NHS
Airedale
NHS Foundation Trust

# Patient Safety Incident Response Plan

WHITAKER, Adam (AIREDALE NHS FOUNDATION TRUST)

July 2025 V5.0

# Patient safety incident response plan

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## 1. INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF)[1] August 2022 sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a **proportionate approach** to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for **learning and improvement**. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

(NHSE Patient Safety Incident Response Framework August 2022)

This plan details how we will implement PSIRF at Airedale.

[1] PSIRF NHS England https://www.england.nhs.uk/patient-safety/incident-response-framework/

## 2. PURPOSE, SCOPE, AIMS AND OBJECTIVES

Implementing PSIRF
Moving forwards together

### 2.1 PURPOSE

This Patient Safety Incident Response Plan (PSIRP) describes how Airedale NHS Foundation Trust 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.

This plan will help the Trust to measurably improve the effectiveness of our local patient safety incident investigations (PSII's) and refocus, by:

- Using a systems approach[2] which recognises the complexities that healthcare staff work in and analyses the systems, rather than the individuals.
- Focusing on addressing the factors and system issues to prevent or reduce repeat patient safety risks and incidents.
- Focusing on stakeholder engagement within PSII's, in particular that of patients, families, carers and staff so that it increases confidence in the improvement of patient safety through learning.
- Further detail can be found on this approach here: SEIPS-quick-reference-guide

[2] The approach is broken down into units to make it to understand the complexity, interactive nature and interdependence of the various external and internal factors.

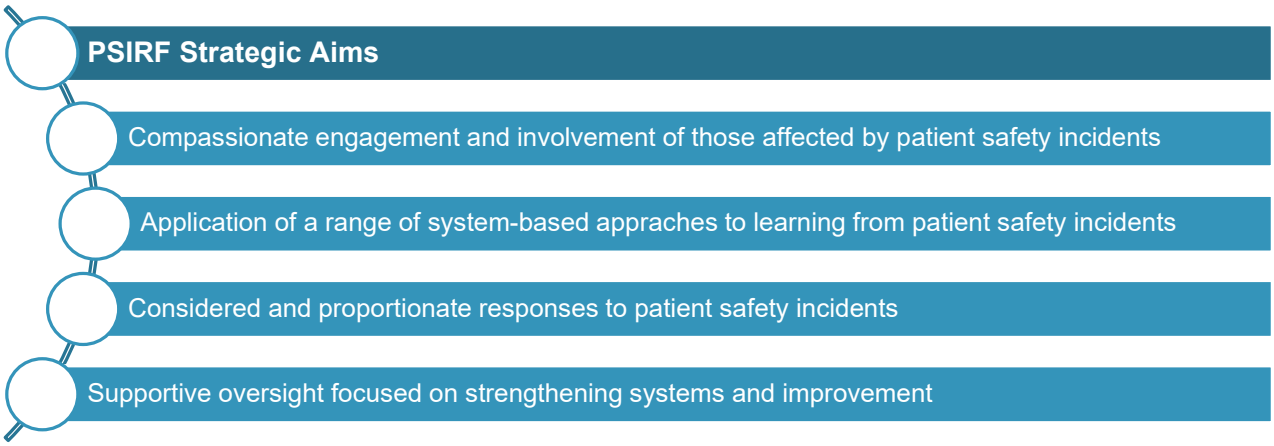
## 2.2 SCOPE

This document relates to responses to patient safety incidents which are conducted solely for the purpose of systems learning and improvement; Therefore, issues related to professional conduct, determining liability, cause of death or criminal proceedings are outside the scope of PSIRF.

Responses covered in this plan are:

- Patient Safety Incident Investigations (PSIIs)
- After Action reviews (AAR's)
- Thematic reviews

