**Patient and Resident Safety Incident Response Policy**

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| **Relevant to** | HMT-wide |
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| **Approved by** | HMT Quality Group |
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| **Date of next review** | May 2027 |
| **Related Policy** | Incident Reporting and Management Policy  Duty of Candour/Being Open Policy  Never Events Policy |
| **Related Supporting Documents** | Patient and Resident Safety Incident Response Plan (PSIRP) |
| **Key search terms** | Learning response, investigation, improvement, priorities, involvement, compassionate, support, Duty of Candour, action planning |
| Please avoid referring to printed versions of this document or saving it on shared/individual drives. Printed and saved versions may quickly go out of date.  **J:\Quality Improvement\Policy Related\Policy Development and Prioritisation\Policy Development Resources\Policy icons\policy_1s.png**  **This document must be followed in order to fully comply with HMT policies.**  This document should not be shared externally without permission from the document owner. | |

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Description automatically generated**The information in this document applies to colleagues working in all parts of the UK unless stated otherwise.** Sections marked with an England or Welsh flag to highlight information which is specific or relevant to that country.

**1.** **Introduction**

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Healthcare Management Trust’s (HMT) approach to developing and maintaining effective systems and processes for responding to patient and resident safety incidents and issues, for the purpose of learning and improving patient and resident safety.

**2. Purpose**

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

This policy supports the development and maintenance of an effective patient/resident safety incident response system that integrates the four key aims of the PSIRF as follows.

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

This policy should be read in conjunction with the below HMT policies and the Patient and Resident Safety Incident Response Plan (PSIRP), which is a separate document outlining how this policy will be implemented. All of which can be found on SharePoint. This policy, and the PSIRP will be published on HMT’s website.

* HMT Incident Reporting and Management Policy
* HMT Duty of Candour/Being Open Policy
* HMT Never Events Policy
* HMT Whistle blowing Policy
* HMT Complaints, Concerns, Comments and Compliments Policy

**3. Scope**

This policy is specific to patient and resident safety incident responses conducted solely for the purpose of learning and improvement across all HMT sites (hospitals and care homes in England and Wales).

Responses under this policy follow a systems-based approach. This recognises that patient/resident safety is an emergent property of the health/social care 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. Patient/resident safety learning responses are therefore insulated from other processes that exist for these purposes, such as the following.

* Claims handling
* Safeguarding concerns
* Coronial inquests and criminal investigations
* Complaints (except where significant patient safety concern is highlighted)
* Human resources investigations into employment concerns
* Professional Standards investigations
* Information governance concerns
* Estates and facilities concerns
* Financial investigations and audits

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

**4. Duties/responsibilities**

See Appendix 1 for full list of duties and responsibilities

**5. Process**

**Insight**

**Patient safety culture survey**

A bespoke patient/resident safety culture survey was undertaken in 2024 with the intention to build on insights from the annual Staff Survey, as a benchmarking exercise as we implement PSIRF as well as to help us focus our resources on areas in need of most improvement. This will be undertaken yearly to monitor progress and respond accordingly.

**Ulysses**

HMT’s migration to Ulysses for all sites will simplify the safety event reporting process and our ability to gain insights into the nature of our incidents, from one local risk management system. This will include good care events as well as triangulation with other sources of insight such as complaints, claims and audit outcomes. The system will be developed further over the next 12-24 months to further support this, and continually as and when needed.

**Learn from Patient Safety Events (LFPSE)**

At HMT we report all our patient and resident safety incidents in *England*, to the LfPSE service.

The new LFPSE service is a major upgrade, creating a single national system for recording patient safety events. It introduces improved capabilities for the analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current healthcare environment. *The national team at NHS England are looking to develop the system to include social care, and for this reason HMT continue to report resident safety events to the service.*

The development of Ulysses and LFPSE will support HMT in encouraging the reporting of events, issues and good care, as well as a culture of openness and transparency in the following ways.

* Make it easier for staff across our health and social care settings in England to record safety events, with automated uploads from Ulysses to LfPSE to save time and effort
* Collect information that is better suited to learning for improvement than what was previously gathered by systems
* Make data on safety events easier to access, to support improvement work
* Utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback to staff

**Safety II**

**Learning from Excellence**

HMT plan to implement the ability to report good care events in Ulysses, as part of the Learning from Excellence initiative, to ensure that we learn from what works at HMT to keep patients and residents safe and share this across our sites.

