Patient safety incident response plan

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Document Author:	Claire Taylor, Head of Patient Safety and Patient Safety Specialist		
Document Owner:	Patient Safety		
Approved By:	Quality, Safety and Effectiveness Management Group		
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Introduction

This patient safety incident response plan sets out how Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not permanently fixed and can be changed if required. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Patient Safety Incident Response Framework (PSIRF)helps us learn from patient safety events and improve care. It asks us to look at the systems, processes and culture around care, rather than blaming individuals.

A patient safety event can be any unintended or unexpected incident that could have or did lead to harm for one or more patient's receiving healthcare. This includes near misses where a patient safety adverse event could have happened, but it was avoided as a result of staff intervention. It can also include examples where positive practice, effective systems or good outcomes provide an opportunity for learning and sharing.

Under PSIRF, we undertake fewer formal investigations but ensure that they are of a higher quality. We focus on the areas where we can learn the most and improve safety. Trained people carry out reviews and examine the systems that support care.

This plan, together with our policy and guidance, explains how PSIRF will work at NNUH. Patient safety reviews help us understand what happened, how it happened and what needs to improve. We choose the right learning response based on the event and what we already know. Our response is driven by the opportunity for learning and improvement, not simply by the level of harm. Level of harm is a set of description provided by NHS England that describes the impact on the patient physically and/or psychologically when it is avoidable. We aim to increase our understanding from all types of incident so we can make patient care safer and reduce future harm.

A key part of PSIRF is compassionate engagement with patients, families and carers. We will treat people with kindness, respect and sensitivity, listen to and seek to understand their experience, and involve them in ways that reflect their individual needs and wishes. Their insights will help us understand what happened and learn how care can be improved. Every patient and family involved in a Patient Safety Incident Investigation will be offered the opportunity to take part in the review process, supported by a member of the Patient Safety Team or senior member of the clinical team.

We will also support and engage staff involved in patient safety events. We will provide a safe and respectful space for them to share their perspective, help us understand the context and systems in which care was delivered, and ensure their wellbeing is considered and supported throughout the review process.

PSIRF is for learning and improvement. It is not used to blame people, decide legal responsibility, decide whether something could have been prevented, or decide the cause of death. It does not replace other processes, such as complaints, human resources processes, legal claims or inquests.

Our services

Norfolk and Norwich University Hospital (NNUH) is a member of the Norfolk and Waveney University Hospitals Group. This enables James Paget University Hospitals, Queen Elizabeth Hospital King's Lynn and Norfolk and Norwich University Hospitals to work together under a Group Board while keeping their own names, identities and local hospitals. This model helps us tackle shared challenges, improve services for patients and make the most of our combined strengths.

NNUH is a 1,200-bedded teaching hospital with more than 10,000 staff and modern facilities for patient care. Nearly one million outpatient appointments, day-case procedures and inpatient admissions take place each year at the main Colney Lane site, which includes the Jenny Lind Children's Hospital, and at Cromer and District Hospital.

The Trust predominantly serves the people of Norfolk and North Suffolk, although some patients are referred from further afield. NNUH organises its clinical services through 10 Care Groups, each bringing together related specialties and services around a defined area of care. Care Groups provide a clear operational and professional structure between frontline teams and Trust-wide governance. Each Care Group is led by clinical and operational leaders, typically bringing together medical, nursing and operational perspectives. These leaders are accountable for the quality, safety, performance, workforce, finance and risks within their services. Individual specialties and clinical teams manage day-to-day care and escalate themes, risks and improvement needs through their Care Group arrangements. This supports decisions being made as close as possible to patients while ensuring that significant issues can be shared, triangulated and escalated through Trust governance.

Several corporate teams support the Care Groups, including the Patient Safety Team, Clinical Governance and Quality Team, Corporate Risk and Compliance Team, Patient Experience and Engagement Team, Quality Improvement Team, Clinical Excellence Team, Transformation Team, Complex Health Hub, Organisational Development and Legal Services. Front-line staff carry out much of the day-to-day patient safety work. We also learn from reviews of deaths, complaints, feedback, legal claims and inquests. Together, our Care Groups and Corporate team form our Patient Safety Network alongside our patients and their relatives.

