Lincolnshire Community and Hospitals NHS Group

Patient Safety Incident Response Plan (PSIRP)

Reference No: LCHG-P-CG-06

Version: V1.0

Approved by: Patient Safety Group, Quality Committee and Group Trust Board

Date Approved: April 2026 - Pending

Division and Specialty: Clinical Governance Directorate/ Patient Safety Team

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Date Issued: May 2026

Review Date: May 2027

Target Audience: All Staff

Distributed Via: LCHS Public Website and ULTH SharePoint

Version Control Sheet

This table should record key changes made to each version. If a previous document is replaced or merged into this document it should be included in this table including the reference number and full title of the archived document. Each full review should be a new number.

Version	Section / Paragraph / Appendix	Version / Description of Amendments	Date	Author / Amended by
V1.0	Not Applicable	New Document	May 2026	Helen Shelton, Group Deputy Chief Clinical Governance Officer

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Policy Document Statement

Background Statement	Please see the Corporate Policy Statement on Page 5 of this plan.
Key words	Never Event, Patient Safety Audit, Patient Safety Incident Investigation, Patient Safety Incident Response Plan, Patient Safety Incident Response Framework, PSA, PSII, PSIRF, PSIRP
Responsibilities	All Staff
Training	None.
Dissemination	This document will be shared with appropriate staff at the Patient Safety Group, Quality Committee and Group Trust Board, and once approved, published on both the LCHS Public Website and ULTH SharePoint mediums so staff can view it.
Resource implication	Listed throughout the document.
Consultation	This document requires consultation with the Patient Safety Group, Quality Committee and the Group Trust Board.
Monitoring	Listed throughout the document.
Equality Statement	As part of our on-going commitment to promoting equality, valuing diversity and protecting human rights, Lincolnshire Community and Hospitals NHS Group is committed to eliminating discrimination against any individual (individual means employees, patients, services users and carers) on the grounds of gender, gender reassignment, disability, age, race, ethnicity, sexual orientation, socio-economic status, language, religion or beliefs, marriage or civil partnerships, pregnancy and maternity, appearance, nationality or culture.

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Corporate Policy Statement

The Lincolnshire Community and Hospitals Group is committed to promoting equality and diversity in all its activities to promote inclusive services, processes, practices and culture.

This plan reflects the Lincolnshire Community and Hospitals Group vision, values and behaviours and supports employees in working for the benefit of patient care. It takes account of the provisions outlined in the Equality Act 2010 to ensure no individual receives less favourable treatment on the grounds of age, disability, sex, race, gender reassignment, sexual orientation, religion and belief, marriage/civil partnership and pregnancy/maternity.

Alongside being committed to a proactive delivery of the Equality Act 2010, the Lincolnshire Community and Hospitals Group proudly seeks to embody the duties of the Public Sector Equality Duty (2011) in all its activity by:

1) Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2) Advancing equality of opportunity between people who share a protected characteristic and those who do not.
3) Fostering good relations between people who share a protected characteristic and those who do not.

We recognise high quality NHS patient care benefits by having a diverse community of staff who value one another.

Forward

‘The introduction of the PSIRF framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them.’

Aidan Fowler, National Director of Patient Safety, NHS England.

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves doing the same thing and calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how an incident is prevented from happening again. The challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework (SIF). This document is the Patient Safety Incident Response Plan (PSIRP) which outlines how the Lincolnshire Community and Hospitals Group (LCHG) will look at patient safety incidents, what tools will be used to investigate and how it will share and embed learning into everyday work. This document is the ‘LCHG’ PSIRP and details joint and individual priorities across both ULTH and LCHS Trusts – aligning focus and process to identify and embed the best learning and improvement opportunities for our patients.

This PSRIP will replace the previous United Lincolnshire Hospitals Trust and Lincolnshire Community Health Services PSIRP (2025/2026).

The Serious Incident Framework set the expectations for when and how organisations should investigate Serious Incidents. However, evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these. The introduction of PSIRF supports a more autonomous flexible approach to management of patient safety events, underpinned by behaviours, decisions and actions that assist learning and improvement. PSIRF facilitates a move to examine incidents openly without fear of inappropriate sanction, support those affected and improve services. Unlike SIF, PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

- Advocates a coordinated and data driven approach to patients’ safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.
- Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Meaningful engagement with our patients, families and carers is a priority to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our appointment to patient safety partners helps to ensure that the patient voice is involved at all stages of our patient safety processes.

