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# Patient Safety Incident Response Plan 2025/2026

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| Document Properties | |
| **Version:** | 2 |
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| **Name of Approval Committee** | Patient Safety Board |
| **Date Approved** | January 2025 |
| **Name of Ratifying Committee** | Safety and Quality Assurance Committee |
| **Date Ratified** | February 2025 |
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| **Date Issued** | March 2025 |
| **Review Date** | February 2026 |

**Version Control, Review and Amendment Logs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version Control Table | | | | |
| **Version** | **Date** | **Author** | **Status** | **Comment** |
| 2 | February 2025 | Jackie Rooney  Chris Talbot | Active/Approved | Annual Patient Safety Profile developed for 2025 |
| 1 | October 2023 | Jackie Rooney  Chris Talbot | Archived | Annual Patient Safety Profile developed for 2025 |

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| Record of changes made to Patient Safety Incident Response Plan -  Version 1 | | | |
| **Section Number** | **Page Number** | **Change/s made** | **Reason for change** |
| Section 6 | Various | Update to national and local patient safety priorities section 6 | Changes made according to patient safety profile for 2024/25 |
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## Introduction

This Patient Safety Incident Response Plan (PSIRP) for 2025/2026 sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

This 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.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more child or young person in our care receiving healthcare.

This PSIRP covers responses conducted solely for the purpose of system learning and improvement and that reduce risk and/or prevent or significantly reduce recurrence.

The plan is data driven, will remain flexible and may change to consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

It will be underpinned by the existing Trust Incident Reporting and Management Policy and the Trusts Patient Safety Incident Response Policy.

Responses covered in this Plan include:

* Patient Safety Incident Investigations (PSIIs)
* Patient Safety Reviews (PSRs)

Other types of responses exist to deal with specific issues or concerns, for example: complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners’ inquests, or criminal investigations. The principle aims of each of these responses differ from the aims of a PSII or PSR and are therefore outside the scope of this plan.

## Our Services

Alder Hey Children’s NHS Foundation Trust is one of Europe’s biggest and busiest children’s hospitals, caring for over 330,000 children, young people and their families every year.

Located in Liverpool UK, we treat everything from common illnesses to highly complex and specialist conditions. We also have several community outreach sites enabling us to deliver care closer to children and young people’s homes in local clinics locations from Cumbria to Shropshire, in Wales and the Isle of Man.

We know that a children’s hospital is different and that our job is more than just treating an illness. To us, every child is an individual. As well as giving them the very best care, we set out to make them feel happy, safe, and confident as they play, learn, and grow. At Alder Hey, we are here to look after a child and their family and that includes mums, dads, brothers, and sisters.

We have several well-established Children and Young Peoples’ Forums which help us develop new ideas for how they can be at the centre of the Trust’s plans and activities helping us keep children and young people’s voices at the forefront, including continuing to play a key role in the recruitment of key Board level posts. In 2025, our recently recruited Patient Safety Partners (PSP’s) will be in post, who will be involved in all aspects of patient safety across and throughout the Trust.

The Trust is supported by several charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children and young people.

Alder Hey has a strong history of quality improvement and our Brilliant Basics approach supports the team to make small changes that lead to big improvements and healthier futures for our children, young people and families. Brilliant Basics is our approach to improving quality, safety, effectiveness and experience. As we move into 2025 the focus will be on maturing and sustaining our approach to continuous improvement by:

* Supporting leaders at all levels to adopt the style and approach that will support improvement efforts.
* Supporting divisions to go further to align, enable and improve.
* Utilising the voice and ideas of children, young people and families that Alder Hey work with.

## Defining our Patient Safety Incident Profile

Patient safety incidents for Alder Hey have been profiled using available organisational data between January 2024 to December 2024 from:

* Patient safety incident reports
* Clinical and non-clinical incident data
* Top 10 incident cause groups
* Complaints and PALs themes
* Legal claims
* Staff survey results
* Mortality and in patient death thematic reviews
* Trust wide quality improvement workstreams
* Regulation 28 Prevent Future Deaths reports

Additional resources reviewed include: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, Complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families and our staff via open forums and through a range of children and young person’s and staff forums that we have in place.

## Data Sources

A data review of the Trusts Risk and Incident Management System (InPhase) was conducted for patient safety risks and incidents reported between 1st January 2024 to 31st December 2024, to establish the number of reported patient safety incidences, reported harm levels and any subsequent patient safety investigations that took place. Data was acquired from the above list of sources to guide this plan.

## Stakeholder Engagement

Key stakeholders have been consulted to determine and agree the identified priorities and Alder Hey’s Patient Safety Incident Response Plan for 2025/2026.

## Stakeholder Activity

Feedback and information provided by internal stakeholders, our children, young people, their families and carers and subject matter experts were considered in the development of our patient safety profile. Attendance and discussion at a range of children and young person’s forum events (including PSP recruitment events) and staff forums enabled plan development.

