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NHS
Bolton
NHS Foundation Trust

Patient Safety Incident Response Plan

2025-27

Improving care,
transforming lives...for a better Bolton

Version Control

Version	Type of change	Date	Revisions
1	New document	November 2023	n/a
2	Revised document	September 2025	Review of local priorities and addition of maternity local priorities.

Contents

Introduction

This Patient Safety Incident Response Plan sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

We recognise we do not always get things right. This plan signifies the Trusts continued commitment to proactively improving patient safety when receiving healthcare.

We have reviewed our data from multiple data sources to understand our patient safety profile and have worked with our internal and external key stakeholders.

This has allowed us to be able to identify five local Patient Safety focus priorities which we feel accurately reflect the Trust's Patient Safety risks.

These priorities will be subject to a number of comprehensive Patient Safety Incident Investigations (PSIIs) and will be underpinned by robust quality improvement processes.

This will ensure that learning is embedded and shared across the organisation.

Purpose and Scope

Purpose: This Patient Safety Incident Response Plan (PSIRP) sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents over a period of 18 to 24 months.

Scope: This Patient Safety Incident Response Plan (PSIRP) will detail the Trust's approach to responding to patient safety incidents and should be followed by all staff across the organisation.

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Roles and Responsibilities

Chief Executive Officer: The Chief Executive Officer (CEO) holds ultimate accountability for all aspects of patient safety, including the oversight and management of incidents. This responsibility encompasses ensuring that robust structures are in place to support thorough investigation, analysis, and organisational learning. The CEO must also ensure that adequate resources are allocated to support compliance with this plan. Furthermore, the CEO is responsible for the establishment and maintenance of appropriate policies and procedures governing all areas of health and safety, in accordance with the Health and Safety at Work Act 1974.

Chief Nurse: The Chief Nurse is the Executive Lead who has responsibility for patient safety within the Trust and is accountable for ensuring an adequate system is in place to enable appropriate and proportionate responses to safety incidents that occur within the Trust.

Executive/Non-executive Directors: All Directors who sit on the Trust Board (either Executive or Non-Executive) have responsibility for adhering to, championing and supporting the implementation of this patient safety plan within the remits of their identified portfolios.

Director of Quality Governance will support the Chief Nurse with all elements of their portfolio in relation to Patient Safety. The Director of Quality Governance has overall responsibility as the lead manager for the Trust's patient safety function and will provide strategic direction in relation to the implementation of this plan.

Assistant Director of Quality Governance will support the Director of Quality Governance with all elements of their portfolio and provide senior day to-day leadership in relation to patient safety which includes ensuring the successful implementation of this plan.

Head of Quality Governance & Patient Safety Specialist: will operationally manage the patient safety function within the Trust. This includes ensuring an appropriate system is in place for staff to report, manage and investigate patient safety events in line with this plan. They will be responsible for maintaining this plan and ensuring emerging themes and trends relating to patient safety are incorporated into this document.

Safeguarding Teams (Children & Adult) will be responsible for operationally leading the Trust's established Safeguarding processes. In addition to this, they will be responsible for ensuring appropriate safeguarding cases, which meet the national requirements for investigation are identified and escalated as appropriate

Mortality Steering Group will ensure deaths are reviewed in accordance with national policy. Any learning identified through these processes will feed into established processes and any deaths felt to be preventable will be escalated for review in line with the national priorities set out in this plan.

Patient Safety Team will support the Head of Quality Governance & Patient Safety Specialist with the implementation of this document.

Patient Safety Partners will play an essential role in the implementation of this plan by ensuring the voice of patients, families and carers is heard at all levels within the organisation in relation to patient safety activity.

Divisional Governance Teams will have responsibility for adhering to, championing and supporting the implementation of this plan within the remits of their identified portfolios. They will ensure emerging themes and trends are escalated as and when appropriate. Respond to patient safety events appropriately and proportionately and ensure any learning identified as part of any patient safety activity is assessed, discussed at Divisional level for oversight and shared through established routes as appropriate.

