

# Patient Safety Incident Response Policy

This policy supports the requirements of the NHS Patient Safety Incident Response Framework (PSIRF). It sets out Leicestershire Partnership NHS Trust's (LPT) 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.



**Key words:** Incident reporting, Patient Safety Incident Response Framework (PSIRF), incident response policy, incident review, learning response, patient safety, Culture of Candour

**Version: 6**

**Approved by: Safety Forum**

**Ratified By: Incident Oversight Group (IOG)**

**Date this version was ratified:** December 2024 – IOG – February 2025 Safety Forum

**Date issued for publication: 13<sup>th</sup> May 2025**

**Review date:** 1st May 2026

**Expiry date:** 30<sup>th</sup> November 2026

**Type of Policy:** clinical and non-clinical.

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## Policy On A Page

### SUMMARY & AIM

What is this policy for?

This policy supports the requirements of the NHS Patient Safety Incident Response Framework (PSIRF).

It sets out Leicestershire Partnership NHS Trust's (LPT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues, for the purpose of learning and improving patient safety.

It provides guidance on roles and responsibilities throughout the processes of managing patient safety incidents under PSIRF as well as on response methodologies using a 'Human Factors' and 'just culture' approach.

Oversight responsibilities of the Trust's Executives and Directorate Leaders is also detailed.

The policy seeks to support improvements to address health inequalities identified within areas of its remit.

It also supports a just culture with 'psychological

### KEY REQUIREMENTS

What do I need to follow?

The PSIRF is a different and exciting approach to how we respond to patient safety incidents and replaces the most recent Serious Incident Framework (SIF) (2015) and makes no distinction between 'PSIs' and 'Serious Incidents'. Unlike SIF, it is not an investigation framework.

Your expectation to have an understanding how LPT responds to patient safety incidents and your role.

How LPT responds to patient safety incidents with the principle of learning and the decision making around this.

Follow your role expectation if you are required to participate in, and support staff, patients, and families following a patient safety incident.

Understand your role how you, and your colleagues will compassionately engage with patients, families, and staff.

How we will engage, listen, and gain feedback from those affected by a patient safety incident in a compassionate way.

The timescales and standards expected for undertaking and completing a learning response.

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Establish the training available and training standards expected of those who undertake learning response/investigations.

How we will ensure that national and local criteria for responding to specific patient safety events will be managed at LPT.

To understand the just and learning culture approach taken at LPT through the lens of system and human factors reviews.

Using PSIRF to promote quality and safety improvement that is continuous and embedded in our culture/commitment of delivering safer patient care.

## TARGET AUDIENCE

Who is involved with this policy?

All staff employed by Leicestershire Partnership Trust (LPT/the 'Trust') both substantive and temporary.

## TRAINING

What training is there for this policy?

NHSE Patient Safety 1 and 2 are available on Ulearn to support learning of all staff with basic (1) and wider understanding (2) of patient safety in the NHS, the reporting and managing of patient safety events (incidents) and the influence of using a systems, processes and human factors approach in the NHS for the review of incidents with the aim of learning for safety improvement and to prevent recurrence.

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## 1.0 Quick look summary (Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy).

This policy supports the requirements of the NHS Patient Safety Incident Response Framework (PSIRF) and sets out Leicestershire Partnership NHS Trust's (LPT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues, for the purpose of learning and improving patient safety.

It provides guidance on roles and responsibilities throughout the processes of responding to and managing patient safety incidents under PSIRF as well as on response methodologies using a 'Systems and Human Factors' approach.

Oversight responsibilities of the Trust's Executives are also detailed.

Shares our requirements as a Trust and as individuals how we will respond compassionately and engage with those affected by a patient safety incident (patients, families, and staff).

The policy seeks to support improvements to address health inequalities identified within areas of its remit.

It also supports a 'just culture' with 'psychological safety' approach to learning from patient safety events.

## 1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Initial Draft	March – May 2024	Through PSIRF project group
1	August – October 2024	Revised & Reviewed Initial Draft version shared through Incident Oversight Group (IOG) and Patient Safety Improvement Project Pathway Members
2	October – 05/11/2024	Review of feedback, request to expand and in roles and responsibilities
3	10/11/2024	Final review of feedback for sharing into IOG
4	14/11 – 23/11/2024	Further review of feedback & request for additions of appendices
5	24/11/2024 - 04/12/2024	Amendments following review by Trust Medical Director, Tracy Ward Head of Patient Safety, Helen Thompson Rapid Improvement Project Lead & board direction re roles & responsibilities
6	10/12/2024	Amendments & review by Corporate Patient Safety Team Members, Head of Patient Safety

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## 1.2 Key individuals involved in developing and consulting on the document.

Name	Designation
Accountable Director	Executive Director of Nursing, Allied Health Professionals and Quality
Author(s)	Sue Arnold Lead Nurse Corporate Patient Safety Team (CPST) Tracy Ward, Head of Patient Safety and Patient Safety Specialist. Jo Nicholls, Incident Investigation Corporate Lead and Patient Safety Specialist. Elizabeth Kemp, PSIRF Implementation Project Lead, (initial draft)
Implementation Leads	CPST and Directorate Clinical Governance Teams
Core policy reviewer group	PSIRF Project Group for Initial Draft Corporate Patient Safety Team (CPST)
Wider consultation	Internal stakeholders - Directorate teams through IOG, Patient Safety Partner Patient Safety Improvement Pathway group members through MS Teams channels Leicester, Leicestershire & Rutland Integrated Care Board (ICB) (for inclusion of collaboration)
For information once reviewed at policy group	External stakeholders -, Provider Collaboratives (PCs), Public Health Local Authority (PHLA)

## 1.3 Governance

**Level 2 or 3 approving delivery group** –Safety Forum

**Level 1 Committee to ratify policy** - Incident Oversight Group

## 1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account

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the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

If you would like a copy of this document in any other format, please contact [lpt.corporateaffairs@nhs.net](mailto:lpt.corporateaffairs@nhs.net)

## 1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

## 1.6 Definitions that apply to this policy.

**Consent:** a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision.
- have received sufficient information to take it and not be acting under duress.

**Due Regard:** Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

## Specific definitions that apply to this policy

<b>AAR</b>	After Action Review (AAR) is a method of evaluation that is used when the outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase the occasions where success occurs.
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<b>Apology</b>	An 'apology' is an expression of sorrow or regret in respect of a notifiable safety incident. It is not an admission of guilt. Saying 'Sorry' is always best practice
<b>Being Open</b>	Discussing and communicating openly, promptly, fully, effectively, and compassionately with those affected by incidents, complaints, or claims. It is about being open and transparent with patients, families and staff about care and treatment, including when it goes wrong.
<b>CPST</b>	Corporate Patient Safety Team
<b>CQC</b>	Care Quality Commission
<b>Duty of Candour</b>	The statutory (legal) duty to be open and honest with patients or their families, when something goes wrong that appears to have caused/could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England. It is also linked to CQC regulation 20. LPT's policy a 'Culture of Candour' describes our commitment of a general duty to be open and transparent with people receiving care. We work with patients to involve them in the planning of their care and keep them informed including where care has not gone as expected.
<b>Incident Review Learning Meeting (IRLM)</b>	Trust weekly meeting to review escalated incidents that have occurred usually in the last two weeks and have potential for investigation beyond local manager review. Chaired by the Head of Patient Safety/Deputy Director of Nursing, with core membership of other relevant and specialist professionals. The purpose is to consider the factors surrounding an incident that is initially identified. Based upon this discussion, a review of the circumstances around the incident is undertaken and decision made as to what level of investigation/learning response is required, if any, or what further information is outstanding, to ensure that an appropriate and timely decision can be made. It is also a venue to offer assurance to the Trusts stakeholders and is used for any immediate learning/sharing/action and to facilitate early feedback to patients, families, and staff.
<b>Initial Service managers Review (ISMR)</b>	Following a patient safety incident that may meet the threshold requirement for a learning response an ISMR will be undertaken to obtain more detailed information relating to the incident to assist with next steps decision making.

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<b>Integrated Care Board (ICB)</b>	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
<b>Just Culture</b>	Supports consistent, constructive, and fair evaluation of the actions of staff involved in patient safety incidents
<b>Never Event</b>	Never Events (2018) are defined as the incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
<b>PSIRF</b>	The Patient Safety Incident Response Framework (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. The framework 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 (2019).
<b>PSIRF Policy</b>	Patient Safety Incident Response Policy (this policy)
<b>PSIRP</b>	Patient Safety Incident Response Plan. Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the Directorates and specialist risk leads, supported by analysis of local data.
<b>Policy</b>	A policy is principles and rules formulated or adopted by an organisation to reach its long-term goals. Policies will be prescriptive by nature. They will state the Trusts expectations for action in a specific subject area and set the parameters within which individuals will operate.
<b>PSIs</b>	Patient safety incidents (PSIs) are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.
<b>PSII</b>	Patient Safety Incident Investigation. PSII are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed

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	to address those system factors and help deliver safer care for our patients effectively and sustainably.
<b>RIDDOR</b>	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
<b>SEIPS</b>	System Engineering Initiative for Patient Safety - a framework for understanding outcomes within complex socio-technical systems.
<b>SIRAN</b>	Safety Incident Response Accreditation Network (SIRAN Accreditation) through Royal College of Psychiatrists – External review for the Standard of patient safety learning responses/ investigations and the processes that support this.
<b>SJR</b>	Structured Judgement Review: Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.
<b>SMART</b>	<p>SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting (applied at LPT for patient safety improvement actions) as follows:</p> <p><b>S- Specific</b> – a goal should not be too broad but target a specific area for improvement.</p> <p><b>M- Measurable</b> – a goal should include some indicator of how progress can be shown to have been made.</p> <p><b>A- Achievable</b> – a goal should be able to be achieved within the available resources including any potential development needed.</p> <p><b>R- Relevant</b> – a goal should be relevant to the nature of the issue for improvement.</p> <p><b>T- Time-related</b> – a goal should specify when a result should be achieved, or targets might slip.</p>

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<b>Stakeholder</b>	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions (Staff, Patients, Families, Carers, Commissioners)
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## 2.0 Introduction/Why we need this policy.

The NHS definition of patient safety is “maximising the things that go right and minimising the things that go wrong”. The NHS Patient Safety Strategy, which was launched in 2019 and later updated in 2021, sets out how the NHS will achieve its vision to continuously improve patient safety.

One of the key initiatives of the strategy is the Patient Safety Incident Response Framework (PSIRF), which requires organisations to consider their unique patient safety challenges and improvement opportunities. PSIRF is a major step towards improving safety management across the healthcare system in England and will greatly support the NHS to embed the key principles of a patient safety culture. It will ensure the NHS focuses on understanding how incidents happen, rather than apportioning blame on individuals, allowing for more effective learning and improvement, and ultimately making NHS care safer for patients.

The PSIRF is a different and exciting approach to how we respond to patient safety incidents and replaces the most recent Serious Incident Framework (SIF) (2015) and makes no distinction between ‘PSIs’ and ‘Serious Incidents’. As such, it removes the ‘Serious Incidents’ classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to PSIs by ensuring resources allocated to learning are balanced with those needed to deliver improvement. Unlike SIF, it is not an investigation framework.

PSIRF is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims. This policy supports the development and maintenance of an effective PSI response system that integrates these four key aims which are:

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

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This PSIRF policy, and the associated PSIRP (the Plan), describe how Leicestershire Partnership NHS Trust's (LPT – the 'Trust') responds to incidents under PSIRF to maximise learning and improvement except for incidents that currently require a nationally mandated response to certain categories of events, such as 'Never Events' and deaths of patients who at the time of their death are under the care of the Mental Health Act (1983).

This policy supports how we will:

- Balance effort between learning from responding to incidents and/or exploring issues and our improvement work.
- Broaden the methodologies that we use to learn from PSIs, e.g., clinical audit, thematic analysis.
- Focus our attention on understanding patient safety events that we may not have previously had the resource to examine. Our chosen response will not be solely based on harm that has already occurred; we will be able to consider the risk of future harm occurring and then identify how that risk can be reduced across the organisation.
- Further develop our existing learning system and ensure that the output of the proportionate learning responses that we undertake are shared across the organisation and that local improvement opportunities, in areas other than that in which a patient safety event occurred, can be considered by teams.

## External Accreditation

LPT has also worked to achieve the SIRAN accreditation awarded by the Royal College of Psychiatrists; this provides a level of quality assurance in the organisations incident review and learning process. This policy has been designed to ensure that with the move to PSIRF these standards continue to be met and where possible exceeded.

### 2.1 Purpose

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

LPT is responsible for the development and delivery of its own local patient safety policy and plan and is committed to working towards achieving the patient safety incident response standards.

This policy has been considered in line with other Trust policies and meets the requirements of PSIRF and it should be noted that this policy will evolve as the

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organisation transitions to PSIRF, and its principles are embedded.

