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Patient safety incident response plan

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Foreword

“The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. “

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents, here at Liverpool Heart and Chest Hospital. This is not a change which involves us doing the same thing but calling it something different, but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. We will continue to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that very much support learning and improvement to prevent recurrence. We already have a strong and embedded safety culture within the Trust, and are very much a learning focused organisation, and PSIRF will support us in maximising this.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to and although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage even more meaningfully with our patients, families and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our teams continue to work in improving our safety and just culture, and this will underpin how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe, and we have promoted this daily in our senior led Trust Safety Huddle since 2013. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of

reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Contents

1. Introduction

This patient safety incident response plan sets out how Liverpool Heart and Chest Hospital intends to respond to patient safety incidents over a period of 18-36 months and how we will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide. 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.

This plan is underpinned by our existing Trust policy on reporting, management, review and learning from incidents currently in redraft and the new Trust patient safety incident response policy.

A glossary of terms used can be found at Appendix A

PSIRF Aims

Compassionate engagement and involvement of those affected by patient safety incidents

- Expectations are clearly set for engaging, involving, and supporting those affected by patient safety incidents
- Aligned with ongoing research around improving patient and family involvement

Considered and proportionate responses to patient safety incidents

- No distinction between 'patient safety incidents' and 'Serious incidents' as it replaces Serious incident framework
- Changes blunt rules to determine what to learn from incidents
- Resource planning based on thorough understanding of patient safety incident profiles and ongoing improvement activity.
- Supports organisations to be more proportionate, sensitive and considered in their approach

Application of a range of system-based approaches to learning from patient safety incidents

- Promotes a range of methods for responding to and learning from patient safety incidents
- Moves away from RCA and uses range of tools, underpinned by Human Factors
- Timelines are more flexible and set in consultation with the patient and/or family
- Quality of response and resulting improvement work is the priority

Supportive oversight focused on strengthening response system functioning and improvement

- Regulators and ICSs will consider the strength and effectiveness of organisations' incident response processes
- Senior leads in providers will be 'signing off' learning instead of ICB
- Makes leaders of organisations providing healthcare accountable for how their organisation responds and improves following patient safety incidents

This plan will help us measurably improve the efficacy of our local patient safety investigations by:

Enabling better quality in-depth investigations and an introduction of a range of approaches to respond to incidents subject to full investigation.

Refocusing Patient Safety Incident Investigation (PSII) towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues.

Enable us to focus on addressing causal factors and use improvement science by using the 6i's Quality Improvement approach, to prevent or continuously and measurably reduce repeat patient safety risks and incidents. This approach enables us to use our understanding of the needs of our service.

Our Liverpool Heart and Chest Hospital Trust values underpin everything we do, and they include a learning and improvement culture that empowers staff to make and lead change, be curious and seek continuous improvement. Our Trust values are:

The values are embedded within all Trust policies and are also part of the Personal Development Review process undertaken annually by all members of staff.

2. Our services

The Liverpool Heart and Chest Hospital Foundation Trust provide specialist services in cardiothoracic and vascular surgery, cardiology, respiratory medicine including adult cystic fibrosis and diagnostic imaging, both in the hospital and out in the community.

We serve a catchment area of 2.8 million people, spanning Merseyside, Cheshire, North Wales and the Isle of Man, and increasingly we receive referrals from outside these areas for highly specialised services such as aortic.surgery

Heart and lung disease continue to be amongst the biggest killers in the UK and the communities we serve are marked by increased prevalence of cardiovascular disease, higher levels of heart failure, hypertension, coronary artery disease and an ageing population.

Our reputation for strong performance is important in delivering the ***best care*** for our patients and high-quality clinical services. This is underpinned by a culture of research and innovation, delivered in a semi-modern estate and facilitated by technology. New and upgraded clinical areas are designed with patients and families fully involved to deliver their needs.

