June
2025

East and North Hertfordshire Teaching NHS Trust

Patient safety incident response plan

East and North Hertfordshire Teaching NHS Trust

Effective date: March 2025

Estimated refresh date: August 2026

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Glossary of terms

Acronym	Meaning
AAR	After action review
AfC	Agenda of Change
DOC	Duty of Candour
DSIRP/DIRM/DISH	Divisional Safety Incident Response Panel /Divisional Incident Response Meeting/Divisional Incident Safety Huddle
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPO	Kaizen Promotion Office
LFPSE	Learning from patient safety event
MDT	Multi-disciplinary Team
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partner
QM	Quality Management
RJLC	Restorative, Just and Learning Culture
PSERP	Patient Safety Event Review Panel
SOP	Standard Operating Procedure
TEL	Technology Enhanced Learning
VMI	Virginia Mason Institute

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Foreword from our Director of Quality

We have transitioned through year one of implementation of the Patient Safety Incident Response Framework (PSIRF). We have:

- Trained over 150 staff in various PSIRF methodologies.
- We have established a Human Factors Faculty and e-learning curriculum.
- Reported over 15,200 safety incidents on ENHance within required national Learning from Patient Safety Event categories.
- Created safety oversight dashboards on ENHance

We have evolved our governance processes in line with new care group operational management structures, and supported ward to board oversight of incidents. Staff have supported the testing new ways of working and positively welcomed PSIRF changes.

Through re-designing the trust Patient Safety Event Review Panel (PSERP) and divisional safety governance structures we have seen sustained increased reporting of an average of 1,600 per month. The processes now include reliable reporting of good care events, with 800 events reported in 2023/24, demonstrating the commitment to adopt 'safety 2 principles' where we learn from when things go well.

As we embark on our second year of PSIRF we are proud that our plans continue to adhere to Patient safety Principles by:

- Engaging and co-designing our safety priorities for 2025/26
- Continue to embed our safety culture and promote reporting of safety incidents and driving improvements.
- Include and respect the voice of staff and service users
- Continue to design and deliver more bespoke safety oversight dashboards at service level
- Developing our ENHT accredited human factors curriculum.

Margaret Mary Devaney
Director of Quality

Margaret Mary Devaney
RCN, Director of Quality

1. Introduction

Our patient safety incident response plan sets out how East and North Hertfordshire NHS Trust intends to continue to respond to patient safety incidents over the next period of 12 to 18 months. Through learning and improvement from year one of transition to the PSIRF, we have re-reviewed our safety profile and agreed safety priorities for 2025/26. The plan will also remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

1. Compassionate engagement and involvement of those affected by patient safety
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4.Supportive oversight focused on strengthening response system functioning and improvement. occurring nationally through some early adopter sites, but some local changes have also been happening here that lend us to

The national framework sets no rules or thresholds to determine what method of learning response should be used, apart from those priorities nationally mandated patient safety incident Investigation (PSII), to support learning and improvement. Instead, organisations are now able to balance attention between learning through responding to incidents and exploring issues and improvement work. We will apply the criteria of where we will gain maximum learning when choosing a focus for investigations and other response tools

We continue to transition to this new way of working through building more capability and capacity to adopt multidisciplinary learning responses, including After Action Reviews (AARs) hot debriefs, SWARMs and round table forums.

This PSIRF plan has been produced following interrogation of information across ENHT services, collating patients' and family experience and asking staff what response they need when an error occurs. Our Patient Safety Partner has been involved in the production of our plan. We intend to continue wider stakeholder engagement with ICB and system colleagues, HM Coroner and local authority colleagues.

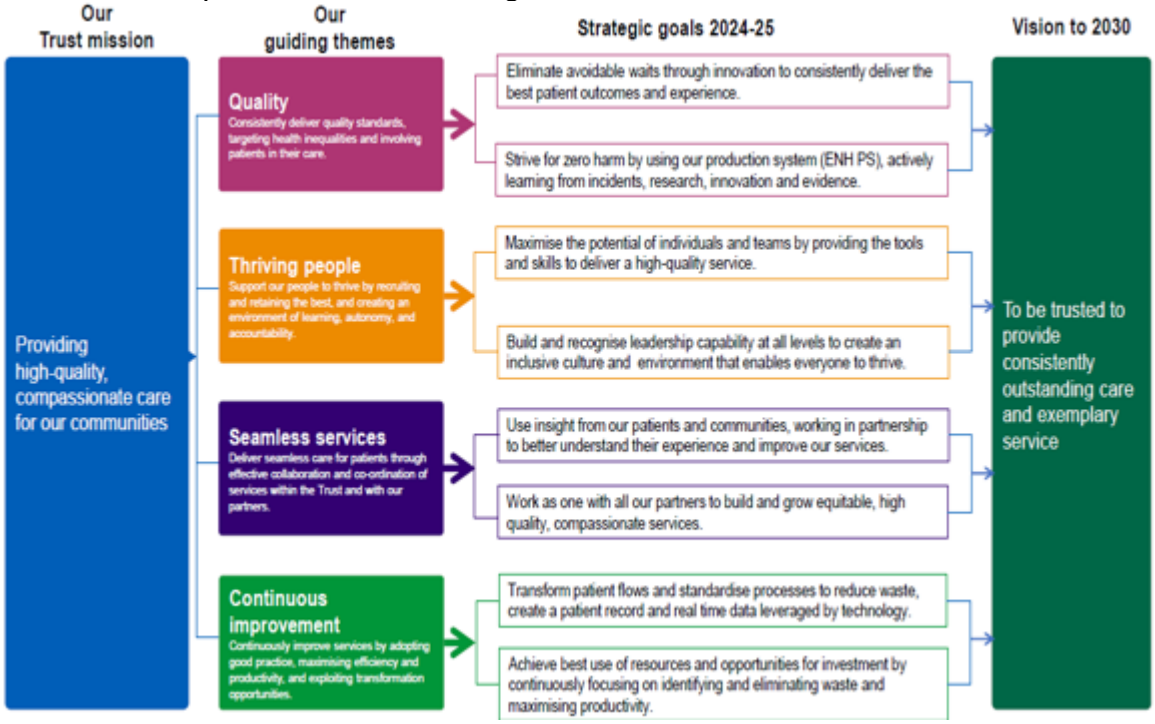
2.0 Purpose and Scope

2.1 Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how East and North Hertfordshire NHS Trust will seek to learn and improve from patient safety incidents reported by staff and patients, their families and carers, as part of our work to provide high quality, compassionate care for our community.