## Learning and improvement

Learning responses available under PSIRF provide a range of tools and approaches to elicit learning from PSIs. These tools and approaches enable us to understand any vulnerabilities in our systems which need to be addressed, to strive to avoid repeat. The Plan that supports this policy outlines the trust learning responses against our identified incident priorities.

The Trust weekly incident review and learning meeting (IRLM) will determine, using the Plan as guidance, where a learning response to explore the contributory factors to a patient safety incident or cluster of incidents, is required to inform improvement.

Where the IRLM determines that the contributory factors are known and determines there is already a robust workstream in place to support improvement (that is a learning response has already occurred), the PSI will be fed into the most appropriate improvement workstream as described below and in more detail in the Trusts PSIRP.

### Improvement programmes

Checking and searching of patients in inpatient areas	PDSA
Reducing the dependency of therapeutic observations on MHSOP organic wards	PDSA
Charge Nurse's weekly Environmental Check	Monitoring audit
CHS community therapy clinical observations practice improvement.	PDSA
Improve the use of Sepsis tools and pathways on Community Hospital and Bradgate Mental Health Unit inpatient wards.	PDSA
Reducing the number of pressure ulcer incidents occurring in LPT care (CHS District Nursing)	PDSA
Reducing the number of category 2 pressure ulcers occurring in LPT care	PDSA
Introduction of Falls Huddles	PDSA
Improve identification and management of falls risks	PDSA
The impact of a medications alert tool on falls in a Mental Health for Older People inpatient setting	PDSA
Use of Flat Lifting equipment post fall	PDSA
Best Practice seating	PDSA

## 3.0 Policy Requirements

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across services provided by LPT and should

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be followed by all staff working at LPT.

The policy has been initiated initially through the PSIRF Project Group. The group consisted of representatives from Corporate and Clinical Directorates Group staff and associated quality improvement colleagues.

## Four Key Points

1. Responses under this policy follow a systems-based approach. This recognises 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.
2. 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. This is reflected in the NHSE 'Just Culture Charter' reviewed alongside this policy and the Trust's PSIRF Plan.
3. 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.
4. 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.

## Key LPT policies relevant and of interest to this policy:

- Equality, Diversity, and Inclusion Policy (2021)
- Freedom to Speak Up Policy: Speak up, Listen up, Follow up Policy (2023)
- A Culture of Candour Policy (Incorporating 'Being Open' and 'Duty of Candour') (2024)
- Concerns and Complaints Policy (2024)
- Health and Safety Policy (2022)
- Incident Reporting and Management Policy (2024)
- Medication Errors Policy (2024)
- Risk Management Policy (2024)
- Quality Strategy (2024)
- The Trust's Patient Safety Incident Response plan (PSIRP) ('the Plan'), which is a separate document setting out how this policy will be implemented (2023).
- Post-Incident Pathway for Staff Support (PIPSS) Policy (2024)
- Learning from Deaths Policy (2019 - under review 2024)

## Other associated policies/Strategies include:

- Infection Prevention and Control Assurance Framework Policy (2023)

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- Data Protection and Information Sharing Policy: (incorporating Confidentiality, Information Sharing, safe-haven and Pseudonymisation procedures) (2021)
- 2021- 25 Our Equality, Diversity, and Inclusion (EDI) Strategy

Details of the principles and core standards to be used in the development and management of policies.

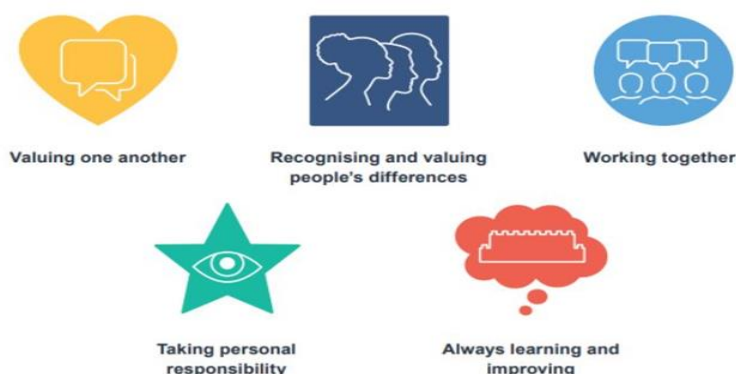
## 4.0 Duties within the Organisation - Roles and Responsibilities

### Our Patient safety culture

LPT is committed to continuously learn from patient safety incidents and has developed understanding and insights into patient safety activity over a number of years. The Trust promotes a 'just culture' approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture.

A 'just culture' is one that clearly defines acceptable behaviour and recognises the potential for human error. We are conscious that fear of blame and lack of psychological safety can be barriers to raising concerns and therefore reduces opportunities to learn and improve. To support staff, this policy aims to encourage managers to treat staff involved in a patient safety incident in a consistent, constructive, and fair way that maximises learning opportunities.

Our leadership behaviours framework sets the standards we expect in our daily work. Meeting these standards and developing the capability to exceed them, will ensure that we continue to improve and respond flexibly to changing needs as an organisation. We believe this will also help our staff to fulfil their potential, both in terms of personal achievement and career advancement. The behaviours we expect



to see at LPT are:

Patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk and improve safety and are not undertaken to apportion blame, liability, define avoidability, or cause of death. We are committed to enabling a 'just and learning' culture, where people feel able to speak up when things go wrong to enable us to share knowledge, learn and continuously improve. We demonstrate our commitment to a 'just and learning' culture throughout our organisation, and this is reflected in our policies and procedures, including our human resources policies and procedures.

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- Openness and transparency through prompt reporting of patient safety events and concerns which is a requirement of all our staff.
- Ensuring our staff feel able to report incidents and raise concerns without fear of recrimination is essential to improving safety.
- Fully supporting staff to report patient safety incidents, near misses and to raise any safety related concerns to ensure timely safety improvement and learning so that system risks can be addressed, and future harm prevented.
- Ensuring our staff feel confident and able to speak up about any concerns they may have and feel safe when doing so. However, we recognise sometimes staff do not wish to raise concerns with their direct line manager and therefore advocate the use of our Freedom to Speak Up Guardians who support staff to raise concerns and facilitate escalation.
- Being open and honest with patients, relatives, carers, and our staff when things appeared to have gone wrong.
- Creating a review and investigation approach that engages those involved in a patient safety incident from the outset and encourages a transparent, open, and safe space to discuss patient safety concerns. Staff will never be left feeling isolated and uninformed about what will happen following a patient safety incident.
- Creating a positive incident reporting culture across all areas of the organisation, ensuring that the principles of 'Just Culture' apply in the way in which we treat our staff involved in incidents in a fair and consistent way.

To enable this in practice, as part of our incident responses and compassionate engagement we will ask:

- Who has been hurt?
- What are their needs? What matters to them?
- How do we best meet those needs?

The Trust recognises some staff may find it stressful or traumatic to raise concerns about an event and that they may prefer to speak with an organisation outside of their own initially. Line managers will ensure that staff are aware of the Trust's Freedom to Speak Up (Raising Concerns) Policy and that open disclosure by staff will be treated with confidence and support will be provided to staff who openly disclose information connected to any safety incident or potential safety incident.

### **Promotion of 3 key areas of a positive patient safety culture through:**

- Promoting a just and restorative approach to patient safety incidents
- Using a systems-based approach to respond to and learn from patient safety incidents which focus on how the design of the wider-system in which staff work creates challenges to the delivery of care.
- Ensuring HR policies prevent the automatic suspension or any other disciplinary process for staff affected by a patient safety incident.

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- Ensuring disciplinary processes related to patient safety are overseen by staff with an understanding of patient safety, system factors and just and restorative practice (e.g., trained oversight leads).
- Ensuring investigation reports and improvement plans following an incident do not focus primarily on staff involved, including individual reflection or re-training.

### **Compassionate engagement and support**

- Ensuring engagement, involvement and support of all people affected by patient safety incidents is the number one priority for any response.
- Ensuring systems are in place to support, or at the minimum signpost to support services, people affected by patient safety incidents.
- Promoting the meaningful involvement of patients and families in sharing how the organisation learns and improves following a patient safety incident.
- Proactively identifying and answering questions of people affected.
- Open and transparent reporting and investigating of patient safety incidents.
- Promoting and facilitating the recording of patient safety incidents by staff affected by them, or those who become aware of them within the organisation and wider system for the purpose of developing meaningful insight and supporting the delivery of effective improvement work.
- To gain feedback from those involved in patient safety investigations including staff, patients, and families with the purpose of learning and improving the review and investigation process.

### **Focusing on system-wide improvement**

- Ensuring the delivery and evaluation of effective and sustainable safety improvement work is at the forefront of governance and oversight processes rather than performance management or focus on individuals.
- Promoting collaboration on patient safety improvement projects across organisational boundaries.

The organisation is committed to ongoing safety culture improvement activities in line with the NHS Patient Safety Strategy. This includes the use of:

- Recognised safety culture assessment tools
- NHS England safety culture guide to provide insight and inform improvement in safety culture.
- Use of safety culture metrics within NHS staff survey to triangulate data regarding staff experience/safety and data on diversity to drive improvements in culture and addressing inequalities.
- Collaboration between patient safety, workforce, and wellbeing teams.

## **Roles and Responsibilities (individuals and teams)**

### **Chief Executive**

The Chief Executive has ultimate responsibility for all aspects of patient safety, ensuring incident responses are proportionate and effective and learning is identified and shared across the organisation. The Chief Executive is committed to LPT

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demonstrating sustainable improvement based on learning from patient safety incidents. This involves ensuring services are adequately resourced to comply fully with the NHSE Patient Safety Responsibility and the Patient Safety Incident Response Framework with clear oversight roles and responsibilities.

### **Executive Directors**

Have a responsibility to:

- Ensure staff awareness and understanding of Trust and NHSE policy relating to patient safety.
- Ensure responses to patient safety incidents are proportionate and all reviews and investigations are managed effectively and appropriately and there is a focus on learning and improvement.
- Ensure that areas for improvement and patient safety actions are appropriate and implemented within their services.
- Provide assurance through active participation in corporate committees that learning has been shared Trust wide.
- Provide evidence that practice has improved as a result of what we have found through our learning responses.
- Ensure patients, families, and carers along with staff are involved in all learning responses.

### **Director of Nursing, AHPs, Quality and Patient Safety**

Is the designated PSIRF executive lead and has the following responsibilities in addition to those of all Executive Directors:

- Ensuring all patient safety incidents are managed and reviewed or investigated appropriately according to LPT Policy and meet the national patient safety incident response standards.
- Alerting the Chief Executive in relation to high-profile cases or those that risk organisational reputation.
- Sharing learning, appraising the Chief Executive and Trust Board of incidents that are reportable to the Care Quality Commission, NHSE, ICB and other external stakeholders.
- Interface with the ICB regarding system quality updates and National Quality Board requirements.
- Ensure staff and patients involved in patient safety incidents, actual and near misses, are supported.

Ensuring PSIRF is central to overarching safety governance arrangements:

- Patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, PSII thematic analysis and oversight and progress are discussed at Board and leadership teams' relevant sub-committees.
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

Quality assuring learning response outputs:

- Ensuring the PSII and other learning responses are conducted to the highest standards.

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- Ensure that learning is demonstrable and evidenced with areas for improvement identified, safety actions and improvement plans being appropriate and robustly monitored.
- Ensure effective arbitration where differences of opinion arise.
- Oversee and complete the Executive sign-off process, being accountable for the quality and content of the organisation's patient safety learning responses.

### **Medical Director**

Has the following responsibilities in addition to those of all Executive Directors:

- As Caldicott Guardian the MD ensures the principles of 'Being Open' and 'Duty of Candour' underpin all patient safety incident responses (see information governance section below).
- Ensure staff and patients involved in patient safety incidents, actual and near misses, are supported.
- Ensure medical engagement and expertise in the review and investigation process, where appropriate.
- Monitor the quality and effectiveness of reporting and subsequent investigations by receiving and commenting on trend analysis and learning response and investigation reports.
- Quality assures learning response outputs, reviewing reports which are likely to be reviewed externally in line with patient safety response standards.
- Ensure effective arbitration where differences of opinion arise.
- Oversee and complete the Executive sign-off process, being accountable for the quality and content of the organisation's patient safety learning responses.

### **Directorate Operational Directors**

Have the following responsibilities in addition to those of all Executive Directors:

- Ensure policies relating to patient safety incident reporting and learning responses are applied consistently by staff within their directorate.
- Ensure all information submitted through the IRLM process is robust and appropriate.
- Ensure that family/carer feedback and queries are addressed as part of the investigation and learning response process.
- Ensure learning responses undertaken by clinical and operational leads within their directorate are completed within agreed timescales and to a good standard using a systems approach.
- Ensure the report approval process within their directorate is robust and inclusive, taking account of the investigator, clinical leads, patient, family, and staff views.
- Approve completed learning response reports, including agreement and ownership of SMART patient safety actions in response to identified areas for improvement, prior to submission to the Chief Nurse and / or Medical Director.
- Ensure evidence to close actions is suitably robust and accessible to all relevant parties and is stored in the incident on Ulysses.
- Facilitate quality improvement to continuously improve patient safety through demonstrable practice change.

