Bridgewater Community Healthcare NHS Foundation Trust

Patient Safety Incident Response Policy

Policy Number	**Gov/Pol/022**
Target Audience	**All staff including bank/agency and learners in practice**
Lead Executive Director	**Chief Nurse/Deputy CEO**
Recommending Committee/Group	**PSIRF Implementation Group**
Approving Committee(s)	**Corporate Clinical Policy Group**
Ratifying Committee	**Corporate Clinical Policy Group**
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Lead Author(s)	**Head of Risk Management & Patient Safety**
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Applicable Statutory, Legal or National Best Practice Requirements	NHS England (2022) Patient safety incident investigation NHS England (2022) Patient Safety Incident Response Framework and supporting guidance NHS England (2022) Patient safety incident response standards NHS England and NHS Improvement (2019).National Patient Safety Strategy Safer culture, safer systems, safer patients NHS England Health Education: Patient Safety Syllabus Training Data Protection Act 2018 c. 12 Equality Act 20210 c. 15 Freedom of Information Act 2000, c.36 Human Rights Act 1998, c.42 NHS (2019) The NHS Long Term Plan NHS England (2022) Safety action development guide NHS Engand (2018) National Quality Board: Learning from deaths

Document retention – lifetime of the Trust or 20 year review
Document owner – Head of Risk Management & Patient Safety

	NHS England (2018) Learning from deaths: Information for families National Data Guardian (NDG) 2020, The Caldicott Principles Protection of Freedoms Act 2012, c.9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 20 Duty of Candour The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 UK Caldicott Guardian Council 2020, The Eight Caldicott Principles

The Trust is committed to an environment that promotes equality, embraces diversity, and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

This document can only be considered valid when viewed via the Trust's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Version Control Sheet

Version	Date	Reviewed By	Comment
0.1	August 2023	Alan Lee – Head of Risk Management and Patient Safety and Sharan Arkwright – Project support	Draft document created
0.2	10th Aug 2023	PSIRF Implementation Group	Reviewed, comments made
0.3	24th Aug 2023	Q&S Committee	Signed-off
0.4	25th Aug 2023	Board via E Governance	Signed-off
0.5	13th Nov 2023	CCPG	Discussed, document requires transferring onto policy template, updating, CCPG virtual review, recommending group sign-off and CCPG chair approval
0.6	14th Nov 2023	Mary Corkery – Policy Officer	Transferred onto policy template, reviewed, comments made
0.7	17th Nov 2023	Alan Lee – chair of PSIRF Implementation Group	Sign-off confirmed
0.8	20th Nov 2023	J Cheung	Comments and amendments
1.0	21st Nov 2023	CCPG (via E Governance)	Approved
1.1	December 2023	M. Corkery	Minor amendments to section 5.9 and 19 following CCPG E Governance consultation
1.2	December 2023	J. Cheung	Approved by chair action

Equality impact assessment

Consider if this document impacts/potentially impacts:

- Staff
- Patients
- Family members
- Carers
- Communities

Yes [ ] **complete box A**	**No** [X] **complete box B**
Box A Contact the Trust's equality & inclusion manager at: **Email: ruth.besford@nhs.net** **Date contacted:**	**Box B** Complete details below: **Name: Alan Lee** **Email: Alan.lee5@nhs.net** **Date: 15th November 2023**

Education & professional development (EPD) question

To ensure that any training requirements are discussed, and resources planned and allocated to meet the needs of the service, you must consider whether this document has additional training requirements. Please answer the following question by entering a cross in the Yes or No box below:

	Yes	**No**
Does this document have any additional training requirements or implications?	**X**	

If you have answered **YES** you must forward a copy of this document to EPD **before** submitting to the policy officer.

Date submitted to EPD: August 2023

No further action is required if you have answered NO.

This table below must be completed in full for audit and governance purposes. Please note documents will be returned if section 1 in the table below is not completed fully. This will result in a delay in listing the document for approval.

