The Christie
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE POLICY

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Key points

To outline the Trusts approach to implementing the Patient Safety Incident Response Framework, including:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive Oversight focused on strengthening response system functioning and improvement

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2. INTRODUCTION

2.1 Statement of intent

The Patient Safety Incident Response Framework (PSIRF) represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

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

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The Board of Directors is committed to ensuring that:

- the safety of patients, staff, visitors are maintained.
- effective reporting of near misses and untoward incidents takes place.
- Meaningful learning happens, and system-based changes are made to mitigate future similar incidents.
- a culture exists where staff can freely express their concerns in the interest of patient safety.

2.2 Equality and Health Inequality Analysis

As part of its development, this policy was analysed to consider its impact on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended impact for some groups, and to consider if the policy will minimise discrimination for all protected groups in accessing services across the Trust.

This analysis has been undertaken and recorded using the Trust's Equality and Health Inequality Analysis (EHIA) toolkit, and appropriate measures incorporated to remove barriers and advance equality in the delivery of this policy.

2.3 Greener NHS

This policy has been developed in line with the statutory requirement to progress towards net zero carbon. As a result, the document is designed to be used electronically in order to reduce paper waste

2.4 Values and Behaviours

Our Trust's Values and Behaviours define how we approach our work and treat each other and sits alongside what we do. It applies to all colleagues and outlines the

behaviours that is required when we interact with each other, our patients, and our visitors.

2.5 Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety across our services.

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 as an integral aspect to operational processes across the Trust.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can align to our Trust values and behaviours.

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2.6 Scope

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

Responses under this policy follow a systems-based approach. This recognises that safety is provided by interactions between components of the 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.

Where other investigative processes exist with a remit of determining liability or to apportion responsibility for acts or omissions, or cause of death, their principal aims differ from a patient safety incident response; are therefore outside of the scope of this policy;

- claims handling
- human resources investigations into employment concerns
- professional standards investigations
- information governance concerns
- estates and facilities concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- mortality reviews
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes as separate from any patient safety incident response., However, Information from a patient safety incident response process can be shared with those leading other types of investigation, but these other processes, and their findings, should not influence the remit of a patient safety

incident response and its subsequent recommendations for improving patient safety in a given area.

3. DEFINITIONS

Term	Meaning
Chief Executive	The person who has delegated responsibility from the Board of Directors for the management of governance arrangements within the Trust and is ultimately responsible for ensuring that the Trust meets its obligations with regards to the safe and effective delivery of services. This is delegated to responsible individuals within the Trust.
Clinician	A qualified medically trained doctor, nurse, allied health professional or pharmacist
Incident	An unplanned, unintended event or circumstance which caused actual or potential damage, loss or harm to a patient, staff, visitor or member of the public. It may be clinical in origin, (i.e., relating to the direct care of a patient) or non-clinical (i.e., property or financial loss, theft, fire, verbal abuse or threatening behaviour).
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS funded care
Patient safety learning response	The PSIRF promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed which trust's should utilise to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform learning and improvement.
Patient Safety Incident Response Framework (PSIRF)	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient Safety Incident Investigation (PSII)	An in-depth review of a single patient safety incident or cluster of events to understand what happened and how. Utilised where there has been serious harm to patients
Patient Safety Partner (PSP)	A new and evolving role developed by NHS England to help improve patient safety across the NHS. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation)
Patient	A person who is receiving medical care from the Christie.
Treatment	The application of medicines, surgery etc to a patient, the care and management of a patient in order to combat, ameliorate or prevent a disease, disorder or injury.
Trust	The Christie NHS Foundation Trust

4. DUTIES

4.1 Board of Directors

The Board is responsible for ensuring that a framework is in place to support the reporting and investigation of incidents and near misses in line with the Patient Safety Incident Response Framework.

4.1.1 Chief executive

The chief executive has overall accountability for patient safety and therefore this policy. Responsibility for ensuring compliance with this policy is delegated to the executive directors, who must ensure that all their staff are informed of the need to report incidents and that all incidents, complaints, or claims are investigated and managed effectively and appropriately.

