Imperial College Healthcare
NHS Trust

Patient safety incident response plan

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	NAME	TITLE	DATE
Author	Removed for external publication	Safety Improvement Partner	21/02/2024
Reviewer	Removed for external publication	Chief of Staff	21/02/2024
Authoriser	Raymond Anakwe	Medical Director	22/02/2024

Contents

Introduction

This patient safety incident response plan (PSIRP) sets out how **Imperial College Healthcare NHS Trust (ICHT)** intends to respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve the quality and safety of the care we provide. The plan is not a permanent rule that cannot be changed but will guide our incident response activity over a period of 12 to 18 months. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

A PSIRP is a requirement of each provider of NHS-funded care. This document should be read alongside the Patient Safety Incident Response Framework (PSIRF) 2021 and our Patient Safety Incident Response Policy.

Our plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues
- focusing on addressing these causal 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

The plan is underpinned by our trust policies on incident reporting and management available to all staff via our organisation's intranet.

Our services

Imperial College Healthcare NHS Trust provides acute and specialist healthcare for over one million people every year. We particularly serve the local communities in the eight boroughs that form the North West London Integrated Care System. Formed in 2007, we are one of the largest NHS trusts in the country, with more than 15,000 staff.

Our five hospitals in central and west London – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and The Western Eye – have a long track record in research and education, influencing care and treatment nationally and worldwide. We are developing a growing range of integrated and digital care services and offer private healthcare in dedicated facilities on all our sites, including at the Lindo Wing at St Mary's Hospital.

We have four clinical divisions within the organisation:

- Medicine and integrated care
- Surgery and cancer
- Women's, cardiac, clinical support, and sexual health services
- West London children's healthcare

There are over 200 clinical services at the Trust. All the services we offer have been considered within our PSIRP, including specialist areas such as pathology, children's services, and maternity services.

In September 2022, we formalised our partnership with the three other acute NHS trusts in North West London as an acute provider collaborative. This included the appointment of a chair in common to all four trusts. We have developed our PSIRF plans and policies collaboratively across the acute provider collaborative to maximise opportunities for shared learning and improvement.

Further information relating to our services can be found on our website.

Defining our patient safety incident profile

To define our key patient safety risks and planned responses we have taken a collaborative approach that involved the following stakeholders:

- Patient Safety Partners
- Patient groups
- Staff
- Senior leaders
- Commissioners / ICS
- Partner organisations through the acute provider collaborative

We have developed our understanding and insights over the past year, including regular discussions and engagement through our PSIRF task and finish group, as well as discussion at the executive management board for quality (EMBQ) and quality committee.

Our patient safety issues and risks have been identified from the following data sources:

- Review and analysis of four years of incident reporting data, across all levels of harm including serious incidents (additional year added due to covid-pandemic)
- Key themes from complaints, PALS contacts, claims and inquests
- Key harm-free care metrics
- Key themes and issues from committees and groups with a remit relating to aspects of quality and patient safety (for example our medication safety group, falls steering group etc).
- Risk registers
- Key themes from learning from deaths reviews
- Stakeholder discussions

The insights obtained from this thematic review were used to inform our safety improvement priorities and local priorities for learning responses within our plan.

We recognise that our plan is not a static document and we will continue to use our insights to inform themes, trends, emerging risks and we will respond and update our plan accordingly.

Defining our patient safety improvement profile

We have had a safety improvement programme in place since 2018. The programme is supported by the safety improvement team, with steering groups in place for individual work streams and overall reporting to our executive management board quality group.

Following review of our quality and safety insights and data, and progress with our previous priorities, we have agreed eight priority improvement areas for the safety improvement programme in 2024/25. These have been identified as our key areas of risk internally and were agreed by our executive management board for quality (EMBQ).

Each of our safety improvement priorities has its own set of defined metrics for improvement. The main metric is a reduction in the percentage of incidents causing harm to patients for each of these key areas of risk. All process and outcome measures for our improvement priorities are monitored by the Safety Improvement Group and associated steering group.

We are to reduce harm to patients through our safety improvement programme with a focus on the following safety improvement priorities:

- Reduce infection transmission through improving basic standards of IP&C practice with a focus on hand hygiene;
- Improve the treatment of patients with sepsis & signs of deterioration;
- Reduce harm from inpatient falls;
- Reduce medication related harm with a focus on anticoagulants and insulin;
- Reduce the harm caused when undertaking invasive procedures by implementing NatSSIPs 2;
- Improve nutrition and hydration, in particular the identification and management of adult patients with dysphagia;
- Improve positive patient identification;
- Improve safe transfers of care;

We also have ongoing improvement work underway within our wider quality priorities, as outlined in our quality account:

- Develop a robust plan to collect and review data to identify inequalities in all of the quality and safety priorities
- Fully implement and embed the Patient Safety Incident Response Framework (PSIRF) with a focus on experience of and compassionate engagement with those involved
- To fully development of our approach to patient centred safety focusing on the impact of our patient safety partners.
- Improve the treatment of patients with deterioration in their mental health.

