Queen Victoria Hospital
NHS Foundation Trust

Patient safety incident response plan

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1. Introduction

This patient safety incident response plan sets out how Queen Victoria Hospital (QVH) intends to respond to patient safety incidents over a period of 12 to 18 months initial implementation and embedding. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our trust policies on incident reporting and investigation available to all staff via QVH intranet.

This plan will be supported by a PSIRF policy to outline pathways for escalation, methods of review safety action plans and monitoring.

PSIRF is a whole system change to how we think and respond when an incident happens to learn from it and prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement.

In the last three years (2020-2022), 2791 patient safety incidents have been reported in QVH with 0.25% of these being investigated as a Serious Incident as per the Serious Incident Framework. Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99.75% of patient safety incidents. In short, the burden of effort is placed on 0.25% of all patient safety.

The NHS Patient Safety Strategy 2019, challenges the NHS to think differently about learning and what this means for a healthcare organisation and one of the underpinning principles of PSIRF is to do fewer 'investigations' but to do them better to allowing maximum learning; better means taking time to conduct systems-based investigations by people who have been trained to do them. This plan and related policies and guidelines will describe how it all works.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean 'do nothing'; it means respond in the right way depending on the type of incidents and associated factors. It means we respond in a timely way, working even more closely with the patient/families and staff to achieve effective sustainable learning and change, where appropriate.

This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. It is outside of the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resources (HR) matters, legal claims and inquests.

2. Our services

Queen Victoria Hospital NHS Foundation Trust (QVH) is a leading specialist centre for reconstructive surgery and rehabilitation, helping people who have been injured or disfigured through accidents or disease.

The principal activities of the Trust were the provision of:

- plastic surgery (including reconstructive surgery for cancer patients) and burns care
- corneoplastic surgery
- head, neck, and dental services (including associated cancer surgery and orthodontics)
- sleep disorder services
- a wide range of therapy services and community-based services
- minor injuries unit

Patients are admitted from the south east of England including south and east London. QVH also provides 'hub and spoke' specialist services at other hospitals in the south east of England, taking staff with specialist skills to remote hospital locations.

We provide a minor injuries unit and community services for people living in and around East Grinstead.

In 2021/22, when the pandemic impacted on the ability of other trusts to maintain cancer surgery, patients from other hospitals in the south east were able to receive their cancer surgery at QVH with surgeons from other trusts operating at QVH alongside our expert theatre teams.

QVH holds contracts with Integrated Care Boards (ICB's): Kent and Medway, Surrey Heartlands and Sussex. The coordinating commissioning is Sussex. QVH also holds a contract with NHS England for the provision of specialised head and neck surgery, ophthalmic, burns services and other specialist dental services.

Further information about our organisation can be found on the QVH website.

3. Defining our patient safety incident and improvement profile

The patient safety risk process is a collaborative process. To define the QVH patient safety risks and responses for 2023/24 the following stakeholders were involved:

- Patient groups – review of complaints and Patient Advice and Liaison service (PALS) contacts, Friends and Family
- Staff – through the incidents reported on the QVH Datix incident reporting and management system. In addition through *Tell Nicky* and with consideration for issues raised though *Freedom to Speak Up* reports.
- Discussion with stakeholders for the Trust 2023/24 Quality Account.
- Review of data/key themes from inquests and claims.
- Review of data/key themes from learning from deaths
- Thematic review of health and safety data
- Discussions with the Commissioners Integrated Care Board (ICB) at the local and national Patient Safety Specialist forums and the national discussion on the Futures Platform for Patient Safety Specialists.

Patient safety priorities represent opportunities for learning and improvement at QVH. There is much work ongoing across the organisation with patient safety at its heart including quality improvement programmes.

Acknowledging the current workloads and the need to appropriately support existing initiatives, QVH patient safety priorities will, in the first instance, provide specialist input to maintain those already underway. This approach will ensure the safety of our patients and that their voice and that of their friends and family remain central to any proposed developments.

A review of this approach, along with any safety actions identified in response to completed AAR's and PSII's will be undertaken in the autumn of 2024. QVH is committed to ensuring patient safety priorities are relevant, achievable and sustainable.

Learning from good practice will be included in safety action plans to inform development and improvements across QVH.

4. Our patient safety incident response plan: national requirements

PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances or review by, or referral to, another body or team, depending on the nature of the event

Incidents meeting the Never Events criteria (2018, updated February 2021) or its replacement, and deaths thought more likely than not to have been due to problems in care (i.e. incidents meeting the learning from deaths criteria for PSII) require a locally-led PSII.

Incidents which do not require a PSII will be reviewed utilising the after action review framework; templates will be attached to the PSIRF Policy

Table 1 below sets out the national or local mandated responses. As QVH does not directly provide mental health, obstetrics or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types 6 to 11 in the table.

Table 1 National priorities and expected response by QVH.