This plan will help us consistently deliver quality standards that aim to reduce health inequalities through active adoption of research, evidence based innovations. It will support our staff to build leadership capabilities in responding to incidents through a system thinking mindset and human factors approach. The plan will be delivered through insight form staff, patient and families in partnership to understand lived experience and improve our services through rigorous identification of interconnected factors where adoption of improvement science can be applied to prevent, or continuously reduce, repeat patient safety risks and incidents.

Trust mission, priorities, vision, and goals for 2024-25



2.2 Scope

A PSIRP is a requirement of each healthcare provider delivering NHS funded care. This document should be read alongside the introductory Patient Safety Incident Response Framework (NHSE PSIRF, 2022), which sets out the requirement for this plan to be developed. We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation's local commissioner Herts and West Essex integrated Care Board (HWE ICB). The aim of this approach is to continually improve services by adopting good practice, maximising efficiency and productively, and exploiting transformation opportunities.

3.0 Our services

3.1 About the Trust

East and North Hertfordshire NHS Trust was created in April 2000, following the merger of two former NHS Trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and tertiary care services from four hospitals, namely: the Lister in Stevenage; the New Queen Elizabeth Hospital II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, within the London Borough of Hillingdon.

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, which was commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened fully from June 2015 and provides outpatient, diagnostic and antenatal services, along with an urgent care centre. Hertford County also provides outpatient and diagnostic services. The Mount Vernon cancer centre provides tertiary cancer services including radiotherapy, chemotherapy and immunology services.

The Trust owns the freehold for each of the Lister and Hertford County; the New QEII is operated on behalf of the NHS by Community Health Partnerships and the Mount Vernon Cancer centre operates out of facilities owned by the Hillingdon Hospitals NHS Foundation Trust.

The area served by the Trust for acute hospital care covers a population of just over 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some three million people from across Hertfordshire, Bedfordshire, Luton, north-west London and parts of the Thames Valley. The Trust's main catchment is a mixture of urban and rural areas that are in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City. From early 2020 to mid-2021, the Trust saw a consistent reduction in mortality, with rates that were consistently lower than our national peers. There followed a gradual upward trend until early 2023, followed by a strong downturn. While both these trends have been mirrored nationally, the Trust has consistently remained well positioned compared to our national peers.

The birth rate is slightly lower than the England average, with the Trust's core catchment population forecast to rise by approximately 6% in the years to 2030; the most significant growth is expected in people aged 65 and over (25%) with this age group also more likely to have the greatest impact in terms of health needs. Black and minority ethnic groups (i.e. non-white British) make up approximately 10% of the population in east and north

Hertfordshire. In addition, it is expected that just under 17,000 new houses are planned to be built in the Trust's core catchment area by 2030.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 6,937 staff are employed by the Trust. The Trust's annual turnover is approximately £ 658.58million.

3.2 Organisational Structure

The Trust has a clinical operational structure of four Divisions consisting of Planned Care; Unplanned Care; Women's and Children; and Cancer. Prior to this the Trust had two operational Divisions: Planned Care, and Unplanned Care.

Supporting the clinical divisions are corporate teams covering areas including finance and planning, digital; medical practice, education and research; nursing practice; strategy; estates and facilities; transformation, and workforce and organisational development.

4.0 Safety principles

The Patient Safety Principles act as a guide for leaders at all levels on how to design and deliver safe care.

4.1 Safety Culture

We undertook a review of our safety culture, involving a wide range of multi-disciplinary staff (including People Team colleagues, clinical leaders, and Freedom to Speak Up Guardian) to:

- Interview staff involved in various incident and HR investigations to understand their experiences to inform improvements and culture change where required – the findings were that experience was variable, with some staff feeling well supported, whereas others experienced difficulty with initial response from line managers or other senior colleagues. Recommendations included:

- Staff to be given written guidance on what to expect at each step, what is expected of the individual, anticipated timeframe and how to get support, along with providing guidance on writing a statement.
- Consider investigator having direct face to face conversations with clinicians involved and ensuring they are involved in approval of report.
- Introduction of "incident support partners" for staff in all clinical areas to access peer support. This can be introduced as part of the project work about to start related to the Royal College of Surgeons support collaborative.
- Introduce "one minute bite size learning" at every clinical handover.
- Use the findings from our staff survey metrics based on specific patient and staff safety questions to assess if we are progressing in improving our safety culture, as

well as using regular specifically designed patient safety culture questionnaires – this is an area we will be focusing on in 2025 to inform areas for improvement.

- As PSIRF was introduced, ensuring that the following key elements were incorporated:

  - Leadership development through a “healthy teams approach”
  - Teamwork
  - Communication
  - Restorative and Just Learning Culture (RJLC)
  - Psychological Safety
  - Promoting inclusion and diversity
  - Staff well-being
  - Civility and kindness initiative
  - Encouraging “speaking up”
  - Focus on how learning Is shared

- Review and revise HR policies to ensure they do not undermine just culture through sanctions or suspensions, and they reflect a restorative and just culture approach, this work is ongoing.

The Trust recognises the importance of Freedom to Speak Up and that it is crucial to encourage a positive culture where people feel they can speak up without fear and their voices will be heard, and result in meaningful actions. The Speaking Up policy ensures that all our staff (including permanent employees, agency staff, students, contractors and volunteers) have a voice that counts. It enables staff to feel safe and confident to speak up through a variety of methods. It advocates that at ENHT the time is taken to really listen to understand the hopes and fears that lie behind the words. It supports us to build a culture and behaviours that is responsive to feedback from workers.

