Patient Safety Incident Response Plan

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Cromer Hospital

April 2025 – October 2026

Our Values People focused Respect Integrity Dedication Excellence

Approved by: Trust Board | Approval Date: May 2025 | Review Date: October 2026

Contents

Foreword from our Associate Director of Quality and Safety

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles which we need work to but outside of that, we determine what we will investigate and how.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

When asked why we investigate incidents, the common response is to learn from them. Often, we mean learning as understanding what has happened, but it should be much more than that. It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological resolution for those involved are all core objectives of an investigation.

Our approach acknowledges the importance of organisational culture and what it feels like to be involved in a patient safety incident. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak up. PSIRF is a core component in this journey, ensuring we create a psychologically safe culture where people are confident to speak candidly about patient safety events and to simply express their opinion.

During the life of our initial Patient Safety Incident Response Plan, we explored 2 local safety priorities, and between 01/09/23 and 31/01/25 our Patient Safety Investigators have conducted meaningful engagement with patients &/or families involved in 11 PSII's associated with these areas and 12 with national priorities. They also conducted over 48 Structured Judgement Reviews following inpatient deaths associated with a reported safety incident.

As a result, we now understand more about the contributory factors of these safety risks and are undertaking improvement work to strengthen our systems and processes to reduce the level of risk. This includes an extensive work programme to improve our care and management of frailty.

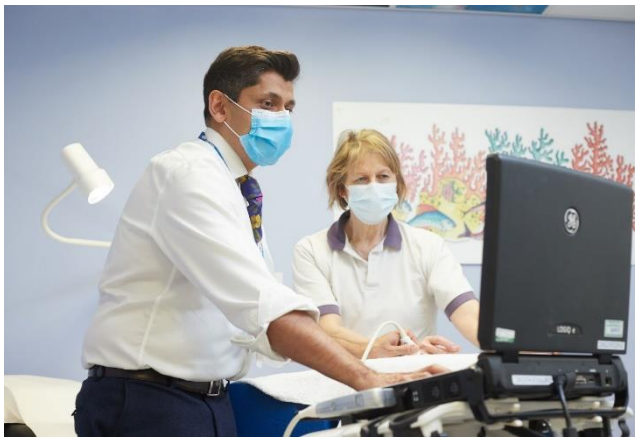
We now need to identify new local priorities for PSII in order to continue to learn about our systems and processes and reduce the highest-level safety risks.

Thank-you for being part of this different way of working and we are excited to continue to learn in this new way together to really make a difference to the safety of care delivered to our patients.

Karen Kemp
Associate Director of Quality and Safety

An introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), which replaces the NHS Serious Incident Framework. This document is our Patient Safety Incident Response Plan (PSIRP). It sets out how we intend to respond to safety incidents.



PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better in a small number of areas of highest patient safety risk for us as organisation. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associated policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify new insight and rich learning. Patient safety incidents are responded to in a proportionate way depending on the type of incident and associated factors rather than on an individual level of harm.

The challenge is to have a balanced approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is a psychologically safe culture shown in our leaders, our Trust-wide strategy and our reporting systems.

We have developed our understanding and insights about our patient safety profile since we started PSIRF in September 2023. In March/April 2025, the Clinical Safety and Effectiveness Sub- Board and the Quality and Safety Committee received and supported the thematic situational analysis and highest patient safety risks that informs our local priorities for PSIRF. This plan provides the headlines and description of how PSIRF will be applied in Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust).

The scope of PSIRP and our vision

There are many ways to respond to an incident. 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 the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims or inquests.

This plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

There are four strategic aims of the PSIRF upon which this plan is based.

The strategic aims are aligned with our own Trust vision and purpose statements. The Trust's vision statement is:

"The best care for every patient"

Our Purpose is:

"Working together, continuously improving for all"

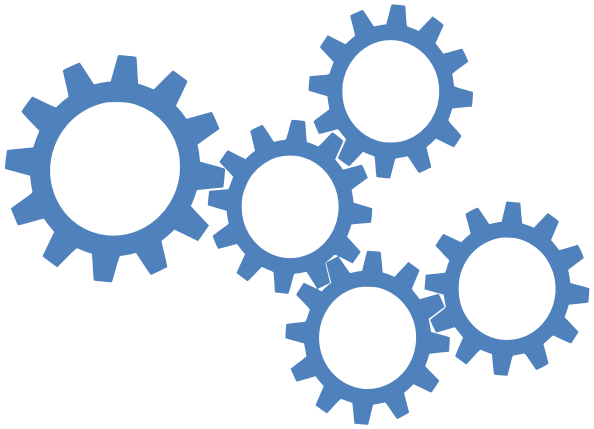
The implementation of PSIRF will see the strategic aims and our Trust values embodied in our work.

