NHS
The Christie
NHS Foundation Trust

Patient Safety Incident Response Plan

Effective Date: April 2025

Estimated Refresh Date: 12-18 Months

Author: Patient Safety Team
Reviewer: Risk and Quality Governance Committee | **Date:** 13th August 2025
Authoriser: Quality Assurance Committee | **Date:** 18th September 2025

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Introduction to the Patient Safety Incident Response Framework

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months from May 2025. The plan is not a permanent rule that cannot be changed, and we acknowledge the challenge that this fundamental shift in approach continues to bring with it. As an organisation we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of the people affected.

The NHS Patient Safety Strategy (PSS) was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework 2015 (SIF). This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at The Christie NHS Foundation Trust to implement PSIRF and our ongoing plans to further embed the principles for the next year.

The Serious Incident Framework (2015) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF, on the other hand, is best considered as a learning and improvement framework with an emphasis on the system and culture. One of the underpinning principles of PSIRF is to undertake fewer "investigations" and deploy resource to improving systems and processes; this means taking the time to conduct systems-based investigations by people that have been trained to do them.

The Patient Safety Strategy challenges everyone to think differently about learning and what it means for our organisation. This Patient Safety Incident Response Plan (PSIRP) sets out how The Christie will respond to patient safety incidents reported by staff and patients, their families, and carers as part of work to continually improve Patient Safety Learning Responses (PSLRs) by:

- Refocusing Patient Safety Learning Responses towards a system analysis approach and the rigorous identification of factors and system issues.
- Focusing on addressing these causal factors and the use of improvement sciences to prevent or continuously and measurably reduce repeated patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents.
- Acting proportionately to incidents and risks, ensuring a compassionate and engaged response is taken with affected parties whilst aiming to release resource from investigation processes to improvement programmes and work streams.

Scope

This document covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Therefore, other processes and governance is outside of the scope of this document for example:

- Inquests
- HR issues
- Professional Conduct
- Complaints
- Claims
- PALS
- Freedom to Speak Up

The principal aims of each of the above responses differ from the aims of a patient safety response and are outside the scope of this plan.

This plan explains the scope for a systems-based approach to learning from Patient Safety Incidents (PSIs). We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this plan.

Responses covered in this plan include:

- Patient Safety Learning Responses (PSLRs)
- Patient Safety Incident Investigations (PSIIs)

Our Safety Culture

As a Trust, The Christie have endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. The Christie encourages the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

We plan to collaborate with our HR team over 2025/26 to incorporate the newly launched NHS England 'Being Fair Tool' to ensure the principles of PSIRF filter through our HR processes. This will ensure a systems approach has been considered following adverse events and when considering staff performance.

Engagement and Involvement in Patient Safety Incidents

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff).

We are committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

For 2025/26 we will review our available resources for patients and families involved in patient safety learning responses. This will be done in collaboration with our newly appointed Patient Safety Partners. The aim of this will be to empower patients and families to collaborate and be actively involved in the learning responses.

Our Values

The Christie Trust Values

The Christie NHS Foundation Trust aims to demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.

Our Value

Our Behaviours
We are courageous and try new ideas
We are honest and take responsibility

What this looks like: We demonstrate integrity by listening to others and taking ownership of our actions. We back each other to challenge the status-quo to keep improving.

Our Value

Our Behaviours
We care for each other and our environment
We show appreciation and celebrate success

What this looks like: We are caring and compassionate, taking care of our environment and those within it. We remember that every person is different, and every interaction is a real moment in their lives.

Our Value

Our Behaviours
We are inclusive
We work together as one team

What this looks like: We support each other, across disciplines and roles, to share insights, skills and resources, to deliver the highest standards of service delivery and patient care.

Aims and Objectives

The implementation of PSIRF will incorporate the four strategic aims of the PSIRF upon which this plan is based, the overarching aims and how these will be achieved through specific objectives (see Table 1), and our Trust visions embodied in our work.

Table 1

PSIRF, Strategic Objectives and Values and Behaviours

To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer.

