Shropshire Community Health NHS Trust

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| 5 | | |

# Patient Safety Incident Response Policy

Ref: 2278-85741

# Contents

# Purpose

This policy supports the requirements of the and sets out the approach taken by Shropshire Community Health NHS Trust (SCHT) to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

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

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

# Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across SCHT. However, the principles of the policy, particularly the learning response methods described in the SCHT Patient Safety Response Plan (PSIRP), should be used to support learning and improvement in relation to other non-patient safety incident types alongside any other statutory or regulatory requirements applicable to those incident types (e.g health and safety regulations, information commissioner requirements).

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

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

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

# Roles and Responsibilities

### Trust Board

The Trust board is responsible and accountable for effective patient safety incident management within SCHT. It is responsible for ensuring it has effective policies, oversight and resource in place to meet the national patient safety response standards. The Board is responsible setting the patient safety priorities and ensuring the Trust takes a proportionate response to safety incidents. The Trust must have in place a safety improvement plan through which the Board (or committee with delegated responsibility) will monitor and review the delivery of safety actions and improvement.

### Quality and Safety Committee

The Board has delegated responsibility for quality and safety assurance to the Quality and Safety Committee which will quality assure learning response outputs. The Committee will have oversight of the Patient Safety Incident Investigations that take place and all other incident data for quality assurance purposes. The Committee will oversee the delivery of the Safety Improvement Plan to ensure that appropriate actions are put in place, monitored for completion and assessed for delivery of the required improvement.

### Patient Safety Committee

The role and purpose of the Committee is to oversee all aspects of patient safety in order to provide onward assurance to the Quality and Safety Committee. Specifically, it advises on the Trust's Strategy for patient safety and monitors progress with implementation. It oversees

the clinical risk register and clinical incidents to ensure mitigating actions are taken and that cross organisational learning takes place. The Committee monitors the Trust's statutory and regulatory compliance in relation to patient safety and approves clinical safety policies.

## Chief Executive

The Chief Executive has overall accountability for the safety of the Trust's patients, staff, and visitors. The Chief Executive is support with this through delegation of responsibilities to the following roles:

### Director of Nursing, Workforce and Clinical Delivery and Medical Director

The Director of Nursing, Workforce and Clinical Delivery and Medical Director are jointly responsible for patient safety in the organisation and for identifying an appropriate learning response lead to undertake a proportionate response.

The Director of Nursing, Workforce and Clinical Delivery has responsibility for:

- overseeing the quality of the PSIRF process which includes the development, implementation, and review of this policy.
- ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Board.
- ensuring processes are in place for triangulating incident information for early identification of themes and trends.
- ensuring there are adequate mechanisms for learning and feedback of outcomes of incidents.
- overseeing compliance with the duty of candour
- Leading the assessment of incidents that fall outside of the local priorities for new and emerging themes (to be undertaken by the Chief Medical Officer in the Chief Nurse absence)
- ensuring that the Chief Executive is kept fully informed about any national priorities aligned to PSIRF reporting the details of the incident to the Quality and Safety Committee.

The Medical director and Chair for Learning from Deaths is responsible for how the Trust responds to and pays due attention to mortality of patients in our care and ensures that any lessons learned from care delivery and avoid ability are clear and cascaded. The aims are:

- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Promote organisational learning and improvement

**Director of Governance**

- Ensuring compliance with the statutory and regulatory responsibilities of the Trust in relation to patient safety incidents and providing advice to the Trust Board in relation to the same.
- Overseeing the governance framework to support the response to and oversight of patient safety incident management.
- Liaising with external bodies in relation to national priorities as required. This responsibility may be delegated where appropriate.