4.2 Senior manager and individuals as applicable

4.2.1 Executive Chief Nurse and Director of Quality/Medical Director

Responsible for:

- Ensuring the executive directors and chief executive receives effective communication of the progress and outcome of patient safety learning responses and safety improvement work internally and with our external stakeholders such as the NHSE Specialist Commissioner, Integrated Care Board and the CQC.
- Informing the executive directors of any suspected criminal or malicious activity and, following consultation, inform the police where necessary.
- Ensuring key learning points are disseminated through the appropriate forums and committees, including the board of directors.
- Promote the trust patient safety culture
- Ensure the organisation meets national patient safety incident response standard
- Ensure PSIRF is central to overarching safety governance arrangement
- Quality assure learning response outputs (PSII)

4.2.2 Associate Chief Nurse &Associate Medical Director for Quality and Patient Safety

- To support the Chief Nurse and Medical Director with oversight of patient safety activity within the Trust
- To support the Patient Safety Specialist (PSS) and Patient Safety team to promote continuous improvement and and compassionate engagement in patient safety improvements
- To support the PSIRF Delivery Group (Associate Chief Nurse to Chair)
- Promote the trust patient safety culture
- Ensure the organisation meets national patient safety incident response standard

4.2.3 Patient Safety Specialist

- Lead and support local implementation of the NHS Patient Safety Strategy
- PSSs lead and directly support, patient safety ‘insight’, ‘involvement’ and ‘improvement’ activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Support other leads in the organisation in ensuring that all staff are trained in Level 1 of the NHS patient safety syllabus
- Work closely and collaboratively with those within their organisation who have specific patient safety responsibilities, including at operational level
- Support and advise Executive Directors, and Trust Board on matters of patient safety and process

4.2.4 Divisional associate chief nurse

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy

- Chair Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst nursing staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.5 Divisional Directors

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Support compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.6 Divisional Associate medical director

- Oversight of divisional incidents/ emerging themes/concerns
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy.
- Assist the chair of divisional Patient Safety Improvement Group to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements amongst medical staff
- Ensure the dissemination of learning, both locally and trust-wide
- Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

4.2.7 Patient safety team

- Review divisional learning response decision making and agree terms of reference
- Assign patient safety incident investigation (PSII) leads
- Review recommendations from learning responses to develop safety action plans to support ongoing improvement work
- Undertake regular audits of PSIRF process to support successful implementation
- Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes
- Promote the trust patient safety culture

- Monitor trust compliance with incident management, duty of candour, safety action plans and training
- Support all employees with the escalation of concerns
- Support the safety improvement plans for patient safety priorities

4.2.8 Divisional governance teams

- Oversight and governance of the local management of incidents
- Oversight of patient safety incident responses and improvements
- Ensure compliance with Duty of Candour guidelines and policy
- Participate in the Divisional Patient Safety Improvement Group on a weekly basis to review moderate + harm incidents as well as emergent incident themes/concerns
- Ensure the involvement and engagement of staff and patients in incident investigations
- Ensure compliance with patient safety training requirements
- Ensure the dissemination of learning, both locally and trust-wide
- Promote the trust patient safety culture

4.2.9 All staff

All Trust employees, whether permanent, temporary or working under an honorary contract, have a duty to report something that has happened that is:

- contrary to the trust's specified standards of care,
- an individual has been or could have been injured,
- an incident that places or has placed individuals at unnecessary risk or
- an incident that could put the trust in an adverse legal or media situation.

Any member of staff who is involved in, witnesses, or discovers an incident or near miss must:

- ensure that the situation is made safe and the relevant manager is informed of the incident or near miss.
- complete an incident report form within 48 hours of knowledge of the incident, accurately completing the appropriate sections within the incident report form and provide a reason if not reported within 48 hours
- assist with any incident investigation and take all reasonable steps to minimise risks
- Work in line with trust values and behaviours, upholding a positive patient safety culture

4.3 Committees in level of hierarchy

4.3.1 Quality Assurance Committee

The Quality assurance committee will assess trust performance regarding patient safety from cross-examination of the following reports:

- Patient Safety Incident Panels reports
- Quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile

4.3.2 Risk and Quality Governance Committee

The Risk and Quality Governance Committee will provide information and assurances to the board of directors that The Trust is safely managing all issues relating to patient safety and risk.

The committee receives a monthly report on progress of agreed actions and/or recommendations from patient safety incident investigations as well as assurance of improvement group/ workstream progress and safety action plans.

4.3.3 Patient safety committee

The Patient Safety Committee will monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities and ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Improvement groups/workstreams will report directly into this committee to gain support and give assurance. This committee will review the trust patient safety profile and priorities on a quarterly basis.

5. PATIENT SAFETY INCIDENCE RESPONSE FRAMEWORK

5.1 Our patient safety culture

As a Trust, The Christie have endeavoured to approach incident investigations with openness, transparency, and with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

The main goals of restoration when an incident has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning for improvement.

We recognise a culture of strong psychological safety underpins openness and transparency in incident reporting and promotes respectful investigations with meaningful system-based learning. We encourage the reporting of incidents where any member of staff feels something has happened, or there is a risk, which has led to, or may lead to, harm to patients or staff.

We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at learning and improvement within the culture we strive for. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability of an individual or the organisation.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time. The introduction of a new incident management system, Datix Cloud IQ, (DCIQ), in 2024 which will simplify internal reporting for staff whilst improving our insight into themes and trends. The introduction of Datix Cloud IQ will enable staff to report incidences of ‘good care’ assisting in learning from episodes which have gone well or better than expected.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. The Trust has endeavoured to approach incident investigations with a focus on learning for improvement, seeking to adopt a restorative just culture within the organisation.

5.2 Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK. At The Christie, we are excited to welcome PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services.

PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in The Christie the main purpose of the role is to be a voice for the people who use our services and ensure that patient safety is at the forefront of all we do. The PSPs will be supported in their role by the Patient Safety Specialist for the Trust who will provide supervision, guidance, and development for the role.

5.3 Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate:

- health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

- When constructing our safety actions in response to any incident we will consider inequalities, and these will be inbuilt into our documentation and governance processes.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and our response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

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

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports

the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. We will include this feedback in considering terms of reference for investigations.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent reoccurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, carers and staff. Getting involvement right with patients , their families and staff in how we respond to incidents is crucial, particularly to support improving the safety of the services we provide.

Part of this involves our key principle of being open, honest and transparent whenever there is a concern about care not being as planned or expected.
As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures to support patients, families, and carers – based on our existing Duty of Candour Policy.This will be underpinned by nominated individuals within our divisions who will assist with family liaison and support families and carers through any investigation or learning review. Patients and their families will be provided information on the learning response process and timelines, as well as contact details for further available support.

Compassionate engagement of staff involved in a patient safety incident is a priority of the trust as we recognise the impact an incident can have on staff, their health and personal/work lives.

Through engagement and support of staff we can ensure impactful learning is identified and safety recommendations/actions are considered both on a local and organisational level, with the goal of improving patient and staff safety. Where staff are engaging in learning responses, guidance documents will be available to ensure they understand and are supported throughout the process.

Staff are supported by the trust by a leadership team who promote a culture of psychological safety and are invested in the positive engagement of staff in patient safety incidents. Staff are encouraged to access support available including professional advocates, employee assistance programme, local leadership support, occupational health and staff complementary therapy.

We will continue to engage our staff with the assistance of Patient Safety Champions within a variety of areas across the Trust. These members of staff will, with support from the Patient Safety Team, work to enhance our patient safety culture, embed core PSIRF principles and share trust wide learning.

In addition, in The Christie we have a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or

ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

- advice and information
- comments and suggestions
- compliments and thanks
- informal complaints
- advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this. Links to available support can be found in appendix 1.

5.5 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 to arbitrary and subjective definitions of harm or severity.

Beyond nationally set requirements, organisations can explore patient safety incidents relevant to context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement, this marks a fundamental shift in the operational response to a safety event and our collective understanding of how to respond to it.

To fulfil this, we have undertaken planning of our current resource for patient safety responses and our existing improvement workstreams. We have used insight from our patient safety incidents and other data sources both qualitative and quantitative to explore what we know about our safety position and culture; this has formed our Patient Safety Profile and Patient Safety Incident Response Plan.

Our Patient Safety Incident Response Plan 2024 details how this has been achieved as well as how The Trust will meet both national and local priorities for patient safety. This plan represents how we will respond to patient safety incidents over the next 12-18 month. However, this will remain flexible and will be regularly reviewed. Each patient safety incident will be assessed in light of the specific circumstances in which it occurred, and the needs of those affected.

5.51 Resources and training to support patient safety incident response

The Trust has committed to ensuring we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. undertaken by the most appropriate staff, but not the staff directly involved in the incident. Local learning is a key principle of this policy and our services, specialities and divisions can decide on the most appropriate person to undertake a learning response.

