

Patient Safety Incident Response Plan

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Introduction

This is an interim refresh of our Patient Safety Incident Response Plan for University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) pending a full update in November 2025 which aligns with North Bristol NHS Trust's review timescale as part of the NHS Bristol Group collaborative partnership.

This plan sets out how we intend to respond to patient safety incidents in line with the national Patient Safety Strategy for England (2019) and the new Patient Safety Incident Response Framework (PSIRF) **Figure 1**. This 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.

Figure 1.

The [Patient Safety Incident Response Framework \(PSIRF\)](#) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

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

Our Patient Safety Incident Response Plan (PSIRP) is integral to the implementation of PSIRF and aligns with UHBW strategic priorities.

1. PSIRF fits with our continuous improvement journey in UHBW called Patient First.

Patient First is a whole organisation focus on improvement work which will see us move from trying to do too many things to working together on fewer improvement goals and doing them

well - with the patient at the heart of everything we do. It will help us to do this collaboratively in a way that sticks. It will:

- Create a shared vision and destination for the Trust - our Strategic Priorities
- Adopt a new way of working for all staff who will be trained and empowered to resolve problems and issues at a local level.
- Reduce the number of priorities and objectives, so that we can all focus on moving in the right direction together.

Similarly, PSIRF both requires and enables us to focus on our key patient safety risks and seek an in-depth understanding of the complexity of our safety systems that underpin these risks. It also enables more supportive engagement of patients, families and staff and inclusivity by considering multiple perspectives. It's about understanding and learning together "doing with, rather than doing to". Insights obtained from our PSIRP will feed into future continuous improvement work.

2. PSIRF is also aligned with the strategic priorities shown in **Figure 2**.

Clinical Strategy

Our commitment to quality

The quality of the care our patients receive is ultimately the measure of the success of our clinical strategy.

We will

- Promote clinical excellence to achieve the best possible clinical outcomes.
- Keep people safe by reducing preventable harm; this includes a robust focus on implementation of the NHS Patient Safety Strategy.

Patient safety

Vision	Strategic goal
We will continue to build responsive, sustainable and resilient healthcare delivery systems within a developed safety culture to enable us to reduce risk of harm, provide consistent, high quality, safe and effective care and reduce moral injury to staff.	We will be within 1% of the best NHS trust for safety culture as reported by our staff and we will build more resilient systems focusing on key patient safety risks.

We have been working hard for the past 24 months to further develop and embed our structure, processes, organisational approach and culture and to take forward learning to improve healthcare delivery systems cross our organisation. Our Patient Safety Incident Response Plan is one of these elements. We are on a journey of discovery and we may not get it right first time, but we will learn and improve for the future.

Our plan has been approved by our Board of Directors and is accompanied by an updated Patient Safety Incident Response Policy and associated documents.

Our services

1. Services at UHBW

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) delivers over 100 different clinical services across 10 different sites serving a core population of more than 500,000 people.

With services from the neonatal intensive care unit to care of the elderly, we provide care to the people of Bristol, Weston and the south west from the very beginning of life to its later stages.

Our staff provide general diagnostic, medical and surgical services to the populations of central Bristol, south Bristol and North Somerset. These services are delivered from our Bristol city centre campus and Weston General Hospital with some services delivered in community settings such as South Bristol Community Hospital.

We also provide specialist services such as children's services including tertiary paediatric trauma, cardiac and cancer services, and other smaller specialist services that are nationally commissioned, to a wider population throughout the south west and beyond.

Our services are delivered through five clinical divisions across Bristol and Weston campuses supported by a management team at Weston General Hospital and a sixth division providing support and infrastructure for service delivery.

In 2024/25 we formed a hospital group (Bristol NHS Group) with North Bristol NHS Trust (NBT) and started deliver Phase 1 of the UHBW and NBT Joint Clinical Strategy 2024-2027, including developing single managed services across both organisations.

2. Patient Safety at UHBW

UHBW has operated a hub and spoke model for responding to patient safety incidents with a small central team setting standards and the strategic direction for patient safety, whilst providing practical support, training and advice on the full range of patient safety activity. The central patient safety team manage the serious incident process in accordance with the current Serious Incident Framework 2015, but the work of managing patient safety incidents and risks is currently held within our operational divisions.

Core patient safety activities undertaken at UHBW include:

- Implementing the NHS Patient Safety Strategy
- Delivering a Patient Safety Improvement Programme

- Participating in local and national improvement programmes e.g. maternity, medicines safety
- Developing our patient safety culture
- Embedding Patient Safety Incident Response Framework
- Recruiting and supporting our Patient Safety Partners
- Providing a range of patient safety training
- Supporting compliance with statutory duty of candour
- Involving patients and families in keeping themselves safe
- Identifying and supporting mitigation of new patient safety risks
- Implementing actions in response to patient safety alerts

Other activities within the Trust that provide insights to patient safety include:

- Learning from Deaths Mortality Reviews (Structured Judgement Reviews) for adult patients
- Child Death Reviews and Peri-natal Mortality Reviews
- Learning from Disabilities Mortality Reviews (LeDeR)
- Routine quality surveillance
- Freedom to Speak Up
- Safeguarding concerns, complaints and patient feedback and inquests

