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1. INTRODUCTION

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out HUC'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.

PSIRF advocates a co-ordinated response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and facilitates significant cultural developments towards systematic patient safety management.

This policy supports and promotes the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Use 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 system functioning and improvement

The PSIRF replaces the Serious Incident Framework (SIF), 2015, and makes no distinction between 'Patient Safety Incidents' (PSIs) and 'Serious Incidents'. 'Serious Incidents' and their associated thresholds are not defined under PSIRF.

2. SCOPE

This PSIRF policy is supplementary to the wider organisational 'Incident Management Policy'; this details the processes followed in relation to both patient safety and non-patient safety incident and near miss identification, reporting, investigation and learning actions.

This policy is specific to roles and responsibilities in relation to patient safety incident responses conducted solely for the purpose of learning and improvement across HUC.

PSIs are unintended or unexpected events (including omissions), in healthcare that could have or did cause harm to one or more patients.

Responses under this policy follow a 'systems-based approach' to learn what risks there are across the organisation in relation to patient safety and how to respond to these to improve safety in line with our ethos of continuous learning and improvement.

A system-based approach recognises that healthcare is provided within a multifaceted working environment. One that is comprised of people, systems, tasks, equipment and the different environments/ localities in which care is provided. All these aspects of the system vary and interact with each other to produce different outcomes. By exploring how these different aspects work together, across different situations, a deeper understanding of the risks and issues facing patients and HUC colleagues can be gathered, and more effective learning identified.

Human error is understood to be, in the vast majority of cases, a symptom of an issue in the healthcare system, rather than a cause of an incident. When responding to incidents and safety events under PSIRF, 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 listed below (noting this may not be an exhaustive list), exist for this remit and are therefore outside of the scope of this policy:

- Claims handling
- Human resources investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Coronial Inquests and criminal investigations
- Complaints (except where a significant patent safety concern is highlighted)

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

HUC is committed to holistic, partnership working, extending to our commissioning Integrated Care Boards (ICBs) and system partners / colleagues to nurture meaningful investigation, learning and robust safety actions across the entire patient journey footprint.

This policy, in conjunction with the wider organisational Incident Management Policy, supports the real time, effective implementation, transition and management of PSIRF to ensure we incorporate and meet the required standards, principally covering:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

3. OVERSIGHT ROLES AND RESPONSIBILITIES

This policy embraces the principles advocated through the PSIRF to underpin the processes we have put in place to allow us to implement PSIRF.

All colleagues are responsible for ensuring they are aware of all the applicable HUC polices and work within the guidance provided.

In line with the ethos of PSIRF, this policy seeks to support the design and oversight of processes regarding continuous learning and improvement through patient safety incident responses and our ability to demonstrate improvement rather than our compliance with any centrally mandated measures.

Roles and responsibilities, in line with this policy and the principles of PSIRF are divided as follows:

- **Patient Safety Specialist (PSS):**

Patient Safety Specialists provide dynamic senior patient safety leadership. Each PSS provides expert support and has direct access to the executive team, which facilitates the escalation of patient safety issues or concerns.

The requirement for NHS organisations in England to identify one or more PSS as a key part of the NHS patient safety strategy and is included in the NHS standard contract. HUC's identified PSSs are:

- Dr Sivanthi Sivakumar- Chief Medical officer
- Leanne Walsh- Associate Director of Clinical Quality and Governance
- Helen Cullen- Head of Clinical Governance

The PSSs will also actively support our transition from the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) to the new Learning from Patient Safety Events (LFPSE) portal and the change in organisational culture and practice as we move away from the SIF to PSIRF and Patient Safety Incident Response Plan (PSIRP).

- **Chief Medical Officer (CMO):**

Holds executive accountability for PSIRF and PSIRP, ensuring that the organisation has the necessary processes and systems in place to enable the effective management of reported patient safety incidents and near misses and wider Clinical Governance processes, to include the facilitation of DoC and shared learning.