Family Liaison and Engagement Lead: Family Liaison and Engagement Leads are responsible for ensuring appropriate support is offered to the patient/family/carers. They will confirm any questions of concern the family/patient/carer would like to include as part of the key lines of enquiry of an investigation. They will act as the link person for the patient/carer/family and ensure 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.

All other staff across the organisation are responsible for ensuring any patient safety event is reported into the Trust Incident reporting system at the earliest opportunity. All staff will also be required to refer and adhere to this plan.

Our Services

Bolton NHS Foundation Trust provides healthcare in hospital and community to people across the Northwest Sector of Greater Manchester.

We deliver services from the Royal Bolton Hospital site in Farnworth, in the Southwest of Bolton, close to the boundaries of Salford, Wigan, Blackburn and Bury as well as providing a wide range of community services from locations within Bolton.

The Royal Bolton Hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist surgery and full consultant led obstetric and paediatric service for women, children, and babies. The Integrated Community Services Division consists of domiciliary, clinic and bed-based services across the Bolton footprint to GP registered population.

In total, we have 617 general and acute beds available, including escalation winter pressure areas. There are presently 74 maternity beds and 21 critical care beds.

The Trust has an estimated catchment population of 292,000 (2021 census)

Medicine

The Medicine Division provides a wide range of medical services both within the Royal Bolton Hospital and community settings.

They manage the busiest single site Emergency Department in Greater Manchester, and have adult inpatient wards providing acute medicine, and specialist medical services.

The Division provide the following services:

Acute Medicine		
Bowel Cancer Screening		
Cardiology	Care of the Elderly	
Dermatology		
ED and Paediatric ED	Endoscopy	
Gastroenterology	Haematology	
Respiratory		
Stroke		

Surgery

The Surgery Division delivers elective and non-elective specialist care across a wide range of clinical specialties.

They also offer both elective and non-elective surgery, as well as specialist clinical services delivered both at Royal Bolton Hospital and in the community.

The Division provide the following services:

Access, booking and choice	Acute Pain	Anaesthetics
Breast		
Cancer Services	Chronic Pain	Critical Care
ENT		
General Surgery		
Ophthalmology	Oral & Maxillofacial surgery	
Pre op care		
Theatres	Trauma & Ortho	
Urology		

Family Care & Diagnostics Division

The Family Care & Diagnostics Division provides a variety of services for adults and children across Bolton and beyond.

The Division provide the following services:

Acute Paediatrics	Audiology	
Bereavement Services	Breast Screening	
Community Diagnostics Centre		
Digital Autopsy		
FIT Testing		
General Outpatients	Gynaecology	
Health Records		
Infection Prevention Control		
Laboratory Medicine		
Maternity	Medical Examiners	Medical Illustration
Mortuary		
Neonatal Unit/SCBU	Nurse led IV service	
Pharmacy	Phlebotomy	
Radiology	Reception	

Community Services

The Community Division places an emphasis on avoiding hospital attendances and admissions by responding to health and social care issues in the community. This includes providing intensive therapy and re-ablement packages to support patients' independence.

They also provide 24-hour intermediate care services run by both the Trust and Bolton Council at Laburnum Lodge, Wilfred Gere and a day care facility at Winifred Kettle.

The Division provide the following services:

Admission Avoidance Team	ICPS - Continuing Care
Adult Learning Disabilities	ICPS - Reactive
Adult Speech & Language	ICPS - Proactive
Anticipatory care Team	ICPS - Children's Cont Care Packages
Anticoagulation Service	ICPS - Special Schools
Bladder & Bowel	ICPS - Paediatric Diabetes
Community Pharmacy Team	ICPS - PLDS
Community Receptions	ICPS - Admin & Clerical
Diabetes & Endocrinology	Integrated Discharge Team
Dietetics	Intermediate Care Bed Base
District Nursing Central North	IV therapy
District Nursing Central South	MSK Therapies
District Nursing East	Neurology Long term conditions
District Nursing Evenings & Nights	Palliative Care
District Nursing North	Rheumatology
District Nursing South	Specialist Podiatry Services
District Nursing Treatment Room	Single Point of Access (SPA)
District Nursing West	Therapies Inpatient
District Therapies Central North	Therapy - Orthopaedic inpatient and outreach team
District Therapies Central South	Therapy - Surgery and Critical care team
District Therapies East	Therapy- Stroke
District therapies North	Sexual Health
District Therapies South	0-19 Team Adolescent Health
District Therapies West	0-19 PHN North District
Health Improvement Practitioners	0-19 PHN South District
Home First	0-19 PHN West District
Homeless & Vulnerable Adults	0-19 Healthy Families