## 2.3 AIMS AND OBJECTIVES



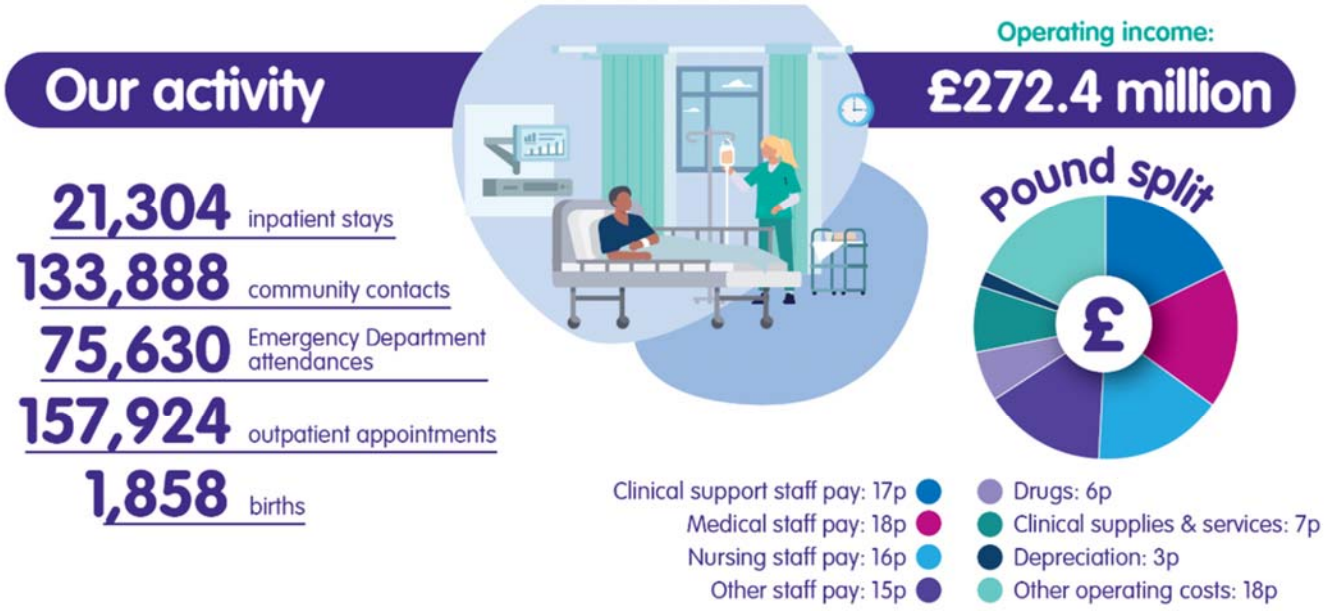

**Strategic objectives**

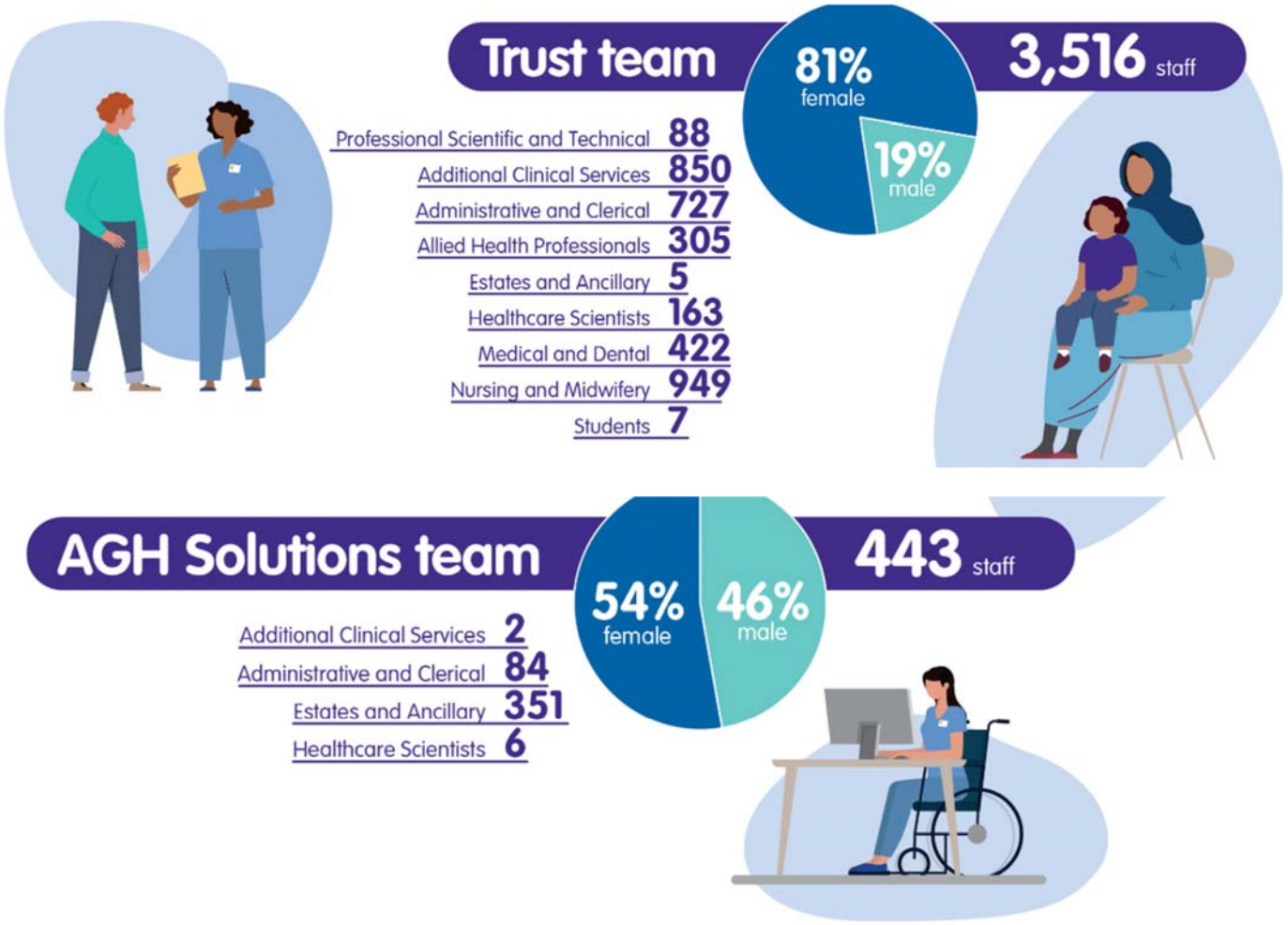
- Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS
- Develop a climate that supports a just culture[3] and an effective learning response to patient safety incidents

