SUBMISSION FROM MEDWAY NHS FOUNDATION TRUST

Health and Adult Social Care Overview and Scrutiny Committee

19 August 2026

Medway NHS Foundation Trust – Patient Safety Incident Investigations

Report from: Evonne Hunt, Chief Nursing Officer, Medway NHS Foundation Trust

Summary

The Trust identified a significant backlog of patient safety incident learning responses, together with cultural, operational and governance weaknesses that had contributed to delay, variable ownership, and inconsistent application of the Patient Safety Incident Response Framework (PSIRF). This report explains the scale and nature of the issue, the progress made in reducing the backlog and completing Duty of Candour requirements, and the actions being taken to establish a transparent, compassionate, and learning-focused patient safety system.

The backlog has reduced substantially. However, the Trust recognises that completing cases is not, by itself, the measure of success. The central objective is to ensure that patients and families receive timely answers, that risks are identified, that learning is translated into measurable improvement, and that the organisation can demonstrate sustained oversight from ward to Board.

1. Budget and policy framework for MFT

1.2. PSIRF is part of the NHS Patient Safety Strategy and is mandatory for services provided under the NHS Standard Contract. It requires organisations to maintain effective systems and processes for responding to patient safety incidents, enabling learning and improvement in patient safety.

2. Background

2.1. Patient safety is the Trust's highest priority. Real and lasting improvement depends on openness when care or Trust processes have not met the standards that patients and families rightly expect.

2.2. Delayed or incomplete learning responses reduce the Trust's ability to understand what happened, identify contributory system factors and prevent recurrence. They also leave patients and families waiting too long for answers and deny staff timely opportunities to reflect, learn and improve.

2.3. The Trust therefore regards the historic backlog as a serious organisational governance and learning breakdown, rather than solely an administrative accumulation of cases. It fully accepts the need to address both the outstanding work and the conditions that led to the backlog.

National framework

2.4. A patient safety investigation is the NHS's formal process for understanding what happened, why it happened, and what needs to change to prevent similar incidents from occurring in future.

2.5. NHS England published the Patient Safety Incident Response Framework (PSIRF) in August 2022, with providers expected to complete their transition from the Serious Incident Framework by autumn 2023. It marks a fundamental shift away from blame and a single "Serious Incident" threshold towards proportionate responses that focus on learning, improvement, openness, and compassionate support for patients and families.

2.6. PSIRF sets national expectations for NHS organisations to provide compassionate, proportionate and system-based responses to patient safety incidents, informed by risk and the potential for learning and improvement, with timely Duty of Candour, meaningful involvement of patients, families and staff, competent investigation capacity, human-factors analysis, clear timescales, transparent reporting, effective governance and safety actions focused on systems rather than individual blame.

2.7. The framework includes a range of investigation approaches, which are selected based on the nature, severity, and complexity of the incident. Not all incidents require the same level of investigation. These include:

2.8. A Patient Safety Incident Investigation (PSII) is an in-depth, system-based investigation undertaken when an incident, near miss or cluster of incidents indicates significant patient safety risks and potential for new learning to inform safety improvement;

2.9. A Multidisciplinary Team (MDT) Review is a structured, system-based review involving relevant health and care professionals to identify learning and contributory factors across an episode of care, pathway, safety theme or group of incidents, and is selected according to the learning required rather than solely the recorded level of harm;

2.10. An After Action Review (AAR) is a structured, facilitated discussion that supports those involved in an event to consider what was expected to happen, what actually happened, why there were differences and what can be learned to inform improvement, with its use determined by the learning required rather than solely by the recorded level of harm;

2.11. A Swarm huddle is a rapid, multidisciplinary review held as soon as practicable after a patient safety incident, involving staff close to the event to establish what happened, identify immediate learning and agree actions to

reduce the risk of recurrence, with its use determined by the need for a timely response rather than solely by the recorded level of harm;

2.12. A Thematic Review is a structured analysis of a group of patient safety incidents and other relevant information to identify recurring patterns, trends, contributory factors and wider system issues—such as concerns relating to culture, processes or the care environment—that may not be apparent from reviewing incidents individually;

2.13. Other proportionate learning responses may include structured conversations, observations and reviews of everyday work, selected in accordance with the Trust's Patient Safety Incident Response Plan and the potential to generate meaningful learning and improvement, rather than solely by the recorded level of harm or the apparent cause of the incident.