Defining our Patient Safety Incident profile

Royal Bolton NHS Foundation Trust has a developed quality and safety assurance process ensuring services are safe and effective.

A key part of developing the Patient Safety Incident Response Framework (PSIRF) is to understand the amount of patient safety activity the trust has undertaken over the last year.

This enables us to plan appropriately and ensure that we have the people, system and processes to support the Patient Safety Incident Response Framework.

A review of the activity associated with patient safety incident investigation for the period 2024/2025 of identified risks, audit findings, claims, inquests, complaints has been undertaken to determine key priorities.

This review has been undertaken by the Trust's Quality Governance Department, Divisional Governance Teams, and Patient Safety Specialist with the support and involvement from colleagues, committees, and groups to identify the Trusts local focus priorities.

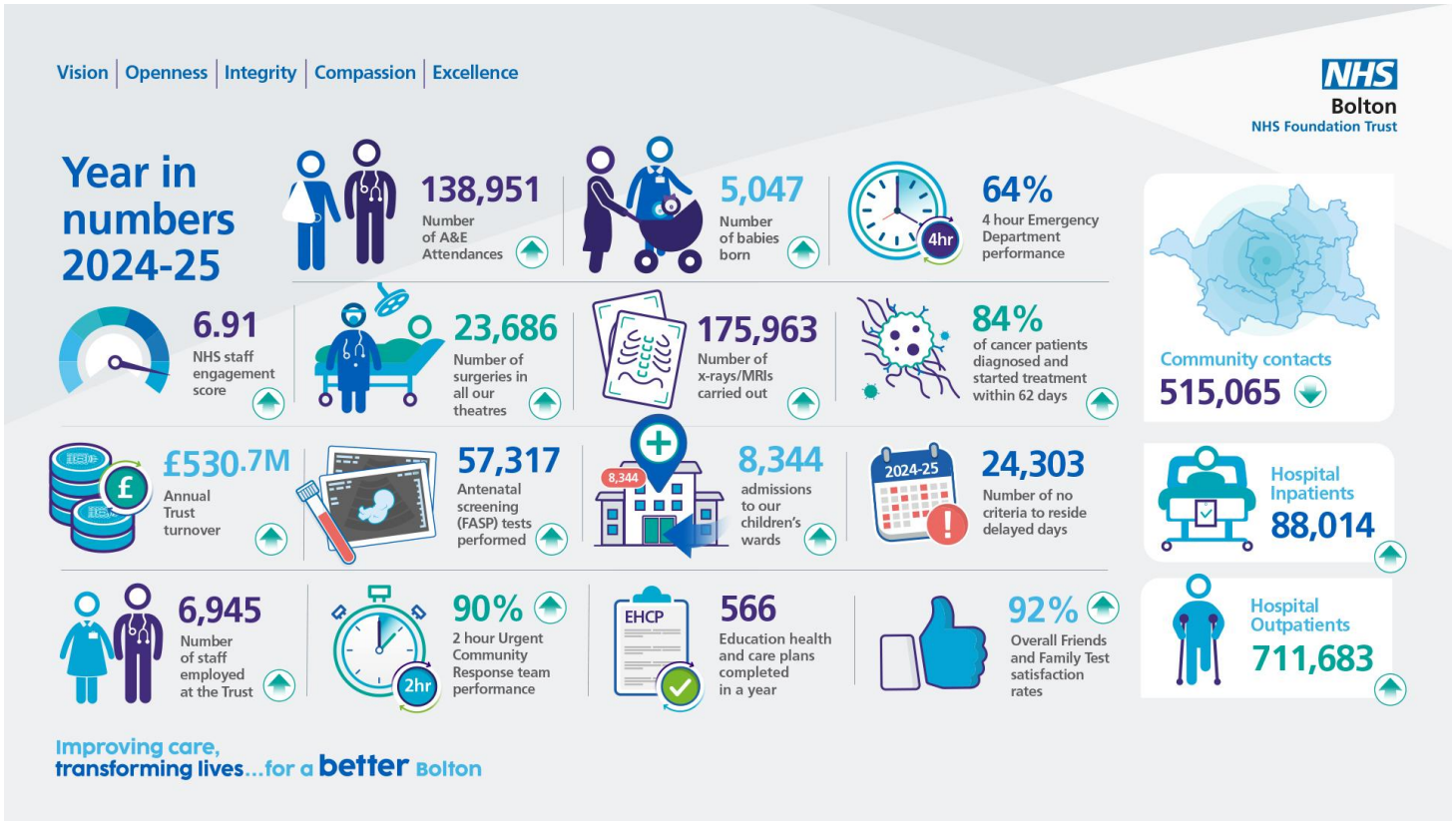
Investigation of patient safety incidents will include specialists, investigators and subject matter experts as appropriate.