- **Associate Director of Quality and Clinical Governance (ADCG):**

Holds first line accountability for the organisation's Clinical Governance processes to include PSIRF and PSIRP, ensuring fair, effective, and robust process for managing all levels of patient safety incident response / investigation. They hold overall responsibility for the completion of robust, fair investigations and reports. They liaise as required with the governance teams of partner and external organisations and our commissioning ICBs.

- **Head of Clinical Governance:**

Holds responsibility for the day-to-day management of all patient safety incidents and near miss investigations, ensuring a fair, effective, and robust process for managing all levels of incident investigation. They liaise as required with the governance teams of partner and external organisations and the ICB(s).

- **Clinical Directors (CDs):**

Holds day to day responsibility for the clinical safety of the services within their defined portfolio, to include service line patient incidents and near misses, providing senior clinical oversight to ensure patient care is at the centre of all investigations and all actions are completed to mitigate risks and maintain safety.

- **Head of Nursing:**

Holds responsibility for overseeing actions related to the nursing and non-medical team with regards to patient safety standards following incident investigations. The Head of Nursing will participate with investigations as required to share their knowledge, expertise, and experience.

- **Head of Safeguarding:**

Holds responsibility for overseeing actions related to the safeguarding team with regards to patient safety standards following incident investigations. The Head of Safeguarding will participate in investigations to share their knowledge, expertise, and experience as appropriate.

- **Clinical Governance Managers:**

Deliver first line support for all levels of patient safety incident and near miss management, advice, and guidance to all services within their defined portfolios and across the organisation as appropriate; they are responsible for the collation of patient safety data.
They monitor the timeliness of patient safety incident investigation and the completion of all safety actions developed to share and implement learning

- **Operational Management Teams (Head of Service, Deputy Heads of Service):**

Responsible for the oversight of all patient safety incidents and near misses within their service line, ensuring those allocated are actioned appropriately with clear learning and safety actions developed. They are responsible for ensuring that all colleagues working within their service line are aware of and adhere to this policy (and any future updates / amendments) and work within its guidance.

4. PATIENT SAFETY PARTNERS

Patient Safety Partners (PSP) are a key element of the National Patient Safety Strategy relating to the involvement of patients, carers, families and lay people as partners in improving the quality and safety of NHS care.

PSPs have an important role within the PSIRF, bringing the patient perspective to patient safety investigation responses and learning alongside those people directly involved in incidents.

The appointment of PSPs will afford us an exciting opportunity to enhance support for our colleagues, patients, families/carers and their ability to influence and improve quality and safety across our range of services. The role will be developed organically, fostering the shared views, experience, and perspective of the community for the benefit of all involved in patient safety workstreams. The primary focus of our PSPs is to strengthen the voice of our patients and the communities we serve.

Our PSPs will support our PSIRF and PSIRP by contributing proportional, and objective feedback on selective written work to include, but not limited to policies, investigations, and reports. PSPs may also be invited to attend, as appropriate, service level Clinical Governance meetings, the Clinical Safety and Quality Assurance Forum, Safeguarding Assurance Group and the Clinical Quality Committee, a sub-committee of the board.

The PSPs will be supported in their honorary role by the PSPs who will advise and provide guidance for all workstreams they are asked to participate with and offer reflective sessions and supervision to ensure their wellbeing. PSPs will have access to the organisational Employee Assistance Programme (EAP) and training platform (HUC Academy) to ensure they receive the relevant training.

The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

5. ADDRESSING HEALTH INEQUALITIES

We have a key role to play in tackling health inequalities in partnership with our local partner agencies and services. We are committed to providing equality of opportunity for all individuals involved in an incident and recognise the importance of effective engagement and involvement, considering the different needs of individuals, to facilitate equal opportunities.

Through the implementation of PSIRF, we will seek to utilise internal data and learning from investigations to identify actual and potential health inequalities and make recommendations to the HUC Board and partner agencies to tackle these.

We will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. As part of our new incident response framework, protected characteristics will be considered as part of the patient safety review to give insight into any potential inequalities.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

Our engagement with patients, families and carers following a patient safety investigation will seek to recognise and identify diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process and engagement with patients and families, for example, during the duty of candour process.