2.14. The statutory Duty of Candour, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is separate from but complementary to PSIRF. It requires the Trust to act openly and transparently regarding all care and treatment. As soon as reasonably practicable after identifying a notifiable safety incident, the Trust must inform the patient or their lawful representative, provide a truthful account of the known facts and any further enquiries, offer an apology and reasonable support, provide written follow-up—including the outcomes of further enquiries—and securely retain appropriate records and correspondence.

Identifying and validating the backlog

2.15. The Trust commissioned an external review of how PSIRF had been implemented across the Trust following concerns raised. It found that, although staff are working hard to improve patient safety, inconsistent multidisciplinary engagement, and reliance on informal relationships rather than standardised processes, cultural challenges—including a lack of trust between clinical teams and corporate patient safety function—had undermined confidence in the process and contributed to the inconsistent application of PSIRF throughout the organisation.

2.16. The review also highlighted inconsistent ownership of investigations, variable engagement across divisions, and a tendency for incident management to rely on informal relationships rather than clear, standardised processes. These cultural factors affected the visibility of risk, slowed decision-making, and limited the Trust's ability to embed learning systematically.

2.17. These weaknesses reduced visibility of risk, delayed decisions and made it difficult to demonstrate that learning had been translated into improvement. The independent assurance assessment did not identify any immediate unmanaged patient safety risk. It nevertheless concluded that the scale and age of the backlog, data-quality weaknesses, and variable implementation of PSIRF represented significant organisational, governance, regulatory, and reputational risks, requiring accelerated recovery and strengthened oversight. The Trust accepts these findings, and its response therefore addresses

leadership, culture, accountability, capacity, and improvement, as well as case closure.

2.18. The Trust fully accepts these findings and is using them to strengthen our processes, culture, and approach to learning.

2.19. The initial findings from the external review prompted a comprehensive internal review of patient safety incident records. This uncovered 839 historical incidents that had not been investigated but had been removed from the Datix incident reporting system and recorded as closed, with no action taken.

2.20. A structured desktop review and risk assessment approach was used to evaluate cases against PSIRF principles, ensuring investigations are proportionate and aligned with the framework, identifying cases that require further investigation, and linking cases to quality improvement plans.

2.21. Of the 839 historical incidents, 428 investigations remain open from January 2024 to March 2026. Of these, 110 are classified as high-level within the PSIRF framework, such as PSII, MDT, and AAR investigations.

2.22. This also included 59 cases in which the evidence recorded in the Trust's incident management system (Datix) was insufficient to demonstrate that the Duty of Candour requirements had been met.

2.23. The absence of Duty of Candour documentation does not necessarily mean that this important process was not undertaken. Variations in recording practises have resulted in this being recorded in the patient's clinical record rather than in the incident management system. Nevertheless, fragmented recording prevented reliable organisational assurance and was therefore treated as a compliance gap requiring active follow-up.

Backlog recovery and current position

2.24. The investigation backlog is being actively reduced. A formal Trust-wide recovery programme has been established, supported by an external senior clinician with PSIRF expertise, to ensure opportunities for learning are fully identified and embedded. Cases have been prioritised according to risk, including incidents involving severe harm or death, vulnerable people, coronial proceedings, potential regulatory scrutiny, prolonged delays or significant learning potential.

2.25. Where Duty of Candour compliance had not been sufficiently evidenced, these have been followed up, with 45 of the 59 since completed. The remaining 14 are being actively progressed with patients or families or appropriately evidenced, and this work will be completed shortly.

Strengthening systems and governance

2.26. The Trust has revised its PSIRF implementation to address the cultural and operational issues identified in the external review and to ensure it is carried out as intended – to foster openness, learning, and improvement rather than assigning blame. The main measures are:

2.27. Clearer roles and responsibilities for executives, corporate, divisional, and clinical teams have been established. Multidisciplinary engagement has been enhanced, and the quality and timeliness of incident investigations have been improved. Standardised governance processes are being implemented to ensure consistent decision-making and clearer escalation routes.

2.28. The Incident Review Sub-Group is now chaired by the Chief Medical Officer, and the Chief Nursing Officer chairs the Patient Investigation Review Group.

2.29. Formal reporting to the Patient Safety and Harm Prevention Subcommittee, then to the Quality Assurance Committee and Trust Board, with external oversight by NHS England and the Kent and Medway Integrated Care Board.

