Patient safety incident response policy

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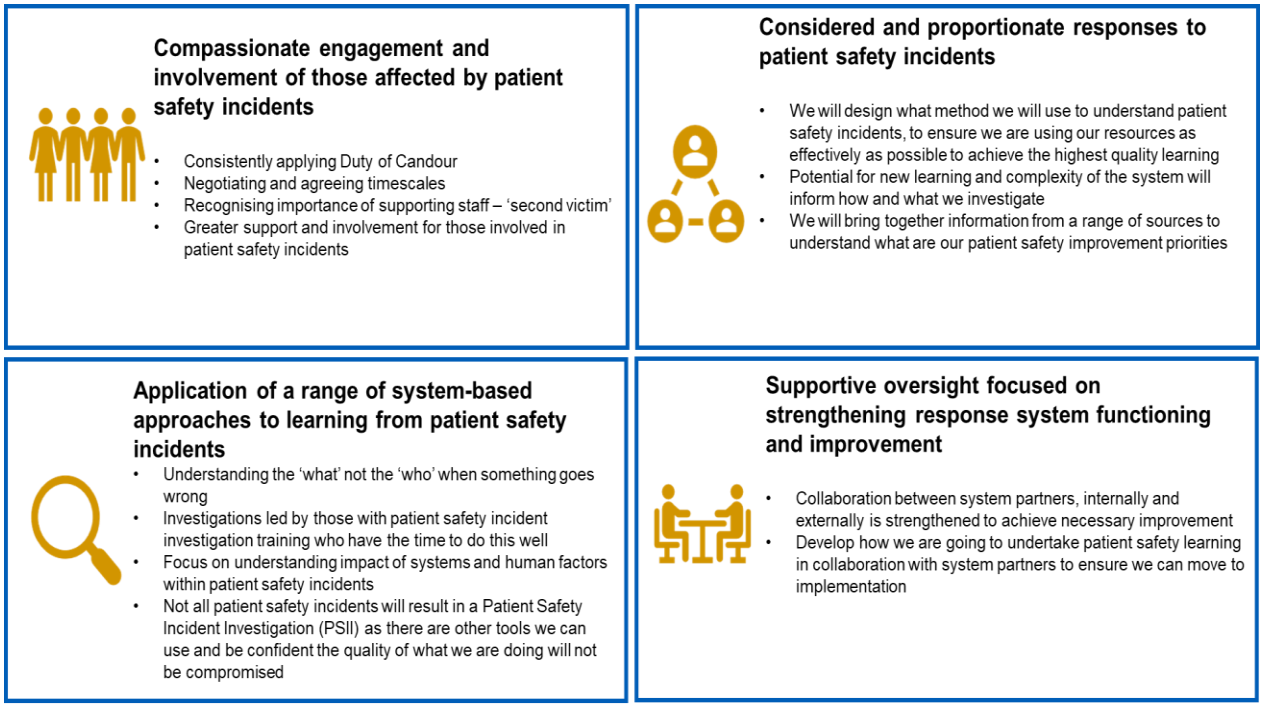
Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Countess of Chester Hospital NHS Foundation Trust 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.

It presents our systems and processes in place, as well as the respective roles and responsibilities that enable us to undertake high quality learning response and show how we learn and improve patient safety. This policy must be read in conjunction with our patient safety incident response plan and contains our updated Incident management, Supporting Staff and Duty of Candour Policies within the appendices of this document and are designed to describe what we do as accessibly as possible.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses (the tools we use to learn from patient safety incidents), within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. We are now on a journey to improve and strengthen how we link our learning to making things better and safer.

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



Scope

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

The following elements are within scope of this policy:

- Patient safety incident responses
- Supporting and involving those affected by patient safety incidents
- Statutory Duty of Candour

Patient safety incident learning responses under this policy follow a systems-based approach. This recognises that patient safety is provided by interactions between components of a system 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.

Processes that sit outside the scope of this policy are set out below, as the principle aims of each of these responses differ from those of a patient safety incident response:

- Claims handling (current policy – Appendix 6, this policy is under review and will be updated and ratified for implementation in February 2024)
- Human resources investigations into employment concerns (Appendix 7)
- Professional standards investigations
- Coronial inquests
- Criminal investigations

Information from a patient safety incident response process can be shared with those leading other types of responses, but other processes will not influence the remit of a patient safety incident response.

Our patient safety culture

Just Culture

We already recognise the distinct basis on which patient safety incident responses are undertaken within our trust, to ensure that they are completed for the sole purpose of learning and to identify system improvements. Our human resources policies reflect this.

We are working to strengthen our approach to ensuring that the experience of those involved in and affected by patient safety incidents or issues, is one that is fair and proportionate.

We are working as a whole organisation to review and update our vision and values, to emphasise our commitment to Just Culture. This is in addition to strengthening our Freedom to Speak Up approach to ensure that learning arising from this is connected to the patient safety agenda, which would include education and coaching to ensure we are effectively and compassionately supporting those staff involved in patient safety incidents.

Safety Culture

All of us work hard to deliver the most positively experienced, effective and safe care. In the main we do achieve this; however, we also review our care and learn from it when things have not happened as expected or we have received feedback highlighting concerns. The psychological safety required to be able to do this is a cornerstone of a positive safety culture. We anticipate that our work to re-frame and set our values and vision will form the basis of work that will shape the safety culture that sustainably assures open and transparent reporting.

We have daily executive led quality and safety meetings, that ensure visibility of what is happening across the organisation and responsiveness, at all levels. This has strengthened the visibility of safety issues reviewed in service level safety huddles that occur across the trust as incidents over the preceding 24 hours are reviewed daily by the executive team. We are working to refine how we do this all the time.

We have already undertaken work across the trust to provide training around incident, risk management and learning to promote the conditions that reflect a positive safety culture that learns. This has resulted in increased reporting rates and increased interest in how we develop mechanisms to link learning to improvement.

Over recent years the trust has continued to invest in developing staff working across a range of professional backgrounds, to build continuous improvement capacity within our organisation. We work predominately with LEAN methodology. This work will influence the development of a culture required that strives for continuous refinements to quality improvement programmes linked to recognised and emerging patient safety issues. PSIRF will promote this link through the increased emphasis on quality improvement.

We are now working to strengthen how we measure patient safety improvement and learning, as well as how we make learning visible in a way that helps to influence systems changes, practice and culture.

We are in the process of designing how we will respond to feedback from staff through the staff survey that relates to patient safety, this will become incorporated as a PSIRF improvement measure.

Patient safety partners

In line with our refocused patient experience vision and strategy, we have been working to develop how patient safety partner roles will be adopted and embedded at the Countess of Chester Hospital NHS Foundation Trust. This work has involved patient and carer representatives working in partnership with trust PSIRF leads, to develop the role focus and governance.

We recognise that whilst patient safety partner roles are relatively new, partnership working is not, and we have a unique opportunity to ensure there is a voice for patients and those who use our services.

The function of these roles would include:

- Attendance at governance meetings at various levels, to join reviews of patient safety, risk and quality issues
- Contribution to patient safety investigations, policies and reports
- Participation in quality improvement projects

The basis on which patient safety partners are engaged is under review and will be supported through defined line management structures within the corporate quality governance team. This support will include 1:1 meetings and provision of training, based on the training needs identified individually.

Addressing health inequalities

The trust has statutory obligations under the Equality Act (2010) as part of our commitment to reducing inequality in health. This is relevant to how we understand and respond to patient safety incidents, to ensure our approach is inclusive and tailored to the needs of those we are engaging with.

We are working in collaboration with our organisational development team to strengthen how our patient safety data capture allows us to identify any disproportionality in patient safety incidents, for people with protected characteristics. This will enable us to shape improvement work focused on reducing inequalities that will be shaped by the Core20PLUS5 approach (NHSE/I).

Our policy guidance for staff about how to engage with and support those involved and affected by patient safety incidents has been strengthened to prompt proactive consideration of any necessary adjustments that may be required.

We will build on work to date around learning disability and neurodiversity knowledge and skills, to ensure our learning response processes set out within our Incident Management Policy are inclusive and promote our ability to collate data to allow us to assess how effectively we have achieved this.

We recognise that working collaboratively with patients, families and friends means ensuring information is accessible and can be understood. We are developing how we can sustainably access translation services to ensure that we can communicate effectively at all points through the process through a range of media.

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 the systems and processes in place are supportive. 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 positively with patients, families and staff who have been 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.

We are committed to getting this engagement right the first time and to ensure it happens in a timely way.

We have developed this policy recognising that some patient safety incidents are identified and reported by patients, their families or carers. As such we are working to ensure that patient safety incident or issues arising from complaints or concerns received by our Patient Advice and Liaison Service (PALS) or Complaints team, are fed into the incident management process and a learning response developed in line with our patient safety incident response plan. The listening and responding to concerns and complaints policy can be found in Appendix 1. The trust is working on an engagement policy for patients and family and will be completed as we transition from December 2023, the policy will be implemented in January 2024.

Supporting those involved with, and affected by, patient safety incidents is explained the trust's Just Culture support mechanism document (Appendix 2). It describes the practice standards and expected approach to be taken to support staff, with links to internal support systems and external organisations.

Duty of Candour

The practice standards set out within this policy align with the statutory and professional requirements for Duty of Candour and Being Open, in line with Regulation 20 of the Health and Social Care Act 2008, in that all staff are empowered to:

- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- Apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain fully to the patient (or, where applicable, the patient's advocate, carer, or family) the short-term and long-term effects of what has happened.

(The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

It is important to ensure the spirit within which Duty of Candour and Being Open conversations are undertaken is held in mind, so that they remain meaningful.

Appendix 3 Duty of Candour and Being Open policy sets out the practice standards and expected approach that must be taken in line with statutory duty of candour and a culture of being open and transparent.

Patient safety incident response planning

The PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. Rather than basing our responses on arbitrary and subjective definitions of harm, we need to focus on the learning and improvement opportunities.

Beyond nationally set requirements for learning responses, PSIRF means that we can now explore patient safety incidents relevant to their context and the populations we serve, rather than only those that meet a certain defined threshold. We have set out how we will do this through our patient safety incident response plan document which has been based on our organisational risk profile and informed by this policy document.

Resources and training to support patient safety incident response

NHS England patient safety incident response standards set out the resources and training required to effectively deliver PSIRF in practice. We have undertaken work to understand our activity and existing resources, against our projected activity once we have transitioned to PSIRF and these standards. This has meant that we have been able to develop a training response to meet the needs of our staff, to ensure they are supported to complete high quality patient safety incident responses.

We have a number of commitments we highlight here that are recognises as critical to effectively embed PSIRF:

- Our process of incident management will ensure that no staff member involved in an incident, or who manages those staff involved, are in a position where they would lead a learning response.

The incident reporting and management policy (Appendix 4) sets out how learning responses are assigned and overseen, this policy has recently been reviewed and aligns to PSIRF principles as we start to transition to PSIRF in January 2024.

- Depending on complexity, all systems-based patient safety incident investigations will be led by staff working at a minimum of a Band 8a, in collaboration and leading Band 7 colleagues where appropriate to undertake patient safety incident investigations and other learning responses
- Where necessary we will ensure that learning responses include subject matter experts, either external or internally sourced.
- Staff undertaking learning responses will do so with support from corporate quality governance colleagues, as well as divisional staff
- Our patient safety incident response plan and the corporate quality governance team will support staff at all levels in their decision-making about appropriate learning responses
- We will ensure staff affected by patient safety incidents will receive all necessary support and be actively supported to participate in learning responses

We are implementing externally sourced patient safety training that reflects the requirements of PSIRF, focused on ensuring our staff have the necessary skills and confidence to complete robust and high-quality systems-based investigations and reviews of care. The training also equips our staff to effectively engage and support those affected as well as understand how to deliver patient safety oversight roles and responsibility for our senior leaders. In line with Health Education England Patient Safety Training Syllabus, we have implemented Level 1 training as essential to role since January 2023:

Level 1:

- Part 1 – Essentials of patient safety targeted at all trust staff
- Part 2 – Essentials of patient safety for board and senior leadership teams

Training for Level 1 is accessed via ESR and will show within individual staff competency requirements that form part of annual appraisal conversations, as well as monthly compliance reporting visibility at divisional senior leadership team level.

The table below sets out how compliance with the wider training offer will be monitored.

The trust will support the continuous professional development of those staff who receive training through the following processes:

- Quarterly communities of practice sessions
- Regional level connection with partner providers to share experience and new learning opportunities

It is expected that all staff undertaking investigation and engagement training will undertake a minimum of two patient safety incident investigations per year.

Training required	Competencies to be acquired	Monitored	Target staff
Patient safety incident investigation training – 2 days minimum	• Learners will be able to plan, lead on, undertake, and document a robust and comprehensive patient safety incident response investigation or improvement project • Be able to adopt a systems-based learning about complex systems, systems thinking and human factors in the context of incident learning responses • Acquire understanding and skill to use a range of learning response methods: including patient safety incident response investigations, interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Applies best practice in understanding and compassionately supporting those affected by patient safety incidents • Able to use systems-based analysis techniques (e.g. SEIPS) to inform safety action development • Skills and knowledge that will enable design and sustainable impact of safety action, measurement, and monitoring	ESR System will monitor and retain training records	• Risk and safety leads • Quality governance business partners • Heads of Nursing • Matrons • Professional leads • Ward managers • Triumvirate teams • Executive leads

Involving those affected by patient safety incidents – 6 Hours	• Able to describe legislation and delivery in practice of Duty of Candour • Able to describe and evidence understanding of the principles and importance of Just Culture and psychological safety, within a safety culture and all learning response process • Applies best practice in understanding and compassionately supporting those affected by patient safety incidents • With due regard to promoting equity: o Develop enhanced skills in Being open and apologising o Effective and enhanced communication of complex and distressing information in an accessible and compassionate format and manner; including the sharing of investigation findings and learning o Display and describe the characteristics of effective involvement in patient safety incident investigation o Signposting and support	ESR System will monitor and retain training records	• Risk and safety leads • Quality governance business partners • Heads of Nursing • Matrons • Professional leads • Ward managers • Triumvirate teams • Executive leads
Oversight – 1 day minimum	• Acquisition of knowledge of the guidance set out within NHSE PSIRF and associated documents • Be able to promote and embed system wide learning in the context of patient safety incident responses and improvement planning, that engages internal and external stakeholders, as appropriate – this includes application of human factors and system thinking principles • Recognise when safety actions do not take a systems - based approach and test through constructive challenge, the robustness and sustainability of actions • Use information from qualitative and quantitative sources • Be able to design, implement and participate in at senior level/lead, effective oversight and supporting processes within which to deliver effective and sustainable high quality patient safety improvement works, in line with regulatory requirements and PSIRF • Define and adopt the characteristics of a sustainably open, transparent and improvement focused culture	ESR System will monitor and retain training records	• Quality governance business partners • Triumvirate teams • Executive leads

	• Define understanding parameters within which PSII commissioning and planning occurs to support delivery and embedding of improvement focused culture		

Our patient safety incident response plan

Our PSIRF plan (Appendix 5) sets out how Countess of Chester Hospital NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 months.

The plan gives specific guidance on what type of learning response will be expected for specific incident types. This includes those incidents that require a nationally mandated response and external reporting that is coordinated through the corporate quality governance team.

This approach aims to support staff to take a consistent approach in how we intend to learn from patient safety incident responses we undertake. Through this plan we will be able to prioritise how we undertake learning responses to maximise the time spent on improvement work. The plan is not a permanent set of rules that cannot be changed as we recognise that we are continually learning and developing. 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.

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 in 12 months’ time 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 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

All staff are responsible for reporting potential or actual patient safety incidents using the trust incident reporting system. This will include the recording of harm experienced by the person affected.

The Incident management policy (Appendix 4) sets out how incidents are managed from reporting to response.

We have several forums in place from ward to board that support the delivery of the Incident Management Policy, reports are being developed to support their functioning, the forums are set out below:

Level of oversight	Forum title	Membership (core)	Purpose	Terms of reference
	Daily senior safety huddle	Clinical and non-clinical team leads Chaired by Deputy CEO/DoN/Nominated deputy	○ Review safety over preceding 24 hours ○ Communicate and address anticipated safety issues over coming 24 hours	- Action log retained - MSTeams forum - Safety visibility and support needs ward to board

Executive	**Weekly Executive Patient Safety Panel Meeting**	• Director of Nursing and Quality and Executive Medical Director or Patient Safety Lead • Deputy Director of Nursing and Quality • Divisional Triumvirate representative • Divisional Corporate Quality Governance Business Partners	**Patient safety incidents and learning responses executive sign off** – PSII **Quality improvement for all levels of incidents** - Themes and trends arising from learning data and workstreams being informed by them, areas of new learning emerging **Quality assurance for all levels of incidents -** Performance management through weekly meeting – ensuring all processes are functioning and status for incidents requiring a defined response is known e.g DoC, response timelines, actions	- Action log retained - Minuted meeting – administrated by corporate patient safety support B4 staff - Executive final sign off PSII and challenge to ensure PSIRF response standards are met through constructive challenge - Review and highlight themes and trends in learning data to relevant workstream leads - Ensure external reporting has occurred e.g. HSIB, SHOT, PHE - Commission new patient safety improvement plans on the basis of divisional escalation and evidence of emerging trends/risks - Oversee compliance with KPIs associated with incident management - ***Receive outputs and action plans from ad hoc divisional meetings for incidents meeting national and/or external reporting requirements within 24 hours of incident***

Divisional	**Weekly Divisional Senior Team Patient Safety Panel Meeting**	• Triumvirate lead • Heads of Nursing • Matrons • Clinical leads • Corporate quality governance business partners • Divisional risk and safety leads	**Weekly incidents review all incidents** **Learning response choice validation** **Incidents and learning responses divisional quality assurance review and sign off –** PSIIs, ARR/Swarm Huddles/72hr review **Quality improvement -** Themes and trends arising from learning data (including claims and complaints) and workstreams being informed by them, areas of new learning emerging **Quality assurance -** Performance management through weekly meeting – ensuring all processes are functioning and status for incidents requiring a defined response is known e.g. DoC, investigation timelines, actions	- Action log retained - Minuted meeting – administrated by corporate patient safety support B4 staff - Divisional sign off learning responses, to confirm PSIRF response quality standards are met - Review and highlight to themes and trends in learning data to relevant workstream leads - Identify emergent risks or issues for action plans to be developed - Oversee compliance with KPIs associated with incident management - Report into divisional governance meeting - Ensure external reporting has occurred e.g. HSIB, SHOT, PHE - ***Lead ad hoc divisional meetings for incidents meeting national and/or external reporting requirements on day of incident***

Service	**Daily service level incidents review and validation of all incidents from past 24 hours**	• Divisional ward/service managers • Risk and safety leads • Heads of nursing • Matrons	Validate all harm levels within trust incident management system Confirm Duty of Candour (DoC) has been completed/follow up needed to complete and monitor daily until complete using DoC tracker within DATIX Initial learning response allocation confirmed in line with PSIRF Plan and Policy, commenced and confirmed on track **unless incidents meet national reporting requirements** Escalation of emerging risks, moderate + harms and incidents meeting national and external reporting requirements to divisional meeting	- Action log retained within trust incident management system - Assurance of harm validation - Monitoring of DoC status to ensure completed in line with timescales - Monitoring initial learning response allocation and feedback to ensure on track - Identify emerging risks and communicate to divisional meeting - ***Escalate incidents meeting national reporting requirements to senior divisional leaders same day to undertake senior led review meeting and immediate action planning***

Patient safety incident response decision-making

PSIRF sets out nationally mandated learning responses for specific incident types and these are presented within our patient safety incident response plan.

This policy document contains the trust incident reporting and management policy (Appendix 4) sets out how learning responses for incidents are decided and must be read in conjunction with the PSIRF Plan document.

The decision-making process for all incidents is led by divisional senior leads acting in line with this policy, its supporting documents and the PSIRF Plan document. Learning responses must prioritise opportunity for new learning and reflect consideration of how existing improvement workstreams can be informed by the learning arising from a patient safety incident.

Guidance can be obtained through the corporate quality governance team at any time if the appropriate and proportionate learning response is not clear.

All learning response templates will outline how learning will be shared and become visible as indicators for our quality improvement workstreams and to our staff, patients, and families, as our mechanisms to achieve this are developing.

The incident reporting and management policy sets out how all incidents are managed from reporting to response, key performance indicators (including how learning responses are decided locally and across systems).

Responding to cross-system incidents/issues

The corporate quality governance team will be responsible for sharing summary incident details to external providers where it is considered that they have areas for learning and improvement. This will be recorded within the trust incident management system.

We will work with partner organisations and our Integrated Care Board (ICB) to ensure there is open and transparent sharing of information to inform system wide understanding of cross-system incidents. The corporate quality governance team will coordinate such liaison and joint working. This will include circumstances where it is considered by the organisation that an incident is better managed across a system and support will be obtained from the ICB to facilitate this. This will need to ensure that the learning response and measurable improvement actions will be agreed and overseen by all stakeholders and fed into respective organisations.

The reviewed incident reporting and management policy will set out the process for managing cross system incidents and reports of potential patient safety incidents from external sources.

Timeframes for learning responses

We recognise that the timeliness of learning responses is important however we also know that to ensure the quality of the response is robust, this can take time depending on several factors - such as complexity and accessibility of key people. We must always involve those affected by the patient safety incident when deciding timeframes for learning responses.

The table below sets out the expected maximum timescales for learning responses, this aligns with NHS England guidance and seeks to ensure the quality of learning responses as well as their timeliness:

Learning response type	Minimum timescale from incident report	Maximum timescale from incident report
Patient safety incident investigation (PSII)	2 months	6 months
Swarm Huddle, After Action review, MDT meeting	As soon as possible post incident	2 months
72 Hour rapid review	As soon as possible post incident	5 Working days (by exception)

There will be divisional monitoring reports that track performance against these metrics that are scrutinised at weekly divisional patient safety meetings and then also at weekly executive meeting.

Safety action development and monitoring improvement

Informed by NHS England guidance on safety action development, we recognise that any improvements we seek to make must be based on a robust understanding work as done and what system factors influence work. The investigation or review stage is only the start. PSIRF has highlighted several tools that enable us to analyse incidents in the context of systems within which they occur. However, simply developing actions does not necessarily reduce risk. We need to know what improvements need to be made to sustain changes.

Through PSIRF we now focus on what aspects of the system could be changed to reduce risk and potential for harm. Our actions to reduce risk, our safety actions, are then generated in relation to each area for improvement. We then must define the measures and mechanisms for monitoring and review. Therefore, our actions must be Specific Measurable Achievable, Realistic, and Time-focused (SMART) at all times.

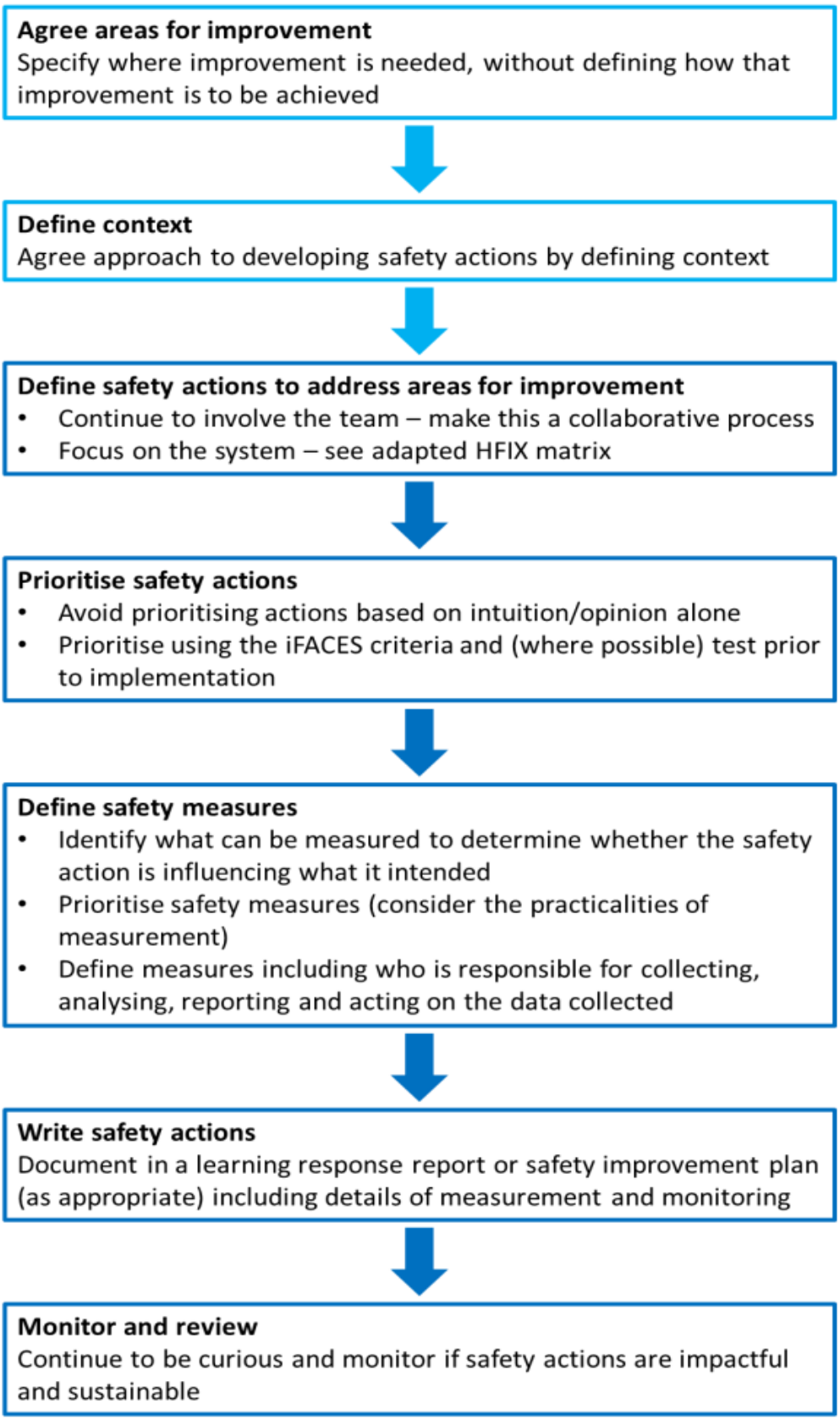
Recommendations therefore now are known as ‘areas for improvement’ and the process of developing actions in response to these areas mut be a systematic and collaborative one. During the process of developing safety actions, it is important to consider levels of influence of those responsible for delivering safety actions. This ensures that actions are not allocated outside of an individual’s/service sphere of influence.

Additionally, wider system improvements must be considered as mechanisms through which actions can be implemented, to ensure there is no duplication of improvement work already in progress. This will include involvement with our Continuous Improvement and Quality Teams where appropriate.

In doing all of this we can then promote improved engagement, increased feasibility and sustainability of improvements made.

Appendix 4 Incident management policy sets out how safety actions will be developed and monitored.

The process to be followed in developing actions reflects that set out within NHS England safety action development guide:



Safety improvement plans

We have several improvement workstreams underway, their development has arisen from analysis of the recurring nature of our incidents. These workstreams are presented within our patient safety incident response plan document.

These are trust-wide programmes of work that have several workstreams sitting within them. Our plan document presents our improvement workstreams and how learning responses from incidents within our organisational safety profile will feed into these programmes. The mechanism through which learning responses will do this is through either:

1. Learning is translated into actual data and used to measure changes in incident occurrences and/or harm as a measure of improvement workstream

or

2. To highlight new areas for improvement workstreams for the organisation to focus on

Our involvement in national and regional improvement work is also described within our plan.

Where new learning, including overarching systems issues, are identified through learning responses and sit outside of our improvement workstreams already in progress. These will be recognised at divisional levels initially through the oversight forums and reporting described within this policy.

These will then be escalated to the executive patient safety panel by the relevant division, for approval to commission a patient safety improvement plan or alternative response as appropriate.

Oversight roles and responsibilities

We recognise that PSIRF required our leadership and management functions to expand and become multifaceted. Our focus has therefore moved towards seeking to demonstrate improvement rather than purely compliance with externally mandated criteria.

The incident reporting and management policy presents our oversight systems and processes and evidence how they are underpinned by the oversight ‘mindset’ principles:

- Improvement as the focus
- Blame restricts insight
- Learning from patient safety incidents is a proactive step towards improvement
- Collaboration is key
- Psychological safety allows learning to occur
- Curiosity is powerful

These principles will be reflected in the practice of those in oversight roles within the organisation.

Our oversight systems and processes ensure we can deliver the patient safety incident response standards in practice. We have undertaken a gap analysis that highlighted areas requiring action to enable us to robustly fulfil all incident response standards.

The executive leadership for PSIRF is driven by our executive medical director and director of nursing and quality. They are responsible for ensuring we meet NHS England Patient safety incident response standards are met and provide advice and support in complex/high profile cases. They also will liaise with external bodies as appropriate.

The table below presents the executive responsibilities and how these are executed:

Responsibility	Mechanism to achieve
Ensure the organisation meets national patient safety incident response standards	• Enabled through internal lead roles to develop and review the trust policy and plan in preparation for transition • Internal PSIRF Working Group brought local internal perspectives as well as quantitative data together to understand and define the organisation's safety profile • Outputs of the Working Group have been reported through the executive leads into the trust Quality and Safety Committee and through to Trust Board in form of plan and policy documents
Ensure PSIRF is central to overarching safety governance arrangements	• Progress against PSIRF work plan is monitored through the trust improvement group that reports into the system improvement group • The Board receive updates about PSIRF and requirements, through direct reporting structures into board meetings via monthly trust improvement group highlight reports • Patient safety incident reporting and associated trend data are communicated to the Trust Board via Quality Governance Group Quality and Safety Committee • Updated incident management processes reflected within this policy, ratified by Trust Board, will reflect updated roles and responsibilities as well as the training and processes; developed to meet PSIRF requirements • We are working to update our ward to board reporting format to incorporate greater emphasis on trend analysis

	and the link between safety actions, improvement and improvement planning, as well as PSIRF oversight question responses
Quality assure learning response outputs	• In preparation for PSIRF transition we are embedding updated and strengthen processes for incident management, learning responses, quality improvement and oversight; so that we can monitor through improved report formats from division through to board and to ensure we can demonstrate compliance against patient safety incident response standards. This will assure the board on the quality of learning responses and efficacy of improvement work being undertaken • The trust has, through this policy, moved to an oversight structure that will ensure there is executive level scrutiny and quality assurance for patient safety incident investigations, other learning responses and KPIs linked to statutory requirements and patient safety incident response standards • Existing reporting structures will communicate assurance through to board • This policy and the plan documents will be reviewed after 12 months of implementation, in recognition of significant amount of improvement work underway in year • Training required by our staff in line with HEE patient safety syllabus has been sourced and commissioned. There is mandated requirement for all staff to complete Level 1 training and this is monitored through divisional training compliance reports

Complaints and appeals

We know that changes to how we undertake patient safety incident responses arising through how we embed PSIRF will mean that we must carefully and openly discuss the rationale for the use of different types of learning responses we will be using with those involved with patient safety incidents. This ensures that it is clear about why we are choosing to learn in different ways and how our approach maintains the individual nature of a review of care.

Through strengthening our approach to engaging those affected by patient safety incidents, we will be responding to any specific areas of concern that need to be incorporated in learning responses very early on in the process. This seeks to mitigate the likelihood that those involved in patient safety incidents may be dissatisfied or remain concerned about patient safety issues due to how we have responded to an incident they have been involved in and our learning actions arising as a result.

We recognise that despite this approach, our patients, their families and friends may have concerns or raise a complaint in relation to how we have responded to a patient safety incident. We are committed to supporting them through this process and being timely in our responses.

A complaint is any expression of dissatisfaction with the Trust's care, services or facilities that requires a response. Comments, questions, concerns, general enquiries, or suggestions are not complaints, although provide timely and accurate information and advice.

In line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (SI 2009:309) and the Local Authority Social Services and National Health Service Complaints (England) (Amendment) Regulations 2009 (SI 2009:1768) and the Health and Social Care (Community Health and Standards) Act 2003, the trust has specific processes through which concerns and complaints are responded to, the standards and timeframes to be followed are set out within our Policy for Listening and Responding to Concerns and Complaints (Appendix 1).

Learning that arises from complaints or concerns relating to the patient safety incident management and response processes will be fed back into improvement work for our processes, policies and procedures through the corporate risk and safety team, via our Patient Advice and Liaison Service or Complaints team.

Appendix

1. Listening and Responding to Concerns and Complaints Policy

Listening and Responding to Concer

2. Just Culture support mechanism

COCH Just culture support mechanism

3. Duty of Candour and Being Open Policy

Duty of Candour Policy final.docx

4. Patient Safety Incident Response Reporting and Management Policy

Patient Safety Incident Reporting a

5. COCH PSIRF Plan

CoCH PSIRF Plan .pdf

6. Claims handling policy

CLAIMS HANDLING POLICY Jan 2021.doc

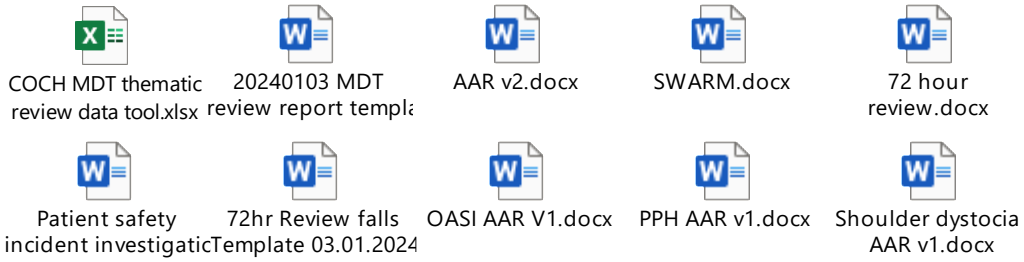
7. Disciplinary policy

The disciplinary policy has recently been updated and ratified, it will be implemented in 1 March 2024.

8. Supporting and Involving People Involved in Patient Safety Incidents

9. Freedom to speak up (whistleblowing) policy

10. Learning response templates



1. Checklist for Approval of Policies

		Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear that the document is a Trust policy?	Yes	
2.	**Rationale**		
	Are reasons for development of the policy stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	

		Yes/No/ Unsure	Comments
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	No	It will be reviewed in January 2024. It is not anticipated there will be any significant amendments.
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document include version history and identify key changes since the last approved version?	Yes	
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable (Default is 3 years)?	Yes	
11.	**Overall Responsibility for the Document**		

		Yes/No/ Unsure	Comments
	Is it clear who will be responsible for coordinating the dissemination, implementation, and review of the documentation?	Yes	

The policy author is responsible for completing the above checklist prior to submission for approval.

2. Equality Analysis

Equality Analysis (EA) for Policies	
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the need to achieve the following objectives in conducting their functions: a) Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by orunder the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic andpersons who do not share it. c) Foster good relations between persons who share a relevant protected characteristic and personswho do not share it.	
Policy Name	**Patient Safety Incident Response Framework Policy**
Policy Overview	This policy aims to provide guidance on the management of all levels of harm reported through the Trust's incident reporting system – Datix. It should be read in conjunction with the PSIRF plan. The policy and plan describe which learning responses the trust should enact to examples of types of incidents. This policy will run alongside the updated Incident reporting and management policy until such time the two can be amalgamated to create one policy, when the trust has fully transitioned to and embedded PSIRF methodology for the reporting, response and management of patient safety incidents.
Relevant Changes (if any)	This policy in line with national mandatory changes implemented by NHS England from 2022. It is expected the trust will commence transition to PSIRF before 1 April 2024.
Equality Relevance Select LOW, MEDIUM, or HIGH	High
If the policy is LOW relevance,you **MUST** state the reasons here.	

Form completed on:	26 January 2024	
Form completed by:	Bev Hunt	Quality Governance Business Partner (Women & Children's division)

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (See '**Equality Relevance**' to assess the impact on each protected characteristic)	**Protected Characteristic**	**Mitigation**
	Age All patients of all ages have the potential to be involved in a patient safety incident. We need to understand from our data – what is it telling us, for example what is the most common age group affected by incidents, complaints, and friends & family test. Another resource to benchmark our performance is utilising information from system partners, for example model hospital and GIRFT.	FFT: data is currently not rich enough. A robust action plan over the next two years to improve FFT responses and maintain the feedback loop is required. The trust is currently planning how this can be improved. The key findings of the data will influence the mitigation plan and how specific age groups will be targeted.
	Disability We need to understand from our data – what is it telling us, for example what is the most common disability group affected by incidents. National data tells us people with learning disabilities have a shorter life expectancy and are more likely to have poor outcomes during an episode of healthcare provided in secondary care settings. We need to know the baseline of patients with disabilities and incidents (even if that is zero). We will then be in a position to audit determined metrics, and work toward meeting the priorities of the trust in line with it's new strategy from 2026. We will then have possession of rich disability data and we will understand if appropriate improvements have been implemented through performance trend analysis going forward.	There is limited data at COCH on people with learning disabilities and the incidence of clinical safety events. This demographic need to be included in a focus consultation to provide lived experiences and advice on how we can improve. The trust has commenced an inclusivity group to capture feedback to improve the provision of care and reduce the risk of patient safety incidents within this group of patients. All staff now must complete the Oliver McGowan training for LD awareness. The EDI annual report provides data for training compliance.

	Gender reassignment We need to understand from our data – what is it telling us, for example if trans people are affected by incidents, are more likely to complain or raise concerns, and complete the friends & family test. This data can be difficult to capture in view of patients' preference not to disclose their gender or reassignment.	This demographic need to be included in a focus consultation to provide lived experiences and advice on how we can improve. There is an opportunity to link in with local LGBTQ+ groups, mindful confidentiality and GDPR must be adhered.
	Marriage & Civil Partnership The trust can currently capture data on partnerships within its electronic patient record system called Cerner. This information needs to be scrutinized to understand this group.	We need to understand what steps the trust is undertaking to ensure inclusivity for patients with partners who may have a disability. For example, when we need to break bad news to a patient about their diagnosis and prognosis when the patient has significant hearing loss/ profoundly deaf – there may be a need to include their partner to perform sign language. When we have sight of the volume of patients and our geographical population in this demographic, we can plan resources required by the trust to ensure inclusivity of disabled people.
	Pregnancy or Maternity/ Paternity The Women & Children's division capture rich data on pregnant women who choose to use the maternity services at COCH. This data is exported externally to various arm's length bodies to feed into national datasets. The trust is currently planning requisite resources in line with the new purpose built Women and Children's Unit, which is currently in construction. The resources being planned are sufficient safe workforce to safely deliver care in a majority single occupancy facility.	The trust has a project management team in post working on both the construction of the building and undertaking a system analysis to understand necessary resources. Business cases will follow to ensure the trust are prepared for the numbers of pregnant women accessing our services and the receive the appropriate care throughout their pregnancies and in the early postpartum period. The building is currently on schedule to open in late spring 2025.

	There is a high likelihood the number of women who book at COCH will significantly increase – as has been seen in other trusts across the region when they have opened new facilities.	
	Race There is ability to capture race/ ethnicity data within the electronic patient record system (Cerner). However, a targeted piece of work needs to be undertaken to analyse it and understand if our patients' ethnicity is a factor in raised poor outcomes and is representative of the geographical local population. Additionally, we need to understand if English not the first language is a blocker to quality care, for example.	We know last year women from a BAME background were disproportionately represented in local peri-natal mortality data. Of the ten infant deaths five were from BAME backgrounds. This requires further interrogation to understand any commonalities and if it is disproportionate to the local population. A wider piece of work is required to capture ethnicity within the incident reporting system so we can analysis all incidents, morbidity and mortality.
	Religion or Belief Data from patients' health records captures religion. This requires analysis to understand what would help patients from a variety of religious faiths and no faith. The trust has a multi-faith chaplaincy service and chapel.	It would be useful to understand the ethnicity of all our patients, notwithstanding some people prefer not to disclose for personal reasons. An audit of our patients' ethnicity should be conducted annually, in line with the Workforce Race Equality Standard (WRES) report, and cross reference with patient safety incidents involving minority groups.
	Sex Data is captured on our patients' gender. This is a key clinical metric to document as medical comorbidities can affect men and women slightly differently. The NHS has a national standard to safeguard same sex clinical environments to protect the dignity of patients while in hospital. The hospital reports breaches of this through Datix.	The trust could audit if a specific sex is disproportionately represented in patient safety incidents – by type of incident, such as falls. The trust completed a small thematic analysis in July 2023 of several falls with harm incidents – there was no significant difference in gender. These findings align to a national report by NHS Resolution of falls I n the Emergency Department (2022). This type of response to harm will become more common through PSIRF principles to focus on improvements rather than investigation. Therefore,

		the trust will have greater understanding of commonalities in patient safety incidents relating to sex.
	Sexual Orientation We should scrutinize incident and complaints information to understand if we monitor this data.	An internal focus group consultation is required to ask the LGBTQ+ community for advice on inclusivity and equality regarding PSIRF. We should utilise model hospital information to know what the comparable data from neighbouring trusts looks like. The trust will need to review national reports for health outcomes for this group.
	Human Rights (FREDA principles) Data for inclusion groups, such as the 20PLUS5 groups (the most vulnerable in society) is not consistently collected within the electronic patient record and in Datix. Therefore, knowledge of incidence of this group being affected by a patient safety incident is low.	The trust should consider how to promote inclusion of this information in patient records and how it can be easily extracted, so we might understand the incidence. The trust could consider an outward look approach to look outside our organisation to work collaboratively and understand how we can prevent incidents for this demographic.

Equality Information & Gaps What equality information is available for protected groupsaffected by the policy? If none are available, include steps to be taken to fill gaps.	Workforce equality information is available at COCH. The data for patients is variable for each of the protected characteristics. The gaps for each of the nine protected characteristics is detailed in each of the sections above.
Stakeholder Engagement What stakeholders are engagedto help understand the potentialeffects on protected groups? See '**Gunning Principles**' forpublic consultation requirements. **How has consultation influenced the policy?**	There are several stakeholders required to ensure we can capture the data of the trust's position, in terms of equality and inclusion for all the protected characteristics. The data needs analysis by suitably trained person/ people. External collaboration with demographic groups as highlighted in the sections above. Information from these groups will determine next steps.
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	There some associated policies embedded within the PSIRF policy, which are currently affected. Some policies may not be affected for longer than a year or two as the trust fully embeds PSIRF management of patient safety incidents. Such policies will be reviewed with the PSIRF policy for relevance.

Public Sector Equality Duty Include a summary of how eachof the PSED requirements have been considered to demonstratecompliance with the Act.	a) Eliminate discrimination, harassment, victimisation through taking cognisance of patients with a protected characteristics I.E. Disability thereby mitigating and managing risks and reducing safety incidents.
	b) Advance equality of opportunity through identifying trends and address specific areas of concerns relating to patients with a protected characteristics I.E. over-representation of women from BME Backgrounds across perinatal case reviews.
	c) Foster good relations by involving patients and families with protected characteristics in the local population, attending community groups or recruiting a Patient Safety Partner with a protected characteristic.
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐
Monitoring Include details of how theequality impact will be monitored.	The policy will be monitored annually with results published within the Trusts Equality Delivery System Assessment Report.

Approval & Ratification of Equality Analysis		
Policy Author:	Ana Sanderson	Associate Director of Quality Governance
Approval Committee:	Quality Governance Group	Date approved: 14/12/2023
Ratification Committee:	Quality and Safety Committee	Date ratified: 15/01/2024
Person to Review Equality Analysis:	Surendra Shroff	Review Date: 31/01/2025
Comments:	Impact analysis completed by Bev Hunt with Surendra Shroff	24/01/2024

If **MEDIUM** or **HIGH** relevance, the EA should be reviewed annually. Complete Approval and RatificationSection.

Review of Equality Analysis (If indicated)	**Rationale for review:**	
	Changes made:	**Reason for change:**