Group work in moving towards a ‘just culture’ underpins how we will approach our incident responses; fostering a culture to allow people to feel psychologically safe, enabling them to speak up and highlight safety concerns without fear or repercussions. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

This continues to be a new way of managing our patient safety learning reviews. As a newly formed group we are still learning and accept that we may not get it right at the beginning, but 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. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Importantly PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff.

As a revised way of working we need to embrace a different cultural approach. PSIRF is a process of learning across LCHG and continues to require ongoing review, revision and evaluation of impact and effectiveness to enable the refining of our PSIRF application.

1. Introduction

The NHS is changing the way it embraces patient safety, moving from a focus on individual incidents and issues to a more comprehensive look at system improvement with a holistic review of safety across the organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how Lincolnshire Community and Hospitals Group (incorporating United Lincolnshire Teaching Hospitals Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS) intends to respond to patient safety incidents reported by staff, patients, their families, and carers. This PSIRP outlines a plan over a period of 12 months (April 2026 – March 2027) and is central to ongoing work to continually improve the quality and safety of the care we provide. The plan will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our existing Lincolnshire Community and Hospitals Group policies on incident reporting, management, review and learning and the Group Patient Safety Incident Response Policy.

2. Our Services

Lincolnshire Community and Hospitals Group cares for patients across the whole of Lincolnshire as both a community (LCHS) and acute (ULTH) provider. Both Trusts are statutory organisations working in partnership under a group collaboration to govern a provider collaborative. This Group model provides a central leadership body responsible for the strategic direction, and governance, of the two trusts.

Lincolnshire Community Health Services NHS Trust

- LCHS cares for patients across the whole of Lincolnshire
- LCHS provides a wide range of community care across the county to meet the physical health needs of our community as close to their homes as possible. Lincolnshire is one of the largest counties by area in England. It has a population of 782,808, however season variation means this increased significantly certain times of the year.
- Services are delivered through over 2049 substantive staff (2024/25), a range of trained healthcare professionals including Registered Nurses, Allied Health Professionals, public health professionals, medics and GPs enabling great care across our communities. In 2024 / 2025 there were over 800,000 contacts in community services and 2,305 admissions to community hospitals.
- Urgent Care Services: 174,476 attendances at Urgent Treatment Centres.
- Our staff provide high quality clinical care and expertise, coordinate, connect and advocate for our patients and carers in addition to driving digital innovation to improve access to services.
- The Trust has a wide portfolio of healthcare services, in 46 different sites across 37 locations that includes:

- District nursing and hospice care to support patients to get better care closer to home
- Children and young people's services, including children in care and children's therapy services
- Electronic assistive technology service (EATS)
- General and specialist integrated community nursing, immunisation, and vaccination services
- Inpatient beds and outpatient clinics
- 4 community hospitals
- Urgent care services including urgent treatment centres at Boston, Gainsborough, Louth, Lincoln, Skegness, Grantham and Spalding
- Musculoskeletal (MSK) physiotherapy services
- Occupational therapy, physiotherapy and speech and language therapy
- Podiatry service
- Safeguarding services for both children and adults
- Integrated sexual health and contraceptive health.

United Lincolnshire Teaching Hospitals Trust

- United Lincolnshire Teaching Hospitals NHS Trust (ULTH), situated in Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 782,808 people. The trust provides acute care and specialist services to people in Lincolnshire and neighbouring counties.
- Services are delivered through over 9,313 substantive staff (2024/5), a variety of trained healthcare professionals including nurses, allied health professionals, public health professionals and medics enabling great care across all services.
- ULTH is registered with the Care Quality Commission (CQC) to provide services at the following locations:
    - Lincoln County Hospital (Acute Inpatient Beds, Maternity Unit, Emergency Department)
    - Pilgrim Hospital Boston (Acute Inpatient Beds Maternity Unit, Emergency Department)
    - Grantham District Hospital (Acute Inpatient Beds, Urgent Treatment Centre)
- The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by NHS property services. These include:
    - County Hospital Louth
    - John Coupland Hospital, Gainsborough
    - Johnson Community Hospital, Spalding

  - Skegness and District General Hospital.

- In the average year, we treat more than 150,000 Emergency Department patients, over 700,000 outpatients and over 130,000 inpatients, and deliver around 4000 babies.
- The Trust provides a broad range of clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary services.

3. Scope

Other types of incident responses exist to deal with specific issues or concerns. Examples of such responses include 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 incident responses differ from the aims of a patient safety response and are outside the scope of this PSIRP.