As part of our long-term plan, we aim to form strong clinical and organisational relationships where possible. There is clear evidence that partnerships improve patient care and enhance quality and we aim to collaborate with a range of other providers and professionals with the aim to extending access and improve quality.

Alongside divisional services sit Trust-wide corporate services that support a range of functions that relate to patient safety and quality improvement work:

- Risk and safety teams
- Legal Team
- Quality Improvement team
- Safeguarding team
- Complaints and PALS team

3. Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years. We have a regular Executive-led daily Safety huddle which was created in 2014 to have additional oversight of the Trust's patient safety improvement and activity. These then led to the role out of Departmental safety huddles across the Trust, which occur daily at various times of the day. We also have Patient Safety Champions within the majority of areas across the Trust, that attend regular meetings and bring patient safety to the forefront of their department.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p15-16 below. To fully implement the Framework the Trust has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve.

The Risk, Safety and Quality Improvement Teams have engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses/emergent themes listed on p15.

The LHCH PSIRP will outline local priorities for focus or response under the PSIRF. These are developed due to the opportunity they offer for learning an improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in risk or harm.
The trust will use the outcomes from existing patient safety reviews and any relevant learning response conducted under PSIRF to create related improvement plans to assist focus on our improvement work.

Stakeholder engagement
The Trust Patient Safety Lead and Patient Safety Lead Nurse begun by engaging with the Quality Improvement and Risk Management Teams to gather initial incident reporting data and current workstreams underway, this then expanded to involve Senior Management Teams. Further thoughts and engagement occurred at an Operational Board away day whereby collectively senior leaders from across the Trust brought thoughts and ideas to a discussion group. We have also utilised Quality Priority engagement events where patients attend to discuss themes, trends and gather intel from a patient perspective on what should be included.

Staff were engaged throughout the process in a variety of forums, from weekly meetings to safety culture surveys.

We have engaged with other local providers within the region to gain an understanding of how they are planning to review and renew their Trust local priorities, with the experience gained over the previous 2 years since the original ones were agreed. We have also engaged with our Specialist Commissioners, who oversee care delivery and management of incidents to explore how PSIRF will affect reporting and management for them, and shared ideas for how we envisage our Trust priorities will change.

Internally, a presentation was shared outlining the upcoming changes to our local priorities; due to not agreeing any specific local priorities originally, an overview of the status of the emergent themes was also provided. This was shared at Operational Board, Board of Directors, Quality, Safety and Experience Committee, to our Patient Safety Partners, Trust Sharing and Learning and at our weekly Patient Safety Learning Meeting.