Defining our patient safety incident profile

This section explains how we used different sources of information to identify the patient safety issues we should focus on over the next 18 months.

We conducted a thematic analysis to identify our highest areas of patient safety risk and define our local priorities. Rather than relying on one measure, we brought together quantitative data, professional intelligence and the experiences of patients, families and staff. This enabled us to identify recurring themes, compare what different sources were telling us and consider where a focused learning response could add the greatest value.

We reviewed information from many sources to identify patterns and possible local priorities. The review covered 1 June 2025 to 30 June 2026. It included 23,604 incident reports, 1,475 complaints, 3,468 contacts with the Patient Advice and Liaison Service, 170 reports about good care, one report from a coroner about action needed to prevent future deaths, and 72 structured reviews of care before a patient died. The volume of reports helped us understand frequently occurring issues, while the different types of information provided detail about impact, experience, context and opportunities for learning.

We also considered information from Pharmacy, Medical Devices, Digital Health, Legal Services, Safeguarding, the Medical Examiners' Office, Care Groups, Governance and the Complex Health Hub. This specialist and operational intelligence helped test whether themes seen in reported data were also recognised within services, linked to known risks or improvement work, or required further exploration.

We did not select priorities only because harm had occurred. We compared evidence to look for themes that appeared in more than one source of information, involved actual or possible harm, had limited current oversight, and offered a meaningful opportunity to improve the systems that support care. We also considered what was already known, whether improvement work was in place and whether further review was likely to generate useful new learning. We excluded reports that had been rejected and events that did not affect patients.

Defining our patient safety improvement profile

This section explains how we will turn learning from patient safety incidents into actions that improve care.

Investigation and review findings provide important learning, but learning alone does not improve safety. Findings must be translated into proportionate patient safety actions, implemented at the appropriate level and monitored to determine whether they have achieved the intended improvement.

There are a range of ways we learning from incidents

Method	What it involves
After Action Review	A structured, facilitated discussion held after an event. The people involved explore what happened, why the outcome differed from what was expected and what can be learned.
Case note review	A review of a patient's clinical record to identify any problems in the care provided by a particular service.
Local validation/review	A focused review undertaken by the relevant clinical or service team to confirm the facts, consider the care provided, identify any immediate learning or action and determine whether a further learning response is required.
Multidisciplinary team review	A team of staff from different professions reviews one or more incidents, identifies learning, considers factors that influenced care and agrees areas for improvement.
Patient Safety Incident Investigation (PSII)	A systems-based investigation undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. It explores how and why care was delivered as it was, identifies contributory system factors and supports improvement.
Structured Judgement Review	A structured review of a patient's clinical record before an inpatient death. Trained reviewers consider each stage of care and record their judgement about its quality and safety.
SWARM huddle	A short team discussion held soon after an incident. Staff share what they know, identify immediate risks and agree what needs to happen next.
Thematic Review	A structured review of a group of similar patient safety events to identify recurring patterns, contributory system factors and opportunities for shared learning and improvement.

After Action Reviews (AARs), Patient Safety Multidisciplinary Team (MDT) Reviews, SWARMs and Patient Safety Incident Investigations (PSIIs) are structured, system-based learning responses specifically used to learn from patient safety incidents and inform improvement.

Local learning identifies patient safety actions for the teams directly involved. Where learning is relevant beyond the immediate team, it will be shared with other services so they can consider whether similar changes are needed in their own systems and practice.

For Patient Safety Incident Investigations, the senior leadership-led PSII Review and Sign-off Group will approve the report and confirm the learning identified. The group will agree where patient safety actions are most likely to have an impact and whether implementation is required within a local team, across a Care Group or across the organisation.

