreed timeframes for completion. The patient safety team will ensure patients and families are kept up to date with the investigation and share the learning when completed.

Table 3: The table below outlines the available techniques under PSIRF.

Technique	Method	Objective

Patient Safety Incident Investigation (PSII)	In-depth review of a single patient safety incident or cluster	To understand and identify system factors that contributed to the incident which indicates significant patient safety risks and potential for new learning.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot Debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety Huddle/SWARM	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm
After Action Review	Team Review	A structured, facilitated discussion on an incident, or event to identify a group's strengths, weaknesses, and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
Mortality Review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding a patient's death

This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk. The local priorities listed above are subject to routine review to account for emerging risks and the strengths of associated improvement work.

Frimley Health will take a proportionate response to patient safety incidents in order to maximise learning. Where an investigation is deemed appropriate, a "systems based approach" to learning will be applied. This means that investigations will focus on examining the components of the "work system" (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies and those interdependencies that may contribute to patient safety. As such, different learning responses and investigation techniques will be adopted to patient safety incidents, depending on the intended aim and required outcome.

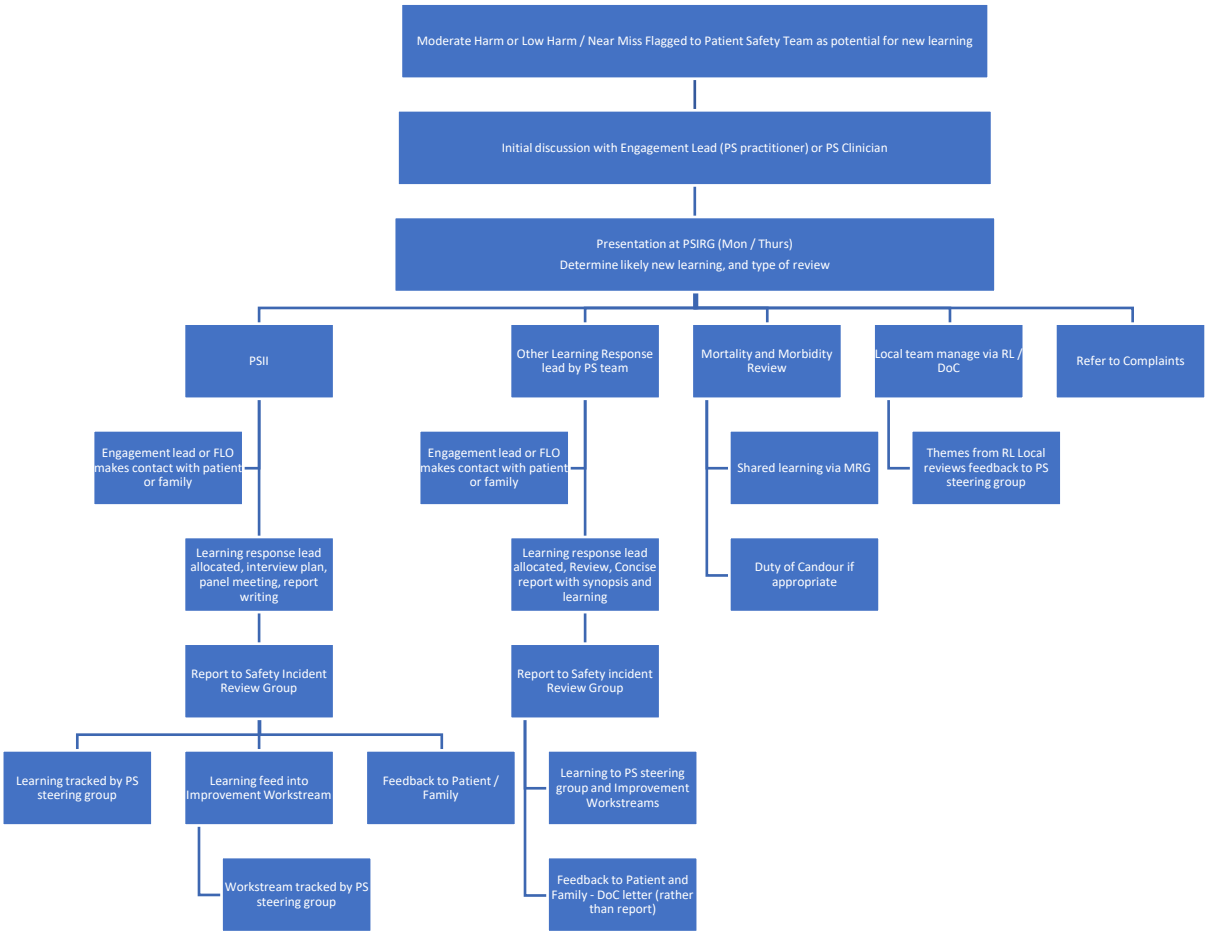
7.0 Governance and Oversight

The Governance Structure for the Patient Safety Incident Reporting Framework (PSIRF) provides a high-level overview of the process for the review of patient safety incidents and associated learning responses.

The governance structure includes:

- Twice weekly Patient Safety Incident Review Group (PSIRG) to determine PSII and oversight of all patient safety activity.
- Bi-monthly Safety Incident Review Group (SIRG) to review PSII's and learning from all patient safety investigations
- Monthly Patient Safety Steering Group to review progress against improvement workstreams and directorate led patient safety improvement actions arising from local reviews and PSIIs.
- Thematic review of clusters of reviews to inform improvement workstreams
- The Trust Board and Executives will be responsible for patient safety and sign off of patient safety incidents.

The table below demonstrates the process for the identification of a patient safety incident to governance and oversight.



Annex 1 – Glossary

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

AAR – After action review