	Patient safety incident type	Required response	Anticipated improvement route
1.	Incidents that meet the criteria set in the Never Events list (2018, updated February 2021)	PSII	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
2.	Learning from Deaths (LfD) due to for example care and service issues when reviewed rated between 1-3 using the LfD Framework and rating criteria.	PSII	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee

	Patient safety incident type	Required response	Anticipated improvement route
3.	Obstetrics, for example, incidents that meet Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation.	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
4.	Child deaths	Refer for Child Death Overview Panel decision via the Trust's Safeguarding Team. Locally led – could be a PSII or another response, for example After Action Review (AAR) alongside the Panel review.	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
5.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led – could be aPSII or another response, for example After Action Review (AAR) alongside the Panel review.	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
6.	Safeguarding incidents in which: Baby, child and young person is on a child protection plan; looked after plan or is a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) who are in receipt of care and support needs by their Local Authority. The incident relates to female genital mutilation (FGM), Prevent 9radicalisation to terrorism); modern day slavery and human trafficking or domestic abuse/violence.	Refer to Trust Safeguarding Lead, Local Authority Safeguarding Lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee

	Patient safety incident type	Required response	Anticipated improvement route
7.	Deaths in custody (e.g., police custody, in prison, etc.) where health 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. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
8.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria).	Locally led PSII by the provider in which the event occurred.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
9.	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.	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee
10.	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,	Respond to recommendations as required. Create local organisational learning and actions. Completion of actions to be audited prior to closure. Accountable to CGG and Quality and Governance Committee

	Patient safety incident type	Required response	Anticipated improvement route
		they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, set out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	

5. Our patient safety incident response plan: local focus

Patient safety incident type or issue	Description	Planned response	Anticipated improvement route
Medication error	Medication errors resulting in severe or moderate harm	Rapid response leading to: • PSII or Timeline and AAR (or template)	Actions developed will be in the report and will be recorded on Datix. Thematic analysis of investigations to be summarised biannually by the clinical lead (Advanced Pharmacist Medicines Governance and Safety Officer) and presented to Quality & Safety Committee.
Tissue damage	pressure ulcers, surgical wounds, leg ulcers, extravasation	AAR (or template)	Actions developed will be in the report and will be recorded on Datix until completed and evidenced by audit. Thematic analysis of investigations to be summarised biannually by the clinical lead (TVN) and presented to Nursing & Quality Forum
Unexpected deaths	All unexpected deaths (?reference to LfD)	PSII	Create local organisational learning and actions. Accountable to CGG and Quality and Governance Committee
Other	Patient safety incidents which meet a criterion for harm or potential harm not included in the areas highlighted above.	Where an incident does not fall into any of the categories above then an investigation and / or review method may be used except PSII (which must be undertaken by the QVH Patient Safety Team who have undertaken and completed additional investigation training). Methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/ or structured proformas may be used. QVH Infection Control Team in collaboration with the Patient Safety Team will make sure robust PSIRF compliant templates are available for the service for infection control issues, events/incidents, as highlighted in a letter received 16th August 2023 Alignment of Infection Prevention and Control (IPC) with the Patient Safety Incident Response Framework (PSIRF).	
NHS Sussex to be involved in and review, from an improvement opportunities lens, a minimum of two learning responses *with a system focus* per financial year. The learning response to be selected by the provider and can range from an AAR, thematic review or PSII. This will enable the ICB to fulfil its oversight and assurance function and support in reviewing the process and learning. This will also facilitate the sharing of learning across Sussex as well as regionally and nationally via NHSE. The PSIRP to be reviewed with NHS Sussex bi-monthly for the first six months of implementation to use a “plan, study, do, act (PDSA) approach” to understand any changes that may be required, learning identified and improvements to be realised. To be reviewed with the ICB quarterly thereafter.			

6. Training and competence

Specific knowledge and experience are required for those leading learning responses and those in oversight roles. This includes knowledge of systems thinking and system-based approaches to learning from patient safety incidents.

Those involved in the quality assurance of patient safety incident response (i.e. boards/executive leads) must have the knowledge to constructively challenge the strength and feasibility of safety actions to improve underlying system issues. They must be able to recognise when the proposed safety actions following a patient safety incident response do not take a system-based approach; for example, where they inappropriately focus on revising policies without understanding 'work as done', or involve self-reflection for certain individuals rather than reviewing wider system influences.

Learning response leads are required to have completed two days/12 hours of systems approach to learning from patient safety incidents. This training will include:

- introduction to complex systems, systems thinking and human factors
- learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after action reviews
- Safety action development, measurement and monitoring

Health Education England has published the first NHS-wide Patient Safety Syllabus (NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk)) which applies to all NHS employees and will result in NHS employees receiving enhanced patient safety training.

Level 1 training is mandatory for all staff (Patient Safety | Health Education England (hee.nhs.uk)).

The eLfH level 1 training takes approximately 30 minutes and level 2 approximately 40-45 minutes. It is recommended that level 1 is undertaken three yearly.

Note: shaded boxes below are mandatory

role	Board	Executive lead and Q&S chair	Learning response & Oversight leads	Clinical Directors	Heads of Nursing and Governance Leads	Heads of Department	All staff
eLfH level 1	✓	✓	✓	✓	✓	✓	✓
eLfH level 2	✓	✓	✓	✓	✓	✓	
Human Factors		✓	✓	✓	✓	✓	
AAR		✓	✓		✓	✓	
HSBI level 2		✓	✓				
Duty of Candour	✓	✓	✓	✓	✓	✓	
Just Culture	✓	✓	✓	✓	✓	✓	