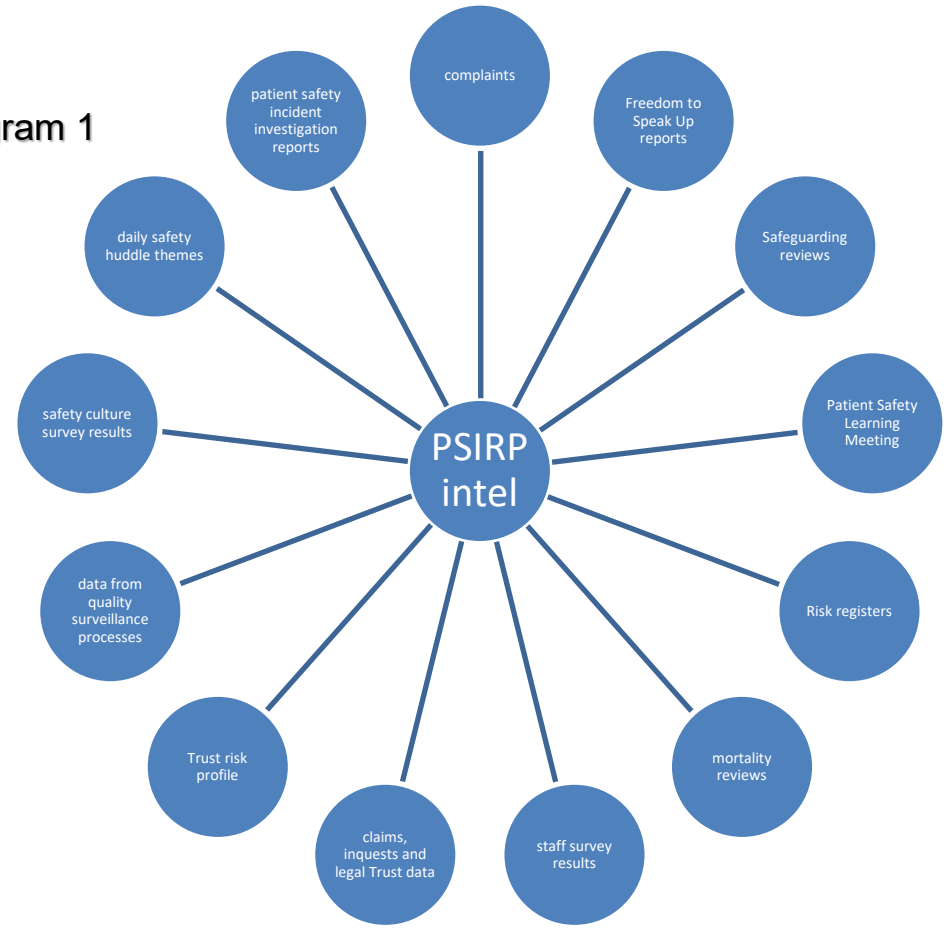
We have reflected on the previous PSIRP, along with what we have learnt on our PSIRF journey since 2023 and we recognise the benefits from a learning and improvement perspective and have embraced the use of the systems tools Trust wide. We have a dedicated Patient Safety Lead Nurse who promotes PSIRF, supporting and facilitating learning responses and who will guide the Trust to the best way of utilising the knowledge we now possess, with those trained by accredited companies. We have also been required and continue to engage with multi-organisations not just from a PSII perspective, but by facilitating and welcoming MDT reviews for example, that cross various organisations, for the purpose of quick learning, improvement and mitigation; again, these are all led by the Patient Safety Lead Nurse and working relationships continue to be built regionally which have proven invaluable for promoting patient safety.

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 meetings with our key internal and external stakeholders to review this together to finalise our local focus and priorities for review by PSII. Our engagement workshops have included presentations, group work, discussions, surveys and meetings co-working on the development of our safety profile and response planning.

Data sources
To define our patient safety response profile, we drew data from a variety of sources. We moved to collate data on the actual incidents that had taken place over the period July 2023 – January 2025. We decided to look at this period to allow for consistency of the data first and foremost, as we moved to a new incident reporting system in July 2023; as well as allowing current data to be used, knowing now that we have PSIRF methodology well embedded across the Trust.

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:

Diagram 1



As part of our meetings, we have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

We need to recognise that whilst planning our responses and planning proactive allocation of patient safety incidents, there needs to be a reactive element in responding to patient safety incidents. A response will always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in our plan.
We have planned how to respond proportionately to the issues identified and listed in our organisations patient safety incident profile to maximise learning and improvement.

Safety issues highlighted by the data

We undertook initial data analysis on all incidents reported through InPhase between July 2023 and January 2025.
These were the themes considered in our engagement sessions, with further details on the subcategories within the themes considered to identify and hone our overall profile.

By volume, the Top 6 (and their subsequent top sub-category) over the previous 18 months were:

1	Administration Processes = 592	
	• Appointment processes, insufficient/incorrect/incomplete (eg appointment recording error)	86 in total
2	Communication = 238	
	• Communication error within the team	22 in total
3	Diagnostics = 233	
	• Laboratory results unavailable	14 in total
4	Medications = 433	
	• Drug not prescribed or delayed	24 in total
5	Pressure Ulcers = 161	
	• Pressure ulcer category 3 or more developed or worsened during care by this organisation *(this was sub-category #2 – the highest volume within this category related to pressure sores present on admission).*	21 in total