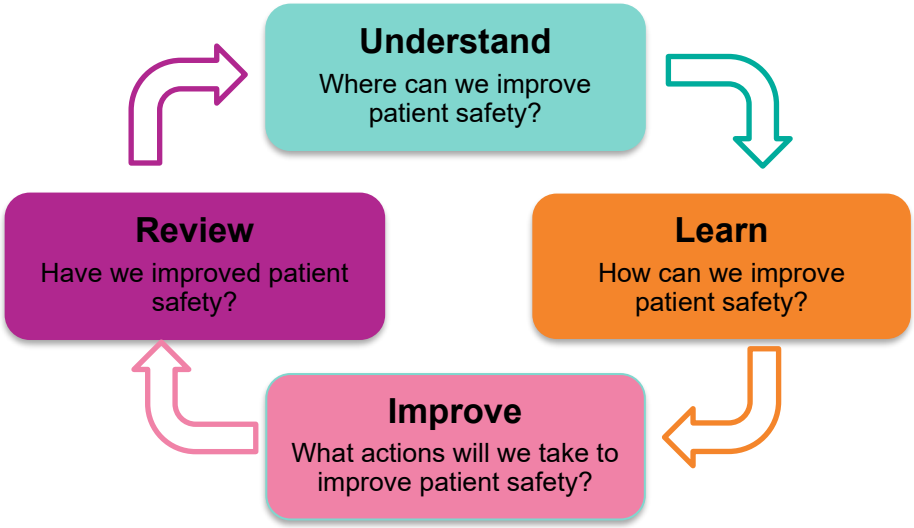
Where a patient safety incident has been influenced by factors involving another organisation, or where the patient's care journey has involved multiple organisations or providers, we will work with the relevant system partners to agree a coordinated and proportionate response. Arrangements will be decided on a case-by-case basis, in liaison with the Patient Safety Specialist or equivalent lead in each organisation, so that responsibilities are clear and opportunities for shared systems learning and improvement are identified.

The impact of improvement work will be reviewed against the intended outcome. Where monitoring shows that the change has not achieved the expected impact, further analysis and additional action will be considered.

Reports to the relevant governance meetings will bring together insights from patient safety incidents, learning from deaths, safeguarding, complaints, patient and staff experience, legal claims, inquests, clinical governance and improvement monitoring. Triangulating these sources will help the organisation identify emerging patient safety concerns, assess progress against this plan and understand the impact of improvement actions.

We are focused on turning learning into action that makes a measurable difference, through a continuous cycle of reviewing patient safety insights, identifying learning, implementing proportionate actions and evaluating their impact.

We will focus on the areas where we can have the most impact on patient safety – to make improvement meaningful



Our patient safety incident response plan: national requirements

Some incidents must be referred for a specific national or legal response. The table below sets out the required approach and anticipated improvement route.

Type of Safety event	Approach	Improvement
Meeting Each Baby Counts criteria	Refer to the Maternity and Newborn Safety Investigation programme (MNSI)	Respond to recommendations made by the external agency, as applicable.
All perinatal and maternal deaths	Use the Perinatal Mortality Review Tool (PMRT) and refer to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	Respond to recommendations made by the external agency, as applicable.
Child death	Refer to the Child Death Overview Panel (CDOP)	Respond to recommendations made by the external agency, as applicable.
Death involving a patient with a learning disability	Report and review through Learning from Lives	Respond to recommendations made by the external agency, as applicable.
Safeguarding	Refer to the NNUH Complex Health Hub for safeguarding review or referral	Respond to recommendations made by the external agency, as applicable.
Information governance	Refer to the Trust Information Governance Lead for Data Security and Protection Toolkit review and, where required, the Information Commissioner	Respond to recommendations made by the external agency, as applicable.
Incidents related to national screening programmes	Report to the Screening Quality Assurance Service	Respond to recommendations made by the external agency, as applicable.
Deaths of patients in custody, in prison or on probation	Report to the Prison and Probation Ombudsman	Respond to recommendations made by the external agency, as applicable.
Incidents meeting Never Event criteria	Apply the Statutory Duty of Candour and determine a proportionate learning response locally	Create local organisational recommendations and actions.
Incidents resulting in death	Apply the Statutory Duty of Candour, complete an SJR and undertake a PSII where death is more likely than not due to problems in care	Create local organisational recommendations and actions.

Our patient safety incident response plan: local focus

We have identified three local patient safety priorities for the next 18 months. These priorities will focus our investigations and learning on areas where we believe there is the greatest opportunity to understand how care can be made safer. We will use different learning responses for different types of patient safety incidents.