Qualitative and anecdotal feedback from our children, young people, their families and carers and our staff were sought via QR code to inform potential future categories for local patient safety responses and system improvement. The review also highlighted areas which required collation of further intelligence to inform subsequent plans.

## Defining our Patient Safety Improvement Profile

Our patient safety profile and subsequent plan was discussed, shared, and approved by our locally established Patient Safety Board and presented to our Safety and Quality Assurance Committee for ratification.

All patient safety improvement workstreams that currently report into our Patient Safety Board together with other patient safety initiatives ongoing across the Trust were also considered as noted below.

## Current Patient Safety Board Improvement Workstreams:

* + - Meditech Unacknowledged Notices
    - Parity of Esteem (Restrictive Intervention)
    - Antimicrobial Resistance (AMR)

## Patient Safety Board Improvement Workstreams completed in 2024 now reporting business as usual:

## Total Parenteral Nutrition (TPN)

## Medication Safety

## Learning Disabilities

## Litigation and negligence

## Assurance reports to Patient Safety Board:

## Sepsis

## Neonate Safety

## Medication Safety

## Pressure Ulcers

## Mortality Review/Learning from deaths

## Trauma Safety and Quality

## National Safety Standards for Invasive Procedures (NatSSIPs)

## Blood Transfusion

## Medical Devices

## Radiation Protection

## Other Trust Patient Safety Improvement Programmes:

* Neonatal team development support
* Laboratory Medicine - blood testing and blood product ordering process improvement
* Clinical summit - leadership development offer
* Divisional productivity - audiology
* 3B day case improvement
* Out-patients; admin process improvement, new model of care
* Neurology Transformation
* General Paediatrics @Its Best
* Vision 2030: personalise my care, thriving leaders, experience (variety of support offers)
* Venous Thromboembolism Improvement Group

All the above patient safety programmes are supported and delivered using our Brilliant Basics Quality Improvement (QI) methodology that is widely embedded across the Trust.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and quality improvement interventions already in place.

## Our Patient Safety Incident Response Plan: National Requirements

National patient safety priorities are set by the PSIRF and other national initiatives for the period 2025/2026. These priorities require a Patient Safety Incident Investigation (PSII) to be conducted by the Trust to identify and maximise opportunities for learning.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs will be conducted locally by our organisation, some may be conducted independently and funded by our organisation or regionally/nationally.

In addition to a PSII some patient safety incident types will require specific statutory reporting and/or review process to be followed. All types of incidents that have been defined nationally as requiring specific responses are outlined below and will be reviewed according to the national suggested methods.

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| **National Focus Priorities** | | |
| **Patient safety incident type** | **Required response** | **Anticipated improvement route** |
| All incidents meeting the Never Events criteria (2018) or  its replacement | Patient Safety Incident Investigation | Create local organisational actions and feed these into the Patient Safety Board as part of the QI process for Trust wide/Divisional action |
| Any incident meeting the learning from deaths criteria i.e. death thought more likely than not due to  problems in care | Patient Safety Incident Investigation |
| All child deaths (including children with learning disabilities) | All child deaths are reviewed as part of the Trusts HRMG process and referred to the Trusts Mortality lead. If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trusts Safeguarding team for investigation. Refer to the Child death review statutory and operational guidance | Safeguarding team to liaise with CDOP as locally led PSII may be required. Respond to recommendations from external parties for learning purposes. |
| Neonatal incidents | Referred to Maternity and Newborn Safety Investigations (MNSI) for independent patient safety incident investigation  <https://www.mnsi.org.uk/>  All perinatal deaths must be referred to MBRRACE.  [MBRRACE-UK website](https://eu-west-1.protection.sophos.com?d=ox.ac.uk&u=aHR0cHM6Ly93d3cubnBldS5veC5hYy51ay9hc3NldHMvZG93bmxvYWRzL21icnJhY2UtdWsvQ2FzY2FkZSUyMGd1aWRhbmNlJTIwZm9yJTIwVHJ1c3RzJTIwRGVjJTIwMjAyNC5wZGY=&i=NWI2OTdlN2JiMjFjNjMxNmMwOWQzZjMw&t=RUJmejIyQ0YzR3VNanBKZUlEMkduK2xFRXQrMTVoczE3YXE2YnhWUFVtRT0=&h=72b988719175493c9155d0acbcf84828&s=AVNPUEhUT0NFTkNSWVBUSVbFg2JrvQ8TBbTANwco8cb6jnXJWaVeTjOktk1_rtfrqA) | Respond to recommendations as required from external referred agency and feed actions into the Patient Safety Board to be considered as part of QI process.  MBRRACE recommendations will be presented and monitored via Clinical Outcomes and Effectiveness Group (CEOG) and if required shared at our local Neonate Partnership (LNP) Board |
| All Safeguarding/ Rainbow Centre incidents | Incidents must be reported to the Trusts safeguarding team/Named safeguarding leads for review/multi-professional investigation and possible local authority referral. | Respond to recommendations as required from external referred agency and feed actions into the Trust Safeguarding and Statutory Services Assurance Group to be considered as part of  QI process. |
| Incidents in screening programmes | Incidents must be reported by Director of Infection Prevention Control (DIPC) 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) | Respond to recommendations as required from external referred agency and feed actions into the Patient Safety Board to be considered as part  of QI process. |
| Mental health- related homicides by persons in receipt of mental health services or within six months of their discharge | Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT) | Respond to recommendations as required from external referred agency  /Divisional oversight and improvement. |
| Incidents resulting in moderate or above physical /psychological harm to child/young person | Statutory Duty of Candour | All Moderate/severe physical and psychological harm initial reviews presented to the Patient Safety Incident Response Investigation (PSIRI) Panel for discussion/ decision on requirement for PSII /improvement route (if  applicable) |
| Haemovigilance (MHRA/SHOT reportable incidents) | It is a regulatory and legal requirement to report all serious adverse events (SAE) and serious adverse reactions to the MHRA/SHOT  <http://www.shotuk.org/r>[eporting](http://www.shotuk.org/reporting). ‘Appropriate level of investigation of contributing factors using a systems approach and application of human factors principles’ | Appropriate corrective and/or preventative actions identified and taken in response to investigation.  Transfusion Committee oversight and improvement Feeding into Patient Safety Board via assurance reports |
| Ionising radiation CQC notifiable incidents (IR(ME)R) | All significant accidental or unintended exposure incidents (SAUE) are notifiable to regulator within 2 weeks of event.  PSII or PSR to be decided locally via PSIRI panel depending on the incident and report available to regulator within 12 weeks | Respond to regulators recommendations following internal investigation.  Divisional oversight and improvement in conjunction with radiology radiation protection lead |
| Health Care Acquired Infections (HCAIs) | Initial Review / SBARD | Via Infection Prevention  Control Committee |

