Group Policy- Patient Safety Incident Response policy (PSIRP)

Reference Number: GP-Q&G-011

Category: Quality & Governance

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Responsible Director: Des Shiels – CEO/Chairman and SRO for PSIRF

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1	**Initial circulation of 1st draft of policy for comment or feedback to:**	**Date completed**
	Specialist staff – Steven Luttrell – Group Medical Director	11 July 2023
	Subject matter experts – Quality and Risk Lead at each site	
	Stakeholders – Kent & Medway ICB, Hertfordshire & West Essex ICB, Des Shiels – SRO for PSIRF	3 – 5 Aug 2023
2	**Following amendment draft policy sent to:**	
	Hospital Director (non-clinical policies) Jo Nolan – Hospital Director at One Ashford Hospital Claire Armstrong – Hospital Director at One Hatfield Hospital	11 July 2023
	Director of Clinical Services & Group Clinical Director (clinical policies) Sabina Hughes – Director of Clinical Services at One Ashford Hospital Claire McGauran – Director of Clinical Services at One Hatfield Hospital	Via Cross Site Governance Committee
3	**Changes made following Ratifying Committee – to Cross Site Governance Committee for sign off on 21 August 2023**	21 Aug 2023

REVISION RECORD

NOTE: The Company reserves the right to amend this policy in the light of any future changes in legislation or business need.

Date	Author	Version	Description
May - June 2023	Brenda Corby – Group Clinical Director/ CNO	V0.1	First draft
11 July 2023	Brenda Corby – Group Clinical Director/CNO	V0.2	Reviewed following input from Group Medical Director
6 August 2023	Brenda Corby – Group Clinical Director/CNO	V0.3	Updated following advice from Herts and West Essex ICB
21 August 2023	Brenda Corby – Group Clinical Director/CNO	V0.3	Reviewed at Ratified at Cross Site Governance Committee – no changes made

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INTRODUCTION

The NHS safety vision is to continuously improve patient safety. In 2019, NHS England published their Patient Safety Strategy. This sets out their vision and aims which include:

- to adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is;
- to use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system, and
- to introduce the Patient Safety Incident Response Framework to improve the response to and investigation of incidents.

PSIRF replaces the previous Serious Incident Framework (2015) and represents a significant shift in the way the healthcare providers respond to patient safety incidents. It supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- 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

By adopting this new approach to incident management, One Healthcare is able to examine a wider range of patient safety incidents "in the spirit of reflection and learning" rather than as part of a "framework of accountability".

Patient Safety Incident Investigations (PSII) will now focus on areas where the resulting improvement can have the greatest impact on the safety of our patients, whilst other methods of responding to patient safety incidents can be used, such as AARs, thematic reviews etc.

PURPOSE AND CONTEXT

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

Our PSIRF policy and plan:

- Describes the principles, systems, processes, skills and behaviours for incident management as part of a broader system approach, provide and signposting guidance and support for preparing for and responding to patient safety incidents in a range of ways, moving away from a focus on current thresholds for 'Serious Incidents'.
- Provides transparency and support for those affected, setting expectations for informing, involving and supporting patients, families, carers and staff affected by patient safety incidents.
- Outlines a risk-based approach and strategy that will allow us to use a range of proportionate and effective learning responses to incidents. We have selected those incidents for PSII investigation, giving us the greatest opportunity for learning
- Ensures that safety investigations are no longer asked to judge 'avoidability', predictability, liability, fitness to practise or cause of death.

SCOPE

This policy is specific to roles and responsibilities in relation to patient safety incident responses conducted for the purpose of learning and improvement across all of our services, namely at our two hospital sites. The following principles underpin the oversight of our patient safety incident responses:

1. Improvement is the focus;
2. Blame restricts insight;
3. Learning from patient safety incidents is a proactive step towards improvement;
4. Collaboration is key;
5. Psychological safety allows learning to occur;
6. Curiosity is powerful.

Roles and responsibilities under this policy support a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety emerges from interactions and not from a single component. Actions or inactions of people, or 'human error', are not accepted as the cause of an incident.

This policy applies to all patient safety incidents irrespective of payor.