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## Directorate Clinical Leadership Team

Heads of Nursing and Associate Medical Directors have a responsibility to:

- Ensure policies relating to patient safety incident reporting and learning responses are applied consistently by staff within their directorate.
- Ensure that detailed incident reports are completed on Ulysses as soon as is practicable and within 24 hours of incidents/near misses occurring.
- Ensure review of their daily patient safety incident reports by their team / service / department ensuring timely escalation and determining whether an ISMR is required.
- Raise and record any concerns regarding patient safety incidents with the relevant Service Manager / Clinical Teams.
- Maintain robust processes for the review of relevant risk assessments following a patient safety incident and ensure early learning and action where required.
- Ensure all completed ISMRs are reviewed and the CPST informed of the outcome, escalating appropriate incidents for review through the Incident Review and Learning Meeting (IRLM).
- Inform the health and safety team if the patient safety incident results in staff absence from work (even if this does not happen immediately after the incident) or any changes to staff duties and ensure Ulysses is updated.
- Agree and record Terms of Reference (ToR) of all investigations using designated template.
- With the relevant departments, ensure support is available to all staff and patients/families involved in an incident.
- Review and approve all investigations before sharing with patient / family / carers and staff, as part of their right to reply.
- Quality assures learning response outputs, reviewing SEIPS, AAR and PSII reports in line with patient safety response standards and sign-off completed reports.
- Ensure that all patient safety actions are appropriate and SMART and will deliver improvements in areas identified, notifying the directorate governance team of any amendments.
- Quality assure evidence collated to complete the actions within timescales and ensure it is stored on Ulysses.
- Ensure Being Open/Duty of Candour process and family/carer involvement is complete.

## Corporate Patient Safety Team

Has a responsibility to:

- Update and provide clear and current policy guidance and plans for staff relating to LPTs patient safety incident reporting and response framework, including culture of candour, and engaging and involving patients, families, and staff.
- Maintain an accurate patient safety incident management system on Ulysses for all incidents resulting in moderate or severe harm, where problems in care are thought to have contributed.
- Ensure multidisciplinary review of ISMRs / safeguarding alerts where there is potential for further learning, to determine a proportionate response through the Trust weekly Incident review and learning meeting (IRLM).

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- Complete Patient Safety Incident Investigations (PSIIs), consistent with national expectations, where required.
- Support the thematic review of findings and areas for improvement from patient safety incidents in directorates, through the relevant governance groups.
- Produce comprehensive patient safety assurance reports for the Board and sub-committees, presenting themes and trends and highlighting risk and mitigations.
- Provide specialist safety support to learning response leads and investigators.
- Ensure staff in LPT have the necessary skills to report, review, investigate and learn from patient safety incidents, setting out essential training and delivering or commissioning training for learning response leads, investigators, and oversight officers.
- Provide support to directorates with the quality assurance and sign-off process.
- Track and monitor all reviews and investigations through a central tracker.
- Provide specialist patient safety and specialist clinical advice related to patient safety to directorates and Executive Team
- Provides assurance for the statutory responsibility for regulation 20 Duty of Candour.
- Maintain up to date patient safety information on the Trust website to enable PSIRF delivery and learning to be shared.

### **Directorate Clinical Governance Teams**

Have responsibility to:

- Support local governance processes, including incident and risk management. Oversee the progression and quality of local learning responses.
- Lead on the assurance of engagement with patients, families and carers following a patient safety event themselves or through clinical services familiar to the patient/family.
- Uphold and engage with the principles of PSIRF and identify and support learning and safety improvements through quality improvement programmes within their individual directorates.
- Ensure concerns, changes to practice, best practice and learning from incidents, are captured, and shared with relevant staff and across the Trust.
- Produce comprehensive patient safety incident response reports for the directorate analysing and presenting trends and highlighting areas of concern and good practice.
- Track and monitor directorate reviews and investigations through a central tracker and oversee the delivery and completion of action plans within agreed timescales.

### **Health and Safety team**

Has a responsibility to:

- Report all incidents that result in harm to patients under Reporting of Diseases and Dangerous Occurrences Regulations (RIDDOR) to the Health and Safety Executive (HSE) when harm to patients arises out of or from activities related to provision of care giving tasks.
- Contribute to IRLM from a health and safety approach.

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- Provide specialist support and information and engage in the learning response and patient safety investigation process.
- Utilise recording of their information and involvement in patient safety incidents and near misses reporting on Ulysses.
- Be aware of and act consistently within LPTs patient safety policy framework.
- Escalate through local reporting procedures any patient safety concerns or risks that may require further investigation, along-with potential solutions.

### **Information Governance (IG) Team:**

Has responsibility for:

- Ensuring all IG incidents are reported to the appropriate bodies including the Information Commissioners Office (ICO).
- Contributing to, as a specialist officer, or investigating all IG incidents producing IG reports, showing trends.
- Discussing work system or socio-technical system learning from these incidents at the Information Governance Steering Committee.
- Reporting annually all IG incidents in the annual report and the Statement of Internal Control (SIC)

### **The Caldicott Guardian and Senior Information Risk Officer (SIRO)**

Has responsibility for:

- Reflecting patients' interests regarding the use of patient identifiable information.
- Ensuring patient identifiable information is shared in an appropriate and secure manner.
- Fostering a culture for protecting and using data.
- Providing a focal point for managing information risks and incidents.

### **All Employees**

Have a responsibility to:

- Report patient safety incidents and near misses on Ulysses, in line with timescales set out in local and corporate supporting policies and procedures.
- Inform and apologise to patients and families at the time of the incident.
- Be aware of, and act consistently within LPTs patient safety policy framework.
- Describe details of early learning and actions taken on the incident reporting template.
- Escalate through local reporting procedures any safety concerns or risks that could require further investigation.
- Be fully open and engage in the learning response and investigation process.
- Escalate concerns through local reporting procedures and solutions to improve patient safety.

### **Patient Safety Partners (PSPs) role is to:**

- Work with the Trust to deliver the PSIRF standards by being involved in training and safety improvements.
- Offer insight as a 'critical safety friend'.

Their key function under PSIRF is shared separately in the report.

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## **Preparation, transition, and implementation of the new framework**

Is led and facilitated by the Corporate Patient Safety Team and supported by, and includes of the following roles:

- Director of Nursing, Allied Health Professionals, Quality and Patient Safety
- Deputy Director of Nursing Quality and Patient Safety
- Trust Medical Director and associated deputies
- Patient Safety Specialist Lead – Head of Patient Safety
- Incident Investigation Corporate Lead and Patient Safety Specialist
- Lead Nurse for Patient Safety
- Directorate Quality and Safety Governance Leads
- Trust Lead for Quality Improvement and Governance
- Heads of Nursing/Leads for Allied Health Professionals (AHP) for all Clinical Directorates supported by Deputy Heads of Nursing/Service Leads
- Clinical Operational Directors/Heads of Services

The following governing committees are in place to oversee the successful transition to and implementation of PSIRF through:

### **Trust Board**

The Trust Board has the responsibility to ensure it receives assurance that the PSIRF plan is being implemented, and that the organisation has a focus on learning and improvement. It will do this through robust reporting arrangements from the relevant sub committees.

### **Quality Forum**

The Trust's Quality Forum will monitor the output of patient safety learning responses on behalf of the Trust Board. The forum's terms of reference will include the need to ensure regular thematic reviews are undertaken to extract learning and support the development of organisational memory and continuous improvement regarding patient safety. In addition, the forum will have responsibility for receiving appropriate assurance that adequate governance arrangements are in place to monitor the embedding and delivery of PSIRF.

### **Trust Board Bi-Monthly Assurance Reporting**

The purpose is to enable the Trust Executive to obtain assurance that high standards of quality and safe patient care are provided by the Trust and adequate governance structures, processes and controls are in place. It receives the Quality and Safety report which has an overview of incidents, complaints, and claims data. The report contains the monthly submission of learning responses, including Patient Safety Incident Investigations (PSII).

### **Incident Oversight Group**

The Incident Oversight and Learning Group (IOG) is responsible for the operational processes in relation to managing incidents through the PSIRF standards. They will review incidents, ensuring the appropriate level of review is undertaken and confirming which incidents require a PSII.

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## 4.2 Patient Safety Partners

As part of our commitment to working with patients and members of the public LPT has a patient partner programme in place. Patient Safety Partner (PSP) roles are members of the public who support our quality and safety improvement work. In line with the NHSE guidance [Framework for involving patients in patient safety](#)

The role of the PSP continues to develop; currently the main role is to gradually integrate into the Corporate Patient Safety team, attend committees, and key safety projects identified through PSIs. Using lived experience as a patient or a member of the local community PSPs can support and advise LPT on activities, policies and procedures that will improve Patient Safety and high-quality care. PSPs will have an important role in supporting our work under PSIRF; this includes:

- Undertaking the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as other relevant training.
- Participate in investigation oversight and learning groups and be active members of other patient safety governance and oversight groups and work streams, with the aim of helping us design safer systems of care and prioritise risk.
- Encourage Patients, Families and Carers to play an active role in their safety.
- Contribute to safety improvement plans following investigation, particularly around improvement actions that address the needs of patients.
- Contribute to patient safety and engagement training for staff where appropriate.

## The wider picture of patient safety

### Addressing health inequalities

LPT has an Equality, Diversity, and Inclusion (EDI) policy which outlines the Trust's approach to meeting the diverse needs of the population it serves and its workforce.

LPT will consider EDI as part of implementing PSIRF through:

- Recognition that some groups of society can experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, transgender, pregnancy/maternity, and marriage/civil partnership. However, the Trust also acknowledges that other minority groups may also experience unfair treatment and discrimination.
- Impact from health inequalities or equality, diversity issues have also been included in the standard terms of reference for all PSIs, because of the gaps in data identified with stakeholders, during the development of the PSIRP.
- Our engagement with patients, families and carers following a patient safety incident, must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues should be identified early, and their needs supported through engagement with patients and families, for example,

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during the duty of candour / being open process and explaining a patient safety investigation process and the importance of hearing their voice.

- Considering our safety actions in response to any incident we will consider if there are any inequalities, and this will be built into our governance and safety actions.
- Gaining data as part of the transition to the Learn From Patient Safety Events Service (LFPSE), which captures all reported patient safety incidents from NHS care providers in England, it is expected that data analysis will be used to identify themes relating to specific characteristics on an annual basis. Any themes identified will be used for informing subsequent versions of the Trust's patient safety incident response policy and plan.
- Improving our recording of EDI data related to our patients as part of incident reporting and responses.
- EDI data will be collected on all learning responses and collated on a 6monthly basis and reported into Trust wide EDI group and through patient safety board assurance report.

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

PSIRF recognises that learning and improvement following a PSI can only be achieved if supportive systems and processes are in place. It supports the development of an effective PSI 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 PSIs to understand and answer any questions they have in relation to the incident and signpost them to support as required.

LPT will embrace the guidance for engagement with those affected by a patient safety incident outlined in the [Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide](#)

We recognise the significant impact PSIs can have on patients, their families/carers, as well as on staff. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the Trust as part of the investigation process. Engaging with those affected by a PSI helps us to improve our understanding of what happened, and potentially how to prevent a similar incident in future. Equally, we will respect the wishes of patients, families/carers who do not wish to contribute to an investigation or engage with our staff.

LPT has a robust Culture of Candour /Being Open (incorporating Duty of Candour) process in place which is followed at corporate and clinical directorate levels based on the Trust Policy which aligns with this policy in relation to openness and transparency and patient, family/carer engagement.

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## How Duty of Candour/Being Open will be upheld.

LPT has a statutory obligation to uphold the Duty of Candour and its staff must provide a meaningful verbal and written apology, expressing regret, responsibility, reason, and remedy, to the patient or their family or carers in line with the “A Culture of Candour Policy (Incorporating ‘Being Open’ and ‘Duty of Candour)’ for all PSI’s of moderate harm and above.

There is no legal duty to investigate a patient safety incident whereby low/no harm/near miss was the outcome as the consideration for the psychological impact should always be considered and to embrace the opportunity for learning., However, staff should follow the ‘Being Open’ process and inform the patient and/or family when incidents happen.

Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must as part of an initial and final response to patients/family/carers:

1. Tell the person/people involved (including family) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened.”
3. Provide a true account of what happened, explaining whatever is known at that point, especially soon after an incident has occurred.
4. Explain what else is going to be undertaken to understand the events, their role and who will undertake the review. For example, review the facts and develop a brief timeline of events, to identify any learning.
5. Follow up by providing this information, and a further apology, in writing, and providing an update. For example, talking them through the timeline and findings giving the opportunity to discuss.
6. Keep a secure written record of all meetings and communications and final apology linked to the findings.

