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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

The Patient Safety Incident Response Framework (PSIR) sets out a new and completely different approach to how we respond to patient safety incidents. This is not a change where we do the same thing but call it something different, this is a cultural and whole system shift in the way we think about and response to patient safety incidents and importantly how we work together to prevent similar incidents from happening again. Our challenge is to shift the focus away from investigating and producing a reports because it might meet specific criteria in a framework and move towards an emphasis on the outcomes of patient safety incident responses that support shared learning and improvement to prevent recurrence.

PSIRF gives us a set of principles to work with and provides the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim being to learn and improve. We have always investigated incidents to drive learning but it has to be acknowledge that previous emphasis has been on the production of a report and action plan within directed timeframes, that is how we have been measured, rather than on demonstrating how we have made meaningful changes to care and treatment delivery to ensure that we keep patients and staff safe.

We need to engage meaningfully with patients, families and carers to ensure that their voice is heard when we undertake investigations. The PSIRF sets out the principles for engagement and our move to appointing patient safety partners will ensure that the voice of the individual is involved at all stages in the patient safety processes.

Moving towards a restorative and just culture underpins 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. The 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 staff validate the decisions made in caring for and treating a patient and facilitate psychological closure.

As we move into adopting this new way of managing patient safety learning reviews, we accept that we may not get it right from the outset. We will through established patient safety processes 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 journey we have been supported by NHS Greater Manchester Integrated Care quality leads 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.

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1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how **Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust** (hereafter referred to as WWLFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Important Note: *WWLFT has also developed a specific **Patient Safety Incident Response Framework (PSIRF) Policy** to provide further clarity for staff on pathways for escalation, methods of review, safety action development, safety improvement plans and monitoring improvement.* The PSIRP should be read in conjunction with this Policy.

A glossary of terms used can be found at Annex 1

2. Our Services

WWLFT is registered with the Care Quality Commission (CQC) and serves a local population that includes residents of Ashton Leigh and Wigan.

WWLFT delivers Acute and Community services, the Trust site and services have been outlined below.

	<p>Royal Albert Edward Infirmary (RAEI) sometimes referred to as ‘Wigan Infirmary’ is a District General Hospital providing an inpatient base for urgent and emergency care and acute services.</p>
	<p>Wrightington Hospital is a renown centre of excellence for Orthopaedic and Musculoskeletal surgery and Rheumatology Services (Both Inpatient and Outpatient facilities at site)</p>
	<p>Leigh Infirmary is our elective diagnostic and rehabilitation site that complements our emergency site Wigan Infirmary. This site is devoted to day services elective care, protected from the pressures of emergency work and also provides an atmosphere that is appealing to patients who require elective diagnostic procedures.</p>
	<p>The Thomas Linacre Outpatients Centre provides outpatient care to residents of the WWLFT catchment area, with 96 Consultant led clinics per week and treating over 100,000 patients per annum.</p>
	<p>Community Services provide out of hospital care and treatment for adults and children across the locality and often support people with multiple or complex health care needs. The services are provided in a wide range of locations including community centres, schools and in people's own homes.</p>

Further information about our organisation can be found on the WWLFT website.

[WWL Teaching Hospitals NHS Foundation Trust | WWL NHS Foundation Trust](#)

3. Defining our Patient Safety Incident Profile

WWLFT has a continuous commitment to learning from patient safety incidents and has developed our understanding and insights into patient safety matters over a significant number of years. The Trust has an Executive-led Safety Group, Divisional Safety Huddles and a Strategic Patient Safety Group to ensure the oversight of the Trust's patient safety activity and improvement.

In the last two years, more than 35,000 patient safety incidents have been reported, demonstrating a strong reporting culture and commitment to learning and improvement. Analysis of this data has shown that the majority of reports relate to no or low harm events. Higher harm incidents occur far less frequently but provide important opportunities for focussed learning.

This incident profiled has been used to identify areas of greatest risk and learning potential, and to prioritise those themes that will be explored, ensuring resources are directed towards incidents with the greatest potential to improve patient safety and outcomes.

Stakeholder Engagement

An important component of this work is to understand our patient safety incident profile, to undertake this work the following stakeholders were engaged.

- Trust Staff: through the incidents reported on the WWLFT Datix system.
- Quality Improvement leads who have supported the stakeholder mapping process.
- Senior leaders across the Trusts divisions through stakeholder meetings and events.
- Patient groups through a review of the thematic contents of complaints and Patient advice and liaison service (PALS) contacts.
- Organisation Development/Human Resources leads.
- NHS Greater Manchester Integrated Care System (NHS GM ICS) partner organisation through partnership working with the NHS GM ICS Quality leads.