Trust Values	People focused	Respect	Integrity	Dedication	Excellence
PSIRF Strategic Aims	Improve the experience of care by patients, their families and carers, by improving the safety of care delivered	When a patient safety incident, or need for a PSII is identified, we will keep staff, patients, their families and carers at the centre of the investigation & learning process	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations	Equip patients, staff & partners with the skills & opportunities to improve safety throughout the whole system	Improvement programmes enable effective and sustainable change in the most important areas

System overview of Norfolk and Norwich University Hospitals NHS Foundation Trust

We reviewed our local system to understand the people who are involved in patient safety activities across the Trust, as well as the systems and mechanisms that support them. The Trust is a centre of excellence for health care in the East of England in several fields as well as one of the largest University teaching Trusts in the country. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

The Trust is a complex system with many interrelated components that are crucial to ensuring that everything works. We have reviewed all patient safety activities and our network of key stakeholders across the Trust who are integral to the Patient Safety agenda.



This Trust has several Corporate Departments working alongside each other providing support to the Clinical Divisions; The Risk and Patient Safety Team, the Patient Experience and Engagement Team, Quality Improvement team, Transformation Team, Complex Health Hub, Organisational Development and Legal Services.

There are 4 Clinical Divisions consisting of Medicine, Women and Children, Surgery Critical and Emergency Care, and Clinical Support Services.

Core patient safety activities undertaken at the Trust include:

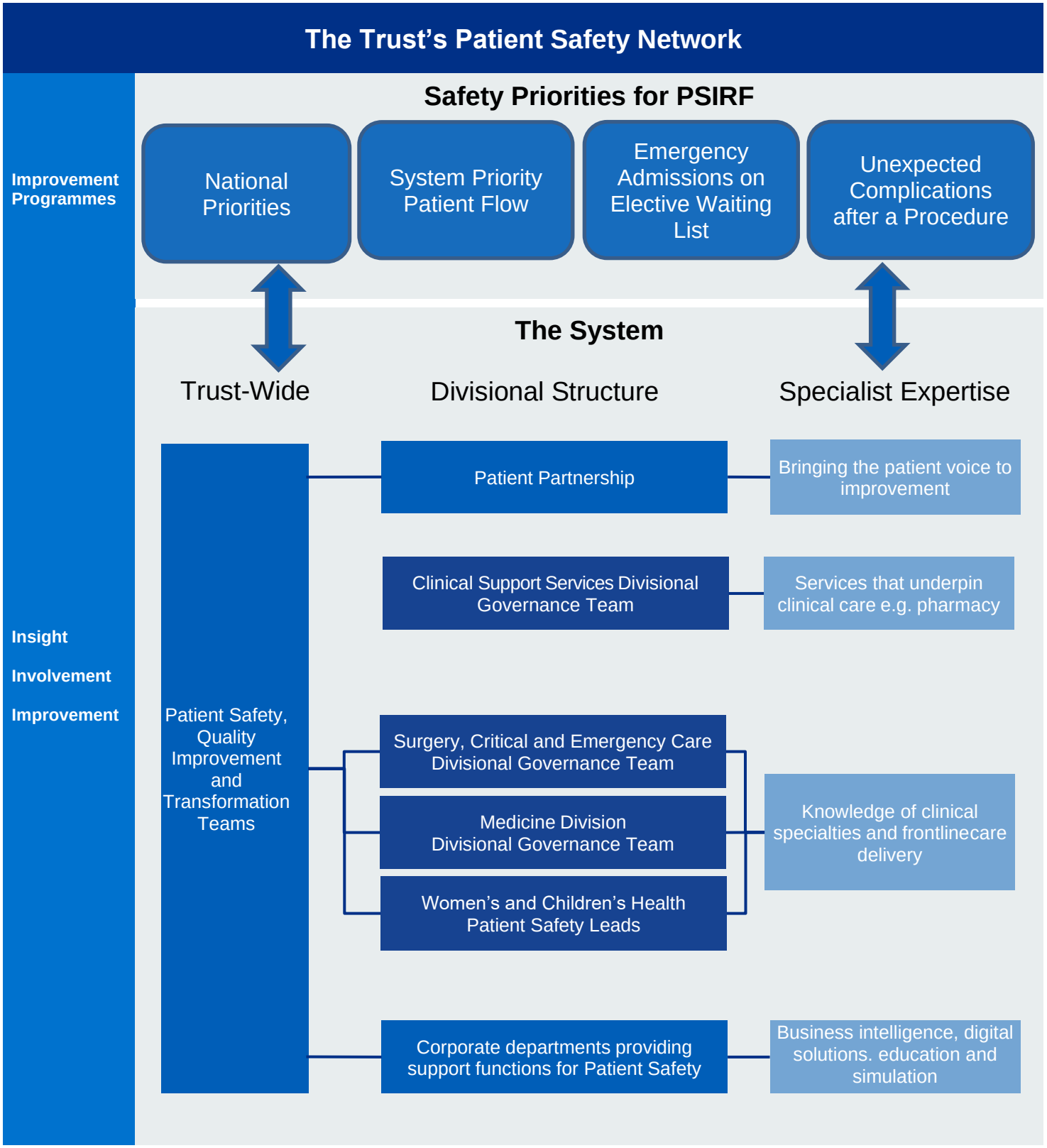
- NHS Patient Safety Strategy
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Supporting improvement and transformation programmes

