Patient Safety Incident Response (PSIRF) Policy

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Responsible person for coordinating dissemination and implementation		Louise Roper, Head of Patient Safety	
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Consultation

List of those consulted	ICSU Risk Managers, ADONs, Clinical Leads, all members of PSIRF Implementation Group, IBC. ***Public consultation required following approval (3 weeks on Trust Website)*
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Version Control Summary

Version No	Description of change	Author	Date
1	New regulation, guidance, change of practice etc	Louise Roper	16/01/2024

Contents

1.0 INTRODUCTION

The Whittington Health NHS Trust (the Trust), is fully committed to making Patient Safety its' number one priority, adhering to the Duty of Candour principles of being open and transparent and doing so within a supportive environment.

This policy supports the requirements of the NHS England's (NHSE) Patient Safety Incident Response Framework (PSIRF) (NHSE,2022 https://www.england.nhs.uk/patient-safety/incident-response-framework) and sets out the 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. (accessed 24/04/2024)

The existing Serious Incident Framework, with its thresholds for investigation and set timelines, is being replaced by a more flexible, improvement-focused system called the Patient Safety Incident Response Framework (PSIRF).

Under the PSIRF, healthcare organisations will no longer be talking about serious incident investigations or root causes. In their place will be a more flexible, system-focused approach, with improvement and engagement with patients/families/staff taking centre stage. This new system aims to channel resources where they will have most impact, rather than committing most time and effort to delivering incident investigation reports in every case.

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, increasing focus on understanding how incidents happen rather than apportioning blame.

Supporting the principles outlined in the PSIRF, this policy will develop and maintain an effective patient safety incident response system that integrates the four key aims:

- 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.

By ensuring compliance with the training requirements outlined by NHSE, the Trust will promote a system-based approach and considering human factors when investigating patient safety incidents or risks in supporting the development of a Just

Culture. This will identify where changes need to be made and then monitored within the system to improve patient safety.

This policy should be read in conjunction with the Whittington Health NHS Trust Patient Safety Incident Response Plan (PSIRP) which sets out how this policy will be implemented. This can be found on the Trust website.

2.0 EXECUTIVE SUMMARY

This policy sets out the Trusts approach to learning and improving from patient safety incidents under the new PSIRF national guidance (NHSE 2022), which replaces the Serious Incident Framework. This guidance requires providers to implement new systems and processes to ensure there is a greater focus on learning and improving, compassionate engagement with staff and patients effected by incidents. better use of data to identify priority improvement areas and using human factors and systems thinking methodologies to investigate and make improvements.

This policy sets out the key requirements of the PSIRF and the Trusts commitment to its implementation. It is a statutory requirement under the implementation guidance. A PSIRF Plan will sit alongside this policy providing more detail of the operational implementation of the PSIRF.

3.0 PURPOSE

This policy describes:

- How the Trust will promote a climate that fosters a restorative and just culture and the work planned or underway to improve safety culture. It includes what is being done to support open and transparent reporting and the development of a restorative and just culture.
- How the Trust will engage Patient Safety Partners (PSP) in the patient safety incident response policy and plan, development, and maintenance.
- How the Trust's patient safety incident response processes will support health equality and reduce inequality.
- How the Trust will engage with those affected by patient safety incidents, including their involvement in a learning response
- How Duty of Candour will be upheld in line with the PSIRF
- How the Trust will take a proportionate approach to patient safety incident responses
- How patient safety incident responses will be delivered, including ensuring adequate training for those undertaking the responses
- What steps the Trust took to develop the PSIR plan, including stakeholder engagement, how patient safety incident records and safety data was analysed,

described the safety issues demonstrated by the data, and how improvement work underway was identified in relation to safety issues and agreeing response methods.

- The process for reviewing our patient safety incident response policy and plan
- What internal and external notification requirements will be for the reporting of patient safety-related incidents
- The processes in place to decide how to respond to patient safety incidents as they arise, including how decisions take into account the Trust's patient safety incident response plan
- The process to recognise incidents or issues that require a cross-system learning response, including how the Trust will seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system
- How learning from incident responses will be used to inform improvements and how safety actions will be monitored
- The Trust's approach to oversight and how the relevant patient safety incident response standards will be met.

