The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

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Patient safety incident response policy

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The RJAH approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated 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.

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

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

Scope

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

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error,’ are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The

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

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

The learning response methods described in the RJAH Patient Safety Response Plan (PSIRP), whilst specific to exploring events regarding patient safety incidents, can be used to support learning and improvement in relation to other non-patient safety incident types, providing their application complies with any wider requirements.

Oversight roles and responsibilities

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. When working under PSIRF, NHS providers should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures."

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports.

The Trust board 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 for PSIRF is the Chief Nurse and Patient Safety Officer.

The Trust Board have a responsibility, the through the PSIRF Executive Lead to;

1. Ensure the Trust meets the national patient safety response standards
    - Policy, planning and oversight
    - Competence and capacity
    - Engagement and involvement of those affected by patient safety incidents
    - Proportionate responses

2. Ensure PSIRF is central to overarching safety governance arrangements
    - The Board must have access to relevant information about their organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents.

- Through the safety improvement plan the board (or committee with delegated responsibility) will monitor and review the delivery of safety actions and improvement ensuring there is clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.

- Ensure an overall review of the patient safety incident response policy and plan is undertaken at least every three years alongside a review of all safety actions.

3. Quality assures learning response outputs
    - A final report for individual PSIIs should be reviewed and signed off as complete. Sign off is the responsibility of the Board (or designated sub-committee) and the CNO (or designated individual in their absence), is responsible for ensuring the reports are in line with the PSIRF standards.

    - Recognising a full report for submission to the Board may not be produced for every learning method other than a PSII. Learning response will be collectively evaluated every 12-18 months to monitor the quality of all response methods.

    - The Safety Improvement Plan ensures that the Trust has a process to ensure that all safety actions implemented in response to learning are monitored, to check they are delivering the required improvement.

Individual Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for the safety of the Trust's patients, staff, and visitors. The systems and process management responsibilities for the Patient Safety Incident Response Framework are delegated by the Chief Executive as follows:

Chief Nurse and Patient Safety Officer / Chief Medical Officer

The Chief Nurse (jointly with the Chief Medical Officer) is responsible for patient safety in the organisation.

Further, the Chief Nurse has responsibility for:

- overseeing the quality of the PSIRF process which includes the development, implementation, and review of this policy.
- ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Board.
- ensuring processes are in place for triangulating incident information for early identification of themes and trends.
- ensuring there are adequate mechanisms for learning and feedback of outcomes of incidents.

- overseeing compliance with the duty of candour
- Leading the assessment of incidents that fall outside of the local priorities for new and emerging themes (to be undertaken by the Chief Medical Officer in the Chief Nurse absence)
- ensuring that the Chief Executive (CEO) is kept fully informed about any national priorities aligned to PSIRF reporting the details of the incident to the Quality and Safety Committee.

In conjunction with the Chief Medical Officer, the Chief Nurse is responsible for identifying an appropriate learning response lead undertake a proportionate response.

Head of Clinical Governance, Quality and Patient Safety Specialist

- Ensuring the implementation and adherence to this policy and the Trust's Patient Safety Incident Response Plan and set timescales.
- Advise the CNO/CMO on a proportionate response method in relation to patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's patient safety incident response plan.
- Liaising with external bodies in relation to national priorities as required. This responsibility may be delegated where appropriate.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.
- Advising on the adequacy of safety actions following an investigation and for bringing urgent risk matters to the attention of the CNO and CMO.
- To monitor completion of organisational safety improvement actions, working with the Quality Improvement Facilitator.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- To lead on revising the Trust PSIRP and full PSIRF review as stipulated in the policy, including an evaluation of learning responses and effectiveness of safety actions.
- Provide training on PSIRF as required.

Patient Safety Specialist(s)

- Patient Safety Specialists are individuals in healthcare organisations who have been designated to provide dynamic senior patient safety leadership.
- Patient Safety Specialists, play a key role in supporting the development of a patient safety culture, safety systems and improvement activity.
- As well as coordinating and supporting local patient safety priorities, Patient Safety Specialists will help the trust to review their PSIRP and a full review of the PSIRF policy.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.

- Patient Safety Specialist will also ensure the rapid dissemination of key learning from patient safety events.