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews (SJR), Learning from Deaths, complaints and feedback, claims and inquest responses.

The operational ‘work-as-done’ for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed with expert support from their respective Divisional Governance colleagues who are supported through strategic, educational and subject matter expert support flowing from the Corporate Departments.

This ‘Patient Safety Network’ involves key people and teams within the Trust who are integral in facilitating our patient safety system and patient safety culture to support learning and improvement.

System overview – our networks



Thematic analysis and our ongoing patient safety risks

We conducted a thematic analysis, to identify our highest areas of patient safety risk to identify our local priorities.

Our analysis used additional sources of patient safety insights, beyond that of incidents. The thematic review looked at patient safety activity between April 2023 and August 2024.

The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting. PSIRF allows us to focus on these risks with our framework for patient safety incident response.

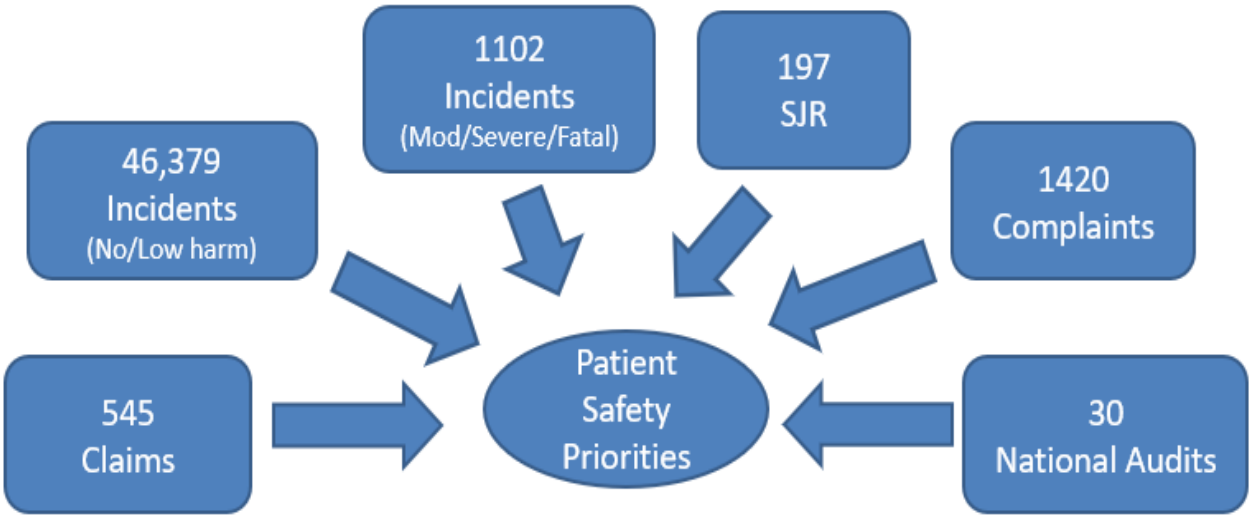
We have developed patient safety recommendations overleaf which are based on this thematic analysis.