Maternity services are considered as part of and inclusive of this patient safety incident response plan to ensure integration across the organisation and to promote shared learning in the widest sense. This ensures that all areas are included in the insight and improvement work associated with shared issues/challenges. Divisions and specialists' areas are all encouraged to work together to support a collaborative and integrated approach.

4. Patient Safety Incident Response Planning – Defining our Profile

PSIRF sets no rules or thresholds to determine what needs to be learned to inform improvement apart from the National requirements (see Table 2). A full review of all types of patient safety incidents across the Lincolnshire Community and Hospitals Group has been completed to understand what opportunities to learn and improve and develop a truly representative PSIRP.

Lincolnshire Community and Hospitals Group has a continuous commitment to learning from patient safety incidents and has an embedded understanding and insight into patient safety themes. This is supported through the Patient Safety Group that reports into the Quality Committee monthly. The role of the Patient Safety Group is to receive, review, scrutinise, challenge and respond to or escalate data and information across the clinical activities of the organisation that supports the LCHG to deliver its strategic objectives.

A weekly Patient Safety Response Planning Meeting, as a subgroup of Patient Safety Group, provides scrutiny and assurance that all aspects of patient safety incidents are being appropriately governed. This includes evidence that appropriate keys lines of enquiry are drafted and that lead investigators and Family Liaison Officers are appointed to support and represent the patient/family/carer.

As part of the review and planning around PSIRF there has been engagement with key stakeholders, both internal and external, and a review of data from a wide variety of

sources to revise the safety profile. Using this approach has provided the opportunity to maximise learning and improvement and has facilitated the development of a Lincolnshire Community Hospitals Group Patient Safety Incident Response plan outlining local trust, group and national priorities. These priorities are detailed on page 20.

5. Stakeholder Engagement

Development of the very first PSIRP across group was led by representatives from the original PSIRF implementation team supported by system and ICB partners. A wide variety of internal and external stakeholders were consulted including Maternity Voice Partners and the LMNS.

Subsequent stakeholder events have been undertaken, with a multi-disciplinary event including clinical and operational teams, strategy and performance, service improvement, ICB and Patient Safety Partners, to review the previous year data set.

Data sources and how they were used to define our safety profile is detailed below.

6. Data Sources

A thematic analysis approach was used to determine which areas of patient safety activity it should focus its local patient safety priorities. Our analysis used several data sources and safety insights from key stakeholders both internal and external.

A review of services across the group was undertaken based on the service codes set up in the Datix Risk Management system. Wider data sources were triangulated to look at themes / trends and areas of focus and improvement already underway. This was then shared with Corporate and Operational teams across the group to ensure that all services had been captured. This approach sought to ensure that the shape and structure of the plan reflect the likely incidents that are experienced across Lincolnshire community and Hospitals Group.

Patient safety data from January 2025 – January 2026 was reviewed which included (but not limited to) the following data sources:

- Themed analysis of Datix Incident data
- Patient Safety investigations (PSIIs)
- After Action reviews / Multi-disciplinary review
- Maternity investigations - including Maternity Incentive Scheme (NHS Resolution), Maternity and Newborn Safety Investigations programme (MNSI), Perinatal Mortality Review Tool, MBRRACE
- Risks held on the risk register
- Key themes from clinical audit and case note reviews
- Key themes from claims

- Key themes from incidents raised with the Trust from the ICB (known as HPFs)
- Issues identified from CQC inspections and other quality surveillance processes / visits
- Issues identified through safeguarding reviews
- Complaints / PALs data
- Themes arising from mortality/ learning from deaths and medical examiner reviews
- Patient experience data
- Nursing metric data
- Themes from safety climate surveys
- Themes from the Freedom to Speak Up Guardian feedback.
- Staff survey data
- Infection prevention and control data
- Learning from national inquiries (e.g. Ockenden) and the Core20PLUS5 programme (maternal health inequalities a top priority) to complement local safety intelligence.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place. A range of staff, including leads for each of the above data collection systems, were consulted and the review also highlighted areas which required the collation of further intelligence to inform subsequent plans.

Cross-referencing the data from these various sources over the past year assisted with theming incidents and identification of an extensive list of incident types. Further stakeholder engagement and analysis enabled identification of the Group's local priorities for focus as part of our PSIRP. It is recognised that there may be occasion to respond to an event that holds significant learning and that this is not within the priority list. The plan is a proactive mechanism to allocate resources to prioritise safety improvement, which aligns to the Group's Patient Safety Incident Response policy. The approach outlines the process for reviewing all patient safety incidents including maternity specific events. For this reason, capacity has been identified for ad-hoc PSIIs and use of a variety of PSIRF tools to support the greatest learning and improvement opportunity.