EXCLUSIONS

Any response that seeks to find liability, accountability or causality is beyond the scope of this policy.

This will include complaints, human resources investigations, professional standards investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns, and estates and facilities issues. These will all be dealt with through the existing relevant process in place within One Healthcare.

LOCATION

This policy applies within all our services, for all staff, including our clinicians who work with us under Practicing Privilege's. Current services include those provided at:

One Ashford Hospital, Kennington Road, Willesborough, Ashford, Kent, TN24 0YS;
One Hatfield Hospital, Hatfield Ave, Hatfield, AL10 9UA.

DEFINITIONS

CQC	Care Quality Commission
DCS	Director of Clinical Services
HD	Hospital Director
HSIB	Healthcare Safety Investigation Branch
HSE	Health & Safety Executive
IRMER	Ionising Radiation (Medical Exposure) Regulations
FTSU	Freedom to speak up
MHRA	Medicines and Healthcare products Regulatory Agency and Health
NIHR	National Institute for Health and Care research
Patient Safety Incident	A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare, and can range in scale from the most minor to the other end of the scale.
PSIRP	Patient Safety Incident Response Plan

PSR	Patient Safety Reviews
Patient's family/ carers	Formally a family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. However, in the case of our patients and their carers, we would like to be flexible and agree with the individual patient who they would like to identify as their family member(s) or carer, with whom our teams will liaise.
SRO	Senior Responsible Officer
ICB / ICS	Integrated Care board/ Integrated Care System
ICO	Information Commissioners Office
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SEIPS	Systems Engineering Initiative for Patient Safety
SBAR	Situation, Background, Assessment, Recommendation - Tool
UKHSA	UK Health Security Agency

ROLES AND RESPONSIBILITES

Within One Healthcare we have clear roles and responsibilities in relation to our response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

All Staff

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response policy. Information regarding the reporting and management of incidents is provided for new staff at hospital level induction.

SRO

Our PSIRF Implementation team is led by our CEO who acts as the senior responsible officer (SRO), ensuring that this implementation project meets its objectives, delivers the required outcomes, and realises the required benefits.

Executive Lead

Our Group Clinical Director is our PSIRF executive lead and has the overarching responsibility for quality and patient safety, including ensuring an effective organisational response to incidents. This role holds responsibility for ensuring the we meet the national patient safety incident response standards, but also ensures that PSIRF is central to our overarching safety governance arrangements. The Group Clinical Director also acts as our corporate level Oversight lead. This role ensures that investigation findings, safety actions, safety improvement plans, and progress are discussed at the board level and at all relevant sub-committees.

Oversight Leads

Our Hospital Directors at each site, supported by their local leadership teams, provide an additional level of oversight, specifically at local level. They will monitor and assure local processes, thereby ensuring:

- An adequate and appropriately trained level of local resource is in place in order to be able to effectively manage our patients safety responses;
- Oversight of local safety governance arrangements, with investigation findings, safety actions, safety improvement plans, and progress being discussed at all relevant local level committees;

- Local level quality assurance of the learning response outputs, with the PSIRF executive lead reviewing all PSII reports;
- That all safety actions are implemented in response to learning and wider safety improvement plan(s) are monitored, to check they are delivering the required improvements.

Engagement Leads

Our Engagement Leads are key to ensure compassionate engagement prioritises and respects the needs of people who have been affected by a patient safety incident. Our Directors of Clinical Services at each site, will take responsibility for this role, supported by their senior clinical team.

Learning Response leads

Our Quality and Risk Leads at each of our sites will take on the role of Learning Response Leads. However, learning responses are not undertaken by staff working in isolation. Our Quality and Risk Leads will co-ordinate the response teams, working closely with the Directors of Clinical Services to initiate the triage stage of our response once an incident has occurred. The team will then identify a specific Response Lead to steer and guide that individual incident. Subject matter experts with relevant knowledge and skills will be involved, where necessary, throughout the learning response process to provide expertise, advice and review of draft reports. This will include members of our medical staff, who are either speciality experts, were involved in the incident or are advisers as part of our internal governance processes.

