Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Framework (PSIRF) Policy

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Type of Document	Policy		
Target Audience	All Trust staff		
Document Purpose	This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIF) and sets out how Warrington and Halton Teaching Hospitals NHS Foundation Trust 9The Trust) will continue to develop and maintain effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.		
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WHH documents to be read in conjunction with
Patient Safety Incident Response Plan Learning from Deaths Policy Risk Management Strategy Risk Management Plan Risk Assessment Policy Health and Safety Policy Freedom to Speak Up Policy Duty of Candour Policy Complaints Policy Claims Policy Inquest Policy

Document change history	
Version	2
What is different?	Trust Patient Safety Culture – revised Patient Safety Partners – minor revisions Engaging and involving patients, families and staff following a patient safety incident – revised Patient safety incident response planning – minor revisions

	Resources and training to support patient safety incident responses – revised Patient Safety Incident Response decision making – revised Timeframes for learning responses – revised Timescales for other forms of learning response – revised and defined. Safety action development and monitoring improvement - revised Training Needs Analysis - Updated		
Appendices/electronic forms	Appendix 1: Training Matrix Appendix 2: Level of Harm Appendix 3: Complaints Flow Chart of Process		
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1. Executive summary

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Warrington and Halton Teaching Hospitals NHS Foundation Trust (the Trust) will continue to develop and maintain effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. The aim is to embed patient safety incident responses 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 and which we can also align to our existing Trust values:

- compassionate engagement and involvement of those affected by patient safety incidents (Kind)
- application of a range of system-based approaches to learning from patient safety incidents (Embracing Change & Excellence)
- considered and proportionate responses to patient safety incidents and safety issues (Inclusive)
- supportive oversight focused on strengthening response system functioning and improvement (Working together)

This policy should be read in conjunction with our patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. Purpose and scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

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.

For clarity, the Trust considers these processes as separate from any patient safety investigation. 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.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. 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. Such processes as those listed below and are therefore outside of the scope this policy:

- claims handling
- Human resources investigations into employment concerns
- professional standards investigations
- structured judgement reviews
- medical examiner reviews
- estates and facilities concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests
- criminal investigations
- complaints (except for where a significant patient safety concern is highlighted)

Other incidents that fall outside of this policy as they have alternative reporting arrangements include:

- Incidents relating to research.
- Information governance (procedures required by the Information Commissioner relating to investigating information breach incidents are unchanged by the introduction of PSIRF)
- Reporting of injuries, diseases, and dangerous occurrences (RIDDOR) reporting
- Ionizing Radiation (Medical Exposure) Regulations IR(ME)R reporting
- Blood Transfusion incidents (SHOT reporting)
- Those meeting the criteria for ‘Each Baby Counts’ and maternal deaths – automatic reporting to the Maternity and Newborn Safety Investigations Programme (MNSIP)
- Safeguarding incidents
- Human Tissue Authority reportable incidents
- Root cause analysis for hospitals acquired thrombosis.

This policy should be read in conjunction with the following other WHH policies, which can be located on the WHH Policies and Procedures page in Share Point:

- Freedom to Speak Up - Policy for the NHS
- Policy and Procedure for the Management of Claims
- Risk Management Strategy and Associated Policy
- Complaints Management
- Duty of Candour Policy (Being Open).

3. Duties and responsibilities

Role	Responsibilities
Chief Executive	• Has overall accountability for the effective management of all patient safety incidents internally, including contribution to cross-system/multi-agency reviews and/or investigations where required. • Model's behaviours that support the development of patient safety reporting, learning and improvement system and ensures that members of the Trust Board follow their lead. • Ensures that systems and processes are adequately resourced including funding, management time, equipment, and training.
Executive Chief Nurse and trust Medical Director	The Chief Nurse and Medical Director have joint delegated accountability to support effective implementation and monitoring of PSIRF, ensuring that the organisation meets the national patient safety standards as follows • Enables systems and processes to support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required). • Oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the just and restorative working culture. • Agrees sufficient resources to support the delivery of the PSIRP in line with best practice standards (including support for those

Role	Responsibilities
	affected, such as named contacts for staff, patients, families, and carers where required. • Ensures the organisation complies with the national patient safety investigation standards. • Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards.
The Governance Team	• Works with the Care Group's Leads and associated Clinical Business Unit (CBU's) Leads to manage the selection of appropriate learning responses. • Lead and ensure the rigour of approach to reviews and investigations in their Care Group's and will maintain records to ensure an equitable allocation. • Supports learning responses and provide advice on cross-system and cross-Care Group's working where this is required. • Develops and maintains local risk management systems and relevant event reporting systems to support the recording and sharing of patient safety events and monitoring of event response processes. • Ensures the organisation has procedures that support the management of patient safety events in line with the organization's PSIRP (including convening review and investigation teams as required and identifying trained named contacts to support those affected). • Has established procedures to monitor/ review learning responses, their progress, and the delivery of improvements. • Works with Executive and Care Group's/CBU leads to address identified areas for improvement in the organisations response to patient safety events including gaps in resources including skills and training. • Supports and advises staff involved in the patient safety incident response.