Where the incident meets the threshold for a PSII, the investigator role will be identified through the ERG. Responsibility for the proposal to designate leadership of any other learning response sits within the senior leadership team of the relevant Division. Clinical, Operational and Nursing & AHP leadership will need to work collaboratively to deliver PSIRF principles in their area.

The Trust has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional Governance leads including the designated member of the senior leadership team and their Governance Manager, will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation.

The Patient Safety team will support learning responses and can provide advice on cross-system and cross-divisional working where this is required.
Those staff affected by patient safety incidents will be provided the necessary support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other staff support such as staff advocates to ensure there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure managers work within this framework to ensure psychological safety throughout the organisation.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

5.52 Training

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Training	Content	Staff Group	Training route	Provider
Patient safety syllabus level 1	Essentials for patient safety	Required for all staff	E-learning	Health Education England
Patient safety syllabus level 2	Access to practice	Recommended for staff managing incidents and undertaking local investigations and/or the following learning responses: • After Action Review • SWARM huddle • MDT review • Themed review	E-learning	Health Education England
Patient safety Investigation lead (PSII)	Systems-based approach to investigations	Recommended for Investigation Lead for PSII	Approximately 20 hours pre-recorded online study session	Health services safety investigations body

5.53 Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. The plan was developed by using a range of data sources:

- Incident data
- Risk data
- Stakeholder engagement
- Complaints

A variety of stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were divisional governance leads, committee groups, complaints and claims team, and subject matter experts. Anecdotal insight was also sourced from 'frontline' staff via qualitative care audits and feedback in response to incidents. Our full plan is available on our Trust internet page.

5.54 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 full every 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 months. There will also be a quarterly review of the plan and its effectiveness, which will be reported into Risk and Quality Governance Committee via Patient Safety Committee.

We will continue to assess ourselves against the Patient safety incident response standards, and update our policy accordingly. This will form part of annual reports to Risk and Quality Governance Committee, and Quality Assurance Committee.

Updated plans will be published on our website, replacing the previous version.
A rigorous planning exercise will be undertaken every three 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.

5.6 Responding to patient safety incidents

5.61 Patient safety incident reporting arrangements

Incident report forms should be completed as soon as possible after the incident or near miss has occurred (whilst events can be clearly remembered), and certainly within 48 hours of knowledge of the incident. A reason should be provided if reported beyond 48 hours. This timescale enables timely escalation and assessment of the incidents internally, but also means that the relevant external reporting requirements can also be met. These reports will then be routinely uploaded to Learning from Patient Safety Events platform (LFPSE) to support national learning. Incidents that need to be shared across organisations need to be highlighted to the Patient Safety Team (as per external incident SOP), so that they can be reported and allow for cross- system learning.

5.62 Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan .

Nationally, PSIRF itself sets no further rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents and/ or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear ‘Ward to Board’ set of mechanisms allowing for oversight of incident management and our PSIRF response (Appendix 2).

5.62.1 Divisional Patient Safety Improvement Group (DPSIG)

Oversight and governance of the local management of incidents will be the role of the Divisional Patient Safety Improvement Group (DPSIG). Chaired by a nominated senior lead within the Division e.g. The Associate Chief Nurse or equivalent and supported by the divisional medical director and divisional director as required. The DPSIG should adopt a multidisciplinary approach to local oversight of patient safety incident responses and improvements.

Where it is felt that the opportunity for learning and improvement is significant, regardless of severity or result of the event, incidents should be escalated within the Division.

The DPSIG will meet on a weekly basis to discuss the previous week's incidents that have been escalated within division, are moderate and above or those that are considered to meet the thresholds for a learning response as set out in the Patient Safety Incident Response Plan. The group will ensure any mitigation that is needed to prevent recurrence and whether the Statutory Duty of Candour requirement has been met.

Divisions will have review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion in line with the timeframes detailed in the table (see section 5.64). This should include consideration and prompting to service teams where Duty of Candour applies.

Most incidents will only require local review within the management structure of the service(s), this local management of incidents is captured in Datix DCIQ, incident handlers will be assigned within a service or division and for the incident record to be finally approved feedback to the reporter will be mandated.

