Manchester University
NHS Foundation Trust

Patient safety incident response plan

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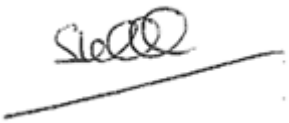
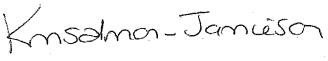
Authoriser	Sohail Munshi Kimberley Salmon - Jamieson	Joint Chief Medical Officer Interim Deputy Trust Chief Executive & Chief Nursing Officer	 	**23/4/2026** **23/4/2026**

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Introduction

This Patient Safety Incident Response Plan sets out how Manchester University NHS Foundation Trust (MFT) intends to respond to patient safety incidents. We've written it in clear language so that everyone - patients, families, staff, and our communities - can understand how we learn from incidents and continuously improve the care we provide.

This plan covers the period from 1st May 2026 to 1st May 2028, and we will review it regularly to ensure it remains relevant and effective. We recognise that implementing this new approach is a significant change, and we remain flexible to adapt our response based on individual circumstances and the needs of those affected.

Why This Matters

When something goes wrong with a patient's care, or has the potential to cause harm, it's essential that we respond in a way that:

- Shows compassion to everyone affected
- Seeks to understand what happened and why
- Leads to meaningful improvements
- Prevents similar incidents from happening again

The development of a Patient Safety Incident Response Plan is a requirement of NHS organisations under the Patient Safety Incident Response Framework which replaces the NHS Serious Incident Framework (2015). PSIRF represents a fundamental shift in how we approach patient safety. Rather than focusing on individual blame, we look at the wider systems and processes to understand how incidents happen and what we can do better.

Scope of This Plan

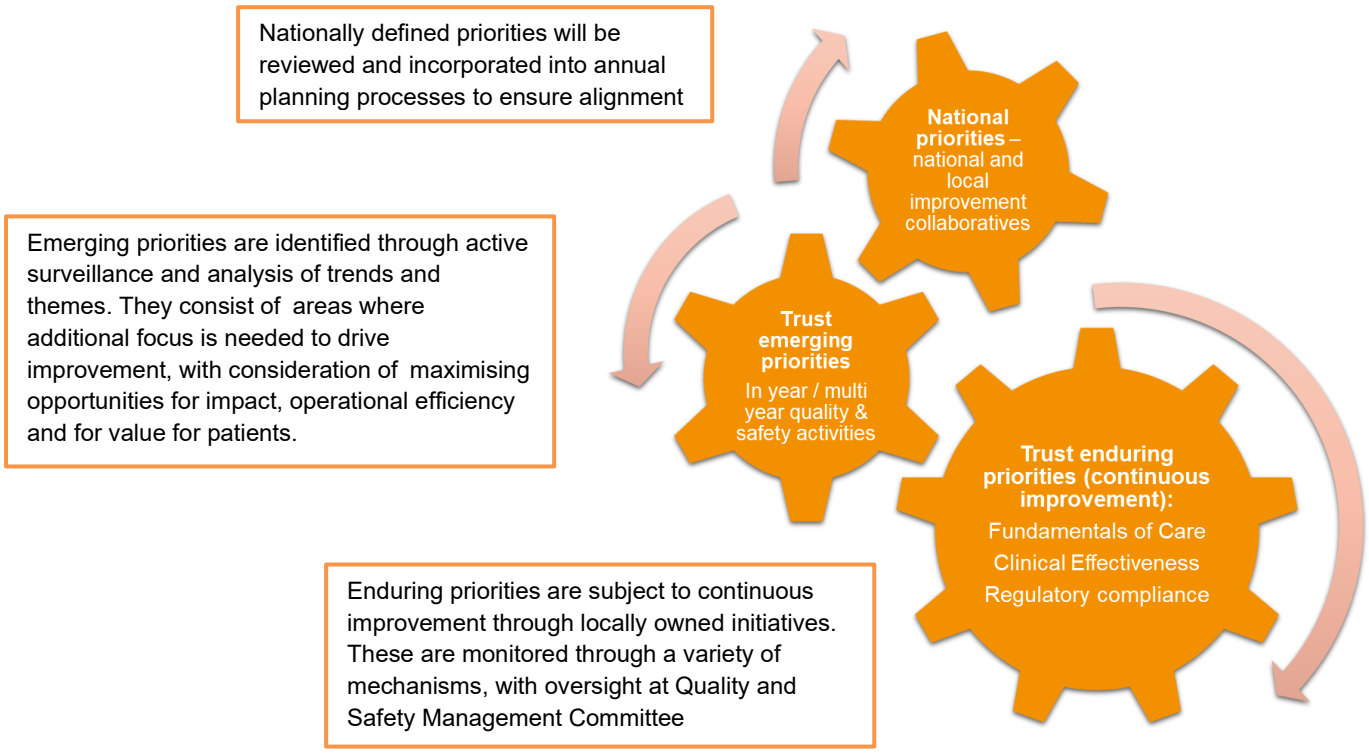
This plan covers how we respond to patient safety incidents for the purpose of learning and improvement. It does not cover processes that have different aims, such as:

- Inquests
- Human Resources matters
- Professional conduct investigations
- Complaints processes
- Legal claims
- PALS (Patient Advice and Liaison Service)
- Freedom to Speak Up concerns

These important processes run separately and have their own procedures, though we always aim to share learning across all areas where appropriate.

Furthermore, the patient safety priorities identified in this plan and any improvement activity commissioned as a result will be in addition to the wider quality improvement activity as part of the organisation's Quality Strategy:

MFT Quality strategy planning process:

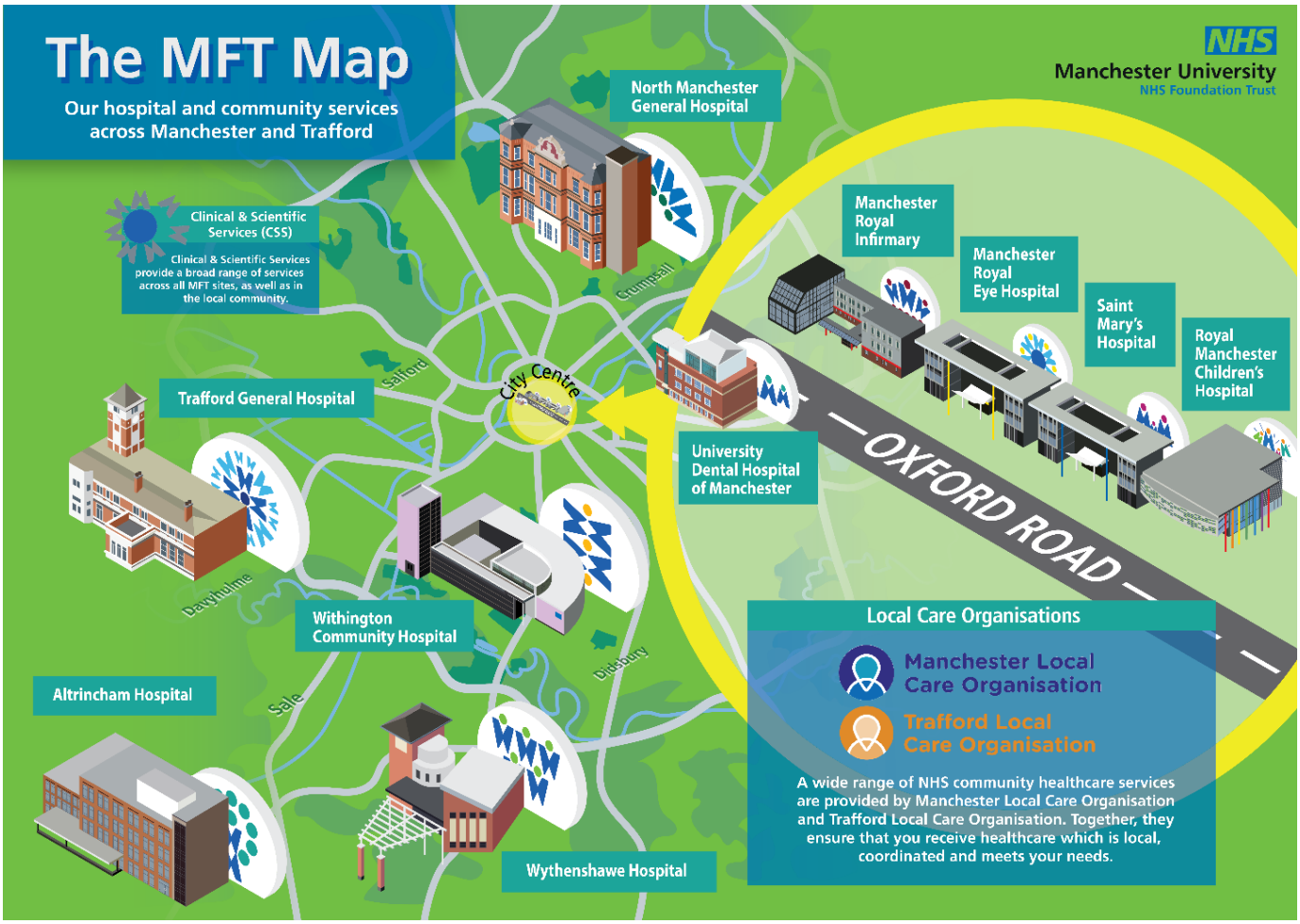


Our services

About Manchester University NHS Foundation Trust

Manchester University NHS Foundation Trust (MFT) provides local hospital and community services to a diverse population of almost 1 million people in Greater Manchester and beyond. We care for people before they are born right through to the end of their lives, including accident and emergency, diagnostic tests, outpatient appointments and day case surgery. We are the biggest provider of specialised services in England – which include Breast Care, Vascular, Cardiac, Respiratory, Urology Cancer, Paediatrics, Women's Services, Ophthalmology and Genomic Medicine.

MFT was formed in 2017 when Central Manchester Foundation Trust and the University Hospital of South Manchester Foundation Trust merged. In April 2018, Manchester Local Care Organisation was formed with Trafford Care Organisation following in October 2019. North Manchester General Hospital joined the MFT family on 1 April 2021.



Our Clinical Groups

MFT's hospitals and community services are grouped into six Clinical Groups, each with their own senior leadership team. Clinical Groups are accountable for the management and governance of their sites and services:

- Manchester and Trafford Local Care Organisations and University Dental Hospital of Manchester
- Clinical and Scientific Services
- Manchester Royal Infirmary
- Specialist Hospitals Clinical Group:
  - Saint Mary's Managed Clinical Service
  - Manchester Royal Eye Hospital
  - Royal Manchester Children's Hospital Managed Clinical Service
- North Manchester General Hospital
- Wythenshawe, Trafford, Withington and Altrincham:
  - Wythenshawe Hospital
  - Trafford General Hospital
  - Withington Community Hospital
  - Altrincham Hospital

Working Together as One Team

The Trust employs over 30,000 colleagues who support people with both their physical and mental health, including mental health services for children and young people. We recruit more people to research studies than any other provider in the Northwest region, with the second highest number of participants nationally. This allows us to give the communities who access our services access to the very latest treatments and innovations.

We are proud to be rooted in our local communities. Many colleagues are recruited from and live in the areas we serve, facing the same challenges as the people we care for. This connection drives our commitment to excellence and compassion in everything we do.

Our Values and How They Guide Our Approach to Patient Safety

Our five core values shape how we respond to patient safety incidents and guide every decision we make.

Because we are **Compassionate**, we will:

- Put patients, families and staff at the centre of everything we do when responding to incidents
- Recognise the emotional impact incidents have on all those affected
- Provide support to everyone affected by a patient safety incident
- Listen with empathy and respond with kindness

Because we are **Curious**, we will:

- Ask meaningful questions to understand what happened
- Use data, evidence and innovation to improve our responses
- Seek to learn rather than to blame
- Embrace new approaches and tools for investigating incidents

Because we are **Collaborative,** we will:

- Work together with patients, families and staff throughout our response process
- Involve people with lived experience in shaping how we respond to incidents, through our Patient Safety Partners
- Work together across our organisation and with partners in our response to incidents, therefore ensuring our learning benefits everyone
- Work as one team across all our clinical groups and sites

Because we are **Open and Honest** we will:

- Be transparent about what happened when things go wrong
- Fulfil our Duty of Candour obligations with integrity
- Share our findings and learning openly
- Celebrate improvements while acknowledging where we can do better

Because we are **Inclusive,** we will:

- Ensure we build ways to make sure everyone's voice is heard in our incident response process
- Recognise that patient safety incidents can affect people differently based on their identity and background
- Ensure that when we are choosing which incidents to investigate, we consider that these are representative of those living in our communities with greatest need
- Address health inequalities through the improvements we make

Defining our patient safety incident profile

To develop this plan, we undertook a thorough analysis of our patient safety profile over the past 24 months. This helped us understand where patient safety incidents are occurring, what themes are emerging, and where we should focus our efforts for maximum impact.

We reviewed:

- **Incident reports:** All incidents reported by colleagues through our incident reporting system
- **Complaints and feedback:** Concerns raised by patients and families
- **Friends & Family Test feedback:** Free text analysis
- **Claims data:** Information from legal claims
- **Mortality reviews:** Learning from our medical examiner team and learning from deaths reviews
- **Risk register:** Existing known risks
- **Freedom to Speak Up:** Anonymised, pre-themed data from our FTSU Guardians
- **National learning:** Alerts and guidance from NHS England and other national bodies

What we found:

The comprehensive analysis resulted in the identification of six overarching themes:

- Communication and coordination across care boundaries
- Delays in diagnosis and care provision
- Safe discharge and transitions
- Medication safety
- Falls
- Maternity safety

Across these, 20 sub themes were identified as being significant in the data as shown in the table below:

Overarching theme	Sub themes
Communication and coordination across care boundaries	• Communication with other teams within MFT • Communication with other care partners • Communication with patients and their families
Delay in diagnosis & care provision	• Delayed diagnosis: fractures • Missed cancer diagnosis • Cardiac events • Extended waiting/lost to follow up • Diagnosis & treatment of sepsis

Safe discharge & care transitions	• Discharge from ED that leads to re-presentation • Vulnerable patients with complex needs • Medication at discharge • Self-discharge/patients who leave before optimal planning completed
Medication safety	• Omitted/delayed critical medications • IV infusion errors • Delays/inaccuracies in prescribing
Falls	• Unwitnessed falls
Maternity safety	• Unexpected NNU admission • Post-partum haemorrhage • Delay/cancel IOL/CS • CTG monitoring

Stakeholder Engagement

Following identification of the overarching and subthemes from patient safety incidents, we spoke with people across our organisation to understand their perspectives on patient safety priorities:

- **Clinical colleagues:** Doctors, nurses, allied health professionals, and healthcare scientists across all Clinical Groups (CG list of clinical colleagues is not exhaustive)
- **Patients and families:** Through our Governors and through analysis of feedback from the Friends & Family Test and from complaints processes
- **Governance leads:** Patient safety and quality leads from each clinical group
- **Specialist teams:** Including safeguarding, infection prevention, medicines safety, and others.
- **Support services:** Teams who play vital roles in patient safety
- **Senior leadership:** Trust Board and Executive Team members
- **External partners:** Greater Manchester ICB

This process of engagement included sharing of the themes, discussions regarding whether the themes identified reflected experience and the opportunity for colleagues to rank the themes and subthemes via an online survey.

Defining our patient safety improvement profile

From our data analysis and stakeholder engagement, the following local patient safety priorities were identified and agreed. These priorities will be a focus for incident responses and safety improvement over the next two years from May 2026.

In formulating these priorities, we have considered what our patient safety data and intelligence is telling us alongside an evaluation of existing quality improvement activity. In agreeing our final priorities, we have focussed on those areas where effective quality improvement activity is not already underway and/or those areas where the underlying causes are poorly understood.

MFT local patient safety priorities:

- **Maximising opportunities for personalised timely delivery of cancer care**
- **Communication challenges with key stakeholders in the patient's care pathway impacting care provision and outcome**
- **Medication at discharge**
- **Post-partum Haemorrhage (PPH) >1500ml**

The MFT Improvement Strategic Delivery Plan sets out that "We want everyone who uses services or works at MFT to contribute to our improvement, be excited to explore 'better is possible', and have the skills, time and permission to make improvements"

To deliver this aim the organisation will:

- Deliver Improvement At Scale
- Equip our people to improve
- Create the conditions for improvement to thrive
- Co-produce a world class quality management system.

There is an established MFT Improvement Academy and Improvement Hub which provide MFT colleagues with a single point of access to a catalogue of information, training and support on all aspects of quality improvement. These aim to create a culture of continuous improvement across MFT; building quality improvement capacity and capability at all levels of the organisation through the provision of training and resources to empower colleagues to contribute and support service improvement and transformational work.

Our patient safety incident response plan: local focus

The table below outlines the advised learning response/action for each of our local priorities:

Priority	Action	Anticipated improvement route /Assurance	Priority Lead & Executive Team Oversight
Maximising opportunities for personalised timely delivery of cancer care	• Cases will be identified via Ulysses reporting and/or Cancer harm review processes • Cases which meet this criterion and where the harm level is moderate or above will be discussed at PSOAG and assessed for features which create the greatest opportunity for learning • For these cases a PSII** will be completed • PSIIs will be completed across MFT until sufficient learning to inform development of an overarching improvement plan	Create actions based on a systems approach. Position reported bi-monthly through the Patient Safety overview paper to Quality & Safety Management Committee	**Priority Lead:** Dr Susi Penney/Emma Dodds **Exec oversight:** Sohail Munshi /Kimberley Salmon - Jamieson
Communication challenges with key stakeholders in the patient's care pathway impacting care provision and outcome	• Cases will be identified via Ulysses reporting • Cases which meet this criterion and where the harm level is moderate or above will be discussed at PSOAG and assessed for features which create the greatest opportunity for learning • For these cases an MFT led PSII will be completed • Up to 3 PSIIs to be completed across MFT and then development of an overarching improvement plan	Create actions based on a systems approach. Position reported bi-monthly through the Patient Safety overview paper to Quality & Safety Management Committee	**Priority Lead:** Andrew Hilditch-Roberts **Exec oversight:** Sohail Munshi /Kimberley Salmon - Jamieson

Medication at discharge	• Cases will be identified via Ulysses reporting • Cases which meet this criterion and where the harm level or risk of harm is moderate or above will be discussed at PSOAG and assessed for features which create the greatest opportunity for learning • For these cases an MFT led PSII will be completed • Up to 3 PSIIs to be completed across MFT and then development of an overarching improvement plan	Create actions based on a systems approach. Position reported bi-monthly through the Patient Safety overview paper to Quality & Safety Management Committee	**Priority Lead:** Layla Alani **Exec oversight:** Sohail Munshi /Kimberley Salmon - Jamieson
Post-partum Haemorrhage (PPH) >1.5 litres	• Cases will be identified via Specialist Hospitals Clinical Group (SHCG) governance processes • Cases which meet this criterion and where the harm level is moderate or above will be subject to an SHCG led proportionate learning response which will be noted at PSOAG • Learning from these cases will inform the ongoing improvement plan	Create actions based on a systems approach. Position reported through the maternity IPR and maternity bi-monthly assurance paper to Quality & Safety Performance Board Committee and regularly through the Patient Safety overview paper to Quality & Safety Management Committee	**Priority Lead:** Kathy Murphy **Exec oversight:** Kimberley Salmon - Jamieson

Whilst these learning responses will be utilised to explore to any incident meeting the criteria of our patient safety priorities, all patient safety incidents will subject to an appropriate learning response in line with the organisation's Patient Safety Incident Response Policy ensuring effective exploration of those where we feel there is additional significant learning.

*Grading of harm as per the NHS England Learn from Patient Safety Events (LFPSE) service
**Further details of the different types of learning response follow a patient safety incident are included on p16-19

Our patient safety incident response plan: national requirements

In addition to our local priorities there are patient safety incident types that must be responded to according to national requirements. These are detailed on the table below alongside detail regarding the anticipated improvement route.

Event	Action	Anticipated improvement route
Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria for PSII)	MFT led PSII	Create local organisational actions and feed these into quality improvement workstreams.
Deaths of patient 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 (meeting the learning from deaths criteria)	MFT led PSII	Create local organisational actions and feed these into quality improvement workstreams.
Incident meeting the 2018 Never Events Criteria	Locally led learning response	Create local organisational actions and feed these into quality improvement workstreams
Mental health-related homicides	Referred to the NHSE Regional Independent Investigation Team (RIIT) for consideration for an independent PSII – may be MFT led PSII	Create local organisational actions based on learning/RIIT recommendations
Child deaths	Refer for Child Death Overview Panel review. MFT led PSII (or other response) may be required alongside panel review – organisation should liaise with the panel	Create local organisational actions based on learning/RIIT recommendations

Event	Action	Anticipated improvement route
Deaths that meet MBRRACE-UK perinatal surveillance. This includes: All late fetal loses and stillbirths (excluding medical termination) and neonatal deaths	Completion of Perinatal Mortality Review Tool within mandated timeframe. Identify and disseminate learning. Where issues in care have contributed to the outcome consider PSII led by the Trust	Organisation in which event occurred
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review. Locally led PSII (or other response may be required alongside panel review – organisation should liaise with the panel	LeDeR programme
Incidents meeting Every Baby Counts (EBC) criteria	Referred to MNSI	Create local organisational actions based on MNSI recommendations

Never Events, as well as being recorded as part of the PSIRF framework will continue to be recorded via other existing reporting and response mechanisms (this includes the Learn from Patient Safety Events (LFPSE) service, the statutory requirements of the Duty of Candour, and as Care Quality Commission (CQC) notifiable incidents).

In completing learning responses the following will apply:

- Incidents will be explored with patients, families, staff and others affected reflecting a compassionate engagement approach.
- For notifiable safety incidents Statutory Duty of Candour in line with Trust Duty of Candour Policy will be completed
- The organisation's position regarding these national and local patient safety priorities will be monitored through the organisation's governance structures via bimonthly reporting to Quality and Safety Management Committee.

Keeping Our Priorities Current

We recognise that patient safety priorities can change as we improve services, as new risks emerge, or as our understanding develops. We will:

- Review incident data continuously to identify emerging themes
- Respond flexibly to new safety concerns
- Update this plan every 2-3 years
- Communicate any changes to our priorities clearly with all stakeholders

Exploring patient safety incidents:

The MFT Patient Safety Incident Response Policy 2026 directly supports this Patient Safety Incident Response Plan and sets out MFT's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. When considering our response to patient safety incidents which relate to one of the priority areas the following assessment process should take place:

Step 1: Initial Safety Review
Patient Safety Team reviews the incident with the relevant clinical group governance lead to understand:

- Who was affected by the incident and what support they need
- What happened
- Initial assessment of contributory factors
- Existing understanding of similar incidents
- Current improvement work related to this type of incident

Step 2: Compassionate response
For all incidents commence compassionate engagement response (if needed) and Duty of Candour applied (where required).

Step 3: Decision on Response
Based on the triage, we choose:

Option A: Contributory factors are well understood and align with existing improvement work

- Incident reviewed within existing governance processes
- Feedback on outcome provided to staff and patients/families
- Monitored as part of priority workstream

Option B: New or additional contributory factors identified requiring further learning

- Appropriate learning response initiated (PSII, AAR, thematic review, etc.)
- Investigation conducted using relevant methodology
- Findings and recommendations shared
- Actions incorporated into priority workstream

Step 4: Ongoing Monitoring
Patient Safety Priority Groups monitor incident trends within each priority area to:

- Track whether improvements are having the desired effect
- Identify emerging sub-themes
- Adjust response approach as needed

How We Respond to Patient Safety Incidents

Our Range of Learning Responses

PSIRF introduces different tools for learning from incidents, allowing us to match our response to the situation. We will use the following approaches:

Patient Safety Incident Investigation (PSII)

What it is: A comprehensive, in-depth investigation using systems thinking to understand contributory factors.

When we use it:

- Deaths thought more likely than not due to problems in care
- Significant incidents within our priority areas where deeper understanding is needed
- Incidents with complex contributory factors requiring detailed analysis

What to expect:

- Investigation team appointed
- Patients, families and staff meaningfully involved throughout
- Timeline: typically 2-6 months depending on complexity
- Comprehensive report with system-based recommendations
- Focus on understanding, not blame

Multidisciplinary Team (MDT) Systems Review

What it is: A structured review bringing together professionals from different disciplines to examine an incident from multiple perspectives and identify system-level contributory factors.