**Associate Director of Governance and Patient Safety Specialist**

- Ensuring the implementation and adherence to this policy and the Trust's Patient Safety Incident Response Plan and set timescales.
- Advise the Executive Leads on a proportionate response method in relation to patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's patient safety incident response plan.
- Support learning response leads where required but in particular, where a full PSII Investigation is needed.
- Advising on the adequacy of safety actions following an investigation and for bringing urgent risk matters to the attention of the Executive Leads.
- To monitor completion of organisational safety improvement actions, working with the Quality Improvement Facilitator.
- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool

- To lead on revising the Trust PSIRP and full PSIRF review as stipulated in the policy, including an evaluation of learning responses and effectiveness of safety actions.
- Provide training on PSIRF as required.

**Patient Safety Specialist(s)**

- Provide dynamic senior patient safety leadership
- Play a key role in supporting the development of a patient safety culture, safety systems and improvement activity
- Coordinate and support local patient safety priorities, help the Trust to review its PSIRP and a full review of the PSIRF policy
- Support learning response leads where required but in particular, where a full PSII is needed
- Ensure the rapid dissemination of key learning from patient safety events

**Divisional Clinical Manager**

- Ensuring that local and organisational safety actions are implemented and monitored.
- Dissemination of learning is facilitated using the SHARE debrief tool.
- As minimum Level 1 & 2 of the patient safety training is completed as indicated by the training needs assessment.
- Monitor through their respective Governance Meetings any new or emergent themes for their areas, that may require a learning response.

**Governance Managers**

- The Governance Managers are responsible for ensuring that all adverse incidents and near misses are reported and managed within their allocated SDGs in line with this policy; are discussed at the governance meetings and shared with staff as required.
- Ensure that any patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents

described in the organisation's plan are bought to the attention of the Head of Clinical Governance and Patient Safety Specialist.

- Ensuring rapid dissemination of key learning using the SHARE Debrief Tool
- Act as the engagement lead for patients and families where required

**Learning Response Lead**

- The Learning Response Lead for local priorities (as defined in the PSIRP) will work with subject matter experts to use the defined learning method and frequency to review patient safety incidents, reporting their findings to the Patient Safety Committee.
- Learning response leads for National priorities will be responsible for completing a PSII. They will be responsible for identifying all staff, departments and key teams who have some involvement in the incident and for informing all appropriate managers of the investigation.
- Areas for improvement and findings from learning responses should be shared with those involved and the wider team, to share learning and gain feedback from patients and staff members in the involvement of patient safety incident.
- Safety actions must be produced in collaboration with those who understand 'work as done' the most.
- Ensure the relevant training has been completed and competencies acquired to be a learning response lead (see appendix 1).

**Subject Matter Leads**

- Subject matter leads within the Trust are expected to support the Learning Response Leads as indicated in the PSIRF priorities.
- The corporate subject matter leads are identified in Appendix 2
- In addition expertise may be co-opted as required, with a focus on independence where possible.

**Engagement Lead (Staff /Manager/Governance Manager)**

- Ensure that the patient and/or their family if appropriate is informed of the incident and is kept informed during the investigation process to ensure that Duty of Candour is followed.
- Facilitate a face-to-face meeting and / or a response to any queries the patient or their next of kin may have.
- Support the Learning Response Lead, to gain the patients perspective if appropriate to do so.
- ensure that should the patient or family are provided with the opportunity to review the outcomes and improvements identified on concluding the learning response.

**Quality Leads**

- The Quality Leads are expected to engage in the organisational safety improvement plan, to understand the priorities for Quality Improvement from a patient safety perspective.
- To ensure organisational quality improvement initiatives support the organisational safety improvement actions identified from patient safety incidents
- Quality Leads are expected to support the rapid dissemination of learning from patient safety incidents across the organisation
- Establishes procedures to monitor/review PSII progress and the delivery of improvements.

**All Managers**

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

**All Staff**

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

## Our patient safety culture

The SCHT is committed to developing an organisational culture focussed on safety and improvement and where a 'just culture' is embedded to ensure openness and transparency at all levels.

The implementation of PSIRF has provided an opportunity to review current systems and processes and whilst the Trust already had robust processes in place to respond to patient safety incidents areas for further strengthening have been identified to ensure the national patient safety standards are met and that the Trust transitions to PSIRF smoothly.

- Over the last 12 months the Trust has been moving to a systems based approach to the review of incidents with systems based review training rolled out to staff
- The decision making regarding the level of response required for an incident has been moved to a new multi-disciplinary panel which includes the Quality Lead of NHS STW. This panel is also open to all staff involved in the incident to ensure openness and transparency.
- The Trust has been on a journey to improve the involvement of patients by nominating patient liaison leads where appropriate to liaise with the patient and/or family involved in a safety incident.
- Mandated Patient Safety Level 1 training to all staff in the organisation and Patient Safety Level 2 training to those who have a responsibility to investigate patient safety events.

Areas for improvement are identified.

- Development of Datix system to improve the capture of incident data and ensure a systems-based approach to patient safety events at all levels of the organisation.

- More robust feedback to staff who submit Datix incidents.

- Effective ways to communicate shared learning from patient safety events, wider than the immediate team where the incident occurred.

- Greater evidence of organisational learning

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

## Patient safety partners

The Trust has established the role of Patient Safety Partner in line with the NHSE guidance Framework for involving patients in patient safety. The Patient Safety Partners (PSP) will have an important role in providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

The Trust currently has one PSP in post who works alongside staff, volunteers and patients to co-design initiatives aimed at improving patient experience and patient safety. The PSP attends the Trust's Patient Safety Committee and Quality and Safety Committee to provide appropriate challenge from a patient perspective to ensure learning and change. As part of this attendance they have been involved in the development and implementation of relevant strategy and policy.

In addition to the formal role of patient safety partner the Trust involves other stakeholders and patient representatives to inform its safety systems and processes.

The Trusts Observe and Act checklist and Patient Story guidance are well established 'systems' designed by patients and volunteers and the feedback from this involvement contributes to providing safer healthcare.

The Trust's governance framework provides for both patient safety and patient experience to input and provide assurance to its Quality and Safety Committee and the patient stories, observe and act, focus groups and friends and family test are all considered at Patient Experience Committee and Delivery Group which have patient representatives and use a co-production approach. We also engage regularly with partners who offer scrutiny such as Healthwatch and NHS STW Quality Lead.

## Addressing health inequalities

As a provider of community services, the Trust has a key role to play in tackling health inequalities in collaboration with our system partners.

Through the implementation of PSIRF, we will utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and system partners on how to tackle these. The integrated approach to patient safety under PSIRF will see the Trust work more collaboratively with patients and make improve links between patient safety, patient experience and the inclusivity agenda. The learning responses are designed to ensure the wider health and societal agenda is not overlooked and that there is conscious consideration of health inequalities.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

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

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

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

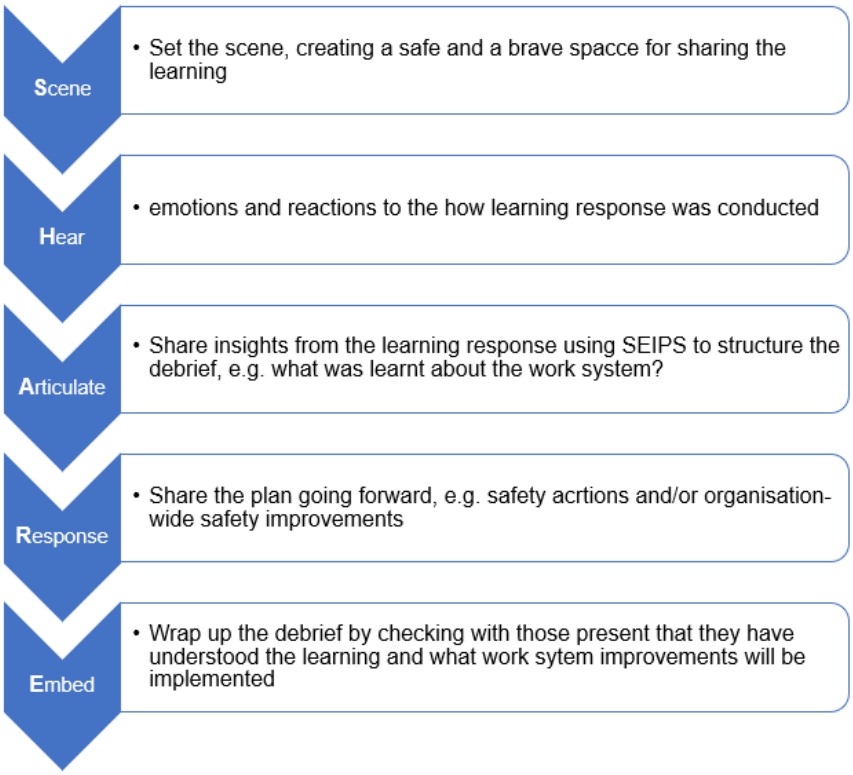
In line with the PSIRF standard, engagement and involvement of those affected by patient safety incidents. The trust has in place the following systems and processes:

- Duty of Candour – a robust policy in place with appropriate governance oversight and monitoring at committee. The templates for patient safety incidents all require consideration of duty of candour as does the incident reporting system

- Patient Liaison Lead – Every patient safety incident which requires investigation will have a patient liaison lead identified to provide ongoing engagement regarding the investigation process and outcome.

- Sharing of information with those affected by patient safety incidents – any staff involved in the incidents are included in all panel meetings, patients and/or families are offered the opportunity to input into terms of reference and offered a copy of the final report along with an offer to attend an explanatory meeting.

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




There is further information on this in the responding to patient safety incidents section of the policy.

## Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. There are nationally set priorities such as meeting the Never Events criteria (2018) and deaths related to care which have mandated responses (set out in the Trust's Patient Safety Incident Response Plan) and then locally set priorities.

### Resources and training to support patient safety incident response

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

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

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

2. **Competencies for Learning Response Leads**

    All staff leading learning responses should be able to:
    - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
    - Summarise and present complex information in a clear and logical manner and in report form.
    - Manage conflicting information from different internal and external sources.
    - Communicate complex matters and in difficult situations.

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

4. **Competencies and behaviours for engagement leads**
    - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
    - Listen and hear the distress of others in a measured and supportive way.

- Maintain clear records of information gathered and contact with those affected.
- Identify key risks and issues that may affect the involvement of patients, families, and staff.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

**5. Oversight training**

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

**6. Competencies for individuals in oversight roles**

**All staff in oversight roles can:**

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

The Trust has a responsibility to ensure that training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in

learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation is preferred.

A detailed training analysis is available in appendix one.

## Our patient safety incident response plan

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

The SCHT PSIRP is in line with the following standards.

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

## Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity

to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

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

A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

# Responding to patient safety incidents

## Patient safety incident reporting arrangements

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

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

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

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

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

## Patient safety incident response decision-making

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

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

### Reactive Issues

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

### Emergent Issues

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

## Timeframes for learning responses

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

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

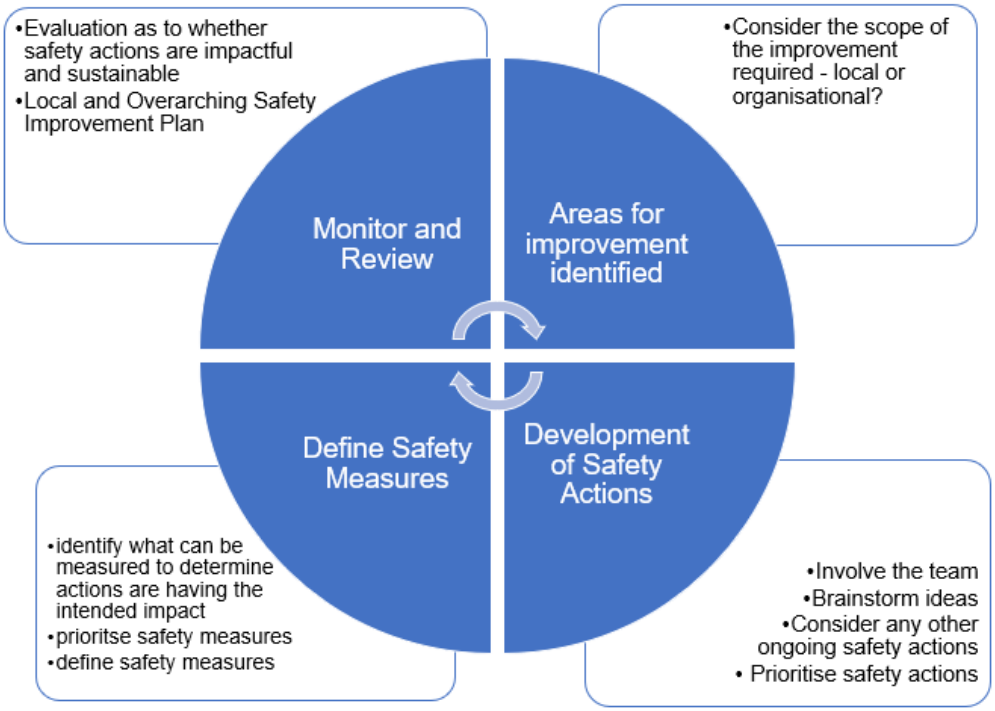
## Safety action development and monitoring improvement

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

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

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

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



## Writing Safety Actions

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

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

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

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

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

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

## Safety improvement plans

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

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

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

## Complaints and appeals

For any complaints or appeals relating to the Trusts response to patient safety incidents should be referred to the Trusts Complaint Policy if local resolution via the Patient Liaison Lead is not possible.

**Appendix 1 – PSIRF Training Needs Analysis**

| | | SCHT PSIRF Training Requirements | | | | | |
|---|---|---|---|---|---|---|---|
| **Training Topic** | **Duration/ Frequency** | **Identified Training** | **All Staff** | **Subject Matter Lead** | **Learning Response Leads** | **Engagement Leads** | **Oversight Roles** |
| **Systems approach to learning from Patient Safety Incidents** | 2 days/12 hours | Systems Based RCA Training<br>Human Factors Study Day<br>**OR**<br>HSIB Level 2 Safety Investigation | | | ✓ | | ✓ |
| **Systems Based Review Training** | 1 day | In-House Training | | ✓ | | | |
| **Oversight of learning from patient safety incidents** | 1 day/6hrs | To be confirmed | | | | | ✓ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Involving those affected by patient safety incidents in the learning process** | 1 day/6hrs | To be confirmed / Engagement Development Day, hosted by Governance and FTSUG | | | ✓ | ✓ | |
| **Patient Safety syllabus level 1: Essentials for patient safety** | E-learning | E-learning module | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Patient Safety syllabus level 2: Access to practice** | e-learning/ 1.5hrs | E-learning module | | ✓ | ✓ | ✓ | ✓ |
| | | **OR** | | | | | |
| | | Facilitated Session / HF Day | | | | | |
| **CPD** | Annually | Contribute to a minimum of 2 learning responses | | | ✓ | ✓ | ✓ |

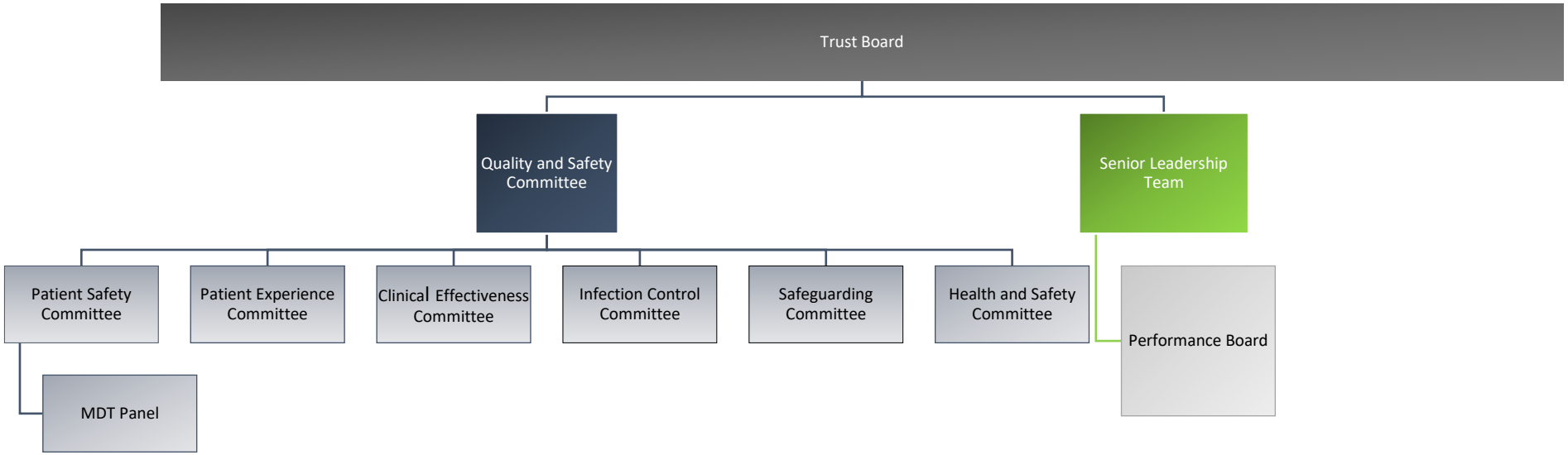
| Lead | Definition | Role |
|---|---|---|
| **Learning Response Leads** | Individuals who will take a lead of a learning response | Head of Clinical Governance/ Governance Managers / Corporate Subject Matter Experts |
| **Engagement Leads** | Individuals who will support both staff and patients through a learning response | Patient Experience Lead / Nominated staff members with support from Patient Experience Lead |
| **Oversight Role** | Individuals who have a responsibility for overseeing patient safety for the Organisation | Chief Executive, Director of Nursing, Workforce and Clinical Delivery, Medical Director, Director of Governance, Head of Clinical Governance |

**Appendix 2 – Corporate Subject Matter Leads**

| Subject | Lead | Contact |
|---|---|---|
| Tissue Viability | Jodie Jordan | jodie.jordan3@nhs.net |
| Health and Safety | Ian Gingell | ian.gingell@nhs.net |
| Falls | Lisa Manning | lisa.jordan-manning@nhs.net |
| Infection Prevention and Control | Sharon Toland | sharon.toland1@nhs.net |
| Information Governance | Gill Richards | gill.richards8@nhs.net |
| Integrated Discharge | Amber Bugler | amber.bugler@nhs.net |
| Medicines | Lucy Manning | lucy.manning3@nhs.net |
| Safeguarding | Julie Harris / Sarah Rock | julie.harris12@nhs.net<br><br>sarah.rock1@nhs.net |

| | | |
|---|---|---|
| Learning from Deaths | Dr Ganesh / Amy Fairweather | mahadeva.ganesh@nhs.net |

Appendix 3 – Governance Framework




The MDT Panel consists of members of the operational, clinical, governance and quality teams and will review any incidents of concern that require a learning response. The panel will determine the appropriate level of response to an incident and will sign off any improvement actions.