

Patient Safety Incident Response Plan

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Introduction

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework.

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.

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 North Cheshire and Mersey NHS Foundation Trust intends to respond to patient safety incidents over a period of 6 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.

This plan is underpinned by our existing Trust policy on Duty of Candour and the revised Trust Patient Safety Incident Response Policy Framework (PSIRF).

Following review of progress in terms of embedding learning and improvement and scrutinising the data 2023-24, reports presented via the Trust Governance structure the decision was taken in consultation with colleagues that we would continue with the same local priorities through the next phase of PSIRF to enable robust sustained learning and improvement.

Note: This plan is a combined plan for previous organisations know as Bridgewater Community Healthcare NHS Foundation Trust, and Warrington & Halton Teaching Hospitals NHS Foundation Trust. Therefore, the intention is to review and revise the plan for North Cheshire and Mersey NHS Foundation Trust within 6 months of integration.

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Our services

North Cheshire and Mersey NHS Foundation Trust provide services to both patients in hospital and community. The demographic of the area shows most people are born in England and there are a small percentage of people from other nationalities.

The hospital site at Warrington provides and the Halton Hospital Nightingale building in Runcorn, alongside the Halton Hospital Captain Sir Tom Moore Building the home of the breast care centre and surgery provide acute services. Our community and Dental services strategy is to bring care closer to home. This means providing a wide range of services in community settings and to keep people healthier for longer by developing more specialist services to support people to live independently at home.

The Trust has a total of 668 beds across all three sites: acute care inpatient, day case and specialist beds at Warrington, elective surgical beds, and intermediate care beds at Halton Hospital Nightingale Building and Halton Hospital Captain Sir Tom Moore Building for surgery.

North Cheshire and Mersey NHS Foundation Trust employs more than 6,000 staff from over 50 nationalities, many who live in the boroughs we serve and provide a range of services such as urgent and emergency care, maternity, surgery, outpatients, therapies, and children's health. On average 3000 babies are born at Warrington Hospital each year. In addition, our community and dental services are delivered in patients' homes or at locations close to where they live, such as Clinics, Health centres, General practitioner (GP) premises, Community centres and schools.

Defining our patient safety incident profile

The Trust has a commitment to continuously learning from patient safety incidents and has developed an understanding and insights into patient safety matters over a period of years. North Cheshire and Mersey NHS Foundation Trust have weekly Executive-led Safety Oversight Meetings (SOM), and monthly Executive Led Review Group.

The SOM has responsibility for overseeing safety processes, to enable assurance to the Patient Safety Incident Response Framework (PSIRF), Executive Review Group, that the true intent of PSIRF is implemented, within the organisation, and the Trust is meeting the National Patient Safety Incident Response Framework Standards

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The Executive Led Review Group ensures that the four main aims of PSIRF are implemented and embedded across WHH:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

There is a daily patient safety triage with the Clinical Governance Team with proactive input from the Care Groups and associated Clinical Business Units. The SOM supports and oversees the operation and decision-making for incident responses.

Trust Executive teams, Clinical Governance Team and appropriate Care Group Triumvirates and associated Clinical Business Unit (CBU) leaders are alerted by email of any incidents of moderate or above grading. The Clinical Governance Team will support review of all incidents reported to ascertain actual level of harm and identify any immediate actions to ensure patient safety. These incidents are monitored daily and discussed at the daily patient triage meeting to ensure the most appropriate level of investigation is undertaken.

Incidents meeting a lower harm threshold that may be of concern, or where themes are developing, are monitored by the Care Groups and associated CBU's and at the triage meeting and taken forward to SOM for executive oversight when required. (refer to Patient Safety policy framework)

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p12-13 below. To fully implement the Framework the Trust has completed a review of the types of patient safety incidents that occur to understand the learning needs that will inform improvements. The review was again repeated for all incident types reported in 2023-24 to inform decision making. As a result of this further review and discussion with colleagues the decision was that we would continue with the current local priorities

The PSIRF SRO and leadership group has 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

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methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on p14.