Engagement of patients, families and colleagues following a patient safety incident is critical, we will draft all written documentation in line with the principles of making it readily accessible for all; this will be supported by our PSPs.

Equity, Diversity and Inclusion (EDI) remain a clear priority for the organisation and through this we endorse a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our colleagues, our patients, carers and families. With explicit role modelling led by our Senior Leadership and Executive Teams, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

6. OUR PATIENT SAFETY CULTURE

Our organisational philosophy is that all incidents and near misses offer invaluable learning opportunities and as such, reporting is viewed as a positive action. Colleagues are trained, supported, empowered, and encouraged to feel confident to report incidents freely in the knowledge that each one has a detailed and thorough investigation (in line with our internal Incident Mapping, detailed in our Incident Management Policy).

It is important for all colleagues to be aware that as an organisation we work hard to nurture and promote an open and honest blame free culture. Where safety actions are needed to reduce the chance of incidents reoccurring these are always implemented in a positive way and not as a punitive measure.

Most incidents occur due to system failures and not as a result of deliberate actions or omissions of individual healthcare colleagues. Looking at what was wrong in the system helps the organisation to learn lessons that can prevent the incident recurring in the future.

We are open and transparent with our investigation and patient safety incident response processes and ensure learning is shared at an individual level as well as with the entire team in a positive, constructive way.

It is understood that as an organisation we are regulated on the quality of our investigations but are not performance managed or regulated on the basis of the number or type of incidents we report. By highlighting this to colleagues we hope to encourage reporting and allow colleagues to share information to aid learning and practice improvement.

Underpinning all our learning responses and investigations is the concept that the patient and their needs (and / or those of the carer / relatives etc.) are at the heart of everything we do. Where appropriate we also involve patients, their family, or carers under duty of candour, as well as being a statutory responsibility this also helps to build trust and maintain professionalism.

HUC promotes a safe and Just Culture approach (in line with the NHS Just Culture Guide), with all workstreams developed to reflect this ethos. .

Psychological safety underpins openness and transparency to encourage incident reporting and raising concerns. We encourage and support incident reporting where an incident may have, or is likely to occur, which has caused, contributed to or may lead to harm of a patient or colleague.

In addition to incident and near miss reporting, colleagues have access to our Freedom to Speak Up Guardian; this is independently provided by the Guardian Service, the UK's leading provider of confidential staff liaison services (further details available in the Whistle Blowing Policy)

7. ENGAGING AND INVOLVING PATIENTS, FAMILIES AND COLLEGUES 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 colleagues). 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.