Role	Responsibilities
	• Act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust as required.
Care Group Triumvirates	• Has arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective. • Has daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. • Highlights to the Governance Team (Corporate Governance) any incident which meets the requirement for reporting externally. • Works with the Governance Team to manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review. • Enables sufficient time and resources for reviewers and investigators and family liaison officers dedicated time to undertake their role. • Enables appropriate training and maintenance of competencies for reviewers and investigators. • Reviews and quality checks patient safety incident learning responses and investigations and their associated actions for improvement via the Trust committee governance structure. • Monitors safety actions within the Care Group's/CBU governance arrangements to ensure that any actions put in place remain impactful and sustainable. • Reports on patient safety incidents learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement. • Enables protected time for training in patient safety disciplines to support skill development across the wider staff group. • Enables protected time for participation in investigations as required.

Role	Responsibilities
	• Enables advice and support throughout the learning response process to staff affected by a patient safety incident and access to additional support services as required.
Learning Response Leads	• Will ensure that learning responses are undertaken in line with the current national patient safety investigation guidance. • Ensure they are competent and trained to undertake the learning responses and investigations assigned to them. • Undertakes patient safety learning response related duties in line with current national guidance and training. •
Family Liaison Officers (FLO)	• Work in partnership with patients, families/carers ensuring they are provided with opportunities to actively participate in the investing process in line with best practice. • Provide timely and accessible information and advice to patients, families/carers • Agree timescales for responses with patients and family and provide regular updates to ensure transparency and inclusion. • Enables patients/ families/carers opportunities to access relevant support services. •
All Staff	• All staff are responsible for reporting any potential or actual patient safety incident on the Trust's local incident reporting and management system (Datix) and will record the level of harm they know has been experienced by the person(s) affected. • Understand their responsibilities in relation to the organisations PSIRP. • Know how to access help and support in relation to patient safety event response process. • To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

Role	Responsibilities
The Trust Board and Associated Committees/Groups	The Trust Board and associated committees ensures that PSIRF is central to overarching safety governance arrangements. The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing governance committee reporting mechanisms including the Quality Assurance Committee and associated Patient Experience and Safety Sub-Committee. Both meet monthly, safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety. The Strategic Safety Meeting (SOM) held weekly, and Executive led bi-monthly PSIRF meeting will provide assurance to the Quality Assurance Committee (QAC) that PSIRF and related workstreams have been implemented to the highest standards. Care Group's Triumvirates will be expected to report on their patient safety learning responses from safety reviews for example Multidisciplinary reviews (MDT) and associated outcomes to SOM. In addition, the Care Group's Triumvirates will provide assurance to SOM that PSIIs are conducted to the highest standards to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed. Assurance. In addition, they will be expected to include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement to QAC via the Patient Experience and Safety Sub-Committee. Care Group's and associated Clinical Business Units will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

4. Policy Details

Trust Patient Safety Culture

As a Trust, Warrington and Halton NHS Trust have worked over a number of years to develop and implement a supportive and remedial approach to different types of incidents, such as patient safety and workforce, in order to establish a restorative just culture within the organisation.

We are continuing with our organisation wide culture change programme focusing on key priorities to enable effective cultural change through the impact of collective, compassionate, and inclusive leadership, to foster a culture of psychological safety. This is essential to underpin the ongoing development of a high-quality safe patient care system and a just, fair and learning culture. Through embracing change in how we support our staff members through an incident with a compassionate and just approach, ensuring there is no focus on blame or punitive measures for individuals involved in events. Working collaboratively across services and teams to ensure a supportive, fair, and just approach in the management of incidents and reviews, that is consistent across all areas and teams.

In this context the wellbeing of our workforce is paramount and as such an increased wellbeing offer is provided for those involved in incidents from our mental health and wellbeing team, supporting to recognise the needs of those involved in incidents and near misses with the aim of avoiding the creation of a second victim and any work-related absence.

Through the lens of the People Promise of “we are always learning”, the learning from events will be shared widely across the organisation and incorporated into existing learning pathways such as the safety brief and team huddles, with the development of ‘celebration of learning’ events to further enhance and optimise our learning opportunities. This learning can then also be incorporated into patient safety training packages and within leadership development offers so that the learning from events is embedded to support in prevention of recurrence. It is envisaged that whilst working through our organisational cultural change that there will be an improvement in near miss reporting and in reporting incidents at the correct level to further support learning and prevention through staff feeling safe and able to report without fear of reprise or blame.

Our patient safety culture will also be reflected in our organisational cultural change workstreams of kindness, civility, and respect. Civility saves lives will be a platform to encompass both the wellbeing and emotional impact of an event, the impact of our actions and behaviours on others and ultimately patient care. How we can all build a culture of

inclusivity, belonging and kindness to positively impact on our patient and workforce experience and ultimately on how we provide safe, high quality patient care.

