



# Patient Safety Incident Response Plan 2023-2024



## Foreword

The Patient Safety Incident Response Framework (PSIRF) is a new approach to how the NHS will respond and learn from Patient Safety Incidents. This is a new process to investigate incidents and learn from them when they occur; a marked cultural shift in our approach to systems, protocols, and thinking. Working closely with families, patients, and staff this new framework will support us to make changes to ensure incidents that have occurred may be prevented from happening again.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patients Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at Mersey and West Lancashire Teaching Hospitals NHS Trust to prepare for “go live” with PSIRF.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents. PSIRF promotes a proportionate approach to responding to patient safety incidents.

Under the new PSIRF framework, each organisation internally determines the type of incidents to be investigated, based upon local risks, trends and priorities for highest impact.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better, means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how Mersey and West Lancashire Teaching Hospitals NHS Trust will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve patient safety incident investigations (PSIIs) by:

- Refocusing Patient safety incident investigation (PSII) towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders’ (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.

**Aidan Fowler, National Director of Patient Safety, NHS England** – “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. “

## A note from Mersey and West Lancashire Teaching Hospitals Executive Director of Nursing, Midwifery and Governance and Trust PSIRF Executive

I am proud to introduce our plan for the management of investigations under the new Patient Safety Incident Response Framework. The Trust has worked hard to develop this plan. We will embed this new framework into our existing safety processes and ensure we have developed the right team, tools, and response to managing these investigations.

As part of the review, we have undertaken in the Trust, we have consulted with staff, patients, specialists, and our data to create our 'local priorities' which will be the indicators to when we will conduct a Patient Safety Incident Investigation. This investigation will be done, using methodology which we have adopted to support incident investigation and ultimately support us in learning from that event, putting things right and ensuring that there are mechanisms and risk management to stop it from happening again.

I hope this plan provides you an insight into how we will conduct these investigations in the future and evidence the care for our patients, our staff, and delivering 5-star care across Mersey and West Lancashire Teaching Hospitals NHS Trust.



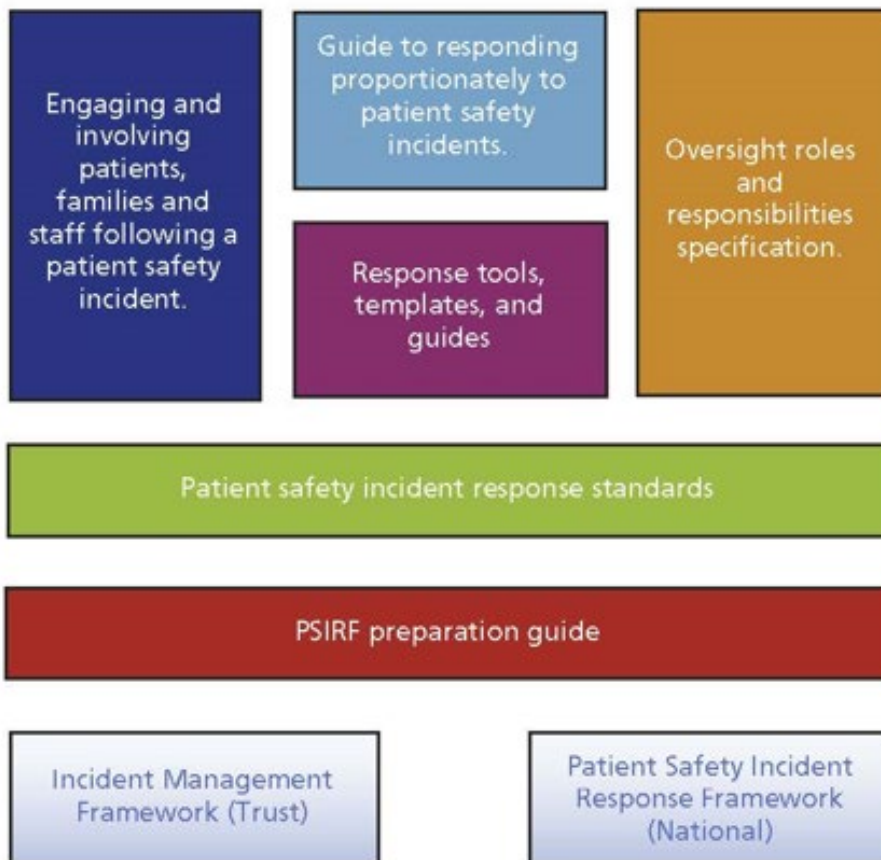
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# Overview of the Patient Safety Incident Response Framework

## PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK



## SUPPORTING DOCUMENTATION



## Who we are?

Mersey and West Lancashire Teaching Hospitals NHS Trust provides healthcare in hospital and the community to people across St Helens, Knowsley, Halton, Liverpool Southport, Formby and West Lancashire.

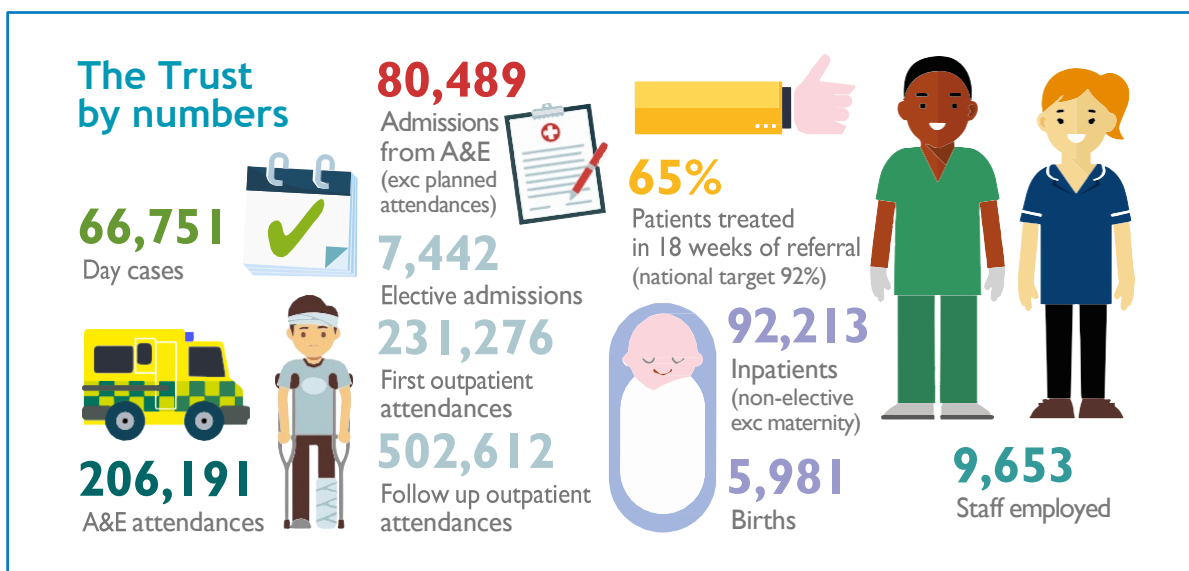
Acute care is provided at Southport and Formby District General Hospital, Ormskirk District General Hospital, Whiston Hospital, St Helens Hospital and Newton Hospital.

This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities.

In addition, the Trust hosts the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital. The Trust provides the Mid-Mersey Hyper-Acute Stroke Unit (HASU) and the Mersey Regional Burns and Plastic Surgery Unit, Northwest Regional Spinal Injuries Centre at Southport Hospital and provides specialist care for patients from across the North West of England, North Wales and the Isle of Man.

Women's and children's services, including maternity, are provided at both Whiston Hospital and Ormskirk Hospital.

The Trust also provides an Urgent Treatment Centre (UTC) at the Millennium Centre in St Helens, and Marshalls Cross Medical Centre (primary care services) and intermediate care and community services at Newton Hospital. In addition, the Trust delivers a range of community services, including adult community nursing (for St Helens), Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence, chronic obstructive pulmonary disease (COPD) services and intravenous (IV) therapy, plus outpatient and diagnostic services from a range of other community premises.



This plan intends to be delivered with the existing Trust shared vision, which is:

***“To provide 5-star patient care to all of our patients across Merseyside and West Lancashire.”***

## What PSIRF will mean?

PSIRF will replace the Serious Incidents process. This means our incident response will change but PSIRF will allow us further learning and opportunity to make improvements on the back of future incident investigations.