**Learning Teams**

Learning Teams as a form of learning response are being undertaken at HMT, which aim to learn from everyday work to help inform patient/resident safety and quality improvement. A Learning Team is a multi-disciplinary review of a systemic safety issue (theme/recurring issue) or a complex problem. The intention is to understand what needs to happen for care or service provision to go well (which is usually most of the time), and what gets in the way of that sometimes (barriers), to direct improvement work in the right places but also acknowledge what we can learn from good practice/excellence as well as adverse events.

The critical part of this is that the Learning Team focuses on the ‘Work as Done’ by those who do it, as opposed to the work as we imagine it to be, how it is prescribed in policies or as it is disclosed to us following an event. This is to aid understanding of the ‘real work’ to make real improvements.

**Involvement**

**Patient and Resident Safety Partners**

The involvement of patients in their care and in the development of safer services are both priorities set out in the NHS Patient Safety Strategy. Patient Safety Partners is the term used for patients, carers and other lay people who become involved in improving and leading organisational patient safety.

HMT will engage with its Patient and Resident Safety Partners by appointing a small pool of individuals to draw on their personal and/or professional experience, to collaborate closely with HMT staff to support and contribute to the organisation’s governance and management processes for patient and resident safety and experience. This will be piloted at St Hugh’s Hospital in the first instance for learning and development purposes.

This role will include but is not limited to the following.

* Membership of safety and quality committees whose responsibilities include the review and analysis of safety information
* Involvement in patient/resident safety improvement projects
* Working with HMT, local partners and the public to consider how to improve safety and experience
* Involvement in staff patient/resident safety training

The benefits of involving Patient Safety Partners in developing a safety culture include the following.

* Promoting openness and transparency
* Supporting the organisation to consider how processes appear and feel to patients and residents
* Helping the organisation know what is important to patients and residents
* Helping the organisation identify risk by hearing what feels unsafe to patients and residents

These exciting new roles will evolve over time with the support of site leads as well as the Head of Patient Safety and Improvement, who will provide support and guidance and will hold regular one-to-one meetings with Patient Safety Partners. Our Partners will also have direct access to an identified Executive and Trustee.

**Addressing Health Inequalities**

HMT recognises it has a role to play in reducing inequalities in health by improving access to its services and tailoring those services around the needs of the local population in an inclusive way. HMT is committed to delivering on its statutory obligations under the Equality Act (2010) and will use available data intelligently to assess for any disproportionate patient/resident safety risk from across the range of protected characteristics.

Within our patient/resident safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities which 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 all consider inequalities.

We will engage and involve patients/residents, families, carers and staff following a patient/resident safety event with consideration of any identified different needs, including the use of available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise the potential for their involvement.

We will also address apparent health inequalities as part of our safety improvement work. In establishing our Plan and this policy we will work to identify variations that signify potential inequalities or access issues. By using our population data and our patient and resident safety data we will ensure that this is considered as part of the development process for future iterations of our PSIRP. We consider this as an integral part of the future development process.

Further to this, HMT has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/residents, carers and families. As part of this, discrimination of any kind including racism will be taken very seriously and may result in disciplinary when related to a staff member. With explicit role modelling led by the Board, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

**Engaging and involving those affected by a patient/resident safety incident**

The PSIRF recognises that learning and improvement following a patient/resident safety event can only be achieved if supportive systems and processes are in place. Engaging with those affected by a patient/resident safety event and involving them in a learning response is based on both moral and logical arguments as follows.

Firstly, those affected by a patient safety event may have a range of needs (including clinical) as a result, as well as inclusivity and support needs, and these must be met where possible. This is part of our duty of care. Meeting people’s needs not only helps alleviate the harm experienced but also helps avoid compounding that harm. Whilst we cannot change the fact that an event has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

Secondly, engaging with those affected by a patient/resident safety event substantially improves our understanding of what happened, and potentially how to prevent a similar event in future. Patients/residents, their family members, and carers may be the only people with insight into what occurred at every stage of a person’s journey through the health/social care system. Not including those insights could mean an incomplete picture of what happened is created.

