Document title: **Patient Safety Incident Response Framework (PSIRF) Annual Plan for January 2024 - March 2025**

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Key points of this document

- This Patient Safety Incident Response Plan (PSIRP) sets out how Royal Papworth Hospital Foundation Trust will seek to learn from patient safety incidents reported by staff, patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.
- This plan sets out how we will implement the requirements of the Patient Safety Incident Response Framework (PSIRF) at Royal Papworth Hospital Foundation Trust.
- The plan must be viewed alongside the Royal Papworth Hospital Foundation Trust, DN665 Patient Safety Incident Response Framework Policy.

Contents

1. Introduction

This patient safety incident response plan (PSIRP) sets out how Royal Papworth Hospital (Trust) Foundation Trust intends to respond to patient safety incidents commencing from January 2024 until March 2025. The plan is not a permanent rule that cannot be changed. 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 our organisation's intranet. The Royal Papworth Patient Safety Incident Response Policy (DN665) should be referred to support the delivery of this plan for pathways for escalation, methods of review, safety action development, safety improvement plans' and monitoring improvement.

Our patient safety incident response plan is a 'live document' that will be amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes needed.

2. Our services

Royal Papworth Hospital (RPH) is a regional centre for the diagnosis and treatment of cardiothoracic disease. It is also a national centre for a range of specialist services, including heart and lung transplantation, pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.

The Trust moved to its new building on the Cambridge Biomedical Campus in May 2019. The hospital encompasses 246 beds, six operating theatres, six cardiac catheterisation labs and two bronchoscopy rooms. In addition, in April 2022, the Heart & Lung Research Institute (HLRI) opened which houses University of Cambridge (UoC) research laboratories, and a Clinical Research Facility.

3. Defining our patient safety incident profile

To define and scope for our first annual plan (which for the first year covers a 15-month period), we carried out a local situational analysis and review of the Trust's incident and patient experience reporting profile. Data was reviewed from incidents reported by staff on the Datix incident system and previously reported themes, and key priorities were reviewed from the Trust's preceding

annual reports and quality accounts from 2019-2023. This provided a broad range of context from our staff reported incidents and from service users' feedback, raised through our complaints and Patient Advice and Liaison Service (PALS) contacts.

The rational for the selected date range chosen for the purposes of identification of our incident profile is from May 2019 - March 2023 (4 year period). This range coincides with the relocation to the New Royal Papworth Hospital site (May 2019) and allows for an equilibrium to settle after the COVID 19 surge and the implementation of new ways of delivering patient care. Reported patient safety concerns, risks, patient and staff feedback attributed to the hospital move, where resolved, have been discounted and fall outside of the current Trust safety incident profile.

The top local patient safety risks have also been considered, alongside the near miss incidents that are reported to identify opportunities for learning and improvement using the following criteria for the review:

Potential for harm

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

Likelihood of occurrence

- Persistence of the risk
- Frequency
- Potential to escalate/deteriorate.

Key identified areas from the four-year review:

From May 2019 - March 2023 the following key areas were identified as being significant to our patient safety incident profile. Within this data period there were 152 moderate harm and above patient safety incidents where Serious Incidents or Internal Incident investigations were declared, and incident learning responses and improvement actions were required.

For the purposes of this analysis, patient safety incidents where death occurred during or after a procedure or treatment have also been included as these cases often prompt a Rapid Case Review (or as required Structured Judgement review), Morbidity and Mortality Meeting discussion or an incident investigation and a learning response to take place.

Table 1 below shows the data for the last four years that has been broken down into the incident types and the harm categories for the incidents.

Incident type	Moderate	Severe	Death unrelated to incident	Death related to incident	Total
Treatment and Procedures	46	7	29	3	85
Implementation of care during patient pathway	10	6	5	0	21
Inpatient falls	16	1	0	0	17
Other e.g.: Blood transfusion Accidental injury, infection prevention	9	0	3	0	12
Medication Safety (including medical gases).	6	1	4	0	11
Hospital acquired pressure ulcers	5	1	0	0	6
Total	92	16	41	3	**152**

Table 1: Key identified areas from the Trust's moderate harm and above investigations over a four-year period May 2019- March 2023.

4. Defining our patient safety improvement profile

Clinical quality and risk at the Trust are monitored through an embedded governance structure, part of which includes clinical oversight and improvement groups. These groups are responsive and are driven by the recognition of emerging risks and thematic reviews to identify immediate actions and improvement plans. These are flexible, ongoing and ensure we are continuously monitoring and learning.

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types, either those within national priorities, or those we have identified locally. We will remain responsive and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

The current governance structure has well established existing workstreams that report into the Trust Quality and Risk Management Group (QRMG), through the internal structure to Trust Board. These focus on prevention and improvement to patient safety & risk and include the following key areas, Falls Prevention Group, Pressure Ulcer Scrutiny Group, Venous Thromboembolism (VTE) Groups, Infection Prevention and Control, Hospital Transfusion Committee, Drugs & Therapeutics and Medication Safety Committee, Delirium Group, Consent Working Group, CPR/Alert Steering Group, Discharge Assurance Group, ReSPECT Steering Group, Tracheostomy Group, Digital

Clinical Safety Group, Medical Gases Committee and Clinical Practice Committee.

Royal Papworth Hospital has a culture of proactively responding to patient safety incidents. As well as existing improvement work, focussed task and finish groups are formed when a clear outcome or immediate risk management response is required. Examples of these are incident/topic specific groups have been set up in response to outbreaks or emerging risks, which have included Surgical Site Infection and Mycobacterium abscessus oversight groups. These were set up to strengthen governance and to manage patient and staff safety and risk.

Our PSIRF plan will not diminish existing work plans for current groups. The tools outlined in the PSIRF Policy (DN665) can be used to further strengthen the improvement profile, such as embedding the use of thematic reviews of past learning responses to inform the development of their safety improvement plan, or alternatively, a 'horizon scan' may be useful where pathway issues are identified or predicted regardless of whether or not an incident has occurred.

5. Our patient safety 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. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII. These are laid out in the Trust's Patient Safety Incident Response Policy (DN665) section 16.

6. Our Patient Safety Incident Response Plan (PSIRP)

Following the full analysis of our four-year data review, taking into account the Trust's profile, our services, alongside recognising there is a national requirement for a mandated response to specified incidents, we have identified the following five areas that we will focus on in our first annual plan.

Table 2 below lays out the **five key incident types/issues** that the Trust will focus on. These have been identified from the data reviewed as laid out in Table one. Furthermore, how we will use the learning toolkit for our planned responses, alongside how we anticipate the improvement outcomes will be monitored.

Patient safety incident type or issue	Planned response	Anticipated improvement route

Patient safety incident type or issue	Planned response	Anticipated improvement route
Recognised but unintended outcome of treatment or procedure - with adverse consequences e.g. • Misplacement of central venous catheter, • Hospital acquired infections, • Surgical site Infections (SSI's) • Deteriorating patient.	Local After Action Review (AAR), Multidisciplinary Team (MDT), Patient Safety Incident Investigation (PSII) Escalation from any AAR or MDT to PSII, if Patient Safety Investigator (PSI) or lead has identified a new risk to patients or current actions do not provide mitigation.	Create local organisational and / or system response through a dedicated QI response panel. Reviewed through Speciality Morbidity and Mortality meetings. Outcome from above learning response to feed into the Divisional Safety Improvement Plan, overseen by QRMG.
Identified Implementation of care or treatment - issues within the patient pathway e.g. -Referral process -Appointment delays, cancellations -Access issues (falling outside of Referral to Treatment (RTT) and Harm review) -Admission, diagnostic errors, or safety incidents relating to patient transfer or discharge (internal or externally).	Local AAR or Multidisciplinary Team (MDT) Review. Escalation from any of the above to PSII if PSI or lead has identified a new risk to patients or current actions do not provide mitigation. Consideration of cross-organisation or system wide incident response.	Create local organisational and / or system through a dedicated QI response panel. Outcome from above learning response to feed into the Divisional Safety Improvement Plan, overseen by QRMG.
Medication safety incident e.g. omission of critical medication, prescribing, or administration.	Local AAR or MDT Review. Escalation from any of the above to PSII if PSI or lead has identified a new risk to patients or current actions do not provide mitigation.	Through Medication Safety Committee with relevant divisional lead. Outcome from learning response to feed into the Divisional Safety Improvement Plan. Monitored and supported by QRMG. Improvement resources provided by designated PSI or corporate team.
Unwitnessed falls resulting in fracture or haemorrhage	Local Swarm huddle, AAR or MDT review. Escalation from any of the above to PSII if PSI or lead has identified a new risk to patients or current actions do not provide mitigation.	Through Falls Prevention Group with oversight from Harm Free Care Panel. Improvement resources provided by designated PSI or corporate team. Monitored and supported by QRMG
Hospital Acquired pressure ulcers category 3, 4 or unstageable (including medical device related).	Local Swarm huddle, AAR or MDT review. Escalation from any of the above to PSII if PSI or lead has identified a new risk to patients or current actions do not provide mitigation.	Through Pressure Ulcer Prevention Group with oversight from Harm Free Care Panel. Monitored by QRMG. Improvement resources provided by designated PSI or corporate team.

Table 2: The five key incident types/issues that the Trust will focus on for the first annual plan.

7. Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients / service users, families and staff).

As we implement our Trust annual plan, we endeavour to include those affected in a meaningful way and ensure the standards laid out in our Policy DN665 Patient safety incident response Framework (PSIRF) are followed. See the full policy in section 9 for further details.

8. Implementing our plan and responding to cross-system incidents / issues

We recognise that Patient Safety Incidents (PSIs) can often be complex and involve a number of organisations. Where multiple organisations need to be involved in a single learning response, the Clinical Governance Team will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required.

The Patient Safety Incident Investigation will be led by the organisation best placed to investigate the concerns and may depend on capability, capacity, or remit. For further details of how we will achieve cross-system engagement and learning see section 15 in DN665 Patient safety incident response Framework (PSIRF).

9. Overseeing continuous improvement through our development of our annual plan

Safety action development and monitoring improvement are key steps in our approach to continuous quality improvement of our care and safety for patients. Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Learning response methods enable collection of information to acquire knowledge. We must move from identifying the learning to implementation of the lessons.

Delivery of these improvement plans will continue to be monitored by the Quality Risk Management Group (QRMG) via their respective specialist subgroup with executive oversight by Quality and Risk Committee to Board.

Further document information

Approval – this is required for all documents. Approval should be by the relevant committee(s)*. State the name(s) of the committee(s) and the full date(s) of the relevant meeting(s): *In exceptional circumstances only, approval can be by Chair's Action or by appropriate ED or NED – state full date of approval	Quality & Risk Management Group (Chair's action): 23.08.23 Management Executive Group 30/08/23
Approval date (*this version*) (Day, month, year):	23/08/23 & 30/08/2023
Approval by Board of Directors or Committee of the Board **(required for Strategies and Policies only):**	Quality and Risk (Q&R) Committee- 31/08/2023 and Trust Board 07/09/2023
Date (Day, month, year):	31/08/2023
This document supports: *standards and legislation – include exact details of any CQC regulations.*	Care Quality Commission (Registration) Regulations 2009 Care Quality Commission (Registration and Membership) (Amendment) Regulations 2012
Key associated documents:	DN665 Patient Safety Incident Response Framework Policy.
Counter Fraud In creating/revising this document, the contributors have considered and minimised any risks which might arise from it of fraud, theft, corruption or other illegal acts, and ensured that the document is robust enough to withstand evidential scrutiny in the event of a criminal investigation. Where appropriate, they have sought advice from the Trust's Local Counter Fraud Specialist (LCFS).	