7.1 Patients, Families and Carers

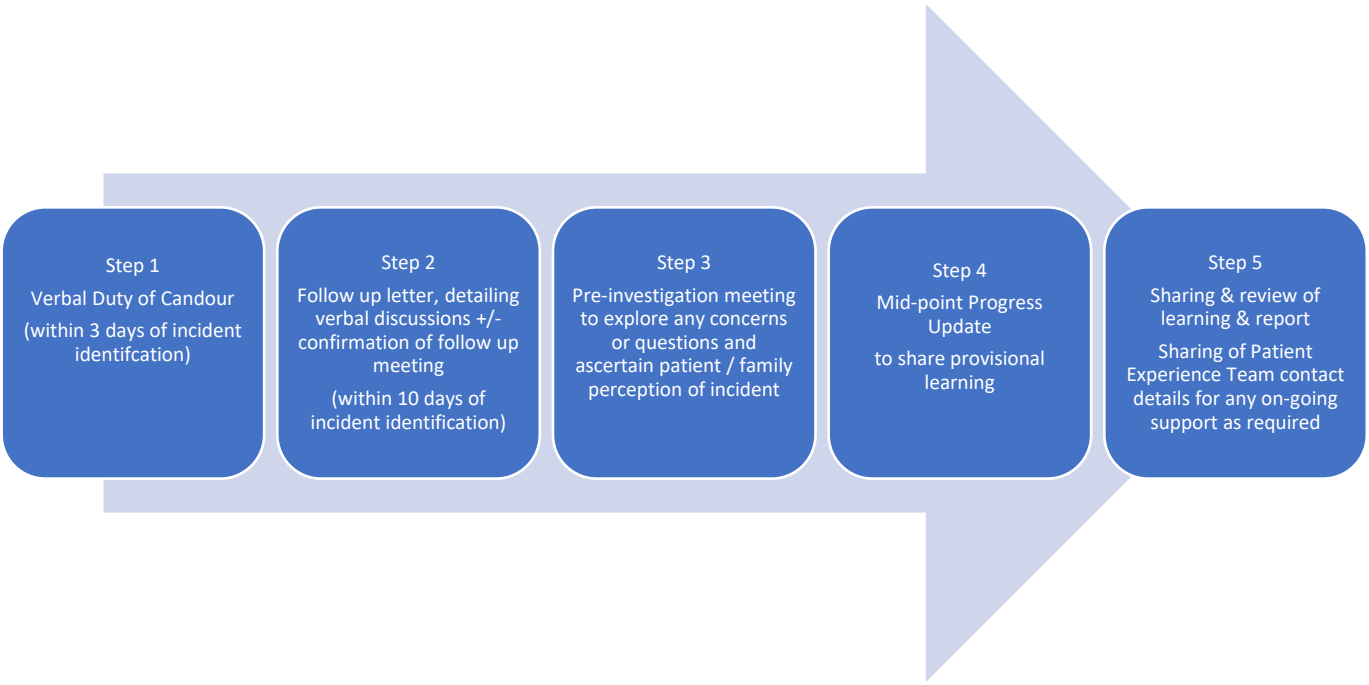
We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers; we are firmly committed to continuously improving the care and services we provide.

Patients, families and carers often provide invaluable, unique, and new perspectives to the circumstances around patient safety incidents.

As an organisation we advocate for candour at all times by actively promoting the importance of being frank, open and honest. Full Duty of Candour details, including the processes and timeframes are detailed with the Incident Management Policy. In summary, patients, or their family as appropriate, who sustain moderate harm and above as a result of an action of omission within the care / service provided

receive a genuine, specific verbal apology that is appropriate and sincere, within three days of identification.

Duty of Candour Steps:



It is important to be clear when communicating with patients (relatives / carers etc.) regarding the purpose of patient safety incident responses / investigations, in that the aim is to learn lessons and ensure there are no misconceptions or unrealistic expectations regarding disciplinary proceedings or governing body involvement etc.

Further guidance in relation to involving patient and families following a patient safety incident is available via NHSE guidance – Engaging and involving patient, families and staff following a patient safety incident.

7.2 Colleagues

Involvement of colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset.

Colleagues involved in Patient Safety Incident Investigations (PSIIs) are offered a debrief as soon as possible; this is facilitated by the local management team, although additional support can be sought from the Clinical Governance team, Quality Improvement team, or Clinical Director as required.

Peer support is also encouraged; colleagues benefit from access to our organisational Employee Assistance Programme (EAP) and free counselling service (via Care First).

Colleagues are supported with written guidance on how to produce a first-hand account / statement with a template to help format their statement and are given a colleague information leaflet explaining the PSII process.

Key members of the team involved in the incident are invited to contribute to the investigation by attending a meeting to share details of the incident with the investigating team. This meeting is conducted in a non-threatening manner; the aim is not to seek and apportion blame but rather to establish the facts of the case extract learning and agree actions going forward.

On completion of the investigation all members colleagues involved in the incident will have the learning response shared with them during individual feedback and learning session.

As an organisation we will, in accordance with the Fair and Just Culture, continue to promote, support and encourage incident reporting, including near misses and all levels of harm.

8. PATIENT SAFETY INCIDENT RESPONSE PLANNING

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather that only those that meet a certain defined threshold.

We welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as patient feedback, complaints, risks, legal claims, mortality reviews and other forms of direct feedback from colleagues and patients. PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on HUC's external facing website

Our PSIRP reflects these standards and should be read alongside this overarching policy framework.