[3] A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, willful violations and destructive acts are not tolerated. Eurocontrol (2019)

- Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy
- Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a more proportionate, higher quality, response to patient safety incidents, which aims to:
    - engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
    - make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
    - develop and implement improvements more effectively
    - explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

## 3. OUR SERVICES






## 4. PATIENT SAFETY INCIDENT REPONSE PLAN: NATIONAL REQUIREMENTS

Some patient safety incidents will need a specific type of response as set out in other national policies and regulations.

| Patient Safety Event Type | Required Response | Anticipated Improvement Route |
|---|---|---|
| Never Event e.g., Wrong Site Surgery, Retained Foreign Object | PSII – Template Available | WYATT shared learning |
| Unexpected Patient Deaths | Structured Judgment Review | Medical Examiner / Learning From Deaths |
| Deaths of Persons with Learning Disability | LeDer Review | As per requirements of case |
| Adult and Children's Safeguarding Events | Safeguarding Review | As per requirements of case |

| | | |
|---|---|---|
| Maternity events that meet the "Each Baby Counts" and Maternal Death Criteria[4] | MNSI<br>MBRRACE | As per requirements of case<br>Ongoing improvement work in relation to induction of labour, term babies admitted to the NNU, blood loss of >1500mls and Fetal Monitoring |
| Events in screening programs | NHS reportable | As per requirements of case |
| (IR(ME)R) reportable incidents | CQC reportable | As per requirements of case |
| Serious Hazards Of Transfusion (SHOT) reportable incidents<br>SHOT definitions 2023 | As per reporting guidance | As per requirements of case |
| IPC incidents (refer to PSIRF infection Control review Process) | As per flowchart | As per requirements of case |
| RIDDOR reportable incidents | As per reporting guidance | As per requirements of case |

## 5. DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

From the initial PSIRF implementation group a workstream was developed to focus on Trust data and analytics to inform our safety incident profile.

Incident data from our Ulysses system was reviewed from 1 December 2020 to 28 November 2022. During this timeframe, 14,549 patient safety incidents were reported; of these, 73 were identified as meeting the criteria described in the serious incident framework, and comprehensive investigations were undertaken.

