NHS
East Suffolk and North Essex
NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: January 2023

Estimated refresh date: June 2024

Contents

Introduction

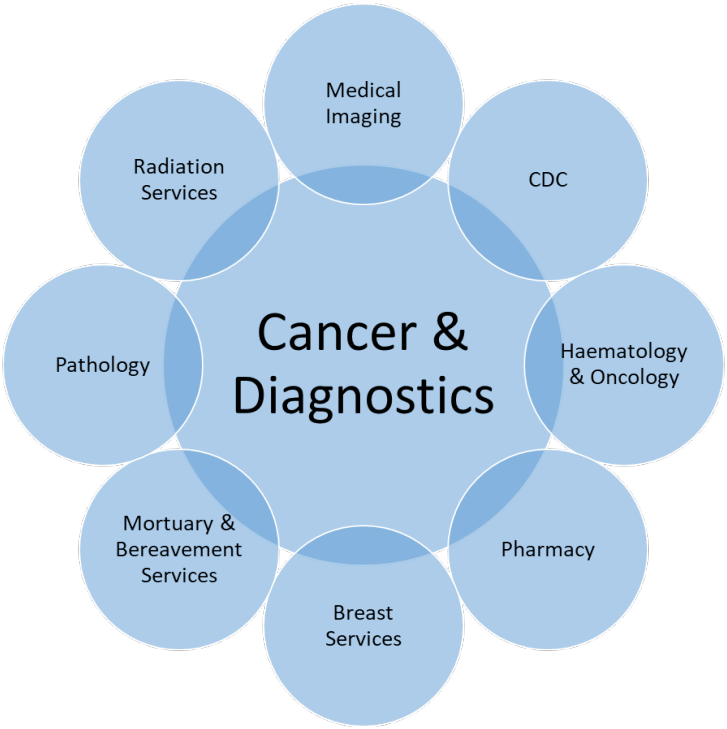
This patient safety incident response plan sets out how East Suffolk & North Essex NHS Foundation Trust (ESNEFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

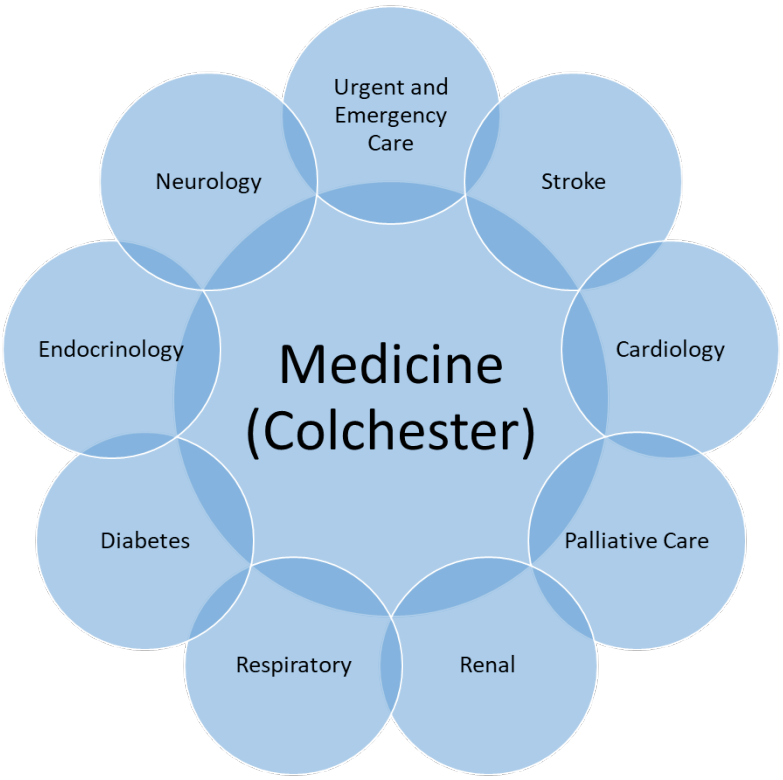
We have committed to improve patient safety through the early adoption of the Patient Safety Incident Response Framework, supporting a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents are rare, ESNEFT prioritises compassionate engagement with patients, family and staff affected by incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen – including the factors which contribute to them.

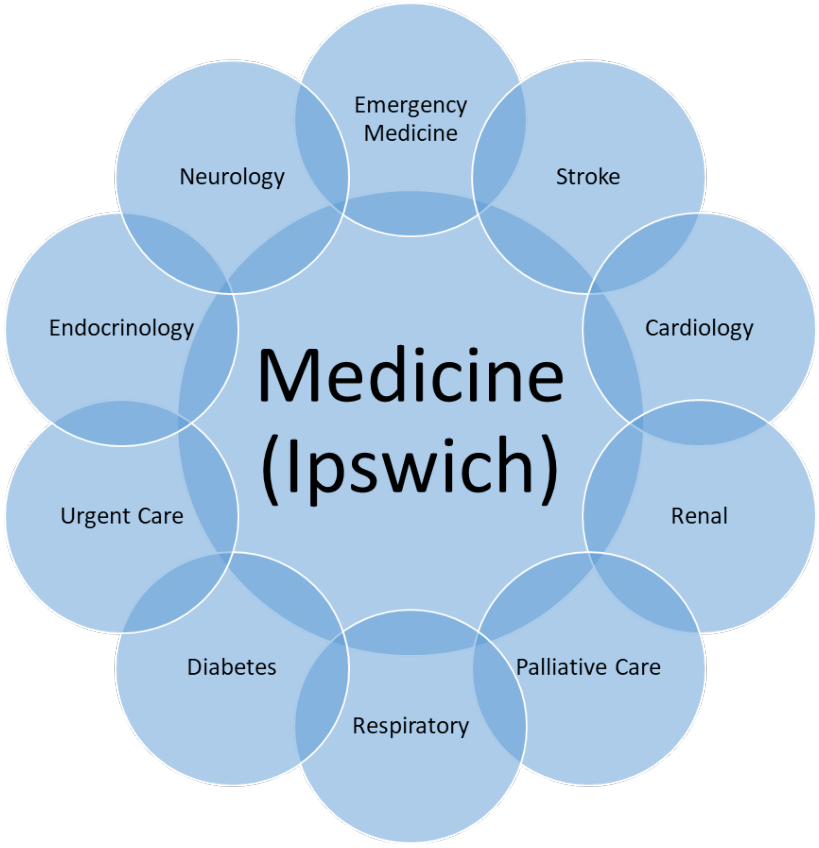
Our services

ESNEFT delivers a wide range of services across our communities and our hospitals and our ambition is to offer the best care and experience.