Name of document	Patient Safety Incident Response Policy
Document number	Gov/Pol/022
Document author	Head of Risk Management & Patient Safety

Section 1 - actions required by author	**Authors response**
Date proposal form submitted to policy officer (new documents)	19th October
Date proposal form presented to CCPG (new documents)	13th November 2023
Date proposal approved by CCPG (new documents)	13th November 2023
Date literature search/reference review requested	None required
Date EqIA considered	15th November 2023
Date additional training requirements considered	Regularly reviewed at PSIRF Implementation Group
Date fraud-proofed by the Anti-Fraud Specialist (AFS) if applicable	N/A
Date template accessed on the Hub Add 'OFFICIALSENSITIVE: COMMERCIAL' to front cover if the document can be shared on the internet Add 'OFFICIALSENSITIVE: PERSONAL' to appendices if they include or will include personally identifiable information (PID)	14th November 2023
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Date returned by policy officer following initial review	14th November 2023
Date submitted to key individuals/groups/subject matter experts for comments (add names and designations of responders to consultation table)	N/A
For clinical documents, date document submitted to consultation group for sign-off i.e., IPC, Medicines Management (this applies if the document contains medication or medical gases - update version control sheet to confirm sign-off)	N/A
Name of Recommending Committee/group	PSIRF Implementation Group
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Section 2 – for completion by the policy officer	
Date approved by CCPG	21st November 2023
The following policies require Board approval and must be submitted to Board following CCPG approval: • Risk Management Framework Policy • Health & Safety Policy • Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies") Date submitted for Board approval: Date approved by Board:	N/A

Contents

1 Introduction

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Bridgewater Community Healthcare NHS Foundation Trust (hereafter the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The Trust's Patient Safety Incident Response Plan considers what the Trust's review of reported patient safety incident data and the resulting engagement with key internal and external stakeholders, has shown the Trust about their patient safety incident profile. The Trust have used this intelligence to build their local priorities for patient safety incident investigation (PSII) and to develop a toolkit for responding to other patient safety incidents.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principle aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy.

- Claims handling
- Human resources investigations into employment concerns
- Professional standards investigations
- Information governance concerns
- Estates and facilities concern
- Financial investigations and audits
- Safeguarding concerns
- Coronial inquests and criminal investigations
- Complaints (except where a significant patient safety concern is highlighted).

For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. The Trust will implement a Patient Safety Incident Response Framework (PSIRF) and Learning Panel to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

Directorates will have arrangements in place to manage the local response to patient safety incidents and to ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the Trust as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents - see section 5.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development. alongside a review of all safety actions.

This policy should read in conjunction with the Trust's current Patient Safety Incident Response Plan.

1.1 Objective

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can also align to existing Trust values:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

1.2 Scope

This policy applies to all Trust staff including bank/agency and learners in practice.

2 Definitions

The definitions applicable to this policy are as follows:

Patient Safety Incident Response Framework	Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incident investigation (PSII)	Undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time (NHS England, 2022)
Family liaison officer (FLO)	A role to ensure that families are supported sensitively and compassionately during the investigation, giving them a chance to ask questions and raise concerns. FLOs will also keep them informed about progress and share any lessons learned in an open and transparent way
NHS National Patient Safety Syllabus	Outlines the approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors
Specific, measurable, achievable, relevant, and time-bound (SMART)	Criteria to guide in the setting of goals and objectives that are assumed to give better results
Complaints	Expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review

3 Abbreviations

The abbreviations applicable to this policy are as follows:

CEO	Chief executive officer
CQUINs	Commissioning for Quality and Innovations
DOC	Duty of Candour
EPD	Education and Professional Development
FLO	Family liaison officers
ICB	Integrated Care Board
LFPSE	Learning from Patient Safety Events
MDR	Multi-Disciplinary Review
PALS	Patient advice and liaison service
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient safety partner
PSR	Patient safety response
QI	Quality improvement

RCA	Root cause analysis
SBAR	Situation, background, assessment, and review
SI	Safety incident reviews
SMART	Specific, measurable, achievable, relevant, and time-bound
SME	Subject matter expert
TOR	Terms of reference

4 Other relevant procedural documents

This policy should be read in conjunction with the following documents:

Patient Safety Incident Response Plan

Incident Reporting Policy

Incident Investigation Procedure

Risk Management Framework

Risk Assessment and Risk Register Process Guideline

Complaints, Compliments, Comments & Concerns Handling Policy

Data Protection and Confidentiality Policy

Freedom to Speak Up in the NHS Policy

Learning from Deaths Policy

Mandatory Training and Induction Policy

Pressure Ulcer Policy (Adopted): Prevention and Management

Dignity and Respect at Work Policy and Procedure

Duty of Candour (Being Open) Policy

Clinical Supervision Policy

Corporate Records (including Document Management) Policy

Managing Allegations of Abuse Policy

Medical Device Policy

Medication Incident Policy

Medicines Policy

Safeguarding Adults Policy

Safeguarding Children Policy

Safeguarding Supervision Policy

Health and Safety Policy

Central Alerting System (CAS) Policy and Procedure

5 Roles and responsibilities

Roles and responsibilities of key staff regarding reporting and management of incidents are identified in the Trust Incident Reporting Policy. Roles and responsibilities specific to PSIRF are as follows:

5.1 Chief nurse / deputy chief executive officer

The chief nurse / deputy chief executive officer (CEO) will:

- Report to the Trust Board regarding all matters pertaining to PSIRF
- Oversee the development, review and approval of the Trust's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy and Plan ensuring that they meet the expectations set out in the patient safety incident response standards
- The chief nurse and executive medical director will be responsible for advising the Trust Board in all matters regarding the safety of patients.

5.2 Trust Board

The Trust Board will be responsible for:

- The oversight of the patient safety incident response framework in the Trust
- Receiving assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms from the Quality and Safety Committee.

Reporting will comprise of an overview of activity and any risks identified to ensure that the Trust Board has a formative and continuous understanding of organisational patient safety.

5.3 Patient Safety Incident Response Framework and Learning Panel

The Trust Patient Safety Incident Response Framework and Learning Panel will be responsible for:

- Providing assurance to the Quality and Safety Committee that PSIRF and related workstreams have been implemented to the highest standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

5.4 Director of quality governance

The director of quality governance will be responsible for:

- Ensuring that the Patient Safety Incident Response Framework and Learning Panel, meets on a fortnightly basis

- Ensuring that the Trust risk management system (Ulysses), is managed effectively to provide an effective tool for the reporting and management of incidents.

5.5 Head of risk management and patient safety

The head of risk management and patient safety is responsible for:

- Development and review of the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy

- Management and development of the Trust's risk management system

- Providing reports on patient safety incident trends

- Providing training in the reporting and management of incidents

- Escalating any matters of concern to the appropriate associate borough director

- Supporting and developing incident response processes

- Monitoring the completion of learning plans arising from patient safety incidents.

5.6 Associate borough directors

Associate borough directors are responsible for:

- Ensuring that all staff are made aware of the Trust's arrangements for responding to patient safety incidents

- Ensuring that weekly Directorate Incident Review and Learning Groups are established and meet weekly to review patient safety incidents from within the directorate

- Ensuring that all learning identified from patient safety incident investigation is implemented in a timely manner

5.7 Directors of nursing

Directors of nursing are responsible for:

- Leading the Weekly Directorate Incident Review and Learning Group

- Ensuring that all incidents are managed correctly, and when required learning responses are commissioned

5.8 Managers

Managers are responsible for:

- Ensuring that patient safety events are recorded on the Trust risk management reporting system (Ulysses)
- Ensuring staff can access support following a patient safety event, should this be required, including giving the employee details of services available through Occupational Health
- Supporting the release of staff to provide statements or attend interviews or participate in learning response activities
- Ensure the prompt delivery of all action identified from learning responses.

5.9 Education and Professional Development team

The Education and Professional Development (EPD) team is responsible for:

- Liaising with the PSIRF lead/subject matter expert (SME) to support and facilitate the delivery of all relevant training as identified by them and within this policy. This will include any training required to effectively deliver the PSIRF as well as training relating to the reporting and management of incidents
- Providing advice and support with regards to the planning, promotion, and management of identified training requirements as required
- Facilitating the recording of any specialised training sessions and staff attendance as identified within this document on the OLM system, and liaising with the PSIRF lead/SME to support with compliance reports and other training data as required.

5.10 All staff

All staff are responsible for:

- Reporting all incidents and near misses, onto the Trust risk management reporting system (Ulysses)
- Cooperating with any learning responses and provide any requested information and participate in any learning responses that are relevant to their roles
- Completing levels 1 and 2 of the patient safety training modules.

6 Equipment

Computer

Smartcard

7 Patient safety culture

The Trust has worked over a number of years to move from a retribution approach to types of incidents, such as patient safety and workforce, to establishing a restorative just culture.

The Trust senior leadership have strongly embraced this work and, with support from staff side colleagues, have been instrumental in establishing the Trust transition to a restorative just culture.

The main goals of restoration when an incident has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst Trust staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

8 Patient safety partners

The patient safety partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK. It is a key element of the National Patient Safety Strategy (NHS England and NHS Improvement, 2019).