Stakeholder engagement

Planning for PSIRF was commenced on release of National Guidance in August 2022. North Cheshire and Mersey NHS Foundation Trust have worked with a number of the PSIRF early adopters to learn from their approaches, with support from the North-West PSIRF Collaborative network to better understand the practicalities of planning for and implementation of PSIRF.

North Cheshire and Mersey NHS Foundation Trust have a proactive approach to patient safety incidents. This approach supports the embedding of the PSIRF culture, and as such sees North Cheshire and Mersey NHS Foundation Trust developing this attribute as PSIRF embeds further within the organisation.

Regular contact with Place and the Integrated Care Board (ICB) has seen this approach progress and provides assurance to internal and external stakeholders.

Awareness of PSIRF began early, following initial preparatory work and then the launch of the PSIRF in August 2022, with communications sent Trust wide through the communications teams. This was supported with engagement sessions to Trust board and the wider senior clinical teams. Governance meetings and relevant groups from across the Trust have participated in presentations and discussions to share PSIRF updates and widen knowledge.

It should be noted that whilst priorities have been identified, the Trust remain flexible in utilisation of the toolkit and aim to collaboratively commission the most appropriate investigation based upon the findings of initial investigations. Likewise, incidents of concerns that may not be outlined within stated priorities, must be shown due diligence by investigating appropriately.

Data sources

To define our patient safety response profile, data was drawn from a variety of sources. Data was collated on the actual incidents that had taken place over the period of the 3 years, that is, from 2020 to 2023. It was decided to look at these years to minimise the possibility of any variation in data arising from the COVID-19 pandemic. Data was collected in financial years – 01/04/2020 to 31/03/2023.

This data was extracted for our initial engagement meetings with key internal stakeholders.

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Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident reporting systems
- Complaints, both formal and informal
- Safeguarding reviews
- Freedom to Speak Up
- Mortality Reviews
- Staff survey and learning surveys
- Claims
- Trust risk profile
- Data from Quality Surveillance processes
- Coronial information Inquests.
- Freedom to speak up reports.
- Inquest reports

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. 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.

Safety issues highlighted by the data

From the original data review, and the data from 2023/24 we were able to identify the top ten reported incidents by category, level of harm was also considered as part of these reviews. These are shown in the table below. (The term patient is used to describe an individual in receipt of care and treatment, for some services the term service user is preferred):

Hospital sites

Category	Descriptor
Medication	All medication issues, including errors, administration, and prescribing.
Infection Prevention and Control	All incidents relating to infection control concerns.
Access, Transfer & Discharge	All incidents related to accessing care, transferring in or out of WHH and discharging concerns.
Patient Fall	All patient falls.
Clinical Care - ongoing & review	All incidents related to a concern in treatment
Skin Damage – Admitted with	All incident where skin damage has been noted upon admission to the Trust.

Assessment, diagnosis, and Investigation	All incidents relating to assessment diagnosis or investigations.
Security	All security incidents
Staffing	All staffing related incidents.
MASD – other wound to skin	All incidents where skin damage has been attributed to a Trust admission.

Community and Dental sites

Category	Descriptor
Clinical Assessment – including diagnostic tests	All incidents that relate to clinical assessment processes including diagnostic testing.
Communication	All incidents that relate to communication either within / outside the sites
Consent, Patient ID	All incidents where there have been consent issues either in a legal or statutory framework, it also captures problems with documentation within the Mental Capacity Act (MCA), Mental Health Act (MHA) / Deprivation of Liberty Scheme (DOL's) processes.
Death	All deaths reported.
Demand / Capacity / Resource	All incidents that relate to demand on sites services and the capacity of services to meet the demand.
Documentation (electronic/paper/identification)	All incidents relating to issues with recording and storage or management of patient and staff information.
Equipment - Medical	All incidents with equipment including failure or difficulties with supply or use.
Estates & Facilities	All incidents involving environmental matters, estates, or facilities provision.
Finance	All incidents relating to the handling of money in the organisation
Fire	All fire related incidents, including actual fires and false alarms.
Health and safety	All incidents relating to safety & welfare.
People CBU	All incidents relating to processes for management of staff