Patient Safety Partners

Patient Safety Partners often have the insight of a user of services, or even experience of avoidable harm and can therefore be instrumental in helping us to develop safety solutions following incidents. We are keen to use these useful roles to promote our openness and transparency, helping us to know what is important to patients and supporting us to consider how processes appear and feel to patients. We will value their contribution to our governance and management processes.

Coroner / Medical examiner

A coroner investigates unnatural or violent deaths, where the cause of death is unknown. The investigation may include an inquest hearing. The coroner's role is to find out who died and how, when, and where they died. The Notification of Deaths regulations require registered medical practitioners to notify the senior coroner of a death if one or more of the circumstances set out in the regulations applies, including where they "suspect" that the person's death was due to "undergoing any treatment or procedure of a medical or similar nature". PSRIF requires all deaths to be investigated where the death is thought more likely than not to have been due to problems in care. Patient deaths are a very unlikely event in our hospitals, with none occurring since our sites have been open (since 2017). However should these type of event occur we will be liaising directly with our coroners and respond when they ask for information. We anticipate that any requested documents, may include PSII reports, learning from other response methods and any other relevant supporting materials.

Our Coroners can be contacted via:

One Ashford Hospital	Patricia Harding, Senior Coroner for South East Kent. KentandMedwayCoroners@kent.gov.uk
One Hatfield Hospital	Geoffrey Sullivan coroner.service@hertfordshire.gov.uk

Medical examiners, supported by medical examiner officers, work to:

- listen to the bereaved, increasing transparency and offering them the opportunity to raise concerns about care;
- improve the quality and accuracy of the Medical Certificate of Cause of Death;
- ensure notification of deaths to the coroner where appropriate.

All deaths will be reported to the Medical Examiner who will advise on completion of the death certificate, make contact with an appropriate family member or near friend of the deceased and advise on whether a referral to the coroner is required.

If our local Medical Examiner or coroners identify concerns, they may raise these with our Group Clinical or Medical Director. Our approach will be to ensure the death is considered for a response in line with our patient safety incident response plan. Where evidence, however identified, suggests problems in care were more likely than not to have led to the death occurring at the time that it did, a PSII must be undertaken.

Our ICBs

ICBs are required to approve and sign off the incident response policies and plans of the providers in their system. Our Patient Safety Incident Response Plan has been reviewed and signed off by Hertfordshire and West Essex ICB on behalf of our commissioners. Under this Plan all incidents where a PSII has taken place, will be escalated to our ICBs and also to the relevant Medical Insurer for insurance funded patients.

Our ICBs PSIRF leads can be contacted via:

Kent and Medway ICB PSIRF Lead	Jessica Campbell Jessica.campbell5@nhs.net
Hertfordshire and West Essex ICB PSIRF Lead	Chris Harvey chris.harvey2@nhs.net

Medical staff/ Group Medical Director

Our Group Medical Director is a crucial member of our PSIRF Implementation Team and has been actively involved in advising the team from the medical staffing perspective. This role plays a fundamental role in advising One Healthcare on all issues relating to Medical Practitioners assurance and will be both personally involved in our learning response activities, but will also be central to supporting the participation of our consultant body in these patient safety reviews and learning responses.

Clinicians/Specialist Advisors

Incident reviewers may need to involve specialist advisors to assist in their review (e.g. Safeguarding, Health and Safety, Pharmacy, Radiation Protection Advisor, Clinicians with experience in a particular medical or surgical technique). Patient safety reviewers/ Learning responders are responsible for determining when specialist advice is required and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, and review of recommendations.

Our Board

The One Healthcare Board is responsible and accountable for effective patient safety incident management within our organisation. Through the CEO and Group Clinical Director, they will receive assurance that our Patient Safety Incident Response Plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving via our internal governance reporting processes. Assurance will be provided primarily through our group level Governance Committee. Where concerns are identified relating to the

robustness of lessons learned or actions planned the Board will seek assurances that these concerns are being acted upon.