We will respond to Patient Safety incidents using a systems-based approach, removing a 'person focused' approach where the actions or inactions of people or 'human error', are stated as the cause of an incident.

Our Trust Board will have increased accountability and oversight of Patient Safety Incident Investigations.

Our investigations team will be specially trained and have the right skills and knowledge to conduct a Patient Safety Investigation with PSIRF methodology.

We will support Patients, families, and our staff through the process.



## How PSIRF is different

The Patient Safety Incident Response Framework (PSIRF) 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.

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.

### PSIRF will:

- Advocate a coordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by the patient safety incidents.
- Embed patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programs. To do so, information is collected from a wide variety of sources, including wider stakeholder engagement.



## How we have prioritised our incidents and our investigation resource

Mersey and West Lancashire Teaching Hospitals NHS Trust has a developed quality and safety assurance process to ensuring services are safe and effective.

A key part of developing the new approach is to understand the amount of patient safety activity the trust has undertaken over the last 5 years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

A review of the activity associated with patient safety incident investigation for the period 2018-2023, claims, inquests and complaints has been undertaken to determine key priorities. This review has been undertaken by the Trust's Patient Safety Specialists with support and involvement from colleagues, committees, and groups to identify the Trusts local priorities.

A new framework for investigation of patient safety incidents will be established, supported by a team, which will include specialists, investigators and subject matter experts as appropriate. Support will be provided by clinical staff within specialties to ensure patient/family/carers are involved and kept informed of progress.

**To improve our ability to deliver against PSII standards, the Trust plan to:**

- Assign a team of appropriately trained Patient Safety Incident investigators who have received system-based training on incident investigation methodologies.
- Assign an Executive Team/Board member to oversee delivery of PSII standards and support the sign off, of all PSII's.
- Develop an incident investigation toolkit to support other Trust staff so they can review patient safety incidents where a PSII is not indicated but learning can still be identified.
- Ensure that the Trust has a Patient Safety Partner to be part of the PSIRF implementation and sub-committees as a patient voice and help shape investigations and learnings.
- Support and provide training to staff to develop and implement tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.





## How we have prioritised our incidents and our investigation resource (continued)

The Trust used a thematic analysis approach to determine which areas of patient safety activity it should focus on, to establish the local priorities.

Our analysis used several data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top patient safety risks from incident reporting and then cross reference these from several other data sources including key stakeholders.

The key priorities were defined from this list based on number of Serious Incident investigations conducted and areas where the Trust had existing quality priorities or initiatives in place.

### Key stakeholders included:

- Staff from all levels and areas
- Senior Managers within the Trust.
- Patient Safety Specialists.
- Staff from all levels and areas.
- Commissioners.
- Patient Safety Partners.
- Patient Safety teams.
- Healthwatch.
- Cheshire and Mersey ICB

### The Trust reviewed five years of data, the sources included:

- Patient safety incident reports.
- Complaints.
- Mortality reviews.
- Claims and outcomes of inquests.
- Trust Risk Register
- Staff survey on patient safety key priorities
- Feedback from Safety groups.



## National Priorities for PSIRF

Listed below are the national priorities which will either require a full Patient Safety Incident Investigation (PSII) or the use of an appropriate Patient Safety Tool.

		Event	Approach	Improvement
Patient Safety Incident Investigation	National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency / organisation as required. Potentially local led PSII.
		Incidents meeting maternal death criteria		
		Child Death	Initiate child death review process	
		Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme	
		Safeguarding incidents meeting criteria	Reported to named safeguarding Lead	
		Incidents in screening programmes	Reported to Public Health England (PHE)	
		Deaths of patients in custody, in prison or on probation	Reported to Prison and Probation Ombudsman (PPO)	
		Incidents meeting the Never Event criteria	Patient Safety Incident Investigation Team	
			Incidents resulting in death (incidents meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation Team
	Trust Priorities	Local organisation PSIRF priorities	Patient Safety Incident Investigation Team	
Patient Safety Review	Local Level	No / Low Harm Patient Safety Incidents	Validation of facts at local level recorded on DATIX	Inform thematic analysis of ongoing patient safety risks at teams, speciality, directorate, division, and trust level. Relevant patient safety tool will be used to investigate incident.
		Moderate and Severe Harm incidents	Statutory duty of candour and appropriate PSR tool	

## Our Trust priorities

Listed below are the Trust priorities which will either require a full Patient Safety Incident Investigation (PSII) to learn and improve, these will be conducted by the PSIRF team. Whilst other types of priorities will be investigated by a separate resource or governing body or locally in the Trust by the specialist area the incident occurred in.