7. Patient Safety Data

From all the initial data collated, information was grouped into a number of broad themes which formed the Group's patient safety incident profile. The themes were reflective of the range of services provided across both Trusts and under the Group portfolio and the types of incidents reported. These are shown in the **Table 1** below:

Table 1:

Themes
Palliative and End of Life / Respect
Management of the Deteriorating patient
Re-admissions within 72 hours
Communication with families
Best interest decisions
Medication Issues
Fundamentals of care
Clinical Ownership
Discharge Processes
Documentation
Referral Pathways / Communication Between Specialties
Care of Vulnerable Patients
Frailty – identification of and management
Digital solutions
EPMA
Delays in diagnosis and treatment
Administrative Processes
Culture
Leadership development
Falls
Pressure Ulcers
Nutritional Needs / Nil by mouth decisions
Children / Paediatric pathways

Speech and Language therapy
Delays in Appointments / Waiting Lists
Behaviour

Workshops were convened to discuss the outputs of the data. This scrutiny was led initially with wider stakeholders and a second to triangulate themes with existing improvement workstreams and identify priority areas that would generate the most learning as local Patient Safety Incident investigations (PSII).

Whilst the final list has been agreed it is recognised that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

8. Defining our Patient Safety Improvement Profile

Lincolnshire Community and Hospitals Group have existing governance processes to ensure it gains insight from patient safety incidents and that this intelligence directly feeds into quality improvement activity. Consideration is also given to guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define any wider quality improvement work.

The Quality Committee (QC) will provide assurance that patient safety improvements, as part of PSIRF, continue to be of the highest standard. Its sub-group, the Patient Safety Group (PSG), will be responsible for the oversight of this patient safety improvement work including the robust use of quality improvement methodology.

Clinical and Corporate Care Groups across both arms of the Group are required to report to the PSG in order to monitor and measure patient safety activity across the organisations. The Patient Safety Group also provides assurance during the development of new safety improvement plans, following reviews undertaken within PSIRF, to ensure robust processes have been followed and requirements are met and are sufficient to improve patient safety in future.

Focus will be given to the development of safety improvement plans across the most significant incident types either those within national priorities, or those identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

9. Our Patient Safety Incident Response Plan: National Requirements

Certain events within 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.

Specific patient safety incidents, incidents meeting the Never Events criteria (2018) and Deaths thought more likely than not due to problems in care i.e., incidents meeting the Learning from Deaths criteria will require a locally led Patient Safety Incident Investigation (PSII) to support learning and improvement. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but this approach is endorsed within Lincolnshire Community and Hospitals group as it fits with our intention to learn and improve within a 'just culture'. As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below. From our incident and resource analysis we estimate, due to the services we provide across the LCHG, we will complete approximately 24 PSII reviews where both local and national requirements have been met per annum.

Table 2 below sets out the local and national mandated responses. As LCHS and ULTH do not directly provide mental health or custodial services it is more likely that these incident types (8,9,10 and 11) will be led by a secondary participant rather than being led from within LCHG.

Table 2:

	National Priority	Required response	Anticipated improvement route
1	Incidents meeting the Never Events criteria 2018	Locally led PSII	Create local organisational recommendations and actions and feed these into the quality improvement strategy
2	Deaths 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	Create local organisational recommendations and actions and feed these into the quality improvement strategy
3	Patient safety incidents meeting the 'Each Baby Counts' and	Referred to Maternity and Newborn Safety Investigations	Respond to recommendations as required and feed learning

	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).	Programme (MNSI) for independent patient safety incident investigation Referral to MBRRACE where applicable Perinatal Mortality Review Tool (PMRT) **See Appendix 1**	into safety profile planning and improvement priorities
4	Child Deaths	Refer for Child Death Overview Panel review Locally led PSII (or other response) may be required alongside the panel review	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)	Respond to recommendations from external referred agency/organisation as required and feed actions

		Locally led PSII may be required alongside the LeDeR review.	into the quality improvement strategy
6	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 via named safeguarding lead Internal stakeholders will contribute to 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 the local safeguarding adults boards	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy. See: Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
8	Deaths of patients in custody (e.g., police custody, in prison etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman or the Independent Office for Police	Respond to recommendations from external referred agency/organisation as required and feed actions

		Conduct to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so.	into the quality improvement strategy
9	Deaths of patients detained under the Mental Health Act (1983), or where the mental Capacity Act (2005) applies, where there is a reason to think that the death may be linked to problems in care (incidents meeting the Learning from Death criteria)	Locally led PSII by the provider in which the event occurred with participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and local participation if required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
11	Domestic homicide	Identified by the police usually in partnership with the local Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing review of the case.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

Perinatal mortality review tool (PMRT) – patient safety incidents aligned to this programme of work will continue to be reviewed in line with the PMRT process. If learning is indicated by the PMRT review the local PSIRF decision making process will be followed to determine, on a case-by-case basis, the most proportionate response to maximise learning for improvement. This will involve input from all those affected.