PSIRF will continue to enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoid ability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time alongside the development of our incident management system which will align our internal reporting to the Learn from Patient Safety Events system (LFPSE), thereby contributing to wider system learning across the NHS.

To enhance our safety culture, we have safety huddles at all levels of the organisation which consider emerging or known risks, and the insight offered from incidents that have occurred and an opportunity to share learning.
We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

Patient Safety Partners

The Patient Safety Partner (PSP) is an evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK. Warrington and Halton Teaching Hospitals NHS Foundation Trust have been an integral part of the national implementation group for PSP's (Involving Patients in Patient Safety – IPIPS) and have supported and contributed to the development of national guidance to support the role.

Warrington and Halton NHS Trust PSPs will continue to develop their role offering support alongside our staff, patients, families/carers to influence and improve safety across our range of services. We have recruited PSPs from the local community in order that they can present their views as patients, carers or family members. Their appointment offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting role across the NHS is evolving over time and in Warrington and Halton NHS Foundation Trust the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this will include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will continue to receive support to provide feedback to ensure that patient safety is always our priority. As the role continues to evolve, we may ask PSPs to participate in the ongoing development of our Local Priorities as well as investigation of patient safety events. PSP's will assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this role in collaboration with the Governance Team to ensure PSPs have the essential tools and advice they need.

The PSPs will be supported in their role by the Trusts Deputy Director of Integrated Governance, Trust's Patient Safety Specialists and Head of Patient Experience and Inclusion who will also provide expectations and guidance for the role. Warrington and Halton NHS Trust have developed a PSP role profile based on national best practice as well as other supporting documentation.
PSPs will have regular scheduled reviews and regular one-to-one sessions with our Deputy Director of Integrated Governance and training needs will be agreed together based on the experience and knowledge of each PSP. In addition, they have access to the Trust's Wellbeing and Occupational Health services, to ensure they are afforded appropriate support, acknowledging some of the sensitivity of issues they will be involved with.

The PSP placements are on a voluntary basis, (whilst still being remunerated in line with the NHSE Reimbursement Policy) in order for them to be independent of the Trust and will be reviewed yearly to ensure we keep the role aligned to the patient safety agenda as this develops.

Addressing Health Inequalities

The Trust recognises that at both a national and local level the NHS has a pivotal role in reducing and removing health inequalities which impact on people's outcomes and experiences, across all our services. We will do this by reviewing how people access our services by ensuring equality of opportunity where we know there is a disproportionate risk to patients with specific characteristics. In addition, we will continue to develop and review informative datasets and intelligence to proactively reduce the likelihood of poor health inequalities occurring.

The Trust has a legal responsibility under the Equality Act 2010[1] to ensure that no one is disproportionately impacted on the grounds of their specific characteristics. In addition, the act identifies that as a public sector body the Trust must meet the statutory obligations outlined in the Public Sector Equality Duty[2]. Part of the duty outlines how the organisation should monitor the characteristics of its patients ensuring that no disproportionate harm occurs. Where this does, the Trust will ensure that action is taken imminently with information informing the Trust's local patient safety incident response.
As part of the patient safety incident response framework (PSIRF) the Trust will utilise the available protected characteristic datasets held on the incident management system to allow for incidents and intelligence to be analysed by protected characteristics, providing insight into any apparent inequalities.

In addition to the current equality analysis process in the Trust, known as the Equality Impact Assessment, when constructing our PSIRF actions and local priorities in response to any incidents we will consider local inequalities. This will be built into our governance, documentation and risk management processes. In addition to the local equality analysis process, we will address health inequalities as part of our safety incident response work, utilising the national NHS England Core20PLUS5[3] approach. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. By establishing our local priorities, plan and policies aligned to the patient safety incident response framework we will work to triangulate intelligence, ensuring that potential inequalities are considered. Where data suggests additional areas for improvement this will be aligned to future PSIRF plans and this policy. As a Trust we are aware that data continuously provides up-to-date intelligence in association with addressing health inequalities and therefore the use of our incident management system, aligned to patient characteristics and local intelligence, is pivotal to supporting health equality and the reduction of inequalities.

On an annual basis the Trust completes the Equality Delivery System[4], of which Domain 1 is associated with patient and service user health outcomes. This is aligned to the Core20PLUS5 model and learnings from this system review will be triangulated against local priorities at the Trust in the final quarter of each financial year.