Patients/residents, their family members, and carers will be given the opportunity to contribute to the Terms of Reference of a learning response and receive a copy of the report produced. If they are not satisfied with the report, their feedback will be considered and this may necessitate further information being provided, a meeting, or even the report being revisited.

Similarly, staff have important contributions to make about their experience of the event and the and should be supported to share their account as individuals. Staff involved in a learning response will be supported as appropriate, depending on what they feel they may need, at any point of the response. This may include Wellbeing Support Services.

HMT will remain curious about the effectiveness of our processes for engagement and involvement. We will systematically assess the progression and outcome of engaging with those affected by a patient/resident safety event and, where applicable, their involvement in a learning response, by developing an end of learning response questionnaire.

Professional and statutory Duty of Candour will remain unchanged under PSIRF (see Duty of Candour/Being Open Policy). This does not automatically mean that a learning review will be undertaken however, as has predominantly been the case for a notifiable patient safety event in the past. It may be deemed that there is no opportunity for *new* learning and/or is not part of our PSIRP for a Patient Safety Incident Investigation (PSII) to be undertaken. This does not negate the need for meaningful engagement and involvement in those instances however, and any relevant existing learning or quality improvement work planned or being undertaken should be shared with those affected by events of that nature, with an opportunity to ask questions and share insights.

**Improvement**

**Patient/resident safety incident response planning and review**

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, PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, the organisation can balance effort between learning through responding to incidents or exploring issues and improving work.

HMT will use several methods promoted by PSIRF to learn from patient/resident safety incidents. This includes the application of a range of system-based approaches to learning from safety incidents to understand how work systems and processes can influence outcomes. The organisation will apply human factors principles to learn from patient/resident safety incidents, supported by developing the use of the Systems Engineering Initiative for Patient Safety (SEIPS).

The PSIRP has been developed which sets out how HMT is responding to PSIRF. This Plan is not a permanent set of rules and will be monitored and changed as insights evolve. We will remain flexible and will consider the specific circumstances in which each patient/resident safety incident occurred and the needs of those affected, as well as the different incident and learning response options outlined in the Plan. Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every two years to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include review of our response capacity, mapping our services, a wide review of organisational data, for example, patient/resident safety incident investigation (PSII) reports and other types of learning response reports, improvement plans, complaints, claims, risks, staff survey results, inequalities data, and reporting data, and wider stakeholder engagement.

**Patient/resident safety incident reporting arrangements**

All staff have a responsibility to report any potential or actual patient/resident safety incidents including near misses onto the organisation’s incident reporting system, Ulysees. HMT’s Incident Reporting and Management Policy outlines the internal and external notification requirements for the reporting of patient/resident safety related incidents and related processes. The site senior management team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact.

**Decision making**

Incidents are discussed at site level daily as part of the daily huddles, and weekly as part of patient safety/quality/risk meetings, in relation to opportunities for learning and confirmation of harm levels, including the requirement for statutory Duty of Candour where relevant. The Head of Patient Safety and Improvement and Executives are involved in decision making where required, such as in the event of a potential PSII.

**Patient Safety Incident Investigations (PSIIs)**

A PSII is nationally mandated for some types of incidents outlined in the PSIRP, and/or referral to another process/body for review.

HMT has governance arrangements in place to ensure that PSIIs are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. The individual leading a PSII will always have an appropriate level of seniority and influence within the organisation. Due to the low number of PSIIs expected, the Head of Patient Safety and Improvement/HMT’s Patient Safety Specialist will most likely undertake any PSIIs, until such a time others in the organisation are trained to do so. A buddying arrangement may also be made, as part of building competence and confidence following nationally mandated investigation training. The Head of Patient Safety and Improvement will support and have oversight of all PSIIs, if they are not the lead investigator.

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

**Declaration of the PSII**

The PSII Learning Response Lead, supported by the Head of Patient Safety and Improvement, will ensure that the four key aims of the PSIRF are integrated into the PSII and reflected within the report as follows.