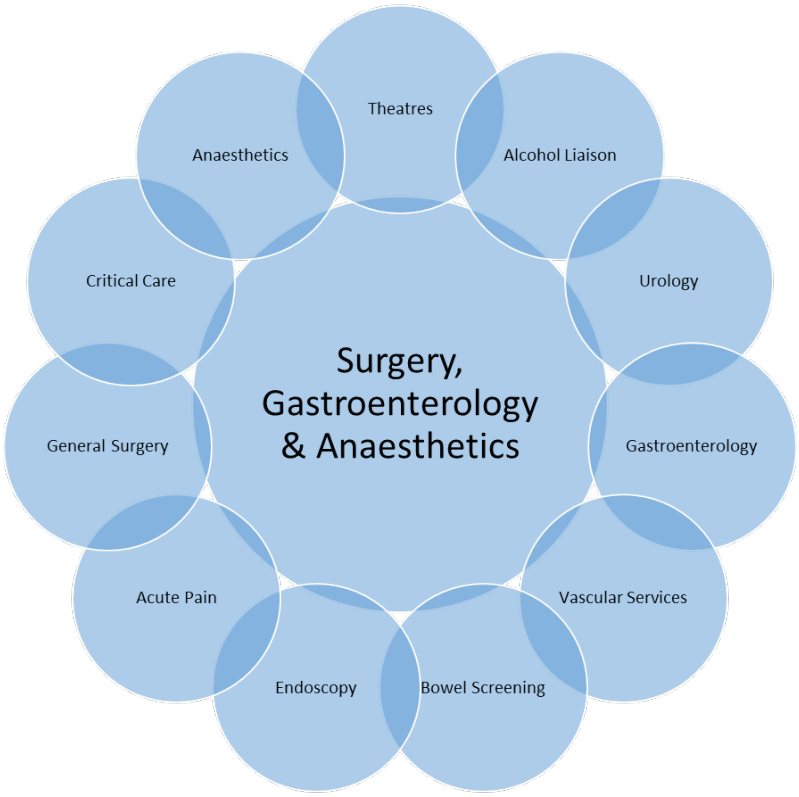


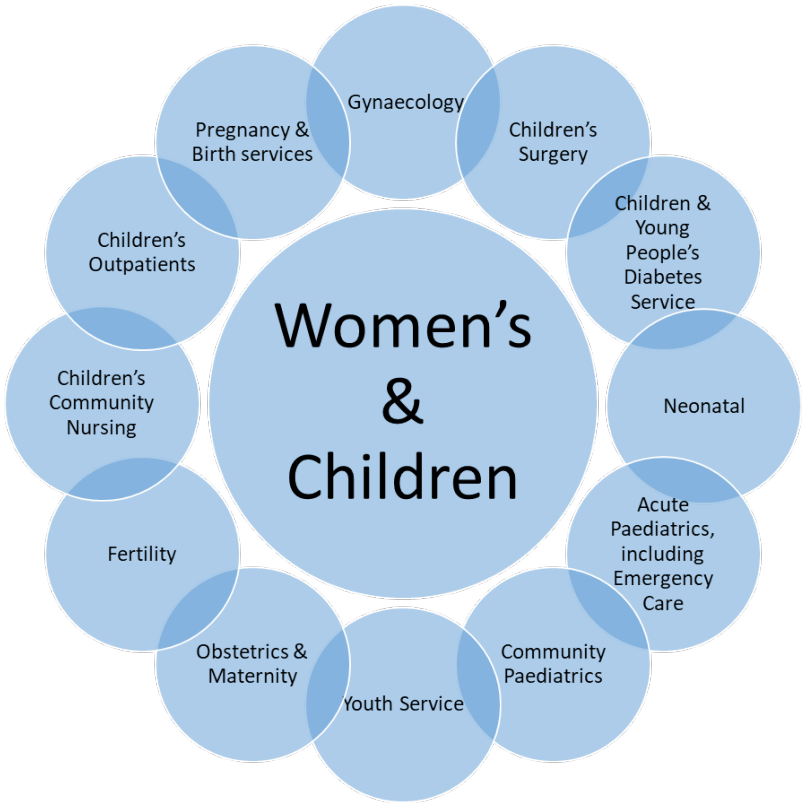

Medicine (Colchester)
Urgent and Emergency Care
Stroke
Cardiology
Palliative Care
Renal
Respiratory
Diabetes
Endocrinology
Neurology