PSIRF Aims	Aim Description	Christie Values
Compassionate engagement and involvement of those affected by patient safety incidents.	When a patient safety incident investigation (PSII) or other learning response is undertaken, organisations should meaningfully involve those affected, where they wish to be involved.	**Connect with People** We are Inclusive, We work as one team.
Application of a range of system-based approaches to learning from patient safety incidents.	Organisations are encouraged to use the national system-based learning response tools and guides, or system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.	**Make a Difference** We are Courageous and try new ideas.
Considered and proportionate responses to patient safety incidents.	Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a PSII to learn and improve. Some incident types will also require specific reporting and / or review processes to be followed.	**We are Honest and take Responsibility**
Supportive oversight focused on strengthening response system functioning and improvement.	All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a mutual understanding of the aims of this framework, to provide an effective governance structure around the NHS response to patient safety incidents. Adopting a culture of psychological safety within governance and safety reporting.	**We act with Kindness** We show appreciation and celebrate successes.

The Christie Services

The Christie NHS Foundation Trust is the largest single cancer centre in Europe, treating over 60,000 patients per year. The trust provides Radiotherapy, systemic anti-cancer therapy (chemotherapy, immunotherapy, trial drugs), specialist surgery and a wide range of diagnostic and supportive services. Proton Beam therapy is also delivered, making the Christie the first NHS trust in the UK to offer this specialised treatment.

The Christie serves a population of 3.2 million across Greater Manchester and Cheshire, at our main Withington site and across satellite sites. As a national specialist in Cancer care, around a quarter of our patients are referred to us from other parts of the country.

The Christie at Home service provides chemotherapy and immunotherapy treatments to patients in their own homes.

Our sites:

- The Christie main site (Withington)
- The Christie at Macclesfield
- The Christie at Oldham
- The Christie at Salford
- Peripheral Outreach clinics (Bolton, Oldham, Wigan, Leighton, Stepping Hill)
- Bloods closer to Home (Winsford, Ashton-under Lyne, Worsley, Cheadle, Oldham, Bury, Bolton, Altrincham)

A trust wide review of our divisions and services was conducted to support our understanding of the scope of PSIRF. The services and their relevant divisions have been outlined in the below table.

Our Divisions and Associated Services:

Network Services

- Clinical Oncology
- Medical Oncology
- Referrals and Bookings
- Haematology Services
- Teenage / Young Adult Oncology
- Metastatic Spinal Cord Compression
- Systemic Anti-cancer Treatment Services
- Outpatient Services
- Proton Beam Therapy
- Radiotherapy
- Pharmacy Services
- Satellite Sites
- Medical Physics
- Clinical Engineering
- Diagnostic Radiology (Physics)
- Mechanical Workshop
- Medical Illustration
- Nuclear Medicine
- Radiopharmacy
- Radiotherapy Physics
- Ultrasound Medical Physics

Clinical Support and Specialist Surgery

- Inpatient Wards
- Acute Ambulatory Care
- Critical Care / Acute Oncology Outreach
- Chaplaincy
- Complex Discharge
- Complementary Therapies
- Endocrinology
- Hospital at Night Team
- Health Records / Central Admin
- Integrated Procedures Unit / Procedure Team
- Surgical Admissions
- Radiology Services
- Interpreter service and Transport
- Nutrition and Dietetics
- Critical Care Unit
- Patient Flow / Bed Management
- Pre-op Assessment
- Rehabilitation
- Surgical Theatres
- Anaesthetic
- Supportive Care
- Psycho-Oncology

Research and Innovation

- Clinical Research Facility
- Clinical Trials Unit
- Biobank
- Disease Specific Research Teams
- Research Teams
- Central Research
- Patient Recruitment

Corporate

- Patient Experience, Quality, and Complaints
- Patient Safety
- Infection Prevention and Control
- Tissue Viability
- Sepsis
- Safeguarding
- Quality Improvement and Clinical Audit
- Freedom to Speak Up
- Health and Safety
- Performance
- Finance
- Workforce
- Human Resources

Corporate Development

- Occupational Health
- Communications
- Engagement
- Marketing

Digital Services

- Applications
- Analytics and Statistics
- Business Intelligence
- Clinical Data Capture
- Cyber Security
- Information Governance
- Infrastructure
- Software Development / Solutions / CWP
- Techbar Support

Capital Estates and Facilities

- Capital / Facilities Projects
- Soft Facilities
- Hard Facilities
- Site services

Christie Pathology Partnership

- Bereavement Services
- Blood Sciences
- Oncology Genetics
- Pathology
- Histopathology
- Haematology
- Biochemistry
- Blood Transfusion Lab

The Christie Institute for Cancer Education

- Education
- Education Centre
- Clinical Skills Team
- Medical Library

Defining our Patient Safety Incident Profile: 12 Month Review

Our PSIRF Plan Review

In alignment with national guidance, our PSIRF plan has been reviewed 12 months after its initial launch within the Trust.