* Compassionate engagement and involvement of those affected by patient (or resident) safety incidents
* Application of a range of system-based approaches to learning from patient (or resident) safety incidents
* Considered and proportionate responses to patient (or resident) safety incidents and safety issues
* Supportive oversight focused on strengthening response system functioning and improvement

**Timescales for PSIIs**

Where a PSII is indicated, the investigation must be started as soon as possible after the patient/resident safety incident is identified. The timeframe for completing a PSII will be agreed with those affected by the incident, as part of setting the Terms of Reference for the PSII, 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.

PSIIs should take no longer than six months, but this must not become a default target. In exceptional circumstances, a longer timeframe may be required for completion of the PSII (e.g. when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information). The organisation 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 Executive leads. In this case, any extended timeframe should be agreed between the organisation and those affected.

**Responding to Patient Safety incidents not meeting PSII criteria**

The Organisation has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation but from an MDT approach. Site senior leaders, with oversight from the Head of Patient Safety and Improvement, will manage the selection of an appropriate learning response to ensure the rigor of approach to the review. The different types of learning response to choose from are in our PSIRP, however these continue to be developed. The Head of Patient Safety and Improvement will support learning responses wherever possible and required and can provide advice on cross-system and cross-site working where this is required.

**Timescales for other forms of learning response e.g. AAR and Thematic Reviews**

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one month (e.g. Ulysses incident review) to three months (e.g. thematic review) of their start date. No learning response for an incident not meeting PSII criteria should take longer than six months to complete.

**Improvement based on learning**

When a safety issue or incident is well understood, usually due to the investigation of similar past incidents resulting in improvement plans having been implemented and monitored, our resources will focus on making improvements instead of investigating the same issue again. These areas for focused quality improvement are outlined in our PSIRP. We will only carry our further investigations if there is a chance for new learning to be identified or if the event is significant.

**Responding to cross-system incidents/issues**

HMT will work with partner providers and the relevant ICB to facilitate the free flow of information and minimise delays in joint working on cross-system incidents. The Head of Patient Safety and Improvement alongside site management will act as the liaison point for such work.

HMT 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, as is their responsibility in relation to PSIRF arrangements.

**Learning and Sharing**

Learning responses undertaken will then be shared at the monthly site Quality Governance Meetings, with some cases identified to be shared at the quarterly HMT Quality Group and Quality Governance Committee, whereby significant learning is identified that may be helpful to share with other sites, who may also take part in the planned quality improvement work. There were also plans to develop a quarterly Quality Newsletter to include this learning for wide dissemination.

**Safety action development and monitoring improvement**

To achieve successful improvement, safety actions and system improvement plans will be developed in a collaborative way, based on the principles of Work as Done, with a flexible approach from site leadership teams and the support of continuous quality improvement methodology. Imposed solutions are known to fail to engage staff and lack sustainability. The development of safety actions and plans is outlined in our PSIRP, including how we aim to prioritise, write and measure actions.

Local priorities outlined in the PSIRP will have a Quality Improvement Plan developed where there is not already a plan in place. Where overarching systems issues are identified via learning responses, not already within the scope of an existing improvement plan, a plan will be developed and monitored via the same arrangements. The Head of Patient Safety and Improvement will support this activity. Quality/System Improvement Plans will be monitored by the monthly site Quality Governance meetings and Quality Group for oversight and assurance purposes, and to inform the development of the PSIRP. They will also be triangulated with data and other quality insights at these meetings.

**Resource and training**

HMT has committed to ensuring that we fully embed PSIRF and meet its requirements and have developed a Gap Analysis for assurance and escalation purposes. This is based on the NHS England Patient Safety Incident Response Standards (2022).

**Training**

HMT has implemented a patient/resident safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows.

**Level one**

* Ulysses incident reporting training and Guide. This comprises a local incident module setting out HMT’s expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour.
* Patient Safety Syllabus Level 1: Essentials for Patient Safety: aimed at all staff, clinical and non-clinical. This module is available via Learning Pool.