Our plan sets out how LCHG intends to respond to patient safety incidents over the following period of 01 April 2026 to 31 March 2027. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The PSIRP is based on a thorough analysis of themes and trends from all incidents over the previous 12-month period (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Patient Safety Incident Investigations (PSII) mortality reviews, legal claims and inquests, risks and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

10. Our Patient Safety Incident Response Plan: Local Focus

PSIRF allows organisations to focus learning response resources on areas where improvement will have the greatest impact, based on their local incident profile and existing improvement work. Through analysis of our patient safety insights, based on the review of patient safety data and engagement meetings and workshops, it has been estimated that Lincolnshire Community and Hospitals Group will undertake no more than 24 patient safety incident investigations (PSII) over the next 12 months, 4 of which being locally defined projects (**See Table 3 below)**. The 4 locally defined priorities will be focused across Group. These selections reflect the breadth of services and patient pathways across the LCH Group and recognise the areas of focus required across both community and acute pathways of care.

All other incidents will continue to be reviewed using alternative review methods which will be outlined later within this plan. It is not the case that only the incidents identified for a PSII will get a review of care. This includes ensuring that reviews of maternity / obstetric incidents are undertaken in line with CNST / Saving Babies Lives requirements.

The breakdown of PSIIs is identified below in **Table 3**:

Criteria	Number of PSIIs
Deaths meeting the level 3 learning from deaths criteria	Estimating 15
Incidents meeting the Never Event Criteria	Estimating 2
Locally defined projects	4
Allocation for issues identified in year	Estimating 3
Total	**24**

The above calculation allows for decisions to be made in year to undertake a PSII outside of the locally defined projects if determined that the learning from the incident warrants

this. The detail of this process, how the incidents for the locally defined projects will be identified and the other review methods to be used will be outlined in the Group Patient Safety Incident Response Policy. The outcomes and learning from PSIIs will be used to inform patient safety improvement planning and work.

11. Locally Defined Responses

Table 4 demonstrates the criteria for selecting priorities for a PSII response:

Criteria	Considerations
Potential for learning and improvement	Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding. Likelihood of influencing: healthcare systems, professional practice, safety culture. Value: extent of overlap with other improvement work; adequacy of past actions.
Systemic risk	Complexity of interactions between different parts of the healthcare system.

Based on the analysis and selection criteria described above, local priorities for PSII have been set for the period 1st April 2026 to March 2027. The patient safety priorities were agreed through a wider representation of stakeholders across the Lincolnshire Community and Hospitals Group, Patient Safety Group, Group Leadership Team and Quality Committee in March 2026.

The agreed priorities are outlined in **Table 5** below:

Theme	Key Theme		Key Risks from Activity
1	Re-admission to hospital within 72 hours (failed discharge)	Group priority	Patients are frequently re-admitted to hospital within a short space of time after discharge. The initial LCHS data indicates concern around safe discharge process and medication transfer to community teams. There are opportunities to understand how a joined-up approach to discharge could reduce re-admissions within 72 hours of discharge reducing impact on acute services.

2	Communication with patients/families about their care	Group priority	Triangulation of data across Clinical Governance has shown that patients and their families do not always receive the information and updates they required to understand diagnosis/prognosis and decision making around a patients care. The manner, methods and timeliness of communication with families needs to be understood further.
3	End of life care / ReSPECT	Group priority	This has been identified as a theme in a previous PSIRP, this was paused due to ongoing work in this area, however concerns around recognition of end of life, inclusive of the, ReSPECT process are still regularly reported. There are further opportunities to understand the reasons as to why there are delays in recognising patients who are approaching end of life.
4	Patient nutrition including decision making around patients who are nil by mouth	Group priority	Multiple concerns have been raised that patients are being made nil by mouth for prolonged periods of time with poor appetite for risk feeding and delays in insertion of nasogastric tubes. There are opportunities to explore the systems and processes that support effective patient nutrition strategies.

Additionally, Infection Prevention and Control (IPC) incidents that compromise patient safety for example amputation consequential to sepsis, death due to C. Difficile, MRSA/MSSA bacteraemia, and Legionnaires disease outbreak will be reviewed utilising the available PSIRF methodologies as per the devised IPC PSIRF matrix document.

Alongside the mandated PSII response (for Never Events, deaths assessed due to problems in care) will be undertaken where there is the potential for greatest learning and improvement, where it is perceived, there is opportunity for increased knowledge or insight of systems influence.

All incidents not meeting the PSII criteria will be managed at a local level via the use of the Learning from Patient Safety Events (LfPSE) within the Datix reporting system with ongoing thematic analysis via our existing Group assurance processes which may lead to new or supplement existing improvement work. Further information on this and the Duty of Candour principles can be found in the Group Incident Management Policy and the Group Duty of Candour Policy.

PSIRF guidance states:

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

12. Timescales for PSII's

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety event is identified. PSII's will normally be completed within three months of their start date however, in exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between LCHG and the patient/family/carer.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigation.

13. Patient Safety Reviews

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resource investigations into employment concerns, professional standards investigations, coroner inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

For any incident not meeting the PSII criteria, or any other incident, different review techniques can be adopted, depending on the intended aim and required outcome as reflected below:

Patient Safety Review type	Methods	Objective
Incident recovery	Initial safety review (ISR)	To take urgent measures to address serious and imminent: Discomfort, injury, or threat to life Damage to equipment or the environment.

	Risk Assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised and control measures apply.
Team Review	Debrief	To conduct a post incident review as a team by discussing and answering a series of questions.
	Safety Huddle – Proactive and reactive	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data to: Improve situational awareness Focus on the patients most at risk Share understanding of the day's focus and priorities Agree actions Enhance teamwork through communication and collaborative problem-solving Celebrate successes in reducing harm.
	After Action Review (AAR)	A structured, facilitated discussion of an incident or event to identify: What was expected to happen? What happened? Why was there a difference between what was expected and what happened? What are the lessons that can be learnt?
	Multi-disciplinary team (MDT)	A structured discussion to identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents). Examples include: delayed recognition of deteriorating patients medication errors admission or discharge-related safety events

<table>
<tr><td rowspan="5">Systematic Reviews

To determine:
The circumstances and care leading up to and surrounding the incident.
Whether there were any problems with the care provided to the patient</td><td>Perinatal Mortality Review Tool (PMRT)</td><td>Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding each still birth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.</td></tr>
<tr><td>Atain Review Tool</td><td>Joint review by maternity and neonatal services to identify learning points to care provision and improve understanding of potential areas of suboptimal care.</td></tr>
<tr><td>Structured Judgement Review (SJR)</td><td>To determine whether there were any problems with the care provided to a patient by a service.</td></tr>
<tr><td>Specialised Reviews</td><td>For example, falls, pressure ulcers, IPC reviews.</td></tr>
<tr><td>Thematic Review</td><td>A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents for example, pressure ulcers, deteriorating patient, post-partum haemorrhage, 3rd and 4th degree tears.</td></tr>
<tr><td>Monitoring</td><td>Audit</td><td>Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both).</td></tr>
</table>

Human Factors principles will underpin all patient safety incident response activity, shaping how incidents are received, understood and learned from, regardless of the response approach or methodology applied. A systems-based Human Factors lens will be embedded throughout to explore how conditions such as system design, processes, environment, workload, communication, technology and organisational culture influence human performance and patient outcomes. This approach supports the consistent application of a positive and psychologically safe Just Culture, enabling meaningful staff involvement alongside purposeful patient and family engagement. Learning and insights derived through Human Factors analysis will directly inform proportionate and sustainable patient safety improvement planning and ongoing safety work across the organisation.

The intelligence collated from the AAR, MDTs and PSII will be discussed at a local level with ongoing thematic analysis via existing assurance processes. The thematic action outcomes will contribute to the development of an overarching improvement plan for said

‘theme’ for example pressure ulcers; the improvement plan will incorporate the SMART criteria. The use of the SMART criteria will guide objective/goal setting by being specific, measurable, achievable, relevant and time related.

Grounded in Being Fair tool (this replaced the Just Culture guide in May 2025), the Clinical Governance Directorate Learning Framework has been developed to ensure that learning from all PSIRF methodologies is consistently captured, understood and communicated in a way that leads to measurable improvement in quality, safety and compliance across all Care Groups, and care settings.

14. Duty of Candour

Priorities for ‘being open’ conversations and Duty of Candour include:

- All patient safety incidents leading to moderate harm or above.
- All incidents for which an investigation is undertaken.

Reference is made to the Group Policy around Duty of Candour.

15. Reviewing our PSIRP and Policy

The patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated to respond to patient safety incidents. The plan will be reviewed every 12 months to ensure the focus remains up to date; as such it is expected that the PSIRP will continue to evolve over time. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on individual Trust websites, replacing the previous version.

An annual review will be undertaken and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement feedback.

16. Glossary

- **AAR** (After Action Review) – A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.
- **Learning from Deaths**

    - Deaths thought more likely than not due to problems in care.
    - Incidents that meet the 'Learning from Deaths' (LfD) criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- **Never Event –** Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf
- **MNSI** (Maternity and Newborn Safety Investigations) – The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England, maternal deaths in England. https://www.mnsi.org.uk/our-investigations
- **PMRT** (Perinatal Mortality Review Tool) – Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. Perinatal Mortality Review Tool | PMRT | NPEU (ox.ac.uk)
- **PSA** (Patient Safety Audit) – A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline).
- **PSII** (Patient Safety Incident Investigation) – 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 address those system factors and help deliver safer care for our patients effectively and sustainably.
- **PSIRF** (Patient Safety Incident Response Framework) – 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.
- **PSIRP** (Patient Safety Incident Response Plan) – Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

- **SJR** (Structured Judgement Review) – Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

17. References and Other Documentation

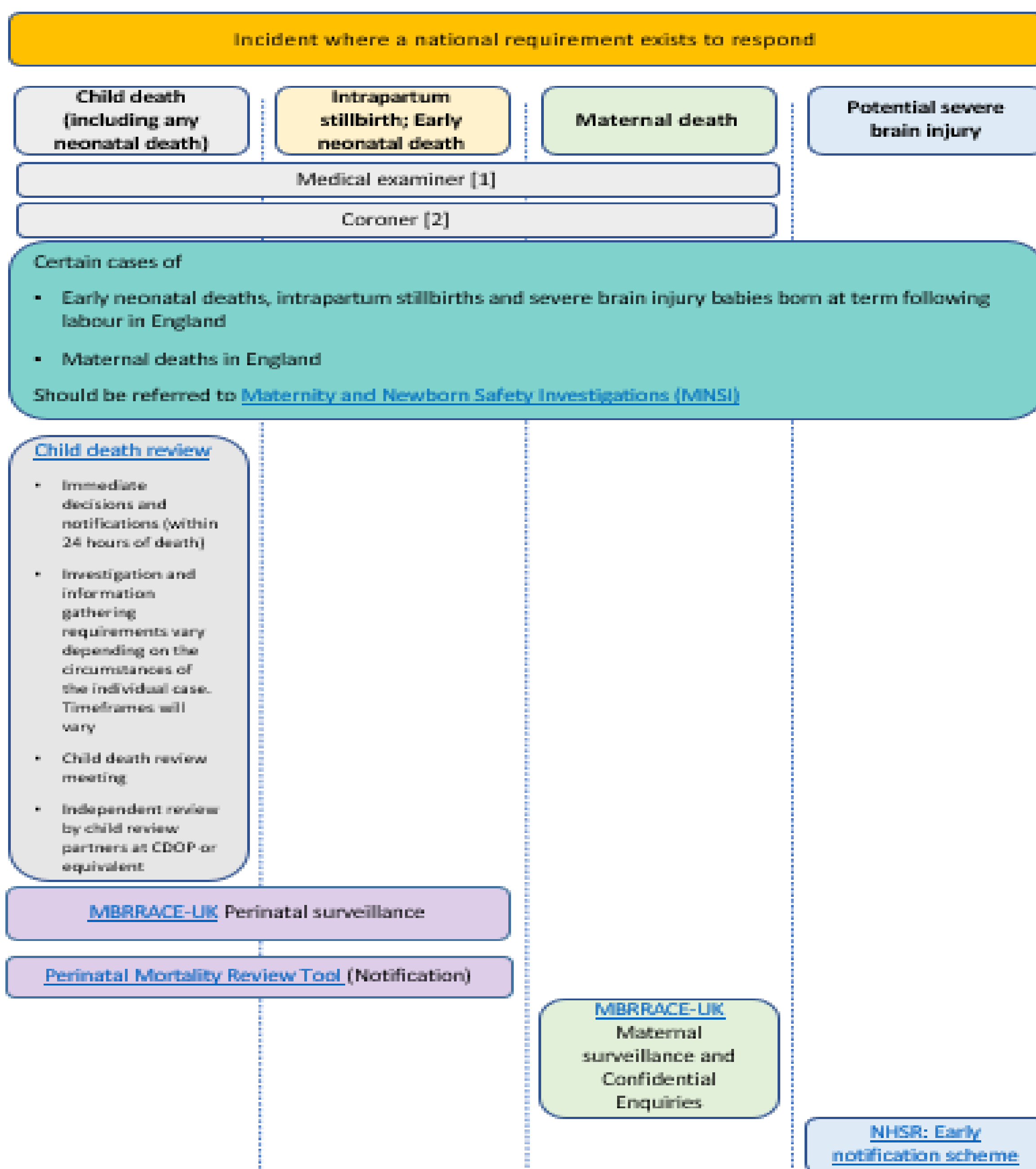
References

Lincolnshire Community and Hospitals NHS Group (2024) Duty of Candour Policy V1.1. Available at: Corporate Governance - LCHG-P-CG-04 LCHG Duty of Candour Policy.pdf - Document View [accessed 23 March 2026]

Lincolnshire Community and Hospitals NHS Group (2024) Incident Management Policy V1.1. Available at: LCHG-P-CG-03 Incident Management Policy [accessed 23 March 2026]

Other Documents

Appendix A – National Requirements for Patient Safety Incident Response in Maternity



1. Medical Examiners offer independent scrutiny of the causes of death; ensure appropriate direction of deaths to the coroner; provide a better service for the bereaved and opportunity to raise any concerns; improve quality of death certification; improve quality of mortality data
2. Coroner inquest when the cause of death is unknown or there is reason to think the death may not be due to natural causes. Inquest is to establish the medical cause of death, and how, when and where the death occurred

Appendix B – Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in **bold**
Email for all correspondence: email to lhnt.edifirst@nhs.net

Service or Workforce Activity Details

Description of activity	Patient Safety Incident response plan. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims: Compassionate engagement and involvement of those affected by patient safety incidents. Application of a range of system-based approached to learning from patient safety incidents. Considered and proportionate responses to patient safety incidents Supportive oversight focused on strengthening response system functioning and improvement