## Engagement of patients, families, and staff

As part of our compassionate engagement and inclusion in PSI investigations we will adopt the following approach with our patients, families/carers by:

- Informing them investigation is being undertaken into the incident and what this means to them.
- Encouraging them to be engaged/involved in the investigation which will include the sharing of terms of reference and asking for them to share any concerns /questions in relation to the incident for learning response leads to include and ensuring we understand if they have additional needs to help them participate in this process.
- Broader concerns raised by the patient/family relating to care provision not

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directly associated with the incident, should be addressed through an alternative route agreed with the family.

- Agreeing a named contact and contact times/updates.
- Agreeing how they or their loved one will be addressed in the report and inviting them to share a short story of themselves or loved ones and offer inclusion of a photograph in the final report.
- Keeping them up to date with the investigation progress.
- Being given the opportunity to review the findings and respond to a draft copy of the completed report that will be written in a way that they can understand its content and if required, translated to their native language.
- Being informed of the eventual outcome and learning to be implemented.

## Summary of effective and compassionate engagement



### Leadership

Managers and leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions.



### Training and competencies

PSIRF sets specific expectations regarding training required for engaging and involving those affected by patient safety incidents.



### Support systems

Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response.



### Ensuring inclusivity

Engagement and involvement must take into account individual needs. Organisations should consider this in the design and delivery of their service.



### Information resources

Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process.



### Processes for seeking and acting on feedback

Organisations must assess the progression and outcome of engaging with those affected by a patient safety incident and their involvement in a learning response.



### Processes for managing dissatisfaction

When the expectations of those affected are not met, families and staff must be given meaningful, truthful and clear explanations as to why this was not possible.

The above is in addition to the Trusts statutory requirement to undertake duty of candour/being open.

As part of adoption of the PSIRF and learning, we are supporting staff in effectively engaging in a compassionate way, with staff, patients, and their families during all levels of patient safety incident reviews. We have developed a process for gathering

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feedback proactively to allow us to learn from our engagement and develop our response as we embed PSIRF. Following a completed learning response an online anonymous questionnaire, or a paper format which will be distributed and evaluated undertaken by the Corporate Patient safety Team.

To summarise our compassionate response will include:

- Ensuring engagement, involvement and support of all people affected by patient safety incidents is the number one priority for any response.
- Ensuring systems are in place to support, or at the minimum to signpost to support services, people affected by patient safety incidents.
- Promoting the meaningful involvement of patients and families in sharing how the organisation learns and improves following a patient safety incident.
- Proactively identifying and answering questions of people affected in line with the scope of the learning review or signpost to other organisations and to signpost to gain support for other aspects of care that are not part of the incident response.
- Open and transparent reporting and investigating of patient safety incidents.
- Gaining feedback from those involved in learning responses including staff, patients, and families with the purpose of learning, and improving from their experience of the learning response process.

### **Patient and Family Liaison Officer Role (also known as the 'FLO')**

The role is to ensure that patients/families are supported sensitively and compassionately during the review process, giving them a chance to ask questions and raise concerns. They will work in collaboration with learning response leads/corporate patient safety investigators to keep them informed about progress and support the sharing of any learning identified in an open and transparent way.

The Patient and Family Liaison Officer will:

- Develop a supportive and ethical relationship with the patient/family by building trust.
- Act as a single point of contact and sharing information between patient/families and in collaboration with the learning response leads and will agree a communication strategy to avoid confusion and provide consistency related to 'engagement'.
- Provide information about additional services available to families and signposting to support agencies, such as bereavement support charities.
- Explain how HM Coroners work if appropriate, so that families can access related services and support.
- Record any contact they have with the patient/family.
- Share questions or concerns raised by patient/family with the learning response leads.
- Ensure equality and diversity needs of patients/families are considered.
- In conjunction and agreement with the learning response leads, will update patient/families about the progress of a review.

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- Ensure patients/families continue to be supported, if needed, when the learning response is completed and 'closed' with a plan to withdraw the support gradually.

## **Supporting and Involving our Staff/Partners**

When a staff member reports an PSI or is sharing their insights/involvement into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. It is recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame.

Where an incident of assault to a member of staff has occurred, the member of staff manager is also required to notify the Local Security Management Specialist (LSMS).

We recognise that many staff will be involved with a PSI at some point in their careers and for some, this can be a traumatic experience. As part of our commitment to staff health and wellbeing we currently have the following staff support available:

- Immediate individual support through line manager, team leader, shift coordinators, professional nursing/midwifery advocates at the time of the incident including release from duties and cover arranged for the remainder of the shift if necessary.
- Arranging a team de-brief immediately after the incident
- Individual counselling via Occupational Health and Wellbeing
- Self-referral scheme for external Confidential Staff Counselling Service
- Support provided by the Chaplaincy department.
- Debriefing utilising staff psychology services in mental health services
- Referring to the Post-Incident Pathway for Staff Support (PIPSS) Policy (2024)

### **Staff involved must inform their manager if:**

- They are experiencing difficulties following an incident or because of the requirement to act as a witness.
- They wish to request referral to relevant support services.
- They require time away from the workplace to attend meetings associated with a claim or court proceedings, or to attend for counselling or support.

Staff involved in an investigation may find the process stressful and it is therefore important that staff are also appropriately supported at this time and must also:

- Be informed if a learning response is being undertaken into the incident in which they were involved.
- Engage in the learning response and be invited to be involved which will include the sharing of terms of reference, ISMR, copy of the incident report and information around what to expect as part of the learning response.
- Be kept up to date with the progress.
- Be given the opportunity to review the findings and respond to a draft copy of the completed report.

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- Be informed of the eventual outcome and learning to be implemented.

As part of adoption of the PSIRF framework, and part of supporting our staff engaging in learning responses, we have developed a process for gathering staff feedback following a completed investigation through an online anonymous questionnaire to proactively allow us to learn from our response leads engagement and develop our future engagement as we embed PSIRF. This will be facilitated by the Corporate Patient safety Team and feedback shared through IOG, anticipated on a quarterly basis.

## **Patient safety incident response planning**

Organisations are expected to uphold the patient safety incident response standards to ensure they meet the minimum expectations of the Patient Safety Incident Response Framework (PSIRF). The standards cover the following aspects of PSIRF:

- Policy, planning and oversight.
- Competence and capacity.
- Engagement and involvement of those affected by patient safety incidents.
- Proportionate responses.

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 and some previous 'serious incident' definitions.

Beyond nationally set requirements, LPT will explore patient safety incidents relevant to their context and the populations it serves rather than only those that meet a certain defined threshold and those chosen through incident data analysis and the opportunity for learning. PSIs considered to meet threshold for review against PSII or local priorities incidents for review, will continue to be reviewed at the Trusts Incident Review Meeting that is currently held weekly.

Staff will be supported in being involved in reviewing and learning from patient safety incidents with the principles outlined in the 'NHSE Just Culture' approach underpinning this and will apply the principles outlined in the [Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide](#) and includes:

- PSII's will only be undertaken by corporate patient safety investigators.
- Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience.
- Learning responses are not led by staff who were involved in the PSI itself or by those who directly manage those staff. Directorates are responsible for ensuring this.
- Learning response leads should have an appropriate level of seniority and influence within an organisation – this may depend on the nature and complexity of the incident and response required.
- Learning responses are not undertaken by staff working in isolation. A learning response team should be established to support learning responses wherever

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possible. This could include a lead reviewer/investigator, subject specialist, safeguarding specialist, pharmacist, nurse/Allied Health Professional specialist (AHP).

- Engagement and involvement activity may be led by the person leading a learning response, or by a family/staff liaison officer or similar.
- Staff affected by patient safety incidents are given time and are supported to participate in learning responses.
- Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.
- There is dedicated staff resource to support engagement and involvement of those affected.

Our Patient Safety Incident Response plan (<https://www.leicspart.nhs.uk/wp-content/uploads/2023/11/LPT-PSIRP-Sept-2023-FINAL.pdf>), sets out how LPT intends to respond to patient safety incidents over a period of 12 to 18 months and will be regularly reviewed. 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.

In addition, the Trust Investigation profile was identified between the dates of April 2022 and December 2023 which identified there were:

- 93 serious incident investigations undertaken.
- 276 Internal/SEIPs approach investigations were undertaken.

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## Resources & training to support patient safety incident responses.

Training for key staff has been mapped according to the role descriptions and related training requirements set out in the Patient Safety Incident Response Standards, and as set out below:

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
<b>Systems approach to learning from patient safety incidents</b>	2 days/12 hours	<ul style="list-style-type: none"> <li>• Introduction to complex systems, systems thinking and human factors</li> <li>• Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews</li> <li>• Safety action development, measurement, and monitoring</li> </ul>	✓		✓
<b>Oversight of learning from patient safety incidents</b>	1 day/6 hours	<ul style="list-style-type: none"> <li>• NHS PSIRF and associated documents</li> <li>• Effective oversight and supporting processes</li> <li>• Maintaining an open, transparent and improvement focused culture</li> <li>• PSII commissioning and planning</li> </ul>			✓
<b>Involving those affected by patient safety incidents in the learning process</b>	1 day/6 hours	<ul style="list-style-type: none"> <li>• Duty of Candour</li> <li>• Just culture</li> <li>• Being open and apologising</li> <li>• Effective communication</li> <li>• Effective involvement</li> <li>• Sharing findings</li> <li>• Signposting and support</li> </ul>		✓	✓
<b>Patient safety syllabus level 1: Essentials for patient safety</b>	eLearning	<ul style="list-style-type: none"> <li>• Listening to patients and raising concerns</li> <li>• The systems approach to safety: improving the way we work, rather than the performance of individual members of staff</li> <li>• Avoiding inappropriate blame when things don't go well</li> <li>• Creating a just culture that prioritises safety and is open to learning about risk and safety</li> </ul>	✓	✓	✓
<b>Patient safety syllabus level 2: Access to practice</b>	eLearning	<ul style="list-style-type: none"> <li>• Introduction to systems thinking and risk expertise</li> <li>• Human factors</li> <li>• Safety culture</li> </ul>	✓	✓	✓
<b>Continuing professional development (CPD)</b>	At least annually	<ul style="list-style-type: none"> <li>• To stay up to date with best practice (eg through conferences, webinars, etc)</li> <li>• Contribute to a minimum of two learning responses</li> </ul>	✓	✓	✓

## LPT's capacity to respond & learn from patient safety incidents.

The Trust has a commitment to continuously learn from patient safety incidents and has developed understanding and insights into patient safety activity over several years. We have committed to the recruitment of corporate patient safety investigators to ensure we have the resource, skill, and expertise to undertake PSII system reviews.

For existing directorate staff who are expected to undertake local learning reviews training continues to be available and is now focussed on Systems Engineering

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Initiative for Patient Safety (SEIPS) training and engagement. The Corporate Patient Safety Team will continue to support the upskilling of staff to use human factors approach and system thinking to consider and review all incidents. This will require a long-term approach to develop and build on these skills and competencies across the organisation.

Human factors, systems training, and engagement is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days through accredited organisation with a recognised organisation, are up to date in learning response best practice and have both undertaken and reviewed learning responses.

Training is expected to cover the methodologies within PSIRF including:

- Systems approach to learning from patient safety incidents - SEIPS (Led by LPT CPST)
- Engaging and involving those affected by PSIs in the learning response process. (Led by LPT CPST)
- Oversight of learning from PSIs. (Led by LPT CPST in conjunction with clinical directorates)
- After Action Reviews (AAR) – external training
- Structured Judgement case Reviews (SJR) for learning from deaths – external training

Training is available to all relevant staff groups and has been running throughout 2021, 2022 and 2023 applying the human factors approaches to investigating and in 2024 as Systems approach to learning from patient safety incidents - SEIPS.

As part of the organisational review for PSIRF; dedicated roles could be considered for assignment to staff groups in keeping with the Patient Safety Incident Response standards as linked above, and are defined as below (this should be part of aspirational development to support PSIRF):

<b>Staff Group</b>	<b>PSIRF roles</b>
Director of Nursing/AHP & Trust Medical Director	Oversight & Overall PSIRF Executive Leads responsibility
Executives	Oversight
Clinical Directorates Heads of Nursing/AHP	Oversight
Clinical Directors, Directors of Operations, Deputy Directors of Nursing, Head of Nursing/Service Leads	Oversight
Directorate Clinical Quality Governance Teams	Support Learning Response Leads Engagement Leads
Corporate Patient Safety Team	Oversight Learning Response Lead Support Engagement Lead

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	External & Internal Organisational Liaison
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## PSIRF executive lead responsibilities in responding to patient safety incidents and learning for improvement.