4.0 SCOPE

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all specialities within:

- Emergency & Integrated Medicine
- Surgery & Cancer
- Children & Young Persons
- Adult Community Services
- Acute Patient Access, Clinical Support Services and Women's Health (including Maternity)

Learning responses under this policy follow a systems-based approach. The focus of a system-based approach is examining the components of a system (eg person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (ie how they influence each other) and how those interdependencies may contribute to patient safety that is, safety is provided by interactions between components and not from a single component. Responses under PSIRF 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 (*Patient Safety Incident Response Framework supporting guidance Guide to responding proportionately to patient safety incidents, August NHSE 2022)*

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.

Where other processes' principal aims differ from a patient safety incident response they will be deemed to fall outside the scope of this policy and include:

- Complaints (Unless an incident is raised)
- Professional standards investigations
- Coronial inquests
- Criminal investigations
- Claims management
- Financial investigations and audits,
- Safeguarding Incidents, where they fall under Section 42 of the Care Act 2014

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.

5.0 DEFINITIONS

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned services outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan
The Trust 's local plan sets out how PSIRF will be carried out the locally including the list of priorities. These have been developed by analysis of local data, consideration of other safety priorities and consultation with stakeholders.

PSIRF Project Plan
The project work plan that sets out all the work streams and tasks for all ongoing work in relation to the implementation of PSIRF.

Learning Responses:
The system-based learning response methods available for the Trust and its staff to respond to a patient safety incident or cluster of incidents.

Patient Safety Incident Investigation (PSII)
A PSII is an in-depth investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. A PSII investigation uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to understand outcomes within complex systems and which can be applied to support the analysis of incidents and safety issues more broadly. Investigations explore decisions or

actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

6.0 DUTIES (Roles and Responsibilities)

6.1 The overall responsibility for ensuring implementation and PSIRF standards are met is the Trust Board. The Trust Board is responsible and accountable for effective patient safety incident management. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

6.2 The PSIRF Executive Director lead is the Medical Director with the delegated following responsibilities:

- Ensure the Trust meets the standards expected by the PSIRF
- The PSIRF Executive Lead, supported by the Trust Board, will oversee the development, review and approval of this policy and plan for patient safety incident response, ensuring that expectations set out in the patient safety incident response standards are met
- Ensure that the PSIRF is central to the Trust's overarching clinical and quality governance arrangements
- Provide quality assurance and oversight of learning response to the Trust Board and Quality Assurance Committee
- Ensuring the Trust Board has access to relevant information about the organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents. It is the PSIRF Executive Director Lead's responsibility to ensure:
    - patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the Quality Governance Committee on behalf of the Board
    - roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.
- Ensure that mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement forms part of the overarching quality governance arrangements and that it is supported by clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.
- Ensure the Board will monitor the balance of resources going into patient safety incident response versus improvement. Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.

- Ensure updates to the PSIRF policy and plan are made as required as part of regular oversight processes and that overall review of the patient safety incident response policy and plan will be undertaken within 12- 18 months, alongside a review of all safety actions
- Ensure appropriate levels of training are delivered across the Trust, dependent on the roles assigned within the framework.
- Quality assure learning response outputs - a final report should be produced for all individual PSIIs, and this reviewed and signed off as complete. The PSIRF Executive Director Lead is responsible for reviewing PSII reports in line with the patient safety incident response standards and signing off as finalised on behalf of the Board. They may be supported by another executive colleague or subject matter expert.