[1] The Equality Act 2010: https://www.legislation.gov.uk/ukpga/2010/15/contents
[2] The Public Sector Equality Duty: https://www.legislation.gov.uk/ukpga/2010/15/part/11
[3] NHS England - Core20PLUS5 (adults) – an approach to reducing healthcare inequalities: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
[4] NHS England – Equality Delivery System 2022: https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

Whilst triangulating data provides us with quantitative information, qualitative intelligence is essential to ensure that our priorities and plans associated with PSIRF are coherent with the needs and known inequalities of our local boroughs. Therefore, part of our local priorities and plan is met through the engagement of patients, families and our workforce – this includes engagement following a patient safety incident. Recognising different communication styles and the Accessible Information Standard[5] we will ensure that our communication and engagement methods are available in different formats, including Easy Read, different languages, large print. In addition, the Trust utilises interpretation and translation providers to ensure that where English is not an individual's first language, they do not suffer any detrimental impact as part of the patient safety incident review process. By proactively acting in an accessible manner, we aim to maximise the potential of patients, families, and our staff to be involved in the patient safety incident response framework at our Trust.

The Trust is committed to ensuring that "our hospitals are the best places to receive care and to work", therefore as a Trust this means that we do not tolerate, under any circumstances, any form of racial abuse or discrimination by our patients, visitors or by our staff. This includes all protected characteristics as our focus is to deliver the best care to our patients, regardless of, their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability. This commitment is led by our Trust Board, and staff are encouraged to report incidents using our incident reporting system. We will use this commitment to underpin future patient safety training, communications and the rollout of our local priorities and plan. In addition, this will feature as part of our wider organisational cultural change programmes. Recognising this, we will ensure that this is pivotal to upholding a system-based approach to reducing health inequalities and poor experience of our staff and ultimately patient outcomes based on individuals' specific characteristics.

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. The framework 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. The Trust will work with the principals contained within the guidance document "Engaging and involving patients,

[5] NHS England – Accessible Information Standard: https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

families and staff following a patient safety incident" and ensure that these are at the heart of our approach.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.
Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we will be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

As part of our policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will be underpinned by a network of Family Liaison Officers (FLO) within our Governance Team, the Care Group's and Clinical Business Units who are able to guide patients, families and carers through any investigation or learning review.

In addition, Warrington and Halton NHS Teaching Hospitals has a Patient Advice and Liaison Service (PALS) (whh.pals@.nhs.net). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service, and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, other relevant organisations to negotiate immediate and prompt solutions.

PALS can help and support with the following:

- advice and information
- comments and suggestions
- compliments and thanks
- informal complaints

• advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

Our PALS team can be contacted at the email address above or by post or telephone as follows: -
PALS Team, Tel: 01925 662281
Corporate Nursing & Governance Department
First Floor Kendrick Wing, Warrington, and Halton Hospitals Foundation Trust
Lovely Lane, Warrington, Cheshire WA5 1QG
Email: whh.pals@.nhs.net www.whh.nhs.uk

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

National guidance for NHS trusts engaging with bereaved families:
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families

https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide **Help is at hand – Support After Suicide** specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support

https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints.

Healthwatch
https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.
You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site:

https://www.healthwatch.co.uk/your-local-healthwatch/list
Parliamentary and Health Service Ombudsman

https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

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 than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. Our approach will align to the principles in the documents "Guide to responding proportionately to patient safety incidents" and the "Patient safety Incident response standards". To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other

data sources both qualitative and quantitative to explore what we know about our safety position and culture.

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. Therefore, we will revisit our incident profile within a 12–18-month profile and adjust our priorities accordingly. Prior to any changes in our priorities, we will re-engage with our 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 ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.
Our Patient Safety Incident Response Plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

Resources and Training to support patient safety incident responses

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.
The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Care Group in collaboration with the Governance Team. A learning response lead will be nominated by the Care Group's and CBU's, and the individual should have an appropriate level of seniority, training and development and influence within the Trust, this may depend on the nature and complexity of the incident and response required, and learning responses are led by staff at Band 7 and above.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Care Group Governance Leads including

the designated member of the senior leadership team will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Governance team will support learning responses wherever possible and provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our 'just culture' principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Care Groups will have processes in place to ensure that managers work within this framework to ensure psychological safety for staff.

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

Trust Patient Safety Incident Response Plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. A copy of our current plan can be found at **Patient Safety Incident Response Plan.docx**

Reviewing Patient Safety Incident Response Policy and Plan

Our patient safety incident response policy will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the policy at least every 4 years or more frequently as and when national guidance dictates or any changes to our plans emerges.

Updated plans will be published on the Trust website, replacing the previous version.
A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with the Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to Patient Safety Incidents
Safety Incident Reporting Arrangements

All staff are responsible for reporting any potential or actual patient safety incident on the Trust's local incident reporting and management system (currently Datix) and will record the level of harm they know has been experienced by the person affected (see Appendix 1). Whilst staff are encouraged to report incidents via the local risk management system, they also have the ability to report areas of concern via the Freedom to Speak Up (FTSU) route (Whistleblowing). The Trust has a Freedom to Speak Up Guardian, and a network of FTSU champions. Reporting of learning, themes and trends from the FTSU team are shared through the organisation's governance structures.

Care Group's will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (See Trust Duty of Candour policy). Most incidents will only require local review within the service. However, for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Care Group's (see Patient safety incident response decision-making below).

Care Groups'/CBU's will highlight to the Governance Team (Corporate Governance) any incident which meets the requirement for reporting externally. This will enable the Trust to work in a transparent and collaborative way with our ICB 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 Governance Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Safety Incident Reporting Arrangements

All staff are responsible for reporting any potential or actual patient safety incident on the Trust's local incident reporting and management system (currently Datix) and will record the level of harm they know has been experienced by the person affected (see Appendix 1). Whilst staff are encouraged to report incidents via the local risk management system, they also have the ability to report areas of concern via the Freedom to Speak Up (FTSU) route (Whistleblowing). The Trust has a Freedom to Speak Up Guardian, and a network of FTSU champions. Reporting of learning, themes and trends from the FTSU team are shared through the organisation's governance structures.

Clinical Business Units will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (See Trust Duty of Candour policy). Most incidents will only require local review within the service. However, for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the CBU (see Patient safety incident response decision-making below).

Care Groups'/CBU's will highlight to the Governance Team (Corporate Governance) any incident which meets the requirement for reporting externally. This will enable the Trust to work in a transparent and collaborative way with our ICB 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 Governance Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Patient Safety Incident Response Decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan **Patient Safety Incident Response Plan.docx**

The PSIRF does not set further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has used the PSIRF guidance documents to develop its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear 'Ward to Board' set of mechanisms allowing for oversight of incident management and our PSIRF response.

Clinical Business Units have clear escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as an immediate safety review due to possibly meeting the criteria as PSII or other Patient Safety Response or due to the potential for learning and improvement or an unexpected level of risk. Local Patient Safety Panels

within the Care Group's and CBU's will consider any such incidents for further escalation to the Trust's Executive Led Weekly Safety Oversight Meeting (SOM).

The Trust's SOM has responsibility for overseeing safety processes, to enable assurance to the Patient Safety Incident Response Framework (PSIRF), Executive Review Group, that the true intent of PSIRF is implemented, within the organisation, and the Trust is meeting the National Patient Safety Incident Response Framework Standards
The Executive Led Review Group ensures that the four main aims of PSIRF are implemented and embedded across WHH:

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

.
Local level incidents – managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until a further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust guidance and Legal requirements (see DOC Policy)
Care Group's and CBU Patient Safety Panels may commission thematic or cluster reviews of such incidents to consider and understand potential emerging risks.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through /Care Group's/CBU//Trust escalation processes (including out of hours) and this must include the /Care Group's/CBU and Corporate Governance Team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the CBU lead, or department lead should notify the Executive Team and out of hours the executive on call as soon as practicable so that the incident can be shared with the Chief Executive. The incident will be escalated to the CBU and then Trust Governance Team. An initial safety review will be undertaken by the CBU supported by the Governance Team to inform decision making and onward escalation following this.

Other incidents with unclear potential for PSII, must also be reported to the Governance Team. An initial patient safety review will be undertaken by the CBU to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Trust's SOM meets weekly and will discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the initial safety review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The SOM panel will define terms of reference for a PSII and will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the Trust's SOM may request a Patient Safety Review (PSR) or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met if required in line with regulation 20. It will be at the SOM's discretion in such circumstances to specify a particular tool is used to complete a PSR.

Incidents requiring possible patient safety review (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review response as soon as practicable after the event through Care Group's escalation processes (including out of hours) and this must include the Local Governance Lead or senior manager. An Initial Safety Review will be undertaken by the Care Group's governance lead or designated other to inform decision making following this review. The Care Group's Patient Safety Panel will meet at the earliest opportunity to discuss the nature of the incident, immediate learning (which should share via an appropriate local governance platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met.

Where it is clear that a PSII is not required, the Local Patient Safety panel will consider any incident as having potential for a PSR. The tool to be utilised for the review will be specified and a suitable member of the Care Group's team to undertake the review will be allocated. This will not be any staff involved in the incident or by those who directly manage the staff. The Care Group's or CBU will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process.

Local Safety panel arrangements will include the recording of safety actions arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans (see safety actions on p28 below).

The Governance Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Governance Team will work with the Care Group's and CBU's to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Responding to cross-system incidents/issues

The Governance Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's Governance Team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.
The Trust will work with partner providers and the relevant Place/ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Governance Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the Place/ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for Learning Responses
Timescales for Patient Safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified as requiring a PSII investigation the Trust standard is that it will be completed within 12 weeks unless otherwise within the timeframe agreed with the patient, family/carers. However, if the PSII is complex it can take up to 6 months to complete, with agreement from either the Chief Nurse, their Deputy or the Medical Director or their deputy. In addition, in exceptional circumstances, the longer timeframe may be required for completion of the PSII. In this case, any extended timeframe must be agreed between the Executives leads for PSII and those affected.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the

risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Executive Led Patient Safety Oversight Meeting (SOM)

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within the following timeframes:

- Initial Safety Review (ISR) -72 hours (3 working days)
- Multidisciplinary Reviews (MDT) – 15 working days
- After Action Reviews (AAR) – 15 working days
- Cluster Reviews – 12 weeks.
- SWARM – 10 working days.

Timescales for responses should be agreed with patients and family/carers with regular agreed follow up

Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed. The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Care Groups' and the support of the Quality Improvement Team with their improvement expertise.

Safety Action Development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions.
2. Define the context – this will enable agreement on the approach to be taken to safety action development.
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved.
4. Prioritise safety actions to decide on testing for implementation.
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics.
6. Safety actions will be clearly written and follow SMART (see Appendix 2 page 37) principles and have a designated owner.

Safety Action Monitoring

Safety actions must continue to be monitored within the Care Group's governance arrangements to ensure that any actions put in place remain impactful and sustainable. Care Group's reporting on the progress with safety actions will be made to the SOM via the Triumvirate or delegated other (s).

For some safety actions with wider significance, this may require oversight by the Quality Assurance Committee (QAC).

Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvements plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.
The Trust Patient Safety Incident Response Plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm. Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through Care Group's governance processes and reporting to the Strategic Patient Safety

Oversight Group who may commission a safety improvement plan. Again, the Care Group's will work collaboratively with the Governance Team and the Quality Improvement teams and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reporting to the SOM on a scheduled basis.

Complaints and Appeals

Warrington and Halton Teaching Hospitals NHS Foundation Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and the services (including the response to incidents) provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the patient Advice and Liaison service (PALS) who will support the resolution of any concerns raised (whh.pals@nhs.net)
It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

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 Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be managed 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 and processes.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.
If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted directly (whh.complaints.nhs.net).

See Appendix 3 for Complaints flowchart of process.

5. Document Monitoring

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years or more frequently if national guidance changes alongside a review of all safety actions.

6. Glossary of Terms

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response Plan
Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the Clin Care Group's and associated Clinical Business Units and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

ISR - Initial Safety review

AAR – After action review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

SMART
SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows:

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

Time- bound – a goal should specify when a result should be achieved, or targets might slip

7. Associated Documents

PSIRF Plan
Duty of Candour Policy

8. Sources / References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities
core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)
NHS England (2022) Patient safety incident response standards
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)
NHS England (2022) Safety action development guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

9. Training Needs Analysis

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to meet the needs of staff groups and the roles and responsibilities of staff in supporting an effective organisational response to incidents**. (Appendix 1 – Training Matrix)**

Appendix 1: Training Matrix

Training	Summary and audience	Duration and Frequency	Provider and Expected Staff Numbers
Essentials for patient safety for all staff	Level 1: All staff (priority those in engagement, learning response and oversight roles)	30-60mins Completed on induction and every 3 years	eLearning for health (ENH Academy), via ESR access
Essentials for patient safety	Level 1: Essentials of patient safety for boards and senior leadership teams (oversight roles)	30-60mins 3 years	eLearning for health (ENH Academy), via ESR access
Essentials for patient safety Level 2	Level 2: Access to Practice. This is to be undertaken by all clinical staff at AFC Band 7 or above, with potential to support or lead patient safety incident management.	30-60mins 3 years	eLearning for health (ENH Academy), via ESR access
Systems approach to learning from patient safety incidents	*(Required for learning response leads and those in oversight roles)* Learning response leads must have completed Level one and two of the National Patient Safety Syllabus available via ESR. This is to be undertaken by Nursing, Medical and AHP leads Learning response leads will undertake appropriate continuous	2 days formal training and skills development in learning from patient safety incidents and experience of patient safety response	External provider

	professional development on incident response skills and knowledge. To maintain expertise the Trust will *undertake* an annual networking event for all learning response leads via a Trust-wide learning forum. Learning response leads will need to contribute to a minimum of two learning responses per year.	Once only	
Oversight of learning from patient safety incidents oversight	*(Required for those in oversight roles)* All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams. All those with an oversight role in relation to PSIRF will undertake continual professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.	1 day training in oversight of learning from patient safety incidents Once only	External provider.

	Records of such training will be maintained by the individual as part of the professional practice requirements. In addition, individuals may wish to have these held as part of their ESR skill portfolio, and any training certificate can be uploaded by email it to whh.clinicaleducationteam@nhs.net.		
Engagement and involvement with those affected by a patient	*(Required for engagement leads and those in oversight roles)* Engagement leads must have completed Level one and two of the national patient safety syllabus. This is to be undertaken by Nursing, Medical and AHP leads Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge. To maintain expertise the Trust will *undertake* an annual networking event for all engagement leads via a Trust-wide learning forum. Engagement leads will need to contribute to a minimum of two learning responses per year. Records of such training will be maintained by the individual as part of the professional practice requirements. In addition, individuals may wish to have these	1 day Once only	External provider

