TO BE READ BEFORE FOLLOWING THIS POLICY

OP04 Patient Safety Incident Response Policy

From 1 November 2023 this policy commences a phase out period, the guidance and principles of the NHS England Serious Incident Framework (2015) were used to write the OP04, Patient Safety Incident Response Policy.

The National Patient Safety Strategy is introducing new ways of working in relation to patient safety incidents and investigations under the new Patient Safety Incident Response Framework (PSIRF).

The OP10, Risk Management and Patient Safety Reporting Policy will be replaced once these changes are fully implemented by the Trust.

The change from the Serious Incident Framework 2015 to PSIRF *does not* apply to incidents outside the scope of PSIRF (i.e., incidents not involving a patient), including incidents that relate to:

- Professional standards
- Information governance;
- Health and Safety incidents (that do not highlight a significant patient safety concern);
- Digital and IT;
- Financial investigations;
- Estates and facilities;

These will continue to be managed the way they are now.

The transition from the OP10, Risk Management and Patient Safety Reporting Policy to OP04 Patient Safety Incident Response Policy will commence on 1 November 2023 and is expected to take 3 - 6 months.

Serious incidents occurring before 1 November 2023 will be investigated and closed under the Serious Incident framework (2015), this will then conclude the period of policy overlap.

In summary

Serious Incidents reported prior to 1 November 2023 will continue to be managed under the serious incident framework (2015).

Patient safety incidents reported on or after 1 November 2023 will be managed using the PSIRF Policy.

Reference to both policies for processing should be made accordingly.

Patient safety incident response policy

Effective date: 1 November 2023

Estimated refresh date:

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Wolverhampton NHS Trust's 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 response 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 to be read together with the current patient safety incident response plan, which sets out how this policy will be implemented, in conjunction with the Trust's Incident Reporting and Monitoring Procedure 1 (OP10), which sets out how incidents outside of this policy are managed and the Duty of Candour Policy (OP60), which sets out the requirements where harm has been caused as a result of a patient safety incident.

Scope

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

A patient safety response is conducted for the purpose of learning and improvement and there is no remit to apportion blame or determine liability, accountability, causality, preventability or cause of death in a response under this policy. Where the principle aim of a response differs from this, they are beyond the scope of this policy. This includes, but is not limited to, the following processes:

- Claims handling;
- Human resources investigations into employment concerns;
- Professional standards investigations;
- Information governance concerns;
- Health and Safety incidents (that do not highlight a significant patient safety concern)
- Digital and IT concerns;
- Financial investigations and audits;
- Estates and facilities concerns;
- Safeguarding concerns;
- Coronial inquests and criminal investigations; and,
- Complaints (that do not highlight a significant patient safety concern)

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.

Our patient safety culture

The Royal Wolverhampton NHS Trust promotes a just culture approach (in line with the NHS Just Culture Guide) as part of its approach to learning from patient safety incidents.

There are clear mechanisms in place to enable reporting of patient safety related issues via multiple avenues, including a single incident reporting and management system, Freedom to Speak Up Guardians and processes for staff to raise concerns, and Complaint and PALs services for patients and the public.

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the Trust's Incident Reporting and Monitoring Procedure 1 (OP10) for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

In support the development of a just culture, policies and procedures are being updated to ensure Just Culture principles and language are incorporated and to provide a clear distinction between patient safety incident responses and other processes that may involve investigation processes. Our policies do not promote multiple errors as a basis to trigger corrective or punitive processes following involvement in incidents and staff receive appropriate training regarding this.

We will use the findings from safety related staff survey results to evaluate progress with improving our safety culture. This will be supported by implementing new culture related measures to oversee the monitoring of outputs and processes.

Patient safety partners

The Patient Safety Partner (PSP) is an evolving role developed by NHS England and Improvement to help improve patient safety across the NHS in the UK and is involved in the designing of safer healthcare at all levels in the organisation.

PSPs enable the Trust to value, listen and provide meaningful involvement opportunities for patients, their carers and families in the ongoing patient safety work of the organisation, supporting a culture that is ‘patient centred’. They bring an independent non-Trust perspective and are involved, as an equal partner, in a wide range of activities and programmes such as the design of safer healthcare at all levels in the organisation. The Patient Safety Partner role ensures that the patient voice is heard within the Trust, with the core purpose of ensuring we prioritise the safety requirements of patients to improve care.

PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care. PSPs play a vital role by joining relevant safety groups and committees, where they will reflect the voice and needs of people who use hospital and community-based health services and will enhance the committee membership by providing appropriate challenge to ensure learning and change. Working alongside staff, volunteers and patients, PSPs will be involved in projects to co-design developments of patient safety initiatives including having a key role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

PSPs will be supported in their role by the Patient Safety Specialist and the Deputy Head of Patient Experience for the Trust who provide expectations and guidance for the role, along with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled. PSPs will have regular scheduled reviews and regular one-to-one sessions. PSP placements are on a voluntary basis and will be reviewed after one year to ensure the role stays aligned to the patient safety agenda as it evolves.

Addressing health inequalities

As a public authority, the Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. The Trust recognises there is 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.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to intelligently consider health inequalities to patients and advise our Trust Board and partner agencies on how to tackle these. We will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

We will ensure that we use all available tools to meet the needs of those concerned, for example, easy read, translation and interpretation services, to make involvement as accessible as possible following a patient safety incident response.

When constructing our safety actions in response to any incident and/or improvement work, we will consider inequalities, and this will be inbuilt into our documentation and governance processes. This holistic, integrated approach to patient safety under PSIRF will require increased collaboration with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

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, maintaining effective communication with them, sharing the findings of any further review or investigation into the incident and signposting them to support as required.

Involving patients and families

Getting patients and families involved in how we respond to incidents is crucial, particularly to support improving the way we provide our services. Patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents and may have different questions or needs to that of the organisation.

Our key principle is being open and honest whenever there is a concern about care not being as planned or expected, or when an error has been made, regardless of the level of harm caused. The Trust recognises the importance of involving patients and families following patient safety incidents and is committed to engaging them in the investigation process as well as fulfilling the duty of candour requirements.

This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving staff, colleagues and partners

The involvement of staff and colleagues is vitally important when responding to a patient safety incident to ensure a holistic and inclusive approach from the start. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, concentrating on moving toward reviewing incidents, or groups of incidents that provide the greatest opportunities for learning and improvement.

This new way of working will be a culture shift for the organisation, providing support and guidance through the principles of good change management, so staff feel ‘a part of’ rather than ‘being done to’ during an investigation. This policy acknowledges the equal need for staff and colleagues to be involved in the same way as patients and families, as soon as possible, at all stages of an investigation or improvement planning.

Staff and colleagues will need to feel consistently supported to speak up and openly report incidents and concerns without fear of recrimination or blame. The Trust also recognises the importance of ensuring the Just Culture principles are applied and is committed to treating staff equitably during an incident response.

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.

This approach allows the Trust to focus its resources on responding to patient safety incidents that offer the greatest opportunities for learning and improving the safety of the healthcare we deliver. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources, including direct feedback from staff and patients, to explore what we know about our safety position and culture. This will enable us to develop an evidence-based rationale for each identified patient safety incident type in our plan, which can also be updated in response to emerging intelligence and improvement efforts.

Our associated patient safety incident response plan (PSIRP) will reflect this approach, providing more detail on how the Trust will meet the national and local focus and will be published alongside this overarching policy.

Resources and training to support patient safety incident response

The Trust has committed to ensuring that we embed and meet the requirements of PSIRF and 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.

The Trust will also have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The selection of appropriate learning response leads will be monitored to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. 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.

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 our 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 engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety. There will be a pool engagement and involvement lead roles to independently support those affected by patient safety incidents.

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.

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan.

All systems-based Patient Safety Incident Investigations will initially be overseen by the Patient Safety Team; they will have undertaken specific training in systems-based investigation methodology. Currently the Patient Safety Team has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 1 x Patient Safety Specialist
- 2 x Patient Safety Leaders

Other learning responses will be coordinated by the Divisional Teams or specialist subject teams (Quality), supported by the Assurance Team, and should be undertaken by staff who have received specific training in these techniques.

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.

There will be a pool of trained staff who can undertake learning responses, though the majority have a substantive clinical role, so therefore must be allocated time within job plans to complete investigations.

All staff in the trust are required to complete Level 1 National Patient Safety Syllabus training and for those staff who have a responsibility for managing and investigating

patient safety incidents at a local level, must complete Level 2 National Patient Safety Syllabus training.

All staff are also required to complete mandatory patient safety training which covers the basic requirements of reporting, investigating and learning from incidents as well as the PSIRF awareness training that will be developed.

Specific roles and competencies are required for PSIRF which are outlined below:

Learning response lead role

- Led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
  - Summarise and present complex information in a clear and logical manner and in report form.
  - Manage conflicting information from different internal and external sources.
  - Communicate highly complex matters and in difficult situations.