6.3 ICSU (Integrated Clinical Service Units) and Corporate Senior Leads

6.3.1 Directors of each ICSU (Clinical Director, Associate Director of Nursing & Director of Operations) will:

- Ensure this policy and the associated trust documents are implemented within their areas of responsibility
- Report, escalate and review patient safety incidents in accordance with this policy and associated plan
- Ensure compliance with the policy for the analysis of patient safety data and sharing of learning from responses through ICSU governance arrangements on a monthly basis
- Develop and implement safety improvement plans and ensure that actions are completed following an investigation response or quality improvement initiative, promoting and upholding the principles of the PSIRF and a restorative and just culture within the ICSU
- Overseeing compliance with Duty of Candour in line with the Being Open and Duty of Candour policy
- Ensure staff are compliant with the relevant national PSIRF training requirements.

6.3.2 Associate Director of Quality Governance and Head of Patient Safety

- Working closely with the Medical Director ensure the implementation of the PSIRF policy and plan. Ensure updates to the PSIRF policy and plan are made as required as part of regular oversight processes and that overall review of the patient safety incident response policy and plan will be undertaken within 12-18 months alongside a review of all safety actions
- Provide advice and support to the ICSU leads on implementation of the PSIRF
- Regularly report on progress against the Trust PSIRF plan to the Medical Director and Quality Governance and Assurance committees.

6.3.3 Learning Response Leads.

Learning response leads are staff who are leading a learning response to a safety incident using system-based approaches to capture learning to inform safety actions for improvement and will:

- Be fully compliant with the relevant National PSIRF training requirements prior to undertaking any PSII
- Contribute to a minimum of two learning responses per year
- Communicate developments and progress with the PSIRF, including any consultation exercise to respective ICSUs and corporate committees/groups
- Keep up to date with PSIRF developments and participate in local and national network meetings
- Participate in trust wide PSIRF learning and development events as a presenter/facilitator/attendee

6.3.4 Managers and Heads of Departments

Managers and Heads of Departments will:

- Foster an environment in which staff are encouraged to report incidents and discuss them constructively and openly

6.3.5 Risk Managers

- Review patient safety incidents and gather further information required in relation to the incident reporting and investigation policy
- Refer to the Duty of Candour and Being Open policy to ensure requirements are met
- Escalate any incidents of concern (no and low harm incidents as well as moderate harm and above) to the Patient Safety Team and ICSU leads

6.3.6 All staff

All staff have the responsibility to:

- Report incidents in accordance with the trust's incident reporting policy and actively participate in PSIRF learning and development as required.

6.4.1 The following committees/groups oversee patient safety:

- **ICSU Quality and Safety meetings**
  The ICSU Quality and Safety meeting is a sub-committee of the ICSU Board meeting. It provides assurance to the ICSU Board on all matters relating to patient safety and risk, patient experience, clinical effectiveness, and quality improvement. This in turn reports to the Trust Quality Governance Committee

- **Incident Review Meeting**
  This meeting is attended by ICSU Quality & Risk Managers, Maternity Clinical Governance Manager, the Legal Team and Medicines Safety Pharmacist. This meeting reports to the Weekly Incident Safety Huddle (WISH)

- **Whittington Incident Safety Huddle (WISH)**
  The group provides weekly incident governance and oversight. It reports trends, learning and new investigations monthly to the Trust Management Group and bi-monthly to the Quality Governance Committee and Quality Assurance Committee.

- **Patient Safety Group**
  The purpose of this group is to seek assurance on the implementation of patient safety arrangements in compliance with clinical best practice, regulatory and statutory requirements, and internal risk management and governance processes. This group will track the implementation safety improvement plans.
  The overarching group has a wide membership from across the Trust and reports to the Quality Governance Committee. The following sub-groups report into the Patient Safety Group, each of which is responsible patient safety oversight and improvement within its area of expertise:

  - Medication Safety Group
  - Pressure Ulcer Group
  - Deteriorating Patient Group
  - Falls Improvement Working Group

- **Quality Governance Committee**
  This committee oversees all areas of patient safety from subgroups and reports to the Quality Assurance Committee, subcommittee of the Trust Board

- **Quality Assurance Committee**
  The role of the Quality Assurance Committee is to provide assurance to the Board of Directors on the continuous and measurable improvement in the quality of services through the following key areas:
  - Patient safety and clinical risk
  - Clinical audit and effectiveness
  - Patient experience
  - Health and safety and
  - Quality improvement

- **Integrated Care Board (ICB) and partnership working:**
  The ICB currently meet with the Patient Safety Team to monitor investigations under the current Serious Incident Framework. The ICB will collaborate with the Trust in the development, maintenance and review of the patient safety incident response policy and plan. They will oversee and support the effectiveness of our

systems to achieve improvement following patient safety incidents and will support the co-ordination of cross-system learning responses.

