West Suffolk NHS
NHS Foundation Trust

Trust Policy and Procedure **Document ref. no: PP(24)500**

Patient safety incident response (PSIRF) policy

For use in:	The Trust
For use by:	All staff
For use for:	Patient safety incident response
Status:	Final

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Contents

Purpose

This policy supports the requirements of NHS England's Patient Safety Incident Response Framework (PSIRF) and sets out the West Suffolk NHS Foundation Trust (hereafter referred to as WSFT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and events for the purpose of learning and improving patient safety. Patient safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare (NHS England).

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Further information about the PSIRF can be found on the NHS England website[1] and on our local patient safety intranet microsite.

This policy sets out the processes we have put into place to support development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and events
- supportive oversight focused on strengthening response system functioning and improvement.

Our patient safety incident response policy should be considered in the context links to the following documents:

- WSFT Patient Safety Incident Response Plan (PSIRP)
- Strategy for Patient Safety 2022-2026
- PP197 'Being Open – The Duty of Candour'
- PP056 'Freedom to speak up policy'
- PP198 'Supporting staff during an investigation of an adverse incident, complaint or claim'
- PP002 'Formal complaints and concerns management'
- PP350 'Learning from Deaths policy'
- SNEE Policy for a cross learning response requiring ICB coordination.

[1] NHS England - Patient Safety Incident Response framework

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement at WSFT and with our system partners.

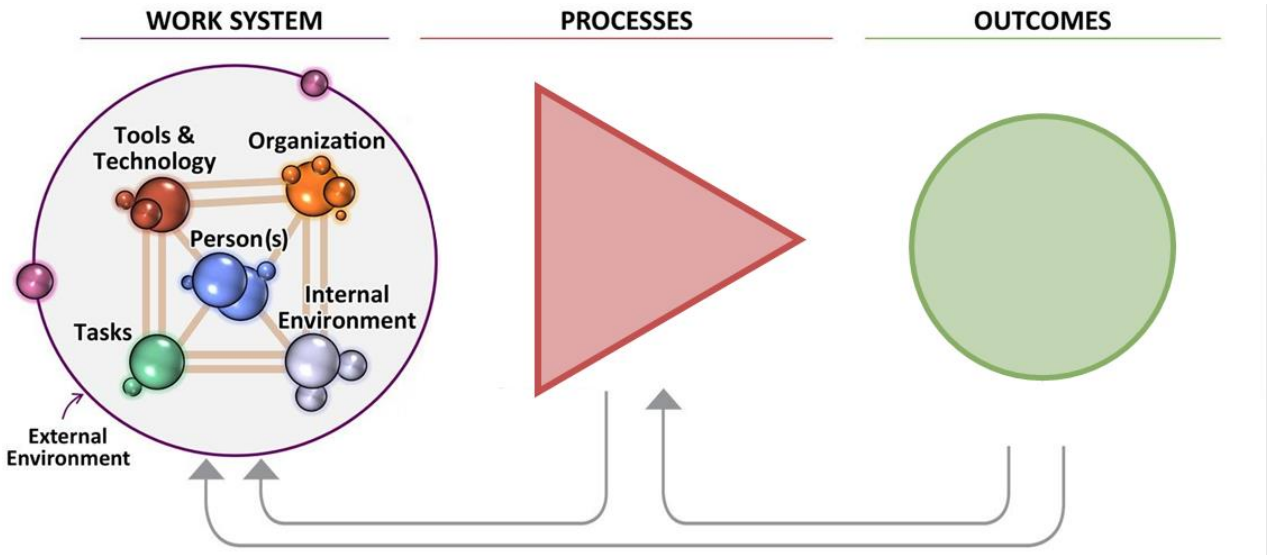
Learning responses under this policy follow a systems-based approach because healthcare is dynamic, variable, and uncertain and relies on interactions which are both human and technological and are referred to socio- technical.

WSFT uses the SEIPS (System engineering Initiative for Patient Safety, Fig 1). Our aim is to understand outcomes by understanding our work system, made up of people, who are central to healthcare, the organisation, our environment, our tools and technologies and the task that needs to be completed. These factors can all influence our work processes, or how we do things. The outcomes will help shape safety improvement.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

Fig 1. SEIPS model[2]



[2] NHS England - SEIPS quick reference guide

Our patient safety culture

The Trust is committed to a culture which promotes openness, honesty and that focuses on improving practice, rather than focusing on individual deficiencies and blame. The board of directors accepts that fear of disciplinary action may deter staff from reporting incidents and has therefore chosen to adopt an open approach, where all reports are viewed as an opportunity to learn rather than punish.

The Trust advocates a fair and just system where staff are held to account for their actions and behaviours, without being unduly blamed. Every effort is made to ensure that reported incidents are managed and investigated positively as a way of improving safety through learning by creating a culture of fairness, transparency, and openness. We use the principles which embed a just and restorative culture, that is to understand who has been harmed, what they need to find resolution and who is best to support them in this.

We are using the NHSE 'Improving a Patient Safety Culture' guide to help us mature in our approach to safety culture whilst we develop a suite of metrics which will help us measure and support the initiatives we introduce.

Patient safety partners

Our organisation has undertaken a commitment to involve patients in organisational safety through the adoption of the Patient Safety Partner (PSP) role. Recruitment and retention of PSPs is one of the key ambitions of our local patient safety strategy.

PSPs are patients or other lay persons who can support and contribute to a healthcare organisation's governance and management processes for patient safety through a range of activities including membership of safety and quality committees, involvement in patient safety improvement projects, participation in safety oversight groups and development of safety strategies.

Our WSFT PSPs will form an important part of our process to agree our annual patient safety incident response plan (PSIRP) as well as the evaluation of its implementation and effectiveness.

More information about PSPs can be found on the NHS England website [3].

[3] NHS England - Framework for involving patients in patient safety

[4] improving-patient-safety-culture-a-practical-guide.pdf

Patient safety specialists

The requirement for every NHS organisation to have one or more Patient Safety Specialist is identified in the NHS standard contract.

The trust has four Patient Safety Specialists (PSSs) who work together as a team to ensure all the requirements of the role are met. PSSs provide senior leadership, visibility and expert support to the patient safety work taking place at WSFT. See 'Oversight role and responsibilities' section for further information.

Patient Safety subject matter experts

The trust has patient safety subject matter experts/speciality leads who work alongside the patient safety team to ensure additional patient safety oversight.

See 'Oversight role and responsibilities' section for further information.

Addressing health inequalities

We are committed to providing a fair system for all and by applying a flexible approach and better use of safety insight we can identify disparity in the care we deliver to all. We use systems thinking, not a person-focussed approach to patient safety investigation as this provides a better understanding of the complex system we work in which is without prejudice and better able to help identify inequalities.

Staff are asked to complete the Level 1 of the national patient safety syllabus as part of their mandatory training, and this sets the scene for understanding safety and risk in relation to health inequalities. Staff are also able to access our patient safety education programme (in development) which sets out how we approach systems thinking for patient safety investigation, human factors and how we involve and engage patients and staff to support this approach. This will support the development of a just culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

Engagement

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. This is underpinned by the involvement principle in the NHS patient safety strategy. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and ensure support is available should this be needed.

Engaging and involving patients and families

The NHS patient safety strategy recognises the importance of involving patients, their families and carers and other lay people in improving the safety of their care. The strategy gives us two clear directions for how we can achieve this, by involving patients and their families in their own safety and by working with patient safety partners in organisational safety.

In September 2005 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice calling on all NHS organisations to develop local 'Being Open' policies with the aim to provide a framework for communicating patient and service user safety incidents that lead to moderate or severe harm to the patients, service users and/or their carers.

Our Trust policy **PP197 'Being Open – The Duty of Candour'** sets out in more detail how we communicate with patients, their families and/or carers following a patient safety incident as well as the process we have in place to ensure this is undertaken in a timely and compassionate way.

Engaging and involving staff

Our staff are integral in enabling effective learning from incidents. It is important to remember however that our staff are human beings who may experience emotional trauma following a patient safety incident which, managed badly can result in feelings of distress, self-doubt and fear which may persist long after the original incident.

A just and supportive culture (see 'Our Patient Safety culture' section) enables the engagement and involvement of our staff in incident investigation in such a way that maximises learning whilst supporting their emotional wellbeing. We seek to understand what is like to do their role and walk in their shoes so we can better understand how our systems interact together. We do this by meeting and talking with staff, observing practice and engaging to understand ideas for safety improvement.

Our Trust policy **PP198 'Supporting staff during an investigation of an adverse incident, complaint or claim'** sets this out in more detail.

Networks available to support staff following a patient safety incident are available and include our staff well-being service, our peer-to-peer support network for doctors, professional nurse and midwifery advocacy service. Support, advice and guidance is readily available from the patient safety team and can be accessed via all regular communication channels.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Our patient safety incident response plan (PSIRP)

Our current PSIRP can be found on the WSFT patient safety intranet pages.

The PSIRP sets out how WSFT intends to respond to patient safety incidents over a period of no less than 12 months. The plan is renewed at the juncture in which we have collated themes and areas for improvement from the current PSIRP. This is done by a series of engagement workshops asking all colleagues to input with their safety concerns. We triangulate this with safety, quality and governance insight from our quality and risk management systems. The Patient Safety team 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. Our overall aim is to widen the scope of patient safety data sources and to include more of the patients' voice in each iteration of the plan.

Utilising a variety of safety data sources enables identification of key risk areas to include in the PSIRP. It also helps pinpoint topics to exclude from a new plan, such as those where improvement work is already underway or significant learning has occurred, making further scrutiny unlikely to yield additional insights. For these topics, the organisation's focus is better directed towards safety improvement.

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 over a period of no less than 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

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

Responding to patient safety incidents

Patient safety incident and reportable occurrence reporting arrangements

The Trust's risk management system Radar should be used to report an incident or reportable occurrence which has resulted in or could have resulted in physical or psychological harm to a patient, member of staff or other person (volunteers, visitors, contractors etc.) or if, as a result of the incident, there has been harm to the Trust, or if, as a result of the incident, there has been harm to the operational management of the Trust.

All incidents and reportable occurrences should be reported as soon as the staff member is able. Further information can be added to the event using the risk management system at a later date if required.

Definitions – incident and reportable occurrence

Incident: any event or circumstance arising that could have, or did, lead to unintended or unexpected harm, loss or damage to a person, property or the organisation.

An incident can cover a wide range of situations but generally a reportable incident is an event that contains one or more of the following components:

- Harm (physical or psychological to individual
- 'Near miss' (where harm may have occurred had action not been taken to prevent it)
- Damage to the infrastructure or property of an individual or the Trust
- Disruption to services provided by the Trust
- Financial loss to an individual or the Trust

Reportable Occurrence: any event that meets all of the follow criteria:

- It requires the collation of a set of data items specific to that item
- It relates to a specific safety topic but is not a patient safety incident
- It has a specific definition that can be used to ensure consistent data capture

A list of the agreed WSFT reportable occurrence events can be found in the Internal team document – Patient Safety and Quality team Risk Management system (Radar) SOP.

WSFT risk management system

The risk management system in use at WSFT is Radar Healthcare. Everyone who works for the Trust is able to use the system to report events (including incidents and reportable occurrences).

Timeframes for learning responses

Proportionate response timeframes

Patient safety learning responses at WSFT start as soon as possible after the event has been identified.

The timeframe is agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions. The timeframe for completing a patient safety incident investigation forms part of setting the terms of reference.

PSIIs (and other local response) should take no longer than six months, but this must not become a new default target. If our response is taking more than 6 months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).

The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

All other incidents and reportable occurrence investigations should be completed and closed within an appropriate timescale. The Radar system has defined timeframes within the system to manage this process and measure its compliance.

Type	Frequency	Responsibility*
Incident triage	Daily excluding weekends/bank holidays	Patient Safety Managers
RO triage – new pressure ulcer (Cat 3 or 4)	Daily excluding weekends/bank holidays	Patient Safety Managers
RO triage – all other	Weekly	Radar central team
Incident and RO learning outcomes	Within one month	Location Managers with oversight from 'Oversight leads' and 'Subject Matter Experts' (SMEs) as required/appropriate
Incident and RO action plan review	Within one month	Location Managers with oversight from 'Oversight leads' and 'Subject Matter Experts' (SMEs) as required/appropriate
Quality control with final close	Quarterly	Radar central team

*An overview of the roles within the risk management system can be found in Appendix 1.

The risk management system (Radar) will send an automated notification on a weekly basis (Monday) to staff regarding open (in date) and overdue workflow tasks and actions.

Education and training

WSFT risk management system (Radar)

Radar training is available to all staff via the learning platform Totara which can be accessed via the Staff Intranet.

Both the Patient Safety & Quality and Radar Central team can offer further support to WSFT staff as and when required.

Patient Safety Education Programme

The Trust will ensure all staff have access to patient safety training and will continue to monitor compliance. Patient safety syllabus training level 1 is mandatory and is available for staff to access via the Trust learning platform Totara.

The WSFT patient safety education programme has been developed and enables staff to further understand how we apply the principles of a strong patient safety culture in practice at our Trust. The WSFT patient safety education programme is delivered in modules and these are grouped within five programmes:

1. Systems thinking for patient safety
2. The learning response to patient safety incidents
3. Human factors for patient safety
4. Engagement
5. Learning into improvement

Further details on how to access the programme can be found via the Staff Intranet.

Definitions - Harm

NHSE's description of the different levels of harm[4] below have been adopted by WSFT and are in place within the risk management system.

Physical harm

No physical harm

- No physical harm

Low physical harm

Low physical harm is when all of the following apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions.

[4] NHS England » Policy guidance on recording patient safety events and levels of harm

Moderate physical harm

Moderate harm is when at least one of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe physical harm

Severe harm is when at least one of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as Death in the National Reporting and Learning System NRLS)[5]

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm

[5] Replaced by LFPSE within WSFT April 2024.

Low psychological harm is when at least one of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm

Moderate psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm

Severe psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Learning from Patient Safety Events (LFPSE)

The 'Learn from Patient Safety Events' (LFPSE) service is a national NHS service for the recording and analysis of patient safety events that occur in healthcare. LFPSE questions are mandatory within the WSFT risk management system as they are used by NHS England to undertake analysis at a national level. The data from this national system provides insight to support the development of national patient safety alerts and national safety campaigns.

Never Events

The NHS England Never Events policy and framework[6] sets out the NHS's policy on Never Events. It explains in detail what they are and how staff providing and commissioning NHS-funded services should identify, investigate and manage the response to them.

In summary, Never Events are defined as incidents that meet the following criteria:

"They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers".

All incidents that are felt to meet this criteria are bought to the weekly Emerging Incident Review (EIR) meeting for discussion and to determine investigation pathway.

Duty of candour

Our Trust policy **PP197 'Being Open – The Duty of Candour'** sets out in detail how we communicate with patients, their families and/or carers following a patient safety incident as well as the process we have in place to ensure this is undertaken in a timely and compassionate way. The Trust has a responsibility to ensure that the Duty of Candour requirements are met and that the DOC section of the incident/reportable occurrence workflow is completed for all moderate and above incidents to evidence that this has been completed.

Arrangements for Duty of Candour are discussed at the weekly EIR.

Patient safety incident response decision-making

There is an expectation that local areas will review incidents at the time they are reported. This policy sets out the steps that are in place in addition to that local immediate scrutiny.

On a daily basis (Monday to Friday, excluding bank holidays)

A report ("yesterday's incidents") is produced by the Patient Safety and Quality team. The Safety Manager of the Day (SMOD) will review the report and will share incidents at the daily safety huddle. Any immediate mitigations required or wider sharing of information will be actioned at the huddle.

The SMOD is responsible for incident triage. Specialist teams are responsible for reportable occurrence triage according to subject. Further details can be found in the Internal team document – Patient Safety and Quality team Risk Management system (Radar) SOP.

Any incident which meets the definition of one of the subjects in the current PSIRP will be highlighted by the Patient Safety team and contact made with the clinical team providing care at the time of the incident. The primary focus of this initial contact is twofold:

[6] NHS England » Never events

- Confirm to the clinical team that the incident meets the definition of an incident requiring a patient safety response and their input will be required in the next steps. This should be undertaken sensitively recognising that, even in an environment that promotes psychological safety, staff may have anxieties.
- Ascertain any immediate duty of candour/being open conversations that are required (or that have already taken place). See WSFT Trust policy **PP197 'Being Open – The Duty of Candour'** for further details.

On a weekly basis (every Thursday lunchtime)

The Emerging incident review meeting (EIR) meets on a weekly basis. The group form a consensus opinion of the appropriate learning response of incident management as per our Patient Safety Incident Response Plan (PSIRP). Clinical incidents reported during a given reporting timeframe (notably Monday – Sunday of the previous week) will be reviewed by the EIR panel with invited relevant clinical membership. Further details regarding meeting expectations can be found on the Patient Safety and Quality pages on the WSFT intranet[7]. The group review all patient safety incidents which met one or more of the following criteria:

- It is (or appears to be) an incident meeting one of our current PSIRP categories
- It has an initial severity rating of severe or fatal
- Deaths referred by the Medical Examiners office and/or learning from deaths team judged to be more likely than not (>50%) preventable.
- Escalation of individual cases from divisional senior leadership (such as the clinical triumvirates) which require executive oversight

For each incident presented the group will consider:

- Category of harm and most appropriate pathway for investigation
- Identify any immediate safety mitigations
- Duty of candour requirements
- Establish if there are any additional staff support requirements
- Address any safeguarding concerns
- Understand if there will there be any media interest
- Notification and involvement of other organisations including our regional colleagues and regulatory bodies (see section External reporting and informing other key stakeholders).

Level of investigation response required

All incidents and reportable occurrences warrant follow-up and an exploration of events to understand what happened, how to prevent a recurrence and achieve organisational learning.

The level of investigation required will depend on a combination of incident category and severity grading and is summarised in detail in the trust's annual patient safety incident response plan (PSIRP).

[7] Presenting at an EIR - West Suffolk NHS Intranet (wsh.nhs.uk)

Where a patient safety incident meets the definition of one of our current PSIRP categories, the allocated response will be as per the PSIRP.

If an incident severity is confirmed as fatal but it does not meet any of the PSIRP categories (including the national 'possibly preventable death' category) then the meeting may agree a proportionate response from the range of options available (see below). It does not require any specific response by virtue of its severity alone.

If an emergent issue is identified that warrants scrutiny although it is not currently reflected in the PSIRP then consideration will be made as to the best method for a proportionate response including how resources will be allocated to support this response.

WSFT Investigation responses (types)

Investigation response	Explanation
Patient Safety Incident Investigation (PSII)	A human factors systems-based investigation which offers an in-depth review of a single patient safety incident or cluster of incidents to help us to understand what happened and how. The template can be found in Appendix B.
Patient Safety Review (PSR)	Identifies key learning from an incident and uses this information to help to identify the improvement opportunities which can increase patient safety in the future. The template can be found in Appendix C.
After Action Review (AAR)	An AAR is a structured facilitated discussion of an event, the outcome of which identifies how and why the outcome differed from that expected. It captures the learning which will drive improvement. The template can be found in Appendix D.
Patient Safety Audit (PSA)	Used for high volume, low harm incidents to measure incidents that have occurred against a set of expected standards.
Local investigation	Used to investigate incidents at a local level using the templates on the incident reporting system for learning and to guide improvements.
Structured Judgement Review (SJR)	The application of a case record review to determine whether there were any problems in the care provided to the patient who died, to learn from what happened. SJRs are allocated following national and local priorities, and the reviewer will look at the death classification to identify potential serious harm and death preventability factors. Deaths are classified using the Hogan et al (2012) scale: 1. Definitely not preventable 2. Slight evident of preventability 3. Possibly preventable but not very likely, less than 50-50 close call 4. Probably preventable, more than 50-50 but close call 5. Strong evidence of preventability 6. Definitely preventable

External reporting and informing other key stakeholders

Depending on the type of incident, it may require reporting to an external agency or key stakeholder, for example, the Care Quality Commission, the Health & Safety Executive or the Information Commissioner. Below is a list of agencies that require and receive notification:

Organisation	Further details
Care Quality Commission	Will be notified of specific clinical incidents including 'Never Events' through the LFPSE.
Coroner	Will be notified of all incidents involving reportable deaths as described in the Trust policies: 'Release of body' (CG10187) and 'Coroners Bodies' (PP156).
Health and Safety Executive	Will be notified of all incidents that are reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 by the Risk Office.
Health Protection Agency (Centre for Communicable Diseases Control (CCDC)	Will be informed of major outbreaks and infection incidents via the lead doctor for Infection Control.
MNSI (Maternity and Newborn Safety Investigations)	Will be notified of all maternity incidents meeting the criteria specified by MNSI and Each Baby Counts.
Human Tissue Authority (HTA)	Will be notified of any reportable incident involving the use of human tissue by the trust's HTA lead using the HTA on-line reporting form.
Information Commissioner	Serious incidents involving personal data loss must be reported in accordance with the Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation. Incidents must be reported within 72 hours via the Data Protection Officer (DPO).
IR(ME)R	Requires notification of incidents under the Ionising Radiation (Medical Exposures) Regulations 2000. This is undertaken by the Radiology Department.
LADO (Local authority designated officer)	For cases of concerns for a person in a position of trust.
MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	Will be notified of all maternity incidents meeting the notification criteria specified by MBRRACE by Maternity Quality and Safety Team.
Medicines and Healthcare Regulatory Authority (MHRA)	Will be notified of incidents involving medical devices that have harmed or had the potential to harm a patient/member of staff via EBME Manager and all incidents involving defective drugs via Pharmacy Department. Will be notified of incidents involving serious adverse events and serious adverse reactions related to blood and blood components via the Hospital Transfusion Team.
Learning from Patient Safety Events (LFPSE) Service	Will be notified of all patient related incidents (data anonymised) via the online reporting portal.

LeDeR (Learning Disability Mortality Review)	Will be notified of a death of someone with a learning disability or an autistic person.
NHS Protect	Will be notified of incidents involving fraud and bribery by the Local Counter Fraud Specialist and all incidents of theft and physical violence against staff via the Local Security Management Specialist.
The Department of Health (Estates & Facilities Division)	Will be notified of incidents involving the plant, non-medical equipment malfunction or fire by the Trust's Facilities Directorate under the 'defects & failure reporting system'.
NHS Resolution	Will be notified of incidents that represent a significant litigation risk via the Legal Services department. This will include maternity incidents qualifying for the Early Notification Scheme.
Preventable deaths	Deaths referred by the Medical Examiners office and/or learning from deaths team judged to be more likely than not (>50%) preventable. Reported externally as appropriate.
Police	Will be notified of incidents involving any suspected criminal activity via senior management.
Safeguarding.	The trust is committed to safeguarding and promoting the welfare of vulnerable children and adults. Any reported incident pertaining to safeguarding will be escalated to the Trust's safeguarding team and communicated to the relevant external partner agency as appropriate (i.e., police, social care, County safeguarding team) In some circumstances these incidents may need to be reported to sub groups of the adult and children's safeguarding boards.
Screening Quality Assurance Service (SQAS).	When a screening safety incident is suspected or declared, the provider will notify SQAS (region) and the PHE screening and immunisation team embedded in/associated with the commissioner of the service. The NHS screening programmes covered by this guidance are: breast screening programme, cervical screening programme, bowel cancer screening programme, diabetic eye screening programme, abdominal aortic aneurysm screening programme, fetal anomaly screening programme, infectious diseases in pregnancy programme, sickle cell and thalassaemia programme, newborn blood spot programme, newborn hearing screening programme and the newborn and Infant physical examination programme.
Serious Hazards of Transfusion (SHOT)	Will be notified any serious adverse reactions and events related to blood components via the Hospital Transfusion Team.

Other organisations and incident sharing

Incidents reported on the Trust risk management system (Radar) that relate to another organisation (e.g., mental health, ambulance service or other NHS Trust) will be communicated to the relevant safety leads at that organisation by the Radar central team. A record of the incident will be held on Radar to enable feedback to the local incident reporter once feedback has been received.

Incidents that are received from other organisations about WSFT care (e.g., a Safeguarding concern about WSFT care) will be input onto the Trust risk management system by the

Radar central team who will provide feedback to the external organisation on completion of the incident investigation.

Investigations involving the Police and/or HSE

Where an incident requires investigation by the police and/or HSE and information is required to be shared, the Trust will follow the guidance contained in the Trust **Data Protection Policy (PP110).**

Process for staff to raise concerns via Freedom to Speak Up

In a positive safety culture, most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage staff to explore this option – it may well be the easiest and simplest way of resolving matters. However, staff have other options in terms of who they can speak up to, depending on what feels most appropriate to them. For further details, see **PP056 'Freedom to speak up' policy.**

Responding to cross-system incidents/issues

Where a cross-system learning response is required, the response should be led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit,[8] but organisations are required to work together and co-operate with any learning response that crosses organisational boundaries.[9] Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.[10] Therefore, the ICB will support the providers involved to identify a suitable lead for the investigation. Where providers cannot agree who should lead the investigation, the ICB will determine who is best to lead.

As per national standards, the ICB lead will liaise with relevant providers (and other ICBs if necessary) to 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.[11]

The **SNEE Policy for a cross learning response requiring ICB coordination** is available from the Head of Patient Safety & Quality.

[8] NHSE, *Patient Safety Incident Response Standards*, Aug 2022, page 12, via B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk), last visited 8 May 2024

[9] above, page 12

[10] NHSE, PSIRF supporting guidance, *Oversight roles and responsibilities specification*, August 2022, page 15, via B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk), last visited 8 May 2024. See also National Quality Board, *National Guidance on Learning From Deaths*, 2017: *All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate*

[11] National Quality Board, *National Guidance on Learning From Deaths*, 2017, via nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk), last visited 8 May 2024

Safety action development and monitoring improvement

Immediate safety actions

Safety actions are formally tracked following an investigation pathway using the Trust risk management system (Radar). Overdue safety actions will be flagged to staff responsible and their manager at regular intervals via an automated email and reported through appropriate governance processes (in development).

Areas for improvement

The Trust has adopted an organisational approach to wider areas for improvement. The Trust is currently exploring optimum way to review these to enable organisational wide improvement but recognises that collectively renewing output from learning responses helps understand system wide issues which will have a far-reaching impact in relation to safety improvement.

The patient safety team are responsible for undertaking a thematic analysis of all areas for improvement at the conclusion of the current years PSIRP and shared via the annual patient safety summit which is a trust wide event.

Safety improvement plans

WSFT Safety Improvement Group

The Trust Safety Improvement Group (SIG) will provide monitoring and oversight of organisational safety and quality improvement and progress the patient safety agenda for WSFT.

The ToR, agenda and membership are currently being reviewed to ensure the scope and objectives of the committee fulfil organisational learning.

Oversight roles and responsibilities

Role	Responsibilities
Chief Executive and Chief Nurse	The overall responsibility for effective risk management in the Trust, including incident reporting and management lies with the Chief Executive. At an operational level, the Executive Chief Nurse is the director designated with responsibility for governance and risk management. Accountability for management of financial (business) risk including the correct application of Standing Financial Instructions and Standing Orders lies with the Executive Director of Resources. The Executive Chief Nurse will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery. The Executive Chief Nurse's key responsibilities in respect of incident reporting and management are: • Notifying the Board of Directors of incidents reported as Never Events. • Notifying the Board of Directors of incidents considered as meeting the criterion of PSII. • Presenting reports to open and closed board which provide detail of new cases, issues of concern, outcome and learning and assurance.
Executive Directors	Responsible for ensuring that risk, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include: • Through a shared schedule of attendees ensure executive presence at panel meetings to coordinate the management of incidents meeting the requirements of the organisation's PSIRP.
Board of Directors	The Board of Directors has delegated authoring for incident reporting and management to the Patient Quality and Safety Governance (PQASG) group. The Board of Directors will be directly appraised of: • New PSIIs, claims, complaints graded as 'red' and dated inquest hearings. • Never Events • Performance against agreed Key Performance Indicators as part of the agreed performance monitoring arrangements (currently in development)

Improvement Committee	The key responsibilities of the committee shall be to provide assurance to the board in relation to: • The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board • The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust • Oversight of the delivery of statutory and mandatory requirements relating to Quality and Safety of care • Trust performance in relation to patient safety outcomes and effectiveness with particular focus on providing assurance to the Board on actions taken to address any major performance variations • Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community
Patient Quality and Safety Governance Group (PQASG)	The PQASG is responsible (as per its terms of reference) for identifying deteriorating trends and/or areas where the Trust is a potential outlier or underperformer, gaining assurance on effective and/or improving systems, seeking to understand the rationale for any improvement or deterioration in performance, identify and prioritise scope for improvement opportunities, ensure the best utilisation of resources (staffing/financial/information/training) and cooperative working to support patient safety and quality. It's key responsibilities in relation to incident reporting and management include: • approve and monitor relevant system measures • approving the Trust policy (this document)
Clinical Directors, Head of Nursing,	The key responsibilities in relation to incident reporting and investigation include: • Provide a point of escalation for any aspects of incident reporting
Patient Safety Specialists	• Provide dynamic, senior leadership, visibility and expert support • Have direct access to the Trust executive team, with the ability to escalate patient safety issues and concerns • Lead and support the local implementation of the NHS Patient Safety Strategy

Patient Safety Partners	• Actively involved in the design of safer healthcare at all levels in the organisation. • Sits on relevant committees to support compliance monitoring and how safety issues should be addressed • Provides appropriate challenge to ensure learning and change • Ensures that the committee/group of which they are a member considers and prioritises the service user, patient, carer and family perspective and champions a diversity of views.
Patient Safety and Quality team	Their key responsibilities in relation to incident reporting and investigation include: • Supporting the review of incidents • Supporting the statutory requirement for Duty of Candour • Providing suitable training to relevant staff on the risk management system • Identify issues arising from incident investigations for inclusion in the Trust clinical audit programme.
Radar central team	• Managing the Trust's system for reporting incidents and reportable occurrence and encouraging prompt reporting of these. • Sharing incidents related to other organisations and coordinating the sharing of learning back into WSFT • Ensuring the quality of incident reporting of all patient related incidents through the Learning from Patient Safety Events (LFPSE) service to NHS England
Patient Safety Incident Investigators	• Supports the Head of Patient Safety to provide Trust-wide oversight, assuring quality and effectiveness of all types of patient safety investigations as part of the Trust's annually agreed Patient Safety Incident Response Plan (PSIRP). • Undertakes robust patient safety incident investigations. • Provides senior leadership to the wider patient safety and quality team.
Subject matter experts/specialist leads	• Provide oversight and expertise of their specialist areas. • Liaising with statutory and other official bodies (as set out in section *'External reporting and informing other key stakeholders'*) • Support the completion of robust patient safety incident learning responses.

Divisional	Each division's key responsibilities in relation to incident reporting and investigation include: • Review incident data and trends • Addressing any significant concerns or issues. • Communicating any lessons learnt locally. • Ensuring all relevant lessons learned are shared both Trust wide and in the wider health community. • Escalating any significant concerns outside the control of the division to the relevant Trust forum. • Ensuring the timely completion of incident investigations by all staff within the division.
Triumvirate/senior leadership	Responsible for ensuring that risk including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include: • Addressing significant concerns/issues from incident investigation escalated by lead clinicians, heads of department, service managers and matrons or by local departmental/speciality meetings. • Ensuring that actions from incident investigations are implemented within given timescales. • Escalating any significant concerns outside the control of the senior leadership team to the relevant Trust forum. • Ensure appropriate action is taken to deliver divisional KPI's related to incident reporting and management.
Managers	• Ensuring that all incidents that occur in their area of responsibility are reported in a timely manner and in accordance with Trust policies and procedures. • Reviewing all Radar reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident. • Identifying learning and implementing actions as appropriate. • Review investigation of incidents reported for their area(s) of responsibility. • Informing their head of department, service manager and wider team of any lessons to be shared both Trust wide and in the wider health community. • Escalating any significant concerns to their head of department, service manager, matron, clinical lead or other appropriate individual. • Ensuring that staff are adequately supported following an incident and as required during an investigation. Support can be provided via their manager, the WSFT wellbeing service, and/or by referring the member of staff to the Trust's occupational health service. • Liaising with the human resources department regarding any precautionary measure, capability or disciplinary action

	proposed regarding a member of their staff following an incident.
Senior member of staff on duty when a significant incident occurs in a hospital setting	The member of staff must immediately: • Inform the Associate Director of Operations/Deputy Directors (or equivalent)/Clinical Director. If out-of-hours contact the Senior Manager on-call via switchboard who will manage the incident until the next working day. • Contact the consultant/medical team if the incident has involved a patient. The consultant must take any necessary clinical action to minimise the effect of the incident and also inform the patient and/or patient's relatives of what has occurred. In cases of death or serious injury, the consultant/medical team must contact the patient's next-of-kin. Where there is difficulty in locating the next-of-kin, the police may be contacted to assist. It is the responsibility of the patient's clinician to notify the Coroner of all cases of death as a direct result of an incident. If the consultant is unavailable, another consultant in the same specialty should be advised of the incident and asked to attend immediately. • Preserve the scene to prevent unauthorised entry or tampering with evidence, this may include taking photographs (consider whether consent is required) and recording the position of equipment and people involved in the incident. • Isolate/retain all evidence i.e. medical records, equipment, drugs and other documentation. This is particularly important where foul play is suspected/has been confirmed.
Senior member of staff on duty when a significant incident or unexpected death occurs in a community setting	The member of staff must immediately: • Inform the Senior Manager on duty. If out-of-hours support is required, contact the Community Manager on-call (via the Care Coordination Centre) who will manage the incident until the next working day. • Notify the GP if the incident has involved a patient death or serious injury. The GP will contact the police to notify of any unexpected death in the community. • Clinician must contact the patient's next-of-kin. Where there is difficulty in locating the next-of-kin, the police may be asked to assist. • It is the responsibility of the GP to ensure the Coroner is notified of all cases unexpected death in the community. • In the case of an unexpected child death the SUDIC (Sudden or Unexpected Collapse and Death in Infancy or Childhood) policy should be followed.
On call managers	On-call managers are responsible for co-ordinating and managing incidents requiring immediate actions during out-of-hours and at weekends in accordance with the Incident Procedure.

All staff	Staff responsibilities include: • Reporting incidents and near misses promptly. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf. • If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their Manager and completing a Trust incident on Radar. • Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence. • Engaging in the investigation of incidents and providing information if and when required.

Complaints and appeals

All incident investigations that have been assigned a learning response through our EIR meeting resulting in the production of a written report are shared with patients, their families and/or carers prior to a report being finalised. The patient, family and/or carer have the opportunity when talking the report through with the patient safety team to ask questions and voice any concerns. The only exception to this is when a patient, family or carer declines to be involved in the investigation process.

The patient safety team works closely with the complaints and PALS teams in any joint investigations.

Complaints management process

The Trust is committed to delivering personal care; providing an accessible, fair and effective means of communication for those who wish to express their concerns about care, treatment or services provided.

The trust is committed to:

- Resolving complaints in an open, efficient and courteous manner.
- Conducting a thorough investigation into any complaints or concerns raised.
- Being transparent including acknowledging, apologising and explaining when things do not go as we would hope.
- Meeting performance targets for the resolution of complaints as set out in the NHS complaints regulations 2009 and internal benchmarking.
- Identifying actions arising from complaints and ensuring improvements are made accordingly.
- Following the six principles of good complaint handling, as defined by the Parliamentary and Health Service Ombudsman:
- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

See PP002 **‘Formal complaints and concerns management’** for further information.

Legal proceedings

Reporting of an incident does not constitute an admission of liability by any person. However, incident report forms may be made available to all parties in the event of legal proceedings and it is therefore essential that they are completed accurately and factually. Never express opinions.

As an employer, the Trust is vicariously liable (responsible) for the acts and omissions of its employees undertaken in the course of their employment. Where it is considered that staff have acted in good faith, the Trust will take full responsibility in the event of any legal action arising from an incident.

Appendix A – Key Roles within risk management system

Role	Access
Super users	Radar central team
Essential role	Everyone in the Trust. This means that all staff members can report an event (incident, reportable occurrence).
Location manager and location deputy	This is the person who will investigate incidents for their area. One ward/team/department may have multiple location deputies for one area.
Oversight lead	This is a role (such as a service manager or matron) who can view incidents across a wider range of locations.
Subject matter expert	These are staff who have a specialist role to investigate a certain type of incident or reportable occurrence (e.g., safeguarding, tissue viability).

A further detailed permissions map is held centrally by the Radar team.

West Suffolk NHS
NHS Foundation Trust

Patient safety incident investigation (PSII) report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template

This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

Distribution list

List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.

You could consider referring to the patient by name or as ‘the patient’ according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Executive summary

Notes on writing the executive summary

To be completed **after the main report has been written.**

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs.

Contents

To update this contents table¸ click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

Appendices

Notes on appendices

Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

References

Notes on references

Include references to national and local policy/procedure/guidance, and other data sources as required.

Appendix C – Patient Safety Review template

Patient Safety Review (PSR)

Incident Number	
Incident Date	
Incident Type	
Department/Location	
Speciality	
Status of Report	

Report Details:

Author(s)	Job Title(s)	Report Date

Trust Sign Off:

Final Approver	Job Title	Date

1. BACKGROUND
Description of care/treatment that was provided
Description of incident
Actual severity of incident
How was the incident detected?
Involvement and support of patients and relatives *(Including Duty of Candour status)*
Involvement and support of staff
Terms of reference
Purpose To identify the key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients.
Objectives • To establish the facts i.e., **what** happened (*effect*), to **whom**, **when, where, how** and **why** • To establish what contributed to the adverse event • To look for improvements rather than to apportion blame • To establish how recurrence may be reduced or eliminated • To consider human factors and complete Yorkshire Contributory Factors Framework (YCFF) if required • To formulate *recommendations* for improvement • To provide a *report and* record of the investigation process & outcome • To provide a means of *sharing learning* from the incident • To identify routes of *sharing learning* from the incident

2. FINDINGS & CONCLUSIONS
What went well? Why?
What could have gone better? Why?
What immediate actions were put in place to reduce harm or mitigate recurrence?

3. Actions and Areas for Improvements			
Specific actions	**Responsible person**	**By When**	**Measuring effectiveness/ Evidence of implementation**
Areas for Improvement			
Arrangements for shared learning of notable practice and issues			

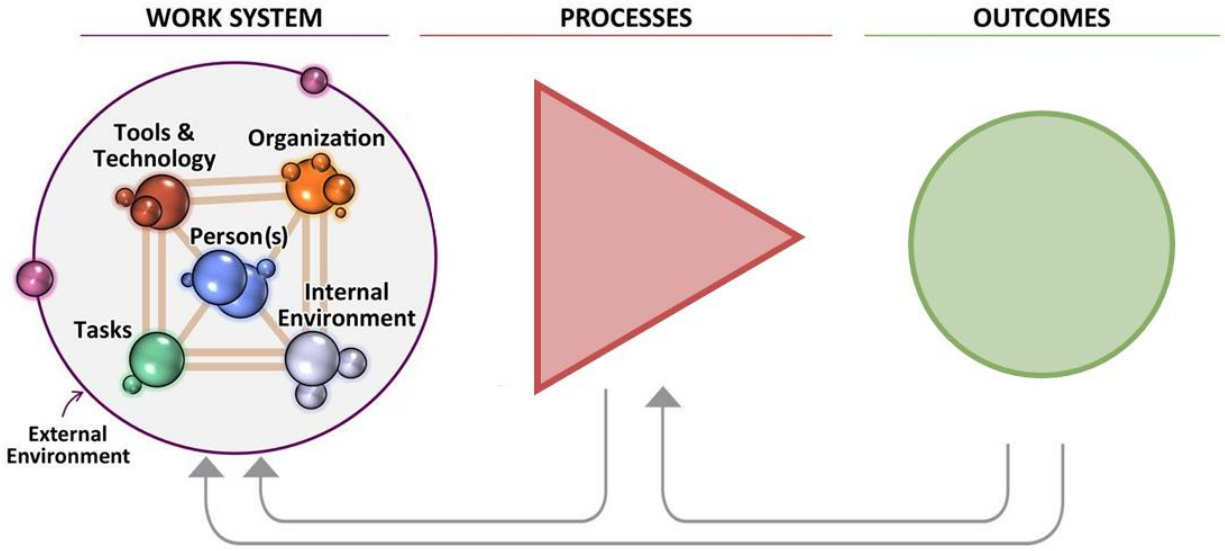
Appendix A: Tabular Timeline

Event Date & Time	Incident Timeline (what happened):

Systems Engineering Initiative for Patient Safety (SEIPS) Framework

Healthcare is a complex socio-technical system
Healthcare is complex because it is highly variable, uncertain, and dynamic.
Healthcare is a socio-technical system because it is characterised by multiple interactions between various components, both human and technological.
What is SEIPS?

- A framework for understanding outcomes within complex socio-technical systems
- Describes how a 'work system' (or 'socio-technical system, left) can influence processes (work done, middle), which in turn shapes outcomes (right)
- Acknowledges that work systems and processes constantly adapt (arrows)



Overview of the SEIPS model, taken from Holden et al (2013), and Holden and Carayon (2021)

What are the different parts of a 'work system'?

- A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s)
- People are not separable from the work system, they are deliberately placed centrally to emphasise that design should support – not replace or compensate for – people.

Using SEIPS to learn from patient safety incidents

- SEIPS can be used by anyone as a general problem-solving tool (e.g., for patient safety incident investigation, proactive risk assessment, system design, checklist and protocol development)
- SEIPS can be used to guide how we learn and improve following a patient safety incident and should be incorporated through the patient safety incident response process.
- Patient safety incidents happen because of multiple interactions amongst work system factors, SEIPS prompts to look for interactions rather than simple linear cause and effect relationships.
- When a patient safety incident investigation thoroughly examines the different work system components and their interactions recommendations should be focused on wider system issues and less so at the person-level

Appendix D – After Action Review template

After Action Review (AAR)

The Event:

Datix Ref.:	**Date of Incident:**	**Points to consider:** • • •

AAR Date: **Facilitated by**: **Attendees**: **Invited:** **Level of harm**: None **DOC status**: N/A

Expected Outcome *(what was expected):*	**The Event/Outcome** *(what happened)*:
Analysis *(What was the difference in the expectation and event)*:	**Any other factors to note** *(Use SEIPS):*

Safety Actions *(Immediate actions taken):*	**Areas for Improvement** *(Wider themes/areas for improvement):*

Quality Improvement Action Plan: Area for improvement	**Specific actions** (SMART- specific, measurable, achievable/action-related, relevant, time-specific)	**Responsible person** (include job titles)	**By when**	**Measuring effectiveness** (What will be measured? How will it be measured? How often will it be measured? How will we know if the change represents an improvement?)

Author(s):	Rebecca Gibson - Head of compliance & effectiveness Lucy Winstanley – Head of Patient safety & quality Jenni Kerr – Patient Safety and Quality Manager (Corporate)
Committee responsible for monitoring	Patient quality & safety governance group (PQASG)
Other contributors:	Megan Pontin – Patient Safety Incident Investigator Kerry Cushing- Patient Safety Incident Investigator Julie Head – Head of Deteriorating Patient Gilda Bass – Hospital Transfusion Team Paul Bunn – WSFT solicitor
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