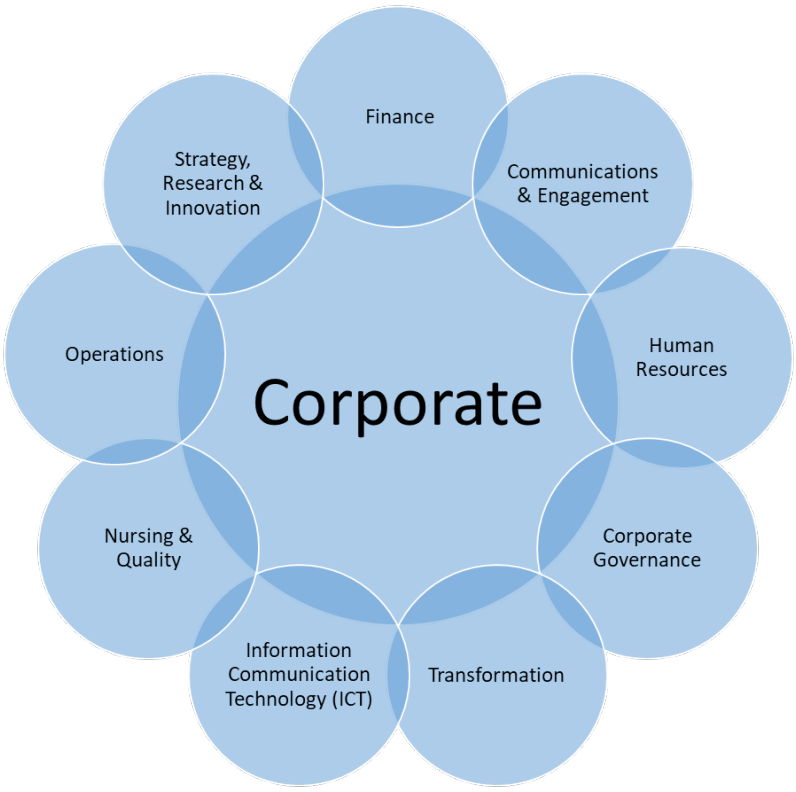

North East Essex Community Services
Community Hospitals, North East Essex
Integrated Therapies
Clacton & Harwich Urgent Treatment Centres
Older people's services
Integrated Urgent Community Response
Community Services, North East Essex
Community Therapies
Community Respiratory
Frailty
Podiatry
Community Cardiology
Community Nursing


Medicine (Ipswich)
Emergency Medicine
Stroke
Cardiology
Renal
Palliative Care
Respiratory
Diabetes
Urgent Care
Endocrinology
Neurology


MSK & Special Surgery
Trauma & Orthopaedics
Audiology
Ophthalmology
Dermatology & Plastic Surgery
Ear, Nose & Throat
Rheumatology
Optometry
Phototherapy
Spinal Surgery
Chronic Pain
Oral & Maxillofacial Surgery
Orthodontics
Orthoptics


Surgery, Gastroenterology & Anaesthetics
Theatres
Alcohol Liaison
Urology
Gastroenterology
Vascular Services
Bowel Screening
Endoscopy
Acute Pain
General Surgery
Critical Care
Anaesthetics


Women's & Children
Gynaecology
Children's Surgery
Children & Young People's Diabetes Service
Neonatal
Acute Paediatrics, including Emergency Care
Community Paediatrics
Youth Service
Obstetrics & Maternity
Fertility
Children's Community Nursing
Children's Outpatients
Pregnancy & Birth services


Finance
Strategy, Research & Innovation
Communications & Engagement
Operations
Corporate
Human Resources
Nursing & Quality
Corporate Governance
Information Communication Technology (ICT)
Transformation

Defining our patient safety incident profile

The patient safety incident risks for this organisation have been profiled using organisational data including:

- Incident Reports: Two years of data has been reviewed and a thematic analysis undertaken. Further deep-dives into specific reporting categories were undertaken, including Obstetric & Maternity Incidents.

- Trust Risk Register: The ESNEFT Risk Register was reviewed, with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes

- Complaints: Complaint themes were reviewed and a thematic analysis undertaken which was triangulated with other data sources.

- Getting it Right First Time (GIRFT) outcomes and recommendations were reviewed and the emerging themes triangulated with other data.

- National & Clinical Audit outcomes and recommendations were reviewed and the themes triangulated with other data.

Defining our patient safety improvement profile

ESNEFT has a comprehensive programme of patient safety improvement across the organisation, as well as an active Quality Improvement programme. The clinical governance framework enables a robust assurance process, providing assurance that improvements are being made, embedded and sustained.

ESNEFT works collaboratively with our colleagues across the Suffolk & North East Essex Integrated Care System to improve patient safety.

The Quality Improvement Programme and Priorities for ESNEFT are:

- Deteriorating Patient
- Interventional Safety
- GIRFT
- End of Life
- Quality Improvement Faculty
- Healthcare Inequalities Programme
- Dementia
- Continence
- Falls prevention
- Nutrition
- Infection Prevention & Control
- Mental Health
- Maternity

These key priorities are discussed and assurance given of progress through the following groups and committees

- Deteriorating Patient Group
- Interventional Procedure Oversight Group
- End of Life Steering Board
- Time Matters Board
- Safeguarding Committee
- Infection Control Committee
- Falls Steering Group
- Nutrition Steering Group
- Mental Health Steering Board
- Every Birth Every Day
- Patient Safety Group
- Clinical Effectiveness Group
- Patient Experience Group
- Quality & Patient Safety Committee
- Discharge Assurance Group
- Medicines Governance Group