Sources of insights for this analysis included:

1. Patient Safety Incidents reported including all moderate and severe harm and fatal incidents.
2. Patient Safety Incidents reported including all no or low harm incidents
3. Structured Judgement Reviews
4. Trust Claims scorecard 2014 – 2024
5. Complaints received relating to clinical care and treatment
6. National Audit key concerns.

N&W ICS system patient safety risk.

As part of the Integrated Care System, we commit to contributing to further discussions and agreement of the system pathway priority, in relation to patient flow. Once established we will carry out a focussed review of our organisation's element of the pathway, with particular attention to the transition periods both to and from other organisations. Once a thorough review has been undertaken by each organisation, we commit to contributing to the final write up of the report, identifying and actioning relevant safety recommendations and disseminating learning across the ICS.



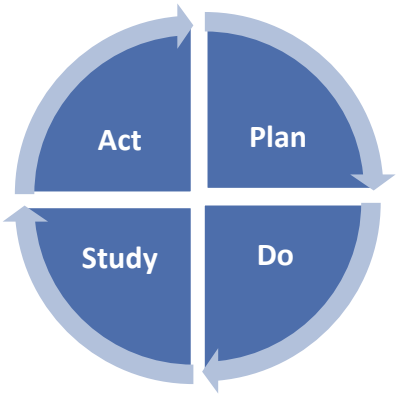
Our Patient Safety Priorities

Through our analysis of our patient safety insights, based on the thematic analysis, we have determined 2 patient safety priorities we will focus on for the next two years.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews.

The patient safety priorities were agreed at the Quality & Safety Committee in April 2025.

Theme	Key Theme	Key Risks from Activity
1	Emergency Admission on Elective Waiting List	Patients under all specialties where there is an emergency admission requiring an inpatient stay and treatment whilst waiting for surgery. This was the highest reported Incident for moderate and above harm and the 3rd highest reported incident resulting in lower level of harm. It was also identified as a theme in complaints and claims.
2	Unexpected Complication after a Procedure	Incidents affecting patients following surgery or an invasive procedure within Cardiology, Angiography and Gastroenterology. This was the 3rd highest reported Incident for moderate and above harm and 4th highest reported incident resulting in lower levels of harm. It was also identified as a theme in complaints, claims and national audit outcomes.
System Priority	Patient Flow	Once the system pathway priority is established by the ICS, we will carry out a focussed review of our organisation's element of the pathway, with particular attention to the transition periods both to and from other organisations.



Falls and Pressure Ulcers were in the highest 4 incident categories reported from the analysis. However, we already understand the contributory factors well and these are already part of active improvement plans which are being monitored to determine efficacy, so they have not been selected as a priority for PSII.

How we will respond to patient safety incidents

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is tofacilitate an approach that involves decision making through a multi -professional approach to commission investigations and receive findings and recommendations.

Our safety governance processes support the decision making for the most appropriate proportionate learning response to use to review a safety incident.

Incident Triage is held daily within each Division when all incidents reported are reviewed. At this point level of harm is reviewed for the purposes of discharging statutory Duty of Candour.

In PSIRF, the approach of greater than or equal to severe harm no longer applies to determine how we will respond, and we will be guided by the national and our local patient safety priorities. The Divisional teams triage each incident based on the level of understanding of the contributory factors. This will guide the level of response required, whether it is validation of facts at a local level or Patient Safety Review.

If an incident meets a national or local priority area for PSII as outlined in this plan it is reviewed at a weekly Complex Case Review Group.

Core to deciding what to investigate was the thematic analysis. The analysis identified two Patient Safety Priority incident categories that learning will be structured against over the first 2 years.

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities and involvement in the Norfolk & Waveney ICS priority this will likely result in 30-33 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Patient Safety incidents that must be investigated under PSIRF:

1. Patient safety incident is a Never Event
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
3. National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above. Any new priorities will be included as they emerge).