Support will be provided by clinical staff within specialties to ensure patient/family/carers are involved and kept informed of progress.

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

The key priorities were defined from this list below and areas where the Trust had existing quality priorities or initiatives in place.

Figure 1



Our analysis used several data sources and safety insights from key stakeholders, figure 1.

Key stakeholders included:

- Staff from all levels and areas
- Divisions via Divisional Governance meetings
- Divisional Governance teams
- Senior Managers within the Trust
- Patient Safety Specialist
    - Patient Experience team
    - Legal Services Department
    - Patient representatives
    - Patient Safety & Risk team
    - Health watch
    - GM ICB (Bolton)

The summary below provides an overview of the scale of the review and the analysed data sources. Where possible the Trust reviewed activity between 1st April 2024 to 31st March 2025

- Patient Safety Incidents: 21,115
- Complaints; 197
- Patient Advice & Liaison Service (PALS):1841
- Risks: 286
- Mortality reviews: 154
- Claims: 60
- CQC enquiries: 10
- Freedom to speak up: 172
- Friends and family tests: 293,941

Following the review of data, we were able to identify the Trust top 10 most significant patient safety themes. These themes are listed below:

- Clinical Treatment/procedures
- Wound
- Medication
- Admission/transfer/Discharge/Planning issues
- Maternity
- Falls
- Staffing problems/training issues
- Data Protection, documentation & Health records
- Communication
- Clinical Assessment/monitoring

By reviewing the current improvement work underway and engaging with stakeholders, we were able to narrow the list down to the Trust top **five** patient safety themes listed below whilst also acknowledges in our patient safety incident plan national requirements.

- Diagnosis & Diagnostics
- Medication
- Unsafe Discharges
- Lost to follow up
- Escalation

The Trust is committed to using our resources efficiently while promoting continuous learning and improvement.

This plan is not a fixed set of rules—it may be adapted when appropriate.

Alongside the plan, we will remain flexible, taking into account the specific circumstances of each patient safety incident and the needs of those affected.

To support the implementation of this approach, a Patient Safety Incident Response Policy is available on the Trust intranet.

Defining our Patient Safety Improvement profile

To define and agree on our Patient Safety Improvement Profile, it was essential to first understand the improvement and transformation work already underway—both within the Trust and across local and national systems.

We reviewed ongoing initiatives that directly or indirectly impact patient safety. This work is shaped by a combination of national, regional, and local programmes, including the NHS Patient Safety Strategy and its associated initiatives. Examples include:

- The appointment of a Patient Safety Specialist
- Implementation of National Patient Safety Improvement Programmes (NatPatSIP)
- Development of a National Patient Safety Syllabus
- Introduction of the Involving Patients in Patient Safety Framework
- Launch of the Learn From Patient Safety Events (LFPSE) service

Much of this work has been catalysed by the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF supports the investigation of incidents identified through both national requirements and locally agreed priorities.

