Patient Safety Incident Response Plan

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CONTENTS

Other related documents:

- Patient Safety Incident Response Policy (2023)
- Duty of Candour Policy (2025)
- Event Reporting SOP (2026)
- NHS England SEIPS Quick Reference Guide and Work System Explorer (2022)

1.0 INTRODUCTION

The NHS Patient Safety Strategy describes the Patient Safety Incident Response Framework (PSIRF) which has replaced the NHS Serious Incident Framework (SIF). This document is the Patient Safety Incident Response Plan (PSIRP), and it outlines how Somerset NHS Foundation Trust (the Trust) will respond to patient safety incidents (PSIs) reported by staff, patients, families, and carers to improve the quality and safety of the care we provide.

The SIF provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is a framework that focuses on learning and improvement with an emphasis on the complex systems and cultures that support continuous improvement in patient safety.

This plan is underpinned by the Trust Patient Safety Incident Response Policy and will be reviewed every 12-18 months. This plan will enable the Trust to remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and ensure the needs of those affected are met.

2.0 DEFINITIONS

The following terms and abbreviations are used within this policy:

After Action Review (AAR)	An After Action Review is 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 tasks to avoid failure and promote success for the future.
Duty of Candour (DoC)	A regulatory requirement for care providers to be open and transparent with service users and includes situations where things have gone wrong with care or treatment. The requirements span communication, support, truthfulness and an apology (see Guidance: Duty of Candour, 2020 on the GOV.UK website).
Learning Response	Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as after-action reviews, SWARM huddles, multidisciplinary team debriefs and thematic analysis.
Multi-disciplinary Team Review (MDT Review)	An MDT Review involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.
Patient Safety Incident (PSI)	A patient safety incident can be defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare.
Patient Safety Incident Investigation (PSII)	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.
Patient Safety Incident Response Framework (PSIRF)	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
Patient Safety Incident Response Plan (PSIRP)	A local plan that sets out how we will carry out the PSIRF locally including our list of local annual priorities.

Swarm Huddle	A Swarm Huddle allows for the rapid review of an incident – staff swarm to a discussion (and where possible the location of an incident) to allow it to be explored on a systematic basis and to support those immediately involved.
Systems Engineering Initiative for Patient Safety (SEIPS)	SEIPS is a framework that can be used in understanding inter-relationships across the structures, processes and outcomes in healthcare. It is used alongside the PSIRF learning response tools to ensure that the system learning is identified.
Thematic Review	A review of a cluster of incidents or investigations that aims to understand common links, themes or issues. The aim of a themed review is to understand key barriers or facilitators to patient safety.

3.0 DEFINING OUR PATIENT SAFETY INCIDENT RESPONSE PROFILE

A clear understanding of the organisation's patient safety incident profile is essential for designing a proportionate, insight-driven Patient Safety Incident Response Plan. This year, the profile has been developed through structured analysis of incident data and triangulation with other patient safety intelligence sources.

To build our updated profile, we used:

- Patient safety event data from Radar following Trust-wide implementation of the Learning from Patient Safety Events (LfPSE) system in May 2025
- 31,409 reported events from July 2024–June 2025, of which 26,152 (83%) involved patients and were categorised as patient safety events
- Extraction of a minimum incident dataset (MIDS) including location, timing, harm level, and reporter-selected safety challenge categories
- Topic-level analysis of the most frequent or highest-risk incident groups (e.g., pressure ulcers, falls, medication events)
- Review of themes in formal complaints, identifying issues such as delays in treatment, poor identification, and unmanaged pain

From a wider list of the topics, the following priority areas were selected for review based on the volume of incidents occurring across the trust, and their relevance – for example those groups that include patient safety incidents.

