Hull University Teaching Hospitals NHS Trust

Patient Safety Incident Response Framework Policy

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Document Control

Document Title:	Patient Safety Incident Response Policy
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November 2023	V1	Donna Pickering	New Policy

Contents

1. Summary

For quick reference, the guide below is a summary of actions required to ensure appropriate implementation of this policy. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy.

2. Purpose, Legal Requirements and Background

This policy supports the requirements of the National Patient Safety Incident Response Framework (PSIRF) and sets out Hull University Teaching Hospitals approach to developing and maintaining 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 responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- 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.

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.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes that exist for these processes and principal aims are outside of the scope of this policy such as:

- claims handling
- human resources investigations into employment concerns
- professional standards investigations
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

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.

In instances where an patient safety incident response into the death of a patient when there is also a coronial investigation and/or police involvement; advice and guidance must be sought from the Head of Legal and Head of Patient Safety and Improvement. Any investigation will be discussed with the police to establish how a police investigation and HUTH learning response can run in parallel wherever possible and to ensure that staff are supported throughout both processes.

3. Responsibilities, Accountabilities and Duties

The organisational roles responsibilities in relation to PSIRF can be found in further detail in Appendix 1 of the document.

4. Policy Details

4.1. Our patient safety culture

The Trust recognises the importance of promoting a culture where systems thinking, human factors and behaviours are embedded in all patient safety activity. In addition, the Trust promotes a culture where staff are confident to report patient safety incidents to support learning and continuous quality improvement to potentially prevent reoccurrence.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

To help support a patient safety culture the Trust will create an environment that facilitates both staff and the organisation to learn, heal, grow and thrive by:

- undertaking a just culture survey to establish a baseline to inform what improvements are needed
- using existing culture metrics from the NHS staff survey to understand the staff perceptions of the fairness and effectiveness of patient safety incident responses
- embed the principles of a safety culture within the organisation ensuring alignment to the well-led framework[1] and key lines of enquiry
- increasing the number of patient safety incidents being reported, learning from events that have the potential to cause harm (near misses) and learning from good care and what works well.

4.2. Patient Safety Partners

The involvement of patients in their care and in the development of safer services are both priorities set out in the NHS Patient Safety Strategy. Patient Safety Partners is the term used for patients, carers and other lay people who become involved in improving and leading organisational patient safety.

The Trust will engage with its Patient Safety Partners by appointing three individuals (in the first instance) to draw on their personal experience as patients, carers or family members, and to collaborate closely with hospital staff to support and contribute to the organisation's governance and management processes for patient safety.

[1] NHS England » Well-led framework

The role will include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with the Boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups

The benefits of involving Patient Safety Partners in developing a safety culture include:

- promoting openness and transparency
- supporting the organisation to consider how processes appear and feel to patients
- helping the organisation know what is important to patients
- helping the organisation identify risk by hearing what feels unsafe to patients

These exciting new roles will evolve overtime with the support of the Trust Patient Safety Specialists who will provide support and guidance and will hold regular one-to-one meetings with the Patient Safety Partners

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

In line with PSIRF the Trust 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.

When a patient, family or staff member informs the Trust that something has gone wrong, either identified via the complaints route or by incident reporting, they must be taken seriously from the outset and treated with compassion and understanding

Aligned with the Duty of Candour and Trust Being Open Policy patients and their families will be offered a meaningful apology and compassionate engagement. As part of the duty of care, although the Trust cannot change the fact an incident has occurred, staff have within their gift the ability to help alleviate the harm experienced, to answer questions and to try to meet the needs of the individual by signposting to sources of support where appropriate such as bereavement and independent advocacy services.

The Trust has a Patient Advice and Liaison Service (PALS), which is a point of contact for patients their families or carers contact should they wish to raise a concern, comment, complaint or compliment about the care provided or the services they have received if local resolution has not been met at ward or service level.

The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

As the Trust continues to transition to PSIRF staff will prioritise and respect the needs of patients and their families at the earliest opportunity following a patient safety incident and will involve them in the learning response to improve the understanding of what happened and to potentially prevent reoccurrence. Patients, their family members or carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. By including those insights, a complete picture of what happened is created.

Individuals will be helped to make an informed decision about whether to be involved in an investigation by being given appropriate information about the level of investigation e.g. After Action Review (AAR) or Patient Safety Incident Investigation (PSII) how the investigation will run, and how they could be involved and supported throughout the process.

Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and will be supported to share their account. Sources of support for staff are available through the Trust Occupational Health and Organisational Development Departments in accordance to their personal needs.

The involvement of a patient, their family or staff member contributing to the learning response will give invaluable insight into safety actions for improvement.

4.4. Patient safety incident response plan (PSIRP)

PSIRF supports the Trust 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, PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, the Trust is able to balance effort between learning through responding to incidents or exploring issues and improvement work.

The Trust will use a number of methods promoted by PSIRF to learn from patient safety incidents. There will be a move away from root cause analysis that prompts simple linear cause-and-effect analysis; healthcare is a complex system that has interactions from multiple factors and contributory factors. Instead the Trust will apply a range of system-based approaches to learning from patient safety incidents to understand how work systems[2] can influence processes which in turn shapes outcomes. As well as systems thinking the Trust will apply human factors principles to learn from patient safety incidents.

A patient safety incident response plan (PSIRP) has been developed which sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules and will be monitored and changed as necessary. The Trust will remain flexible and will consider the specific circumstances in which each patient safety incident occurred

[2] A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s)

and the needs of those affected, as well as the different incident and learning response options outlined plan.

4.5. Reviewing our patient safety incident response policy and plan

The PSIRP will be appropriately amended and updated in line with how the Trust responds to patient safety incidents. The PSIRP will be reviewed every 12 to 18 months to ensure the Trust focus remains up to date; with ongoing improvement work the 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 to 18 months.

The updated PSIRP and policy will be published on our website, replacing the previous version.

4.6. Responding to patient safety incidents

4.6.1. Safety incident reporting arrangements

All staff have a responsibility to report any potential or actual patient safety incidents including near misses onto the Trust incident reporting system DATIX. The Trust Incident Reporting Policy outlines the internal and external notification requirements for the reporting of patient safety related incidents these processes.

4.6.2. Patient safety incident response decision making

The Trust has arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII (as set out in the Trust Patient Safety Incident Response Plan (PSIRP), others will require review and a learning response depending on the event. These are set out in our PSIRP.

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. In preparation to develop the PSIRP the Trust considered the incident insight and engagement with key internal and external stakeholders to identify the patient safety profile. Using this intelligence the Trust built our local priorities for PSII and a toolkit for responding to other patient safety incidents.

A process has been established for a response to incidents which allows for a clear ‘Ward to Board’ set of mechanisms allowing for oversight of incident management and our PSIRP response.

Specialties 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 due to the potential for learning and improvement or an unexpected level of risk. Health Groups will consider any such incidents for further escalation to the Trust Weekly Patient Safety Summit (WPSS).

4.6.3. Weekly Patient Safety Summit (WPSS)

The WPSS is chaired by the Chief Medical Officer and is attended by senior clinical representatives from all Health Groups. All patient safety incidents graded moderate or above are discussed with

immediate actions, improvement and learning shared. Incidents that are reported that meet either the national or local priorities for PSII are recorded as such and formally declared as PSII in line with Trust process. Local response options and tools are advised for other incidents.

4.6.4. Responding to National or local priorities requiring a patient safety incident investigation (PSII options

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

A PSII Learning Response Lead will be nominated by the Executive Team and will be identified at the Learning from Patient Safety Events forum. 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 who have undertaken the 'PSIRF' training as set out in section 4.8.1.

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

Where a PSII is required as set out in the Trust PSIRP the Health Group is responsible for ensuring that immediate learning and action points are captured on a Rapid Review Response (RRR) form, After Action Review (AAR) form (or other learning response template) and must be submitted to the Patient Safety Team. Duty of candour principles should also be met by the Health Group.

<u>On declaration of the PSII</u>
The PSII Learning Response Lead will ensure that the four key aims of the PSIRF are integrated into the PSII and reflected within the report:

- 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.

<u>Timescales for PSIIs</u>
Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. The timeframe for completing a PSII will be agreed with those affected by the incident, as part of setting the terms of reference for the PSII, 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.

PSIIs should take no longer than six months, but this must not become a default target.

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

4.6.5. Responding to Patient Safety incidents not meeting PSII criteria

The Trust has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation but from an MDT approach. Health Group and Specialty senior leaders with oversight from the Weekly Patient Safety Summit (WPSS) executive team will manage the selection of an appropriate learning response to ensure the rigour of approach to the review. The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Timescales for other forms of learning response e.g. AAR and Thematic Reviews

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one month (e.g. DATIX incident review) to three months (e.g. thematic review) of their start date. No learning response not meeting PSII criteria should take longer than six months to complete.