Certain incident types automatically trigger a Patient Safety Incident Investigation (PSII) or a thematic review. The findings from these investigations are aggregated and used to inform our safety Action Improvement plan.

The SIP outlines the actions we will take to implement, monitor, and evaluate the effectiveness of safety improvements. Unlike the previous Serious Incident Framework (2015), which often led to repetitive action plans, PSIRF emphasises continuous quality improvement.

All safety actions within the SIP are developed collaboratively with relevant stakeholders, including those responsible for implementation. Each action is assigned a named individual to ensure accountability and oversight.

Our Patient Safety Incident plan:

National Requirements:

Event	Action Required	Lead Body for Response
Incidents meeting the Never Events criteria	Locally led PSII	The Trust
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	Locally led PSII	The Trust
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	The Trust
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally led PSII may be required	As decided by the RIIT
Child deaths	Refer for Child Death Overview Panel Review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child death overview panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) **Locally-led PSII (or other response) may be required**	LeDeR programme

	alongside the LeDeR – organisations should liaise with this.	
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 (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	The Trust
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, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Community Safety Partnership (CSP)

Incidents meeting 'Each Baby Counts' and maternal deaths criteria	Referred to Maternity and Newborn Safety Investigations (MNSI) for independent PSII	Respond to recommendations as required and feed actions into the quality improvement strategy

Our Patient Safety Incident plan:

Local focus priorities (All Divisions)

The Trust will be flexible with its investigative approach, informed by the national and local priorities detailed within this plan.

An established Divisional 'Daily Triage' group will triangulate events captured through a variety of routes (i.e. incidents, complaints etc.) and agree the most appropriate response based on the potential for learning, improvement and systemic risk.

Event	Subject	Planned Response	Improvement route
Diagnosis & Diagnostics	Missed or delayed diagnosis that has impacted on patient outcomes, with potential for significant learning	**PSII**	Identify areas for improvement and implement safety action improvement plan which feed into Cancer Board & Patient Safety Group
Medication	Medication incident that has significantly impacted on patient outcomes, with potential for significant learning	**PSII**	Identify areas for improvement and implement safety action improvement plan and feed these into Medicines Safety Group
Unsafe Discharges	Discharges from hospital that have been deemed unsafe and impacted on the patient outcome, with potential for significant learning	**PSII**	Identify areas for improvement and safety action improvement plan and feed these into the Patient Safety Group
Lost to follow up	Cancer patient or Management of patient with pre-malignant condition lost to follow up,	**PSII**	Identify areas for improvement and safety action improvement plan

	with potential for significant learning		and feed these into the Patient Safety Group
Escalation	Lack of recognition of deteriorating patient/delay in escalation, with potential for significant learning	**PSII**	Identify areas for improvement and safety action improvement plan and feed these into the Patient Safety Group or relevant group/committee

The Trust recognises that there will be always a reactive element in responding to incidents. Patient safety incidents that signify and an expected level of risk and/or potential for learning and improvement will always be considered even if they fall outside the issues or specific incidents described in this Patient Safety Response Plan.

Our Maternity Patient Safety Incident plan: local focus priorities

The Families and Diagnostics Division continue to focus on the delivery of the national maternity quality and safety initiatives designed to enhance safety and optimise outcomes within the service such as:

- NHS Resolution Clinical Negligence Scheme for Trusts maternity incentive scheme
- Saving Babies Lives Care Bundle version 3 to reduce perinatal mortality

In addition, the Division will continue to support the maternity and neonatal services to deliver all elements of the single delivery plan published in March 2023 as per national requirements to improve the personalisation and equity of care provided to women, babies and their families.

Neonates			
Event	**Subject**	**Planned Response**	**Quality Improvement Oversight**
Unplanned admission to NNU	All unplanned late preterm admissions to NNU >35 – 37 weeks	Audit of cases undertaken quarterly to identify themes	Identify areas for improvement and implement safety action improvement plan/s Share the audit report and monitor the action plan at neonatal quality assurance forum meeting quarterly.