Delivery Unit Triumvirate, Matrons and General Managers

The triumvirate of the delivery units are responsible for:

- Ensuring that local and organisational safety actions are implemented and monitored.
- Dissemination of learning is facilitated using the SHARE debrief tool.
- As minimum Level 1 & 2 of the patient safety training is completed.
- Assistant Chief Nurses, Clinical Chairs and Matrons will be expected to have completed oversight training.
- Monitor through their respective Unit Governance Meetings any new or emergent themes for their areas, that may require a learning response.

Clinical Governance Managers

- The Clinical Governance Leads are responsible for ensuring that all adverse incidents and near misses are reported and managed within the units in line with this policy; are discussed at unit governance meetings and shared with staff as required.
- With regard to a PSII, the clinical governance managers are responsible for providing support and advice on process to the learning response lead and to keep the central governance team updated on progress and any potential issues.
- Ensure that any patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan are bought to the attention of the Head of Clinical Governance, Quality and Patient Safety Specialist.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- Act as the engagement lead for patients and families

Learning Response Leads (Consultants / Ward & Departmental Managers/Matrons/ACN's / Chief Pharmacist)

- The Learning Response Lead for local priorities will work with subject matter experts (as defined in the PSRIP) to use the defined learning method and frequency to review patient safety incidents, reporting their findings to the Patient Safety Meeting.
- Learning response leads for National priorities will be responsible for completing a PSII. They will be responsible for identifying all staff, departments and key teams who have some involvement in the incident and for informing all appropriate managers of the investigation.

- Areas for improvement and findings from learning responses should be shared with those involved and the wider team, to share learning and gain feedback from patients and staff members in the involvement of patient safety incident.
- Safety actions must be produced in collaboration with those who understand 'work as done' the most.
- Ensure the relevant training has been completed and competencies acquired to be a learning response lead (see appendix 1).

Subject Matter Leads

- Subject matter leads within the Trust are expected to support the Learning Response Leads as indicated in the PSIRF priorities.

Engagement Leads (Staff /Manager - Patient & Family / Clinical Governance Manager)

- ensure that the patient is informed of the incident and is kept informed during the investigation process to ensure that Duty of Candour is followed. However, the Consultant in charge of the patient's care will be responsible for giving this information where appropriate. Nominated next of kin will also be informed with the patients consent, or if the patient is unconscious or otherwise incapacitated.
- facilitate a face-to-face meeting and / or a response to any queries the patient or their next of kin may have.
- Support the Learning Response Lead, to gain the patients perspective if appropriate to do so.
- ensure that should the patient or nominated next of kin so wish, they are provided with the outcomes and improvements identified upon conclusion of the learning response.

Quality Improvement Facilitator

- The quality improvement facilitator is expected to engage in the safety improvement plan, to understand the priorities for QI from a patient safety perspective.

All Managers

- Line Managers are responsible for ensuring staff can access support following a patient safety event, should this be required, including giving the employee details of services available through Occupational Health and TRiM.
- Line Managers are required to support the release of staff to provide statements or attend interviews or meetings relating to the patient safety event.
- All managers are expected to complete Level 1 & Level 2 of the patient safety training syllabus.

All Staff

- All staff have a responsibility to report via DatixWeb all incidents and near misses, both patient safety and non-patient safety.
- All staff are required to co-operate with learning responses and provide any requested information, including statements and attend interviews when required.
- All staff are expected to complete Level 1 Patient Safety training.

Our patient safety culture

The RJAH is on a journey to promote an environment that fosters a positive safety and just culture.

During the implementation of PSIRF phase two of the project focused on diagnostic and discovery, an opportunity to review current systems and processes and through them how the Trust already responds to patient safety incidents for the purpose of learning and improvement.

Through this process, several strengths as well as areas of improvement were identified that will support the requirements and transition to PSIRF.

- Over the last 12- 18 months the Trust have moved to ensuring that investigation training provided to individuals is focused on System Based Analysis (SBA), and those asked to lead investigations are required to have completing completed SBA training.

The Trust template for formal investigations reflected the human factors system model of Systems Engineering Initiative for Patient Safety (SEIPS), to ensure all contributing factors are explored.

- Introduced an MDT review process for significant incidents, that would have previously had the potential to meet the definition of a 'Serious Incident.' If significant learning were identified, the same level of resource would still be applied, focusing on learning to inform improvement.