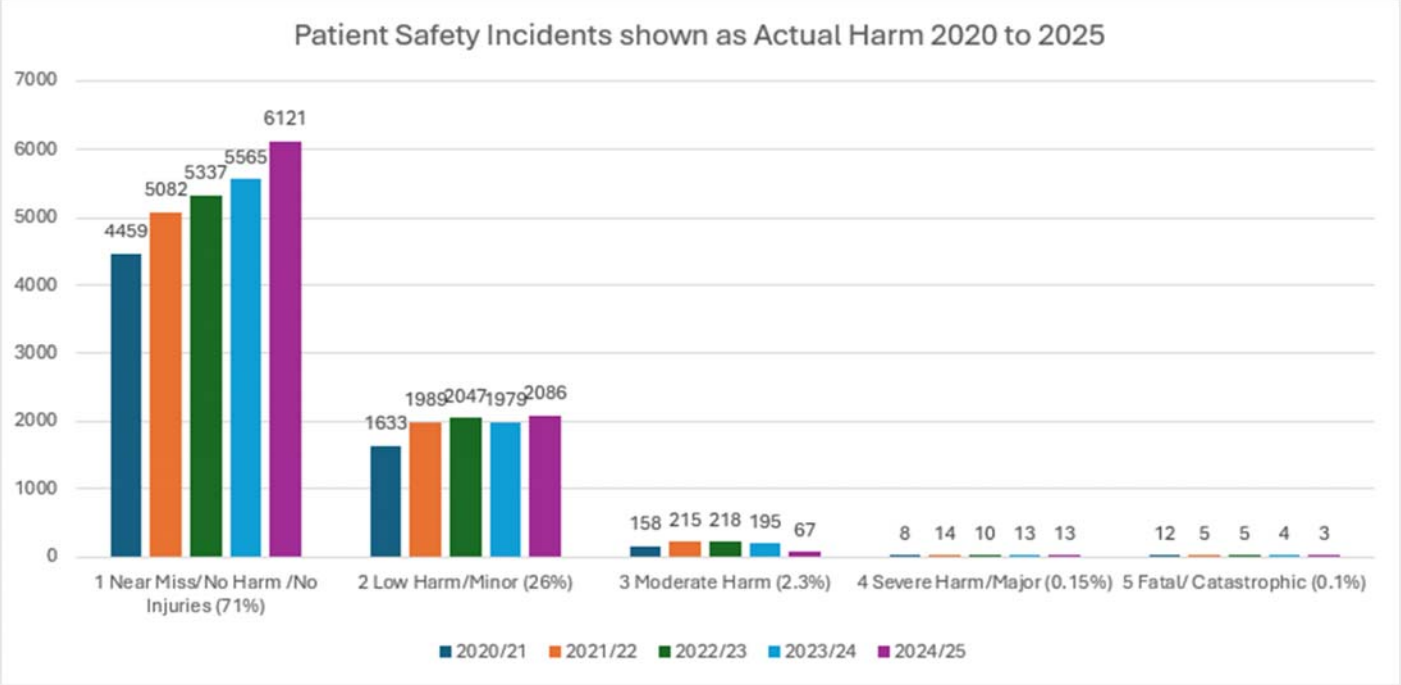
The time and resources needed to undertake a serious incident investigation is significant. Incidents of moderate and above harm make up a small proportion (<3%) of all reported incidents.

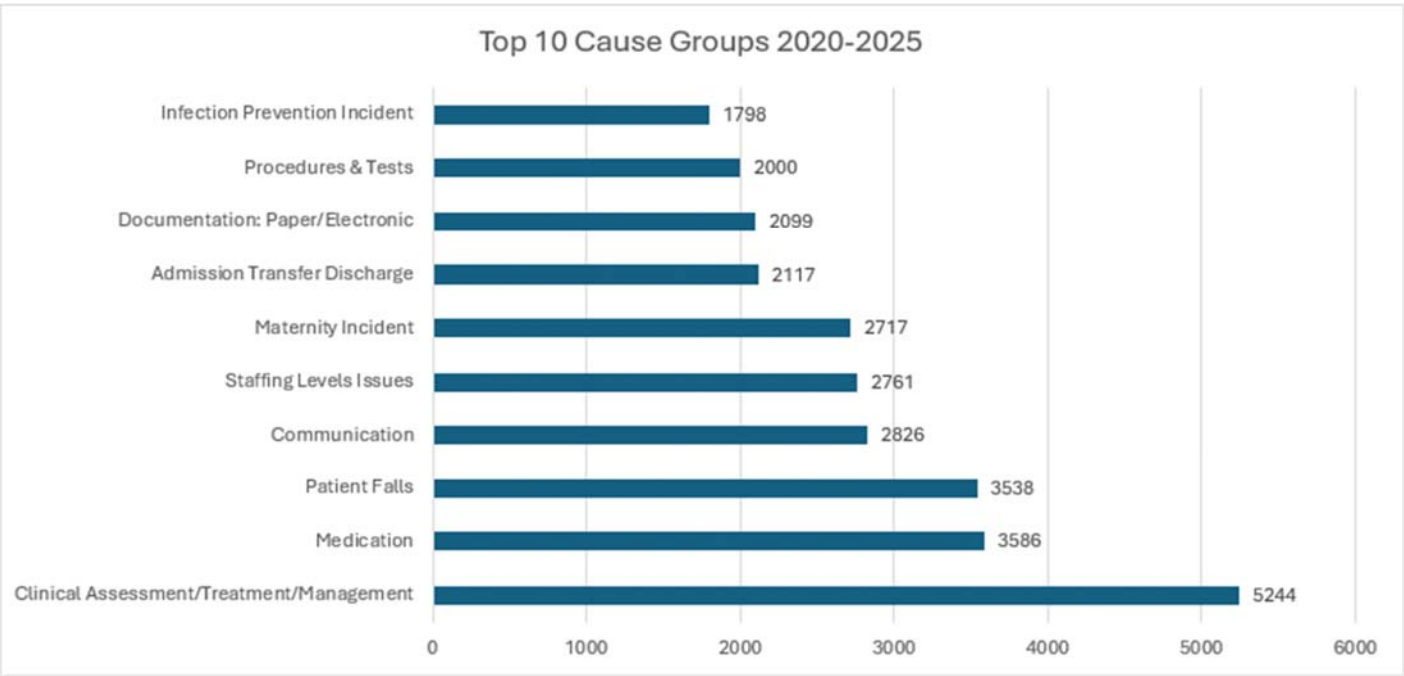
Whilst it is important to understand these incidents, both for families and staff in the Trust, the current framework for investigation does not provide any scope for the other 97% of incidents.