7.0 POLICY SPECIFIC CONTENT:

7.1 Whittington Health's Patient Safety Culture

The Trust is committed to creating an open and fair culture in which staff members are confident about reporting incidents and near misses. Evidence suggests that by creating a fair reporting culture, organisations can improve their ability to learn when things go wrong and improve patient safety. The Trust supports an open and transparent reporting culture by way of policies which promote and encourage reporting, such as our incident reporting and whistleblowing policies. Additional fields have been included in the Trust's reporting system to encourage safety ideas in response to incidents by those reporting incidents.

In addition, the Trust has a Freedom to Speak Up Guardian and Speak Up Advocates, to support staff to highlight safety concerns and a Restorative and just culture group.

The Trust is committed to:

- Promoting a fair, open, inclusive, and just culture that will focus on the systems in which staff work, to understand how incidents happen with a focus on effective learning and improvement.
- Learning from patient safety incidents and events
- Improving communication and the development of a mature safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents.
- Openness and transparency in the reporting process and handling of patient safety incidents follows the Duty of Candour and the trust's Being Open policy.
- Justifiable accountability and a zero tolerance for inappropriate blame, with the NHS Improvement 'Just Culture' guide being used to determine a fair and consistent course of action towards staff.

7.2 Patient Safety Partners (PSPs)

PSPs will be appointed as part of the Trust's commitment to patient involvement and engagement as an integral part of the principles of PSIRF. Their knowledge and experience will support the Trust to build a proactive patient safety culture and will provide an unbiased and uncompromised view of what it feels like to receive care and will substantiate where personalised change is necessary.

As a key part of the Patient Safety Team, PSPs will:

- Represent patients, their families, and carers in the Trust to ensure that the patient voice is central to all we do
- Bring ideas and strategies that will make a difference to patient experience and focus the trust's thinking on "what would the patient or family think of what has have discussed today"?
- Challenge the Trust in the way that it works with patients and carers to promote a culture of openness and transparency and to ensure there is a culture of continuous improvement.
- Play an active part in key conversations and meetings trust wide that address patient safety and experience
- Help design and develop patient safety and involvement initiatives

7.3 Addressing Health Inequalities

The Trust recognises the importance of reducing the health inequalities of the population that are served by Whittington Health Hospital by ensuring services are designed around the needs of the local population, ensuring equality of access.

Under the Equality Act (2010), as a public authority, the Trust has statutory obligations for which there is commitment to deliver on. Data which identifies any possible patient safety risks or incidents which disproportionately affects certain cohorts of the population will be proactively gathered and analysed. This will be included in the PSIRF plan.

The Trust is committed to supporting effective communication by compliance with the Accessible Information Standard alongside use of supportive tools such as easy read, translation, and interpretation services. The Trust's Learning Response Leads and will engage with patients, families, and staff following a patient safety incident, for inclusion. This will be considered under the engaging staff and patients' policy which is being developed as part of the PSIRF plan.

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

Under the PSIRF there will be greater engagement with those affected by an incident, including patients, families, and staff ensuring they are treated with compassion and able to be part of any investigation.

Replacing '*Being Open*' as the national standard for engaging those affected by a patient safety incident, the NHSE guidance '*Engaging and involving patients, families and staff following a patient safety incident, 2022' de*tails advice on how to involve patients, carers, and staff in the incident response process. Aligned with this guidance, the Trust will ensure compassionate engagement and involvement through a process that enables patients, families and healthcare staff to contribute to a learning response

and develop a shared understanding of what happened and potentially how to prevent a similar incident in the future.