INCIDENT TYPE	DESCRIPTION	ACTION
Care of the deteriorating patient	Incidents where the identification of a deteriorating patient has been delay leading to significant impact on patient outcome	FULL PSII
Unsafe discharges	Discharges from hospital that have been deemed unsafe and impacted on the patient outcome	FULL PSII
Misdiagnosis	Missed or delayed diagnosis that has impacted on patient outcomes, with potential for significant learning	FULL PSII
Medication	Medication incident that has significantly impacted on patient outcomes	FULL PSII
Pressure ulcers	Hospital Acquired Category 3 pressure ulcers and above, with potential for significant learning	FULL PSII
Slips, trips, and falls	Inpatient fall leading to fracture of hip bone, with potential for significant learning	FULL PSII
Areas of emerging risk	Based on trend or analysis from the patient safety group, PSII will be conducted on specific areas of risk that have been identified	FULL PSII

## How we will respond to a patient safety incident under PSIRF

Aside from the national requirements that have been set out, PSIRF sets no further threshold to determine what method of response is required for any patient safety incident.

We have created our local priorities as a Trust with collective data and input from committees, patient safety groups, staff and patients.

When incidents arise, this does not mean that we will routinely investigate all incidents through PSIRF. This could lead to us recreating the old process of the Serious Incident Framework (SIF). Therefore, we have explored other toolkits and methods suggested for reviewing incidents outside of PSIRF and will use these tools in principle for Patient Safety Reviews (PSR).

### We may undertake:

- Swarm reviews or team huddles (Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.)
- Rapid reviews
- After action reviews
- Audits
- Structured Judgement Reviews (SJR's)
- Thematic Analysis

Staff that undertake these reviews will be trained and supported to conduct the method of review and set processes/frameworks will be in place to oversee this.

We will have 'ward to board' governance mechanisms in place and subsequent reporting structures to ensure that patient safety incidents and improvement is overseen effectively, and we learn from incidents and ensure the learning is placed back into the organisation.



## Involvement of patients, service users, families, carers, and staff during incident investigations

We recognise and acknowledge the impact that patient safety investigations may have on our patients, service users, families, carers, and staff.

The Patient Safety Incident Response Framework has been put in place to ensure that those affected by an incident are engaged with in a meaningful way, shown compassion and ensure they are involved and for those affected to have the ability to understand or ask any questions in relation to an incident.

To ensure that this happens, our organisation will appoint Family Liaison Officers (FLO) who will be trained and supported in giving advice and information during the investigation and supporting those affected.

This will aid our learning and improvements, but it will also allow us to support those affected and ensure that they are kept up to date with the investigation and can contribute towards it.

As a Trust we have worked hard to ensure we move away from a culture of blaming individuals in response to incidents to establishing a well embedded Just Culture. The Trust is committed to ensuring that Patient Safety Incident Investigations are conducted for learning and improvement purposes only.

For staff that are involved in incidents we will ensure that support is at hand when needed. We offer in house training on Human Factors which supports staff around psychological safety at work and offer other forms of patient safety training to ensure we embed a good Patient Safety Culture.

We value our staff and offer additional support from our excellent Health and Wellbeing services and Freedom to speak up services, should they have concerns.



## Duty of Candour

Our Trust will ensure we are open, honest, and transparent about a patient safety incident investigation.

This means explaining when something has gone wrong and apologising for it, ensuring there are steps in place to put it right and keeping a secure record of the events. All our staff are accountable to ensure we comply with this, and this is part of their clinical registration.

We will ensure that we maintain the Statutory Duty of Candour for any incident that meets the national threshold, to do this we must:

- Tell the person/people involved (including the family, where appropriate) that an incident has taken place.
- Apologise and say that we are sorry.
- Provide a true account of what has happened, explaining and being clear about what we know at that point.