Where a PSII is not required, the DPSIG will consider any incident as having potential for a learning response. The tool to be utilised for the learning response will be specified and a suitable member of the divisional team allocated to undertake the learning response. The DPSIG will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process within the minutes of the DPSIG.

Divisional Patient Safety Improvement Groups (DPSIG) will consider any such incidents for further escalation to the PSIRF Delivery Group, followed by Executive Review Group as per process in Appendix 3.

5.62.2 PSIRF Delivery Group

The outcomes of the DPSIG for each division will be discussed weekly with the PSIRF Delivery Group. This group will have oversight of the requested learning responses and the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required. The PSIRF Delivery Group arrangements will include the recording of safety actions arising from any learning response and these details will be used to inform potential safety improvement plans.

The PSIRF Delivery Group will have overall oversight of such processes and will support & review the decision making of the DPSIGs through quarterly audits. This will ensure that the Executive Review Group and Board can be assured that the

intent of PSIRF and its main principles are being implemented within our organisation and meeting the national patient safety incident response standards.

The PSIRF Delivery Group will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust in relation to external incidents. They will also support cross divisional learning responses and enable shared learning for the purpose of improvement.

5.62.3 Trust Executive Review Group

The Trust will maintain the Executive Review Group (ERG) to oversee the operation and decision-making of the PSIRF Delivery Group and the incident responses it has delegated responsibility to commission. Patient Safety Learning Responses that highlight recommendations and/or safety actions outside of the Trust patient safety priorities will be reviewed through this group. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety improvement profile of The Trust. All incidents that meet PSII threshold will initially be reviewed through the Execute Review Group.

5.62.4 Trust Patient Safety Panel

Incidents that meet the threshold of PSII as described in the PSIRF Plan and through the incident management escalation processes will be finally reviewed by the Trust Patient Safety Panel. This review will confirm the actions and/or recommendations from the PSII and assurance of the plans for ongoing improvement. The actions will be monitored through Risk and Quality Governance Committee once confirmed and through the relevant Patient Safety Improvement Project where applicable.

5.62.5 Incident Guidance and Escalation

5.62.5.1 Local level incidents:

Managers of all service areas will have arrangements in place to ensure that staff are supported to report and respond to incidents within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust policy.

Divisional Patient Safety Improvement Group will have specific delegated powers to commission thematic reviews of such events.

5.62.5.2 Incidents with positive or unclear potential for PSII

All staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety team as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to Specialist Commissioners and shared externally through LFPSE reporting. A rapid review will be undertaken by the Division to inform decision making at the DPSIG and onward escalation following this.

Incidents where there is uncertainty if a PSII is required, must also be reported to the Patient Safety team. Decision making regarding escalation to the Trust Patient Safety Panel can be considered at the next possible Executive Review Group. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The PSIRF Delivery Group will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The group will define terms of reference for a PSII to be undertaken and identify the appropriate investigation lead. The panel will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the PSIRF Delivery Group may request a PSLR or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the group's discretion in such circumstances to specify a particular tool is used to complete a PSLR. The PSIRF Delivery Group will also indicate how immediate learning is to be shared.

5.63 Responding to cross-system incidents/issues

The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.
The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

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

5.64 Timeframes for learning responses

Incident	Timeframe for completion
Requiring SWARM tool	As soon as possible, maximum within 1 week
Requiring After Action Review/ MDT Review	1 calendar month
Patient Safety Incident Investigation (PSII)	To be agreed alongside Terms of Reference/ Engagement
All locally managed incidents	1 calendar month

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the start date. No PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference prior to the commencement of the PSII learning response, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

This should be accepted by Divisional PSIG and recorded in Datix. A date for presentation at ERG will be provided by the Patient Safety Team at the commencement of a PSII.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the PSIRF Delivery Group and approval from ERG.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

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

5.65 Safety action development and monitoring of improvements

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety recommendations are needed.

The Trust has developed systems and processes in place to design, implement and monitor safety recommendations using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement.

The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. Under PSIRF it is not the role of the investigator or the learning response lead to define actions at the end of their learning response.

Learning responses should not define actions as this can lead to premature attempts to devise a solution, often in isolation and without the proper consideration of impact on other areas or a reliance of another team to deliver the action. Safety actions in response to a defined area for improvement depend on factors and constraints

outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions and with the support of the PSIRF Delivery Group.