POLICY

Our Patient Safety culture

Open and transparent recording

One Healthcare uses the electronic incident Management system Datix – to record and monitor all of our incidents and patient complaints. However, this isn't the only system in place that provide us with feedback and potential learning. Other systems include:

- Our FTSU processes;
- Our patient, staff and consultant surveys – these outputs help us to understand where there may be gaps in our systems and processes;
- Safeguarding concerns that need referral into local social services;
- Our patient claims processes associated with our 3-stage complaints process.
- Our patient outcome data – including our PROMS data – where patients are reporting their perceived health gains following hip and knee replacement surgery;

Our Hospital's senior teams offer patients and their families the opportunity for face-to-face meetings when they raise concerns or complaints/ or are involved in a patient safety event.

Open and effective communication with patients should begin at the start of their care and continue throughout their time with us. This should be no different when a patient safety incident occurs. The Statutory duty enforced by Regulation 20 of the Health and Social Care Act (2008) Regulated Actives Regulations 2014: Duty of candour – sets out the requirements that we need to meet. (See Group Policy: CP-CL-010 – Duty of Candour – Being Open).

Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. Early engagement with patients and their families is part of our new 'PSIRF' process, but does not negate the need for compliance with the Regulation 20 requirements. We will continue to ensure that we follow our Duty of Candour/Being Open policy and document our compliance both in the patient's notes and within our new Learning response templates, monitoring our activities through our Duty of Candour trackers and reporting compliance within our governance reports.

External reporting

PSIRF does not change the legislation that is in place relating to the formal notification of certain incidents to the Healthcare Regulator (CQC). Regulations 12, 14, 15, 16, 17, 18, 20, 21 and 22 of the Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service or the people using it are notified to CQC. https://www.cqc.org.uk/guidance-providers/notifications. We will continue to meet these requirements, and also report these events through our own internal governance arrangements.

Other mandated external reporting will also continue as before, including reporting to professional bodies in relation to staff practice related issues, equipment or medicines related issues to the Medicines and Healthcare products Regulatory Agency (MHRA) and Health and Safety related incidents/RIDDOR reporting the Health & Safety Executive (HSE).

Development of a Just Culture

Historically, we adopted a Root Cause Analysis Process of investigation. This linear approach tended to focus on contextual factors being prioritised for investigation over behaviour and decision making by staff as part of working within our healthcare 'systems'.

Where Learning Responses/ Patient Safety Review processes under PSIRF identify gaps in our internal processes that relate to staff tasks, these will be considered as part of our improvement plans and how practice and related policy will then change to mitigate risk and prevent reoccurrence wherever possible. We will ensure that staff are not unfairly exposed to punitive disciplinary action. The fair treatment of staff supports a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

We have adopted the use of the NHS Just Culture Guide. This guide encourages our managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way. It will be used in conjunction with our learning response/investigation activities. We won't use this routinely but only when there is already suspicion that a member of staff requires some support or management to work safely, or as part of an individual practitioner performance/case investigation. All professional conduct issues will be dealt with separately as per our staff performance Policies (including our policy for Medical Staff performance).

Patient safety partners

Patient Safety Partners often have the insight of a user of services, or even experience of avoidable harm and can therefore be instrumental in helping us to develop safety solutions following incidents. We are keen to use these useful roles to promote our openness and transparency, helping us to know what is important to patients and supporting us to consider how processes appear and feel to patients. We will value their contribution to our governance and management processes.

Successful recruitment of Patient Safety Partners is a particular challenge for small independent sector providers like ourselves and we will be liaising with our relevant Integrated Care Boards (ICBs) within Hertfordshire and Kent to explore the potential opportunities of participating in their Patient Safety Partner networks.

Once recruited the Patient Safety Partners will have a specific role in safety governance, they will be invited to attend both the hospital and corporate level governance committees to support the monitoring of patient safety activity, providing appropriate challenge to ensure learning and change. They will support committee member by ensuring we consider and prioritise the service user, patient, carer and family perspective and will champion a diversity of views.

Patient Safety Partners will also support Learning Response teams during their review when an incident occurs. They will also work closely with the Engagement Leads at each hospital to help facilitate early and compassionate engagement with our patients and their loved ones, during the Learning Response process. Patient Safey Partners will be key in supporting both our hospital staff and the patient/their family in reviewing and having input into PSII reports, ensuring that their voices are heard and views have been taken into consideration.

Once recruited the Patient Safety Partners will be key to the review of out Patient Safety Incident Plan and this Policy.