Training and development for PSIRF

Through the Trust Training Needs Analysis Human factors and other training have been proactively provided and imbedded into oversight monitoring. Priorities for 2025/26 identified include:

- Skills to support a suite of learning responses that will inform improvement efforts e.g. facilitated debriefs (after action reviews), SWARMs, walk through, talk through, and other learning response skills.
- Access to and early adoption of the trust quality improvement methodology curriculum provided via Kaizen Promotion Office
- Access to Safety Engineering System Engineering Imitative for Patient Safety (SEIPS) resources and curriculum.
- Coaching support through patient safety improvement responses
- Support the development and deployment of Patient Safety Partners

PSIRF training requirements at ENHT

Training	Summary and audience	Duration	Provider & Expected Staff Numbers
Essentials of patient safety for all staff	Level 1: All staff (priority those in engagement, learning response and oversight roles)	30-60mins	eLearning for health (ENH Academy) 6000+
Essentials of patient safety	Level 1b: Essentials of patient safety for Non-Executive Directors	30-60mins	eLearning for health (ENH Academy)
Essentials of patient safety L2	Level 2: Access to Practice (Learning Response Leads) There are two sessions. The first introduces *systems thinking,* the second session looks at *human factors* (the science of work and of working together in safely designed systems) and *safety culture* (the significance of a true learning culture, free of inappropriate blame)	30-60mins	eLearning for health (ENH Academy) All medical staff and AfC staff band 5 and above
Systems approach to learning from patient safety incidents	*(Required for learning response leads)*	2 days	Initially external provider & review in-house capacity and capability to deliver going forward
Oversight of learning from patient safety incidents oversight	*(Required for those in oversight roles)*	1 day	Initially external provider & review in-house capacity and capability to deliver going forward
Patient and staff involvement in learning from patient safety incidents	*(Required for engagement leads and learning response leads)*	1 day	Initially external provider & review in-house capacity and capability to deliver going forward

Training delivered since adoption of PSIRF

Training	Delivered by	Dates	Number of staff attended	Future training for 2025
Systems approach to learning from patient safety incidents	External training provider	April-July 2023	33	10 places 2025
Patient and staff involvement in learning from patient safety incidents	External training provider	April-July 2023	19	10 places 2025
Oversight of learning from patient safety incidents oversight	External training provider	April-July 2023	15	45 places in Jan/Feb 25
AAR training	External training provider	May and July 2024	28	Potential action learning sets for trained AAR conductors in 25/26
Facilitation Skills (Round tables)	In house	September 2023 and March 2024	37	
Safety Action Development workshop	In house	January 2024	15	15 places in Feb 25
Essentials of Patient safety levels 3 & 4	NHS England	Throughout 2024	3 x Patient Safety Specialists	

4.2 Put patients at the heart of everything

At ENHT we want to engage with our patients in new ways that enhance the quality of care and improve the patient experience. We have successfully involved patients with our Continuous Quality Improvement co-design programmes, and we have recruited our first Patient Safety Partner (PSP). The PSP is committed to co-designing how we continue to work with patients, their families and carers, and staff to identify what patients need and want. This will help us to understand the role that patients can play in their own safety, and the different mechanisms that could work to help them be informed and safe.

Alongside work on safety and prevention, we will be actively promoting and encouraging the Duty of Candour. At the same time, we will be working to create a more informed process for patients and families around incidents and future learning reviews.
Through the transition of PSIRF in 2024/25 we committed to design and improve processes that enable early, more meaningful engagement processes for patient and families to contribute to al learning responses.

4.3 Treat people equitably Involvement of patients, families and carers following incidents

We continue to incorporate the views of all through involvement of staff, patient and health partners through respect, equity, and dignity. We continue to proactively seek and capture meaningful feedback from patients, workers, and communities, acknowledging that those from disadvantaged groups may need specific support and encouragement to contribute.
We have acted on feedback through the first year of PSIRF through voices at board, renal LAKPA advocates, staff and patients involved in safety incidents. In the ambition to improve involvement with vulnerable adults and children, priorities reflect adults who lack capacity and children and young people within our neurodiversity pathways.
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 improvements to the services we provide.
The patient voice is very much an integral part of our work at ENHT and as part of our policy framework, with involvement from our Patient Safety Partner, we continue to develop procedures and guidance to support staff in how to discuss incidents and involve patients and families and support for staff following incidents.
We are on a journey at ENHT 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
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 wellbeing support for staff which is explicit in our Equality and Diversity Policy.

4.4 Identify and act on inequalities

The health needs of the population are changing. People are living longer, but with poorer health and multiple long-term conditions. Many long-term conditions are preventable and linked to health behaviours such as diet/exercise, smoking and alcohol use.
This in turn is influenced by socio-economic factors such as education, income and family/social support. These wider determinants of health can influence health outcomes more than the clinical care a person receives
We predominantly treat patients from across Hertfordshire and the surrounding counties, however, the greatest proportion of patients come from the "core catchment area"; this is the area where individuals reside that are most likely to access our general acute services such as the emergency department, diagnostic tests, or support for long term conditions
Health inequalities are reflected in PSIRF priorities by assessing risks within incidents that occur for areas of inequality. We know inequalities exist within vulnerable adults and children on waiting lists or transition between services.
Staff engagement of BAME workforce is a priority to reduce barriers to psychological safety, as we know BAME staff feel less conformable to speak up when they have

concerns. Through PSIRF processes healthcare design and delivery shall scope more insights to inequalities present to drive improvements in patient safety.

4.5 Identify and mitigate risks

The trust delvers a a targeted and coordinated direction towards patient safety risks. Patients, workers, and communities are encouraged and empowered to proactively identify and speak up about risks, hazards, and potential improvements. Through the structure governance structures of Risk Management Group clinical risks are triangulated and mapped against corporate risks and board assurance framework risks.

4.6 Be transparent and accountable

The oversight and application of duty of candour remains a trust priority, with triangulation of FTSU themes and staff feedback continue to strive to promote honest, respectful, and open dialogue. Through safety oversight structures such as Patient Safety Event Panels, areas are identified for continuous improvement, learning from both good care events and safety incidents, and ensures that patients, workers, and systems partners can safely challenge to support the learning. Alongside work on safety and prevention, we will be actively promoting and encouraging the Duty of Candour application. At the same time, we will be working to create a more informed process for patients and families around incidents and future learning reviews.