Important Note: WWLFT aims to incorporate a wider patient perspective into future planning through the introduction of Patient Safety Partners (PSPs). Information on the national PSP programme can be found on the NHS England website at: <https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/>

Thematic Analysis and ongoing Patient Safety Risks

A thematic analysis approach has been utilised to determine which areas of patient safety activity to focus on. The review looked at patient safety activity between January 2024 and November 2025.

The analysis included the review of:

- Datix Patient Safety Incident data reported including all no, low or moderate harm incidents.
- Trust level risks relating to patient safety incidents.
- Key themes identified from specialist safety & quality committees (e.g. deteriorating patient, falls, pressure ulcers)
- Safeguarding notifications.
- Themes from Concerns, Complaints and Claims.
- Themes from the Learning from Deaths Reviews and Coroners Inquests.
- Medicines Management Committee review of frequently occurring medication incidents.

Sources of insight from the analysis have been included within the table below.

Category	Descriptor
Abscond/Missing Patient	All incidents where a patient was expected to remain within an episode of care but chose to leave care or not return to care premises
Access/Admission/Transfer/Discharge	All incidents relating to the stated stages in the patient journey
Communication (including Consent)	All incidents where there have been consent issues either in a legal or statutory framework, it also captures problems with documentation within the MCA/MHA/DOLs processes
Death	All reported deaths
Deterioration	All incidents in which it was reported that a patient's physical health deteriorated
Documentation/IG Breach	All incidents of breach of IG or relating to issues with recording and storage or management of patient and staff information
Equipment Supply/Failure	All incidents with equipment including failure or difficulties with supply or use
Environment, Estates, Facilities	All incidents involving environmental matters, estates or facilities provision
Infection Control	All incidents relating to infection prevention and control events or processes
IT systems	All incidents relating to IT systems and infrastructure (not generally IG or digital communication problems)
Medication	All incidents across the elements of the medication process

Pressure Ulcers and Wound Care	All incidents relating to pressure and related skin damage and other wounds
Planned interventions	Reported within MH and LD services where an intervention has been necessary resulting from measures being indicated as part of a patient's care plan
Security	All incidents recording any breach or lapse in security arrangements and processes and some specifically for Secure services
Serious Allegation	Incidents reported about staff
Service Provision/Discontinuity	All incidents where a service has been impacted or not provided as expected
Slips, Trips, Falls	All incidents where a patient fell, tripped or slipped on or off Trust premises
Vaccines and Immunisations	All incidents related to vaccines/immunisation
Violence and aggression	All incidents where violence and aggression has been witnessed or experienced by patients, staff and others
Staffing	All Staffing related incidents

The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting for many years.

Whilst a final list has been agreed WWLFT 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.

As locally defined priorities, the PSIRF allows us to focus on these risks with our framework for patient safety incident response.

Local patient safety risks related to the 'National Priorities': these have been defined as the list of risks covered by National Priorities that WWLFT anticipates will require a response in the next 12 months. Table 1 below sets out the full list of National Priorities that require a response.

Top 'Local Patient Safety Risks': these have been defined as the list of risks identified through the stakeholder approach and the data reviews described above. These local identified risks represent opportunities for learning and improvement in the WWLFT system. The criteria WWLFT have used for defining the top local patient safety risks is as follows:

- **Potential for Harm**
 - People: physical, psychological, loss of trust (patients, family, caregivers)
 - Service delivery: impact on quality and delivery of healthcare services.
 - Impact on capacity

- Public confidence: including political attention and media coverage
- Likelihood of occurrence
 - Persistence of the risk
 - Frequency
 - Potential to escalate

Following analysis, the following five patient safety priorities have been highlighted and will be in focus for the next two years. These patient safety priorities will form the foundation for how WWLFT will decide to conduct Patient Safety Incident Investigations (PSIIs) and Patient Safety Reviews.

1	Improve harm-free care for patients experiencing prolonged stays (greater than 24 hours) in the Emergency Department, specifically those in the waiting room or on the corridor
2	Improve the safety of transitions of care by learning from incidents relating to patient transfers and discharge both within hospital and on discharge to home
3	Learning from incidents involving diagnostic delays caused by unacknowledged or unacted-upon test results, or cases of misdiagnosis
4	To reduce avoidable pressure ulcer harm (category 3 and above) arising from deterioration of pre-existing skin damage
5	To improve the early recognition and management of deteriorating patients

4. Defining our patient safety improvement profile

Defining and agreeing our Patient Safety Improvement Profile begins with a clear understanding of the improvement and transformation work already underway. Over a number of years, WWLFT has strengthened its governance processes to ensure that learning from patient safety incident reviews is systematically captured and used to drive quality improvement activity. This approach ensures that insights gained from investigations translate into meaningful and sustainable improvements in care.

Our work is shaped by a combination of national, regional, and local programmes aligned to the NHS Patient Safety Strategy. Key examples include:

- Appointment of a Patient Safety Specialist
- Development of the National Patient Safety Syllabus
- Introduction of the Involving Patients in Patient Safety Framework

Much of this progress has been accelerated by the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF provides a structured approach for investigating incidents identified through both national requirements and locally agreed priorities. Certain incident types automatically trigger a Patient Safety Incident Investigation (PSII) or a thematic review, with findings aggregated to inform Safety Action Improvement Plans.

WWLFT will continue to draw on guidance and feedback from national and regional NHS bodies, regulators, partner providers, and other key stakeholders to identify and define the quality improvement work required. The Learning from Patient Safety Events group will oversee the application of robust quality improvement methodology and ensure alignment with best practice.

Our clinical and corporate divisions report to the Strategic Patient Safety Group, which monitors and measures improvement activity across the organisation. This group as well as the Learning from Experience Group, also provides assurance during the development of new safety improvement plans following PSII/PSR reviews, ensuring that plans meet SMART requirements and are sufficient to deliver measurable improvements in patient safety.

Looking ahead, we will focus our efforts on developing safety improvement plans for the most significant incident types, whether nationally mandated or locally identified. We will remain flexible and responsive, initiating improvement planning whenever emerging risks or patient safety issues are identified through internal or external insights.

5. Our patient safety incident response plan: national requirements

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

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria and Deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) will still require a locally led PSII.

Table 1 below sets out the local or national mandated responses. WWLFT does not directly provide mental health or custodial services it is therefore likely that the organisation will be a secondary participant rather than a lead for those incidents identified in types 6 to 11.

Table 1:

National Priority		Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII by WWLFT
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by WWLFT

3	Maternity and neonatal incidents and maternal deaths meeting to Maternity and Newborn Safety Investigations (MNSI) criteria	Refer to MNSI for independent investigation. Locally led PSII by WWLFT if MNSI input declined.
4	Child Deaths	Refer for Child Death Overview Panel review. Locally led PSII (or other response) may be required alongside the Panel review
5	Deaths of Persons with Learning Disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review
6	Safeguarding incidents in which: <ul style="list-style-type: none"> - 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 your local designated professionals for child and adult safeguarding
7	Incidents in screening programmes	Incidents in screening programmes. Refer to local screening quality assurance service for consideration of locally-led learning response
8	Domestic Homicide	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, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers

		and commissioners of health services in relation to domestic homicide reviews.
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6. Our patient safety incident response plan: local focus

WWLFT considers that all of the ten incident types set out in Table 2 below have relevance for all our inpatient services and all except two (items 2 and 7) have relevance for all our inpatient and community services. To this end this is an organisation wide PSIRP and there are no separate PSIRPs plans for individual services.

Table 2:

	Incident Type	Description	Response Type
1	To improve the early recognition and management of deteriorating patients	Failure to recognise, treat and escalate a deteriorating patient. Which has resulted in harm.	PSII
2	Improve discharge/transfer of care for patients both in and out of hospital	Harm occurring when a patient experiences delays or inappropriate discharge/transfer due to incorrect clinical decisions or omissions in planning, communication, or documentation, resulting in unmet care needs and increased risk after leaving hospital or being transferred.	PSII
3	Learning from incidents where diagnostic delays occurred due to unacknowledged or unacted upon test results	Delays in diagnosis resulting from a delay in review of investigation reports and results	PSII
4	Reduce avoidable pressure ulcer harm (category 3 and above) arising from deterioration of pre-existing skin damage	Pressure ulcers that occur when a patient's pre-existing skin condition deteriorates due to missed or delayed interventions. Common factors include inadequate risk assessment, failure to implement or maintain pressure-relieving measures, delays in repositioning or specialist review, and poor documentation or escalation of early signs of skin breakdown.	PSII

5	Improve harm free care for patients experiencing prolonged stays (>24) in Emergency Department	Incidents where there is prolonged stays in ED which has resulted in omissions in care and increased harm	PSII
6	Pressure Ulcers	Pressure ulcers developed in our care category 2 - 4.	ASKING (Cat 2) AAR (Cat 3 & 4)
7	Falls	Inpatient falls resulting in a bone fracture or haemorrhage	Post Falls debrief
8	Abuse/Alleged Abuse Staff Member to Patient	Alleged abuse of a patient by a member of staff working within WWL.	HR Investigation and/or Divisional PSR
9	Abscond/Missing Patient	Harm of a patient following absconding incident, whilst receiving care at WWL	AAR or Thematic Analysis
10	Unexpected PSII	Identified increase in incidence of subject of theme which has potential for harm	PSA Programme
11	Other	Patient safety incidents which meet criteria for harm or potential harm not included in the subjects above	See below

Where an incident does not fall into any of the categories 1 - 10; an investigation and/or review method described in Annex 1 may be used by the local team except PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

Local methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/or structured local proformas may be used. The completion of a narrative response on the Datix incident module is also appropriate.

7. Our maternity patient safety incident plan: local focus

Our maternity plan aligns with PSIRF principles to ensure timely, compassionate responses to incidents and a strong focus on learning. It incorporates national standards and local priorities, addressing key risks through structured reviews and multidisciplinary collaboration. Table 3 incorporates the additional local priorities within maternity services based on intel from incident reporting, the maternity dashboard, claims data and patient feedback and specifies the level of investigation required for each, ensuring consistency and transparency in our approach.

Table 3:

Incident Type		Description	Response Type
1	Category 1 Caesarean section	Delay greater than 30 minutes	Decision to Delivery Time Audit. Presented quarterly.
2	Late fetal loss/ Stillbirth/Neonatal death as per MBRRACE perinatal mortality reporting criteria	All eligible cases (see below)	72 hr Mortality Review with timeline + PMRT review tool PSII to be considered for deaths which are thought more likely than not due to problems in care (Graded D). Can run concurrently with PMRT.
3	Major Obstetric Haemorrhage	Antenatal or postpartum haemorrhage (PPH) >1500mls	PPH Audit (monthly). PPH MDT working group (quarterly). Audit presented quarterly. Overarching action plan.
4.	Term Admissions to the Neonatal Unit	Term baby (≥ 37 weeks) admission to the Neonatal Unit	ATAIN MDT review (weekly). Audit presented quarterly. Overarching action plan.
5.	3 rd and 4 th Degree Tears	All obstetric anal sphincter injuries	Thematic analysis – quarterly. Overarching action plan.

6.	Pre-eclampsia / Hypertension	Harm resulting from the management of pre-eclampsia / hypertension	Rapid review +/- AAR Escalate to PSII as indicated.
7.	Baby falls	Baby's who fall or are dropped whilst in hospital (including compliance with safeguarding processes).	SWARM or Rapid Review +/- AAR.
8.	Incidents in Antenatal and Newborn Screening Program	Incidents in Antenatal and Newborn Screening Program	Manage as per Managing Incidents in NHS Screening Programmes. Refer to local screening quality assurance service for consideration of locally led learning response. Screening Incident Assessment form (SIAF)
9	MNSI incidents	External investigation as per defined criteria (see below)	Rapid review. External PSII by MNSI. Locally led PSII if external review declined by family

MNSI criteria for review

- All term babies (≥ 37 completed weeks gestation) born following labour (as per Each Baby Counts definition) who have one of the following outcomes:
- Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life
- Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause

- Severe brain injury diagnosed in the first 7 days of life, when the baby was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) OR
 - Was therapeutically cooled (active cooling only) OR
 - Had decreased central tone AND was comatose AND had seizures of any kind

MNSI do not investigate cases where genetic or congenital conditions (something that is present before or at birth) have led to the outcome for the baby.

- Maternal Deaths (Death of a woman while pregnant or within 42 days of the end of pregnancy).
 - Direct deaths resulting from obstetric complications OR
 - Indirect deaths from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy in the perinatal period.

MNSI do not investigate cases of maternal suicide.

PMRT - Criteria for review

The PMRT has been designed to support the review of the care of the following babies:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g
- It is suitable to review post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die. (This is not currently a requirement of the CNST Maternity Incentive Scheme)

The PMRT is **not** designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation
- Babies who die in the community 28 days after birth or later who have not received neonatal care

Any PMRT grading which indicates that there were care issues which likely affected the death will be escalated to the Patient Safety Team. Where issues in care have likely contributed to the outcome consider additional PSII led by the WWLFT.

Organisations should refer relevant perinatal safety events to MBRRACE-UK, MNSI, CDOP and NHS Resolution via the one-stop SPEN system as set out in their respective reporting requirements.

8. Responding to patient safety incidents

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach. PSII's are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, connected causal factors that may appear to be precursors to patient safety incidents.

Existing structures will be utilised to support the process of decision making. There is an established weekly meeting chaired by the Medical Director, in which potential serious incidents and other emerging patient safety issues are discussed. This meeting is presently called the Executive Scrutiny Review Group (ESG) but will be rebranded as the Learning from Patient Safety Events Group (LfPSE)

During the transition into PSIRF, the Patient Safety Team will work closely with the Divisional Governance teams to review and identify incidents that may require a patient safety incident investigation. In PSIRF, the approach of ≥severe harm will no longer apply, and we will be guided by the national and local patient safety priorities.

The process will be described in detail in associated policies, particularly in new policies that describe Patient Safety Incident Investigations, Patient Safety Incident Responses and involving patients in discussions about incidents, learning and improvement. These policies will require development.

Central to deciding what to investigate was the situational analysis. The analysis identified the five Patient Safety Priority incident categories that the learning will be structured against over the first stage (2 years) of PSIRF.

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 20-25 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Patient safety incidents that must be investigated via PSIRF as detailed in table 1 above include:

- Never Events
- Deaths more likely than not due to problems in care. This will be identified through an incident and/or the learning from deaths process.
- National priorities for investigations

Apart from the 'must investigate' points, the decision to carry out a patient safety incident investigation should be based on the following:

- The patient safety incident is linked to one of the WWLFTs Patient Safety Priorities agreed as part of the situational analysis
- The patient safety incident is an emergent area of risk, for example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

There is no remit in PSII to apportion blame or determine liability, preventability or cause of death. There are several other types of investigation which, unlike PSII, may be conducted for or around individuals. Examples include complaints, claims, human resources, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

All incidents will be reported in line with existing patient safety incident reporting guidance. Any incident resulting in moderate harm or above will continue to be managed in accordance with Being Open and Duty of Candour. Any request for information about a patient safety incident, by the patient, families and/or staff will be responded to openly, professionally and as much information as possible will be provided regardless of the severity of outcome or the type of response required under this plan.

A Patient Safety Incident Response Framework has been included at Annex 2.

9. Completing Patient Safety Incident Investigations

Each comprehensive Patient Safety Incident Investigation (PSII) will be:

- Conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced investigator and received training.
- Undertaken as per the PSIRP and will adhere to the national PSII standards and with national good practice for PSII.
- Use the national standard template to report the findings of the PSII.
- Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).
- Design strong, achievable and effective improvements to sustainably address common interconnected causal factors.
- Develop a delivery plan to support the implementation of the planned improvements.

To monitor the quality of PSII findings and progress against this PSIRP we will seek answers to the follow:

- Are the actions likely to achieve improvement?
- Is there evidence of improvement?

Timescales for completion

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSIIs should ordinarily be completed within one to three months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Involvement of patients, families and carers following incidents

Patient safety incidents can have a significant impact on patients and their families. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. New policies/SOPs that are to be developed will provide guidance to support staff in how to discuss incidents with patients and family.

Involvement and support of staff following incidents

The local arrangements for supporting staff affected by patient safety incidents will be followed. General arrangements for supporting staff health and wellbeing are detailed on the Trust's intranet.

We make sure that in our daily practice, our conduct and our dealings with colleagues is honest, kind and where we are willing to learn. We promote a 'Just Culture' across WWL and believe that this culture is required to build trust so that a reporting culture will occur. An effective reporting culture is where all safety incidents are reported so that learning can occur and safety improvements can be made.

10. Evaluation and monitoring outcomes from PSIIs

Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

Reports from the Learning from Patient Safety Events (LfPSE) Group and Learning from Excellence Group will go to the Trust Quality and Safety Committee and Board will be provided on a quarterly basis and will include but not limited to aggregated data on:

- Patient Safety Incident reporting i.e. by Directorate, emergent themes and trends.
- Findings and shared learning from:
 - Patient Safety Incident Investigation
 - After Action Review's
 - Patient Safety Audits
 - Reviews of Deaths
 - Safeguarding Notifications
- Results from monitoring of improvement plans from an implementation and an efficacy point of view
- Results of patient surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of staff surveys and freedom to speak up reports and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g., large print, Braille, and audio cd. For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

Annex 1: Glossary

<p>1. Patient Safety Incident Investigation (PSII)</p>	<p>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 address those system factors and help deliver safer care for our patients effectively and sustainably.</p>
<p>Patient Safety Incident Response Framework (PSIRF)</p>	<p>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.</p>

Patient Safety Incident Response plan (PSIRP)	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.
After Action Review (AAR)	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.
Patient Safety Audit (PSA)	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guideline).
Perinatal Mortality Review Tool (PMRT)	Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. Perinatal Mortality Review Tool NPEU (ox.ac.uk)
Structured Judgement Review (SJR)	Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR 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
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
Deaths thought more likely than not due to problems in care	Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)