- The Trust has transitioned away from the traditional format of RCA investigation (unless required to do so under the Serious Incident / Never Event framework) recognising that these investigations can be timely, and evidence now suggests that the process is limited when exploring patient safety events in complex socio-technical systems such as healthcare. Despite best intentions, RCA prompts simple linear cause and-effect analysis and has consistently failed to deliver benefits of the scale and quality needed to thoroughly identify all contributing factors and generate effective safety actions.

- Mandated Patient Safety Level 1 training to all staff in the organisation and Patient Safety Level 2 training to those who have a responsibility to investigate patient safety events.

Areas for improvement are identified.

- Development of Datix system to ensure a systems-based approach to patient safety events at all levels of the organisation.
- More robust feedback to staff who submit Datix incidents.
- Effective ways to communicate shared learning from patient safety events, capturing all levels between Ward to Board.
- Engagement of staff when a patient safety event occurs, promoting a Just and Learning Culture.

Patient safety partners

A patient safety partner (PSP) is actively involved in the design of safer healthcare at all levels in the organisation.

This includes roles in safety governance – for example sitting on relevant committees to support compliance monitoring and how safety issues should be addressed and providing appropriate challenge to ensure learning and change – and in the development and implementation of relevant strategy and policy.

The PSP should ensure that any 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.

The Trust has recruited two Patient Safety Partners who attend the Patient Safety Meeting and Patient Safety Working Group. Both meetings have a responsibility to design and develop incident response processes, as well as monitor patient safety events for new and emerging issues and ensure that safety actions are being monitored and progressed to improve patient safety across the Trust.

Addressing health inequalities

The Trust is currently completing their Equality Diversity and Inclusion assessment, where one of the domains is to assess that patients/service users that access and use our services, do so free from harm. Once this assessment is complete, this section of the policy will be updated to reflect any recommendations/improvement.

The Trust is committed to ensure that all our staff have a 'systems-based approach to patient safety' and have implement Level 1 and Level 2 of the patient safety syllabus training, in line with the NHS Patient Safety Strategy. Further the Trust Human Factors faculty are updating the training content,

moving on from previously discussing non-technical skills and situational awareness, to teach people to understand a systems-based approach to patients' safety and performance influencing factors that increase the likelihood of patient safety events occurring.

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

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

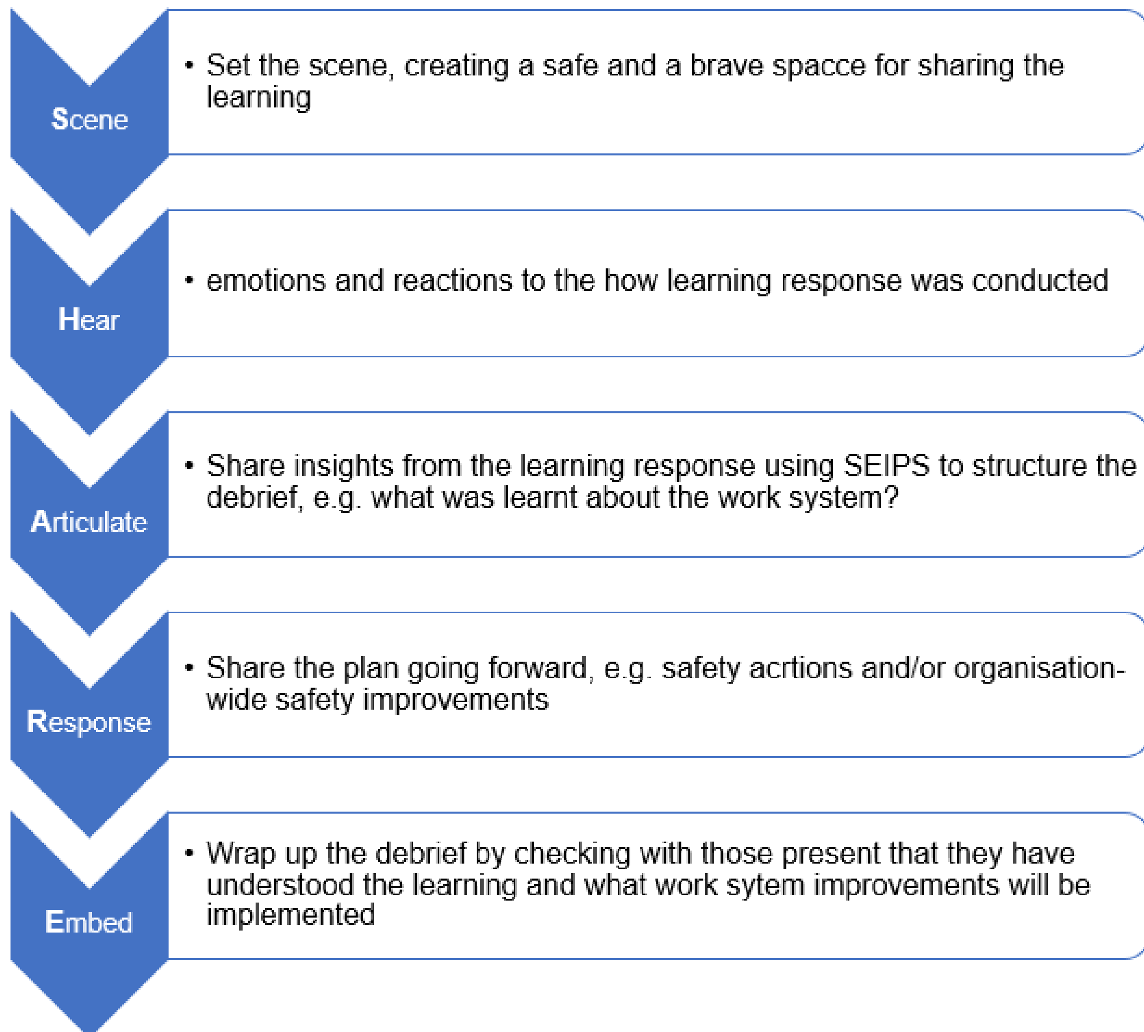
In line with the PSIRF standard, engagement and involvement of those affected by patient safety incidents. The trust is required to ensure;