Engagement and involvement lead role

- Led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - 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 with those affected.
  - Identify key risks and issues that may affect the involvement of patients, families, and staff.
  - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight lead role

- Led/conducted by those with at least 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.
- Have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
- Competencies:
    - 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 (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
    - Constructively challenge the strength and feasibility of safety actions to improve underlying system 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.

All specified roles in relation to PSIRF are required to undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Initial training support for learning responses will be as below:

- Patient safety team, assurance team leaders, governance managers and Corporate Nursing Quality team and quality leads from support services – 3 days training on systems investigations, compassionate engagement and oversight.
- Directorate leadership teams - 3 days training on systems investigations and compassionate engagement
- Divisional Leadership Teams – two half days training on compassionate engagement and oversight. level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Executive Director quality and safety leads (Group Chief Assurance Officer, Chief Nursing Officer, and Chief Medical Officer) - two half days training on

compassionate engagement and oversight and in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.
- Deputy executive leads (Deputy Chief Medical Officer, Deputy Directors of Nursing and Director of Midwifery) - two half days training on compassionate engagement and oversight and in line with PSIRF guidance level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Non-Executive Director members of Quality Committee – half day oversight training and in line with PSIRF guidance and Level 1 for Boards National Patient Safety Syllabus training.

Specific training in PSIRF tools will be made available and will be accessible via the Patient Safety Team. Training and coaching in other learning responses can be accessed via the Patient Safety Team or in the Patient Safety section of The Beat.

Our patient safety incident response plan

Our patient safety incident response plan sets out how The Royal Wolverhampton NHS 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 that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The plan is based on an analysis of themes and trends from all incidents from financial years 2020 to 2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from serious incident investigations, mortality reviews, legal claims and inquests, risk registers, complaints and feedback from staff and patients.

A copy of our current plan can be found at:
http://intranet.xrwh.nhs.uk/pdf/policies/OP_04_Appendix1.pdf

Reviewing our patient safety incident response policy and plan

Our patient safety incident response policy will be reviewed in line with Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01). As the Trust works toward meeting the patient safety incident response standards, any changes to the policy will be shared and discussed with stakeholders. Once agreed, these changes will be presented to Board for approval.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our 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.

Updated plans will be published on our website, replacing the previous version.

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

Responding to patient safety incidents

Patient safety incident reporting arrangements

PSIRF does not change any arrangements to report patient safety incidents. Patient safety incident reporting will remain in line with the Trust's Incident Reporting and Monitoring Procedure 1 (OP10). All patient safety incidents will continue to be recorded and monitored through the Trust's incident reporting system (Datix).

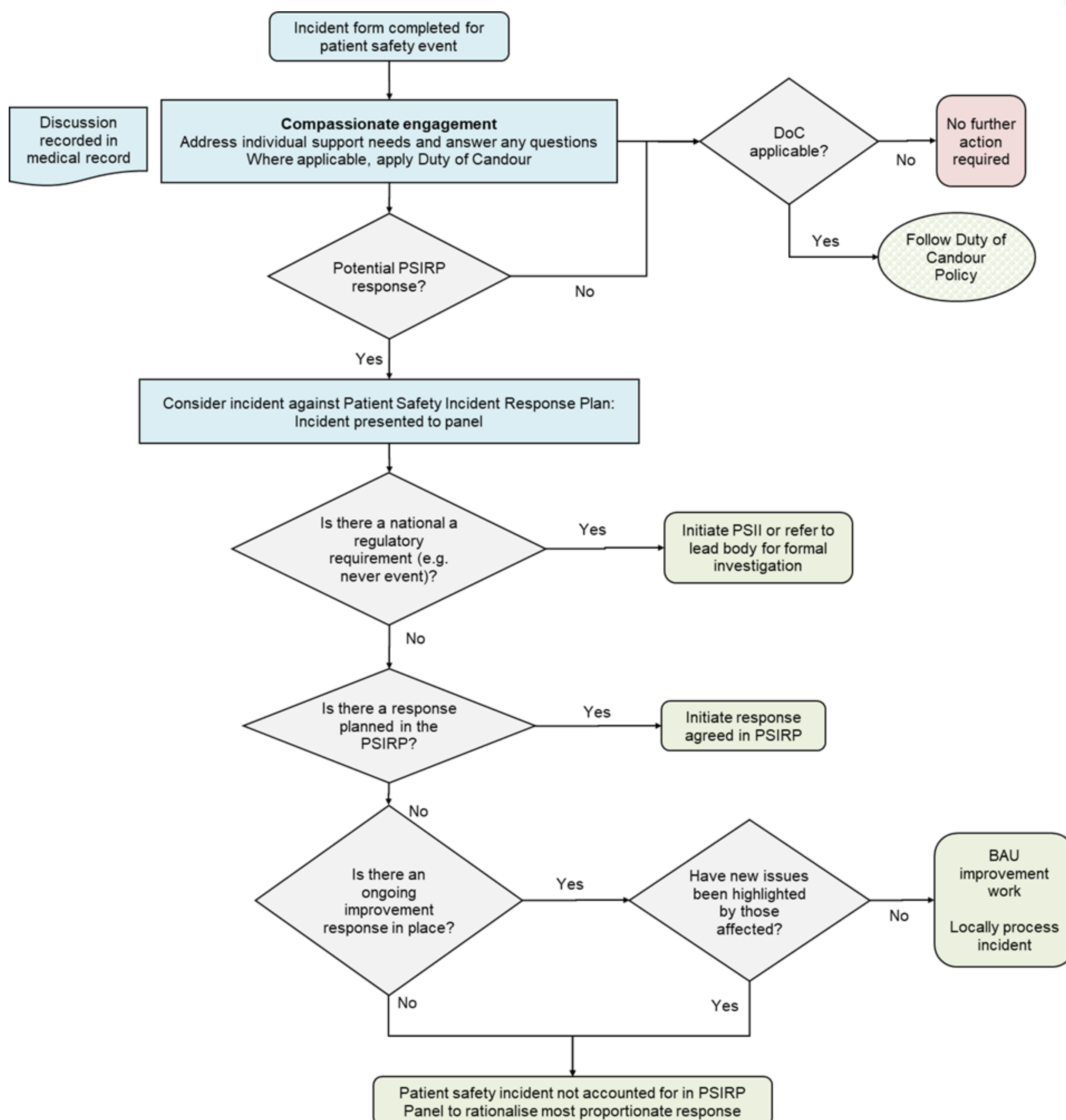
Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (see OP60) Monitoring of patient safety incidents locally, through the Directorate's governance meetings will remain the same, supported by their respective Assurance team members.