This should reduce the number of discrete actions logged in Datix and move the organisation to a more holistic and inclusive set of ongoing and dynamic safety recommendations.

5.66 Safety Action development

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

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with all teams involved
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics i.e. How do we know it has worked?

Safety actions will be clearly written and follow Specific Measurable Achievable Realistic Timely (SMART) principles and have a designated owner. They will also

Be documented in a learning response report or in a safety improvement plan as applicable.

- Start with the owner, eg “Head of patient safety to...”.
- Be directed to the correct level of the system: that is, people who have the
- levers to activate change (ideally this should include the person closest to the
- work and who has been empowered to act).
- Be succinct: any preamble about the safety action should be separate.
- Standalone: that is, readers should know exactly what it means without reading
- the report.
- Make it obvious why it is required (ie given evidence in the learning response
- report or safety improvement plan).

Safety actions will be developed using a systems approach:

Area for improvement		Set out where improvement is needed
Work system	Person(s)	How **can individual or team characteristics** be modified or changed to reduce risk or improve performance?
	Tasks	How can the **task or activity** be modified or redesigned to reduce risk or improve performance?
	Tools and technology	How can **tools, equipment or technology** be modified or redesigned to reduce risk or improve performance?
	Internal environment	How can the **physical environment** be modified or redesigned to reduce risk or improve performance?
	Organisation	How can **organisational factors** be modified or redesigned to reduce risk or improve performance?
	External environment	How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance?

Safety actions will be developed by Divisional Patient Safety Improvement Groups for local issues, with approval from PSIRF Delivery Group. These will be reported through to ERG for oversight.

5.67 Learning Response Action Monitoring:

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety Committee, with escalations to the Risk & Quality Governance Committee.

For some safety actions with wider significance, these will be supported by the PSIRF Delivery Group.

5.68 Safety improvement plans

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety incident reviews (SI and RCA reports, rapid reviews and themed reviews) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Patient Safety Team Divisions will work collaboratively with the Divisions Patient Safety Team and others to ensure there is an aligned approach to development of plans and resultant improvement.

Where overarching system issues are identified by learning responses outside of the Trust local safety priorities, a safety improvement plan will be developed. These will be identified through Divisional governance processes and reporting to the PSIRF Delivery Group which may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and others to ensure

there is an aligned approach to development of the plan and resultant improvement efforts.

Monitoring of progress regarding safety improvement plans will be overseen by reporting by PSIRF Delivery Group. By the Patient Safety Committee, with escalation to Risk and Quality Governance Committee.

5.7 Oversight roles and responsibilities

The trust board (or those with delegated responsibility, including members of board quality sub-committees), is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The executive lead responsibilities are outline in section 4.

5.8 Complaints and appeals

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their clinical or ward/department team. Should the clinical or ward/department team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions. More information can be accessed via the PALS homepage on The Christie website.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services. Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The Trust will treat complaints seriously and ensure that complaints, concerns, and issues raised by the Complainant are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with any resulting actions will be explained to the complainant by the investigating team. The Trust has set out its complaints processes in the Complaints and Concerns Policy.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints will be used positively to improve services and patient experience.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

6. CONSULTATION PROCESS

This revised policy has undergone wide consultation across divisional colleagues and subject matter experts. Relevant feedback has been incorporated into this document.

This policy has been approved by the Patient Safety Committee and the Risk and Quality Governance Committee and this is clearly documented in the minutes of the meetings.

This policy has been ratified by the document ratification committee and this is clearly documented in the minutes of the meeting.

7. DISSEMINATION, IMPLEMENTATION & TRAINING

7.1 Dissemination

This policy will be available on HIVE for all staff to access and sent to managers within the trust for dissemination to staff within their areas of responsibility.

7.2 Implementation

All managers are responsible for ensuring that staff in their departments are aware of the Patient Safety Incident Response Framework and their associated responsibilities. Divisional teams will be supported with their implementation by the Patient Safety Team.

The patient safety team will audit the success of implementation via audits of divisional and trust incident management process as well as output from patient safety priority improvement groups.

7.3 Training/Awareness

The Trust has adopted the E-Learning for Health patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus.

All staff, clinical and non-clinical are expected to undertake level one patient safety syllabus training on induction and to repeat each three years.

