PATIENT SAFETY INCIDENT RESPONSE POLICY

DOCUMENT TYPE

Reference	*Enter an existing or new reference number.*		
Approving Body	*Patient Safety Committee*		
Date Approved	*11-September-2023*		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	x		
Issue Date	*Enter the date the document is effective from*		
Version	*1.0*		
Summary of Changes from Previous Version	*N/A*		
Supersedes	*N/A*		
Document Category	• *Governance*		
Consultation Undertaken	*PSIRF Implementation Group*		
Date of Completion of Equality Impact Assessment	*05-Sept-2023*		
Date of Environmental Impact Assessment (if applicable)	*N/A*		
Legal and/or Accreditation Implications	*None*		
Target Audience	*Trust-wide*		
Review Date	*September-2025*		
Sponsor (Position)	*Phil Bolton, Chief Nurse*		
Author (Position & Name)	Candice Smith Director of Nursing Quality & Governance		
Lead Division/ Directorate	*Corporate*		
Lead Specialty/ Service/ Department	*Governance Support Unit*		
Position of Person able to provide Further Guidance/Information	Candice Smith Director of Nursing Quality & Governance		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Patient Safety Incident Response Plan (PSIRP)	*August-2023*
Template control	June 2020

CONTENTS

APPENDICIES

1.0 INTRODUCTION

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Sherwood Forest NHS Foundation Trusts** 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 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.

2.0 POLICY STATEMENT

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

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, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist

for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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.

3.0 DEFINITIONS/ ABBREVIATIONS

PSIRF – Patient Safety Incident Response Framework
PSP's – Patient Safety Partners
PSII's – Patient Safety Incident Investigators
HSIB – Healthcare Safety Investigation Branch
HSE – Health & Safety Executive
RIDDOR – Reporting of injuries, diseases and dangerous occurrences regulations
MHRA – Medicines and healthcare products regulatory agency
PSIRP – Patient Safety Incident Response Plan

4.0 ROLES AND RESPONSIBILITIES

Responsibility for oversight of the PSIRF sits with the Trust Board. Executive Leads are the Medical Director and Chief Nurse who hold joint responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The Trust is committed to close working, in partnership, with the ICB and other national commissioning bodies as required. Representatives from the ICB will be invited to sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

Under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. The

ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI and have individual patient safety responses 'signed off' by the ICB. They will however seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety.

5.0 APPROVAL

The policy was ratified at the Patient Safety Committee (PSC) on the 11th September 2023 following consultation with the PSIRF Implementation Group.

6.0 DOCUMENT REQUIREMENTS

Our patient safety culture

Sherwood Forest Hospitals NHS Foundation Trust promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. 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 incident management policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient Safety Partners

The Trust has not set a definite number of Patient Safety Partners that it wishes to engage with. We have currently recruited 1 partner and continue to advertise and recruit for additional partners in line with the NHSE guidance: Framework for involving patients in patient safety . Patient Safety Partners (PSP) will have an important role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. 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 will work alongside staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings in the Trust focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are “walking in the patients’ shoes”.

Addressing health inequalities

The Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. This holistic, integrated approach to patient safety under PSIRF will require the Trust to continue to collaborative 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.

Our engagement with patients, families and carers following a patient safety investigation will recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open 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 and signpost them to support as required.

Involving Patients & Families

The Trust recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation.

The recruitment of a dedicated Family Liaison Officer – a new role, demonstrates the trusts ongoing commitment to supporting patients, families and carers involved in incidents

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. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2
See also the trust policy on duty of candour/being open: KING'S MILL CENTRE FOR HEALTH CARE SERVICES NHS TRUST (sfh-tr.nhs.uk)

Involving Staff, Colleagues and Partners

Involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This policy reinforces existing guidance (Incident Reporting Policy), it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance utilising the principles of good change management, so staff feel 'part of' rather than 'done to'. We will therefore ensure regular communication and

involvement through our communication framework and our wider organisational governance structures.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

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.

As a Trust we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will also be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on our external facing website

Our Patient Safety Incident Response Plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

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. The PSIRP provides specific details.