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Interventional Procedure Oversight Group
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Learning from Deaths Patient Safety Group
Early neonatal deaths, intrapartum stillbirths and potential severe brain injury in babies born at term following labour Maternal death within 42 days of people while pregnant or within 42 days of the end of pregnancy	Early Learning Report (ELR) & relevant immediate actions Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation	Maternity Governance Groups Patient Safety Group
Incident in Screening Programmes	PSII	Screening Programme Patient Safety Group
Death of a person with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.	PSII LeDeR Review	Safeguarding Committee Learning from Deaths Deteriorating Patient
Child Death	SUDIC	Paediatric Governance Patient Safety Group
Safeguarding Incidents	As recommended by Safeguarding requirements	Safeguarding Committee
Notification of Infectious Disease	PIR	Infection Control Committee

Information Governance	Following national guidelines	

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Readmission within 48hrs of discharge where patient requires level 2 or 3 care on admission and where failures were identified regarding the care leading to/immediately following, discharge	PSII	Discharge Assurance Group
Nutrition & Hydration – incident of significant weight loss or increase in level of care required where the patient is not offered support to eat and drink, food charts have not been documented or monitored and there is documentation that the patient is independently eating and drinking	PSII	Nutrition Steering Group Quality Programme/Quality Priority Programme
Management of Diabetes, patient referred for level 2 or 3 care as a result of failures in monitoring blood glucose levels or incorrect prescription and administration of insulin	PSII	Diabetes Group Medication Safety Group Deteriorating Patient Group
Deterioration of a patient to level 2 or 3 care due to failures in the referral/acceptance of an inpatient between clinical specialties	PSII	Deteriorating Patient Group
Deterioration of a patient to level 2 or 3 care due to the results of a diagnostic test not being acknowledged and acted upon	PSII	Deteriorating Patient Group

Deterioration of patient condition due to prolonged wait whilst on a surveillance programme or waiting list	Duty of Candour Early Learning Report PSR or PSII	QI or group appropriate to theme and improvements identified.
Delays in ambulance off loads resulting in moderate to severe harm or a near miss where there is potential for systems learning following the completion of an Early Learning Report or early discussion	Duty of Candour Early Learning Report PSR AAR PSII	Patient Safety Group ICB Learning Forums
Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning	Duty of Candour Early Learning Report PSR AAR PSII	QI or group appropriate to theme and improvements identified.
Perinatal Care		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
All intrauterine deaths at or after 22+0 weeks	PMRT Proceed to Early Learning Report and discussion at Maternity Incident Review Group PSR or PSII where concerns indicate further investigation is required	Maternity Risk & Governance Patient Safety Group
Stillbirth <37 weeks not associated with congenital abnormality	PMRT Proceed to Early Learning Report and discussion at Maternity Incident Review Group where care concerns identified in PMRT PSR or PSII where concerns indicate further investigation is required	Maternity Risk & Governance Patient Safety Group

Stillbirth >37 weeks not associated with congenital abnormality	PMRT Proceed to Early Learning Report and discussion at Maternity Incident Review Group where care concerns identified in PMRT PSR or PSII where concerns indicate further investigation is required	Maternity Risk & Governance Patient Safety Group
Potential or confirmed severe neonatal brain injury <37+0 weeks gestation, not associated with extreme prematurity or congenital abnormality	PSR or PSII	Maternity Risk & Governance Patient Safety Group
Obstetric patients who deteriorate and require admission to a Critical Care Unit (excluding Maternal death – refer to HSIB).	PSR or PSII	Maternity Risk & Governance Patient Safety Group
Maternity adverse outcomes associated with pregnancy and childbirth (Maternity trigger)	Local review through senior midwife and/or obstetrician Early Learning Report PSR or PSII considered in circumstances requiring further investigation due to risk Local audit programmes Monitoring data/trends/themes	Maternity Risk & Governance Patient Safety Group
Maternal Death outside of HSIB criteria (>42 days & <1 year)	PSR or PSII	Maternity Risk & Governance Patient Safety Group