Addressing health inequalities

On an annual basis One Healthcare will make intelligent use of data to help identify any disproportionate risk to patients with specific characteristics. We will review our PSIRP annually and continue to assess our learning

response activities remaining mindful of potential health inequalities. Our learning response tools will prompt consideration of inequalities, including when developing safety actions.

Engagement and involvement of patients, families and staff following a patient safety incident will ensure the consideration of their different needs. This new approach upholds a system-based approach (not a 'person focused' approach). System based science and in particular the use of the concepts involve in SEIPS (Systems Engineering Initiative for Patient Safety) will be part of our learning response approach.

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

Involvement has been in principle, part of investigations policy and process. We recognise the significant impact patient safety incidents can have on patients, their families and carers. Compassionate engagement and involvement of those affected by patient safety incidents is central to PSIRF. One Healthcare is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned.

The Directors of Clinical Services are our Engagement Leads at each hospital. We wish to now engage at a much earlier stage of the review process/ learning response, to understand the needs of those involved, to prevent compound harm, and repair relationships while facilitating healing.

We will uphold the following principles:

- Providing apologies that are meaningful
- Ensuring that each approach is individualised
- Being mindful that timing is sensitive
- That those affected are treated with respect and compassion
- That we ensure guidance and clarity are provided
- Making sure that those affected are 'heard'
- That our approach is collaborative and open
- Recognizing that subjectivity is accepted
- Understanding that we need to strive for equity

Patients, their families and carers may need to be signposted to support at any point during their engagement or involvement in the learning response. As part of our new processes we will endeavour to understand their individual needs as soon as possible following an incident.

Our staff should use the National Institute for Health and Care research (NIHR) co-designed guidance booklets to make investigations more human and meaningful for those involved, and support better organisational learning. (See appendix 3) This will ensure that those affected by a patient safety incident have clear information about the purpose of any learning response, and what to expect from the process.

Our teams will also take account of and act on feedback that we receive during the learning response process. Where patients request, we will involve them in the production of investigation reports and they will be provided with the final version of the report. The incident response lead will provide patients and their families with the chance to go through the report with them. Our regular monthly/quarterly reporting to our commissioners, we feedback on our Learning Response activities. All PSII reports, once they have been reviewed through our hospital and corporate level governance and assurance processes will be shared with our commissioners:

One Ashford Hospital	Kent and Medway Integrated Care Board (ICB)
One Hatfield Hospital	Hertfordshire and West Essex Integrated Care Board (ICB)

We realise that we may not always be able to meet every expectation. When we can't meet the patient/families expectations, staff will give clear and meaningful explanations as to why this was not possible.

The Group Clinical Director has the responsibility for corporate level oversight of our Learning Responses. Should an incident involve other provider organisations where cross-system learning responses may be required, the Group Clinical Director will liaise with the relevant ICB to ensure full engagement and commissioner oversight.

We recognise the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. Staff have access to the following support mechanisms:

- All of our staff have access to Occupational Health Services, to access support that may be needed.
- Our staff, and their families, have access to our online staff support programme – WeCare (via Canada Life). This service looks after their wellbeing with a 24/7 UK-based online GP, mental health counselling, a get fit programme, legal and financial guidance, plus much more. Staff can use their phone, tablet or desktop, to have 24/7 access to thousands of experts, all from the comfort of their own home. The Mental Health Support programme helps staff to prevent burnout, tackle major life events or learn to deal with stress and anxiety, which can also be an outcome of involvement with serious patient safety events.
- Our Freedom to Speak Up network provides a confidential service for staff if they have concerns about the organisation's response to a patient safety incident. Our Group Clinical Director is the organisations Freedom to Speak Up Guardian who is supported by a small number of FTSU Champions based within the hospitals.
- Staff also have access to the Mental Health Champions based at each hospital, who will provide confidential support and sign-posting where appropriate.

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 now explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Resources and training to support patient safety incident response

While developing our Patient Safety Incident Response Plan for 2023/24, we undertook a review of our staffing capacity and identified the key roles at corporate and hospital level.