	All unplanned admissions to NNU 37 >weeks	All cases reviewed as part of the Avoidable Term Admissions in Neonatal Unit (ATAIN) audit quarterly.	Identify areas for improvement and implement safety action improvement plan/s Share the ATAIN audit report at clinical audit meeting. Monitor the ATAIN action plan at Maternity Governance meeting quarterly.
Neonatal unit closures	Neonatal unit closures due to staffing/skill mix and capacity issues	MDT review of themes six monthly	Identify areas for improvement and implement safety action improvement plan/s Share the audit report and monitor the action plan at neonatal quality assurance forum meeting quarterly.
Failure to follow process	Failure to follow processes (guidelines/ policies)	Swarm/After action template of initial incident. Consider PSII if physical/psychological harm attributable by the Trust.	Create local safety actions/improvement plan and monitor via Divisional Governance, feeding into Trust quality monitoring and escalation processes as required
Documentation	Documentation – failure to document all clinical care	Quarterly audit to identify key issues and themes	Create local safety actions/improvement plan and monitor via Divisional Governance, feeding into local improvement projects if appropriate.
Infection Prevention Incidents	Any recurring incidence of increased infection	Deep dive MDT review of incidences when required	Create local safety actions/improvement plan and monitor via Divisional

	markers i.e. MRSA, pseudomonas		Governance, feeding into local improvement projects if appropriate.

Maternity			
Event	**Subject**	**Planned Response**	**Quality Improvement Oversight**
Failure to follow protocol/escalate	Failure to follow protocol and/or escalate during antenatal/postnatal care provision i.e.: fetal monitoring concerns and/or deteriorating patient that has impacted on patient outcomes, with potential for significant learning	Swarm huddle of initial incident with progression if harm attributable with potential for significant learning identified consider most appropriate learning tool and/or Trust wide quality improvement work	Discuss themes from incidents, identify areas for improvement and implement safety action improvement plan/s at Maternity Governance meeting quarterly and provide update of ongoing actions to address.
Delay in treatment that has been final graded moderate or above for both or either physical/psychological harm	Delay in provision of care that has led to moderate harm or above.	Swarm huddle of initial incident with progression if harm attributable with potential for significant learning identified consider most appropriate learning tool and/or Trust wide quality improvement work	Discuss themes from incidents, identify areas for improvement and implement safety action improvement plan/s at Maternity Governance meeting quarterly and provide update of ongoing actions to address.
Category 1 Caesarean section	Delay greater than 30 minutes	Clinical audit to be undertaken six monthly to identify themes with SMART action/improvement plan.	Discuss themes from incidents, identify areas for improvement and implement safety action improvement plan/s at Maternity Governance meeting quarterly and provide update

			of ongoing actions to address.
Stillbirth/neonatal death as MBRRACE perinatal mortality reporting criteria	Stillbirth/neonatal death	Report all notifiable cases to MBRRACE PMRT review tool for all eligible cases Quarterly review of all neonatal death and stillbirth cases Deep Dive analysis of outlier status as required	Discuss themes from incidents, identify areas for improvement and implement safety action improvement plan/s at Maternity Governance meeting quarterly and provide update of ongoing actions to address.
Massive Obstetric Haemorrhage	Antenatal or postpartum haemorrhage (PPH) >1500mls >2500mls	Annual audit of PPH cases >1500mls to identify themes. PSIRTT review tool for cases of >2500mls Deep Dive analysis of outlier status as required	Discuss themes from incidents, identify areas for improvement and implement safety action improvement plan/s at Maternity Governance meeting quarterly and provide update of ongoing actions to address.
MNSI incidents	External investigation as per defined criteria*	External investigation report or PSII internal review tool and action plan if external review declined by client.	Discuss themes from incidents at Maternity Governance meeting quarterly and provide update of ongoing actions to address. Provide update on incidence bi-monthly via Quality Assurance Committee report (delegated subcommittee of Board)

* MNSI will undertake maternity investigations which meet the 'following criteria:

- All term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Intrapartum stillbirth: where the baby was thought to be alive at the start of active labour but was born with no signs of life
- Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause
- Severe brain injury diagnosed in the first 7 days of life, when the baby was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) OR
  - Was therapeutically cooled (active cooling only) OR
  - Had decreased central tone AND was comatose AND had seizures of any kind
- Maternal Deaths (Death of a woman while pregnant or within 42 days of the end of pregnancy).
  - Direct deaths resulting from obstetric complications OR
  - Indirect deaths from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy in the perinatal period.