	held as part of their ESR skill portfolio, and any training certificate can be uploaded by email it to whh.clinicaleducationteam@nhs.net.		
Patient Safety Syllabus level 3 and 4	*(Required for those in Patient Safety Specialist roles)* Patient Safety Specialists must have completed Level one and two of the national patient safety syllabus available via ESR. Patient Safety Specialists will undertake appropriate continuous professional development on incident response skills and knowledge. To maintain expertise the Trust will *undertake* an annual networking event for all Patient Safety Specialists via a Trust-wide learning forum. Patient Safety Specialists will need to contribute to a minimum of two learning responses per year. Records of such training will be maintained by the individual as part of the professional practice requirements. In addition, individuals may wish to have these held as part of their ESR skill portfolio, and any training certificate can be uploaded by email it to whh.clinicaleducationteam@nhs.net	Delivered through a blended-learning approach, with a number of modules delivered through online learning and followed up with an in-person event.	External provider

Appendix 2: Level of Harm

Level of Harm

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety incidents.

In summary harm is defined as follows

No harm

This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.

No harm (impact not prevented) - Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the

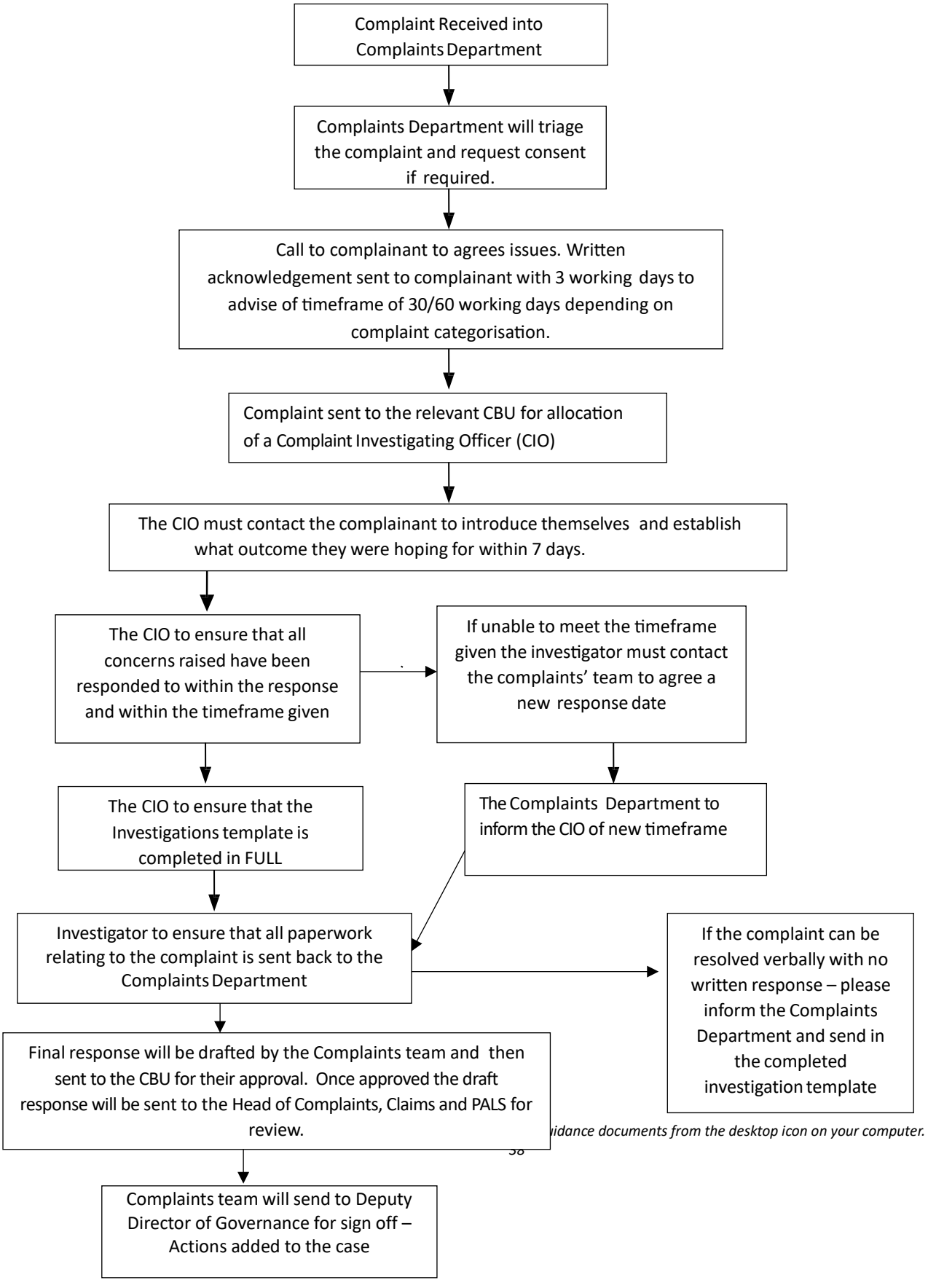
Low harm - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm - Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death – Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix 3: Complaints Flow Chart of Process



idance documents from the desktop icon on your computer.