Three patient safety priorities were agreed by the Hospital Management Group in October 2026. Two relate to specific types of patient safety events where we think we can learn the most. A third is a priority which enables us to respond to an emerging concern in a timely and structured way.

Falls were one of the four most frequently reported incident categories. However, we already understand many of the factors that contribute to falls. Improvement plans are in place and are being monitored to see whether they are working. For this reason, falls were not selected as a priority for a Patient Safety Incident Investigation.

Communication-related incidents appeared frequently in the information we reviewed. However, they covered many different issues and did not form one clear local priority. Previous Patient Safety Incident Investigations have already identified important learning about communication, so we will focus on putting that learning into practice. Patient documentation also appeared in the review, but no single aspect emerged as a clear priority. Future investigations will consider communication, patient identification and documentation as possible system factors.

Theme	Key theme	Key risks from activity	Approach
1	**Delay in essential treatment**	Delay in essential treatment associated with non-recognition of deterioration or delay in obtaining timely clinical review or information where multiple system factors may have impacted on a specific patient safety event	Initial SWARM and/or After-Action Review which will inform Individual PSII or Thematic PSII approach
2	**Discharge failure**	Breakdown in discharge planning for inpatients where there is system complexity or multiple specialties involved potentially resulting in harm.	Thematic PSII with individual PSIIS considered if an individual case will add significant additional learning
3	**Emerging patient safety concern**	Emerging patient safety concern identified through structured data analysis and thematic review, including incidents, patient feedback and other data sources. This PSII route will be progressed where further focused review is expected to generate valuable and proportionate systems learning and improvement.	Commissioned individually by the Chief Nurse and Medical Director

For patient safety events that do not meet the criteria for a Patient Safety Incident Investigation, an appropriate and proportionate learning response will be applied. The data demonstrated that we have a significant opportunity to learn and implement improvement in the following areas of patient safety

- Inappropriate place of a patient (internal to hospital)
- Delay in time critical treatment or procedure

Patient safety events relating to these areas will routinely be considered for a learning response when the patient safety event is initially reviewed jointly by clinical and governance staff. When considering these cases, we will take account of whether the contributory factors are already understood and can be addressed through patient safety actions, or whether the case offers an opportunity for new systems learning.

Any patient safety incident can be considered for a learning response where the contributory factors are not understood. Where the contributory factors are understood patient safety actions will be put in place accordingly.

How we will respond to patient safety incidents

We will use a flexible approach to decide whether a Patient Safety Incident Investigation is needed. Decisions will take account of national requirements, local priorities, what is already known and the opportunity for further learning. A multidisciplinary group will agree which investigations to start and will review the findings and recommendations.

Each Care Group reviews new incident reports every weekday. This daily review helps the team check the facts, identify any immediate action and choose the most suitable learning method. The level of harm does not by itself decide how we respond.

If an incident meets a national or local priority area for PSII, it is then reviewed at the weekly Complex Case Review Group. An investigation may also be started where a number of similar incidents indicates an emerging area of risk.

In addition to national-level investigations, maternity incidents selected for local investigation will involve a multidisciplinary case note review and discussion of all incidents resulting in severe harm. After Action Review will also be used for some incidents where appropriate.

We recognise the significant impact patient safety incidents can have on patients, their families and carers. Meaningful involvement in how we respond to incidents is essential to improving the services we provide. We will ensure patients/families/carers will have the opportunity to help form the terms of reference for learning responses and also be involved in learning responses where possible and appropriate. Feedback will be provided in a way that is agreed with the individual concerned. The patient voice is an integral part of our work at NNUH, supported by our Patient Panel and Patient Safety Partners.

The people affected have lived experience of the event. Their voices will be heard with the same respect and value as those of clinical colleagues. We will support patients, families and carers to be involved as much as they wish throughout the review and follow-up process.

When a colleague reports an incident or provides insight into a patient's care for a review, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement.

Additional Information

Additional information about how we apply this plan can be found in our Patient safety Incident Response Plan Policy, including:

- How we involve patients, families and carers following incidents
- How we involve and support for staff following incidents
- Learning-response methods
- Maternity incidents
- How we support, evaluate and monitor improvements
- What happens when someone comes to harm
- Roles and responsibilities
- Saying sorry and Statutory Duty of Candour