When we use it:

- Incidents of moderate complexity requiring broader expertise
- When examining more than one incident would be helpful
- When understanding requires input from multiple specialties or departments
- When a less resource-intensive alternative to a full PSII is appropriate

What to expect:

- Involves representatives from relevant disciplines (e.g., medical, nursing, pharmacy, therapies)
- Facilitated meeting to review the incident(s) using a systems approach
- Timeline: typically completed within 4-8 weeks
- Produces practical recommendations for system improvements

After Action Review (AAR)

What it is: A facilitated team discussion shortly after an incident to capture immediate learning.

When we use it:

- Incidents requiring rapid learning
- When the team involved wants to reflect together
- To capture learning before memories fade

What to expect:

- Takes place within days or weeks of the incident
- Involves those directly involved
- Structured conversation focusing on: What was supposed to happen? What actually happened? Why? What can we learn?
- Quick turnaround with immediate actions

SWARM Review

What it is: A rapid, multidisciplinary huddle immediately after an incident.

When we use it:

- When immediate learning would prevent recurrence
- Clear, contained incidents
- When real-time information is available

What to expect:

- Happens very quickly (within hours or days)
- Brief, focused discussion
- Quick capture of facts and immediate actions

Thematic Review

What it is: Analysis of multiple related incidents over time to identify patterns.

When we use it:

- When we see patterns across multiple incidents
- To understand whether existing improvement work is effective
- To identify system-wide factors

What to expect:

- Reviews multiple incidents together
- Looks for common themes and system factors
- Produces recommendations for system-wide improvements
- May take several months to complete

More information about the plan:

For patients, their families and the public

If you have questions about this plan or want to provide feedback on your experience of our incident response processes:

Patient Safety Team:
patientsafety.events@mft.nhs.uk

Patient Advice and Liaison Service (PALS):
pals@mft.nhs.uk - Tel: 0161 276 8686

Complaints Team:
complaints@mft.nhs.uk

Staff Support Services:
Employee Health & Wellbeing Service - Employee Health and Wellbeing Service | People Place

Freedom to Speak Up Guardian - FTSUGuardian@mft.nhs.uk

Online Resources

This plan and supporting documents are available on:

- MFT public website: Manchester University NHS Foundation Trust
- Staff intranet: Patient Safety - Home

Feedback on This Plan

We welcome feedback on this plan from patients, families, staff, and partners. Please contact:patientsafety.events@mft.nhs.uk

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Glossary of Terms

After Action Review (AAR): A structured team discussion shortly after an incident to identify what happened and what can be learned.

Duty of Candour: The legal requirement to be open and honest with patients and families when something goes wrong with their care.

Learning from Deaths (LeDeR): A national programme reviewing the deaths of people with learning disabilities.

Never Event: An incident that is monitored differently by NHS England due to special consideration that they may be more likely to be preventable.

Patient Advice and Liaison Service (PALS): A service offering confidential advice, support and information to patients, families and carers.

Patient Safety Incident: Any unintended or unexpected incident which could have led or did lead to harm for one or more patients.

Patient Safety Incident Investigation (PSII): A comprehensive investigation using systems thinking to understand contributory factors to a patient safety incident.

Patient Safety Incident Response Framework (PSIRF): The NHS's approach to developing and maintaining effective systems for responding to patient safety incidents.

Patient Safety Incident Response Plan (PSIRP): This document - explaining how an organisation will respond to patient safety incidents.

Patient Safety Incident Response Policy: A document that accompanies this document which describes the systems, processes, roles and responsibilities in place to respond to and learn from patient safety incidents

SWARM: A rapid, multidisciplinary huddle immediately after an incident to capture immediate learning.

Systems Approach: An approach that looks at how different parts of the healthcare system interact and contribute to incidents, rather than solely focusing on individual actions.

Thematic Review: Analysis of multiple related incidents over time to identify patterns and system-wide factors.

This plan reflects MFT's commitment to 'Where Excellence Meets Compassion' - learning from every incident to continuously improve the safety and quality of care we provide to our diverse communities.