The PSIRF executive leads, supported by the rest of the Board/leadership team, will oversee the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring they meet the expectations set out in the patient safety incident response standards where relevant. Their role is to ensure the organisation meets national patient safety incident response standards.

The board or leadership team 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. It is the PSIRF executive lead's responsibility to ensure:

- Patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s)
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

For further detailed information in relation to the Trust Board please see 'Roles and Responsibilities (individuals and teams)' described earlier in this policy.

## Expectation of oversight roles

- 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 in an oversight role within an integrated care system (ICS) have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- 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.
- 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

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- 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.

Following discussion of incidents of concern at the Trust's Incident Review and Learning Meeting (IRLM), a decision will be made on the type of learning response required. Each Clinical Directorate has an internal Clinical Quality Governance team, which will oversee the production of local learning responses.

### **Expectation of Learning Response Leads in responding to patients safety incidents and learning**

- 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 NHSE 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.
- 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 highly complex matters and in difficult situations.
- Must not be part of the line management chain of the area being investigated and can only be asked to lead a learning response once they have had appropriate training.

### **Expectation of engagement leads in responding to patient safety incidents.**

- 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

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- other leads at least annually to build and maintain their expertise.
- Engagement leads contribute to a minimum of two learning responses per year.
- 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.

Each Clinical Directorate Group is responsible for ensuring appropriate staff have been trained in learning response tools. CPST is currently responsible for arranging PSIRF related training, for keeping a record of staff who have attended that training and when and making this information available to Clinical Governance Teams.

It is expected that all staff involved in learning responses will be provided with adequate time to participate in undertaking and receive managerial support throughout the learning response process.

### **Designated Patient Safety Incident Investigators**

LPT has designated Patient Safety Incident Investigators within the Corporate Patient Safety Team who are competent and trained to the level required as described by NHSE. They can apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources and to summarise and present complex information clearly and logically. They also have a range of skills to manage conflicting information from many sources and to communicate highly complex information, often, in difficult situations. These staff are responsible for completion of Patient Safety Incident Investigations (PSIIs) across multiple clinical groups/directorates and hold no other role at LPT.

### **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 learn from using it to respond to patient safety incidents. The Trust's PSIRF Policy and Plan will be reviewed and updated within two years of initial transition to PSIRF as part of regular oversight processes. An overall review of the PSIRF Policy and Plan should be undertaken at least every two - three years alongside a review of all safety actions 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 collaboratively agree any changes deemed necessary.

Updated plans will be published on our trust website, replacing the previous version(s).

It is envisaged that a rigorous planning exercise will be undertaken every 2-3 years

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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
- Wide review of organisational data (for example, patient safety incident investigation (PSII) reports
- Safety improvement plans
- Complaints, claims
- Patient, family/carer, staff, and investigation engagement survey results
- Staff national and local survey results
- Inequalities data
- Incident reporting data
- Wider stakeholder engagement.

When conducting the planning exercise, we will collaboratively assess:

- Allocation of resources – were they correctly balanced?
- Ongoing improvement efforts – are they achieving the desired impact? Should efforts continue or stop (where they are not delivering any improvement)?
- Stakeholder views, including those of patients and the public.
- Where thematic work may be needed to develop a safety improvement plan.

## **Patient safety incident reporting arrangements and oversight through governance processes**

Patient safety incidents are recorded and monitored through the Trust's Ulysses Incident Reporting System and will remain the same under PSIRF.

During the implementation of PSIRF the Trust's governance framework was reviewed and continues to evolve and it is anticipated that meeting functions and Terms of Reference will be reviewed and updated to support PSIRF as required. Monitoring of patient safety incidents at a local level will remain the same and in line with the Trust's Incident Reporting and Management Policy.

## **Patient safety incident response decision-making**

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through analysis of our patient safety insights, based on the review of incidents, engagement meetings and the planning day in June 2023, we have determined that the Trust requires six patient safety priorities as Trust priorities. We have selected this number based on the services that the Trust provides and outcome from the planning day with input from key stakeholders.

The detail for these incidents is described in the Trust Patient safety incident response plan (PSIRP) 2023-2024 which can be found on the trust public website. <https://www.leicspart.nhs.uk/wp-content/uploads/2023/11/LPT-PSIRP-Sept-2023-FINAL.pdf>

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

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risk and / or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

We will undertake five index case PSII in each of the types of incidents proposed (should they occur). This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors. We will use the outcomes of PSII to inform our patient safety quality improvement planning and programme of work.

### Terms of Reference for PSII's

Standard terms of reference have been agreed for all PSII's. These include the gaps that were identified during analysis of incidents for the PSIRF planning day (June 2023) and are described in the PSIRP:

- 1.To establish the impact of any workforce or skills deficit on the incident – this is not about apportioning blame but to review the impact of system issues on staff/staffing.
- 2.To investigate if the patient was in the care of more than one LPT service and to identify any systemic issues or breakdowns in communication between the services.
- 3.To consider if there was an impact on the care or patient experience from health inequalities or the patient's protected characteristics.
- 4.To identify if any electronic system used, impacted on the patient's care and experience.

Bespoke directorate developed terms of reference along with any patient/family concerns identified will developed and responded to within 3 working days from the IRLM and will be recorded in the 'Terms of reference (ToR) for investigations guide' document.

In addition to the above guidance which are related to [PSII's only](#) there is an investigator guide has been developed to include prompt questions for **all patient safety incident reviews** for investigators to consider and are described as:

- 1.To seek assurance for the Directorate Governance Team that DOC or Being Open has been completed.
- 2.The investigator to contact the patient/family member, if the patient is deceased it is family/next of kin to establish if there are any concerns they wish to raise in respect of care and treatment, how they wish the patient or themselves to be referred to in the report.
- 3.To agree with the patient/ relative how they wish to be kept informed of progress with the investigation and ensure any questions raised by the patient/family are clearly detailed in the report with clear answers.
- 4.To establish if the patient was on any waiting lists for any LPT services at the time of the incident.
- 5.To establish if there were any Safeguarding issues related to the patient and their care and how these were escalated and actioned.
- 6.Were there any outstanding tasks relating to this patient on SystemOne?
- 7.Does investigator consider staffing /skill mix (agency & bank) contributed to any

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learning identified?

8. Does staff involved consider staffing/skill mix contributed to the incident? 'yes or no' – would need a brief statement. (Add capacity/capability (knowledge and skills))
9. Was there any relationship with the electronic system/usability in this incident.

### **Immediate Safety/Care issues identified following an incident that signifies an unexpected level of risk / harm and/or potential for learning and improvement.**

Where a patient safety event is reported that signifies an unexpected level of risk / harm and/or potential for learning and improvement an MDT Review meeting will be arranged, chaired by the Director of Nursing or designated deputy or the Trust Medical Director or designated deputy, where the incident will be reviewed, and proportionate learning response agreed, and an initial learning response lead allocated. All discussion and decisions will be recorded on Ulysses. This is likely to occur before IRLM, however, the patient safety incident initial findings will go on to be presented at the next available IRLM.

On some occasions the escalation in relation to immediate safety/care issues that signifies an unexpected level of risk / harm and/or potential for learning and improvement may arise following further review of a patient safety incident at the ISMR stage and also following review at IRLM and further MDT review by the Director of Nursing or designated deputy or the Trust Medical Director or designated deputy sought to agree a response and understand the risks associated with the incident and impact on patient(s).

**A guide and response expectations are described in Appendix A.**

### **Emerging Issues**

It will be the responsibility of the Clinical Directorate Quality and Safety Governance groups 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**

We have collaborative arrangements with our ICB to facilitate cross-system learning responses. This includes processes for recognising when support may be required and raising this with ICB colleagues/collaboratives/PHLA commissioners. Learning responses will be managed locally to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to. However, where a response involving multiple providers and/or services across a care pathway is too complex for LPT to manage, the ICB as lead commissioner, will be asked to support the co-ordination of a cross-system response.

Our processes will support the recognition of incidents or issues that require a cross-system learning response. At local level, agreed governance routes for review of

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incidents will highlight such incidents requiring escalation to IRLM where ICB colleagues are invited to attend.

## Identification and review of incidents

Methodologies for identification of incidents at directorate level have also been agreed and will be reviewed as we learn. The weekly Trust-wide IRLM will provide support and advice for directorate teams and a record of discussion and decision making about learning responses. The type of response will depend on:

- The views of those affected, including staff, patients, and their families.
- What is known about the factors that led to the incident(s)
- If there is existing assured improvement work underway to address the identified contributory factors and if there is evidence that improvement work is having the intended effect/benefit

Patient Safety Incidents not for PSII will be reviewed using other methodologies and we have outlined several ways we can respond to individual incidents, including:

- **SEIPS model:** System Engineering Initiative for Patient Safety - a human factors methodology
- **After Action Review (AAR):** A structured facilitated approach to incident review
- **Multi-disciplinary team (MDT) meetings:** Structured Judgement case Reviews (mortality/morbidity and learning from deaths)

The criteria for selecting the type of response to patient safety incidents will depend on:

- The views of those affected, including patients and their families.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect/benefit.

The Trust has limited resources for patient safety incident response, and we intend to use those resources to maximise learning and improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Patient safety incidents that meet national threshold i.e., Never Events and deaths thought more likely than not due to problems in care/death under the mental health act, will always require a PSII through which we can learn and improve. For other types of incidents which may affect certain groups of our patients; (those with learning disability or a child), a PSII will also be required and are linked to national agreed approach; details are described in the Trusts PSIRP.

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## Timeframes for Learning Responses (also described as ‘investigations’)

Patient safety learning responses start as soon as possible after the incident is identified and will ensure that support is primarily provided to those affected first.

Learning responses must balance the need for timeliness and capture of information as close to the patient safety event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

*“The first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes.*

*It can be tempting to rush to identify what needs to change, but this cannot be done without understanding work as done, and the system factors that influence this. A thorough understanding of the work system can be gained using a learning response method such as investigation, multidisciplinary team review or after-action review, supplemented with a system-based framework to guide thinking (e.g., SEIPS, Yorkshire Contributory Factors Framework, HFACS, etc).” (NHSE PSIRF Guidance: Safety Action Development, p17)*

One of the most important factors in ensuring timeliness of a learning response is thorough, complete, and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only and are guided by NHSE principles Learning responses timescales will be applicable to the type of response taken:

- Initial incident review including Rapid Review should be undertaken as soon as possible, within 5 working days of reporting i.e., death by suicide.
- All initial service managers and learning reviews within 10 working days of reporting for review at IRLM and post Clinical Directorate review where escalation is required for consideration of appropriate patient safety response.
- Comprehensive patient safety investigations (PSII) will be undertaken – 60 – 120 working days depending on complexity, the timeframe for the completion of a PSII will be agreed with those affected, as part of the terms of reference. The aim should be always towards the 60day timescales wherever possible.
- If our PSII's are often taking more than 6 months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved.

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- All other learning responses related to SEIPs review will be completed within a 60 working days timescales, again taking into consideration of those involved in the incident.
- Falls After Action Reviews and any other incident using identified to use this approach to learning should be completed within 25 working days.

For the Trusts detail and expectation of recognition and management of **ALL** patient safety incidents please see:

## **Appendix B: Management of Patient Safety Incidents**

### **Detail for Management of Directorate Local Learning Responses and CPST management of PSIs.**

### **Additional Timeframe Guidance**

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused (i.e., police due to criminal investigation) , a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be shared and agreed with those affected (including the patient, family. and staff). The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

### **Request to Extend Investigation Timescale**

In most investigations, they will be completed with a final report and improvement plan signed off and completed within 60 days of the decision to undertake an investigation being reported. If there are extenuating circumstances that means the report will not be completed within the 60 day time frame, then an extension request can be undertaken and submitted to the Director of Nursing/medical director for review and approval. Examples include:

- Patient/family request
- Police investigation – impact on criminal investigation.
- Safeguarding investigation – overarching.
- Awaiting information or reports from individuals/teams external to the Trust.
- Awaiting external investigation reports.
- Unexpected long-term sickness of lead investigator means re-assigning the investigation.

CPST hold the Investigation ‘Extension to Completion Date’ Request Form and will share upon request. Completed extensions requests will need to be agreed through local directorate processes before being returned to CPST to be shared with Director

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of Nursing/Medical Director for approval. Correspondence will be stored on Ulysses and appropriate amendment of dates updated.

## Report Writing Standards for Patient Safety Investigations

The aim of undertaking a patient safety investigation is to share with those involved in incident our findings when something appears to have gone wrong during delivery of NHS care. It is also to identify learning so that as a Trust we minimise the risk of occurrence, and from a system perspective, share that learning with others. To do this our reports need to be written compassionately, professionally and be factually accurate.