9. RESOURCES AND TRAINING TO SUPPORT PATIENT SAFETY INCIDENT RESPONSE

PSIRF recognises that healthcare providers have limited resources and capacity to investigate and learn effectively from patient safety incidents. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRF provides more specific details in relation to this including the number of comprehensive investigations that may be required for single cases / patients or small groups of incidents that do not fall into one of the broader improvement workstreams/priorities.

The Chief Medical Officer, Associate Director of Clinical Quality and Governance and the Head of Clinical Governance are trained in line with the PSIRF requirements to complete learning responses. The wider senior clinical team, clinical governance and senior operational teams will be trained organically as we continue our transition.

All other colleagues will be required to complete mandatory patient safety training levels 1a which covers the basic requirements of reporting, investigating, and learning from incidents.

General	Course/Topic	Colleague group/Role	Training available	Provided by
NHS Patient Safety Syllabus	Level 1a - Essentials for all colleagues	All colleagues	e-LMS	NHS England
	Level 1b – For senior leaders and board members	Senior leaders and board members	e-LMS	NHS England
	Level 2 – Introduction to systems thinking and human factors	Colleagues undertaking learning responses	e-LMS	NHS England
PSIRF-mandated	A Systems-based approach to investigating and learning from patient safety incidents	Investigation Leads	Online – self paced	HSSIB
	Oversight of learning from patient safety incidents	Investigation Leads	1 Day	External Provider
	Involving those affected by patient safety incidents in the learning process	Investigation Leads	1 Day	External Provider
Optional	Investigative interviewing	Investigation Leads	Online – 1 day	HSSIB

10. PATIENT SAFETY INCIDENT RESPONSE PLAN

Our plan sets out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules, trigger points or criteria 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.

10.1 Reviewing our Patient Safety Incident Response Policy & 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. Rigorous planning exercises will be undertaken every three years and more frequently if appropriate (as agreed with our host Integrated Care Board (Hertfordshire 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 wider review of organisational data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

11. RESPONDING TO PATIENT SAFETY INCIDENTS

11.1 Patient Safety Incident Reporting Arrangements

Patient safety incident reporting will remain in line with HUC's Incident Management Policy. All incidents and near misses are reported via our Incident Reporting System, RADAR.

It is recognised that colleagues must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

11.2 Patient Safety Incident Response Decision-Making

We have clinical governance and assurance systems to ensure oversight of incidents and near misses across the organisation. Clinical Governance managers work closely with the Service Line Heads of Departments and Clinical Directors to ensure the following arrangements are met.

There are processes in place to communicate with and escalate any appropriate incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements, to include, but not limited to:

- Identification and escalation of any incidents that have, or may have caused moderate or serious harm, or death
- Identification of themes, trends, or clusters of incidents / near misses within a specific service
- Identification of any incidents / near misses relating to local risks and issues (e.g., CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g., Never Events & RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

PSIRF itself does not define rules or thresholds to determine what method of response should be used to support learning and improvement. We have developed our own response process to facilitate the balance between robust and proportionate responses.

The Senior Clinical and Governance Team review all potential cases where there is the possibility that moderate harm or above has been caused through an action or omission within a HUC managed service, a significant near miss, complex case or where there is potential for significant learning. These cases can be identified through a number of routes such as reported incidents, complaints, audit findings, health professional feedback etc.

These cases are presented at the weekly Rapid Review and Decision Meeting (RRDM); this meeting is routinely attended by the Chief Medical Officer, Associate Director of Clinical Quality and Governance, Head of Nursing, Clinical Directors, Head of Clinical Governance and Clinical Governance Managers, Head of Patient Experience and Head of Safeguarding. Additional Subject Matter Experts (SMEs) and senior operational colleagues are invited to join by exception as indicated. Additional meetings are stood up as required. This meeting will determine the level of harm caused, internal incident level classification and type of response required.

Across the organisation we have four levels of internal incident classifications (full details and definitions of harm, including physical and psychological, are within the Incident Management Policy):

- **Routine:**

These are usually managed by the local management team, typically these incidents will have been near misses or have resulted in no or low harm.