Summary Equality and Health Inequalities Impact Assessment (EHIA)

This analysis is being undertaken to prevent your policy, guidance or standard operating procedure from adversely affecting people with different protected characteristics or at a known disadvantage. This analysis is referred to as 'proposal' throughout the document.

1.1. This section asks you to consider a few questions relating to your proposal:

Who does your proposal affect? (Please put an x in the relevant group)

Patients/ service users	Workforce	Public
	X	

1.2. Please state if you have completed any engagement as part of this proposal:

Please include any engagement or consultation groups below (e.g. Staff Networks / Partners). Engagement with workforce outlined in associated policy plan **Patient Safety Incident Response Plan.docx**).

Patients/ service users	Workforce	Public
	X	

2.1. Does your proposal impact positively, negatively, or neutrally on any of the below characteristics/groups?

- **Positive impact** – the change may/will have a beneficial impact on this protected group.
- **Neutral impact** – there will be no change in actual/potential impact on this protected group.
- **Negative impact** – the change may/will have a negative impact on this protected group.

2.1.1. Protected characteristics.

Protected characteristics	Scale (select by an x)			Comments / Rationale:
	Positive	Neutral	Negative	
Age		X		
Disability, including learning		X		

disabilities/difficulties, physical/hidden disability, sensory impairment, and mental health condition				
Gender reassignment (trans), include consideration for non-binary people		X		
Race (ethnicity)		X		
Religion or belief		X		
Sex		X		
Sexual orientation including lesbian, gay and bisexual people		X		
Marriage and civil partnership, including same sex relationships		X		
Pregnancy and maternity/paternity		X		
Armed Forces and Military Veterans		X		

Does your proposal support positive action for protected characteristic groups?	☐ **Yes** ☐ **No** ☒ **N/A neutral**

2.1.2. Groups who face health inequalities

Groups who face health inequalities	**Scale** (select by an x)			**Comments / Rationale:**
	Positive	**Neutral**	**Negative**	
Looked after children and young people		X		
Unpaid carers, e.g. family members		X		
Social factors: • People or families on a low income		X		

• People with poor literacy or health literacy • People living in deprived areas and poorer communities. • People living in remote, rural and island locations				
Homeless people		X		
People involved in the criminal justice system		X		
Refugees, asylum seekers or those experiencing modern slavery		X		
Other groups experiencing health inequalities (please describe)		X		

2.2.	Is the impact of the proposal likely to be negative?	☐ **Yes**	☒ **No**

2.3.	If yes, please summarise if the impact can be avoided or are there any alternatives?	

3. Link to legal duties:

Does your proposal support compliance with the Public Sector Equality Duty (Equality Act 2010), consider the Armed Forces Act 2021 and Human Rights Act 1998? Please add an x to the relevant box below:

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			

The proposal may support?			
Uncertain whether the proposal will support?	X	X	X

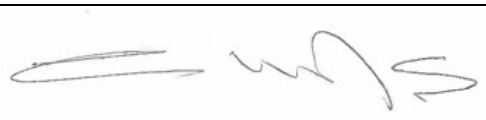
Does your proposal support reducing health inequalities faced by the patients/communities we serve? Please add an x to the relevant box below:

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes through outputs
The proposal will support?		
The proposal may support?		
Uncertain whether the proposal will support?	X	X

Does your proposal support the Trusts commitment to being an anti-racist organisation - **neutral** ☒	☐ **Yes** ☐ **No**

Please provide a rationale / summary for your decision making:
This policy is the same for all characteristics.

4. Sign Off – *This should be completed by a Senior Responsible Officer for the proposal (e.g., Director, CBU Manager, Lead Nurse, policy author)*

Name:	Catherine Umbers	**Business Unit:**	Governance
Signature		**Date:**	31/03/2025

A copy of this EHIA should be sent to whh.equalityimpactassessments@nhs.net once completed.

You will need to complete a full EHIA if your summary EHIA has identified:

- A negative impact which cannot be mitigated, for both protected characteristics and/or groups who face health inequalities.

- You are unsure about the impact on specific groups.
- You do not have sufficient data or evidence.
- You are completing a public consultation or full-service review / redesign.

Support can be provided in identifying impact / next steps by contacting whh.equalityimpactassessments@nhs.net

The full EHIA can be found here.

Document Version History

Version Number	What has changed
2	Trust Patient Safety Culture – revised Patient Safety Partners – minor revisions Engaging and involving patients, families and staff following a patient safety incident – revised Patient safety incident response planning – minor revisions Resources and training to support patient safety incident responses – revised Patient Safety Incident Response decision making – revised Timeframes for learning responses – revised Timescales for other forms of learning response – revised and defined. Safety action development and monitoring improvement - revised Training Needs Analysis - Updated