1. **Compassionate Engagement with those affected**
   - Duty of candour obligations are upheld - Duty of Candour Policy - Percy (interactgo.com)
   - those affected by patient safety incidents should be fully informed about what happened, given the opportunity to provide their perspective and ask questions and to be communicated with in a way that meet their needs, including any form of learning response and subsequent findings.

2. **Meaningful involvement of those affected in a learning response**
   - Provided with a named main contact within the organisation with whom to liaise about any learning response and support.
   - Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.
   - Informed who will conduct any learning response and of any changes to that arrangement.
   - Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
   - Given the opportunity to agree a realistic period for any learning response.
   - Informed in a timely fashion of any delays with the learning response and the reasons for them.
   - Updated at specific milestones in the learning response should they wish to be.

- Given the opportunity to review the learning response report with a member of the learning response team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments. Note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them.
- Invited to contribute to the development of safety actions resulting from the learning response.
- Given the opportunity to feedback on their experience of the learning response and report (e.g., timeliness, fairness, and transparency).

Learning Response and Engagement Leads should use the SHARE debrief tool to not only share findings, areas for improvement and discuss safety actions but also gain feedback from the individuals involved as to how the learning response was conducted.



More information on how the standards described above will be actioned and monitored are included in; 'responding to patient safety incidents' section of the policy.

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.

The PSIRF sets out national priorities, such as incidents meeting the Never Events criteria (2018) and deaths thought more likely than not to have been due to problems in care (i.e., incidents meeting the learning from deaths criteria) where there are mandated responses, which are detailed in the Trust's Patient Safety Incident Response Plan.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, as organisation are now able to balance effort between learning through responding to incidents or exploring issues and improvement work and the patient safety priorities for RJAH are detailed in the Trust's Patient Safety Incident Response Plan.

Resources and training to support patient safety incident response

All staff in the trust are required to complete the Level 1 Patient safety training and for those staff who have a responsibility for managing and investigating patient safety incidents at a local level, must complete Level 2 of the patient safety training.

For PSIRF - learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. The standards are as followed;

1. **Learning Response Lead Training**
    - Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
    - Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
    - Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
    - Learning response leads contribute to a minimum of two learning responses per year.

2. **Competencies for Learning Response Leads**

    All staff leading learning responses should be able to:
    - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.

- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate complex matters and in difficult situations.

3. Engagement and Involvement training

- Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
- Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
- Engagement leads contribute to a minimum of two learning responses per year.

4. Competencies and behaviours for engagement leads

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact with those affected.
- Identify key risks and issues that may affect the involvement of patients, families, and staff.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

5. Oversight training

- All patient safety incident response oversight is led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.
- Those with an oversight role on a provider board or leadership team (e.g., an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
- All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

6. Competencies for individuals in oversight roles
All staff in oversight roles can:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.

- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

The Trust has a responsibility to ensure that training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation is preferred.

A detailed training analysis is available in Appendix 1.

Our patient safety incident response plan

Our plan sets out how RJAH intends to respond to patient safety incidents over the next 12 to 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 RJAH PSIRP is in line with the following standards.

- Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.
- Responses are insulated from remits that seek to determine avoid ability/preventability/predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death.
- With reference to the just culture guide, referral for individual management performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.
- Patient safety incident investigation reports are produced using the standardised national template.
- Patient safety incident investigation reports are written in a clear and accessible way.
- National tools (or similar system-based tools) are used, and guides followed for learning response methods.
- Learning and improvement work are adequately balanced – the organisation does not continue to conduct individual learning responses when sufficient learning exists to inform 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 every 12 to 18 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.

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.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incidents are recorded and monitored through the Trusts Datix System, and this will remain the same under PSIRF.

The trust has Quality Assurance Framework in place provide assurance to the Trust Board that there are effective processes in place to monitor, action and improve quality and safety at RJAH.

As part of the implementation of PSIRF the governance framework has been reviewed and meeting functions and terms of reference have been updated to support PSIRF – a visual aid is detailed in Appendix 2

Monitoring of patient safety incidents at a local level, through the delivery unit's governance meetings will remain the same, supported by their respective Clinical Governance Managers

For incidents identified as cross-system issues, these will be reported via the NHS-to-NHS Concern process, and dependent upon the nature of the incident with our Quality Lead partners at STW ICS. In addition, the ICS Quality Lead for RJAH is in regular attendance at the Trusts Quality and Safety Committee.

Patient safety incident response decision-making

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents.

An assessment of incidents that fall outside of our local PSIRF priorities should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

Reactive Issues

Where a patient safety event is reported that that signifies an unexpected level of risk/harm and/or potential for learning and improvement an MDT Review meeting will be scheduled by the Clinical Governance Team, chaired by the Chief Medical Officer (CMO) / Chief Nursing Officer (CNO) or designated deputy, where the incident will be reviewed, and proportionate learning response agreed and learning response lead allocated.

Emergent Issues

It will be the responsibility of the Patient Safety Meeting chaired by the CNO or CMO to monitor for emerging issues regarding patient safety. Collectively the attendees of the meeting will agree a proportionate learning response agreed and learning response lead allocated. Responding to cross-system incidents/issues

Timeframes for learning responses

Patient safety learning responses start as soon as possible after the incident is identified.

- Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.
- Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

Safety action development and monitoring improvement

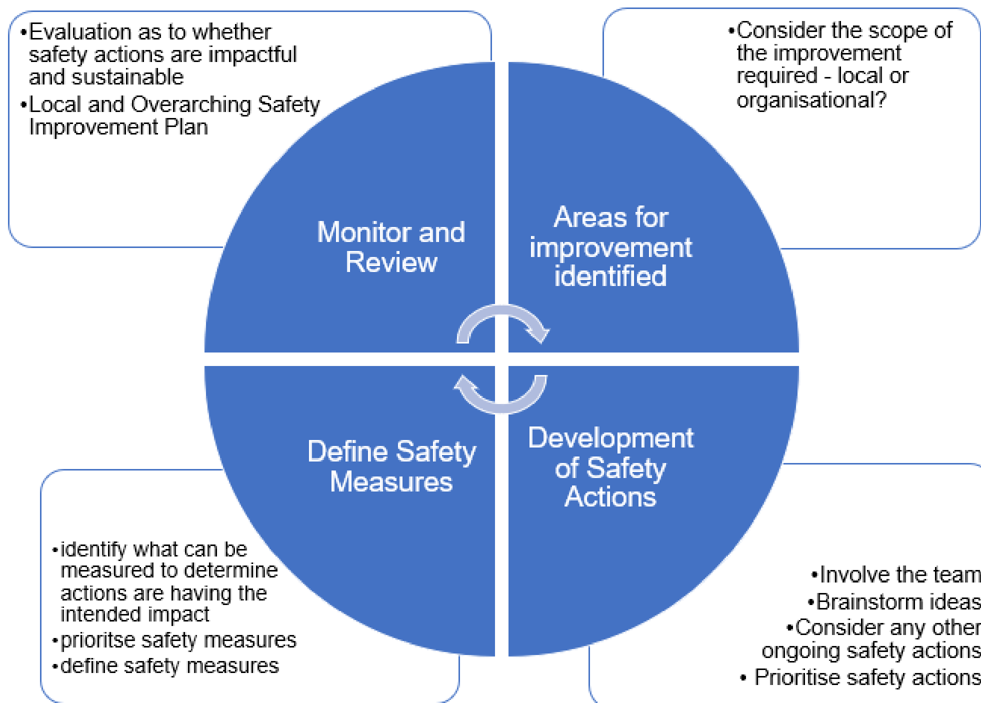
As part of a learning response, areas for improvement will be identified. These should set out where an improvement is needed rather than define how that improvement should be achieved. Once areas for improvement have been identified, then safety actions in collaboration with the relevant teams should be identified.