4.7 Use information and data to drive improved care and outcomes

The trust is committed to digital transformation and one health record system, to ensure that good quality data is collected and meets the needs of all patients.

Staff are supported to use and share information and triangulated data through platforms such as Power BI and Quality Oversight platform (Enhance) to drive improved care and outcomes for patients, in accordance with the Caldicott Principles. Learning from good or positive care will be reported on the Trust's Quality Management System, ENHance as a 'good care' event in line with LFPSE reporting. Themes will be reviewed through operational and corporate oversight structures to ensure that where appropriate, the relevant learning responses are undertaken and the findings shared across teams in order to maximise learning and improvement.

Information from the Quality Management system will continue to be analysed to understand themes and trends across the system and this will be incorporated into the regular incident and compliance reporting.

5.0 Reviewing our patient safety risk profile

5.1 Structure

Oversight and learning from patient safety incidents has continuously developed our understanding and insights into patient safety matters over a period of years. We strive to achieve reliable ward to board oversight of incidents and risks reported, through daily incident huddles at service level, executive oversight through cross hospital learning reviews panels and board oversight of PSii's and other learning responses.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements. To continue fully implementing the Framework the Trust has completed a review of what types of patient safety incident occur and triangulates across wider quality and operational data to understand what needs to be learned from to improve.

5.2 Stakeholder engagement

Both internal and external stakeholders have been engaged to build our patient safety profile from data sources from many sources. This process has also involved identification

and specification of the methods used to maximise learning and improvement. This has led to the revision of the local focus for our incident responses listed on pg 29.
The corporate Patient Safety Team commenced planning for the review of the PSIRF plan during September and October 2024, almost 12 months after 'going live' with the transition to the PSIRF.
An initial series of engagement meetings were held during October and November 2024 with key stakeholders from various disciplines to review last year's safety priorities (as outlined in our 2024/25 inaugural 'plan') to begin to explore the improvements made from learning responses throughout the year and where our focus should be for the forthcoming year.
Our data sources and how they were used to define our safety profile is detailed below. Once the data was collated, we have carried out a series of workshops with our key internal and external stakeholders to review this together to finalise our local focus and priorities for review by PSII.

5.3 Data sources

A wide variety of stakeholders were engaged in analysing the data and reviewing the patient safety priorities for 2025. This group included teams involved in incident investigation, claims, complaints, and risk, mortality surveillance, pharmacy, safeguarding, health safety and security, harm free care leads, resuscitation lead and our patient safety partner .
To define our patient safety response profile, we drew data from a variety of sources. We looked at the data from the preceding year as we had already looked at three years' worth of data for our inaugural plan.
We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process. Data and information (both qualitative and quantitative) have therefore been received from the following sources

Safety events (incidents & good care) learning responses	Prevalence of categories reported, thematic analysis and look back 12 months
Complaints & PALs themes	Complaint themes were reviewed, and a thematic analysis undertaken which was triangulated with other data sources
Freedom to Speak Up themes	Look back to key safety related themes and triangulated with wider data.
Mortality reviews and Structured Judgement Reviews	Themes and categories of lessons learnt, and outcomes triangulated with other data.
Claims & inquests	Themes and prevalence of claims, inquest outcomes and triangulated with other data.
Trust risk profile	Corporate risk register and high emerging risks analysed and triangulated.
CQC intelligence	Recent inspection reports and action plans
Staff Experience	2 Years of staff surveys and a safety culture audit undertaken have been considered