Most incidents will only require local review to ensure an incident has been appropriately dealt with and any mitigating actions have been initiated and shared where needed to prevent recurrence. However, for some, where it is felt that the opportunity for learning and improvement is significant, or it appears to meet the criteria for a learning response, these should be escalated within the Division. Divisions and corporate service leads will highlight these to the Assurance team, initiating the decision-making process.

Certain incidents require external reporting to national bodies such as HSIB, HSE and MHRA. The Patient Safety Team will work closely with relevant Trust departments to ensure we report incidents to external national bodies. Please refer to the Trust's Incident Reporting and Monitoring Procedure 1 (OP10) for full details and guidance.

Patient safety incident response decision-making

The Trust PSII decision making panel will have delegated responsibility for the consideration of incidents for PSII and validation of response approach adopted on a weekly basis for incidents reported in-week. The meetings will be led by the executive lead for patient safety in the Trust. Figure X sets out the essential decision-making steps under PSIRF:



The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified.

Where it is clear a PSII is required (for example, for a Never Event) the Division should notify the Assurance team as soon as practicable so that the incident can be shared to the decision-making panel.

Decision making for escalation to the Trust decision-making panel can be aided by a rapid review. The purpose will be to recommend the most appropriate learning response

method based on the Trust PSIRF plan and the assessed learning potential of each incident being reviewed.

Incidents with positive or unclear potential for PSII will be escalated to the decision-making panel by the division. Cases will be presented by the senior leadership team for the area in which the incident occurred. The Trust PSII decision making panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), and any mitigation identified or that is still required to prevent recurrence.

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents. To ensure that there are sufficient resources to allocate to support responses to emergent issues that are not included in the initial PSIRF plan, one Trust priority will be left unallocated. Collectively the attendees of the panel will agree a proportionate learning response agreed and allocate a learning response lead. This will allow the Trust greater flexibility to react more promptly to emerging system issues to ensure learning and improvement is completed more promptly.

It is also recognised that some incidents may still require a case based comprehensive investigation, like a Serious Incident investigation under the old framework during the transition from that framework to PSIRF. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP.

The Quality and Safety Advisory Group will have overall oversight of the operation and decision-making of the Patient Safety Incident Investigation Panel, providing challenge to the decision making and the incident responses the panel has delegated responsibility to commission. This will support the approval process for all PSIIs. Through this mechanism the Board will be assured that it meets expected oversight standards, the intent of PSIRF is being implemented within our organisation, we are meeting the national patient safety incident response standards and also understanding the ongoing and dynamic patient safety and improvement profile within the organisation.