Patient safety incidents are events where a patient has or could have experienced harm as a result of a healthcare activity. An incident indicates that something is wrong with our systems and processes whether actual harm occurred or not. Therefore, it is important to look at all incidents regardless of level of harm.

How we will respond to patient safety incidents

Apart from the national criteria for PSII above, the decision to carry out a patient safety incident investigation should be based on the following:

- the patient safety incident is linked to one of the Trust's Patient Safety Priorities that were agreed as part of the thematic analysis.
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Care Quality Commission (CQC) Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that a safety incident has taken place.
2. Apologise for what has happened.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking to them about what happened and what we have learned.
6. Keep a secure written record of all meetings and communications.

Patient safety incidents that have resulted in severe harm:

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements and undertake a Patient Safety Review. This will both provide insights to thematic learning and provide information about the events to share with those involved.

How we will respond to patient safety incidents

	Incident	Approach	Improvement
National Priorities	Meeting Each Baby Counts Criteria	Refer to Maternity and Newborn Safety Investigation programme (MNSI)	Respond to recommendations made by external agency as applicable.
	All perinatal and Maternal Deaths	Perinatal Mortality Review Tool (PMRT) Refer to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	
	Child Death	Refer to Child Death Overview Panel (CDOP)	
	Death involving patient with Learning Disability	Reported and reviewed by Learning Disability Mortality Review (LeDeR)	
	Safeguarding	Refer to NNUH Complex Health Hub for Safeguarding review Safeguarding referral	
	Information Governance	Refer to Trust I.G. Lead for Data Security and Protection Toolkit review Refer to Information Commissioner	
	Incidents related to National Screening Programmes	Report to the Screening Quality Assurance Service (SQAS)	
	Deaths of patients in custody, in prison or on probation	Report to Prison and Probation Ombudsman	
	Incidents meeting Never Event Criteria	Statutory Duty of Candour PSII	Create local organisational recommendations and actions.
	Incidents resulting in death	Statutory Duty of Candour SJR ➡ If deaths more than likely than not due to problems in care ➡PSII	
Trust Priorities	Emergency Admission on Elective Waiting List	Statutory Duty of Candour PSII	
	Unexpected Complication after a Procedure	Statutory Duty of Candour PSII	
System Priority	Patient Flow	PSII	Create system level recommendations and actions.
Local Level	Incident resulting in moderate or severe harm	Statutory Duty of Candour Patient Safety Review	Inform thematic analysis of ongoing patient safety risks
	Incident resulting in moderate or severe harm linked to an existing Quality Improvement Programme	Statutory Duty of Candour Validation of facts at local level	
	Incident resulting in low or no harm	Validation of facts at local level Thematic analysis	

Patient Safety Incident Investigations

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents. Investigations analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors. We will no longer search for a single root cause; we will look at the different events that occurred leading up to the incident and analyse the possible causes. This supports us in looking at the system and not the people as individuals who work within it.

Areas for improvement are identified from this evidence-based analysis, to target systems-based improvement.

The Trust conducts **PSII** using the Systems Engineering Initiative for Patient Safety (SEIPS) Model to explore care system interactions and outcomes.

This approach includes a detailed investigation of the tools and technology used, tasks undertaken and the factors that influence the patient and staff involved. It also explores the internal and external factors impacting on systems and processes and how the work has been organised.

The Trust uses the following Patient Safety Review methodologies to review incidents at a local level:

After Action Review (AAR). AAR is a structured facilitated discussion of an event, which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the Multi-Disciplinary Team (MDT) and can be used to discuss both positive outcomes as well as incidents.

Structured Judgement Review (SJR). A case note review methodology that blends traditional, clinical-judgement based review methods with a standard format. This approach requires trained reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase. It used to review the last episode of care prior to an inpatient death.

MDT Review. A multidisciplinary team (MDT) meets to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps; explore a safety theme, pathway, or process; and gain insight into ‘work as done’ in a health and social care system.

Case note review. A method used to determine whether there were any problems in the care provided to a patient within a particular service.

SWARM Huddle. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened, how it happened and decide what needs to be done to reduce risk.