The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutioning at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a

defined area for improvement depend on factors and constraints outside the scope of a learning response.

The process emphasises a collaborative approach throughout, including involvement of those beyond the 'immediate and obvious' professional groups and working closely with those with improvement expertise. Imposed solutions often fail to engage staff and lack sustainability as a result.

The below diagram sets out the principles for the development and monitoring of safety actions for improvement.



Writing Safety Actions

Safety actions should be SMART (specific, measurable, achievable, relevant, timebound). They should also: •

- Be documented in a learning response report or in a safety improvement plan as applicable.
- Start with the owner, e.g., "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 (i.e., given evidence in the learning response report or safety improvement plan).

When finalising safety actions, continue to work with those to whom they are directed to ensure they are on board and willing to implement change.

The number of safety actions for implementation is often high. Monitoring their implementation and tracking the resulting changes can be onerous and therefore under PSIRF it is recommend that safety actions are prioritised into low, medium and high priority based on their potential to minimise risk to patient safety and improve patient experience.

An iFACES criteria and scoring rubric is included, as a suggested guide to help prioritise safety actions.

Criterion	Low	Medium	High
	1 — 2	3	4 — 5
Inequality Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.	The intervention accommodates some inequalities but further investigation is needed.	Inequalities are reduced by this intervention.
Feasibility Can the change be implemented relatively easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.	The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used.	The intervention is readily available and could be implemented in a relatively short period of time without much effort.
Acceptability Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.	The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread.	The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works.
Cost/Benefit Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.	The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.	The cost of the intervention is nominal relative to the expected impact on safety and performance.
Effectiveness How effective will the intervention be at eliminating the problem or reducing its consequences	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.	The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.	The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
Sustainability How well will the intervention last over time	The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working.	The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.	The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits.

Safety improvement plans

Areas for improvement can relate to a specific local context or to the context of the wider organisation. Whilst areas for improvement and developed safety actions, will align to the outcome of a learning response, a safety improvement plan will bring together findings from various responses to patient safety incidents and issues, allowing the Trust to monitor the improvements that are required, ensuring that these link and meet the same priorities as that of the Quality Improvement Team.

The Patient Safety Meeting will be responsible for the delivery of the Trust Safety Improvement Plan, providing assurance to the Quality and Safety Committee that the improvements identified are being actioned and monitored for their impact.

Quality Assurance

As part of reviewing the Trusts Patient Safety Incident Response Plan, an evaluation of learning response completed and their methods to assess their quality and recommendations for improvements required.