**Level two**

* Ulysses reviewer training - see Ulysses Guide. This comprises local training to provide staff with the skills to undertake an investigation into incidents reported onto Ulysses and to identify learning.
* Patient Safety Syllabus Level 2: Access to Practice: aimed at staff who have potential to support or lead patient/resident safety incident learning responses. This training is available via Learning Pool.
* How to facilitate an After-Action Review/SWARM Huddle - this training continues to be provided by the Head of Patient Safety and Improvement as identified by site leads, to provide staff with the skills to facilitate learning responses to quickly identify learning and improvement from patient/resident safety incidents.
* Externally provided ‘Systems Investigation Training’ where available (e.g. HSSIB for St Hugh’s Hospital staff).
* Internally provided ‘Systems Investigation Training’ for those unable to access external training provision, developed and provided by the Head of Patient Safety and Improvement.

**Level three/four for Patient Safety Specialists**

This will apply to the Head of Patient Safety and Improvement in the first instance, as HMT’s registered Patient Safety Specialist, until such a time further Patient Safety Specialists are identified in the organisation.

**Competency**

HMT expects that those staff leading learning responses can do the following.

* Communicate and engage with patients/residents, families, staff, and external agencies in a positive and compassionate way
* Listen to others in a measured and supportive way
* Maintain clear records of information gathered and contact those affected
* Facilitate AARs, SWARM huddles and other learning responses in their area
* Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
* Identify and implement patient safety improvement actions in their area
* Recognise when those affected by patient safety incidents require onward signposting or referral to support services

Expectations of PSII learning response leads are as follows.

* Undertake Systems Investigation training (accredited training provider where available)
* Contribute to a minimum of two learning responses per year
* Apply human factors and systems thinking principles to collate qualitative and quantitative information from a wide range of sources
* Summarise and present complex information in a clear report
* Communicate highly complex matters and in difficult or challenging situations

Expectations of those in oversight roles are as follows.

* 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
* Constructively challenge the strength and feasibility of safety actions to improve underlying systems 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)

**6. Document control and Archiving**

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| Version Number | Effective Date | Amendment made by (name & job title) | Description of Changes |
| 1.0 | March 2024 | Suzanne Rostron – Director of Quality | First version |
| 2.0 | May 2025 | Ashleigh Jack – Head of Patient Safety & Improvement | Changes in line with PSIRP revision, as well as to reporting structures in line with review of Quality Governance Meetings structure |

**7. Equality Impact Assessment**



**8. Definitions**

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| PSIRF | Patient Safety Incident Response Framework | 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. |
| PSIRP | Patient Safety Incident Response Plan | How we plan to respond to patient/resident safety incidents |
| PSII | Patient Safety Incident Investigation | When an incident or near-miss poses significant patient safety risks and has the potential for new learning. |
| LfPSE | Learn from Patient Safety Events (Service) | A centralised system that healthcare staff can use to record patient safety events and access data and analytics about patient safety events nationwide using the NHS database.  At HMT, we use this for resident safety events also. |

**9. Dissemination**

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| **Dissemination Plan** | |
| Dissemination Lead | Ashleigh Jack |
| Previous document already being used? | Yes |
| If yes, in what format and where? | PDF - SharePoint |
| Proposed action to retrieve out-of-date copies of the document: | Support from Central Support Team |
| **To be Disseminated to:** | |
| HMT sites | All sites |
| Proposed actions to communicate document contents to staff: | Site Quality Governance meetings  Quality Group  Quality Governance Committee  Workplace communication |

**10. Implementation and Training**

PSIRF training: see pages 10-12 for breakdown. Implementation of policy overseen by Head of Patient Safety & Improvement on an ongoing, operational basis.

**11. Monitoring, Compliance and Effectiveness**

* Summary/trend reports of reported patient/resident safety incidents are produced upon request but available on the Ulysses live Incident dashboards at all times.
* Any incidents reported following a learning response option as indicated in the PSIRP shared at site Quality Governance meetings
* Assurance/escalation to Quality Group
* Assurance and escalation to Quality Governance Committee via quarterly patient safety reports
* Head of Patient Safety & Experience continuous operational monitoring/oversight of policy compliance and effectiveness
* PSIRP is a live document that will be updated as both quantitative and qualitative insights evolve, alongside this policy

**12. References**

[**NHS England » Engaging and involving patients, families and staff following a patient safety incident**](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident/)