Responding to cross-system incidents/issues

The Trust will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks. Where we identify the involvement of multiple agencies, we will invite our partner organisations to work with us

to understand the system issues, providing the opportunity for partnership colleagues to be fully engaged in investigations and learning as required.

Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

We will seek to involve our Integrated Care Board in the event that it is unclear which organisation should lead on a learning response or where commissioning is identified as an issue.

Where appropriate, we will review our patient safety intelligence alongside our system partners to collectively tackle common issues and promote the opportunity for consistent collaboration across specific themes (e.g., falls, health inequalities, mental health).

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

A key factor in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The purpose of learning responses is to understand the context of the incident and develop a thorough understanding of the work processes. PSIRF places resistance against the temptation to quickly identify what needs to change, instead, learning responses include the requirement to understand the work as done and what system factors affect this.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident.

PSII learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and timeframes for completion should 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. PSIIs should not take longer than six months.

A balance must be struck between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that actions to improve safety may be delayed until completion. This may impact on the need to make further checks to ensure the findings remain relevant.

In the extraordinary circumstance where there are issues with accessing information or where information cannot be provided, the Trust can opt to progress the PSII with the available information, with the caveat this can be revisited should the added information indicate the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety Incident Investigation 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.

Other forms of learning response

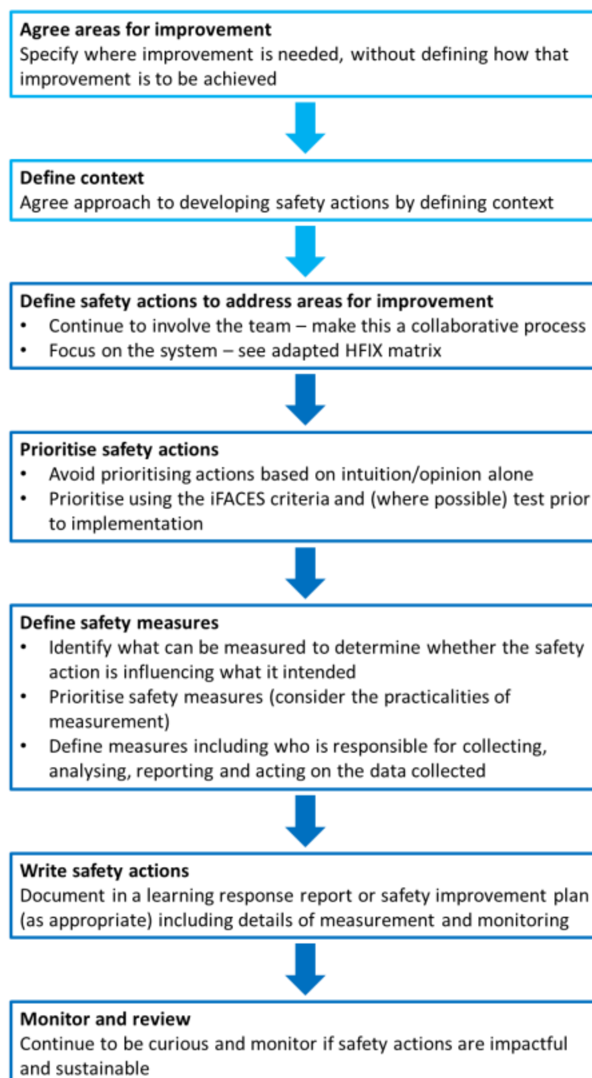
Other forms of learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

Safety action development

PSIRF promotes the term ‘areas for improvement’ instead of ‘recommendations’ with the aim of reducing the possibility of ‘solutionising’ at an early stage of the safety action development process. Following learning from incident responses, areas for improvement will be defined. Safety actions are created in response to each defined area for improvement and can depend on issues and boundaries that sit outside the scope of a learning response. PSIRF advocates a move toward implementing the lessons with an “integrated process for designing, implementing, and monitoring safety actions” to reduce risk and potential for harm.

Safety actions will be developed alongside the clinical and operational teams responsible for implementation to ensure ownership of the actions and outcomes. The Trust will use the process for developing safety actions outlined by NHS England in the Safety Action Development Guide (2022):



A quality improvement approach is essential to learning and improvement following a patient safety investigation. to ensure safety actions are: clearly defined, describe responsibilities and timescales, are aligned to reportable outcome measures and assurance processes. Close links with the Quality Improvement Team will be developed and maintained so their QI expertise and guidance can be utilised when developing safety actions. The quality improvement approach is recognised within the Trust and there is extensive, ongoing work to educate colleagues in the principles of QI methodology. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety teams to work more closely together.