- Develop and embed our approach to improve the use of user insights and focus to drive improvement with a focus on local usage
- Improve end of life care though delivery of the new trust strategy

In addition to our local priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (Chelsea and Westminster NHS Foundation Trust, London North West NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust) on several priority areas. Many of our local priorities are aligned with these collaborative work streams, which are focused on streamlining and ensuring consistent processes and reporting across the four acute collaborative trusts in the following key areas:

- Care of the deteriorating patient and end of life care (including treatment escalation);
- User insights and focus;
- Mortality and clinical harm review outcomes;
- Maternity standards.

Our patient safety incident response plan: national requirements

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.

Table 1 below sets out the nationally mandated responses that we will follow.

	National Patient Safety Event Priority	Required response	Lead body for response
1	Incidents that meet the Never Event List (2018)	PSII	ICHT
2	Deaths clinically assessed as thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	ICHT
3	Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to (MNSI) for independent patient safety incident investigation	MNSI (or SpHA)
4	Child deaths	Refer for Child Death Overview Panel review. Locally led PSII (or other response) may be required alongside the Panel review	Child death overview panel ICHT for locally led PSII if required
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review	LeDeR Programme ICHT for locally led PSII if required
6	Safeguarding incidents in which: Babies, child 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, 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.	Refer to your local designated professionals for child and adult safeguarding
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response, including	ICHT

		confirmation of method to be used. See: Guidance for managing safety incidents in NHS screening programmes	
8	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.	PPO or IOPC
10	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 lead organisation)	ICHT
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, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

We will also continue to report patient safety incidents in line with the external reporting requirements outlined in our incident reporting policy.

Our patient safety incident response plan: local focus

Our local focus for learning responses are outlined in the table below. These have been identified as our key patient safety risks and themes which have been identified for local focus learning responses.

The criteria we have considered in defining the list provided were as follows:

Potential for harm / future harms:

- People: physical, psychological, loss of trust (including impact on patients, family & caregivers)
- Service delivery: impact on the quality and delivery of healthcare services; impacts on service capacity
- Public confidence: including political attention and media coverage.

Potential for learning and improvement:

- To ensure a proportionate response in line with PSIRF standards

Likelihood of occurrence:

- Persistence of the risk
- Frequency
- Potential to escalate

Not all patient safety incidents require PSII but may benefit from a different type of learning response to gain further insight or address queries from the patient, family, carers, or staff. Where this is the case, we will adopt relevant learning response techniques such as an AAR. Further information relating to learning response tools can be found on the national PSIRF website - NHS England » Patient Safety Incident Response Framework

Patient safety incident type or issue	Planned response	Anticipated improvement route
Transfer and discharge	PSII	Inform our understanding of contributory factors to inform safety actions and improvement plan
Missed and/or delayed diagnosis	PSII	Inform our understanding of contributory factors to inform safety actions and improvement plan
Failure to identify a deteriorating patient – including sepsis incidents	PSII	Undertake the number of PSIIs required to inform any amendments to the improvement plan based on learning
Incidents relating to the mental health treatment and care	PSII	Undertake the number of PSIIs required to inform the trust improvement plan for this quality priority.

Unexpected PSII (e.g. not clearly outlined in our PSIRP but due to level of risk or complexity, and lack of improvement plan would require an in-depth review.	PSII	TBC on completion of PSII
Maternity cases that do not meet the Maternity and Newborn Safety Investigations (MNSI) criteria	Initial incident review to inform proportionate decision making as to when an AAR or PSII is required.	Inform our understanding of contributory factors to inform safety actions and improvement plans
Inpatient falls with harm	Initial incident review AAR if opportunity for new learning	Create safety actions and feed these into the safety improvement priority
Pressure ulcers	Initial incident review AAR if opportunity for new learning	Create safety actions and feed these into the safety improvement priority
Medicines incidents with moderate and above harm	Initial incident review AAR if opportunity for new learning	Create safety actions and feed these into the safety improvement priority
Hospital acquired thrombosis	Initial incident review AAR if opportunity for new learning	Create safety actions and feed these into the safety improvement priority
Infection, prevention, and control (IPC)	Initial incident review AAR if opportunity for new learning	Create safety actions and feed these into the safety improvement priority

To support identification of the appropriate learning response, any patient safety incident resulting in moderate harm or above will require an initial incident review (IIR) to be completed and reviewed by the Initial Incident Review Group for a collaborative decision on a proportionate response. These incidents will also continue to be managed in line with our Duty of Candour Policy.

No harm and low harm incidents not defined as a local priority within our plan, will follow our local incident management policy for local review and learning used to inform ongoing areas of improvement at local, divisional, or trust-wide level.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Other patient safety incidents which meet criteria for harm or potential harm not included in the subjects above	Initial incident review findings reported to initial incident review group for decision on proportionate response (e.g. PSII or AAR).	Themes from data and learning to form ongoing improvement work and future PSIR planning.

		If opportunity for learning, or high risk identified, an appropriate learning response will be identified to create safety actions and/or improvement plans.
No / low harm patient safety incidents	Validation of facts and identifying learning/safety actions at a local level, recorded on the incident form.	Themes from data and learning to inform ongoing improvement work and future PSIR planning.

Appendix 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 address those system factors and help deliver safer care for our patients effectively and sustainably.

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 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.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

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.
nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)