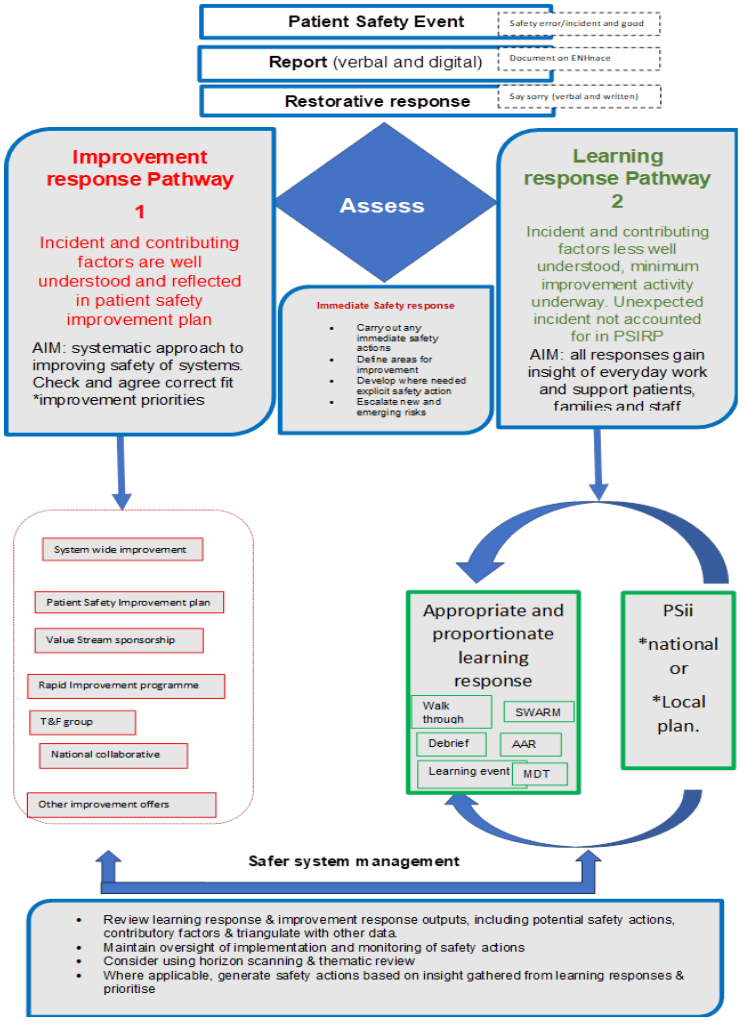
5.4 Themes highlighted by the data

From our staff safety survey, there has been some improvement in learning from incidents and staff not feeling blamed, since a similar survey last year, but measuring improvement in our patient safety culture objectively is challenging. We recommend that “patient safety culture” is not a “stand alone” priority, but is incorporated into each future priority. Staff survey results will be used in future to identify any themes related to our patient safety culture, therefore we will be integrating ‘improving communication, civility and safety culture’ through all our learning and improvement responses.	
Escalation of the acutely unwell/deteriorating patient.	The data (cardiac arrest prevention and Structured Judgement Reviews SJRs) and lived experiences over the past year suggested that whilst improvements have been made, there is still an area for learning and improvement on the ‘escalation of deteriorating patients’. Therefore we will focus our attention on these specific safety events for the next 12-18 months, whilst we embed initiatives such as ‘Call For Concern’ and Martha’s Rule pilot.
Fundamentals of care with vulnerable adults	Whilst we have seen some reductions in reported incidents of verbal aggression, we have noted an increase in reported incidents of physical aggression, particularly in patients who lack capacity. Ensuring the fundamentals of care for our vulnerable patients is essential in preventing harm through omissions or neglect. We will focus on reducing variability for our vulnerable adults, improving the delivery of care (including safer discharges, high quality Mental Capacity Assessments and effective communication tailored to individual needs).
Reducing patient safety risks from long waiting times from admission to discharge	Safety concerns remain in these two distinct areas, therefore we will create 3 safety priorities; • Reducing safety risks for patients on waiting lists and • Reducing risks related to patient flow, including admission to discharge (ED pathways, in patient pathways and discharge processes) • Children and young people awaiting access to neurodiverse pathways

6.0 Defining our patient safety improvement profile

On occasions, an incident type may already be well understood. For example, a previous similar incident may already have been investigated with improvement plans to address the causes implemented along with effective monitoring. In this scenario, resources may be better directed at improvement rather than repeating an investigation that will yield the same outcome.

Incident management and decision-making flow chart



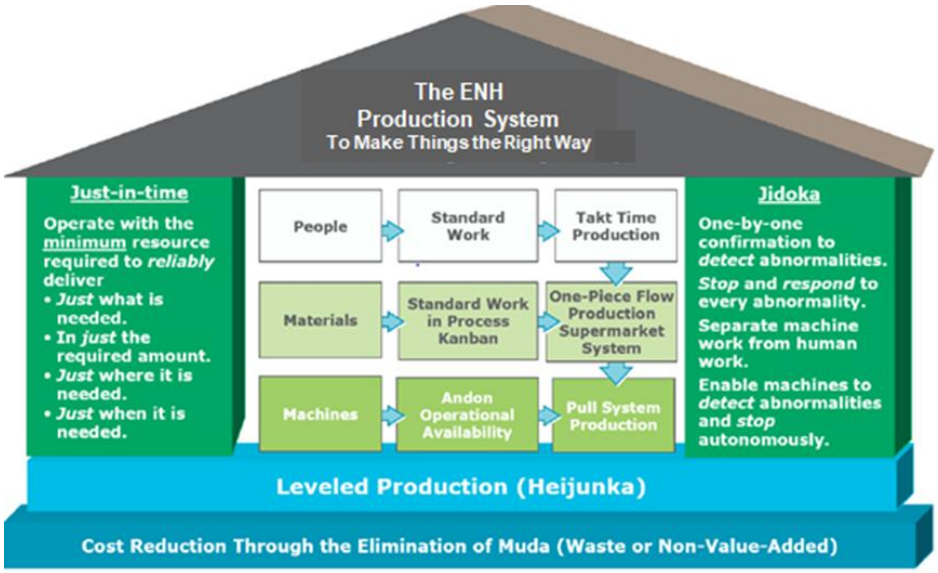
6.1 ENHT approach to improvement

We have adopted the Virginia Mason Production System. The 'house' (see below) is a visual representation of the improvement method which captures over twenty years of experimentation and learning as part of their journey. It is a lean management methodology based on the principles of the Toyota Production System which has since been successfully transferred and adopted into healthcare systems across the world. A fundamental concept of the method is that improvement is led by those that do the work, where the work is done. This requires a different approach to traditional 'superhero' leadership styles, as leaders instead coach their teams through problem framing, building the team's capability to make improvements for themselves.

Lean in healthcare is about creating value and reducing burdens that patients and staff experience every day. So rather than focusing on saving money, lean organisations focus on sustaining high levels of quality, safety, satisfaction and morale. They do this by aligning the entire workforce around a consistent improvement method and use that approach to promote, test and implement process improvements on an ongoing basis. This approach provides a unified way of thinking and acting through a set of philosophies and practices that have been tested for over fifty years. It is built on an underlying philosophy that embraces:

- Patient First
- Focus on Highest Quality and Safety

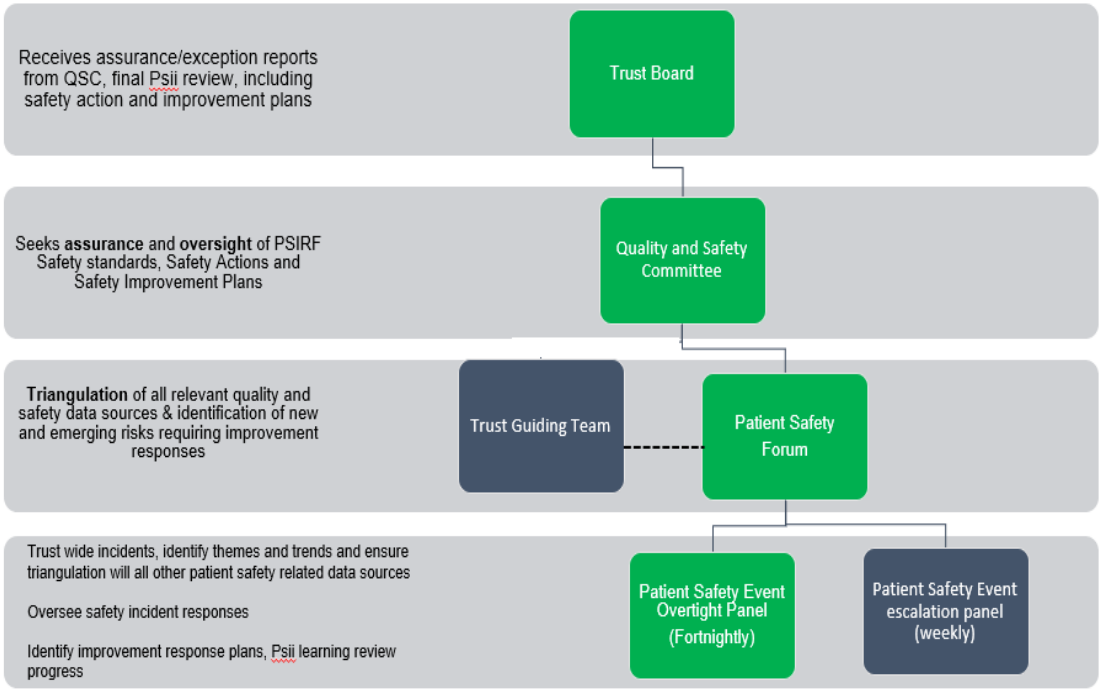
- Respect for People
- Engage all Employees
- Strive for Highest Satisfaction