7.5 Duty of Candour

The current Duty of Candour policy and practice legislation requires the Trust to ensure that when things go wrong which cause in moderate, severe harm, or death, patients and their families are informed. The Trust is currently required to:

- Notify the patient in person that a notifiable safety incident has occurred and apologise
- Provide an account of all the facts known about the incident
- Advise the relevant person what further enquiries into the incident are believed to be appropriate
- Provide an offer of reasonable support to the patient
- Document the above in writing
- Follow up with a written notification confirming information provided and containing results of further enquiries (i.e. outcome or findings of any investigation) and apology

Whilst previously under the Serious Incident Framework, a distinction was made between serious incidents and all other incidents, PSIRF seeks to cover all incidents which caused, or had the potential to cause harm with the focus on opportunities for learning. This change in approach will require careful communication and engagement with staff, patients, and their families to explain the reasons why an incident, which would have required an investigation previously, may not on this occasion be carried out, as other tools for learning will be adopted instead.

These messages may at times be difficult to deliver and could be challenged. Details on the plan to achieve the development of the approach in communicating these more complex issues to ensure that patients and their families are satisfied and feel reassured by the Trust's approach can be found in the PSIRF plan. The Duty of Candour policy will also be updated accordingly.

7.6 Patient Safety Incident Response Planning

The PSIRF enables the Trust to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on pre-defined definitions of harm. Beyond nationally set requirements, the Trust will explore patient safety incidents relevant from the perspective of a local context, around the population which the Trust serves.

7.7 Patient Safety Incident Response Plan

The Patient Safety Incident Response Plan sets out how the Trust intends to respond proportionately to patient safety incidents, this will be reviewed every 12-18 months or more frequently as required to reflect changes in the trust or patient safety priorities. The review process will involve key stakeholders and will be published on the trust website.

In developing and reviewing the plan, the PSIRF Implementation Group included key internal and external stakeholders to identify the Trust's patient safety incident priorities.
Data was taken from Datix and IQVIA over a three-year period (2019 – 2022/23) and included no and low harm incidents, and moderate harm and above incidents. This data was analysed by categories and sub-categories, using the Pareto Principle and charts to extract and interpret the top themes. Family & Friends Test data was captured using IQVIA, generating a statistical correlation chart that ranks responses by importance. In addition to this, opinion was sought from each ICSU on their top areas of concern in relation to patient safety.

Key themes were also analysed by sub-categories data from:

- Patient Advice and Liaison Service (PALS)
- GP concerns
- Complaints
- Risk register Legal: Claims & Coroners inquests
- Freedom to Speak Up (FTSU)
- Staff survey
- Claims
- Coroners Inquests
- Safeguarding
- Quality related reports

7.8 Reviewing our patient safety incident response policy and plan

The Trust's PSIRF policy document sits alongside the PSIRF plan and guides the trust's responses to patient safety incidents. The plan is a proposal which covers how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months however both the policy and plan will be reviewed regularly at the Patient Safety Group to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing the response capacity, mapping the 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.

7.9 Responding to Patient Safety Incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. The Trust is committed to creating an open and fair culture in which staff members are confident when reporting incidents and near misses. There is a clear procedure for reporting incidents, exploring and understanding the circumstances leading to events, and recording learning as well as monitoring processes which are set out in the incident reporting policy.

7.10 Patient safety incident reporting arrangements

All patient safety incidents will be recorded on Datix, the trust's local risk management system.
Using Datix, all staff can:

- Record information about things could have or did affect the safety of patients, or things that have gone well, to support learning and safety improvement
- Access, review, and update incident records they have permission to edit, and undertake governance activities to support local patient safety response and improvement
- View and download data about what patient safety incidents have been recorded within their own organisation to the new Learn From Patient Safety Events service

7.11 Patient safety incident response decision-making

The PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

- Quality and Risk Managers within each ICSU will review reported incidents and escalate any incidents of concern to the Triumvirate as appropriate.