Infection control	All incidents relating to infection prevention and control events or processes.
Information Governance	All incidents regarding the security and confidentiality of personal information, regarding patients or staff.
Information Technology	All incidents regarding management of the Trust's IT infra structure inc. telecoms.
Medication	All incidents across the elements of the medication process.
Moisture lesion / trauma / wounds	All cases of skin damage that is not related to pressure.
Moving and Handling	All incidents regarding moving and handling activity.
Patient collapse	All cases of unexpected patient deterioration.
Person accident (not fall)	All unexpected events that do not relate to clinical activity.
Pressure Ulcer trust acquired	All incidents relating to pressure and related skin damage and other wounds sustained under Trust care.
Pressure Ulcer Non-Trust acquired	All incidents relating to pressure and related skin damage and other wounds sustained outside of Trust care.
Records Management	All incidents regarding the access to and management of records.
Safeguarding	All incidents where it has been reported or noted that a patient has required to be safeguarded.
Security (not aggression / abuse)	All incidents regarding the security of Trust property and staff.
Self-harm / suicide	All cases of self-harm carried out by patients.
Sepsis related incident	All cases regarding the management of sepsis.
Slips / Trips / Falls	All incidents where a patient fell, tripped, or slipped on or off Trust premises.

Treatment Delay / Error	All incidents regarding delays in delivery of clinical care, or errors in the delivery of clinical care.
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These were the themes considered, with further details on the subcategories within the themes considered to identify and hone our overall profile. We have also considered items identified which link to current improvement programmes of work and assessed the potential for new learning.

This led to the local focus priorities highlighted on p14 below and which will be our priorities for review under PSIRF.

Whilst the list has been agreed to continue as our priorities, 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.

Defining our patient safety improvement profile

At North Cheshire and Mersey NHS Foundation Trust we are committed to embedding a culture of continuous improvement to provide the best care possible for our patients. We do this by working together to make slight changes every day as part of our daily work, therefore continually building on the great care that we already provide and striving to make continual improvements for our staff and patients.

The Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into continuous improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the continuous improvement work we need to undertake.

The Quality Academy was established in June 2018. Its ethos is to apply innovative research and innovation to ensure that clinical excellence is embedded throughout the organisation. This is achieved through continuous quality improvement, collaborating with staff in collaboration with our partners and the public.

The Quality Academy is focusing on building quality improvement capacity and capability at all levels of the organisation by providing different types of improvement training in order to achieve spread and maximise the opportunities for improvement work across the trust.

Our improvement priorities are informed by data analysis and engagement with the Care Groups and CBU's teams around operational and pathway improvement priorities from across the organisation and in line with national requirements. Our improvement work currently comprises a combination of:

- Key improvement priorities arising from national reports, audits, incidents, and complaints (e.g. Infection Prevention and Control, communication with relatives, optimising patient flow)
- Supporting teams taking part in National Collaborative (e.g. MatNeoSIP, MedSIP)
- Trust wide harms reduction priorities supported by the Corporate Nursing Team and the Trust Safety Nurses (e.g. safety huddles, pressure ulcers, falls, VTE)
- Care Group and associated CBU's and service specific improvement projects (e.g. medicines safety, Sepsis)

We have brought together all elements of improvement work currently underway within the Trust. This can be located at **Appendix C**. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated workstream noted.

We plan to focus our efforts going forward on the 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.

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident responses, we intend to use those resources to maximise improvement. PSIRF enables 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.

There are specific patient Safety incidents that will require a PSII as this is mandated 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.

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

A review of those incidents reported as per Serious Incident Framework (SIF) at the Warrington and Halton hospital sites that required full comprehensive investigations was undertaken for the last three years:

In 2020/21, 40 comprehensive investigations were undertaken and 65 concise investigations.