Maternity Incidents

In addition to the national level investigations, incidents for local level investigation will involve a multidisciplinary case note review and discussion of all incidents resulting in severe harm. This methodology will ensure a consistent approach and provide assurance that maternity incidents are being reviewed in a robust way to extract maximum learning. After Action Review will also be used for some incidents, where appropriate.

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

The patient voice is very much an integral part of our work at NNUH; we share below insights from the Chair of our Patient Panel who was also our first Patient Safety Partner, to explain our vision for PSIRP.

As the current Chair of the Patient Panel and a Patient Safety Partner at the Trust I am fully focussed on patients, families and their experiences whilst attending our hospital. We all strive to make these as positive and safe as possible but have to acknowledge that sometimes thing will go wrong. When this happens, it is vital that the voice of the affected patients and/or family members is heard loud and clear.

They are the ones with the lived experience, and this is so powerful. Adverse safety incidents can have life changing effects on the individuals concerned. It is therefore critical that their voices are brought to the table and heard with the same respect and value as those of our clinical colleagues. Time and time again you hear from patients that their primary concern is that what has happened to them will not happen again to another individual. The hospital needs to be seen to be taking the appropriate action in learning from events and helping to prevent them in the future.

As a patient safety partner, I try to ensure we never forget why we are all here, to provide the safest treatment and care for all our patients and families and when this may regrettably go wrong to ensure they are at the centre of any investigations into their care and treatment. The patient safety partner role is still developing and will take time to become fully embedded. However, I have been very impressed with the willingness of NNUH staff to work hard when investigating safety incidents to reach out to patients, carers and their families and include them as much as they wish to be, in the investigative process. This can be challenging for both sides but so important for all voices to be heard and a fully rounded response and follow-up plan developed. I look forward to the year ahead in my role and entrust everyone involved will continue to show the same levels of commitment and professionalism I have witnessed to date.

Rosemary Moore
Chair, Patient Panel and Patient Safety Partner.

Involvement and support for staff following incidents

"Underneath every simple, obvious story about 'human error', there is a deeper, more complex story about the organization"

Sidney Dekker.

We are on an ambitious journey at the Trust to build a just and restorative culture to ensure it is a safe and fair place, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a range of psychological wellbeing support for all staff. This includes but is not limited to:

- Local support from line managers, Human Resources and Workplace Health and Wellbeing
- Schwartz Rounds
- Confidential telephone counselling and/or Cognitive Behaviour Therapy (CBT) through our Employee Assistance Programme (Vivup).

  Tel: 0330 380 0658.
- Inhouse legal department will support staff with witness statements and attendance at Coroners court.
- Professional Nurse and Midwifery Advocates

PSII is not the only tool we will use to respond to incidents. Our policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents.

We have outlined several ways we can respond to individual incidents; this includes but is not limited to:

After action review: A structured facilitated debrief.
SWARM huddle (proactive safety huddle or hot debrief): A planned team gathering to regroup, seek advice, talk about the event.
MDT Case note review

Mechanisms to support, evaluate and monitor improvements following patient safety investigations.

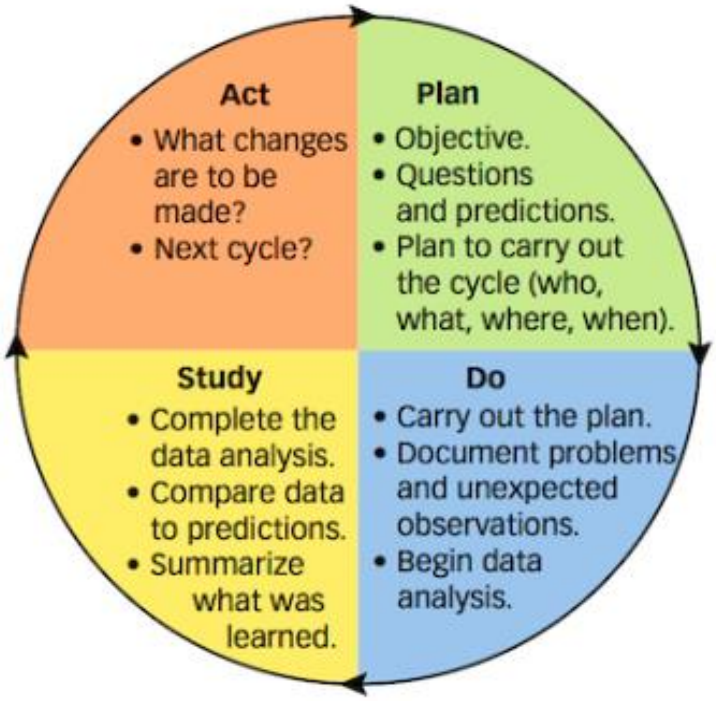
Robust findings from investigations and reviews provide key insights and learning opportunities, but they are not the end of the story.