To effectively assess and update our patient safety profile, we analysed a range of data sources.

Data Sources

A thematic analysis was carried out using data from our Local Incident Reporting System (DCIQ). Between April 2024 and April 2025, a total of 10,100 incidents were reported. The analysis supported in identifying the key areas of focus and allocating resource needs accordingly.

Analysis of feedback and complaints, claims and mortality reviews between April 2024 and April 2025 was also undertaken to identify key areas for improvement from a variety of sources.

Stakeholder Engagement

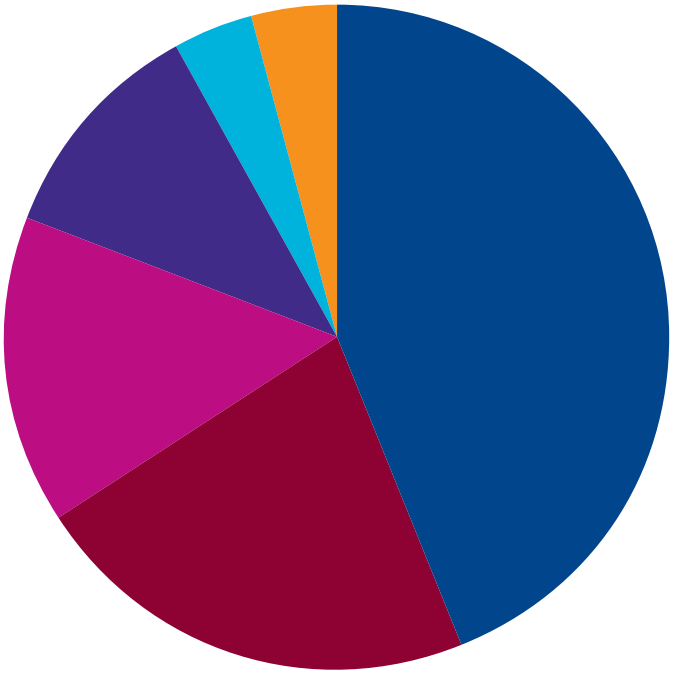
A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts.

Further insight was gathered from staff through a mixed-methods, anonymised questionnaire conducted in early 2025.

The questionnaire focused on the following areas:

- PSIRF implementation
- Patient safety culture
- Shared learning
- Incident feedback
- Patient safety priorities

Sample Profile - Staff Questionnaire



The following question was incorporated into the questionnaire:
What do you believe are the top three patient safety priorities for our organisation?

Responses gathered included:

Culture

- Promotion of a just culture
- Pyschological safety
- Openness and transparency

Patient care

- End of life care
- Transfusion safety
- Care of deteriorating patients

- Medicines management
- Communication
- Falls
- Infection control

Defining our Patient Safety Improvement Profile

Review of Patient Safety Priorities 2024/25

Existing patient safety priorities have been reviewed alongside incident data, stakeholder involvement and resource allocation. The 2024/25 PSIRP included the legacy themes of Harm Free Care; the data on Falls, TVN & IPC demonstrates the Trust is well below national rates per 1000 bed days.

There is dedicated resource and professionals overseeing these themes enabling the Trust to step these down as priorities under PSIRF and move to standard business and clinical quality & safety.

Priority	Assurance
Fundamentals of care – Falls and pressure ulcer prevention.	• Quarterly 'Back to Basics' peer audit. • Annual code accreditation scheme, overseen by the trust's Quality Matron. • Monthly 'mini code' accreditation of inpatient areas to sustain quality care standards. • Monthly incident reports. • Nominated Falls and Tissue Viability leads.
Business as Usual (SACT specific).	• Monitoring within 'business as usual' incident trends and themes within governance and patient safety teams. • Monitoring of incidents within the Systemic anti-cancer treatment services directorate governance structure.
Infection Prevention and Control.	• Continuous monitoring of trends and themes through Infection Prevention Committee. • Dedicated Infection Prevention Team to support learning responses and continued improvement where required.