Learning Response Tools

The Patient Safety Incident Response Framework (PSIRF) promotes a range of system-based approaches for learning from patient safety incidents.

National tools have been developed that incorporate the well-established SEIPS framework (Systems Engineering Initiative for Patient Safety).

Staff are encouraged to use the National or Trust system-based learning response tools and guides, or other system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.

These tools can be found on the 'PSIRF' page on the Trust intranet.

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

At Bolton NHS Foundation Trust, we recognise the emotional and practical impact that patient safety investigations can have on patients, service users, families, carers, and staff.

The Patient Safety Incident Response Framework (PSIRF) has been introduced to ensure that those affected by an incident are engaged in a meaningful and compassionate way. It is our priority to involve them in the process, provide clear information, and create opportunities for them to ask questions and gain a full understanding of what has occurred.

To support this, the Trust will appoint Family Liaison/Engagement Leads who will offer guidance, share information throughout the investigation, and act as a consistent point of

contact. This approach not only supports those affected but also strengthens our ability to learn and improve from incidents.

We are committed to fostering a Just Culture—one that moves away from blame and focuses on learning and accountability. Our investigations are conducted solely for the purpose of learning and improvement, not to assign fault.

For staff involved in incidents, we ensure that support is readily available. We offer in-house training on Human Factors, which promotes psychological safety in the workplace, along with a range of patient safety training to help embed a strong safety culture. We value our staff and provide access to our excellent Health and Wellbeing services and Freedom to Speak Up services for anyone with concerns or in need of additional support.

Duty of Candour

Bolton NHS Foundation Trust is dedicated to providing high-quality healthcare to all patients who access our services. While we strive to deliver safe and effective care to thousands of patients each year, we recognise that, at times, things may not go as planned.

In such instances, we are committed to ensuring that if harm occurs due to an unintended or unexpected incident, the patient, their family, or next of kin is informed as soon as reasonably practicable. This is in line with our core values of openness, honesty, and transparency at every level.

The Patient Safety Incident Response Framework (PSIRF) 2022 outlines the standards and expectations for engaging with those affected by patient safety incidents. Under this framework, we aim to:

- Treat those affected with compassion and involve them meaningfully in any investigation.
- Ensure they are fully informed about the steps taken to understand what happened and why.
- Provide a truthful, written account of the incident, including a written apology where errors have resulted in harm.
- Offer ongoing support, including a named point of contact, regular updates throughout the investigation, and a full explanation of the findings—both in person and in writing.

Our commitment to the Duty of Candour also enables us to share insights and learning from incidents, helping us to improve care and provide meaningful feedback to those affected.

Glossary

Abbreviation	Meaning
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
SEIPS framework	(Systems Engineering Initiative for Patient Safety).
MNSI	Maternity and Newborn Safety Investigations
DHR	Domestic Homicide Review
ED	Emergency Department
AAU	Adult Assessment Units
UTC	Urgent Treatment Centre
SI	Serious Incident
CQC	Care Quality Commission.
LeDeR	LeDeR is a service improvement programme for people with a learning disability and autistic people
NatPatSIP	National Patient Safety Improvement Programmes
LFPSE	Learn From Patient Safety Events

References

Patient Safety Incident Response Framework, NHS England 2022

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients 2019

Being Open and Duty of Candour Policy (BFT)

Saving Babies' Lives: A care bundle for reducing stillbirths, NHS England, 2016

Each Baby Counts, Royal College of Obstetricians and Gynaecologists, 2020

The Tommy's App, Tommy's National Centre for Maternity Improvement, 2023

Maternity and newborn Safety Investigations (MNSI)

Care Quality Commission (CQC)

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