The ENHPS House

6.2 Our Safety Improvement response development and monitoring

The Patient Safety Forum and Patient Safety Oversight Panel both provide oversight opportunities where improvement responses can be deployed. The Patient Safety Forum tracks deployment of learning responses and progress of patient safety improvement responses, the patient safety oversight panel seeks operational assurance across the appropriate, proportionate responses to incidents, including improvement responses. The trust single method of improvement (ENHPS) enables safety improvement responses to be adopted locally, and where wider improvement responses are required **t**he Trust Guiding Team (TGT) will commission and oversee the delivery of continuous improvement responses and the rigor of application of improvement science.



Improvement responses commissioned by TGT may include Rapid Process Improvement Workshops and Kaizen Events where Kaizen Promotion Office facilitate workshops focusing on a particular process in which the people who do the work are bought together in an intensive improvement event to improve that specific process or a specific area. These approaches empower and engage staff to improve their processes and services and include training so teams can generate their own ideas and co-design potential solutions using PDSA tests of change to inform a 30-, 60- and 90-day implementation plan. As part of standard work, the RPIW process will always involve patient and carer involvement and co-production

7.0 Our patient safety incident response plan: national requirements

The aim is to achieve a systematic learning and improvement approach and less of a ‘cause and effect’ approach, through recognising that multiple interactions and contributory factors exist across a ‘whole system’.

7.1 Methodology

Learning shall be achieved through understanding what interdependencies exists across different factors rather than a single factor. Research has demonstrated that the learning should scope SEIPS key factors i.e. person (s), tasks, tools and technology, internal environment, organisation and external environment. When these areas are considered together they will support insight to all elements of our ‘systems’.

Some events in healthcare require a specific type of response as set out in policies or regulations. These responses may include mandatory Patient Safety Incident Investigation (PSII), review by or referral to another body or team, depending on the nature of the event.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 10 PSII reviews over 12/18months where national requirements have been met.

National mandated criteria (NHSE)

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the safety improvement plan
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	Create local organisational actions and feed these into the safety improvement plan
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)	PSII	Create local organisational actions and feed these into the safety improvement plan
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	Respond to recommendations as required and feed actions into the safety improvement plan
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and feed actions into the safety improvement plan
Maternity and neonatal incidents meeting Healthcare	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations as

Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	for independent patient safety incident investigation	required and feed actions into the safety improvement plan
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and feed actions into the safety improvement plan
Safeguarding incidents in which: • babies, children, or 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 from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Respond to recommendations as required and feed actions into the safety improvement plan
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody 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 organisations must fully support these	Respond to recommendations as required and feed actions into the safety improvement plan

	investigations where required to do so	
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	Respond to recommendations as required and feed actions into the safety improvement plan

7.2 Expected demand.

Reviewing data for 2022/25 and making projections for 25/26 based on data as of Nov 2024, highlighted that incident reported increased from an average of 1200 per month to 14000 per month, and under PSIRF, PSii 13 year to be commissioned. However, the amount of work involved in each investigation has been found to be to be more involved and time consuming in year 1 (2023/24). Several learning responses have been commissioned in line with our risk informed response plan in 2023/24. As this increase reporting trend continues, we predict that the overall workload in 2025/26 will increase and provide more opportunity to drive continuous improvements.

7.3 Learning Response model

In 2024/25 the transition to PSIRF has evolved to Patient Safety leaders and Governance teams developing a sustainable learning response model.

Daily oversight of incidents is now undertaken at service and division level by governance teams, operational and clinical leaders.

When a PSii is commissioned a learning response team is formed. Clinical Leads are identified, and a safety learning response lead is deployed alongside a nominated patient safety specialist. Utilising this model has demonstrated expert support and seniority influence for PSII learning responses and blends the adoption of human factors tools with improvement science and knowledge from subject matter experts.

Corporate patient safety learning response leads adopt matrix working with nominated care groups, and partner with triumvirate clinical and operational leads to apply appropriate and proportionate learning responses. This supports continuance of good quality learning responses are being undertaken and utilise expertise in learning response management.

7.4 Responding to cross-system incidents/issues.

The Trust will work with other NHS Trusts, relevant system care providers and stakeholders and ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.
Where it is recognised that an incident requires a cross-system learning response, it will be escalated to the Trust Safety Oversight Panel (Patient Safety Event Review Panel) from the Divisional Safety Oversight Panel (Currently Quality and Safety/Governance groups) and/or escalations from external sources to the Trust.
The Trust will proactively seek out learning opportunities e.g. with other providers, GPs, the local authority, Police and Ambulance Service. Further detail is included in our policy.

7.5 Learning Responses from Good Care

Learning from good or positive care will be reported on the Trust's Quality Management System, ENHance as a 'good care' event in line with LFPSE reporting. These will be reviewed through Divisional Oversight Meetings to ensure that where appropriate, the relevant learning responses are undertaken and the findings shared across teams in order to maximise learning.