- The Patient Safety Team will review incidents reported on the local risk management system and support ICSU governance leads, if necessary, to agree the type of response required. This may include a learning response, patient safety incident investigation (PSII) or local management, in accordance with the patient safety incident response plan (PSIRP).

- WISH will discuss and agree the response to incidents, based on the following options described in the PSIRF and plan:
    - Contributory (system) factors not well understood - learning response indicated. The PSIRF plan will outline the types of responses available and will promote learning. These are aligned with the PSIRF toolkit for types of learning response.

- Safety issues well understood and/or improvement plans are in place and robust – consider not undertaking an investigation as no additional learning is likely to be identified
- Unclear whether a learning response is required – the group will discuss and agree response based on information provided and opportunity for learning / improvement or present to the WISH for a decision
- When potential patient safety incidents are identified through the complaints, clinical negligence or the Inquest process, the PALS (Patient Advice & Liaison Service), Medical Examiners, learning from death reviews, or Legal Services teams, an incident review will take place and escalated as appropriate, for discussion and consideration at the WISH.
- Resources will be allocated to support responses to emergent issues not included in the patient safety incident response plan on a case-by-case basis.

7.12 Responding to Cross-System Incidents/Issues

- The Trust has designed an oversight process in collaboration with stakeholders (including the ICB), to enable the Trust to demonstrate improvements in patient safety.

- Local teams within each ICSU will identify cross-system incidents or issues as they occur and escalate to the WISH for consideration.

- Identified incidents presenting potential for significant learning and improvement for another provider will be sent 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 supportive operating procedures to ensure that this is effectively managed.

- The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. The Trust will look to the ICB to give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

- The ICB can commission an investigation or any other learning response, that is independent of the Trust, if the ICB considers that:

  - The Trust does not have adequate staff resource in order to provide an objective response and analysis
  - an investigation independent of the Trust, is deemed necessary to ensure public confidence in the integrity of the investigation

- in the case of a multi-agency incident, no single provider is the clear lead to undertake the investigation
- the incident(s) represent significant wider learning potential regionally or nationally

- All multi-agency incidents and those representing significant learning potential for the region or nationally, including all incidents of mental health related homicide, will be discussed with the RIIT (NHS England Regional Independent Investigation Team).

7.13 Timeframe for Learning Responses

- Timescales should be set where possible, with a response being started as soon as practicable after an incident is identified. It should usually be completed within one to three months and no longer than six months, depending on the type and complexity of the incident.
- The timeframe for completing a PSII should be agreed with those affected by the incident and this will form part of the terms of reference for the local response.
- Should local responses undertaken by the Trust, take more than six months or exceed the timeframes agreed, then the Trust will review the processes being followed to understand how timeliness can be improved.
- In exceptional circumstances such as when a partner organisation requests an investigation is paused, a longer timeframe may be needed to respond to an incident and this will be agreed with all parties involved in the investigation.
- Where external bodies or those affected by patient safety incidents, cannot provide information to enable the Trust to complete enquiries into an incident within six months or within the agreed timeframe, the learning response leads will work with the information, which is available, to complete the response to the best of their ability. Responses might be revisited in the event that new information comes to light that indicates need for further investigation. .

The WISH will monitor timescales and progress of PSIIs and other learning responses.

7.14 Safety Action Development and Monitoring Improvement

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022).

It will ensure that systems and processes are in place to design, implement and monitor safety actions. This will be part of the process of any learning response which might result in the identification of the Trust's systems where change could reduce risk or potential harm.

Best practice advises that learning responses should not describe recommendations as this can lead to premature attempts to devise a solution. Any safety action devised

in response to a defined area for improvement will be dependent on factors and constraints that sit outside of the scope of a learning response. To achieve successful safety actions, their development will be devised in a collaborative way with a flexible approach from the ICSU as well as with support from the quality improvement team and other subject matter experts in the area.

The monitoring and review of safety action development and improvement from learning will be in line with the quality improvement programme.