<u>Top themes from complaints from 2023 - 2025 include:</u>

- Waiting times for cardiac surgery- previous multiple cancellations impacting patients- including cardiac surgery and lung cancer surgery.
- Follow up cardiac surgery appointments changed several times over 12 weeks.
- Communication of the cancellations/rescheduled dates - trying to receive updates.
- Administration issues - unable to get through to the access/bookings teams and secretarial teams, not receiving calls back, messages not actioned

We then triangulated all of the above information alongside other information resources shown in diagram 1 and developed a refined group of areas to take a deeper dive into, review and improve over the coming months. We have also interlinked these priorities or similar themes with both our Quality Priorities and within our recently updated Quality and Safety Strategy. Through this collaborative approach, we were able to prioritise initiatives that address the most important and impactful patient safety issues, ensuring a focused and effective response strategy; and we therefore determined and agreed the 4 priorities listed on Page 18.

National Priorities will determine whether a PSII is undertaken (see below). It is estimated that a maximum of 6 PSIIs will be undertaken per annum.

Whilst the final list has been agreed we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

4. Defining our patient safety improvement profile

The Trust is committed to delivering outstanding care for patients and monitors quality and safety daily. Safety is reviewed each morning at the Trust safety huddle meeting, which allows all staff (regardless of role and seniority) to escalate any concerns relating to patient, visitors or staff safety. This forum allows staff to act swiftly, address issues and reduce risks. Information from daily safety huddle is shared with all departments via notes/actions each day.

The Trust has developed strong governance processes across the Clinical divisions and Governance teams and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, Commissioners and Partner Agencies.

The Trust Quality Committee will retain oversight of quality improvement measures and safety improvement plans to ensure that they remain of the highest standard. Its' subcommittee, Quality Safety and Experience Committee and Divisional Governance Committee meetings will ensure that the clinical and corporate divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues. The Quality Committee will ensure that the clinical and corporate divisions provide robust assurance to quality improvement, in accordance with the Trust Quality Strategy.

The Trust will continue to ensure that quality and safety of services is paramount to the investigations that it undertakes in accordance with National and any defined Local Priorities and that its' approach remains flexible to new risk and significant opportunities for 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 flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

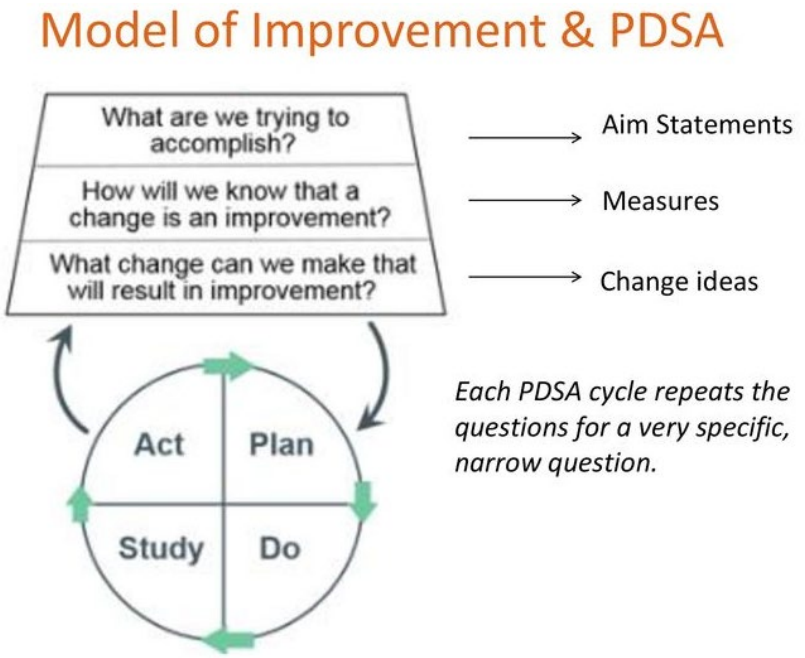
Quality Improvement Methodology

The Trust is keen to ensure that Quality Improvement methodology is intrinsically linked to PSIRF implementation so that learning outcomes utilise evidence-based improvement methodology to create sustainable improvement in the delivery of safe care for our patients. The Trust is committed to building Quality Improvement capability throughout the organisation and with strategic partners, utilising the Model for Improvement as the core methodology. The ambition to embed this approach as part of the PSIRF