Theme and trend analysis of low and no harm incidents can support preventative actions to emerging patient safety issues.

Updated data collection has taken place to include previous data from 2020 up to March 2025. This information is in the charts below.

[4] Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour. direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy




## 5.1 DATA SOURCES

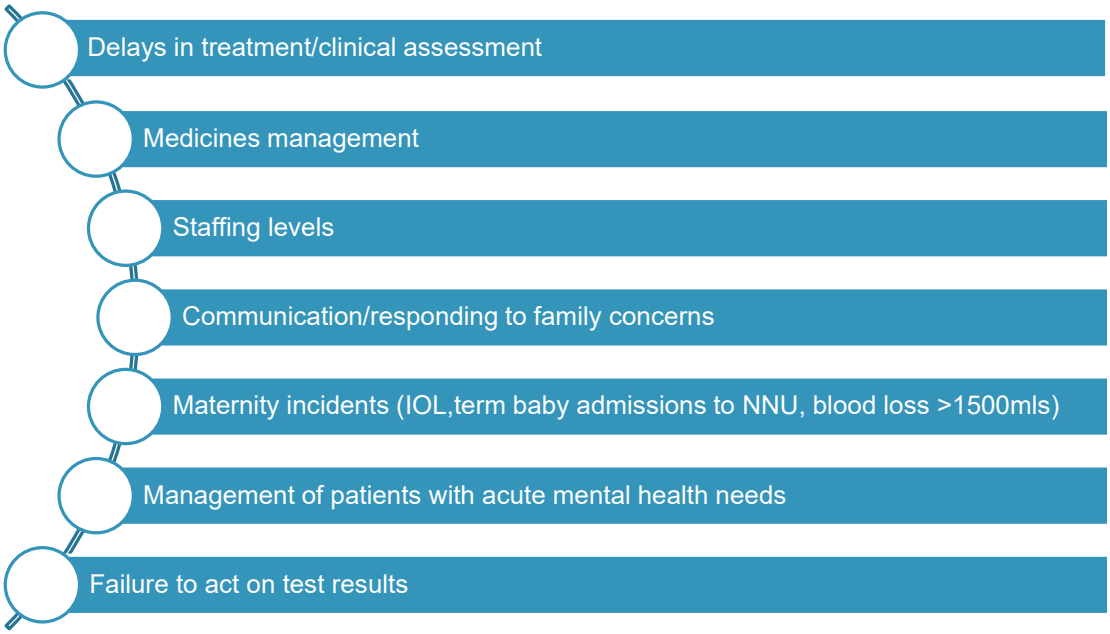
The patient safety incident risks for this organisation have been profiled using organisational data from the following sources:

- Patient safety incident reports
- Serious incident investigations (up to October 2023)

- Falls and pressure damage incidents
- Case note reviews
- Complaint's information
- Patient experience information
- Freedom to speak up reports
- Mortality reviews
- Outcome of inquests
- Claims
- Staff survey results
- Peer review information (The Trusts internal patient safety review programme)

Once collated, a thematic analysis approach was used to determine which areas of patient safety activity we will focus on to identify our patient safety priorities.

The following areas were identified from the different data sources reviewed. These were discussed at the PSIRF implementation group meeting in July 2023.




A number of incident types such as in-patient falls, development/deterioration of pressure ulcers and infection prevention and control incidents, were initially excluded from the priority categories as they have established processes in place for review. See flow chart in Appendix 2. Any incidents where concerns are identified will continue to be escalated as per existing processes.