## Our Patient Safety Incident Response Plan: Local Focus

Local patient safety priorities are set by the Trust. In addition to analysing our local patient safety profile, we have taken the following considerations into account when defining our local patient safety priorities.

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| **Criteria** | **Considerations** |
| **Potential for harm** | * People: physical, psychological, loss of trust (patients, family, caregivers) * Service delivery: impact on quality and delivery of healthcare services; impact on capacity * Public confidence: including political attention and media coverage |
| **Likelihood of occurrence** | * Persistence of the risk * Frequency * Potential to escalate |

Our local patient safety priorities require a Patient Safety Review (PSR), a PSII will also be undertaken where required.

The PSR’s include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected child, young person, family, carer, or staff.

**Note**: There may be patient safety incidents not outlined in the priority list below for which a PSR is undertaken based on the request or views of those affected, including patients and their families.

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome.

There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust.

* Initial Review
* Situation, Background Assessment, Recommendation, Decision (SBARD) review
* Thematic Review
* Multi-disciplinary team (MDT) review
* After Action Review (AAR)

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| **Local Focus Priorities** | | |
| **Patient safety incident type or** **issue** | **Planned response** | **Anticipated improvement**  **route** |
| Incidents relating to the recognition and escalation of the deteriorating patient | * Divisional review of incident (Initial review) * PSII (where agreed) | Divisional local improvement / monitoring of actions and via Patient Safety Board as specific workstream |
| Incidents relating to delay and/or lost to follow up appointments/treatment | * Divisional review of incident (Initial review) * Thematic Review * PSII (where agreed) | Divisional local improvement / monitoring of actions and via Safer Waiting List Programme Board and Patient Safety Board |
| Incidents relating to medication safety - ***Omission/ delay of critical medications*** | * Initial Review * AAR * Thematic review * PSII (where agreed) | Via Medication Safety Group that feeds into Patient Safety Board |
| Incidents relating to documentation – ***consent & medical record keeping*** | * Divisional review of incident (Initial review) * Thematic Review * PSII (where agreed) | Divisional local improvement / monitoring of actions and via PSIRI Panel |
| Incidents relating to IT system failure leading to patient harm | * Divisional review of incident (Initial review) * Thematic Review * PSII (where agreed) | Via Digital oversight Committee/Divisional  governance meetings and PSIRI |

In addition to our local patient safety priorities, we have two further improvement priorities to improve patient safety.

* ***To improve safety culture through enhancing levels of psychological safety and civility across the Trust***
* ***To improve how we identify and share learning across the Trust***

These improvement priorities will be developed over the next 12 months and monitored via the Patient Safety Board.

## Conclusion

This patient safety incident response plan (PSIRP) supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents advocating a coordinated data-driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management.

As we continue to embed this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right, and we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

Most importantly, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our children and young people, their families and carers whilst also protecting the well-being of our staff. We welcome the next phase of our PSIRF journey.