4.6.6. Learning response options

Every incident reported should have a response in line with the Trust PSIRP. If an incident is not categorised as a national or local priority requiring a patient safety incident investigation (PSII) it requires a response in line with the suggested PSIRP response options and the patient safety learning response process at appendix 2 should be followed. For maternity incidents appendix one of the PSIRP should be referred to.

PSIRP – Incident and learning response options

Examples of incident response methods set out in the PSIRP include:

- After Action review (AAR)
- Patient Safety Audit
- SWARM Huddle
- MDT Review
- Observational Analysis
- Thematic Review

Examples of Learning responses set out in the PSIRP include:

- One page learning response template
- Update on Quality Strategy improvement programme for that theme
- Thematic review report and improvement plan
- New improvement plan

As set out in the patient safety learning response process at appendix 2, learning from investigations will be fed through a variety of methods, such as one page learning responses, PSIRF Newsletter, PATTIE repository, Quality Safety Bulletins or aggregated reports to committees in line with the Quality Governance Framework.

4.6.7. Support to staff

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 our just and restorative culture principles to ensure that there is a dedicated staff resource to support such engagement and involvement. Health Groups will have processes in place to ensure that managers work within this framework to ensure psychological safety.

All Trust managers will engage with other teams such as Organisational Development to ensure there is support to staff requiring peer support such as TRiM (trauma risk management) or Occupational Health referral. Individuals who have been away from work may require additional support and supervision to aid confidence when returning to work.

Depending on the outcome of investigations, the Trust may be required, on rare occasions, to adhere to policies of NHS England and the Department of Health or other national regulatory bodies and report matters associated with professional conduct.

4.6.8. Responding to cross-system incidents/issues

The Patient Safety Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's 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 Patient Safety Team will act as the liaison point for such working and will have 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 anticipates 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 improvement actions will be developed, and how the implemented actions will be monitored for sustainable continuous improvement.

4.7. Learning from Patient Safety Events (LfPSE) Forum

The Trust acknowledges that any form of patient safety learning response will allow the circumstances of an incident or set of incidents to be understood. To reliably reduce risk, oversight of safety actions is needed.

The LfPSE is chaired by the Chief Nurse and attended by other Executives and Senior Clinical staff. This includes representation from either Hull or East Riding Health Care partners/ ICB. They are responsible for ensuring there are 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.

The LfPSE will give consideration of patient safety incidents (including PSIIs) and for oversight of the outcomes of such reviews to ensure that area for improvement are founded on a systems-based

approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required. This will support the final sign off process for all PSIIs

The LfPSE will have overall oversight of such processes and will challenge decision making of the Learning Response Leads to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards and understands the ongoing and dynamic patient safety and improvement profile within the organisation.

4.7.1. Safety action development and monitoring improvement

The LfPSE forum terms of reference has systems and processes in place to oversee the implementation and monitoring of 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. Learning responses from local level investigations should identify immediate safety actions undertaken, not safety actions identifying areas for improvement or system issues.

The term 'areas for improvement' should be used instead of 'recommendations' to reduce the likelihood of solutionising at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement identify where improvement is needed, without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

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

To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Health Groups and the support of the Continuous Quality Improvement team with their improvement and QSIR expertise. Imposed solutions are known to fail to engage staff and lack sustainability as a result.

<u>Safety action development</u>
The Trust will use the process for development of safety actions as follows

i. Review learning responses from AARs and Thematic Reviews to identify and agree areas for improvement – specify where improvement is needed, without defining solutions
ii. Where there is an existing quality improvement plans (QIP), safety actions will be aligned to that QIP
iii. Define the context – this will allow agreement on the approach to be taken to safety action development

iv. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
v. Prioritise safety actions to decide on testing for implementation
vi. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
vii. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety action monitoring

Safety actions will continue to be monitored within the Health Groups governance arrangements to ensure that any actions put in place remain impactful and sustainable. Health Group reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety and Clinical Effectiveness committee.

For safety actions with wider significance or those linked to existing work streams e.g. the quality strategy, falls or tissue viability, will require oversight by the relevant steering groups/committees which report to the Quality Committee.

4.7.2. Safety quality improvement plans

Safety quality improvement plans bring together the learning from various responses to patient safety incidents and issues. The Trust has several overarching safety quality improvement plans in place which are adapted to respond to the outcomes of improvement efforts, the quality strategy and other external influences such as national safety improvement programmes or CQUINs.