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

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Deaths thought more likely than not due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Appendix 1 – Maternity Services Incident Response Plan

Patient safety incident type	Required Response	Anticipated improvement route
Deterioration of a patient to level 2 or 3 care due to failures in the referral/acceptance of an inpatient between clinical specialties.	PSII	Maternity Governance Team Trust Patient Safety Team
Deterioration of a patient to level 2 or 3 care due to the results of a diagnostic test not being acknowledged and acted upon	PSII	Maternity Governance Team
All intrauterine deaths at or after 22+0 weeks	Review using PMRT PSII where concerns indicate further investigation is required	Maternity Governance Team
Neonatal deaths from 20+0 weeks and early neonatal deaths (before 7 completed days after birth), late neonatal death (death of baby between 7 and 28 completed after birth) and post-neonatal deaths.	Review using PMRT PSII where concerns indicate further investigation is required	Maternity Governance Team
Obstetric patients who deteriorate and require admission to a Critical Care Unit (excluding Maternal death).	Review at PSQ, (MDT Review) PSII where concerns indicate further investigation is required	
Maternity adverse outcomes associated with pregnancy and childbirth (Maternity trigger) such as: Re-admission of Mother or baby, 3rd and 4th degree tear, PPH >1500 mls, Shoulder dystocia, Failure to escalate,	Local review through senior midwife (BD7) and/or obstetrician PSII considered in circumstances requiring further investigation due to risk Local audit programmes / Monitoring data/trends/themes	Maternity Governance Team
Low arterial cord gases (arterial pH <7.05, venous pH <7.1).	Cross site specialist fetal monitoring midwife.	
Maternal Death outside of HSIB criteria (>42 days &	Review at PSQ, (MDT Review) PSII where concerns indicate further investigation is required	Maternity Governance Team
Incidents meeting HSIB criteria	Refer to HSIB for independent patient safety incident investigation + review at PSQ (MDT review)	HSIB Team
Patient harm/inadequate care provided as a result EPIC implementation (Local Safety Priority)	Review at PSQ, PSII where concerns indicate further investigation is required	Maternity Governance Team
Patient harm/inadequate care provided because of current high vacancy levels (Local Safety Priority)	Review at PSQ, PSII where concerns indicate further investigation is required	Maternity Governance Team
Re-admissions (Local Safety Priority)	Review at PSQ, (MDT Review) PSII where concerns indicate further investigation is required	Maternity Governance Team
Term neonatal deaths / stillbirths Term babies needing ventilation or cooling All maternal ITU admissions All PPH >3000L	72 Hour report and then decide on the level of investigation needed on individual basis	Maternity Governance Team

Eclampsia		