The standards will assist staff undertaking investigations across the Trust in the report writing process, strengthening the consistency and quality of investigation reports to:

- Provide clarity of scope and the points we are making in our writing.
- Ensure reports are complete and concise.
- Respond only to the questions set out in the terms of reference which must demonstrate a proportionate response to the incident; patient/family/carer questions in relation to the incident/agreed timeline within the scope of the investigation, must be clearly described and answered in the report.
- Write in an objective way, that maintains a fair and balanced tone.
- Outline evidence, context and avoid subjective judgements. • Avoid technical language/NHS jargon or abbreviations that are not explained.
- Be mindful of who will read the report and ensure a report 'makes sense' when read on its own. Our reports become public documents that can be quoted in a public arena, on social media or by media outlets.

The Report Writing Standards for Patient Safety Investigations in full are found in **Appendix C**. All learning response leads/investigators are expected to refer to these and review their 'work' against these.

## Safety Action Development and Monitoring Improvement

As part of a learning response, areas for improvement will be identified for the responsible team. These will set out where a safety improvement is needed rather than define how that improvement will be achieved. These areas of safety improvement actions will then be progressed by the responsible team.

Further learning responses may identify that further work is required on areas for improvement to develop the safety actions. Where these are identified further support from a continuous improvement perspective will be explored with a Quality Improvement Facilitator.

Once areas for improvement have been identified, then safety actions in collaboration with the relevant teams will be identified. The safety improvements will then be assigned to the team via Ulysses by clinical governance teams for monitoring and completion.

Key messages:

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- The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutions at an early stage of the safety action development process.
- The process of developing safety actions 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.
- Understanding contributory factors and work as done should not be confused with developing safety actions.

Below provides an overview of the safety action development process that follows the identification of areas for improvement. While the process is depicted as linear, monitoring and review are cyclical in nature and can also inform the development of safety actions. Collaboration with relevant teams should be considered throughout the safety action development process.

Processes for safety action development are outlined by NHS England in the Safety Action Development Guide (2022) as below:

- 'Agree areas of improvement-Specify where improvement is needed without defining how that improvement is to be achieved.
- Define context-Agree approaches to developing safety actions by defining context.
- Define safety actions to address areas of improvement-continue to involve the team-make this a collaborative process, focus on the system.
- Prioritise safety actions -avoid prioritising actions based on intuition/opinion alone.
- Define safety measures-identify what can be measured to determine whether the safety action is influencing what is intended. Prioritise safety measures. Define measures and who is responsible for collecting, analysing, reporting, and acting on the data.
- Write safety actions-document in a safety improvement plan including details of measurement and monitoring.
- Monitor and review'.

## Writing Safety Actions

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found at:

<https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf>.

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 Safety to...".

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- 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).
- Explain the rationale for the action, e.g., “in order to increase the visibility of high-risk patients on the ward.”

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 recommended 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.

## 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 Directorate Management Team (via their Quality & Safety Meetings) will be responsible for the delivery of the Trust Safety Improvement Plan for their areas, providing assurance to PSIG and then onto the Quality Forum that the improvements identified are being actioned and monitored for their impact.

## Evaluating, sharing learning and monitoring outcomes of PSIs and other Patient Safety Reviews

- Learning from PSIs and reviews provide key insights and learning opportunities; they are not the end of the story.
- Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIs.
- Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.
- Reports to the board will be bi-monthly and will include aggregated data on:
  - Patient safety incident reporting
  - Audit and review findings

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- Learning from PSIRs
- Progress against the PSIRP
- Results from monitoring of improvement plans from an implementation and an efficacy point of view.
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

## **Executive Responsibility vs External Partner Oversight from ICBs**

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board.

<https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf>

The Board through the Executive Medical Director and Executive Director of Nursing who hold joint responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The board or leadership team 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. It is the PSIRF executive lead's responsibility to ensure:

- Patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s)
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.
- Mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement must form part of the overarching quality governance arrangements and be supported by clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.
- The board or leadership team should monitor the balance of resources going into patient safety incident response versus improvement. Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.
- Learning response outputs i.e., the final reports from all PSIRs should be reviewed, quality assured and signed off at the executive level.

Under PSIRF there is a shift from 'monitoring of process, timescales, and outputs' to meaningful measures of improvement, quality and safety, and outcomes for patients. It is recognised that this will be a gradual transition along with development of new skills and support to achieve this.

ICB's (including collaboratives) roles will focus on oversight of the PSIRF plan / priorities and monitoring progress with improvements. There will no longer be a

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requirement to 'declare' a serious incident, share initial reviews, and have individual patient safety responses 'signed off' by commissioners. However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety.

Leicester, Leicestershire & Rutland ICB remain LPT's lead commissioner and are engaged with all our weekly patient safety reviews at IRLM and the decision making around this. LLR ICB:

- Value sharing of patient safety incidents and engagement with initial reviews.
- Integral to gaining support where there is cross-system review required or likely to be for the purpose of learning.
- Request the sharing of PSII's and any other learning review that could cross healthcare systems/partners and will facilitate that sharing.

### **Sharing of completed PSIs/Learning Reviews with LLR ICB and all Specialist Commissioners:**

- Completed and LPT executive signed off PSIs will be shared with local system partners; this includes LLR ICB and designated commissioners/public health for specialist services.
- Reviews will not be signed off as it is for learning and sharing only; ICB (including other partners), will be offered the use of NHSE/NHSSIB learning review tool to be used as reflective feedback into LPT. They will not be able to make comments or insist on changes to descriptions/additional details included in a report.
- Non -PSI completed reports will not be shared unless agreed and recorded as such on Ulysses.
- All sharing of reports with LLR ICB and all Specialist Commissioners remains the responsibility of CPST.
- LLR ICB and all Specialist Commissioners will not share completed PSIs or any other learning review without agreement from LPT.

### **Sharing of completed PSIs/Learning Reviews with HM Coroner and CQC:**

- Completed and LPT executive signed off PSIs and Local reviews will be shared with HM Coroner to support the enquiry via LPT Legal team by CPST and recorded on Ulysses.
- Completed and LPT executive signed off PSIs will be shared with CQC via quality and compliance team by CPST and recorded on Ulysses.

### **Concerns from patients/families related to completed reports.**

Following completion of a learning response, a copy will be shared with the patient and/or their family, as identified and consented to during compassionate engagement communications. They will have the opportunity to check for factual accuracy and raise any queries; the investigator, along with identified senior staff member from the directorate will respond and hear their concerns and amendments made as agreed and clearly recorded.

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Should the patient/family still have concerns they will be offered an opportunity to meet with the Lead investigator and identified others via a [‘Being Open to their Concerns’](#) meeting to discuss the findings of the learning response and the unresolved queries they have or resolve any concerns that may arise.

### **Unresolved Concerns by patients/families in relation to completed report.**

Following the above ‘Being Open to their Concerns meeting’ process, should ongoing concerns remain in relation to the learning response process or the content of the report which the directorate/author are unable to reach a satisfactory conclusion with the patient/family this will be escalated to the Medical Director and executive Director of Nursing who will review and offer to meet with the patient/family to hear and work to resolve the concerns.

Should this still not satisfactorily address the concern(s) a complaint should be registered via the trust Complaints Team. The Trust will not be able to re-investigate the clinical concerns; this will however afford the patient /family their Ombudsmen rights and the complaints team will outline these.

The current version of the report must be updated and clearly describe the concern(s) that remain by the patient/family and any action taken to mitigate/explain the findings or why concerns cannot be answered.

The Complaints Team will log the complaint on the Trust incident and customer service database Ulysses.

This process is part of the duty of candour (DOC) process and the final DOC process will not be concluded while the trust continues to work with the patient and family and must be clearly recorded on Ulysses.

## **5.0 Consent**

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

If the patient’s capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

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## 6.0 Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Be realistic with the amount of monitoring you need to do and time scales.

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored.
29	Feedback on patients, families, and staff experiences of patient safety investigations	Online/paper questionnaire for feedback post completion of investigation reports	CPST - IOG	6monthly
12	External review for the Standard of patient safety learning Responses/investigations and the processes that support this	Safety Incident Response Accreditation Network (SIRAN Accreditation) through Royal College of Psychiatrists	CPST - IOG & Quality Forum	3yearly & mid-way review
26	EDI data will be collected on all learning responses and collated on a 6monthly basis	Through collation of data recorded on all completed learning responses	CPST – reported into IOG	Reported into Trust wide EDI group and through patient safety board assurance report

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## 7.0 References and Bibliography

### National guidance

- NHS England and NHS Improvement Patient Safety Strategy, accessible via: [Report template - NHSI website \(england.nhs.uk\)](#)
- [NHS England » Patient Safety Incident Response Framework](#)
- [NHS England » Primary care information on the new national learn from patient safety events service](#)
- [NHS England » Patient Safety Specialists](#)
- [NHS England » Framework for involving patients in patient safety](#)
- NHS England Patient Safety Incident Response Framework, accessible via: [B1465-1.-PSIRF-v1-FINAL.pdf \(england.nhs.uk\)](#)
- NHS England Engaging and involving patients, families and staff following a patient safety incident, accessible via: [B1465-2.-Engaging-and-involving...-v1-FINAL.pdf \(england.nhs.uk\)](#)
- NHS England Guide to responding proportionately to patient safety incidents, accessible via: [B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf \(england.nhs.uk\)](#)
- NHS England Oversight roles and responsibilities specification, accessible via: [B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf \(england.nhs.uk\)](#)
- NHS England Patient safety incident response standards, accessible via: [B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf \(england.nhs.uk\)](#)
- NHS England Patient Safety Incident Response Framework – Preparation guide, accessible via: [B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf \(england.nhs.uk\)](#)
- NHS England Safety action development guide, accessible via: [B1465-Safety-action-development-v1.1.pdf \(england.nhs.uk\)](#)
- NHS England SHARE debrief tool, accessible via: [B1465-SHARE-Debrief-v1-FINAL.pdf \(england.nhs.uk\)](#)
- [NHS Resolution: Being fair 2](#)

### Other PSIRF linked LPT Trust Policies reviewed as part of development

Patient safety incident response plan (PSIRP) 2023-2024 setting out how this policy will be implemented (2023).

<https://www.leicspart.nhs.uk/wp-content/uploads/2023/11/LPT-PSIRP-Sept-2023-FINAL.pdf>

- Equality, Diversity, and Inclusion Policy (2021)
- Freedom to Speak Up Policy: Speak up, Listen up, Follow up Policy (2023)

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- A Culture of Candour Policy (Incorporating 'Being Open' and 'Duty of Candour') (2024)
- Concerns and Complaints Policy (2024)
- Health and Safety Policy (2022)
- Incident Reporting and Management Policy (2024)
- Medication Errors Policy (2024)
- Risk Management Policy (2024)
- Quality Strategy (2024)
- Post-Incident Pathway for Staff Support (PIPSS) Policy (2024)
- Learning from Deaths Policy (2019 – being updated 2024)

**Other associated policies/Strategies include:**

- Infection Prevention and Control Assurance Framework Policy (2023)
- Data Protection and Information Sharing Policy: (incorporating Confidentiality, Information Sharing, safe-haven and Pseudonymisation procedures) (2021)
- 2021- 25 Our Equality, Diversity, and Inclusion (EDI) Strategy

## 8.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

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## Appendix A: Guidance for staff when 'Immediate Safety/Care issues are identified following an incident/event that signifies an unexpected level of risk / harm and/or potential for learning and improvement'. *Waiting for the next Trust IRLM is not appropriate.*

### Action to be taken:

When a patient safety incident/event is reported that signifies an unexpected level of risk / harm and/or potential for learning and improvement notification. Below describes examples to consider (clinical judgement should always be applied for other incidents):

- Homicide.
- Inpatient death of a patient under the Mental Health Act (1983), community patient under a community treatment order (CTO). CTO is an order made by a responsible clinician to give you supervised treatment in the community.
- Unexpected inpatient death of a patient on a mental health ward.
- Event does not allow the Trust to continue its day-to-day business or there is significant interruption to service delivery.
- Significant information governance breach involving many patients/staff's data.
- The incident/event is notified to the Trust through other means i.e., coroner due to family concerns, media.

The most senior directorate staff member responsible for the service(s) at the time of notification should take the following approach after ensuring local service responses have taken place:

- Notify the Executive Nurse (or designated deputy) and Trust Medical Director (or designated deputy) and share known information of the event/incident.
- If out of hours – contact Executive Director on call and Directorate senior manager and share known information of the event/incident.

From this initial information sharing a response to next step planning can be made i.e., who needs to be present at Multi-Disciplinary Team (MDT) planning meeting (this may include calling Trust 'experts' (i.e., safeguarding, Security, Data Privacy, Estates Lead).

### In hours

MDT meeting will need to be arranged usually over MS Teams, chaired by the Executive Nurse, or designated Deputy and Trust Medical Deputy or designated deputy, representative from senior corporate patient safety team (CPST), member of senior nursing/manager, clinical governance team member for responsible directorate, and any identified 'specialist'.