The Trust patient safety incident response plan (PSIRP) has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety incident reviews (SI reports) where present and any relevant learning response conducted under PSIRF to create related safety quality improvement plans to help to focus our improvement work.

The Health Groups will work collaboratively with the Patient Safety and the Continuous Quality Improvement teams and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety quality improvement plan will be developed. These will be identified through Health Group governance processes and reporting to the Patient Safety and Clinical Effectiveness committee who may commission a safety quality improvement plan. Again, the Health Groups will work collaboratively with the Patient Safety and the Continuous Quality Improvement teams and others to ensure there is an aligned approach to development of the plan 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 Quality Committee on a scheduled basis.

4.8. Resources and training to support patient safety incident responses

The Trust is dedicated to fully embedding PSIRF and ensuring that staff are equipped with the training and competencies required to respond to patient safety incidents. This will depend on the nature and complexity of the incident and response required.

The Trust has implemented a training framework which complies with the National Training & Development Services Framework and the NHS England Health Education England Patient Safety Training Syllabus.

The Trust has also introduced a Human Factors Hub which provides bespoke human factors training in-house to multidisciplinary teams and provides expert advice that supports continuous quality improvement in addition to patient safety.

4.8.1. Training

The Trust has implemented a training framework 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 England Patient Safety Training Syllabus.

Level one

- DATIX incident reporting, accessible via HEY247
  This comprises a local incident eLearning module setting out the Trust's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour.
- Patient safety syllabus level 1: Essentials for patient safety
  Aimed at all staff, clinical and non-clinical. This module is available as eLearning via HEY247 or via the Health Education England eLearning for healthcare platform

Level two

- DATIX reviewer training
  This comprises of local training to provide staff with the skills to undertake an investigation into incidents reported onto DATIX and to identify learning.
- How to facilitate an After Action Review/SWARM Huddle.
  This is face to face training facilitated by the Patient Safety Team to provide staff with the skills to facilitate learning responses to rapidly identify learning and improvements from patient safety incidents
- Patient safety syllabus level 2: Access to practice
  Aimed at staff who have the potential to support or lead patient safety incident learning responses (Learning response leads). This modules is available as eLearning via HEY247 or via the Health Education England eLearning for healthcare platform

Level three

- PSIRF - A Human Factors Approach to Patient Safety Incident Investigations (PSII)
  This training is delivered by the external training provider of choice. This training is undertaken by staff expected to lead on PSIIs.

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

PSII learning response leads will need to contribute to a minimum of two PSII learning responses per year. Records for this will be maintained by the Patient Safety Team.

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

Competencies

As a Trust, we expect that those staff leading learning responses are able to

- Will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way
- Will listen to others in a measured and supportive way
- Will maintain clear records of information gathered and contact those affected
- Will facilitate AARs, SWARM huddles and other learning responses in their area
- Will 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.
- Will identify and implement patient safety improvement actions in their area
- Will recognise when those affected by patient safety incidents require onward signposting or referral to support services

As a Trust, we expect those staff who are PSII learning response leads are able to, in addition to the above

- Will have undertaken PSIRF training by the Trust accredited training provider
- Will contribute to a minimum of two PSIIs per year
- Will apply human factors and systems thinking principles to collate qualitative and quantitative information from a wide range of sources
- Will summarise and present complex information in a clear report following a PSII
- Will communicate highly complex matters and in difficult or challenging situations

As a trust, we expect those 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
- 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)

5. Process for Monitoring Compliance

Summary/trend reports of reported patient safety incidents are produced upon request on a weekly, monthly, quarterly, or ad-hoc basis and include:

- Dashboards showing incidents are available to all areas via DATIXweb and PowerBI

- Any incidents reported following a learning response option as indicated in the PSIRP shared at Learning from Patient Safety Events Forum.
- Escalation to the Patient Safety and Clinical Effectiveness Committee
- Escalation and assurances to the Quality Committee on behalf of the Board via the monthly quality report and quarterly patient safety report.

6. References

- CP379 - Incident Reporting Policy
- CP003 - Policy for Handling Complaints, Concerns, Comments and Compliments
- CP259 - Being Open when Patients Are Harmed Policy
- CP205 - Critical Incidents Stress Management for Staff Policy
- CP169 - Raising Concerns at work (Whistleblowing) Policy
- NHS England Patient Safety Strategy (July 2019)
- NHS England Framework for involving patients in patient safety (July 2021)
- NHS England Patient Safety Incident Response Framework (August 2022)
- NHS England Never Event List 2018 (January 2018).