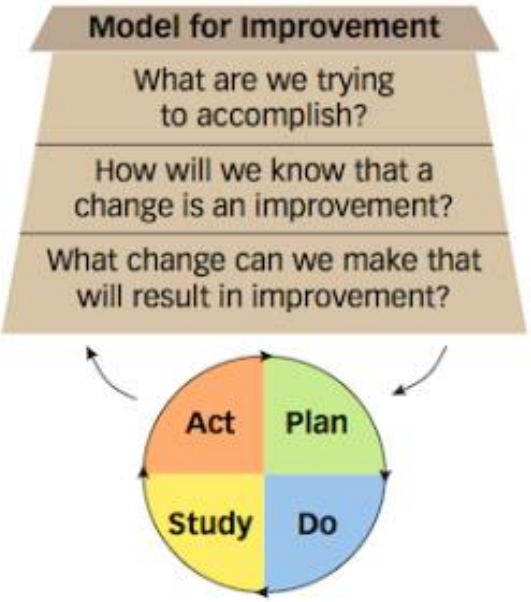
Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and investigations. Therefore, Areas for Improvement will be agreed by the Executive led PSII sign off meeting and feed into the work plans for the Quality Improvement and Transformation teams.

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

Reports to the relevant board sub committees will include aggregated data on:

- patient safety incident reporting
- findings from patient safety incidents
- audit and review findings
- progress against the PSIRP
- results from monitoring of improvement and transformation plans from an implementation and an efficacy point of view
- results of any surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of any surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.





Roles and responsibility in the system

Norfolk and Norwich University Hospitals NHS Foundation Trust is a complex system and has been building a comprehensive patient safety network. The governance structures at the Trust were considered in formulating this plan, and here is an outline of the core meetings and committees which represent our trust-wide approach, bringing the Trust together as a system which will support the implementation and progression of PSIRF.

The **Trust Board** seeks assurance that high quality services are being delivered through its sub-committees and presentation of data within the monthly Integrated Performance Report.

The **Quality and Safety Committee (Board Sub-Committee)** with a Non-Executive Director chair scrutinises quality information and that provided through sub-committees on the quality of care provided.

The **Clinical Safety and Effectiveness Sub Board** is chaired by the Deputy Medical Director, Quality, Safety and Clinical Transformation. This monthly meeting will have oversight of performance and governance arrangements in the Trust regarding patient safety, clinical standards and audit.

The **Hospital Management Board** oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Divisions and the Executive Team

Progress of PSII, ensuring required standards are met will be overseen by **PSII Review and Sign off Group**. Areas for Improvement from PSII approved by this group will be discussed at Learning from Insights and Outcomes Group.

The **Learning from Insights and Outcomes Group** chaired by an Executive Director, the Chief Nurse or Medical Director. This monthly meeting will review all safety recommendations and areas for improvement identified through PSII activity and triangulate with all currently available sources of insight and have oversight and scrutiny of the associated improvement plans where a business-as-usual reporting and monitoring line is not identified.

The **Patient Engagement and Experience Sub Board** chaired by an Executive Director, the Chief Nurse. This monthly meeting has oversight of performance and governance arrangements in the Trust regarding patient engagement and experience.

The **Risk Oversight Committee** chaired by an Executive Director; The Chief Nurse supports oversight of all risks within the Trust

The **Quality Programme Board** chaired by the Chief Executive Officer has oversight of all quality priority and improvement work.

The **Transformation Steering Group**, chaired by the Transformation Director, has oversight of the prioritisation and delivery of transformational change projects and programmes.

“The important thing is not to stop questioning. Curiosity has its own reason for existing”

Einstein.

With thanks to North Bristol NHS Trust.