At the MDT, the incident will be reviewed with initial known details and next steps agreed. Output from this meeting includes:

- Ensuring the event/incident is recorded on the Trusts' incident reporting system Ulysses.
- An initial senior directorate response lead will be delegated to undertake/oversee the initial service managers review and respond within 48hrs to this and return to CPST to share with MDT meeting leads.

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- Consider the response to patient(s), families, and staff and who is responsible for this.
- All actions will be recorded on Ulysses under contact tab and summarised in email titled 'MDT ACTION and Ulysses number' with actions allocated to and by time/date.
- Consider if Trust Communication Team need to be included to assist with external correspondence with media depending on type of incident.
- A proportionate learning response maybe agreed, i.e., it meets PSII level of review before IRLM.
- All discussion and decisions will be recorded on Ulysses by a member of CPST.
- The patient safety incident initial findings will go on to be presented at the next available IRLM for governance completeness.
- All email correspondence, subsequent meetings in directorate in relation to response will be stored on Ulysses.
- Outcome of the meeting will include communication response with appropriate external stakeholders ' i.e., ICB/Commissioners/CQC/NHSE.

### Out of hours

Contact Executive Director on call out of hours and Directorate senior manager and share known information of the event/ incident. Responsibility includes:

- Ensuring the event/incident is recorded on the Trusts' incident reporting system Ulysses.
- Consider the response to patient(s), families, and staff and who is responsible for this.
- An MDT planning meeting should be convened at the earliest possible time to determine next steps.
- Notification to CPST by email, copying in respective clinical governance generic email and key senior directorate staff (they maybe need to be notified before return to work) of all actions taken.

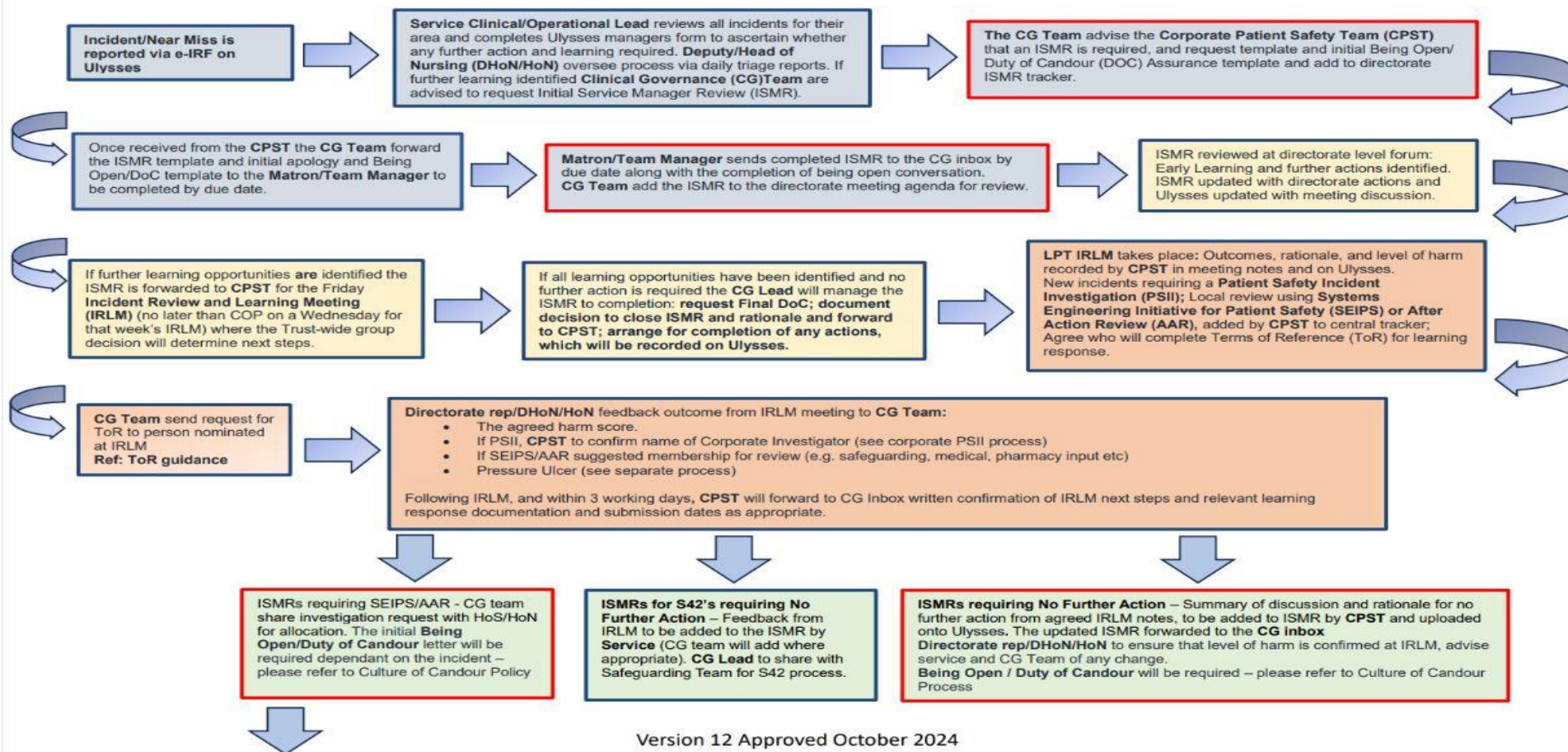
Convening of an MDT planning meeting should take place as soon as practicable and be recorded on Ulysses as above 'in hours' guide.

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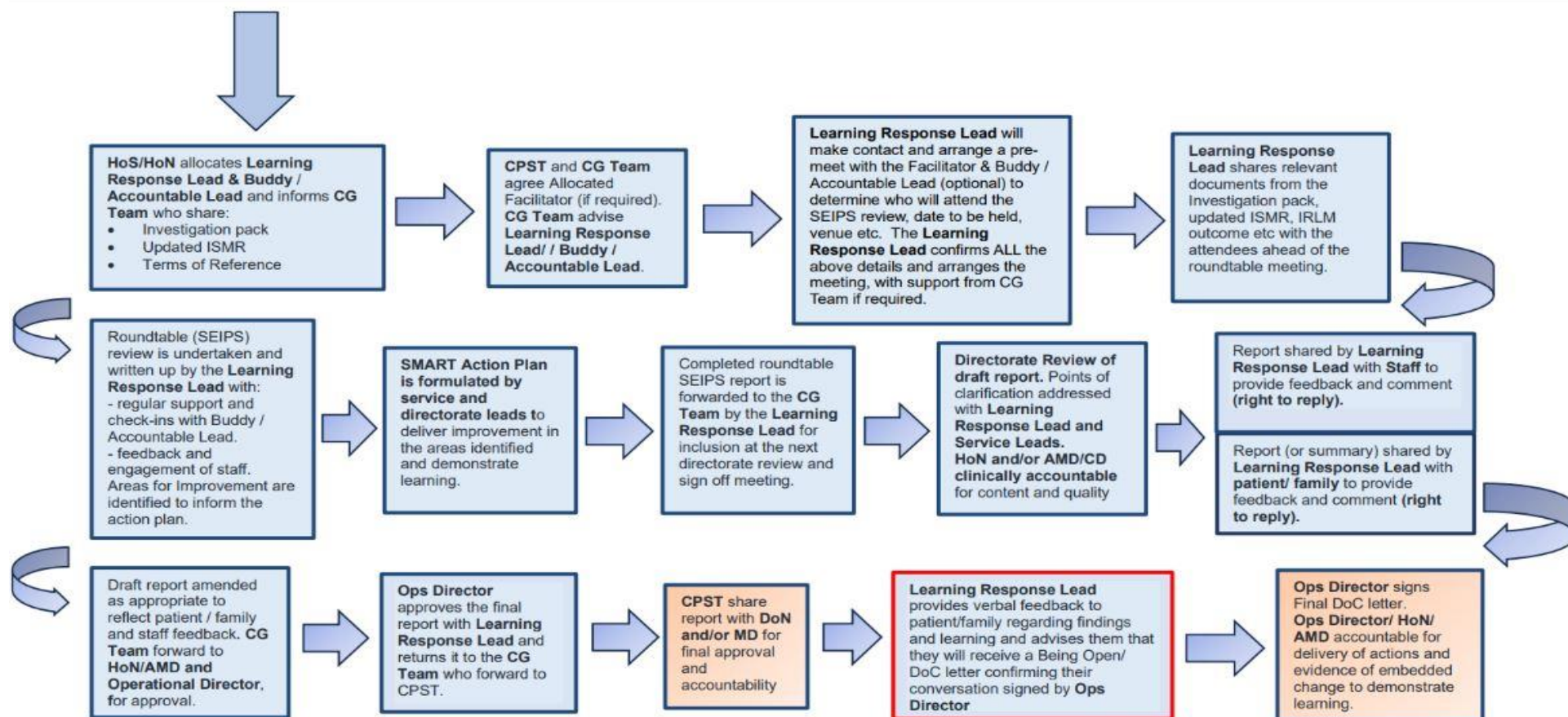
## Appendix B: Management of Patient Safety Incidents