In 2021/22, 56 comprehensive investigations were undertaken and 78 concise investigations.

In 2022/23, 71 comprehensive investigations were undertaken and 91 concise investigations.

In 2023/24.

- Number of Serious Incident Investigations between April and August 23 – **30**
- Number of Patient Safety Incident Investigations (PSIIs) declared between September 23 and March 24 – **8**
- Number of Concise Investigations – **7**
- Number of After-Action Reviews– **30**
- Number of Multi-Disciplinary Team (MDT) Reviews– **22**
- Number of Swarm Huddles – **1**

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Investigation type to be determined at SOM
2	Deaths clinically assessed as more likely than not due to problems in care	Investigation type to be determined at SOM
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII

4	Child deaths	<p>Refer for Child Death Overview Panel review.</p> <p>Locally led PSII (or other response) may be required alongside the Panel review</p>
5	Deaths of people with learning disabilities	<p>Refer for Learning Disability Mortality Review (LeDeR).</p> <p>Locally led PSII (or other response) may be required alongside the Panel review</p>
6	<p>Safeguarding incidents in which:</p> <p>Babies, children, and young people are on a child protection plan; looked after plan or a victim of willful neglect or domestic abuse. / Violence.</p> <p>Adults (over 18 years old) are in receipt of care and support needs by their Local Authority</p> <p>The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.</p>	<p>Refer to the local authority safeguarding lead.</p> <p>Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews, and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.</p>
7	Incidents in screening programmes	<p>Refer to local Screening Quality Assurance Service for consideration of locally led learning response.</p> <p>See: Guidance for managing incidents in NHS screening programmes</p>
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	<p>In prison and police custody, any death 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.</p> <p>Healthcare providers must fully support these investigations where required to do so.</p>

9	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 by the provider in which the event occurred with participation by North Cheshire and Mersey NHS Foundation Trust as required
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider as lead and North Cheshire and Mersey NHS Foundation Trust participation if required.
11	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.

Our patient safety incident response plan: local focus

PSIRF enables organisations to explore patient safety incidents relevant to their context and the populations served. Through analysis of patient safety insights, based on the review of incidents and engagement meetings and workshops the Trust have determined 6 patient safety priorities as local focus. This will enable us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII's to inform our patient safety improvement planning through continuous improvement.

Provider sites – Warrington and Halton hospitals			
	Incident type	Description	Response type
1	Assessment, Diagnosis, and Investigation	Potential for harm when there is a missed or delayed diagnosis of a cancer.	Investigation to type to be determined by SOM following ISR
2	Clinical Care - ongoing & review	Potential for harm when there is a delay in the identification, recognition and response to patient deterioration resulting in delayed escalation and treatment.	Investigation to type to be determined by SOM following ISR
3	Assessment, diagnosis, and Investigation	Potential for harm when there is a delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)	Investigation type to be determined by SOM following ISR

Community and Dental sites			
	Incident Type	Description	Response Type
1	Pressure Ulcers	Incidents involving category 2,3,4 pressure ulcers	Investigation type to be determined following ISR and potential for new learning
2	Inpatient falls	Injuries that cause significant fractures (DoC) Other falls incidents	Investigation type to be determined following ISR and potential for new learning Thematic analysis of ongoing patient safety improvement work

3	Equipment	<p>Delays in provision of Equipment</p> <p>Issues relating to servicing and maintenance of equipment , including decontamination.</p> <p>Scoping review to determine if any other areas to focus on.</p>	<p>Investigation type to be determined following ISR and potential for new learning</p> <p>Thematic analysis of ongoing patient safety improvement work</p>
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Corporate and other Specialist Services

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	<p>Review by CBU in conjunction with IT Continued monitoring through CBU/Trust governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Staffing	<p>Review by operational managers in conjunction with workforce and professional leads as appropriate</p> <p>Continued monitoring through CBU/Trust safety/workforce meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Death	<p>Review by Learning from Deaths process (including family input) and Mortality MDT</p> <p>Review as PSII where index case or meets national priority criteria</p>	Create local safety actions if applicable and feed these into the quality