- **Higher Level Incidents 1 (HLI1):**

Typically, these are managed by the relevant portfolio Clinical Governance Managers in partnership with the Clinical Directors and operational managers; these incidents will have caused moderate harm, with statutory Duty of Candour completed (detailed further in DoC section with the Incident Management Policy)

- **Higher Level Incident 2 (HLI2):**

These may be significantly complex and therefore require a more structured investigation approach; they facilitate a proportionate investigation if the potential for learning is more significant than a 'routine' incident.

- **Adverse Outcome Incidents (AOIs):**

These incidents will continue to have a full, individual PSII, they are usually managed centrally by the Clinical Governance team and Clinical Directors. These incidents will typically have caused serious harm or an unexpected death, with statutory Duty of Candour, or where there was the potential for significant learning. During the PSIRF transition period these incidents will continue to be declared and recorded on a national database (StEIS) and the learning responses and action plans shared with the HUC Board, respective ICBs and the patient or their family / career etc.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under our PSIRP. This may mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP; this will be considered on a case-by-case basis with justification where necessary.

Once a decision is made for a PSII the senior clinical team will define the terms of reference, the lead and supporting team, to include any local, system, service or clinical SME required or highlight any cross system working that may be necessary, as well as indicating how immediate learning / safety actions are to be shared.

Where an incident does not meet the requirement for PSII, investigation/ responses will be undertaken in accordance with patient safety response plan or the toolkit.

The Clinical Governance team will provide regular reports to the Clinical Safety & Quality Assurance Forum, that feed the Clinical Quality Committee (a sub-committee of the Board) to identify, and track known and emerging themes and trends outside of normal variation. This information will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Clinical Quality Committee.

11.3 Responding to Cross-System Incidents/ Issues

We are committed to nurturing positive relationships with partner providers and our ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system patient safety incidents. We recognise that, in some instances, it will be appropriate for us to work in partnership with other providers, such as acute trusts, ambulance trusts or GP practices.

The Clinical Governance team will ensure any incidents or near misses that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. We will reciprocate and fully engage in a proportionate and meaningful way to cases led externally to HUC.

Upon identification that a patient safety incident has occurred within a service that is managed in partnership with HUC, or by a separate provider, the clinical governance team will be the initial and primary contact / liaison point, with supportive operating procedures to ensure that this is effectively managed.

11.4 ICB Collaboration

We are fortunate to have effective and trusted working relationships with all our commissioning ICBs.

We will share the Learning Summary Case Study from each PSII with the relevant ICB; we will reach out to request support, as required, for any specific PSIIs if/when additional or external scrutiny is deemed to be appropriate, to ensure proportionate involvement from the ICBs, recognising their own resource and capacity limitations.

For complex cases, such as multi-touchpoint / provider incidents that span across the system, we will defer to the relevant ICB for co-ordination in identifying a suitable lead reviewer in such circumstances.

Learning response and actions developed will flow through our internal assurance processes and reporting structures in addition to those of our provider colleagues and any recommendations made by the ICB. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

PSIIs and the PSIRP updates will be shared as appropriate at the Contract / Quality monitoring meetings.

12. TIMEFRAMES FOR LEARNING RESPONSES

Learning responses must balance the need for timeliness and capture of information as close to the event, or identification of the event, as possible. 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 time frame for completion of a PSII will be agreed with those affected by the incident, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact any extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety. No local PSII should take longer than six months.

If a partner organisation requests an investigation is paused, or the processes of an external body delays access to information we may consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received.

Different tools and types of learning responses will be utilised in line with what is the 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:

- Initial incident review – as soon as possible, within 3 working days of reporting
- Further learning response- within 30 working days of reporting

A toolkit of learning response types are available from NHSE, with local HUC templates available through the appendices of the Incident Management Policy.

13. SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

Each PSII and patient safety incident response / investigation using a different method from the toolkit facilitate a holistic review of circumstances of an incident or set of incidents to allow us as an organisation to better understand what happened and where learning and safety actions can reduce the risk of recurrence.

We have robust processes and reporting structures across the organisation to monitor and quality assure all safety actions developed from learning from every reported incident and near miss.