[**NHS England » Learn from patient safety events (LFPSE) service**](https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/)

[**NHS England » Patient Safety Incident Response Framework**](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/)

[**NHS England » The NHS Patient Safety Strategy**](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)

[**Patient Safety | NHS England | Workforce, training and education**](https://www.hee.nhs.uk/our-work/patient-safety)

**13. Appendices**

**Appendix 1: Roles & Responsibilities**

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| **Title** | **Duties** | |
| **PSIRF Executive Leads:**  Executive Director of Governance, Standards & Regulation  Executive Director of Clinical Care & Acute Services | | Will ensure the following ‘mindset’ principles underpin HMT’s response to patient/resident safety incidents.   * A focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality * Ensure learning focuses focus on identifying the system factors that contribute to patient/resident safety incidents, not finding individuals to blame * Ensure learning is an active strategy towards continuous improvement, not a reflection of having done something wrong * Ensure system wide collaboration and that HMT is not working in isolation * Promote psychological safety and openness * Encourage consideration of differing perspectives and discussion of solutions to allow learning to occur * Ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed * Apply human factors and systems thinking principles * Constructively challenge the strength and feasibility of improvement actions to improve underlying system-based issues |
| **PSIRF Executive Leads:**  Executive Director of Governance, Standards & Regulation  Executive Director of Clinical Care & Acute Services | * Supported by the Board and Executive Team will oversee the development, review and approval of the organisation’s policy and plan for patient/resident safety incident response, ensuring they meet the expectations set out in the [patient safety incident](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/) [response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/) * Will ensure PSIRF is central to overarching safety governance arrangements * Will oversee the implementation of the PSIRP * Will oversee the training provision of those leading learning responses and those in oversight roles | |
| Head of Patient Safety and Improvement | * To lead the development of the PSIRP and PSIRF policy * To lead with the implementation of the PSIRP and PSIRF policy * Will lead the training provision of those leading learning responses and those in oversight roles * To define the patient safety and improvement profile by reviewing available patient/resident safety incident insight and engagement with internal and external stakeholders * Will have arrangements in place to manage the local response to patient/resident safety incidents and ensure that escalation procedures as described in the PSIRP are effective * Will support learning responses when required and will provide advice on cross-system and cross-specialty working where this is required | |
| Patient Safety Specialist (Head of Patient Safety & Improvement) | * Will promote the principles and practices of PSIRF in line with the NHS Patient Safety Strategy * Will influence and promote a positive safety culture by enabling and empowering speaking up by all by supportive, psychologically safe teamwork * Will support the Patient and Resident Safety Partners to influence change in line with the Involving Patients in Patient Safety Framework * Will encourage uptake of training in the Essentials of Patient Safety as part of the NHS Patient Safety Syllabus (where available) * Will have undertaken PSIRF training by an NHSE accredited training provider * Will work towards levels 3 and 4 of the National Patient Safety Syllabus * Will contribute to a minimum of two PSIIs per year, where available * Will apply human factors and systems thinking principles to collate qualitative and quantitative information from a wide range of sources * Will summarise and present complex information in a clear report following a PSII * Will communicate highly complex matters and in difficult or challenging situations | |
| Learning Response Leads | * Will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way * Will listen to others in a measured and supportive way * Will maintain clear records of information gathered and contact those affected * Will facilitate AARs, SWARM huddles and other learning responses in their area * Will identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation * Will identify and implement patient safety improvement actions in their area * Will recognise when those affected by patient safety incidents require onward signposting or referral to support services | |
| Patient/Resident Safety Champions | * Will promote incident reporting to enable learning * Will identify near miss and no harm incidents to support learning at the earliest opportunity * Will support safety huddles in their area and will share the learning * Will be afforded the necessary managerial support and time to participate in learning responses such as AARs in their area * Will be integral to identifying and implementing patient safety improvements * Will be a point of contact for the Head of Patient Safety and Improvement | |
| All staff | * Will promote incident reporting to enable learning * Will identify near miss and no harm incidents to support learning at the earliest opportunity * Will be afforded the necessary managerial support and time to participate in learning responses such as AARs in their area if they were affected by the patient safety incident * Will be integral to identifying and implementing patient safety improvements | |