3. Developing our approach and capacity to respond to patient safety incidents

With the publication of the original (2019) and subsequent (2022) Patient Safety Incident Response Standards by NHS England it became clear that the current UHBW hub and spoke model for divisions conducting their own in-depth patient safety incident investigations was unsustainable. Specifically, the new standards recommend a higher seniority of lead investigator, dedicated time for learning responses and engagement/support of patients, families and staff. In addition, more advanced training is required and competencies for investigators have been introduced. The aim of these new standards within PSIRF is to:

- a) Conduct fewer high-quality investigations to identify wider systems and organisational learning
- b) Focus on our highest patient safety risks
- c) Enable more agile local learning from incidents

In preparation for transfer to PSIRF we have invested in:

- a) A small central expert team to lead patient safety incident investigations
- b) A Head of Human Factors role to transform and embed human factors and systems thinking into all patient safety activities across UHBW

The Head of Human Factors role is taking the lead in building capacity and capability for a variety of learning responses to patient safety incidents through training and development activities.

4. Capacity for conducting patient safety learning responses

Historically UHBW has completed 70-80 detailed patient safety investigations a year as part of the Serious Incident Framework, with additional local investigations and local learning responses undertaken by divisions. It has been challenging to ensure timeliness and a consistent quality of investigation as investigation leads have had varied training and experience and have needed to prioritise clinical and operational work. This can sometimes leave patients, families without answers for considerable periods and feeling let down by our processes.

The enhanced central patient safety team comprises 2.6 WTE expert investigators supported by an Incident Response Lead, an administrator and some allocated time of the Head of Human Factors. It is estimated this will provide capacity to lead 10 patient safety investigations or thematic reviews per year that meet the standards for PSIRF.

Colleagues in divisions will continue to participate in patient safety incident investigations in the form of clinical or subject matter experts as members of investigation teams.

The shift to fewer patient safety incident investigations will lead to an increase in the use of more agile local learning responses recognised in PSIRF such as: After Action Reviews, local multi-professional safety reviews (MPSR) and swarm huddles **(Appendix 1)**. This has been a change for divisional patient safety teams as a result with more time spent leading these local responses. The central patient safety team will continue to support divisions to undertake local learning responses.

Our interim light-touch review of our Patient Safety Incident Response Plan.

Our 2023-2025 Patient Safety Incident Response Plan was informed by a comprehensive situational analysis, which will be repeated for the planned full update in November 2025.

The recommendation for an interim light-touch review of our Patient Safety incident Response Plan until November 2025 was approved by our Clinical Quality Group and our Board via our Quality and Outcomes Committee.

The plan results from learning from implementing the Patient Safety Incident Response Framework since July 2023 and reflective discussions with patient safety leads across UHBW in our informal patient safety workshops and meetings and more formally in our Patient Safety Group in June 2025 where proposals were received and approved.

Our patient safety incident response plan: national requirements

These remain unchanged.

Figure 3 below describes how we will respond to patient safety incidents that meet the national event response requirements set out in PSIRF. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feeds into future patient safety improvement plans.

Figure 3.

Patient safety incident type	Required response	Lead body for response
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	UHBW
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	UHBW

Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place.	Refer to Healthcare Safety Investigation Branch for independent patient safety incident investigation	HSIB
Deaths of persons with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death	LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria for PSII.	Child Death Overview Panel/UHBW
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)	PSII	UHBW
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
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority	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	Local designated professionals for child and adult safeguarding

3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	partnership (for children) and local safeguarding adults boards	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	UHBW
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	CSP
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody 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 Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC

Our patient safety incident response plan: local focus

Changes have been made to our local responses to patient safety incidents resulting in an amended approach.

Figure 4 below describes how we will respond to patient safety incidents relating to the key patient safety risks identified in our situational analysis. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feeds into future patient safety improvement plans.

Figure 4.

Patient safety incident or issue	UHBW planned response
Staff/staff communication at transfer of care between UHBW teams and departments.	PSII, thematic review, Multi-professional Safety Review (MPSR), After Action Review proportionate to the learning potential
Treatment delay/failure-internal/clinical causes of inpatient delays. Includes incidents relating to patients in hospital beds who are waiting for diagnostic, referrals, surgery, specialist reviews etc. Excludes delays related to patients on waiting lists or lost to follow up.	PSII, thematic review, MPSR Review, After Action Review proportionate to the learning potential
Medication-delayed or non-administration of high-risk medicines	PSII, thematic review, MPSR, After Action Review proportionate to the learning potential
Maternity/perinatal (clinical care)-lack of recognition of maternal or child intra-partum deterioration	PSII, thematic review, MPSR, After Action Review proportionate to the learning potential
Patient falls	Swarm huddle
Healthcare associated pressure injury	Swarm huddle, After Action Review or MPSR as proportionate to the learning potential

Other incidents of concern taking into account: • the views of those affected, including patients and their families • capacity available to undertake a learning response • what is known about the factors that lead to the incident(s) • whether improvement work is underway to address the identified contributory factors • whether there is evidence that improvement work is having the intended effect/benefit • if UHBW and/or BNSSG ICB are satisfied risks are being appropriately managed.	Local review: MPSR, After Action Review
All other patient safety incidents	Managers review or swarm huddle, local action and shared learning

A summary of how this Patient Safety Incident Response Plan works in practice is provided at Appendix 2.

National learning response methods

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multi-Professional Safety review (MPSR)	An MPSR review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

Summary of how the Patient Safety Incident Response Plan works in practice

Appendix 2