PSIRF moves away from the identification of ‘recommendations’ which may lead to determining a resolution at an early stage of the safety action development process. Learning responses articulate safety actions that are developed in response to a defined area for improvement. To achieve successful implementation of all identified safety actions we foster a collaborative multidisciplinary working relationship across all service lines and directorates. PSIRF provides an opportunity to strengthen this across the organisation as we grow and mature.

Safety actions arising from learning responses will follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles enabling us to monitor and measure success.

Routine incidents and their associated learning and safety actions are monitored through the monthly service line Clinical Governance Meetings; in addition each incident is individually quality assured by the service Clinical Governance Manager to ensure the required standards have been met and that all codable fields are correct (level, category, location etc.) in addition to ensuring the 'golden thread' from learning is maintained through to safety actions and that all actions have evidence of completion prior to be closed on the system.

HLIs are also monitored through the monthly service line Clinical Governance Meetings and individual quality assurance review by the Clinical Governance Manager, they also have senior sign off by the Head of Clinical Governance and Chief Medical Officer. Additionally, the completed investigation, Learning Summary Case Study and completed safety action plan are monitored and presented to the Clinical Safety and Quality Assurance Forum for enhanced review and scrutiny.

AOIs / PSIIs have senior sign off by the Associate Director of Clinical Quality and Governance, Chief Medical Officer, and the Chief Executive Officer. Completed PSIIs follow the same processes as HLIs in terms of quality assurance processes with additional coverage and scrutiny through the Clinical Quality Committee for sign off of completed safety action plans. Through this mechanism the Board are assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

The Clinical Quality Committee has delegated responsibility for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

14. SAFETY IMPROVEMENT PLANS

The organisational PSIRP details how we will ensure patient safety incidents and themes are investigated in a more holistic and inclusive way, in relation to the identified local areas of focus, to identify key learning and safety actions which will reduce risk, improve safety and quality of services and improved patient safety outcomes for all patients.

Safety improvement plans bring together findings from various responses to patient safety incidents and issues; these will be developed from a combination of approaches depending on the incident. We may

- create an organisation-wide safety improvement plan summarising improvement work
    - typically, when a learning and actions cross service line / geographical boundaries
- create individual safety improvement plans that focus on a specific service, pathway or location
- collectively review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- create a safety improvement plan to tackle broad areas for improvement (I.e., overarching system issues).

Whichever approach is taken, the rationale for that approach will be fully explained in the learning response process and agreed upon with stakeholders.

Our organisational PSIRP details key priority areas of focus for investigation under PSIRF. These were developed following analysis of internal data (which included but was not limited to reported incidents and near misses, audit findings, patient experience data from complaints, concerns and feedback surveys, the risk register, soft markers picked up through 'Blockers / Challenges' at the Clinical Safety and Quality Assurance Forum and the Clinical Quality Committee) to strengthen our insight regarding the organisational patient safety profile. We have used this intelligence to develop guidance and local priorities for PSIIs and our extended toolkit for responding to other patient safety incidents.

The initial four priority areas were agreed due to the opportunity they offer for learning and improvement across the organisation with the aim of reducing risk, increasing patient safety by reducing harm, and improving patient experience. These are:

1. Holistic review of Safeguarding Practices
2. Care and treatment of palliative care patients in the out of hours period
3. Maintaining safety in the clinical call-back queues in times of high demand
4. Quality and documentation standards relating to history of presenting complaint

Learning will be used to develop safety actions and safety improvement plans; monitoring of these will be presented to the Clinical Safety and Quality Assurance Forum and the Clinical Quality Committee.

15. COMPLAINTS AND APPEALS

We recognise that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided.

Concerns relating to this guidance, or its implementation can be raised informally with the Head of Clinical Governance who will aim to offer local resolution as appropriate.

It is important to understand that there is a distinction between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process. Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the hospice and requires a formal review.