implementation creates a real opportunity for the organisation to fundamentally change the way it responds to patient safety learning and create a culture of continuous improvement.

Model for Improvement

The Model for Improvement outlined in the image below, is a simple, yet powerful tool for accelerating improvement:



5. Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 6 PSII reviews where **national** requirements have been met per annum.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

National event response requirements:

Event	Action required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Locally-led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally-led PSII	The organisation in which the Never Event occurred

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	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII See also Appendix B	HSIB (or SpHA)
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	Child Death Overview Panel
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	LeDeR programme
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	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	Refer to your local designated professionals for child and adult safeguarding
• 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		
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	The organisation in which the event occurred

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 investigations where required to do so	PPO or IOPC
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	CSP
	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	

6. Proportionate Responses under PSIRF

Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response).

Risks or broad patient safety issues may also be identified during patient safety incident response planning that could benefit from focused improvement efforts rather than further incident responses.

As a Trust we may wish to apply methods to support proactive risk assessment or develop specialised reviews to enable systematic data collection to inform wider improvement work. Examples include falls after action reviews and bacteraemia and pressure ulcer prevention and control reviews, with subsequent actions and learnings identified.

If our organisation and our ICB are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored, it is acceptable not to undertake an individual learning response to an incident other than recording that it occurred and ensuring those affected are engaged as outlined in the" Engaging and involving patients, families and staff following a patient safety incident guidance".

A learning response may not be required or may not be the best way to address concerns and questions raised by those affected. If an affected patient, family, or staff member requests a learning response, organisations should carefully consider their request. If such incidents involve moderate or greater harm organisations must fulfil their Duty of Candour obligations, full detail of this can be found in the Trust's Be Open Policy.

If as an organisation we cannot plan to easily identify where an incident fits in relation to our plan (i.e., whether a learning response is required), we may need to perform an assessment to determine whether there were any problems in care that require further exploration and potentially action. Assessment methods include structured judgement reviews or similar (e.g., case record or note reviews) that can determine whether there were any problems in care that require further exploration.

From our data and incident analysis, as a Trust we estimate that we will complete approximately 6 Patient Safety Incident Investigation (PSII) reviews annually where national requirements have been met. To improve our ability to deliver against the PSII standard we plan to assign appropriate trained board members to oversee delivery of PSII standards and support sign off all PSIIs. We continue to train staff in system-based training to support either leading or reviewing and investigation.

7. Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents, various data and intelligence sources, stakeholder and engagement meetings we have determined that the Trust is required to review and monitor 4 areas of emergent themes. Whilst low in number, any particular areas of concern highlighted within the data analysis are already part of and subject to an improvement workgroup. We have selected this number due to the breadth of services that the Trust provides.

We will use the outcomes of any PSII's to inform our patient safety improvement planning and work, as well as any outcomes from PSR's undertaken.

Where an incident has occurred that does not fall into the categories already identified, an investigation and/or review method may be used by the local team except PSIIs which should NOT be undertaken by staff who have not received the specialist training required under PSII. Outcomes following our PSII will be used to inform improvement planning.

The type of response will depend on:

- The views of those affected, including patients and their families
- Capacity available to undertake a learning response
- What is known about the factors that lead to the incident(s)
- Whether improvement work is underway to address the identified contributory factors
- Whether there is evidence that improvement work is having the intended effect/benefit
- If an organisation and its ICB are satisfied risks are being appropriately managed.