Type of change	Updated PSIRP across Lincolnshire Community and Hospitals Group
Form completed by	Emma Horne, Senior Patient Safety Incident Investigator
Date decision discussed & agreed	23 March 2026
Who is this likely to affect?	Service users x Staff x Wider Community ☐ If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.

Equality Impact Assessment

Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc.

Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).

How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	It will provide our people and our patients with a greater opportunity to be involved in patient safety learning events and contribute to learning and improvement. Greater focus on a just culture with emphasis on learning and improvement, quality driven care and services. The framework will support staff and ensure awareness of expectations. The patient voice is clear in all aspects of patient safety learning.
What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	Duty of Candour, patient feedback, staff feedback. Greater emphasis on the role of all stakeholders as part of feedback and learning.

Risks and Mitigations

What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	None
What data / information do you have to monitor the impact of the decision?	To include but not exhaustive: • Incidents and incident trends • Complaints data

	• Available clinical outcomes • Patient stories • Patient survey feedback (including Friends and Family Test) • Soft intelligence via available clinical or patient forums • Adherence to available NICE guidance • External inspection outcomes and ratings

Decision/Accountable Persons

Endorsement to proceed?	By Approval of the Health and Safety Group
Any further actions required?	None.
Name & job title accountable decision makers	Emma Horne, Senior Patient Safety Incident Investigator
Date of decision	23 March 2026
Date for review	March 2027

Purpose of the Equality and Health Inequality Assessment tool

- The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.
- Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist

- Is the purpose of the policy change/decision clearly set out? □
- Have those affected by the policy/decision been involved? □
- Have potential positive and negative impacts been identified? □
- Are there plans to alleviate any negative impact? □
- Are there plans to monitor the actual impact of the proposal? □

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission. Draft NHS Lincolnshire EDI System 2.1

Signature Sheet

Names of people consulted about this policy:

Name	Job title	Department
Helen Shelton	Group Deputy Chief Clinical Governance Officer	Clinical Governance
Emma Horne	Senior Patient Safety Incident Investigator	Clinical Governance
Bridy Rendall	Associate Director of Patient Safety	Clinical Governance
Tia Hynes	Senior Patient Safety Investigator	Clinical Governance
Kathryn Helley	Group Chief Clinical Governance Officer	Clinical Governance

Author(s) confirm that they have collected all the signatures, as listed above, email Corporate Governance at ulth.corporate.policies@nhs.net (ULTH) / lhnt.policies@nhs.net (LCHS)	**YES**

Names of committees which have approved the policy	Approved on
Patient Safety Group	
Quality Committee	
Group Trust Board	