Our PSIRF team is small and led by our SRO – Mr. Des Shiels (CEO). Further corporate leadership comes from our Group Clinical Director who is the Executive and Oversight Lead for implementation within the organisation. Local hospital level oversight and accountability lies with our two Hospital Directors, who will be directly overseeing the work of the Learning Responders and Engagement Leads on their sites. Hospital level implementation will be supported by key individuals, such as Heads of Department, who will support the Engagement and Learning Reponses Leads in undertaking patient safety reviews following an incident. The senior teams are required to undertake the relevant training to comply with the required NHS Patient Safety syllabus (level 2). This is being accessed through Health Education online training and via training opportunities provided by HSIB and our ICBs. Operational training to front line staff is being provided through workshops and our routine committees and team meetings, ensuring our staff understand the principles of a system based approach to investigation.

In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs;
- Ensure all relevant members of the corporate team/implementation team undertake the appropriate levels of training as specified within the National Standards;
- Ensure that for every Patient Safety Incident Investigation (national and local priorities) that a Response lead has been identified to lead the team through this specific process;
- Provide access to update training for current staff who are involved in the incident investigation function on use of updated analytical tools, use of improvement science approaches and utilization of the national report templates;
- Work with senior nursing staff and Heads of Departments to constantly review the tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.

One Healthcare staff will undertake the training that has been set by NHSE under their Patient Safety national syllabus. See Appendix 4 for details of training for staff at all levels, including the corporate team and key lead roles.

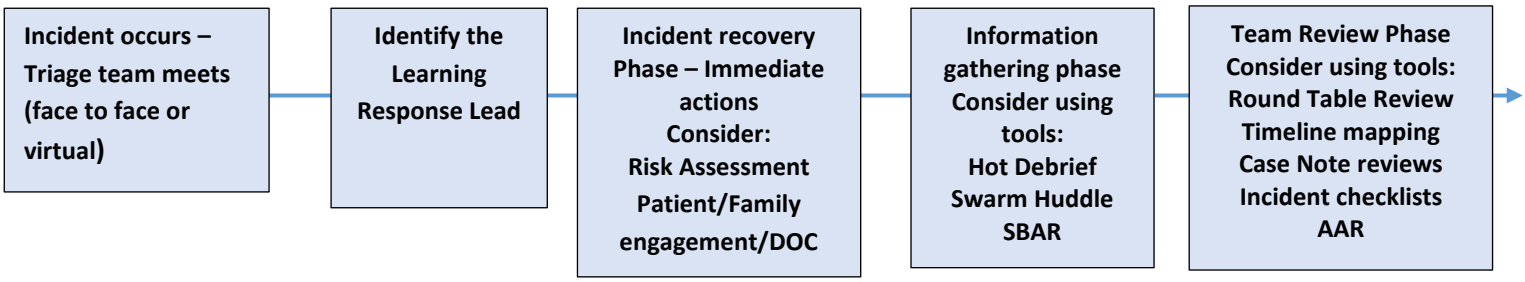
Our patient safety incident response plan

Our Plan sets out how One Healthcare intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. 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.

Our new approach will be more immediate and responsive, and also include patients and their families' right at the start of the process. Our hospital teams will instigate an initial triage process, where the relevant team will gather as a patient safety event occurs. This team will identify a Learning Response lead – who will coordinate the ongoing process, but will make the initial decision as to how the incident links to our PSIRP (Plan), and therefore what proportional response/ patient safety response tool will be adopted for use to gather information and identify the learning to be shared.

The diagram below sets out the process staff will follow – but also includes the patient safety response tools we will consider at each stage. This is not a comprehensive list – as we will make full use of NHSE's toolkit, as appropriate to the incident under consideration. Cascade of learning and appropriate governance and assurance processes will also be in place.

Diagram: New patient safety incident response process



Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents. These investigations will now analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors.

We will be using the mandated Patient Safety Incident investigation template (PSII) for the following categories of incidents: (See Appendix A for the Template and associated guidance)

A National Priorities Incident
Patient safety incidents that have resulted in severe harm, these incidents would have automatically been a serious incident under the Serious Incident Framework.
A reportable deep Surgical Site Infection – as defined by the UKHSA
A know case of sepsis
A reportable radiation exposure incident as per IRMER guidance
CQC notifications – if when discussion with the Regulator – the incident is deemed to warrant this level of investigation
If following engagement with the patient and their family that their concerns and needs can only be adequately addressed using this more in-depth approach.