8. PROCESS FOR MONITORING EFFECTIVE IMPLEMENTATION

Standard to be monitored	**Process for monitoring** e.g. audit, ongoing evaluation etc	**Frequency** e.g. annually 3 yearly	**Person responsible for:** undertaking monitoring & developing action plans	**Committee accountable for:** review of results, monitoring action plan & implementation	**Frequency of monitoring** e.g. monthly, quarterly

Standard to be monitored	Process for monitoring e.g. audit, ongoing evaluation etc	Frequency e.g. annually 3 yearly	Person responsible for: undertaking monitoring & developing action plans	Committee accountable for: review of results, monitoring action plan & implementation	Frequency of monitoring e.g. monthly, quarterly
Adherence to this policy	Audit	Annually	Patient Safety Specialist	Risk and Quality Governance Committee	Annually
Effective divisional triage of incidents and required learning responses	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Effective patient engagement in incident management and learning responses.	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly
Review of improvement workstreams in relation to patient safety priorities	Audit	Quarterly	Clinical Patient Safety and Risk Manager	Patient Safety Committee	Quarterly

9. REFERENCES

NHS England (2022). *Patient Safety Incident Response Framework* [PDF document]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf (Accessed: 19 January 2024).

NHS England (2022). *Engaging and involving patients, families and staff following a patient safety incident* [PDF document]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (Accessed 19 January 2024)

NHS England (2022). *Guide to responding proportionately to patient safety incidents* [PDF document]. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (Accessed 19 January 2024)

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NHS England (2019). *The NHS Patient Safety Strategy* [PDF document]. Available at : https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf (Accessed 19 January 2024).

NHS England (2022). *SEIPS quick reference guide and work system explorer* [PDF document] Available at : https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf (Accessed 19 January 2024).

NHS England (2022). *Safety action development guide* [PDF document] Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf (Accessed 19 January 2024)

10. VERSION CONTROL SHEET

Document name: Patient Safety Incident Response Policy
Document Ref:
Version: V01

Version	Date	Author	Status	Comment
1.0	Jan 2024	Ben Vickers – Patient Safety Specialist Matt Bilney Associate Chief Nurse Katerina Pearson Clinical Patient Safety and Risk Manager Eleanor Jones Clinical Patient Safety and Risk Manager	Draft	New policy

11. APPENDICES

11.1 APPENDIX 1 – Support services

National guidance for NHS trusts engaging with bereaved families;
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide.
https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide -
support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

Healthwatch
https://www.healthwatch.co.uk/ -Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters
You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch sitehttps://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received

11.2 APPENDIX 2 - Operational and Assurance Levels

PSIRF Operational and Assurance Levels	
Quality assurance committee	Risk and Quality Committee Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Risk and Quality Governance Committee	Approve recommendations/action plans resulting from PSII's Receive a summary of learning response outputs monthly Receive a quarterly update of Patient Safety improvement workstreams, aligned to Patient Safety Profile
Patient Safety Committee	To receive and scrutinise evidence of implementation of the PSIRF to effectively assure the Board the Trust is delivering improvements to safety standards aligned to the Patient Safety Profile. Monitor the progress of improvement groups/workstreams relating to local and national patient safety priorities Monitor Safety Improvement plans (for incidents not on Patient Safety Profile) Ensure that any issues are escalated appropriately to the Risk and Quality Governance Committee. Quarterly review of patient safety profile and priorities
Executive Review Group	To assure the board, through oversight and sign off learning responses, that the Trust has maintained or improved insight into patient safety incident responses, that all statutory requirements are met as part of the learning response. Approve all PSIIs and associated recommendations/action plans
PSIRF Delivery Group	Provide assurance and support to the chairs of DPSIG in the implementation of PSIRF Plans, Improvement Programmes and Learning Responses.

	Review recommendations from learning responses to develop safety action plans to support ongoing improvement work. Provide assurance to the Executive Review Group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes.
Divisional Governance Teams / Divisional Patient Safety Improvement Group	Provide assurance to the PSIRF delivery group regarding ongoing divisional learning responses, action plans, recommendations and emerging themes Provide assurance of DPSIG oversight of divisional incidents, emerging themes and safety concerns
Operational Management / Team Leader / Supervisor / Person in Charge	Prompt review of incidents reported within their area of responsibility, to manage or escalate as appropriate
All Staff	Report incidents to Datix to support the management of safety events in their respective areas

11.3 – Appendix 3