### 5.2 STAKEHOLDER ENGAGEMENT

See Appendix 1.

## 6. IDENTIFYING INCIDENTS FOR PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII) AND OTHER LEARNING RESPONSES

It is recommended that the Trust will continue to use existing governance structures to support the process of transition to PSIRF.

The PSIRF implementation group has been well attended by different clinical areas and senior staff. This group will continue to meet to discuss progress and any changes to the PSIRP.

The responsibility for choosing the most appropriate level of patient safety review will remain in line with current governance structures. With discussions taking place at divisional governance groups and recommendations being presented at the weekly Quality Review Group.

Reports to the board will be quarterly and will include details of:

- Patient safety incident reporting trends
- A summary of findings and learning from PSIIs and other learning reviews (After Action Reviews, thematic reviews, case reviews, MDT reviews)
- Progress and any updates against the PSIRP and policy guidance
- Results from monitoring of improvement plans
- Feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Feedback from staff on their experiences of the organisation's response to patient safety incidents.

## 7. OUR PATIENT SAFETY INCIDENT REPONSE PLAN: LOCAL FOCUS

Through analysis of local data and intelligence from the past three years, key patient safety incidents for PSII have been identified for the Trust.

**Consideration for selection of incidents for PSII:**

- The patient safety event is linked to one of the local priorities (listed below) which were identified through reviewing Trust data.
- Potential for learning in terms of the opportunity for influence on wider systems improvement.
- An event that has never occurred or is an emerging area of risk. This could include a cluster of new patient safety events of a similar theme that may identify a new emerging priority to review.

Patient safety events resulting in serious harm would have been investigated as a serious incident under the serious incident framework. It is important that such events are not routinely investigated in the same way using the PSII process.

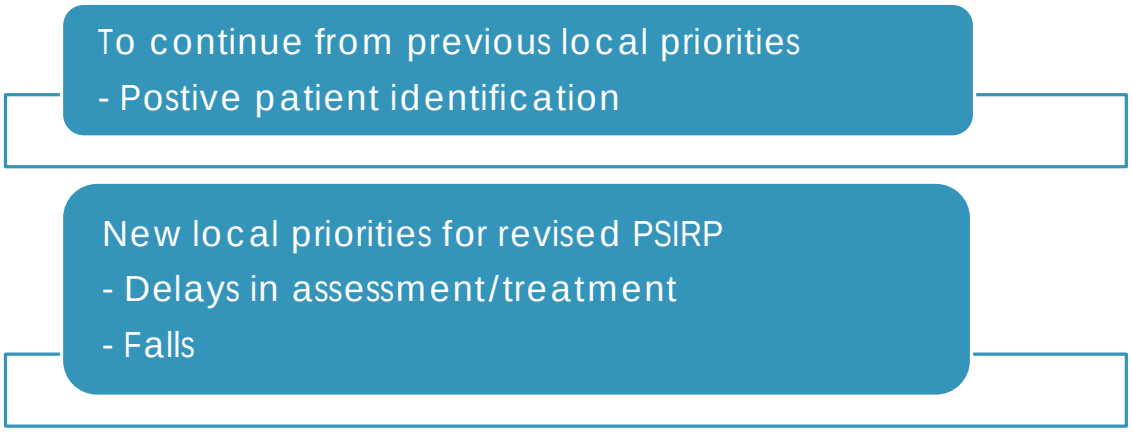
The Statutory Duty of Candour requirements will still apply for any incidents of moderate harm or above.

Not all Patient Safety Incidents require PSII but may benefit from a different type of learning review to gain further insight or address queries from the patient, family, carers or staff. Where this is the case, we will utilise AAR's or a thematic review.

For the period October 2023 to October 2024 local priorities for Patient Safety Incidents have been agreed as illustrated below.

- The safe transfer of patients within the hospital
- The safe discharge of patients
- Positive patient identification
- Near miss incidents

Following review through the PSIRF group the following have been identified as the local safety priorities for the following 18 months.




## 8. DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

Following the review of our data with stakeholders, our improvement profile is aligned with the Trust's Quality Priorities for 2025/2026. These are:

- Care of the acutely ill patient (CAIP)
- Urgent and Emergency Care
- Patient Safety Culture and Speaking up

## 9. GLOSSARY OF TERMS

**PSIRF** – Patient Safety Incident Response Framework

This sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

**PSIRP** – Patient Safety Incident Response Plan

This is the Trusts local plan which sets out how we will implement PSIRF. It details our local priorities which were developed collaboratively and informed by analysis of a number of data sources.