The Trust is committed to involving diverse groups of people to undertake the role of a PSP. The Trust will offer support alongside staff, patients, families/carers to influence and improve safety across their range of services.

PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation); this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of the Trust's team.

This new role across the NHS will evolve over time. The main purpose of the role in the Trust is to be a voice for the patients and community who utilise services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is the Trust's priority.

As the role evolves, PSPs will participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives, and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the Risk Management and Patient Safety team to ensure PSPs have the essential tools and advice they need.

9 Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust, as a public authority, is committed to delivering on its statutory obligations under the Equality Act 2010 and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Within the Trust's incident management process, we will directly address if there are any particular features of an incident which may indicate health inequalities that have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing safety actions in response to any incident, the Trust will consider inequalities, and this will be inbuilt into Trust documentation and governance processes.

The Trust will also address apparent health inequalities as part of the safety improvement work. In establishing the Trust plan and policy, the Trust will work to identify variations that signify potential inequalities by using population data and patient safety data to ensure that this is considered as part of the development process for future iterations of the Trust's Patient Safety Incident Response Plan and this policy. We consider this as an integral part of the future development process.

Engagement of patients, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. The Trust will ensure that they use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in the Trust's patient safety incident response.

The Trust's commitment to transforming organisational culture to that of restorative justice has already been outlined. Further to this, the Trust has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward their workforce and patients/service users, carers, and families.

As part of this, discrimination of any kind including racism will be dealt with by using a 'Support, Educate, Challenge' approach. With explicit role modelling led by the Trust Board, these principles will be used to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

10 Engaging and involving patients, families and staff following a patient safety incident

The 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). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required – see appendix A.

The Trust is firmly committed to continuously improving the care and services they provide. The Trust want to learn from any incident where care does not go as planned or expected by patients, their families, or carers to prevent recurrence.

The Trust 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 services we provide. Part of this involves the Trust's key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting the Trust's regulatory and professional requirements for duty of candour (DOC) (Health and Social Care Act 2008 and (Regulated Activities) Regulations [regulation] 20 Duty of Candour), the Trust want to be open and transparent with their patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident – see appendix B.

As part of PSIRF, we will be outlining procedures that support patients, families, and carers – based on the Trust's existing Duty of Candour (Being Open) Policy. This will be underpinned by a network of FLOs within Trust Directorates who are able to guide patients, families and carers through any investigation or learning review.

In addition, the Trust have a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their care team. Should their care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends.

PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS Service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions. PALS can help and support with the following:

- Advice and information
- Comments and suggestions
- Compliments and thanks
- Informal complaints
- Advice about how to make a formal complaint.

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

The Trust's PALS team can be contacted at the email address below or by post or telephone as follows:

Bchft.patientservices@nhs.net

Telephone: 0800 587 0562
Open 09:00-16:30 Monday-Friday

The Trust recognise there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this – see appendix A.

11 Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement.

To fulfil this, the Trust will:

- Undertake planning of the Trust's current resource for patient safety response and the existing safety improvement workstreams

- Identify insight from the Trust's patient safety and other data sources, both qualitative and quantitative, to explore what we know about the Trust's safety position and culture.

The Trust's Patient Safety Incident Response Plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

11.1 Resources and training to support patient safety incident response

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England Patient Safety Response Standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Directorate.

A learning response lead will be nominated by the Directorate and the individual should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the incident and response required, but learning responses are led by staff at Band 8a and above or by staff who have demonstrated the required competencies as outlined in the NHS England Patient Safety Response Standards (2022).

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The Risk Management and Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses.

All Trust managers will work within the Trust just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Directorates will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

11.2 Training

The Trust has a patient safety training package offer to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education: Patient Safety Syllabus Training (2019) – see appendix C.

11.3 Learning response leads training and competencies

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

Records of such training will be maintained by the EPD team as part of their general education governance processes.

Learning response leads must have completed level one and two of the NHS England Health Education: Patient Safety Syllabus Training (2019).

11.4 Engagement and involvement training and competencies

FLOs, who will be involved in engaging with those affected by a patient safety incident, will undertake a minimum of six hours training.

Records of such training will be maintained by the EPD team as part of their general education governance processes.

FLOs must have completed level one and two of the NHS England Health Education: Patient Safety Syllabus Training (2019).

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via the Trust-wide leadership forums.

The Trust expect that those staff who are engagement leads must be able to:

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way
- Listen and hear the distress of others in a measured and supportive way
- Maintain clear records of information gathered and contact those affected
- Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

11.5 Oversight roles training and competencies

All patient safety response oversight roles will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the EPD team as part of their general education governance processes.

Those with an oversight role on the Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the NHS England Health Education: Patient Safety Syllabus Training (2019) – level one - essentials of patient safety for boards and senior leadership teams. All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

The Trust expect staff with oversight roles to be able to:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement)
- Apply human factors and systems thinking principles
- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences)
- Summarise and present complex information in a clear and logical manner and in report form.

12 The Trust Patient Safety Incident Response Plan

The Trust's Patient Safety Incident Response Plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. The Trust 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. A copy of Trust's Patient Safety Incident Response Plan can be found on the Trust extranet.

12.1 Reviewing the Trust's Patient Safety Incident Response Policy and Plan

The Trust's Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as the Trust use it to respond to patient safety incidents.

The Trust will review the plan every 12-18 months to ensure the Trust's focus remains up to date; with ongoing improvement work, the Trust's patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12-18 months.

Updated Patient Safety Incident Response Plans will be published on the Trust website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate, as agreed with the Integrated Care Board ICB), to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing Trust response capacity, mapping services, a wide review of organisational data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

13 Responding to patient safety incidents

13.1 Patient Safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident on a Trust incident reporting system (Ulysses) and will record the level of harm they know has been experienced by the person affected (see appendix B).

Directorates will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where DOC applies (see the Trust Duty of Candour Policy).

Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Directorate.

Directorates will highlight to the Risk Management and Patient Safety team any incident which appears to meet the requirement for reporting externally. This is to allow the Trust to work in a transparent and collaborative way with ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Risk Management and Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

13.2 Patient safety incident response decision making

The Trust have arrangements in place to allow the Directorates to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to, another body or team depending on the event. These are set out in the Trust's PSIRF plan. PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement.

The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work.

13.3 Local level incidents

Managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area.

Incident responses must include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident must be fed back to those involved or affected and appropriate support offered. Where DOC applies, this must be carried out according to Trust Policy.

Directorates will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a rapid review due to possibly meeting the criteria as PSII or patient safety response (PSR) or due to the potential for learning and improvement or an unexpected level of risk.

13.4 Weekly Directorate Incident Review and Learning Group

This group will consider all incidents that have been reported during the preceding 7-day period and ensure that they are reviewed in line with this policy and the Trust's Patient Safety Incident Response Plan. They may commission thematic reviews of such incidents to consider and understand potential emerging risks.
Any incident highlighted will follow the process for incident management as outlined in diagram form in appendix D.

Where it is clear that a PSII is required (for example, for a Never Event) the Directorate must notify the Risk Management and Patient Safety team as soon as possible to ensure the incident can be shared with the Executive team.

The incident will be escalated to the Directorate Incident Review and Learning Group and the Trust Patient Safety Incident Response Framework and Learning Panel – see section 12.5.

A rapid review must be undertaken by the Directorate to inform decision making at the Directorate Incident Review and Learning Group and onward escalation following this.

The table below outlines the Directorates decision making process for the type of incident that has occurred.

Level 1- PSII	**Level 2- PSR learning**	**Level 3 -Service incident review (improvement)**
• Meets the national or local priority • Proportionate Response discussed and terms of reference (TOR) agreed • PSII Lead nominated/FLO nominated and DOC undertaken • Inform new and ongoing Quality improvement (QI)	• Incidents where contributory factors are not understood • Limited improvement activity • Concerns raised by patient/family other agencies • Proportionate response tools utilised • Lead reviewer identified • Informs QI work	• No/Low physical or psychological harm • Not identified as a local priority, limited concern • Moderate/severe harm incidents where contributory factors are fully understood and are linked to QI work • Incident handler has oversight/review

14 Trust Patient Safety Incident Response Framework and Learning Panel

The Patient Safety Incident Response Framework and Learning Panel will:

- Proactively promote patient safety across the Trust, advancing patient safety culture
- Rigorously advocate an open, transparent, and supportive culture where safety is enhanced through continuous learning
- Have oversight of patient safety work, related improvement programmes, and learning through patient safety incident investigations and reviews
- Provide assurance to the Quality and Safety Committee that high standards of care are provided by the Trust.

The panel will write reports to the Quality and Safety Committee which will report to the Trust Board. The report will include:

- Findings from PSIIs
- Findings from PSRs
- Progress on Trust After-Action reviews
- Progress on QI activities following a patient safety review
- Results of patient safety surveys undertaken.

15 Responding to cross-system incidents/issues

The Risk Management and Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's Risk Management and Patient Safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Risk Management and Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. The Trust anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree:

- How the learning response will be led and managed
- How safety actions will be developed

- How the implemented actions will be monitored for sustainable change and improvement.

16 Timeframes for learning responses

16.1 Timescales for patient safety incident investigations

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should, ordinarily, be completed within one to three months of their start date. No local PSII should take longer than six months.

The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision.

A balance must 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.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety Incident Response Framework and Learning Panel.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

16.2 Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should, ordinarily, be completed within one to three months of their start date. No learning response should take longer than six months to complete.

17 Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or PSR) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning; to reliably reduce risk, better safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement.

The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.

17.1 Safety action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety action development guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow Specific, measurable, achievable, relevant, and time-bound (SMART) principles and have a designated owner.

17.2 Safety action monitoring

Safety actions must continue to be monitored within the Directorates governance arrangements to ensure that any actions put in place remain impactful and sustainable. Directorate reporting on the progress with safety actions including the outcomes of any measurements will be made to the Trust's Patient Safety Incident Response Framework and Learning Panel.

17.3 Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national patient safety improvement programmes or Commissioning for Quality and Innovations (CQUINs).

The Trust Patient Safety Incident Response Plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement.

The Trust will use the outcomes from existing patient serious incident (SI) reviews and root cause analysis (RCA) reports, where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus the Trust's improvement work.

The Directorates will work collaboratively with the Risk Management and Patient Safety, the Quality Improvement teams and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Monitoring of progress with regard to safety/quality improvement plans will be overseen by reporting by the designated lead to the Trust Transformation Council.

18 Complaints and appeals

The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

The first point of contact with the Trust is PALS who will support the resolution of any concerns raised – see section 10 for contact details.

It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

19 Consultation

Key individuals/groups involved in the development of the policy to ensure it is fit for purpose once approved:

Name	Designation
Lynne Carter	Chief Nurse / Deputy Chief Executive

Name	Designation
Jeanette Hogan	Deputy Chief Nurse
Sharan Arkwright	Project Support
Susan Burton	Acting Deputy Chief Curse
Mel McLaughlin	Associate Director - Warrington
Sam Yates	Director Nursing - Halton
Hitesh Chandarana	Head of Service Experience
Barry Hutton	Associate Director - Dental
Karen Worthington	Associate Director – Childrens Services
Jenny Theodore	Quality Matron - Halton
Louise Pendleton	Quality Matron - Warrington
Jimmy Cheung	Head of Medicines Management
Kathryn Phillips	Medication Safety Officer
Adie Richards	EPD Lead
Mary Corkery	Policy Officer
Michaler Kan	Health & Safety Lead
Angela Green	Head of Membership
Sharon Ormesher	Information Governance Manager
Katie Brown	Senior Clinical Skills Trainer
PSIRF Implementation Group	
Trust Board	
Corporate Clinical Policy Group	

20 Dissemination and implementation

20.1 Dissemination

The head of risk management and patient safety will disseminate this policy to associate borough directors for disseminating to all staff.

The policy will be published in the team brief and made available on the Trust extranet.

20.2 Implementation

Managers will ensure this policy is followed by all staff. New starters will be made aware of this policy at corporate induction.

21 Process for monitoring compliance and effectiveness

Process for reviewing compliance and effectiveness i.e., audit, review, survey, incident reporting	Responsible	Frequency of monitoring	Assurance group
Monitor timeliness of response to patient safety incidents	Head of Risk Management and Patient Safety	Monthly	Patient Safety Incident Response and Learning Panel
Monitor training compliance regarding patient safety incidents	EPD Lead	Monthly	Patient Safety Incident Response and Learning Panel
Monitor frequency of meetings of Directorate Review Groups and Learning Panel & Patient Safety Incident Response Framework & Learning Panel	Director of Quality Governance	Bimonthly	Quality & Safety Committee

22 Standards/key performance indicators

- Incident reporting – incidents are reported in line with time scales defined in the Trust Policy
- Incident management – incidents are managed in line with time scales defined in Trust policy.as per policy time scales
- Completion of actions – actions identified from learning reviews are delivered in line with time scales agreed following the learning response

23 References

Child Bereavement UK: Sayin goodbye to your child [website]. Available at: https://www.childbereavementuk.org/grieving-for-a-child-of-any-age Accessed: November 2023

Citizens Advice [webpage]. Available at: https://www.citizensadvice.org.uk/ Accessed: November 2023

Data Protection Act 2018 c. 12 [online]. Available at: https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Equality Act 20210 c. 15 [online]. Available at: https://www.legislation.gov.uk/ukpga/2010/15/contents

Freedom of Information Act 2000, c.36 [online]. Available at: http://www.legislation.gov.uk/ukpga/2000/36/contents

Healthwatch: Your health and social care champion [webpage]. Available at: https://www.healthwatch.co.uk/ and https://www.healthwatch.co.uk/your-local-healthwatch/list Accessed: November 2023

Human Rights Act 1998, c.42 [online]. Available at: https://www.legislation.gov.uk/ukpga/1998/42/contents

NHS (2019) The NHS Long Term Plan [online]. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS England and NHS Improvement (2019). National Patient Safety Strategy Safer culture, safer systems, safer patients [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England (2022) Patient Safety Incident Response Framework and supporting guidance [online]. Available at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

NHS England (2022 Patient safety incident investigation [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-PSII-overview-v1-FINAL.pdf

NHS England (2022) Patient safety incident response standards [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

NHS England (2022) Safety action development guide [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

NHS England Health Education: Patient Safety Syllabus Training (2019) [online]. Available at: https://www.hee.nhs.uk/our-work/patient-safety

NHS England (2018) National Quality Board: Learning from deaths [online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

NHS England (2018) Learning from deaths: Information for families [online]. Available at: https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/

National Data Guardian (NDG) 2020, The Caldicott Principles [online]. Available at: https://www.gov.uk/government/publications/the-caldicott-principles

Protection of Freedoms Act 2012, c.9 [online]. Available at: https://www.legislation.gov.uk/ukpga/2012/9/contents/enacted

Recording Patient Safety Events and Levels of Harm'. Publication reference: PR00444. NHSE

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 20 Duty of Candour [online]. Available at: https://www.legislation.gov.uk/ukdsi/2014/9780111117613

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 [online'. Available at: https://www.legislation.gov.uk/uksi/2009/309/contents/made

UK Caldicott Guardian Council 2020, The Eight Caldicott Principles [webpage]. Available at: https://www.ukcgc.uk/manual/principles

VoiceAbility: NHS complaints advocacy [webpage]. Available at: https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy
Accessed: November 2023

Support contact information for patients and families

National guidance for NHS Trust's engaging with bereaved families
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/

Explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Child death support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age

https://www.lullabytrust.org.uk/bereavement-support/

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy

Healthwatch
https://www.healthwatch.co.uk/

Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

The local Healthwatch can be found from the listing (arranged by council area) on the Healthwatch site:
https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/

Makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/

Provides United Kingdom citizens with information about healthcare rights, including how to make a complaint about care received

Appendix B

Level of harm

Definitions that are used in the Learning from Patient Safety Event (LFPSE) Service
In summary harm is defined as follows

Physical harm grades	Psychological harm grades
No physical harm	No psychological harm
Low physical harm	Low psychological harm
Moderate physical harm	Moderate psychological harm
Severe physical harm	Severe psychological harm
Fatal	N/A

Further detailed guidance can be found in the 'Policy Guidance on Recording Patient Safety Events and Levels of Harm'. Publication reference: PR00444. NHSE

Patient safety syllabus training overview

Training activity	Patient Safety Syllabus Level 1: Essentials for Patient Safety
Who should complete this?	ALL staff except boards & senior leadership teams. Mandatory requirement
How long should it take?	Approximately 20 minutes
How is it delivered?	E Learning
How is it accessed?	Via ESR staff can choose this as an option from the drop-down menu
Is there a cost?	Free
What does it cover?	• Listening to patients and raising concerns • The system approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety
Update required?	Repeat every 3 years

Training activity	Patient Safety Syllabus Level 1: Essentials for Patient Safety for Boards & Senior Leadership Teams
Who should complete this?	ALL Board & Senior Leadership Teams. Mandatory requirement
How long should it take?	Approximately 20 minutes
How is it delivered?	E Learning
How is it accessed?	Via ESR staff can choose this as an option from the drop-down menu
Is there a cost?	Free
What does it cover?	• Listening to patients and raising concerns • The system approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety
Update required?	Repeat every 3 years

Training activity	Patient Safety Syllabus Level 2: Access to Practice
Who should complete this?	ALL staff - mandatory requirement
How long should it take?	Approximately 25 minutes with assessment
How is it delivered?	E Learning
How is it accessed?	Via ESR staff can choose this as an option from the drop-down menu
Is there a cost?	Free
What does it cover?	• Introduction to systems thinking and risk expertise • Human Factors • Safety culture
Update required?	Repeat every 3 years

Training activity	Systems Approach to Learning from Patient Safety Incidents
Who should complete this?	Learning Response Leads Those with PSIRF oversight roles
How long should it take?	2 days or 12 hours
How is it delivered?	Learning response leads must have completed Level one and two of the national patient safety syllabus Option 1: HSSIB 'Level 2 – A systems approach to learning from patient safety incidents' - self-directed online learning course, participants have 6 months to complete via e learning Option 2: Scope other providers on the NHS Framework
How is it accessed?	Will be dependent on the offer
Is there a cost?	Free
What does it cover?	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring

Training activity	Oversight of Learning from Patient Safety Incidents
Who should complete this?	Those with PSIRF oversight roles
How long should it take?	1 day or 6 hours
How is it delivered?	Those in oversight roles must have completed Level one and two of the national patient safety syllabus Option 1: Scope other providers on the NHS Framework
How is it accessed?	Will be dependent on the offer
Is there a cost?	Free
What does it cover?	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focussed culture • PSII commissioning and planning

Appendix D

PSIRF incident management flowchart

Bridgewater Community Healthcare NHS Foundation Trust

Incident occurs - patient safety incident reviewed and recorded on Ulysses within 48 hours of incident occurring

Compassionate engagement with patients & staff
Respond to those affected
Being open and Duty of Candour, when applicable
Incident to be reviewed at one of following weekly groups

Review of Incident
Is it a local priority? Incident added to Directorate log for consideration for AAR or further information requested from Directorate.

Pressure ulcer, medicines or falls incident?

No

Yes

Submit to relevant **Weekly Local Priority Incident Review & Learning Group**

Submit to **Weekly Directorate Incident Review & Learning Group**

Pressure Ulcer Incident & Learning Group

Medicines Management Incident Review & Learning Group

Falls incident Review & Learning Group

Group to:
Review ALL incidents & determine which proportionate response is required
Review & receive feedback from ALL local priority groups within Trust
To propose key lines of enquiry to inform reviews
Allocate Family Liaison Officer (FLO)
Track PIRSF related activity for directorate
To suggest relevant subject matter experts (SME)
To receive & consider completed reviews
To determine timescales for completion of reviews
To upload outcome of findings to Ulysses via SBAR tool
To complete monthly Incident Review & Learning Group report - to be submitted to the PSIRF & Learning Panel
To document monthly activity in directorates Quality Council Report

Group to:

Inform Directorates of changes to practice as a result of Quality Improvement work and learning from incidents.

Review progress of each priority group AAR's
Review trends and undertake thematic reviews of groups subject matter

Chair of each priority group to write quarterly reports to the Trust PSIRF & Learning Panel.

Recommend proportionate response -
After Action Review, MDR, PSII, SBAR, Quality Improvement

Fortnightly Trust Patient Safety Incident Response Framework & Learning Panel
Establish procedures for monitoring & agreeing PSII's
Discuss, approve & sign off Patient Safety Incident Investigations (PSII) reports
Monitor outcomes & learning from PSII's & other safety reviews
Review & discuss monthly incident data, identifying any new emerging trends in triangulation with other organisational data
Promote use of QI in response to identifying learning & receiving feedback
To review any related national strategies, policies & guidance ensuring appropriate action taken
To review any related Trust strategies, policies & guidance ensuring appropriate action taken
To write annual report for Quality Report
To write reports for Quality & Safety Committee & Trust Board

Executive sign off. Reports from the Trust Patient Safety Incident Response & Learning Panel will include:
Patient Safety Incident (PSI) reporting
Findings from PSII
Findings from Patient Safety Reviews
Progress on organisational After-Action Reviews (ARR)
Progress on any Quality Improvement (QI) activity following a Patient Safety Review
Results of any Patient Safety Surveys undertaken