7. Equality Impact Assessments (EIA)

This document forms part of the Trust's commitment to create a positive culture of equality, diversity and inclusion for all staff and service users. The aim is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.

As part of its development this document and its impact on equality has been analysed and no detriment identified.

8. Appendices

Appendix number	Description
Appendix 1	Oversight roles and responsibilities
Appendix 2	Patient safety learning response process

Appendix 1 – Oversight roles and responsibilities

Title	Duties

Chief Medical Officer
Chief Nurse
	• Will ensure the following 'mindset' principles underpin the Trust response to patient safety incidents
	  • To focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality
	  • To ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame
	  • To ensure learning is an active strategy towards continuous improvement, not a reflection of having done something wrong
	  • To ensure system wide collaboration and that the Trust is not working in isolation
	  • To promote psychological safety and openness
	  • To encourage consideration of differing perspectives and discussion of solutions to allow learning to occur
	• Will 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.
	• Will apply human factors and systems thinking principles
	• Will constructively challenge the strength and feasibility of improvement actions to improve underlying system-based issues

PSIRF Executive Lead *Director of Quality Governance*	• Supported by the Board and Executive Team will oversee the development, review and approval of the organisation's policy and plan for patient safety incident responses, ensuring they meet the expectations set out in the patient safety incident response standards • Will ensure PSIRF is central to overarching safety governance arrangements. • Will oversee the implementation and transition to PSIRF as Chair of the PSIRF implementation steering group • Will oversee the implementation of the Trust PSIRP • Will oversee the training provision of those leading learning responses and those in oversight roles
Associate Director of Quality	• To support the development of the PSIRP and PSIRF policy • To define the patient safety and improvement profile by reviewing available patient safety incident insight and engagement with internal and external stakeholders
Head of Patient Safety and Improvement	• To lead the development of the Trust PSIRP and PSIRF policy • To lead with the implementation of the PSIRP and PSIRF policy • Will lead the training provision of those leading learning responses and those in oversight roles • To define the patient safety and improvement profile by reviewing available patient safety incident insight and engagement with internal and external stakeholders
Patient Safety Team	• Will have arrangements in place to manage the local response to

Title	Duties
	patient safety incidents and ensure that escalation procedures as described in the PSIRP are effective • Will support learning responses wherever possible and will provide advice on cross-system and cross-specialty working where this is required.
Patient Safety Specialists *Associate Director of Quality* *Head of Patient Safety and Improvement* *Maternity Patient Safety Specialist*	• Will promote the principles and practices of PSIRF in line with the NHS Patient Safety Strategy • Will influence and promote a positive safety culture by enabling and empowering speaking up by all by supportive, psychologically safe teamwork. • Will support the Patient Safety Partners to influence change in line with the Involving Patients in Patient Safety Framework • Will encourage uptake of training in the essentials of patient safety as part of the NHS Patient Safety Syllabus
Patient Safety Incident Investigation (PSII) Leads	• Will have undertaken PSIRF training by the Trust accredited training provider • Will contribute to a minimum of two PSIIs per year • Will apply human factors and systems thinking principles to collate qualitative and quantitative information from a wide range of sources • Will summarise and present complex information in a clear report following a PSII • Will communicate highly complex matters and in difficult or challenging situations
Learning Response Leads	• Will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way • Will listen to others in a measured and supportive way • Will maintain clear records of information gathered and contact those affected • Will facilitate AARs, SWARM huddles and other learning responses in their area • Will 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. • Will identify and implement patient safety improvement actions in their area • Will recognise when those affected by patient safety incidents require onward signposting or referral to support services
Patient Safety Champions	• Will promote incident reporting as a way to learn • Will identify near miss and no harm incidents to support learning at the earlies opportunity • Will hold safety huddles in their area and will share the learning • Will be afforded the necessary managerial support and time to participate in learning responses such as AARs in their area • Will be integral to identifying and implementing patient safety improvements • Will be a point of contact for the Patient Safety Team

Title	Duties
All staff	• Will promote incident reporting as a way to learn • Will identify near miss and no harm incidents to support learning at the earlies opportunity • Will be afforded the necessary managerial support and time to participate in learning responses such as AARs in their area if they were affected by the patient safety incident • Will be integral to identifying and implementing patient safety improvements

Appendix 2 – Patient safety learning response process