**PSII** – Patient Safety Incident Investigation

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

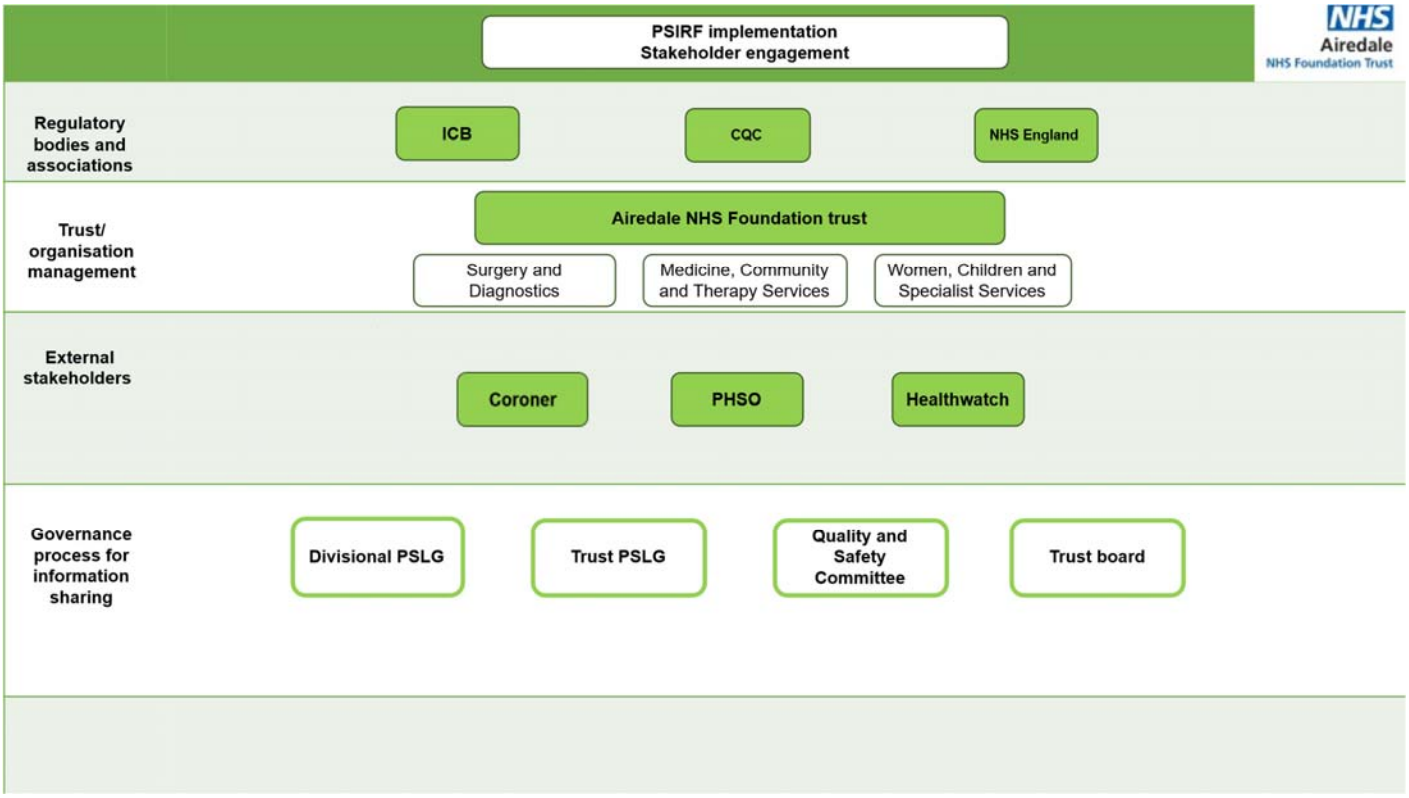
**AAR** – After Action Review

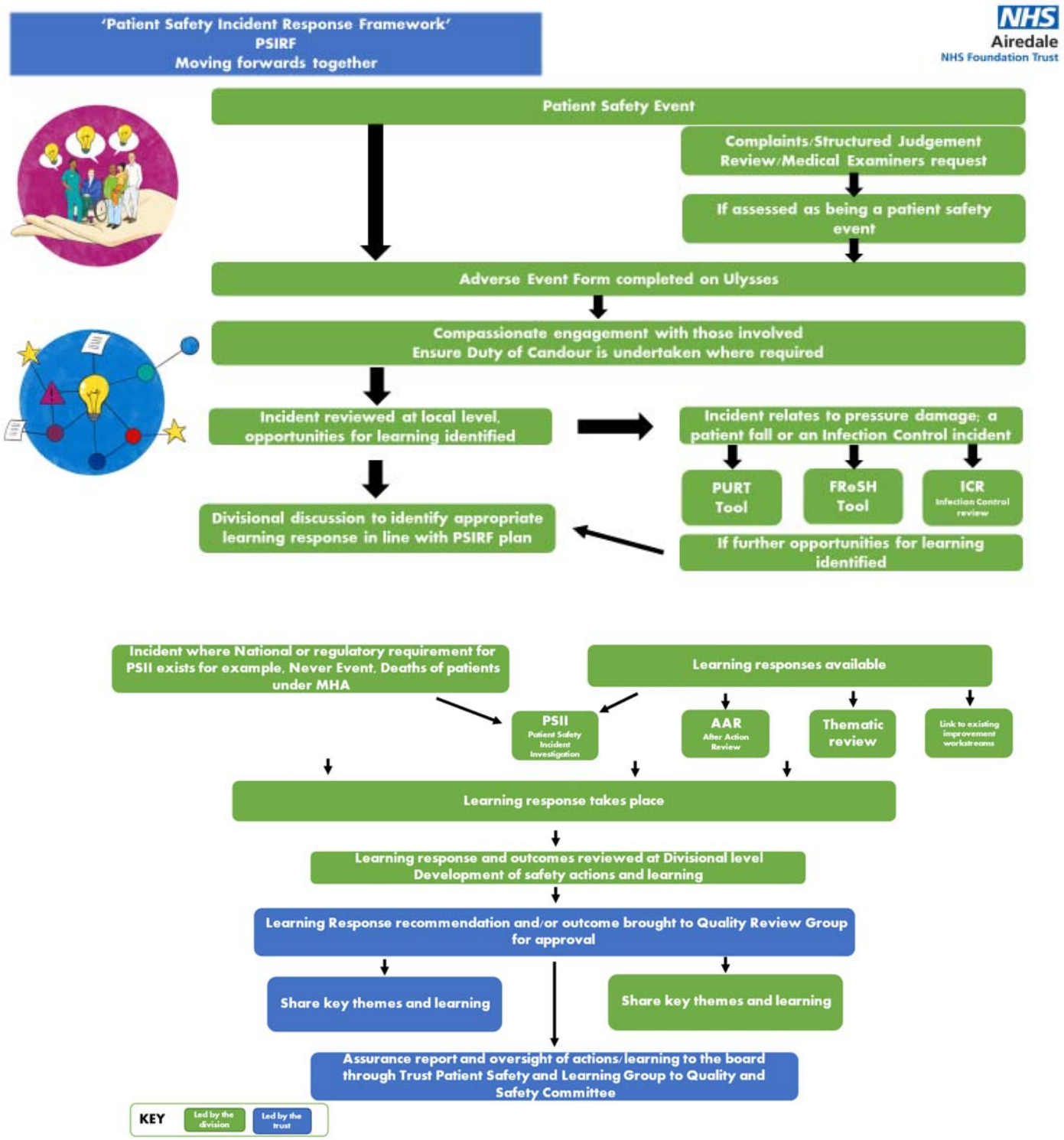
This is a non-hierarchical facilitated structured discussion following an event. It enables teams to discuss what happened, why it happened and to identify learning and improvements.

**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. Never Event Framework

## APPENDIX 1 – STAKEHOLDER ENGAGEMENT




| Key stakeholders for information and oversight | | |
|---|---|---|
| **Role** | **Staff group** | **Mechanism for sharing information** |
| Oversight | Trust Board | Updates via Quality and Safety Committee |
| Oversight | Executive team | Updates via Quality and Safety Committee |
| Oversight | Non-executive directors | PSIRF meeting (November 2022) |
| Oversight | Divisional triumvirates | Updates via Trust Patient Safety and Learning group |
| Oversight | Governance leads | Updates through PSIRF implementation group |
| Oversight | Workstream members | Updates through workstream meetings |
| Oversight | ICB | Updates through monthly Patient Safety Specialist Meetings (Place) |
| Information | Clinical staff | Via governance groups, divisional PSLG, Clinical Leadership forum. Newsletters, bulletins, trust comms |
| Information | Administrative staff | Via governance groups, divisional PSLG, Clinical Leadership forum. Newsletters, bulletins, trust comms |

## APPENDIX 2 – INCIDENT REVIEW AND OVERSIGHT PROCESS