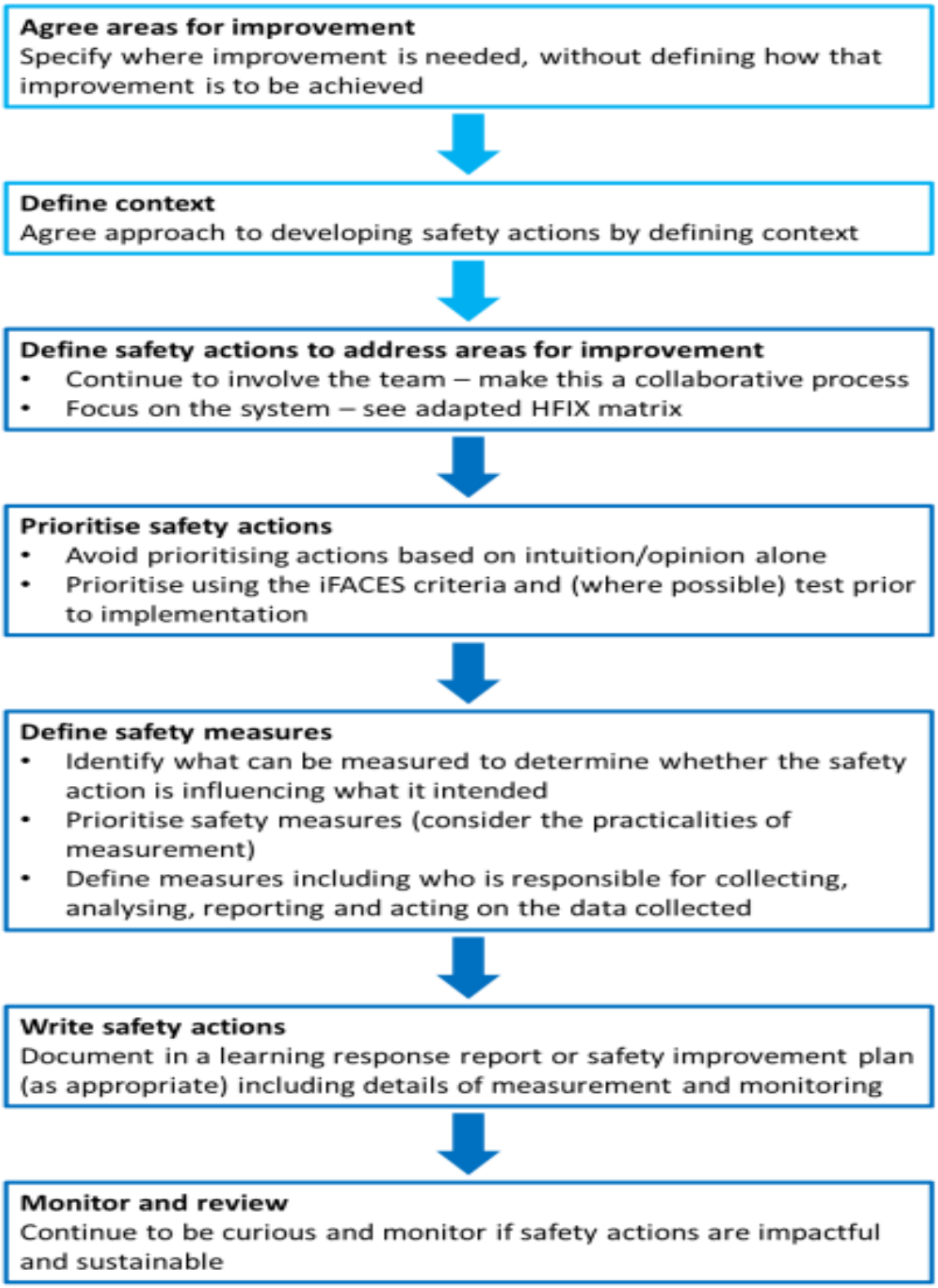
Information from the Quality Management system will be analysed to understand themes and trends across the trust and this will be incorporated into the regular incident and compliance reporting.

7.6 Our patient safety action development

An integrated approach shall be designed within ENHT quality management system, and this will be reviewed formally every 6 months.

Where rapid safety action is needed to respond to imminent risk e.g. removing broken/faulty equipment, this will be undertaken as soon as able. Identified safety actions should be completed as soon as practicable and will be captured as part of one of our specific incident responses. Developing safety actions that respond to underlying system issues starts with identifying and understanding aspects of the work system that need to change to reduce risk and potential for harm (i.e., areas for improvement or system issues). Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement.

Overview of safety action development process



7.7 Our Patient Safety Improvement plans

Governance structures have evolved during 2024/25 across the Trust newly introduced operational management model. Future 2025/26 governance processes will oversee PSIRP improvement priorities will be overseen through the Patient Safety Forum and Patient Safety Event Review Panel.

Safety Improvement Plans (SIPs) will be managed locally with assurance and reporting through divisional operational management and corporate governance structures to provide assurance.

When targeted Kaizen Promotion Office support has been commissioned, progress updates shall be provided via the Trust Guiding Team.

- Where learning responses undertaken in relation to single incidents collectively demonstrate sufficient understanding of the underlying, interlinked system issues then continuous improvement will be more beneficial e.g. a cluster of incidents in one area related to common causes that requires improving e.g. communication at huddles, handover.
- Safety improvement plans can be designed to bring together findings from various responses to patient safety incidents and issues.
- Safety improvement plans may be structured through different methods, appropriate doe scale of problem.
- Organisation-wide safety improvement plans shall be delivered through collaborative partnership working e.g. falls improvement, VTE, tissue viability, nutrition and hydration.
- Individual safety improvement plans can be designed for a specific service, pathway, or location e.g. ward X improvement in hand hygiene compliance
- Creating a safety improvement plan to tackle broad areas for improvement (i.e., overarching system issues) e.g. discharge pathways, medication safety

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses.

The decision to do so must be based on knowledge gained through the learning response process and other relevant data, with consensus from relevant stakeholders and relevant governance structure that an improvement response is required.