Identified Priority	Description	Source of Evidence / Data
End of life care.	Improve staff, patient and relative experience of: • Advance care planning. • Care in the last days of life.	Complaints, incidents, mortality reviews, staff feedback.
Management of the deteriorating patient.	Delay/ failure to recognise and treat deterioration resulting in escalation to level 2 or 3 care including but not limited to the identification and/or management of Sepsis and Acute Kidney Injury.	Incidents, anecdotal evidence, mortality reviews.
Safe administration of medicines and blood products.	Reduce incidence of medication and transfusion administration errors.	Incidents, anecdotal, serious incident investigations, complaints.
Patient's 'lost to follow up' post treatment.	Reduction in incidents from lack of follow up during patient treatment pathway.	Risk Register, Incidents, Complaints, Patient Feedback.

Proposed Priorities for 2025/26

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 12-18 months from April 2025.

Our Patient Safety Incident Response Plan: National Requirements

The national requirements are outline below with the required responses as per PSIRF guidance.

Events Requiring a Specific Type of Response as set out in Policies or Regulations

National Patient Safety Priorities		
Patient Safety Incident Type	**Required Response**	**Anticipated Improvement Route**
Incidents meeting Never Event criteria.	PSII	Create local organisational actions and feed these into the quality improvement workstreams.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs).		
Death of a person with a learning disability / neurodiversity more likely than not due to problems in care.		
Child deaths.	Refer for child death overview panel review.	
Death of a person with a learning disability.	Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	National LeDeR team notification.
Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. • Adults (over 18 years old) are in receipt of care and support needs from their local authority. • The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence.	Refer to local authority safeguarding lead Healthcare. Organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	

Our Patient Safety Incident Response Plan: Local Focus

The guidance in this table outlines the advised learning responses based on criteria within each patient safety profile. The type of response will also depend on:

- The views of those affected, including patients and their families.
- Capacity available to undertake a learning response.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect / benefit.
- If an organisation and its ICB are satisfied risks are being appropriately managed.

Consideration of Learning Response by Divisional PSIG

Local Patient Safety Priorities

Priority	Response Assessment	Response Action
Deteriorating Patient Failure to recognise and act on signs and symptoms of deterioration. **Workstreams to include:** • Martha's Rule Implementation.	Incident falling under these Priority Group themes can be triggered to assess contributory factors involved and identify whether they are well understood and align to existing improvement plans.	**Contributory factors understood and align to PSIRF Priority ongoing project:** • Feedback to be provided to staff and patients in line with PSIRF engagement guidelines. • Notifiable Safety Incidents complete Statutory Duty of Candour in line with Trust Duty of Candour Policy. • Patient Safety Priority groups monitor incident data trends and review recommendations made following learning responses. **Additional contributory factors identified on initial triage and further learning identified:** • Review by DPSIG to identify appropriate learning response. • Recommendations to be outlined in learning response and assessed in relevant Patient Safety Priority group.
Medicines Safety **Workstreams to include:** • Correct identification of patients and safe administration. • Focus on high risk medications, such as insulin and SACT.		
Transfusion Safety **Workstreams to include:** • Safe administration of right blood product at right time for the right patient.		
Lost to Follow Up / Open Referrals Lost to follow up/open referral that has resulted in a significant delay to an individual.		
End of Life Care **Workstreams to include:** • Advanced Care Planning. • Care in the last days of life. • Care after death.		

Patient Safety Priority Workstream Project Proposals

The following process will be followed to determine the individual improvement projects identified by the patient safety priority groups. The project proposals will allow for clear definition of the project, including measures and goals identified for improvement.

Project identified through Priority Group.
Project Proposal completed.

Project Proposal reviewed by Patient Safety Committee for acceptance onto Patient Safety Priority workstream with consideration of timeframes, measures, and resource implications.

Project managed through appropriate Patient Safety Priority Group with monthly AAA and quarterly updates to Patient Safety Committee.

To include progress and any identified delays/ challenges.

Glossary of Terms

Term / Acronym	Definition
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSS	Patient Safety Strategy
SIF	Serious Incident Framework
PSLR	Patient Safety Learning Response
HR	Human Resources
PALS	Patient Advice and Liaison Service
PSII	Patient Safety Incident Investigation
PSI	Patient Safety Incidents
TVN	Tissue Viability
IPC	Infection Prevention and Control
LeDeR	Learning from Lives and Deaths – People with a learning disability and autistic people
FGM	Female Genital Mutilation
DPSIG	Divisional Patient Safety Improvement Group
SACT	Systemic Anti-Cancer Treatment
AAA	Alert, Assure, Advise
ICB	Integrated Care Board