2.30. A refreshed Patient Safety Incident Response Policy and Patient Safety Incident Response Plan (PSIRP) is also being developed to ensure ongoing compliance with PSIRF requirements, incorporate lessons from the backlog, clarify governance arrangements, and strengthen accountability.

2.31. Standardise processes, templates and decision records to ensure incident management does not rely on informal relationships.

2.32. Enhanced multidisciplinary and divisional engagement, including accountability through Divisional Directors of Nursing and Divisional Medical Directors, supported by a review of investigator capability, PSIRF training, and clearer expectations for leaders.

2.33. Increased use of human factors and systems-based investigation methodology.

2.34. Quality Improvement plans linked to all incident investigation recommendations, with named owners, milestones and monitoring through divisional governance and Trust subcommittees; and

2.35. Although additional work is needed to complete retrospective reviews and fully close the backlog, there is now greater assurance that new incidents are being identified, triaged, and responded to using appropriate PSIRF processes. However, the Trust will not consider recovery complete until the remaining cases and outstanding Duty of Candour activities are concluded, the refreshed

policy and plan are embedded, and there is evidence that safety actions have led to sustained improvement.

3. Measures of sustained improvement

3.1. Ongoing will include, as a minimum:

3.1.1. The number and age profile of open learning responses, including cases beyond agreed timescales;

3.1.2. Timeliness and evidencing of Duty of Candour and engagement with patients and families;

3.1.3. Quality assurance of learning responses and safety actions against PSIRF standards;

3.1.4. Completion and effectiveness of improvement actions, rather than closure based only on activity;

3.1.5. Recurrence of key safety themes and evidence of reduced harm;

3.1.6. Divisional ownership, attendance, and escalation compliance;

3.1.7. Coronial and Prevention of Future Death (PFD) actions, including completion within statutory timescales; and

3.1.8. Staff and patient/family feedback on the openness, compassion, and fairness of the process.

3.2. The Trust's measure of success will not be solely the numerical elimination of the backlog alone. It will also be whether patients are safer, whether patients and their families are treated with openness and compassion, whether staff trust in a fair learning system, and whether evidence shows that learning is embedded across services.

4. Risk management for MFT

4.1. The principal risks include delayed identification and management of ongoing patient safety hazards; additional delays or distress for patients and their families; non-compliance with the statutory Duty of Candour; inadequate preparation for coronial proceedings or PFD responses; regulatory and contractual breaches; loss of confidence among the public and staff; and failure to turn learning into lasting improvements.

4.2. These risks are mitigated through risk-based prioritisation, weekly operational oversight, monthly quality assurance, accountability at executive and divisional levels, external expert review, specific coronial/PFD governance, and escalation via the Trust's quality governance framework. Risks and overdue actions are documented and escalated through the Trust's established risk management processes.

4.3. Residual risk persists while retrospective work and Duty of Candour follow-up are unfinished. The position will therefore stay under increased executive and Board oversight until clear exit criteria are achieved and consistent compliance is demonstrated.

5. Consultation

5.1. This report has been informed by internal review, independent external expertise, engagement with clinical divisions and corporate teams, and oversight discussions with NHS England and the Kent and Medway Integrated Care Board. Engagement with individual patients, families and staff is undertaken as part of the relevant learning response and Duty of Candour processes.

6. Financial implications for MFT

6.1. The recovery programme requires staff capacity and external specialist support. These costs are managed within existing Trust resources. Any additional significant financial requirements will be reviewed through the Trust's established financial governance processes.

6.2. Failure to address the issues may lead to indirect financial risks through duplicated work, claims, regulatory actions, lengthy investigations, and unnecessary harm. Prompt learning and effective safety measures are therefore vital both clinically and financially.

7. Legal implications for MFT

7.1. Relevant legal and regulatory duties include the statutory Duty of Candour under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, requirements arising from coronial proceedings and PFD reports, information governance and confidentiality duties, and the Trust's obligations under the NHS Standard Contract and applicable regulatory standards.

7.2. A recipient of a PFD report is usually required to respond to the coroner within 56 days, unless the coroner grants an extension. The strengthened PFD governance arrangements aim to ensure prompt executive oversight, a comprehensive and evidence-based response, and monitoring of all committed actions.

7.3. This report provides an overview and does not reveal confidential information about individual patients, families, or staff. Cases continue to be managed in accordance with legal, regulatory, and information governance requirements.

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