7.8 Time frame for learning responses

Learning responses will balance the need for timeliness and capture of information as close to the event as possible and will start as soon as possible after an incident is identified with thoroughness and a sufficient level of investigation with adoption of SEIPS framework to identify contributory factors and associated learning for improvement. Responsiveness of a learning response will be balanced with being thorough, in collaboration with relevant stakeholders and support accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team.
While prescriptive timeframes for learning responses are not highly mandated nationally, time frames are set locally to support compassionate engagement where needed and timely management of risk identified.
ENHT Learning response operational standard:

Incident stage	Timeframe	Evidence
Incident reporting	As soon as possible to incident occurring, within 24hrs	Reported LFPSE
Initial Learning review e.g. debrief, SWARM	Within 24-72 hrs of reporting,	Daily incident oversight panel
Further learning response AAR, Debrief, MDT	20 working days (6 weeks) of reporting	Published report via governance oversight forum
PSii i.e. mandated or local priority	Within 88 working days (20 weeks) No more than 6 months	Published PSii
In exceptional circumstances a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).		

In exceptional circumstances a longer timeframe may be needed to respond to an incident in full. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).

8.0 Our patient safety incident response plan: local focus 2025/26

ENHT shall continue to explore patient safety incidents relevant to the population we serve rather than exploring only those that meet a certain nationally defined threshold.
8.1 Decision making criteria for Learning Responses are:

PSII Response	Learning Response (AAR, SWARM, Debrief, MDT review)	Local incident safety action management and local safety improvement processes

• Meets national requirements or PSIRP local priority for PSII. • Trained PSII lead to complete, commissioned via PESERP. SEIPS methodology used (national template). • Full involvement of patient, family, carer. • Informs new and ongoing safety actions and improvement plans. Consider • Moderate/severe harm incidents where initial review does not confirm contributory factors are fully understood or linked to robust safety improvement programme.	• Incidents where contributory factors not fully understood. • Limited improvement activity. • Concerns raised by patient, family etc. • Areas of increased reporting / risk. • Lead appointed by division, support as required form corporate services (or other divisions) • SEIPS methodology used via appropriate template. • Full involvement of patient, family, carer. • Informs new and ongoing safety actions and improvement plans.	• No harm / low harm incidents not identified as local priority in PSIRP. • Limited concern. • Moderate/severe harm incidents where initial review confirms contributory factors are fully understood and linked to robust safety improvement programme. • Ward level management of response and communication with those affected. • Themes and learning used to inform ongoing safety improvement work and future PSIRP planning.

8.2 Priorities - ENHT

Following triangulation of the last 12 months data and engagement with stakeholders, local safety priorities for this year are listed below:

Patient safety incident type or issue	Planned response	Anticipated improvement route	Accountable team/ officer
1. Improving the 'escalation' of deteriorating patients.	Learning response pathway – transforming into improvement	Create local safety actions and feed these into the safety improvement plan	Lead Nurse Critical Care Outreach & Associate Medical Director for Quality and Patient Safety

2. Reducing the frequency of drug administration errors	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts	Pharmacy Patient Safety Specialist
3. Ensuring the fundamentals of care for our vulnerable patients who lack capacity	Learning response pathway – transforming into improvement	Create local safety actions and feed these into the safety improvement plan	Director of Quality
4. Reducing safety risks for patients on waiting lists	Learning response pathway	Create local safety actions and feed these into the safety improvement plan	Deputy COO
5. Reducing risks related to patient flow, including admission to discharge (ED pathways, in patient pathways and discharge processes)	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts	Deputy COO
6. Reducing the risk to young people waiting access neurodiversity pathways.	Learning response - transforming into improvement	Create local safety actions and feed these into the system level safety improvement plan	Head of Nursing for Paediatric services and Head of Paediatric services

9.0 Evaluating and Monitoring outcomes of PSII and Learning reviews

- Learning from PSIIs and other learning reviews provide key insights and improvement opportunities. These insights will be translated into effective improvement design and implementation plans. Iterative opportunities through the incident management process will allow oversight of progress of PSii and share information, and this information can be used in different ways to support safety improvement.

- Evaluation of PSii shall be undertaken through peer review against evidenced based 'Learning Response Review and Improvement Tool' to inform authors of, and allow peer reviews from others, of written reports to provide constructive feedback on the quality of reports.

- Both outcome and process measures will be used to interpret the impact of actions and to inform how actions should be adapted if they fail to have the desired effect.

- Organisational escalation processes will be utilised to manage situations where resources are insufficient to robustly implement actions or influence improvement.

- Sampling of wider learning responses shall be routine observed through operational and corporate governance structures, and reports to the board will include aggregated data on: Patient safety incident reporting outcome results:
  - Audit and review findings
  - Findings from PSIIS
  - Progress against the PSIRP
  - Results from monitoring of improvement plans from an implementation and
  - Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents
  - Patient safety incident reporting trends and themes

10.0 Complaints and appeals

Local disagreement on management of incidents will be escalated to corporate patient safety structures, including executive oversight.

Local and national arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are available via ENHT Patient Liaison and Advice Service.

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a service provided by ENHT will be taken seriously and will be managed in a way that reflects the ENHT Values.
ENHT encourages service users to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff. The Trust's Complaints Policy focuses specifically on

those concerns or complaints that require management through the Patient Advice and Liaison Service (PALS) and the Complaints Team.
The Trust's Complaint Policy sets out the principles and processes involved when any person wishes to raise a concern or complaint. This includes the need for the Trust to provide an apology and an opportunity for learning when complaints are responded to, where this is relevant.
If you wish to raise a concern:

Complaints
If you are still unhappy and wish to make a formal complaint, please write to:
Chief Executive East and North Hertfordshire NHS Trust Lister Hospital (L66) Coreys Mill Lane Stevenage Herts SG1 4AB or you can call the Complaints Team on 01438 286959 or email: patcomplaints.enh-tr@nhs.net

Our PALS team, which covers the Lister, New QEII and Hertford County hospitals and the Mount Vernon Cancer Centre, is based at the Lister. The team can be contacted on 01438 285811 or pals.enh-tr@nhs.net.