The first point of contact for a formal complaint is with the Head of Patient Experience who will offer support and facilitate the organisation's complaint process (As detailed in the Complaint Management Policy). It is important to address any issue raised at the earliest opportunity as this may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

Contact details for raising a formal complaints as follows:

- www.hucweb.co.uk/contact
- email huc.feedback@nhs.net
- telephone on 0808 260 9934
- writing to us at:

Patient Experience Team
HUC
The Old Ambulance Station
Ascots Lane
Welwyn Garden City
AL7 4HL

Appendix A Governance, Audit and Monitoring and Equality Impact Assessment

Governance	
Definitions *Any Acronyms or Abbreviations used in policy*	PSIRF – Patient Safety Incident Response Framework ICB – Integrated Care Board PSP – Patient Safety Partners NHSE – National Health Service England PSIRP – Patient Safety Incident Response Plan HSSIB – Health Services Safety Investigations Board CQC – Care Quality Commissioner RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations SMART - Specific, Measurable, Achievable, Realistic, Time-bound PSII – Patient Safety Incident Investigation AAR – After Action Review
Related Policies *Any policies or guidelines that directly impact or are impacted by this policy*	• **S6 Incident Management Policy** **C3** Concerns and Complaint Policy • **W1** Whistleblowing Policy • **S2** Adult Safeguarding Policy • **S3** Children Safeguarding Policy • **I6** Information Governance Policy • **I5** IT and Network Security Policy • **HS1** Health and Safety Policy
References *e.g... NICE guidance, externally recognised reports or research*	• NHS Just Culture Guide • NHSE Guidance – Engaging and involving patients, families and staff following a patient safety incident • Patient safety learning response toolkit • Safety action development guide
Search terms ***Put in key word search terms,***	Patient Safety, Incident, PSIRF
Circulation/ Training *How are you going to ensure that colleagues know about the document and are trained in its use*	The policy will be added to the weekly HUC communications newsletter. All colleagues involved in Incident investigation including Patient Safety Incidents will be signposted to this document Support and advice is available from the Clinical Governance team
Impact Assessment	
Equality and Diversity	The requirement for Equality Analysis Impact Assessment of all changes to policy, strategy or process has been added to this Policy including mention of the need to consider the application of the NHS Accessible Information Standard. Additionally, the Equality Analysis Impact Assessment Screening Tool for Policies has been applied to this policy to ensure consideration of fair treatment, access, inclusion and health inequalities, and the requirement that any evidence or factor being identified which affects one group more or less favourably than another is addressed.
Business	
Legal Implications	The use of standardised procedures should reduce the risk of legal action
Quality	The use of standardised procedures should ensure that quality is maintained
Resources	Colleagues will understand the policy process

Risk	The use of standardised process should ensure compliance with CQC regulations
Statutory Compliance	
Sustainability	The use of the intranet and other electronic systems will reduce paper used within HUC

Monitoring / Audit Criteria

What is the standard / audit criteria	Monitoring method	Responsibility for monitoring	Timeframe	Reported to:
Ensure that policies and guidelines are all within date	Reminders to Authors	Corporate & Clinical Governance team	Monthly	
Review of out-of-date documents	Monthly report	Corporate & Clinical Governance team	Monthly	

Appendix B Equality Analysis - Impact Assessment Screening Tool

AREA	NEGATIVE IMPACT		SIGNIFICANT Y/N?	
	Y ✓	N ✗	Y ✓	N ✗
1. Gender		N ✗		N ✗
2. Religion/ belief		N ✗		N ✗
3. Age		N ✗		N ✗
4. Disability (includes: mental health, learning disability, physical, sensory)		N ✗		N ✗
5. Ethnicity (includes: travellers and gypsies)		N ✗		N ✗
6. Sexual Orientation (includes: gay, lesbian, bisexual)		N ✗		N ✗
7. Transgender / Tran-sexual		N ✗		N ✗
8. Marriage or Civil Partnership		N ✗		N ✗
9. Pregnancy or Maternity		N ✗		N ✗
Additionally		N ✗		N ✗
10. Social / Economic		N ✗		N ✗
11. Rural / Urban		N ✗		N ✗
12. Health Inequalities		N ✗		N ✗
13. Application of NHS Accessible Information Standard		N ✗		N ✗