Patient safety incident type or issue	Planned response	Anticipated improvement route
		improvement work
Environment, Estates, Facilities	Review by operational managers in conjunction with Estates Continued monitoring through CBU/Trust contract meetings Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Inappropriate behaviour	Review by operational managers in conjunction with relevant subject matter experts Continued monitoring through CBU/Trust safety huddles Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Fire	Review by operational managers in conjunction with Estates Continued monitoring through Trust Health & Safety meetings. Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work
Documentation/IG Breach	Review by operational managers in conjunction with IG team with cross system reporting as necessary. Continued monitoring through Trust DIGIT meetings. Continued monitoring of patient safety incident records to determine any emerging risks/issues	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Breach in security	<p>Review by operational managers in conjunction with Estates</p> <p>Continued monitoring through Trust Health & Safety meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Service provision	<p>Review by operational managers in conjunction with service leads and cross system reporting as necessary.</p> <p>Continued monitoring through CBU/Trust operational working groups</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Violence and aggression	<p>Review by operational managers in conjunction with Health and Safety or relevant subject matter experts</p> <p>Continued monitoring through Trust Health & Safety meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Create local safety actions and feed these into the Health & Safety Policy
Equipment failure	<p>Review by operational managers in conjunction with Estates and Equipment Services</p> <p>Continued monitoring through CBU/Trust governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work

Patient safety incident type or issue	Planned response	Anticipated improvement route
Safeguarding	<p>Review by operational managers in conjunction with the Safeguarding Team to ensure referrals made to facilitate external review</p> <p>Continued monitoring through CBU/Corporate Governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues outside of Safeguarding remit</p>	<p>Inform ongoing improvement work</p>
Health and Safety	<p>Review by operational managers in conjunction with Health and Safety team</p> <p>Continued monitoring through Trust Health and Safety meetings.</p> <p>External reporting to relevant bodies as required</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks / issues</p>	<p>Inform ongoing improvement works</p>
Infection Prevention and Control (IPC)	<p>Review by operational managers in conjunction with Infection Prevention and Control team and cross system reporting as necessary</p> <p>Continued monitoring through Trust IPC governance meetings</p> <p>Continue post infection reviews for outbreaks</p> <p>Continue nationally required external reporting for specific infection groups</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	<p>Inform ongoing improvement work</p>

Patient safety incident type or issue	Planned response	Anticipated improvement route
Third party	<p>Review by operational managers in conjunction with appropriate subject matter experts and cross system reporting as necessary</p> <p>Continued monitoring through CBU governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Serious allegation	<p>Review by operational managers in conjunction with Workforce and Safeguarding/Police</p> <p>Continued monitoring through CBU governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	Inform ongoing improvement work
Patient care and treatment	<p>Review by operational managers in conjunction with relevant subject matter experts and cross system reporting as necessary</p> <p>Continued monitoring through CBU/Trust governance meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issue</p>	<p>Create local safety actions and feed these into the quality improvement work</p> <p>Review as PSII where index case requires as part of the national priorities</p>

Patient safety incident type or issue	Planned response	Anticipated improvement route
Catheter related and UTI	<p>Review by operational managers in conjunction with Bladder and Bowel team and cross system reporting as necessary.</p> <p>Continued monitoring through CBU/Trust CAUTI group</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	<p>Inform ongoing improvement work</p>
Accidents	<p>Review by operational managers in conjunction with relevant subject matter experts including Health and Safety</p> <p>Continued monitoring through Trust Health & Safety group meetings</p> <p>Continued monitoring of patient safety incident records to determine any emerging risks/issues</p>	<p>Create local safety actions and feed these into the quality improvement work.</p> <p>Review as PSII where index case requires as part of the national priorities</p>

Appendices

Appendix A - Glossary of terms

<p>Patient Safety Incident Response Framework (PSIRF)</p>	<p>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.</p>
<p>Patient Safety Incident Response plan (PSIRP)</p>	<p>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.</p>
<p>Initial Safety Review (ISR)</p>	<p>Initial safety review of an incident under the Patient Safety Incident Response Framework (PSIRF) is a proportionate, rapid fact-finding process designed to determine the appropriate learning response, rather than merely identifying blame or a single root cause.</p> <p>Key aspects of the initial safety review include:</p> <ul style="list-style-type: none"> • Timeliness: Rapid reviews are typically completed within 5 working days of an incident being reported or identified. • Purpose: The primary goal is to gather initial information (what happened, when, and immediate contextual factors) to decide if further investigation (such as a Patient Safety Incident Investigation - PSII) or a different learning response (like an After-Action Review or MDT review) is required. • Proportionality & Triage: Not all incidents require a full investigation. The review determines if the incident falls under national priorities (e.g., Never Events) or local priorities outlined in the Trust's PSIRP (Patient Safety Incident Response Plan). • Methodology: Systems-based approaches are used, such as the SBAR (Situation, Background, Assessment, Recommendation) tool to ensure a structured, non-blaming summary. It focuses on "work as done" rather than just "work as imagined". • Engagement: The review prioritises compassionate engagement with those affected (patients, families, and staff) from the outset. • Escalation: If the initial review highlights a high-risk, complex issue, it is escalated to Executive Led Patient Safety Group for a decision on the necessary level of investigation.

	<p>Outcome of the Review: The review will result in one of the following actions:</p> <ol style="list-style-type: none"> 1. No further learning response: If the incident is well-understood and managed under existing improvement plans. 2. Local review: Routine review for low-harm/near-miss incidents. 3. Thematic Review/MDT Review: For identifying patterns across similar incidents. 4. Patient Safety Incident Investigation (PSII): A comprehensive, systems-based investigation.
<p>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 effectively and sustainably address those system factors and help deliver safer care for our patients.</p>
<p>After action review (AAR)</p>	<p>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.</p>
<p>SWARM</p>	<p>This is 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.</p>
<p>Structured judgement review (SJR)</p>	<p>Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. 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. 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</p>
<p>Never Event</p>	<p>Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic</p>

	<p>protective barriers are available at a national level and have been implemented by healthcare providers.</p> <p>https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FIN_AL_v5.pdf</p>
<p>SMART</p>	<p>Criteria used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of five criteria or rules to help for the goal setting as follows</p> <ul style="list-style-type: none"> • S- Specific – a goal should not be too broad but target a specific area for improvement • M- Measurable – a goal should include some indicator of how progress can be shown to have been made • Achievable – a goal should be able to be achieved within the available resources including any potential development needed • R- Relevant – a goal should be relevant to the nature of the issue for improvement • T- Time-related – a goal should specify when a result should be achieved, or targets might slip.

Appendix B - Organogram

North Cheshire and Mersey NHS foundation Trust organogram to be added as soon as available

Appendix C

Improvement programmes

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
	Building improvement capability				
1	Increase uptake of existing QI training programmes through: - improved communications - engagement with care groups and CBU leadership - exploring CPD accreditation	Participation in QI Foundation and QI Practitioner training <i>Aim: 10% of staff (400) trained to QI Foundation level and 2.5% of staff (100) completed QI Practitioner.</i>	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	Ongoing Q1-Q4
2	Implement the QI training delivery plan including: - Develop a leadership for improvement training offer, aligned to emerging NHS England programme (Q2-Q3) - Develop and implement a QI coaching programme (Q2-Q4) - Develop a series of bitesize modules (Q2) - Explore options for development of e-learning package (Q4)	Course content developed Participants enrolled Options appraisal for e-learning	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place Support from partners e.g. AQuA, Q community Coaching SIG, subject matter experts QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work People - Growing our WHH Workforce for the future	Q2-Q4
3	Internal QI team development to meet the evolving needs of the service and Trust	PDR with training and development plan in place for all team members, aligned to service need alongside personal priorities Staff Retention	Access to CPD funding where required Access to external training courses	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	01/06/2023 Ongoing