Our Patient Safety Incident Response Plan will be reviewed at least annually. The 2023/34 PSIRP is the first produced by One Healthcare and has set the following as our local Patient Safety Priorities.

- **Medicines incidents** - These incidents may vary in degree of severity and impact and will range from errors in prescribing, dispensing, administration or documentation;
- **Infections** - These incidents may range from the more serious such as outbreaks, diagnosed sepsis or deep surgical site infections – to those with less impact such as minor wound infections.
- **Communication related issues** - There may be elements of communication problems that are identified as gaps when using many of Learning Response Tools to review the 'system' within which an incident has occurred.
- **Administration processes** - There may a number of incidents where administration processes have failed the system. These may include incidents were there are delays in seeing consultant (booking appointments or actual consultations) – scheduling issues. They may also include processes that cause cancellation on the day of surgery
- **Clinical Process issues** - This is a more complex group of incidents. We will be flexible.
- **Imaging incidents** - This category may include a wide range of incidents from reportable incidents with serious consequences (IRMER) to those with less impact;
- **Documentation issues** - These incidents may form part of other more complex incidents or be a specific event. They may include issues such as - failure to access/unavailability of required medical records/ Errors in documentation of clinical notes e.g. incorrect demographics
- **Equipment related incidents** - This category includes a wide range of potential incidents – with varying degrees of impact

Our proportional approach in responding to these types of incidents may involve the use of a number of different tools that form out Learning Response Toolkit. These tools include: (can be found in Appendix B)

- Hot Debrief template
- SBAR template
- Swarm Huddle Template
- AAR

- SMT Debrief Tool
- Round table Review Tool

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. The plan will be reviewed as a minimum 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 provides the opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every three - 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.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Internal reporting of all Learning Responses/Patient Safety Review activities occurs through our exiting governance and assurance processes.

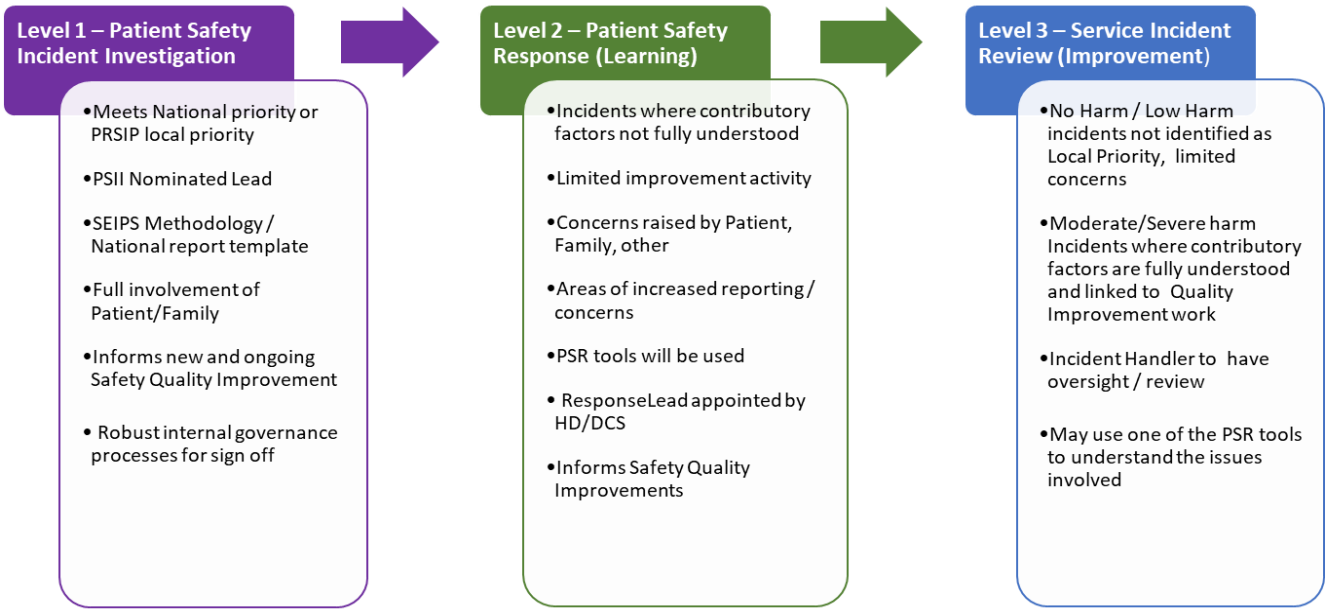
At hospital level a daily review of incidents being logged onto our Incident Management System is undertaken by the Quality and Risk Leads. Our senior management teams formally reviews all 'open' incidents on a weekly basis. Monthly and bi-monthly reporting occurs at our hospital and corporate level Governance Committees. Cross organisational learning is shared at our monthly corporate Governance Committee.