- Explain and be clear about what we are going to do to understand the events (for example if we conduct a PSII or PSR).
- Follow up by providing this information and the apology, in writing.
- Keeping secure written records of any meetings, or communications given.

Duty of Candour will also allow us to take insight and learning from incidents and we can provide this information back to those affected.



## Roles and responsibilities

Our staff will have key roles to play in this new framework and we have listed some of the key roles that will help support this change to patient safety investigations.

### Executive Directors and Non-Executive Directors

All Executive Directors have responsibility for ensuring incidents are investigated in a timely manner and responded to in accordance with this plan and appropriately signed off.

### Patient Safety Specialists

The Trusts PSS team supports the Executive and Non-Executive Directors in carrying out their responsibilities for the management of PSII investigations within the trust and the presentation of learning and assurance back to system partners.

### Patient Safety Partner

The PSP will support the Patient Safety Specialists and be actively involved in the design of safer healthcare at all levels in the organisation, this will be a voluntary role and represent 'the patient'.

### Trust Lead for PSIRF

The Trust Lead for PSIRF will provide assurance on Patient Safety incident management processes and overseeing the functionality of the Trust's Patient Safety Incident panels. PSIRF Lead will work closely with system partners to ensure that PSII's are shared with the board and learning is distributed across the wide ICS and is shared in collaboration with other Trusts.

### Patient Safety Incident Investigation Leads

The Patient Safety Incident Investigation Lead is responsible for undertaking a full investigation into patient safety incidents that meet the criteria within the plan, that they are conducted in accordance with the plan and for working closely with the family liaison officer to ensure patient/family/carers are given an opportunity to provide relevant information that will support the investigation, that they are kept informed of the process and outcome of the investigation.

### Family Liaison Officer

Family Liaison Officer are responsible for ensuring appropriate support is offered to the patient/family/carers and confirming any questions of concern the family/patient/carer would like to include as part of the key lines of enquiry of an investigation being the link person for patient/carer/family and ensuring that they are given the opportunity to provide relevant information that may inform the outcome of the investigation and linking in with the Patient Safety Incident Investigation Lead.

### Divisional/Directorate Managers, Clinical Leads, Lead Matrons/Matrons/Senior Nurses and Service Managers

Ensure that appropriate experts are available to support the Patient Safety Incident Investigation Leads to carry out investigations within the relevant division and departments. They ensure that all investigations are completed in a timely manner by releasing all staff involved within an incident to attend any investigation discussions. They will also conduct Patient Safety Reviews using the appropriate toolkits.

## Patient Safety Leads

The Patient Safety Teams support the Trust's governance teams in ensuring that the review, manage, investigate, and monitor learning from incidents. They work closely with the Patient Safety Incident Reporting and Investigation Teams in supporting the timely and appropriate reporting, recording, investigating and coordination of all incidents. The Patient Safety Leads are responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is included within the Patient Safety and reported to the Governance Meetings so learning can be cascaded through the Quality and Safety processes within the and wider throughout the Trust.

## All Staff

All staff are required to provide information either/both verbal or written reports for any investigation for an unexpected event or incident in a culture of being open and honest, supporting colleagues with a view to learning lessons in a just culture. Line managers have a responsibility to ensure staff are released from duty to attend debriefings, round table discussions, interviews regarding any incident.

## Patient Safety & Governance Team

The Patient Safety and Governance Team are responsible for reviewing all incidents reported on the incident management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Divisional Patient Safety Leads. The Team is required to report incidents to relevant external stakeholders in accordance with their reporting requirements.





## Contact us:

### Whiston Hospital (Trust Head Office)

Patient Safety Team, Nightingale House  
Warrington Road  
Prescot  
L35 5DR

### Southport Hospital

Integrated Governance Team, Trust Management Offices  
Southport Hospital  
Town Lane, Kew  
Southport  
PR8 6PN

**Telephone:** 0151 426 1600

**Website:** <https://www.merseywestlancs.nhs.uk>

**Twitter:** @MWLNHS

**Facebook:** [www.facebook.com/](http://www.facebook.com/)