Complaints and appeals

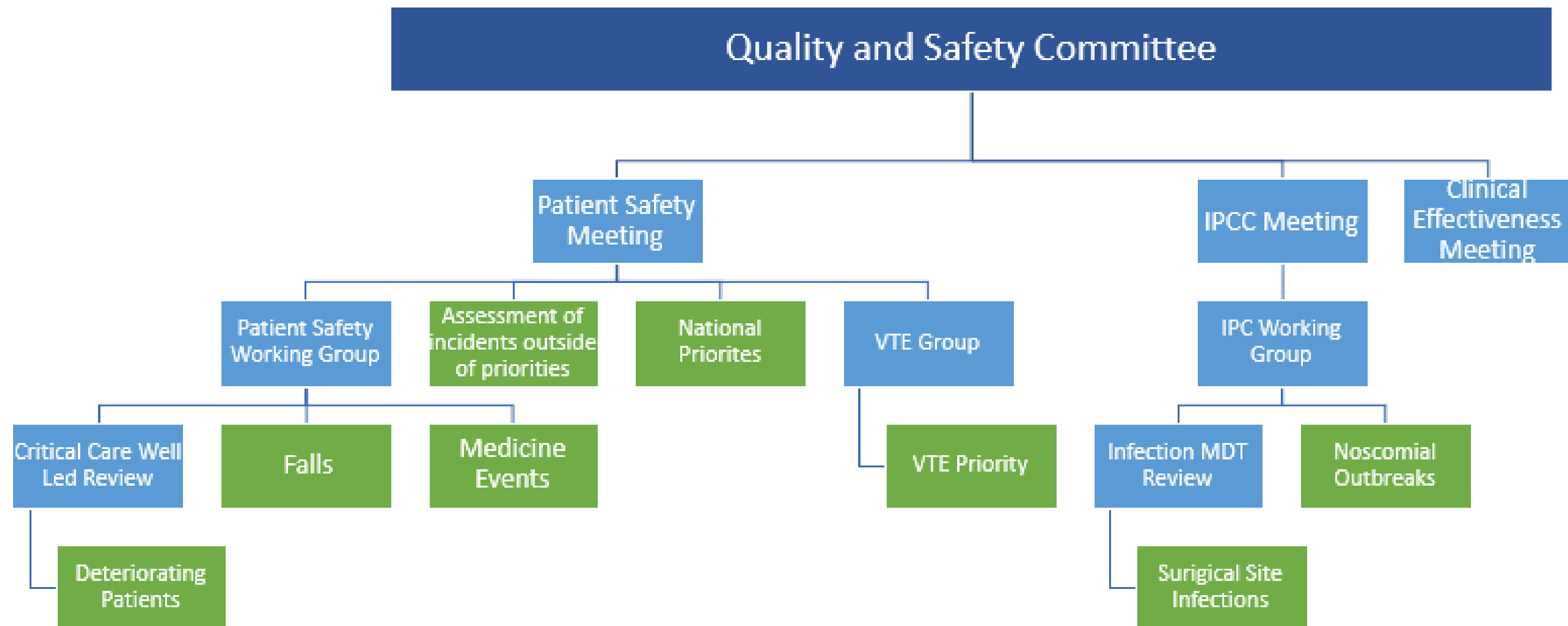
For any complaints or appeals relating to the Trusts response to patient safety incidents, these should be referred to the Trusts, Complaint Policy Complaints Policy - Percy (interactgo.com).

Appendix 1 – PSIRF Training Needs Analysis

RJAH PSIRF Training Requirements					
Training Topic	**Duration/ Frequency**	**Identified Training**	**Learning Response Leads**	**Engagement Leads**	**Oversight Roles**
Systems approach to learning from Patient Safety Incidents	2 days/12 hours	Systems Based RCA Training Human Factors Study Day **OR** HSIB Level 2 Safety Investigation	✓		✓
Oversight of learning from patient safety incidents	1 day/6hrs	To be confirmed			✓
Involving those affected by patient safety incidents in the learning process	1 day/6hrs	To be confirmed / Engagement Development Day, hosted by Governance and FTSUG		✓	✓
Patient Safety syllabus level 1: Essentials for patient safety	E-learning	E-learning module	✓	✓	✓
Patient Safety syllabus level 2: Access to practice	e-learning/ 1.5hrs	E-learning module **OR** Facilitated Session / HF Day	✓	✓	✓
CPD	Annually	Contribute to a minimum of 2 learning responses	✓	✓	✓

Lead	Definition	Role
Learning Response Leads	Individuals who will take a lead of a learning response	Consultants / Ward & Departmental Managers/Matrons/ACN's / Chief Pharmacist
Engagement Leads	Individuals who will support both staff and patients through a learning response	Ward Managers, Clinical Governance Team, People Services
Oversight Role	Individuals who have a responsibility for overseeing patient safety for the Organisation	Chief Nurse & Chief Medical Officer, ACN's, Head of Clinical Governance, Clinical Chairs NED Chair for QSC

Appendix 2 – Governance Framework for PSIRF



Blue: Trust meetings
Green: Priorities

Version Control Sheet

<table>
<tr><td colspan="5">Record of Amendments to: Patient Safety Incident Response Policy</td></tr>
<tr><td colspan="4">Amendments approved by:</td><td>Date</td></tr>
<tr><th>Section number</th><th>Amendment</th><th>Deletion</th><th>Addition</th><th>Reason</th></tr>
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