### Detail for Management of Directorate Local Learning Responses (2 Pages)

#### LPT Directorate Patient Safety Incident Response Flowchart



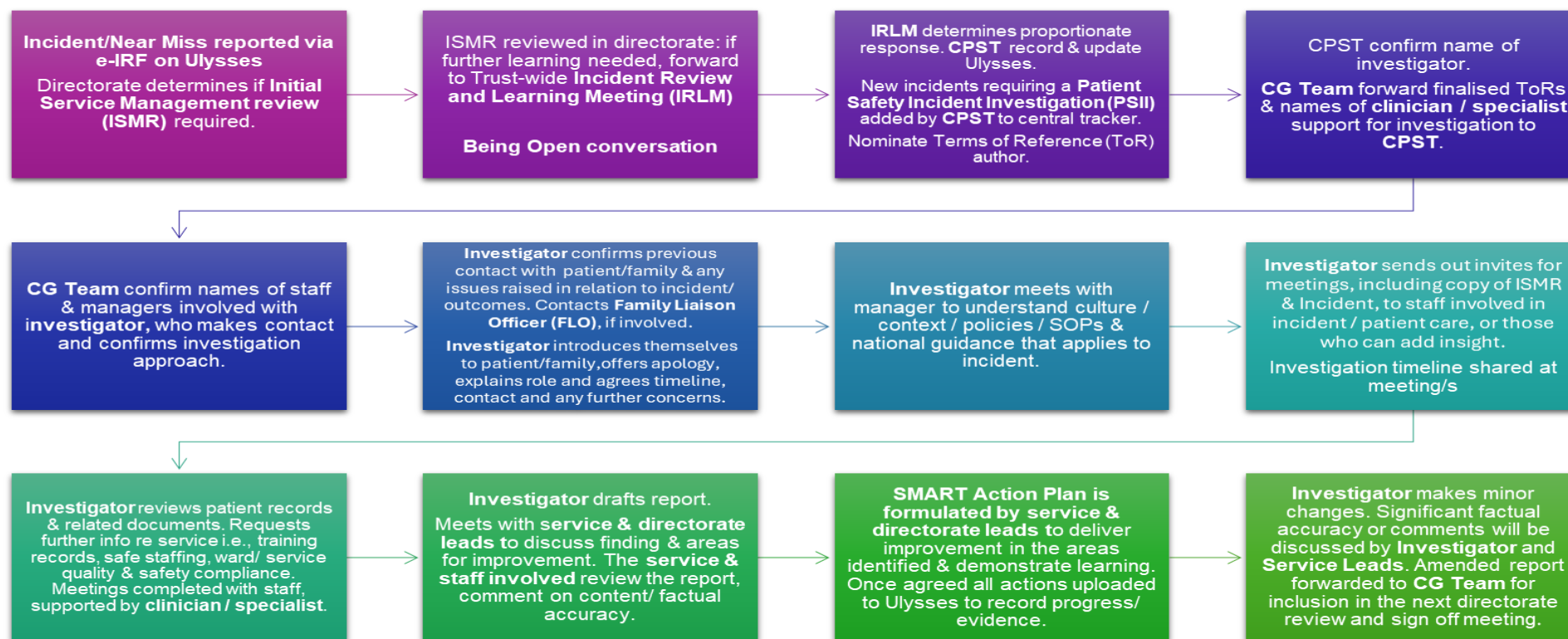
Version 12 Approved October 2024



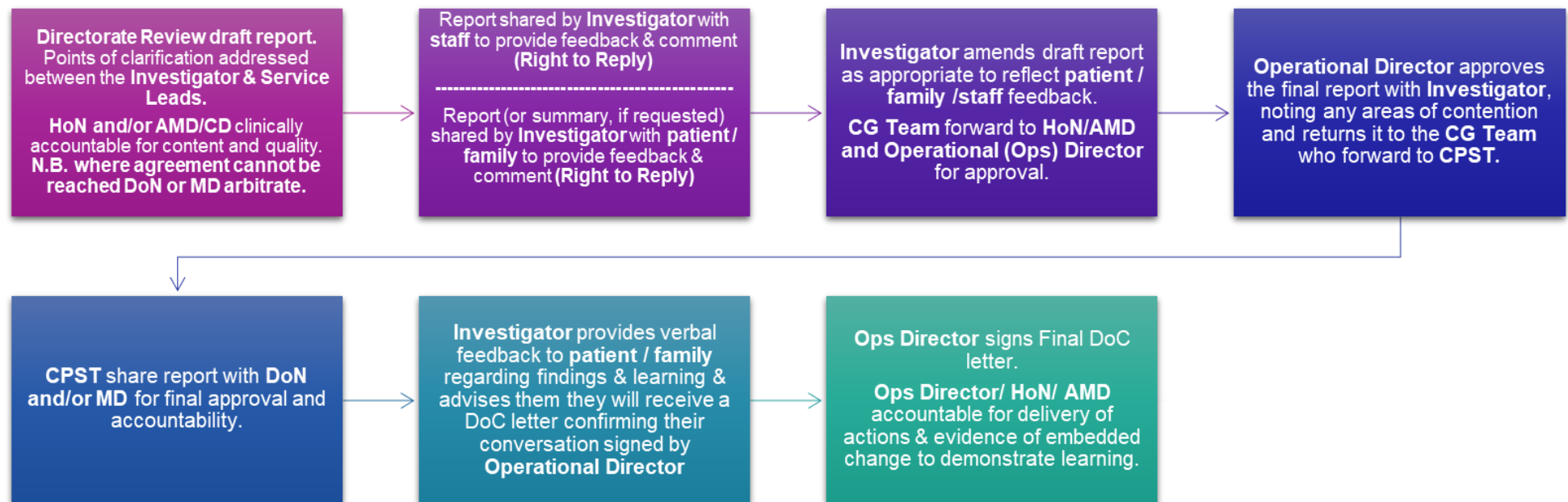
#### KEY:

Boxes with red edging show where the investigation process overlaps with the Being Open / Duty of Candour (DoC) process. Please refer to Culture of Candour Policy for full details.

## Appendix B continued: Detail for Management of Corporate PSIIIs (2 pages)



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## Appendix C – Report Writing Standards for Patient Safety Investigations



Leicestershire Partnership  
NHS Trust

### Report Writing Standards for Patient Safety Investigations

#### Introduction

The aim of undertaking a patient safety investigation is to share with those involved in an incident our findings when something appears to have gone wrong during delivery of NHS care. It is also to identify learning so that as a Trust we minimise the risk of occurrence, and from a system perspective, share that learning with others. To do this our reports need to be written compassionately, professionally and be factually accurate.

The standards set out below will assist staff undertaking investigations across the Trust in the report writing process, strengthening the consistency and quality of investigation reports to:

- Provide clarity of scope and the points we are making in our writing.
- Ensure reports are complete and concise.
- Respond only to the questions set out in the terms of reference which must demonstrate a proportionate response to the incident; patient/family/carer questions in relation to the incident/agreed timeline within the scope of the investigation, must be clearly described and answered in the report.
- Write in an objective way, that maintains a fair and balanced tone.
- Outline evidence, context and avoid subjective judgements.
- Avoid technical language/NHS jargon or abbreviations that are not explained.
- Be mindful of who will read the report and ensure a report 'makes sense' when read on its own. Our reports become public documents that can be quoted in a public arena, on social media or by media outlets.

#### Aim of these standards

- Ensure the completed report focuses on what happened and understanding why an incident happened. The report should not make a judgement on what people, departments or organisations 'could' or 'should' have done during or before the incident.
- Provide a writing style guide to promote clarity and consistency across reports, encourage evidential reporting, seek to eliminate grammatical mistakes, errors, and inconsistencies, and ensure that we do not use emotive language.
- Reduce the length and repetition of reports which contain detail that the critical analysis should be based on and not included in full. The reader needs to be able to quickly identify the key facts and areas identified for safety improvement.
- Ensure reports are written in line with our Trust values; do not blame individuals (including the patient), teams, or organisations.
- Ensure we write in plain English that is as accessible as possible; remember the patient and/or family will be the primary audience. The patient and/or family/carer are within their rights to share the report more publicly, with the media, solicitor, etc.

- Ensure the use of inclusive language i.e., it is written to 'inform rather than impress'.
- Ensure consistent style, using Arial font size 12, and at least 20% larger font for headings (to be in bold) (14-16) unless the patient, family/carer describes any additional needs or amendments. Provide additional space between headings and paragraphs.

#### Top tips for writing well:

1. Frame your writing appropriate to who will receive and read the report, use clear and simple everyday plain English.
2. Explain or avoid technical language and abbreviations. Keep NHS jargon to a minimum and put abbreviations in full the first time you use them. Remember that your report is likely to be read by some staff who are not clinically trained and the patient, family/carer.
3. If including descriptions of test results, explain what the test is - such as 'ECG (heart tracing)'.
4. If you include detail about blood results, include units, reference ranges, and what the result meant to the patient and actions taken if appropriate for example, " the urea and electrolytes (U&E's) and it was noted a high urea level of 19mmol/L [reference range 2.5-7.8] which indicated that..."
5. Stick to the purpose of the report captured in the Terms of Reference; ensure it is written in an evidence based, clear and objective manner.
6. Be direct and to the point – avoiding the use of unnecessary words.
7. Do not make judgements about third party organisations or their staff.
8. Use the active voice, not passive voice. Use a professional, compassionate tone and don't lose sight that this involves a patient and/or a family.
9. Keep your descriptions short and simple, use bullet points where appropriate.
10. Keep sentences short to 15-20 words maximum, one sentence, one idea.
11. Keep paragraphs short.
12. If you're referring to drugs, provide the generic name and include a brief description of what the drug was for as well as the dose and route of administration.
13. Find the right place to say something and say it once. Do not repeat yourself or copy and paste the same point into different sections of the report.
14. Use subheadings that summarise the content and enable accessible navigation of the document.
15. Use correct grammar and the right tense; use a grammar check that is set to the UK.

Report Writing Standards Version 10 – October 2024

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16. Edit, then edit again.
17. Proofread when you've taken a break. Make enough time for this.
18. Revisit the Terms of Reference including patient/family/carer concerns in relation to the incident/and engagement with services included in the agreed timeline for investigation. Ask yourself, 'have you answered them in a clear and factual way without providing subjective judgements that could be taken out of context once the report is shared?'.
19. Include additional documents as appendices in the initial word version of the report. Do not embed documents in reports as these will be secured as a PDF document once final; so please ensure these documents are accessible.
20. Keep in mind that what you write may be quoted back to you, or those involved in the investigation/incident in evidence at a coroners court or in the media.
21. Always consider, if you were to receive this report and it was about your loved one, would you be satisfied with the content, style, and the compassion with which the report was written?

### Determining the areas for improvement

- The report will identify areas for safety and quality improvement (SAQI), and the investigator needs to work with clinical and operational service leads and the relevant subject matter experts, including quality improvement colleagues, to identify and agree the SMART actions required to deliver each area of improvement.
- The actions need to mitigate the right risk, and the reader needs to understand what that risk is (i.e. a one off, systemic, high, or low impact, immediate or long term, relevant to other service areas). The actions must reference systems and processes LPT have in place to ensure quality and safety and not inadvertently imply significant weaknesses in our internal control where this is not the case.
- Areas for SAQI must follow a standard format as set out in the report template and where actions have already been identified and mitigations undertaken and learning shared, evidence should be included in the finding narrative.
- If an area for SAQI is described because of legal, statutory, or regulatory compliance issues, actions must enable us to achieve compliance.

### Further reading

[Dyslexia friendly style guide - British Dyslexia Association \(bdadyslexia.org.uk\)](https://www.bdadyslexia.org.uk/dyslexia-friendly-style-guide)  
<https://www.themdu.com/guidance-and-advice/guides/writing-a-report-or-statement>  
[hssib-learning-response-review-and-improvement-tool-v06-june-2024.pdf \(hssib-ovd42x6f-media.s3.amazonaws.com\)](https://hssib-learning-response-review-and-improvement-tool-v06-june-2024.pdf)  
<https://mhcc.org.au/2021/10/recovery-oriented-language-guide-quick-reference/>

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### Further help

Corporate Patient Safety Team at: [lpt.patientsafety@nhs.net](mailto:lpt.patientsafety@nhs.net)

### You can also approach your respective Directorate Governance Teams

CHS Governance Team at: [lpt.chsgovernance@nhs.net](mailto:lpt.chsgovernance@nhs.net)

DMH Governance Team at: [lpt.dmhinvestigations@nhs.net](mailto:lpt.dmhinvestigations@nhs.net)

FYPCLDA Governance Team at: [lpt.fypcldgovernance@nhs.net](mailto:lpt.fypcldgovernance@nhs.net)

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## Appendix 1 Training Needs Analysis

<b>Training topic:</b>	Patient Safety – complying with national standards for PSIRF (see policy NHSE requirement) Level 1 & Level 2	
Type of training: (see study leave policy)	Not Required^ Role Essential (must be on the role essential training register) * for Level 1 All staff. Level 2 – Band 7 & above – <b>currently will be directorate led oversight due to securing data for compliance vs banding data for role essential record</b>	
Directorate to which the training is applicable:	Adult Mental Health* Community Health Services * Enabling Services * Families Young People Children / Learning Disability/ Autism Services Hosted Services *	
Staff groups who require the training:	<i>All those described in this policy related delivery of PSIRF here at LPT</i>	
Regularity of Update requirement:	Variable and is linked to roles/responsibility as described in this policy. This may also change according to national directive and for some availability of national training	
Who is responsible for delivery of this training?	Various – please see the policy for specific training related to staff groups	
Have resources been identified?	Yes	
Has a training plan been agreed?	Requirement of PSIRF - Ongoing and potential to change according to NHSE evaluation of PSIRF	
Where will completion of this training be recorded?	ULearn	
How is this training going to be monitored?	Through local training reports shared from Ulearn. Registers held at local level by corporate patient safety team	
<b>Signed by Learning and Development Approval name and date</b>	Agreed at EMB	Date: April 2025

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## Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.
  - **Shape its services around the needs and preferences of individual patients, their families and their carers**      **Answer yes to all**
  - **Respond to different needs of different sectors of the population**    **yes**
  - **Work continuously to improve quality services and to minimise errors**    **yes**
  - **Support and value its staff**    **yes**
  - **Work together with others to ensure a seamless service for patients**    **yes**
  - **Help keep people healthy and work to reduce health inequalities**    **yes**
  - **Respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance**    **yes**

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## Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	Patient Safety Incident Response Policy
Date Screening commenced	Oct 2024
Directorate / Service carrying out the assessment	Corporate Patient Safety Team (CPST)
Name and role of person undertaking this Due Regard (Equality Analysis)	Tracy Ward Head of Patient Safety/Patient Safety Specialist
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To describe the Trust response to NHS Patient Safety Incident Response Framework (PSIRF)	
OBJECTIVES: To give guidance and promote assurance of the application of PSIRF and its associated patient safety pathways/decision making here at LPT.	
Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	NA
Disability	NA
Gender reassignment	NA
Marriage & Civil Partnership	NA
Pregnancy & Maternity	NA
Race	NA
Religion and Belief	NA
Sex	NA
Sexual Orientation	NA
Other equality groups?	NA
Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.	
	<b>No</b>
High risk: Complete a full EIA starting click <a href="#">here</a> to proceed to Part B	Low risk: Go to Section 4.
Section 4	
If this proposal is low risk please give evidence or justification for how you reached this decision:	
NHSE standard framework	

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Signed by reviewer/assessor	S Arnold	Date	11/11/2024
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
Head of Service Signed	T Ward	Date	11/11/2024

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## Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.

The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

<b>Name of Document:</b>	<b>Patient Safety Incident Response Policy</b>	
<b>Completed by:</b>	<b>Sue Arnold</b>	
<b>Job title</b>	<b>Lead Nurse Corporate Patient Safety Team</b>	<b>Date 11/11/2024</b>
<b>Screening Questions</b>	<b>Yes / No</b>	<b>Explanatory Note</b>
<b>1.</b> Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
<b>2.</b> Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
<b>3.</b> Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
<b>4.</b> Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
<b>5.</b> Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
<b>6.</b> Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
<b>7.</b> As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise	No	

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privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
<p><b>If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via</b>  <a href="mailto:Lpt-dataprivacy@leicspart.secure.nhs.uk">Lpt-dataprivacy@leicspart.secure.nhs.uk</a>  <b>In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</b></p>		
<b>Data Privacy approval name:</b>	N/a	
<b>Date of approval</b>		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

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