Further details of safety action development and improvement will be outlined in the Trust's plan.

7.15 Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

The Trust will have:

- An organisation-wide safety improvement plan summarising improvement work
- Individual safety improvement plans that focus on a specific service, pathway or location
- Review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- A safety improvement plan for broad areas for improvement (ie overarching system issues).

Plans will be revised in response to any new learning, so they represent the latest and best approach to dealing with a particular patient safety issue. This includes revising improvement plans where evidence indicates that measures are not having the anticipated impact.

8.0 TRAINING

The PSIRF standards have defined the competencies required for individuals leading on the implementation of PSIRF.

All staff leading on the learning responses or being engagement leads or those with oversight roles will have undertaken the PSIRF stipulated training programmes. Resources have been allocated for this training which will be recurrent to meet need.

9.0 MONITORING COMPLIANCE AND EFFECTIVENESS:

What key area(s) need(s) monitoring on this document? (Consider the purpose of the document; processes, procedures, timelines, patient outcomes etc)	**Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.**	**What tools / methods will be used to monitor report and review the identified areas? (Consider audit, observation, minutes, complaints, incidents, claims, reports and documentation etc.)**	**How often is the need to monitor each area? How often is the need to produce a report? How often is the need to share the report?**	**Responsible Committee for scrutiny and arrangements for feedback.**
Element/s to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting and feedback arrangements**
The associated PSIRF Plan details the governance and oversight arrangements for the PSIRF framework.	Operational oversight will be lead by the WISH group, strategic oversight by QAC	Various methods as set out n the PSIRF Plan, such as incidents and harm levels, measures of learning and improvement and reduction in harm to patients.	Weekly oversight by WISH, Bi-monthly reporting to QAC. Annual review of PSIRF plan and priorities.	WISH – operational. QAC – Strategic.

10.0 ASSOCIATED DOCUMENTS:

Title of Document	Intranet link
Title of Document Duty of Candour and Being Open policy	https://whittnet.whittington.nhs.uk/document.ashx?id=768 (accessed 24/04/2024)
Incident reporting and investigation policy	https://whittnet.whittington.nhs.uk/document.ashx?id=2518 (accessed 24/04/2024)
Complaints handling policy	https://whittnet.whittington.nhs.uk/document.ashx?id=1193 (accessed 24/04/2024)
Learning from deaths policy	https://whittnet.whittington.nhs.uk/document.ashx?id=11502 (accessed 24/04/2024)
Legal Services policies and procedures	https://whittnet.whittington.nhs.uk/default.asp?c=9893 (accessed 24/04/2024)
Freedom to speak up/raising concerns	https://whittnet.whittington.nhs.uk/?c=21429 (accessed 24/04/2024)

11.0 REFERENCES

Patient Safety Incident Response Framework (PSIRF) (NHSE,2022). Available online: https://www.england.nhs.uk/patient-safety/incident-response-framework (accessed 24/04/2024)

12.0 EQUALITY IMPACT ANALYSIS: Whittington Health

1. Name of Policy or Service

Patient Safety Incident Response Poilcy

2. Assessment Officer

Richard Matthews, PSIRF Project Lead

3. Officer responsible for policy implementation

Louise Roper, Head of Patient Safety

4. Completion Date of Equality Analysis (In this format;12/May/2013)

11/January/2024

5. Description and aims of policy/service

To ensure the Trust implements the statutory NHSE Patient Safety response to replace the Serious Incident Framework.

6. Initial Screening

An initial analysis has been carried out to explore whether the PSIRF Policy is likely to have a detrimental impact in terms of people included in one or more of the following equality categories:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion and belief
- Gender Reassignment
- Marriage and civil partnership
- Pregnancy and maternity

7. Outcome of initial screening

No adverse effects to any groups. The policy applies to all reported patient safety incidents regardless of equality categories.

8. Monitoring and review/evaluation

To be reviewed at each policy review date or sooner if circumstances require it.

9. Publication of document

As above