Monitoring improvement

Monitoring of completion and efficacy of safety actions will be through the divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions, including the outcomes of any measurements will be made to the Quality and Safety Advisory Group.

The Patient Safety Team will align its work with the Quality Improvement Team to maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

For safety actions with a wider significance, this may require oversight by a Safety Improvement Panel, reporting to the Quality and Safety Advisory Group.

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 will be adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes.

The Patient Safety Incident Response Plan (PSIRP) clarifies what our improvement priorities are and takes into consideration the fundamental priority areas outlined in the Quality and Safety Enabling Strategy.

The themes detailed in the PSIRP that are selected for an improvement pathway will have an improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness.

These improvement plans will be a key focus of the regular thematic reviews within the patient safety groups related to that theme and explore the impact of improvement plans on subsequent incidents. There will be a clear alignment between some safety actions arising from patient safety responses and the overarching safety improvement plans.

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

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed.

Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a directorate or specialty level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach.

The Trust is reviewing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through divisional and corporate governance structures and processes. Directorate level improvements will be managed locally with assurance and reporting to Division, then, corporate oversight and assurance committees will provide ‘ward to board’ assurance.

Safety improvement plans will often lead to the outcome measurement and assurance processes that underpin safety actions and will be considered by the Safety Improvement Group both to receive progress and assurance regarding existing plans but also to recommend the need for future improvement plans following review of responses and individual safety actions.

Completed safety improvement plans should be examined to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared, adapted and adopted with other areas of the organisation and peer organisations via the Patient Safety Specialist to the ICB Patient Safety Incident Surveillance Group and/or Shared Learning Events.

Oversight roles and responsibilities

Responsibility for effective patient safety incident management sits with the Trust Board. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. The Executive Lead is the Group Chief Assurance Officer who holds responsibility for effective monitoring and oversight of PSIRF.

The Trust, through the Executive lead, has a responsibility to:

1. Ensure the Trust meets the national patient safety response standards
2. Ensure PSIRF is central to overarching safety governance arrangements
3. Quality assure learning response outputs

Working under PSIRF, the Trust aims to utilise oversight systems that allow improvements to be demonstrated rather than solely seeking compliance with centrally mandated measures. Oversight will focus on engagement and empowerment rather than the more traditional command and control.

The Trust acknowledges the 'oversight mindset' principles that will underpin the processes put in place to allow PSIRF to be implemented in line with the oversight roles and responsibilities specification supporting document (NHS England 2022, p 3).

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning.

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality and Safety Advisory Group and Quality Committee. Safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Quality and Safety Advisory Group will provide assurance to the Quality Committee that PSIRF and any related workstreams have been implemented to the appropriate standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement and monitoring of the balance of resources going into patient safety incident response versus improvement.

Divisions will be expected to report on their patient safety incident learning responses and outcomes. Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will implement a Patient Safety Incident Investigation 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.

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

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 four years alongside a review of all safety actions.

Complaints and appeals

Any complaints relating to this guidance, or its implementation can be raised informally with the Trust Patient Safety Specialist, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure here.

Part A - Document Control

<table>
<tr><td rowspan="1">Policy number and Policy version:

OP04

Version 1.0</td><td>Policy Title:

Patient Safety Incident Response Policy</td><td colspan="2">Status:

Final</td><td>Author:
Dee Johnson, Group Patient Safety Specialist

Chief Officer Sponsor:
Kevin Bostock, Group Chief Assurance Officer</td></tr>
<tr><td rowspan="2">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1.0</td><td>October 2023</td><td>Group Patient Safety Specialist</td><td>Implementation of policy</td></tr>
<tr><td colspan="5">Intended Recipients: All Staff</td></tr>
<tr><td colspan="5">Consultation Group / Role Titles and Date:
Sponsor of Policy and Chair of Trust Policy Group</td></tr>
<tr><td colspan="2">Name and date of Trust level group where reviewed</td><td colspan="3">Virtual approval via Chair of Trust Policy Group – October 2023</td></tr>
<tr><td colspan="2">Name and date of final approval committee</td><td colspan="3">Sponsor and Chair of TPG sign-off – October 2023</td></tr>
<tr><td colspan="2">Date of Policy issue</td><td colspan="3">25 October 2023</td></tr>
<tr><td colspan="2">Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)</td><td colspan="3">November 2024 (Annual Review)</td></tr>
<tr><td colspan="5">Training and Dissemination:</td></tr>
<tr><td colspan="5">To be read in conjunction with:
OP10 Risk Management and Patient Safety Reporting Policy
OP60 Being Open (Duty of Candour)</td></tr>
<tr><td colspan="5">Initial Equality Impact Assessment (all policies): A national EIA has been completed and therefore an internal assessment is not required.</td></tr>
<tr><td colspan="2">Monitoring arrangements and Committee</td><td colspan="3"></td></tr>
<tr><td colspan="5">Document summary/key issues covered: This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Wolverhampton NHS Trust's 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.</td></tr>
<tr><td colspan="3">Key words for intranet searching purposes</td><td colspan="2">OP04, Safety, Patient, Incident, Response, PSIRF, Reporting, Patient Safety, Incident Response, Safety Incidents, Patient Safety Incident Response, Incident Response Plan</td></tr>
</table>