The trust has invested a team of trained Patient Safety Incident Investigators (PSII) who can undertake PSII investigations, the majority have a substantive clinical or governance role, so they will have allocated time to complete investigations. PSIRP details which incidents will require a PSII and indicates how many of these we plan to complete based on current resources.

All staff are required to complete the patient safety training which covers the basic requirements of reporting, investigating and learning from incidents (Levels 1 & 2) and is found on the Sherwood e academy. (Trusts Learning platform).

Our Patient Safety Incident Response Plan

The PSIRP sets out how we intend to respond to patient safety incidents over a period of 12 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 PSIRP is based on a thorough analysis of themes and trends from all incidents from 2019-2022 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

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. It is recognised that 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 any previous versions.

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

PSIRF guidance states:
"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources

may be better directed at improvement rather than repeat investigation (or other type of learning response).”
(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the Trusts Incident Reporting Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Operational managers and governance teams will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are 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.

Certain incidents require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA. Please refer to the Trusts Incident Reporting Policy for full details and guidance.

Patient safety incident response decision-making

Reporting of incidents will continue in line with existing Trust policy and guidance. The Trust has governance and assurance system in place to ensure oversight of incidents at both a Divisional and Organisational level. Governance teams work with clinical and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

The Governance Support Unit will provide regular reports to the Patient Safety Committee to identify and track emerging themes and trends outside of normal variation. This information

will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Patient Safety Committee.

As outlined in the Incident Reporting Policy, the process for completion of a Patient Safety Incident Review, or 72 hour rapid review, to determine any further investigation or escalation required will remain. This, however will now include a wider range of options for further investigation outlined in the 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 in the PSIRP.

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.
One of the most important factors 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.

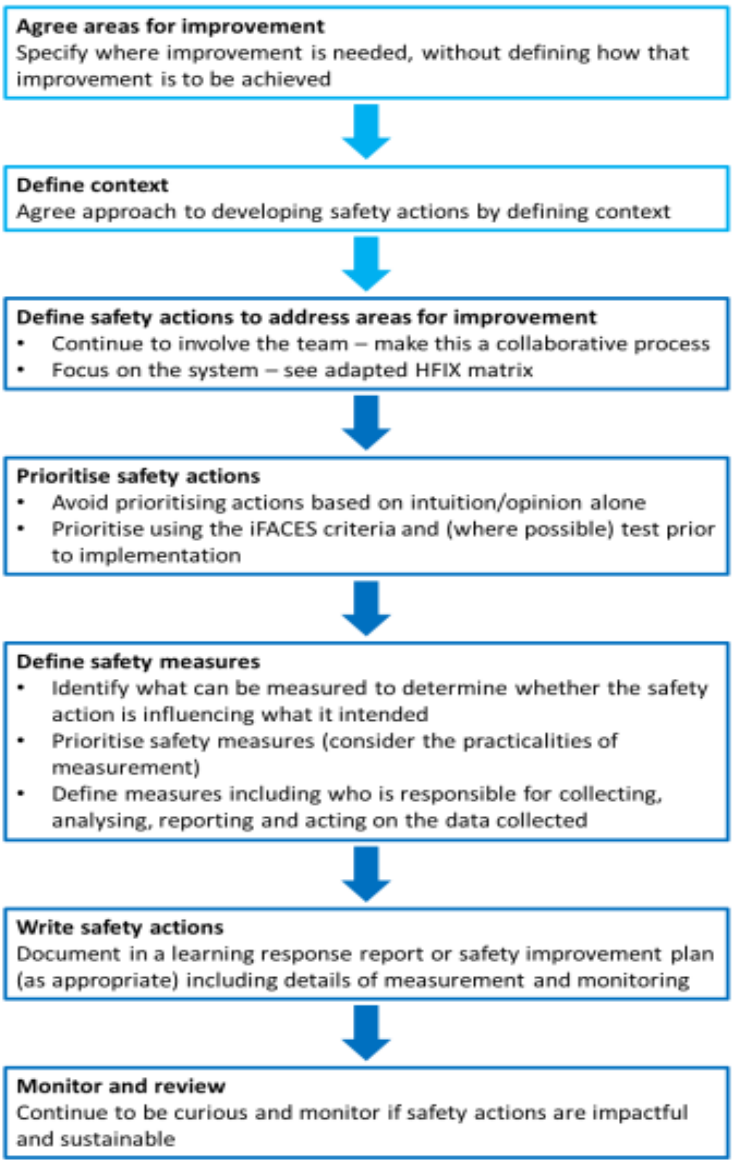
The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Initial incident investigation – as soon as possible, within 5 working days of reporting
- Further learning response (eg: PSII, AAR, learning teams) – within 20 working days of reporting
- Comprehensive Investigation – 60 - 120 working days depending on complexity