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
	Build and sustain a culture of continuous improvement				
4	Support CQC Preparedness: Moving to Outstanding by: - QI involvement in the CQC mock inspection programme - support to use QI methods and tools where requirements for improvement identified - support the use of SPC charts and regular measurement to monitor QI outcomes and ensure sustained improvement	Completion of self-assessment of QI, learning and innovation section of CQC well-led framework <i>Aim: Achieve 80% Quality Improvement assessment score in line with CQC maturity matrix.</i> Attendance at relevant CQC meetings and involvement in mock inspections <i>QIPs identified through</i>	QI team capacity	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q1-Q4
5	Implementation of QI communication and engagement plan	Improved uptake of training courses Increase in QIP registrations Improved quality and outcomes of completed	Support from comms team	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
6	Improve oversight and governance arrangements for QI work at Care group and CBU level	Clear escalation routes for QIPs Reduction in number of discontinued QIPs Improved quality of QIPs Improved oversight and uptake of training Improved alignment of workplans with other teams <i>e.g. transformation</i>	Care group and CBU leadership Support	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Q2
7	Continue to showcase Quality Academy and improvement work and celebrate successes across the organisation, including: (e.g. World Quality Week) - promoting and supporting annual events e.g. Quality Academy Showcase, world Quality Week - Celebration events for QI practitioner participants	Attendance and engagement with celebration events Spread of improvements beyond original location/service	Senior leadership support and attendance at events Support from communications team Budget for refreshments etc	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
8	Support the development of a systematic approach to shared learning, e.g. through the development of a trustwide learning forum	Attendance at learning forum Evaluation of learning forum events	Senior leadership support and attendance at events Support from communications team Budget for refreshments, etc	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework Quality Priority 6 - Improve and embed a culture of Quality Improvement	Q3

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	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
Support application of QI methods to Trust and service strategic improvement areas					
9	Support the delivery of 2023-24 Quality Priorities through coaching, advice and guidance to support use of QI methodologies	Attendance and involvement in relevant working groups Application of QI methods to delivery	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
10	Support the delivery of the 23-24 CQUINS through coaching, advice and guidance to support use of QI methodologies	Application of QI methods to CQUIN delivery QIPs identified through or linked to CQUINS	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
11	Support the implementation of PSIRF	Active involvement in the PSIRF implementation group QIPs identified through or linked to local priorities identified within PSIRP	Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Ongoing Q1-Q4
12	Support Trust participation in national patient safety collaboratives, e.g. Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), Medicines Safety Improvement Programme (MedSIP)		Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	
13	Support Care Groups and CBUs to apply QI methods to deliver annual priorities and ad hoc	Application of QI methods QIPs registered within each CBU	Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity	Quality People Sustainability	Ongoing Q1-Q4

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	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
	Further develop QI systems and processes				
14	Review and further develop the QIP registration process, including: - QIP registration form - Clear criteria for registering as a QIP - Development of a standardised approach and criteria to assess QIP quality and outcomes	Revised process following workshop with relevant staff Digitised registration form Updated project type flow chart (to include transformation, patient experience, etc)	Support and engagement from other team leads to clarify distinctions between project types	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q2
15	Further develop the QI toolkit, resources and project documentation	Updated toolkit/resource pack ? Number of downloads	Support from Comms team to format and ? access download data	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q3
16	Establish and raise awareness of defined QI project roles and responsibilities e.g. SRO, project lead, team member	Clearly defined and documented roles and responsibilities Engagement of key project roles in QI projects	Support from senior leaders, project leads and team members	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q1
17	Increase involvement of patient and service users in QI projects	Number of projects involving service user representation	Support from engagement and involvement officer and experts by experience	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation Quality: Patient Experience People - Innovating the way we work	Ongoing Q1-Q4



Supporting application of QI methods to strategic improvement areas -

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