- Patients who develop pressure ulcers or moisture associated skin damage under the care of district nursing teams.
- Patients who develop pressure ulcer or moisture associated skin damage whilst an acute inpatient.
- Falls in patients aged over 65 years.
- Falls not witnessed by a member of staff.
- Falls in bathrooms or toilets
- Patients cared for in inappropriate locations.
- Patient inappropriately attending urgent treatment centres.
- Patient details recorded incorrectly.
- Issues booking patients for procedures.
- Patients involved in multiple self-harm events.
- Missed doses of medication.
- Medication administration errors in acute and community inpatients
- Patients involved in multiple disruptive / aggressive event.
- Disruptive / aggressive events occurring within the emergency department.
- Patients with frail skin who get skin tears.
- Patients absconding or attempting to abscond from care.

- Patients who are injured during moving and handling procedures
- Patients harmed due to delays in treatment
- Patients where pain is not managed

For each priority area, an initial analysis of incident data was undertaken to describe the number of incidents reported, how this changed over time, where in the organisation they occurred and what level of harm. It also included additional topic specific data that was captured on both incident systems.

The initial analysis was discussed with the topic lead and other subject matter experts knowledgeable about each priority area. A discussion with the leads gave insight into the common types of incidents, current areas of concern, the level of understanding of system factors in relation to these incidents, and any existing quality improvement work in progress.

Additional analytical work was undertaken to further describe the specific areas that could form the trust priorities for patient safety incident investigation. These are subsets of the wider topic that would benefit from a thorough understanding of the system factors that results in these incidents and could benefit from targeted improvement work. This process included pulling in data from a variety of other relevant sources including, but not limited to:

- PALS and Complaints
- Topic Assurance Reports
- Clinical Audits (local and National) and other measurement programmes
- Quality Improvement work
- Claims
- Patient Experience Surveys

A stakeholder workshop reviewed the full incident profile and collectively agreed which areas represented the highest potential for learning and improvement over the next 12–18 months. Recommendations were then presented and approved at Patient Safety Board (November 2023).

4.0 DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

The Trust continues to strengthen and mature its governance processes to ensure that learning from patient safety incidents leads directly to measurable safety improvement. Insight generated through incident reporting, risk identification, thematic analysis, and patient experience is routinely incorporated into quality improvement activity. We will also continue to use guidance and feedback from national and regional NHS bodies, regulators, commissioners and partner providers to inform and refine our safety improvement priorities.

Service Groups hold responsibility for delivering and providing assurance of their patient safety improvement work. Each Service Group will report annually to the Patient Safety Board and the Quality Assurance Group, demonstrating progress, impact and sustainability of improvement activity aligned to national priorities and locally determined PSIRF priorities.

The Patient Safety Board will continue to provide organisational oversight and assurance of patient safety improvement work through the Trust's Quality and Governance Assurance structures. The Operational Patient Safety Board will oversee delivery, including the use of appropriate quality improvement methodology and the monitoring of progress against defined improvement aims.

Safety Improvement Workstreams will report their progress with PSIRF priorities to the Patient Safety Board to enable monitoring of improvement activity across the organisation. The Board will also provide assurance on the development of new safety improvement plans following reviews undertaken within PSIRF, ensuring they follow robust development processes and are capable of enabling meaningful and sustained improvements in patient safety.

The Trust will focus its efforts on the development and delivery of safety improvement plans that align with national patient safety priorities and the locally determined PSIRF priorities outlined in this

plan. Flexibility will be maintained to ensure that new or emerging risks -identified through internal intelligence or external insight - can be escalated, considered and incorporated into safety improvement work where appropriate.

5.0 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Death thought more likely than not due to problems in care require a locally led Patient Safety Incident Investigation.

National priorities for the reporting and referral of patient safety incidents to other bodies for investigation are described in the PSIRF and other national initiatives for the period 2026-2027.

From our incident and resource analysis, we estimate that we will complete approximately 5 PSII reviews where national requirements have been met per annum and 10-15 reviews over a 12–18-month period in line with our local priorities.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Patient safety incidents meeting the 'Each Baby Counts' and maternal deaths criteria for MNSI investigation: • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life, and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).	Referred to Maternity and Newborn Safety Investigations Programme (MNSI) for independent patient safety incident investigation Referral to MBRRACE where applicable Perinatal Mortality Review Tool (PMRT)	Respond to recommendations as required and feed learning into safety profile planning and improvement priorities

Incidents meeting the Never Events criteria	Proportionate response to be determined through event review meeting	Create local organisational actions and feed learning into safety profile planning and improvement priorities
Death thought more likely than not due to problems in care (i.e, incident meeting the *Learning from Deaths* criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed learning into safety profile planning and improvement priorities
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led patient safety learning response may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and feed learning into safety profile planning and improvement priorities
Child deaths	Refer for Child Death Overview Panel review Locally-led patient safety learning response may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and feed learning into safety profile planning and improvement priorities
NHS Screening programme incidents	Report to regional Screening Quality Assurance Service (SQAS) and UK Health Security	Recommendations from SQAS and UK Health Security Agency and feed learning into safety profile planning and improvement priorities
PMRT programme patient safety incidents	Review in line with PMRT process, **PSIRF does not change requirements for review under PMRT.**	If PMRT indicates further learning, the organisation should follow the agreed decision-making process outlined in their policy (e.g. Figure 2) to determine on a case by case basis, with input from those affected, the most proportionate response to maximise learning for improvement. Themes emerging from PMRT reports to feed into safety

		profile planning and improvement priorities
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults are in receipt of care and support needs from their local authority • FGM, Prevent, Modern Slavery, Human Trafficking or Domestic Abuse/Violence is suspected / involved	Refer to named safeguarding lead(s) and follow in line with organisational safeguarding guidance	Respond to recommendations as required and feed learning into safety profile planning and improvement priorities
Mental health-related homicide by patient in receipt of specialist mental health services	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. If an independent investigation is not commissioned, then the Trust may commission an internal PSII.	
Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. 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.	

Incident in screening programmes	Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service).	

6.0 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

PSIRF allows organisations to explore patient safety incidents that are relevant to the organisational context and the populations served. Our analysis of patient safety data has led us to conclude that three patient safety priorities are required to be the local focus for 2026/7. National guidance recommends that 3-6 learning responses per priority are conducted 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. The outcomes of the PSII will be thematically analysed and will inform our patient safety improvement planning and work.

Patient safety priority	**Planned response**	**Anticipated improvement route**
Nutrition and hydration – Incidents where a patient receives the wrong type of food, feed, or nutritional support - such as an inappropriate diet for their clinical condition - resulting in potential or actual harm.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.
Transitions of care – Incidents where information is not handed over during patient transfers outside normal pathways - for example, when patients are moved between wards due to bed pressures or discharged to community settings without essential communication or follow-up, resulting in potential or actual harm.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.
End of life care - Incidents involving missed doses, incorrect medication, or inappropriate prescribing for patients at the end of life,	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.

leading to unmanaged symptoms or distress.		
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.	Patient Safety Incident Investigation	Create local organisational recommendations and actions feeding into new or existing patient safety priorities improvement programmes.

For patient safety incidents that do not meet PSII criteria, we will apply a *proportionate* learning response. Where an incident has the potential to generate new learning or support existing improvement work, an appropriate patient safety review method will be used (including, but not limited to, After Action Reviews, Swarm Huddles, Multi-Disciplinary Reviews, or Thematic Reviews – see Appendices E-I). These reviews will be undertaken locally, with insights feeding into our ongoing thematic analysis through existing Trust assurance processes, ensuring learning is targeted, relevant, and aligned with areas of greatest impact.

The patient safety priorities will be reviewed 12-18 months following the publication of this plan and the safety incident profile will be updated to reflect the changing patient safety priorities.

7.0 PATIENT SAFETY INCIDENT RESPONSE DECISION MAKING

The PSIRF policy outlines the patient safety incident response decision making process and should be read in conjunction with this PSIRP. The PSIRP does not alter the Statutory Duty of Candour requirements. Where Duty of Candour applies this must be carried out according to Trust policy (‘Duty of Candour Policy’).