A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to solutionising at an early stage of the safety action development process.
The following diagram summarises how safety actions should be developed and overseen:



A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety investigation. Close links with the Trusts Improvement Faculty already exist and will continue to be developed and maintained so their expertise and guidance can be utilised when developing the learning response and safety actions. This approach is recognised within the Trust and considerable work has taken place to educate colleagues in the principles of QI methodology. PSIRF therefore provides an opportunity to strengthen this.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and efficacy of safety actions will be through organisational governance processes with oversight at Divisional level reporting to the Patient Safety Committee. The Governance Support Unit will 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.

It is important that monitoring of completion of safety actions remains a means to improve safety and quality outcomes and reduce risk. The Trust will continue to develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

The Patient Safety Incident Response Plan (PSIRP) clarifies what the Trusts improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The themes detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own 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. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a Divisional, Specialty and Sub-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 Governance Support Unit will provide support and guidance, as required, to services and divisions. The Improvement Faculty will assist in improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Compassionate engagement and involvement of those affected by patient safety incidents	GSU and Divisional Management Teams	Review of engagement with Family Liaison Officer, feedback form those involved in Patient Safety Investigations and audit of Duty of Candour engagement and compliance	Six monthly	Patient Safety Committee
Application of a range of system-based approaches to learning from patient safety incidents	GSU and Divisional Management Teams	Review of the Datix incident reporting system for the number, type and trends of incidents reported.	Quarterly	Patient Safety Committee
Considered and proportionate responses to patient safety incidents and safety issues	GSU and Divisional Management Teams	Review of the Datix incident reporting system for the number, type and trends of incidents reported.	Quarterly	Patient Safety Committee

8.0 TRAINING AND IMPLEMENTATION

NHS Patient Safety Syllabus training programme levels 1 & 2 can be accessed on the Trusts e learning platform.
An in-house training course called Incident Reporting Using Datix can be booked using the on-line booking system via the Training, Education and Development intranet site. This is for new starters to the Trust and staff already using Datix as a refresher. Handler training is provided to all new handlers and on request or identified through the quality checking process

On-going Datix handler guidance is provided through the communication section within Datix web. Investigation training has been facilitated by Med led (an external training company) and update training will be provided - details to be decided.
All staff involved in any aspect of reporting and management of incidents must be aware of and be able to access this policy. They should be familiar with the content of this policy, particularly their responsibilities and the tools provided.

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix A

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- NHS Patient Safety Strategy 2019
- NHS Patient Safety Incident Response Framework 2022

Related SFHFT Documents:

- Patient Safety Incident Response Plan
- Duty of Candour Policy
- Incident reporting Policy

11.0 KEYWORDS

N/A

12.0 APPENDICES

- Appendix A – Equality Impact Assessment Form (EQIA)

APPENDIX A - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Patient Safety Incident Response Framework Policy (PSIRF)			
New or existing service/policy/procedure: New			
Date of Assessment: September 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None known	Applies to all patients irrespective of protected characteristic group.	None known
Gender	None known	As above	None known
Age	None known	As above	None known
Religion	None known	As above	None known
Disability	None known	As above	None known
Sexuality	None known	As above	None known
Pregnancy and Maternity	None known	As above	None known
Gender Reassignment	None known	As above	None known
Marriage and Civil Partnership	None known	As above	None known
Socio-Economic Factors	None known	As above	None known

(i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- None required as the policy applies to all patients irrespective of protected characteristic group.

What data or information did you use in support of this EqIA?

- None required as the policy applies to all patients irrespective of protected characteristic group.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

High Level of Impact/Medium Level of Impact/Low Level of Impact *(Delete as appropriate)*

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:

Signature:

Date: