Patient safety incident response policy

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Great Western Hospitals
NHS Foundation Trust

TRUST-WIDE POLICY DOCUMENT

Patient Safety Incident Response Policy

Further information about this document:

Document summary	This document outlines the governance arrangements for responding to Patient Safety Events that occur at Great Western Hospital or through any service provision that the Great Western Hospital NHS Foundation Trust (the Trust) Provides. This policy is aligned to the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework and replaces the Incident Management Policy used by the Trust under the Serious Incident Framework 2014.
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To be read in conjunction with	This policy is aligned to the NHS Patient Safety Strategy and Patient Safety Incident Response Framework. It should be read in conjunction with the Trusts: - Duty of Candour Policy (Ref 1) - Quality Governance Framework (Ref 2) - Risk Management Policy (Ref 3) - Complaints Policy (Ref 4) **Stage 2 Full Equality Impact Assessment**
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.	

Version Control:

	Version History:
1.0	**New Policy – in conjunction with Patient Safety Incident Response Plan**

Contents

1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) 2020 (Ref 5) and sets out **Great Western Hospital NHS Foundation Trust'** 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.

This is an overarching policy detailing all aspects of incident management within the Trust, including patient safety incident reporting and safety improvement monitoring. 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

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust. It does not outline responses to:

- Complaints
- Human Resources Investigations
- Professional Standards Investigations
- Coronial Inquests
- Criminal Investigations
- Claims
- Safeguarding investigations
- Information Governance concerns
- Financial investigations and audits

However, when applying learning responses to incidents, a triangulation process will occur to better understand causal factors and associations to that incident. This may include (for example) analysing claims, complaints and other types of investigations that may provide insights to why the incident occurred. An example of this may be:

- An incident is raised on a ward regarding a medication error. It is considered that there is learning to be derived from this incident. Therefore, in preparation to responding to this incident, analysis will occur to investigate whether there have been complaints, claims, risks, safeguarding issues raised that are linked to the theme of the incident. This

will support in providing oversight into whether there is a wider issue and learning response that needs to be explored.

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. Learning responses will follow SEIPS questioning (System Engineering Initiative for Patient Safety), seeking to understand system factors that caused the event.

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.

3. Our patient safety culture

The Trust is committed to creating the right foundations that fosters a just culture to improve safety and learning. This is achieved by providing training to those that communicate with and involve those that have been affected by a patient safety incident in a learning response. This may also include completing Duty of Candour (DoC) process. Leadership training must focus on compassionate leadership and engagement in a way that prioritises and respects the needs of people who have been affected by a patient safety incident:

Those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible as part of our duty of care.

Engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in the future. Engaging and involving those affected in incidents fosters a culture of openness and transparency thereby resulting in the increase of reporting of incidents.

The patient safety team in conjunction with the organisational development team (Human Resources) must work together to ensure delivery of a Restorative Just & Learning Culture (RJLC) practice to support open and transparent reporting. Review of incidents must focus on the systems in which people work in rather than blaming individuals. RJLC training might include masterclasses and workshops that will include ways of managing dissatisfaction, ensuring inclusivity and processes for seeking and acting on feedback. Regular patient safety culture

surveys must be triangulated with staff surveys to understand the patient safety culture, identify learning opportunities and improvement.

Patient safety partners will be utilised across the Trust and must be incorporated to key patient safety meetings to ensure patient's voice is heard and understood regarding processes in place to learn and improve from patient safety events/incidents.
Other activities such as board safety visits and Schwartz rounds must be scheduled regularly to ensure involvement of staff. Ways of ensuring regular feedback to staff and patients must be developed and shared with staff.

4. Patient safety partners

In July 2019, the NHS Patient Safety Strategy (Ref 6) was released with a framework for Patient Safety Partners (PSPs) involvement in healthcare organisational safety. PSPs are patients, carers and other lay people who can play a part in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. The Trust has recruited PSPs that have been gradually introduced into different governance and patient safety implementation teams. PSPs feedback on work that they have been supporting with and amplify patient voice to support in defining clinical governance and learning and improvement from patient safety processes. They have influence over safety cultural issues and development of patient safety initiatives.

Roles for PSPs can include:

- Membership of divisional and Trust wide safety and quality committees whose responsibilities include the review and analysis of safety data.
- Involvement in divisional and Trust wide patient safety improvement projects.
- Working with organisation and divisional boards to consider how to improve safety (e.g. policy writing, be part of interview panels).
- Involvement in staff patient safety training.
- Participation of investigation oversight groups.

The PSP's role is to provide objectivity; challenge us on our actions and evidence and 'bring us back to reality' of what it's like to be a patient or family member. PSPs remind us that following up when things go wrong is not just about incident reviews and report writing, but understanding that patients, families and carers are involved and impacted by patients' safety evets/incident that occur. They help us close the gap between patients and staff and build the interaction between patients, staff and patient and staff safety, bridging the gap between patients and clinicians responsible for them. PSPs provide real time listening rather than delayed Duty of Candour and are a useful resource for providing opportunities of speaking up and the consequences of not wanting to.

5. Addressing Health inequalities

Insights, intelligent use of data and proactivity are core to our patient safety incident response processes. The incident reporting database and key questions asked when a patient safety

incident response is required are central to understanding any health inequalities related to patient safety within the Trust. Therefore, the modules used within the patient safety database will have questions related to health inequalities built into its reporting and review forms so that this information can be analysed in relation to patient safety events that occur.

For example, the incident reporting form will enquire about protected characteristics regarding the patient(s) who have been involved in the patient safety event and will also ask for narrative as to why those protected characteristics may have been impacted. Alongside this, key demographic information will also be requested regarding patient age, ethnicity, sexual orientation, disabilities and gender to allow analysis in regard to whether patient safety events occur more frequently or have different impacts on patients with certain demographics. Where it is potentially evident that patient safety events are occurring or impacting patients due to demographic identity or protected characteristics, then this should form part of the Terms of Reference for that patient safety response. Additionally, triangulation and analysis should occur to support that learning response, ensuring that health inequalities are understood and addressed, with key actions for improvement established.

Key to understanding how a person is affected by a patient safety event will be inclusion from the outset in the learning response. This ethos extends to families and carers impacted by the event. This involvement and engagement will ensure that the learning response is tailored to the individual, understands their feelings regarding what occurred and addresses the issues they have identified.

As well as patients, families, and carers, it is equally important that staff involved in patient safety events are confident that the processes used are transparent and based on a system factors approach. Too often conclusions of ‘human error’ are stated in learning responses, ‘staff failed to,’ or, ‘the member of staff has reflected on their practice as a result of this incident.’ Whilst individual accounts and reflections are important to understanding events, they should be approached from the viewpoint of understanding what systems, tools and processes around the individual were in use at the time and contributed to the event occurring. For staff involved in patient safety events the prospect of being involved in an investigation can be daunting and it is imperative that throughout the process they are supported, reassured, and given clear understanding that the process is aimed at system wide learning and improvement. These approaches will ensure that there is not disparity for staff involved in incidents, regardless of their identity demographic or protected characteristics.

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

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

answer any questions they have in relation to the incident and signpost them to support as required.

We are pledged to deliver outstanding patient care and focus on quality improvement in all that we do. We want to learn from any incident where care does not go as planned or expected by our patients, their families and carers to prevent recurrence. We understand and acknowledge that being involved in a patient safety incident can cause significant impact on those affected. Involving and engaging with those individuals not only helps alleviate the harm experienced, but also helps avoid compounding that harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to them and answer their questions and try to meet their needs that may result from the incident.

Engaging with those affected by a patient safety incident substantially improves our understanding of what happened and potentially how to prevent a similar incident in future. Patients, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. Not including those insights could mean an incomplete picture of what happened is created. Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account.

The following four step process must be followed to ensure that a meaningful compassionate engagement and DoC (Ref 1) process is followed. With all efforts undertaken to ensure that staff/patients/family/cares are included within the reviewing process.

Table 1 Engagement and Involvement Process

This must be done in an open and transparent manner ensuring that the first victim (patient's and their families involved in incidents) and second victim (staff involved in incidents and those that are supporting them) needs are met. Duty of Candour remains a statutory requirement and discussions must be recorded on the incident management database, and copies shared with the patients/person(s) affected, where agreed.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades (National Reporting &Learning System (NLRS))	New physical harm grades (Learning From Patient Safety Events (LFPSE))	New psychological harm grades (LFPSE)
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

The threshold for DoC is any incident where patients have suspected or come to moderate harm or above including death. If the patient cannot be involved in this process due to various reasons, the next of kin must be contacted. The patients and staff must be provided with leaflets detailing the next steps of the incident review process.

It is important to remember that whilst we use these levels of harm to determine whether the DoC legislation applies, it is not a governing factor into whether we should investigate and learn from an incident. This marks a change from the previous Serious Incident (SI) Framework where often, decisions to investigate incidents were based on the harms caused as opposed to the opportunity for learning. The key theme of the new Patient Safety Strategy is that learning responses should be utilised when a patient safety event/incident indicates there is learning to be gained – regardless of whether it was a near miss/no harm/or harm.

Alongside this it is important to remember that whilst the DoC legislation applies for incidents that have caused Moderate physical or psychological harm (and above) we should always aim to engage and involve patient(s) and other person(s) affected in any learning response.

7. Patient safety incident response planning

Patient safety incident responses should be proportionate and undertaken using an approach that will maximise learning and opportunities for improvement. This approach does not base the learning response required on the level of harm that was caused, but on the potential for learning and improvement at both local and system wide levels.

The Great Western Hospital NHS Foundation Trusts Patient Safety Incident Response Plan (ref 7) (PSIRP) outlines the processes and approaches required to ensure that patient safety incidents are responded to using a range of appropriate tools and methodologies. The foundation for ensuring meaningful learning responses is a systems-based approach that focusses on learning from an event that has occurred. This means that incidents that have had no or minimal harm may present opportunities for learning to prevent future harm. It also means that incidents that have caused harm may not always require a detailed linear investigation, provided that the system issues that contributed to the incident are identified and addressed

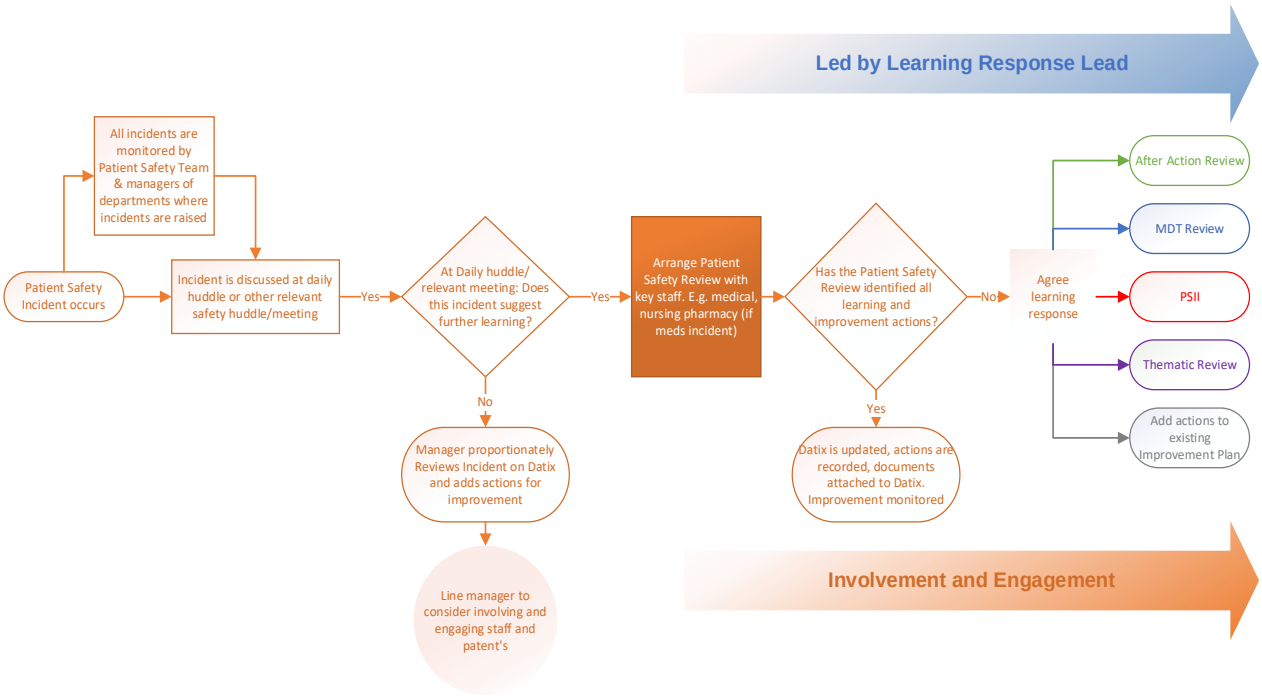
through appropriate learning and improvement. Part of the Trusts PSIRP identifies key safety priorities that require improvement and monitoring across the organisation, these are:

- Reducing Pressure Harm in our patients
- Reducing falls with harm in our patients
- Medicines safety optimisation
- Optimising care pathways and transfers of care
- Optimising communication

Comprehensive improvement plans will be developed and monitored to address the issues stated. A result of this might mean that if a fall has occurred that resulted in severe harm to a patient, it may not be a good use of time and resource to undertake a traditional incident investigation. Instead, a meaningful review should occur as soon as possible after the event to understand; what happened, what the learning is, and what do we need to do to prevent it happening again. Sometimes, this review process may identify causal factors that have been identified in other similar incidents and therefore these should be added to or addressed in the improvement plan.

The PSIRP also outlines learning responses for other patient safety events that are not related to the Trust wide priorities. Following any patient safety event that occurs, the initial step will be a Patient Safety Review with the right people present to discuss the event and record findings from a system factors approach.

Table 2 Learning Response Process



8. Resources and training to support patient safety incident responses

Training for PSIRF is prescribed by the National Patient Safety Strategy (NHS, 2019) (Ref 6). The strategy developed different levels of staff training under the National Patient Safety Syllabus which comprises five patient safety themed domains reflected in Figure 1 below:

Figure 1. National Patient Safety Syllabus domains.

The structure of the syllabus focuses on knowledge, action, and consolidation. Each of the five domains contains subsections, which describe key elements and capabilities to be attained and these are presented with essential learning outcomes, which encompass basic training for all NHS staff and higher training for specific groups of staff.

Training delivery is structured as levels from 1 - 5:

- Level 1 must be completed by both clinical and non-clinical staff as a once only training session
- Level 2 must be completed by all those within patient safety roles.
- Levels 3 – 5 are educational modules that include training material from training providers approved by National Health Service England/Improvement (NHS E/I). There will be overlap of roles such that key staff may need to attend some or all the training. This level of training is for staff who have defined patient safety roles under PSIRF such as:
    - PSIRF learning response leads
    - PSIRF engagement leads
    - PSIRF oversight roles

To deliver the required training a Training Needs Analysis (TNA) has been developed.

The three mandated training packages are:

- Learning Response leads (Band 8a and above) - Systems approach to learning from patient safety incidents
- Engagement & Involvement leads (band 6 and above including senior nurse, doctors & Allied Health Professional (AHP)) - Involving those affected by patient safety incidents in the learning process.
- Oversight leads (Divisional Triumvirates, Medical Director & Associate Medical Directors, Chief Nurse & Divisional Directors of Nursing, AHP leads) - Oversight of Learning from Patient Safety Incidents.

Our training numbers below have not changed. Appropriate staff from the Insights and Learning Team will provide support to investigational leads, ensuring that learning events meet the required standards. This does not negate the need for a separate investigation lead and engagement lead.

Learning Response Leads	Engagement & Involvement Leads	Oversight Leads
All must be 8A HSIB (Healthcare Safety Investigation Branch) online Training.	Must be band 6 and above- hybrid training.	Oversight leads train for all 3 roles in above headings.

9. Our Patient Safety Incident Response Plan

Our Patient Safety Incident Response Plan (Ref 7) (PSIRP) sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. In following the plan we will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected.

The Trust wide Patient Safety Incident Response Plan can be accessed via our internet page (for public) or in our Trust wide documents for staff.

10. 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 or when it is indicated that a review of approaches and focus needs to occur to ensure our plan remains current - 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 four years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB)) to adequate resource and planning is given to 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.

11. Responding to patient safety incidents

When an incident is discovered, all employees have a responsibility to ensure immediate action is taken to reduce further risk, maintain safety and ensure that their own safety is not compromised. The safety of employees, patients, and visitors are paramount. Line managers should be informed immediately if there are ongoing concerns and further risks to safety that require management and escalation.

12. Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents/events on the Trusts' incident reporting system. Divisions and specialities across the trust will have daily or frequent review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. It is at these Patient Safety Huddles that all patient safety events will be briefly reviewed, discussed and further escalation agreed. Examples of these will be:

- Daily Divisional Patient Safety Huddles
- Frequent Specialist Patient Safety Huddles (e.g., Pressure Ulcer Screening Panel/Falls huddles)
- Weekly corporate Patient Safety Huddle

Where further escalation is agreed due to the potential for learning and improvement, a Patient Safety Review (PSR) will be convened at the earliest opportunity. On occasion, the PSR itself may provide enough learning to enable closure of the incident and monitoring of agreed actions. However, at the end of the PSR, further agreement will be reached regarding the next stage of learning responses that may be required, which can include:

- After Action Review
- MDT (Multi-Disciplinary Team) Review
- PSII (Patient Safety Incident Investigation)
- Thematic Review
- Inclusion of actions to existing improvement plan to be monitored through and established group
- Other agreed proportionate learning response

During the daily huddle, consideration of Duty of Candour and/or Engagement and involvement process should begin.

Divisions/specialities will identify and escalate to the Patient Safety Team any incident which appears to meet the requirement for reporting to the third party. This will be to allow the Trust to work in a transparent and collaborative way with our ICB (Integrated Care Board) or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

13. Patient safety incident response decision-making

At Divisional level there are established governance processes for reviewing patient safety incidents daily (excluding weekends and bank holidays) and agreeing the next step required for capturing immediate learning and agreeing if escalation to a Patient Safety Review is required. In addition to the Divisional daily safety huddles, there are additional governance processes established that capture insights from services not normally represented at the huddle. An example of this is the Pressure Ulcer Screening Panel, which discusses and agrees further actions/learning responses for patient incidents related to skin integrity issues. The same process will be adopted for these speciality patient safety huddles, in that incidents will be escalated based on the potential learning that can be derived, as opposed to the harm that has been caused. Involvement and engagement processes and DoC processes will ensure where relevant as outlines in this policy (Ref 1).

All incidents that are escalated to a Patient Safety Review will be tabled for discussion at the trust wide incident review meeting ensuring that there is appropriate oversight of patient safety events and monitoring of the associated actions to improve patient safety. Incidents that automatically meet the threshold for a Patient Safety Incident Investigation will initially have a Patient Safety Review which will be discussed at the trust wide incident review meeting. Following this, when completed, the more detailed Patient Safety Incident Investigation Report will be tabled for the Trust wide Serious Incident and Learning Group. It is here that the report will be discussed, and a check and challenge will occur to ensure that appropriate learning and improvement actions have been established through the investigation.

The Trusts Patient Safety Incident Response Plan sets out the proposals for oversight and monitoring of Patient Safety Events/incidents that have been escalate for further review.

Table 3 route for patient safety Incidents as defined in GWH PSIRP

Patient safety incident type or issue	Planned response	Anticipated improvement route
Any patient safety incident that occurs	Discussed at Daily Huddle	Discussion and agreement for escalation if required. If no escalation is required, then incident manager proportionately investigates the incident and sets appropriate local actions if required.
Patient safety incident escalated	A Patient Safety Review is convened as soon as possible after the incident to discuss the incident on the agreed template and agree any learning and actions for improvement. If	If the Patient Safety Review is confident that all learning has been derived, then actions will be assigned accordingly, and progress will be monitored through team/divisional and Trust wide clinical governance groups.

from Daily Huddle	necessary, further learning responses will be discussed these include:	
Incident escalated from Patient Safety Review	After Action review	Actions for improvement are agreed. Where they are already being managed through an improvement plan, the relevant plan is updated. Actions are monitored through departmental/divisional and Trust wide oversight groups. Where new emerging themes are identified, consideration is given as to whether this theme becomes a priority with an associated improvement plan.
	MDT Review	
	Patient Safety Incident Investigation **Undertaken when there is significant learning to be gained from an in-depth investigation, or when this type of investigation is mandated due to meeting criteria**	
	Further analysis/thematic review	Some learning responses may prompt the requirement for deeper analysis of data to understand whether there are key themes occurring that are contributing to patient safety issues.

Table 4 Oversight of escalated patient safety events/incidents taken from GWH PSIRP

Meeting title	Current	Transition to
Incident Review Meeting	Reviews 72-hour reports & internal comprehensive investigations that have been drafted following an incident escalated for further investigation. Supports in decision making regarding whether the incident is a serious incident.	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate - Patient Safety Review - After Action Review - MDT Review - Other proportionate learning responses
Serious Incident Review & Learning Group	Reviews Serious Incident reports and their actions and agrees closure or further amendments	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive
Patient Safety Learning Group	Receives reports on Serious Incidents and other incidents of concern with a focus on the learning that has been identified	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART (Specific, Measurable, Achievable, Realistic, Timebound) meaningful and making a difference

Patient Safety & Quality Sub Committee	Receives reports on Serious Incidents and other incidents of concern	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

14. Responding to cross-system incidents/issues

The need to further develop and adopt cross-system learning from patient safety events is a significant drive in the National Patient Safety Strategy. The Trust are committed to supporting cross-system working and learning.

14.1 Oversight Roles and Responsibilities

BANES, Swindon and Wiltshire (BSW) system will be recognised as a thriving and empowering patient safety learning system. All system partners will commit to working collectively to ensure the appropriate oversight is in place to maximise the opportunities of sharing insight, participating in collaborative improvement, and learning, to continuously improve patient safety for everybody living in BANES, Swindon, and Wiltshire. A collective approach will be achieved through already existing improvement networks and Community of Practices, for example, Patient Safety Specialists and BSW Local Maternity and Neonatal System, and if required, through the development of new improvement networks to align to shared improvement priorities. The Academic Health Science Networks (AHSN) will be an important partner to help BSW system adopt and optimise continuous improvement and learning. The integral relationship with BSW System Quality Group (SQG) will also offer further opportunity to share learning and ensure further opportunities for:

- Positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect
- Confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight, and learning. This includes confidence that inequalities and unwarranted variation are being addressed.

SQGs are not statutory bodies and will NOT serve as the ICB's formal assurance committee for quality. This will be undertaken by the ICB board itself or by a committee of the board to which it designates responsibility and where senior executives from providers have recognised governance roles. However, SQG discussions and scheduled reports will inform the process of assurance for the ICB.

Active demonstration of Quality Improvement within organisations, alongside engagement, information sharing and participation in system learning and improvement, through the established system boards and networks will be recognised through provider quality schedules, as part of the contracting process.

Information governance agreements will be in place to ensure sharing within and between system partners to support effective communication during both an incident response and improvement endeavours.

Providers will defer to BSW ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. The ICB will give support with identifying a suitable reviewer in such circumstances and will agree with all relevant partners how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement. Providers will ensure they have robust processes and resource in place to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

15. Timeframes for learning responses

Each learning response will be assessed against the national priorities to establish if there is an expected timeframe for completion. If this is the case the timeframe will be discussed at the patient safety review and documented within the terms of reference.

If there is no overarching timeframe required by a governing body, then the attendees at the patient safety review will put forward an agreed timeframe for the patient safety response completion based on the level of review required, and complexity of the event, which is agreed by all involved including the patient or their family.

The Trust will monitor completion of learning responses and where learning responses are not completed within the agreed timeframe detailed in the terms of reference, will work to support the learning response lead and others involved in the review to ensure that it is completed. Barriers to completing within the agreed timeframes will be documented and explored to support learning for future responses, ensuring that those future responses meet expectations of patients, families and carers as well as the Trust.

16. Safety action development and monitoring improvement

The Trust has adopted Improving Together methodology as the agreed approach to continuous improvement. There are five principles of Improving Together:

- A clear vision
- A consistent approach to improvement
- Involving everyone
- Celebrate success
- Speak to the experts

By utilising the Improving Together methodology and the principles it endorses, the Trust can make improvements Trust wide, supporting achievement of the Trust vision in making a real difference to patient care.

Embedding the learning from patient safety events and monitoring the improvements will be achieved through use of the Improving Together methodology. Improvement or oversight groups will be established to monitor the agreed Trust patient safety priorities, building sustainable changes using the A3 methodology in the clinical areas.

Trust wide monitoring, oversight and sharing will be achieved through the Patient Safety Learning Group (PSLG) for improvement groups. Immediate learning and oversight will be achieved through the Incident Review meeting (IRM) for all other patient safety learning responses that do not directly feed into an established improvement group. The Serious Incident Review Learning Group (SIRLG) will provide a forum for discussion and learning related to patient safety events that require a PSII, with an onward summary provide through the governance structure to board level every quarter.

17. Safety improvement plans

PSLG will monitor actions and improvement plans for all patient safety priorities as well as other patient safety improvement work that has not been assessed as a local patient safety priority for the Trust.

An annual planner will be developed and established for PSLG that will pull together a structure that will enable oversight of all agreed priority workstreams, as well as those other patient safety workstreams and groups not assessed as a priority based on the data analysis at the time of developing the PSIRP. PSLG will also make recommendations for any changes to the PSIRP based on emergent themes from patient safety events.

The work plans, where possible, will align to the Trust Strategic Initiatives, therefore supporting a streamlined approach to patient safety.

- Leadership & Management Capability
- Way Forward Programme
- Digital First
- System & Place
- Improving Together

Through ensuring this link is achieved through everything we do, a golden thread for patient safety will be established.

18. Oversight roles and responsibilities

The Trust has established patient safety groups that provide a basis for oversight of patient safety events, and a platform for understanding and sharing learning. To ensure the ethos of PSIRF is captured existing decision-making meetings will be removed and replaced with oversight meetings. The terms of reference have been reviewed to capture the aim of learning form patient safety events and exploring if further learning can be achieved through additional learning responses.

We work in partnership with our commissioners at Banes Swindon and Wiltshire Integrated Care Board (BSWICB) to ensure that there is robust oversight of escalated incidents. Representatives attend our Serious Incident Review and Learning Group, Patient Safety Learning Group and the Patient Safety and Quality Sub Committee.

Regular engagement meetings also occur with the Care Quality Commission (CQC) to provide assurance regarding learning that has been achieved or is in progress from Patient Safety Events.

Table 5 Details of Patient Safety Oversight Meetings

Meeting title	Meeting Purpose
Incident Review Meeting	Is informed of learning and improvement actions that have been agreed from learning responses that are not PSII and provides challenge and support where appropriate - Patient Safety Review - After Action Review - MDT Review - Other proportionate learning responses
Serious Incident Review & Learning Group	Is informed of learning and improvement actions that have been agreed from PSII and provides challenge and support where appropriate. Receives presentations on PSII action progress and escalated to Executive
Patient Safety Learning Group	Oversees Trust wide priority improvement plans, providing advice and support to ensure that plans are SMART meaningful and making a difference
Patient Safety & Quality Sub Committee	Receives information and reports on learning and improvements made from the array of learning responses, including metrics, case studies and feedback.

19. Complaints and appeals

Throughout a learning response process, there will be a designated engagement and involvement lead who will be the continuous point of contact for patients, families and carers regarding information about the event and learning response. In the first instance, if there are concerns following a learning response these should be highlighted to the designated engagement and involvement lead who will provide appropriate support and escalation if required. Additionally, we will share details and information regarding our complaints process, if the patient, family/carers request this.

20. Glossary

Acronym	Meaning
AHP	Allied Health Professional
BSWICB	Banes Swindon and Wiltshire Integrated Care Board
CQC	Care Quality Commission
DoC	Duty of Candour
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board

Acronym	Meaning
IRM	Incident Review Meeting
SI	Serious Incident
LFPSE	Learning From Patient Safety Events
NHSEI	National Health Service England Improvement
NRLS	National Reporting and Learning System
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSII	Patient Safety Incident Investigation
PSLG	Patient Safety Learning Group
PSP	Patient Safety Partners
PSR	Patient Safety Review
RJLC	Restorative Just and Learning Culture
SEIPS	System Engineering Initiative for Patient Safety
SIRLG	Serious Incident Review & learning Group
SMART	Specific Measurable Achievable Realistic Timebound
SQG	System Quality Group
TNA	Training Needs Analysis

21. Consultation

The following is a list of consultees in formulating this document and the date that they approved the document:
The development of this policy has been through a very wide consultation process, and it is not possible to list all those consulted in the below table. Each Division has been able to input into the document development at various meetings, including the Implementation group and the Oversight group. In addition to this the Divisional Quality Governance Facilitators have had direct input to the policy development.

Job Title / Department	Date Consultee Agreed Document Contents
PSIRF Implementation Group	10/08/2023
Divisional Governance Facilitator – Surgery, Women's, and Children's	14/08/2023
Divisional Governance Facilitator – Integrated Care and Community	14/08/2023

Job Title / Department	Date Consultee Agreed Document Contents
Divisional Governance Facilitator – Division of Medicine	14/08/2023
Head of Insights and Learning – Corporate	18/08/2023
Deputy head of Insights and Learning - Corporate	18/08/2023
PSIRF Oversight Group	23/08/2023
Patient Quality Sub Committee	05/09/2023
Quality and Safety Sub Committee	19/10/2023

22. Supporting Documents

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Duty of Candour Policy	Trust wide Documents
2	Quality Governance Framework	Trust wide Documents
3	Risk Management Policy	Trust wide Documents
4	Complaints Policy	Trust wide Documents
5	NHSE Patient Safety Incident Response Framework (2020)	NHS England » Patient Safety Incident Response Framework
6	National Patient Safety Strategy 2019 (updated 2021)	NHS England » NHS Patient Safety Strategy: 2021 update
7	Great Western Hospital NHS Trust Patient Safety Incident Response Plan	Trust wide Documents/GWH Website

Appendix A – Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project?		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet?		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Helen Winter
Date completed	02/02/2024
Job Title	Associate Director of Nursing

On completion of Stage 1: A full impact assessment will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above.

Link to document

NHS
Great Western Hospitals
NHS Foundation Trust

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives			
Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.