	The Royal Wolverhampton NHS Trust

Patient safety incident response plan

Effective date: 1 November 2023

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Dee Johnson**	**Group Patient Safety Specialist**		
Reviewer				
Authoriser	**Kevin Bostock**	**Group Chief Assurance Officer**		**October 2023**

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Introduction

This patient safety incident response plan sets out how The Royal Wolverhampton NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The Royal Wolverhampton NHS Trust is registered with the Care Quality Commission to provide services in the following locations:

- New Cross Hospital
- Cannock Chase Hospital
- West Park Rehabilitation Hospital
- Community sites
- GP practices

The services provided include:

- Emergency and Urgent Care
- Surgery
- Maternity
- Diagnostic services
- End of Life care
- Services for children and young people
- Medical care including older people’s care
- Critical Care
- Outpatients
- Community Services
- Day case services
- Therapy services
- Rehabilitation services
- GP services
- Pharmacy services

Further information can be found on the Trusts website.

Defining our patient safety incident profile

PSIRF sets the national requirements listed within the plan. The remainder of the plan is data driven, covering the last 3 years which has provided an insight into the key patient safety incident themes, patterns and trends, recurrence and the greatest opportunities for learning to improve patient safety outcomes.

The Trust engaged with key stakeholders using a dedicated profile and planning workstream, having reviewed Trustwide data from various sources to determine the Trust safety profile and identify the optimum methods of review to ensure maximum learning and effective plans to improve the quality and safety of services.

Our analysis included creating a list of the incident or issue types identified for each data source along with safety insights. The top 10 patient safety related themes were identified from each data source and then these were cross-referenced to find commonalities for inclusion as a feature in the plan. The list was agreed to take forward to the planning process.

The patient safety issues were identified through the following sources:

- Incident data 2020-21 to 2022-23
- Key themes from complaints, PALs, claims and inquests
- Key themes from specialist safety and quality groups (e.g., falls, pressure ulcers, Learning from Experience Group)
- Themes from learning from deaths reviews
- Trust and divisional risk registers
- Key themes from FTSU, safeguarding and staff survey
- Key themes from GIRFT
- Key themes from mortality reports
- ICS Quality surveillance reports
- Clinical audit data

Safety issues highlighted by the data

From the original data pull, we were able to identify 13 themes, although some themes were noteworthy in one data source, recurrence was a significant contributor in the consideration. These are shown in the table below:

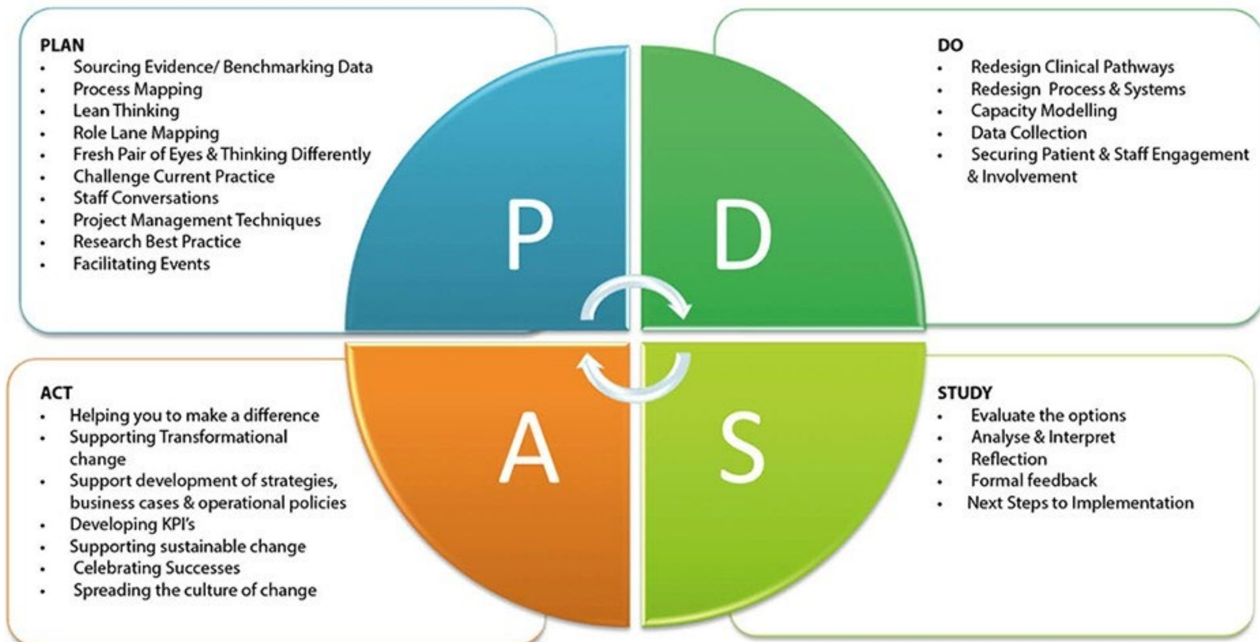
THEME	RESPONDING TO PATIENT CONDITION	FALLS	PRESSURE ULCERS	INFECTION PREVENTION AND CONTROL	COMMUNICATION – VERBAL/WRITTEN
DATA SOURCE	Claims Mortality Risks	Incidents	Incidents	Incidents SIs Quality Surveillance Risks	Complaints Mortality Quality Matters SIs Staff survey Incidents Risks
THEME	DIAGNOSTICS	ADMISSION/TRANSFER /DISCHARGE	MEDICATION	DELAYS (ALL TYPES)	BEHAVIOURS
DATA SOURCE	Claims SIs Risks	Incidents Quality Surveillance Complaints Safeguarding Risks	Incidents Complaints Safeguarding Risks	Claims Mortality Complaints SIs Quality Matters Risks	Complaints FTSU Mortality Safeguarding SIs Quality Surveillance Staff survey
THEME	STAFFING	INVOLVING PATIENTS IN CARE	INEQUALITIES IN CARE		
DATA SOURCE	Incidents Complaints Risks	Complaints Mortality Safeguarding	Complaints MH care (risks)		

Further details on the features within the themes are considered to identify and hone our overall profile. This leads to the priorities highlighted in local focus section below.

Whilst the list has been developed, we are conscious that it is not fixed. The Trust profile must retain flexibility in its approach to risk and learning, and therefore, where there is significant risk, opportunities for significant new learning and impacts on quality and safety of services, the Trust will retain capacity for additional PSII outside of the Trust profile where required.

Defining our patient safety improvement profile

The Trust has a comprehensive quality improvement programme across the organisation, using the Quality Service Improvement and Redesign (QSIR) methodology. The Plan, Do, Study, Act process forms the basis for our improvement work:



The quality improvement programme has patient safety as a theme of its work. The aim is that the use of QI methodology will help staff on the front line identify methods to deliver a safer service. The principles underlying this are to:

- Learn from accurate data from mortality, governance, benchmarking, complaints etc.
- Reduce unwarranted variability
- Develop safe reliable systems that support and empower staff to do the right thing, first time and record it correctly

Our improvement priorities are directly informed by our patient safety priorities, identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation.

Future quality improvement priorities will be directly informed by implementation of the PSIRF, providing an opportunity to streamline and prioritise future improvement activity.

Our improvement priorities are supported by a specialist team of improvement practitioners, our Quality Improvement Team who provide support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels of the Trust.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events 2018 criteria	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria)	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of patients detained under MHA or where MCA applies and are thought more likely than not due to problems in care	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of a patient with learning disabilities (meeting the LeDeR criteria)	Referred to Learning Disabilities Mortality Review (LeDeR) PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Incidents meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Maternity incidents meeting HSIB criteria	Refer to HSIB for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Child deaths	Referred for Child Death Overview Panel PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Safeguarding incidents meeting criteria	Referred to Trust Safeguarding Lead	Respond to recommendations from referred agency/ organisation as required
NHS Screening incidents	Referred to PHE Imms and Screening Quality Assurance for consideration of response	Respond to recommendations from referred agency/ organisation as required

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Patient pathway delays	PSII or MDT	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Transitions of care	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Diagnostic incidents	PSII or MDT	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Communication	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Responding to changes in patient condition	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Falls	Rapid review Quarterly thematic review	Joint Falls Steering Group
Pressure ulcers	Rapid review Quarterly thematic review	Tissue Viability Steering Group
Infection Prevention and Control	Refer to IPC investigation matrix Quarterly thematic review	Infection Prevention Group