The vast majority of incidents reported to the Trust InPhase incident reporting system are related to patient safety. There are three main things to consider when making a decision to investigate an incident.

- The level of severity of harm to the patient/carer/relative or staff member
- The likelihood of the event recurring
- The potential for learning (this could be the investigation of incidents or complaints which are high in frequency, but are low in severity)

We will complete at least one PSII for each of our 4 priorities. Additional PSII's where learning may be extracted will be considered by our Divisional Patient Safety Panel. The Trust Patient Safety Panel is responsible for PSII closure, as per our policy. Other PSIRF learning responses will be carried out i.e. Swarm Huddles, After Action Reviews, MDT Reviews etc, as deemed appropriate following Rapid Review and Divisional Patient Safety Panel agreement.

			Event	Planned Response	Anticipated Improvement/ Monitoring
Patient Safety Event Occurs	Patient Safety Incident Investigation	Trust Priorities	1. Failure of operational or administrative systems that results in a delay of treatment or diagnosis 2. An incident related to VTE that results in potential or actual significant harm to one or more persons. 3. Deterioration of a patient whereby inappropriate or failure to escalate appropriately occurs, this can include failure to provide/review/act upon diagnostic results. 4. An incident whereby a national or local safety checklist was incorrectly followed.	Rapid Review PSII where the delay results in potential or actual significant harm to one or more persons.	• Operational Board • Quality, Safety and Experience Committee
				Rapid Review PSII where the incident results in potential or actual significant harm to one or more persons.	• Safe Medication Committee • Divisional Board • Quality, Safety and Experience Committee
				Rapid Review PSII whereby the failure to escalate leads to potential or actual significant harm to one or more persons.	• Divisional Board • Quality, Safety and Experience Committee
				Rapid Review PSII whereby potential or actual harm could be caused from the not	• Divisional Board • Quality, Safety and Experience Committee

				following the correct safety processes. Or other appropriate PSIRF response	
	Patient Safety	Local Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and appropriate toolkit item	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts
	Incident response		No/Low Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
IT systems	Review by operational managers in conjunction with IT Continued monitoring through Divisional/Trust contract meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	Inform ongoing improvement efforts
Documentation/IG Breach	Review by operational managers in conjunction with IG team with cross	Inform ongoing improvement efforts

	system reporting as necessary Continued monitoring through Divisional/Operational Board/Trust IG Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	
Medication	Review by operational managers in conjunction with Medicines Management and cross system reporting as necessary Continued monitoring through Divisional Board/Safe Medication Committee Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised Review as PSII where index case	Create local safety actions and feed these into the quality improvement strategy
Safeguarding	Review by operational managers in conjunction with Safeguarding to ensure referrals made to facilitate external review	Inform ongoing improvement efforts

	Continued monitoring through Divisional Board/Quality, Safety and Experience Committee Continued monitoring of patient safety incident records to determine any emerging risks/issues outside of Safeguarding remit	
Infection control	Review by Divisional managers in conjunction with Infection Control and Prevention team and cross system reporting as necessary Continued monitoring through Divisional Board and Infection Prevention Committee Continue post infection reviews for outbreaks Continue nationally required external reporting for specific infection groups Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	Inform ongoing improvement efforts
Slips, Trips and Falls	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through Divisional Board and Falls Steering Group	Create local safety actions and feed these into the quality improvement strategy

	Continued monitoring of patient safety incident records to determine any emerging risks/issues Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised	

8. Appendix A

Glossary of terms

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan
Our local plan sets out how we will carry out the PSIRF locally, including our list of . These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

AAR – After Action Review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

MRG – Mortality Review Group
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The MRG blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Endorsed by:

Name of Lead Clinician/Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

Record of Changes to Document - Issue number: 4.1				
Changes approved in this document:			Date: 1st March 2024	
Section Number	Amendment (***shown in bold italics)***	Deletion	Addition	Reason
Page 16-18	***National Priorities***	Chart	National guidance list of priorities	Align with national guidance