We will continue to report all notifiable incidents to the CQC as required under the current legislation. Mandated reporting will also continue as previously required, to the HSE, ICO, MHRA, UKHSA and professional bodies.

When an incident occurs that either aligns with the national priorities or has been mapped within our Plan as requiring a more in-depth review, staff will use the PSII template to guide this process. These types of events will be escalated internally, as soon as they occur. Our Hospital Directors and Group Clinical and Medical Directors will be notified. Oversight and support will be provided to local teams. The Hospital Directors will liaise with their ICB leads in relation to notification of PSII level events, with agreement being reached on each individual incident of the required updating process and anticipated timelines.

Patient safety incident response decision-making

Our proportional response to incidents will vary, dependent on the type of incident. However, we will always take account of the patient and their family's wishes, needs and concerns when deciding our level of response. In principle our response will occur at three levels.



National priorities are set. These priorities require a PSII to be conducted by the organisation. We will therefore be using this approach with the associated mandated template should we have an incident that falls within the categories outlined below.

- Never events
- Learning form Deaths
- Safeguarding incidents
- Deaths of persons with learning disabilities
- Incidents in Screening Programmes

Our level 2 and three responses will align with our patient safety priorities as defined within our Plan. When an incident occurs, our triage team, led by a nominated Response Lead, meets (either face to face or virtually) to assess the immediate actions that need to be taken, engage with the patient and their family, and decide on which proportional response is most appropriate to the individual incident. Information gathering teams and review teams will include, wherever possible, the staff involved in the incident, clinical experts to provide advice, and members from our consultant body to provide the medical staffing viewpoint.

The Learning Response lead, together with the team, will decide on which Learning Response Tool is most appropriate- as mapped within our Plan.

Even where incidents that don't require a specific response (as mapped in our Plan) occur, these will still be logged, monitored and reported on as part of our routine governance and assurance arrangements. If we identify emergent issues not included in our patient safety incident response plan, these will be discussed at our corporate governance committee where the appropriate organisational proportionate response will be agreed.

Responding to cross-system incidents/issues

When we recognise incidents or issues that require a cross-system learning response, be that at the hospital or organisational systems level, staff will work with partners and key stakeholders ensuring that learning responses are co-ordinated at the most appropriate level of the system.

Our Group Clinical Director and the Hospital Directors have oversight responsibilities, and lead the teams in these cross-system responses, liaising with our ICB leads to agree process, timescales and reporting requirements.

Timeframes for learning responses

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified. PSIIs will ordinarily be completed within one to three months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed with the patient/family/carer. No PSII should take longer than six months.

We will ensure that a balance will 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. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

When our teams are using any of the other Learning Response Tools, timescales will be agreed by the initial triage team as to when the team review and sign off phase of the process needs to be completed. The tools within One healthcare Toolbox that are to be considered for use in the information gathering phase of the Learning Response process, should be used as soon as possible after the event, preferably within the first 24 – 48 hours. This will depend on the availability of staff. The teams can meet face to face or via MS Teams if this facilitates a more timely response.

The tools within the Toolbox that are designed for use by the teams to review the response to an incident and identify learning and quality improvements initiatives, should ideally be used within a week or more of the events. Staff should try to use these tools with a month of the event, so that learning can be identified and shared.

The tools for use when identifying trends within incidents can be used once the senior management teams have identified a potential concern or trend and will depend on the number of index cases within the cohort of incidents being reviewed. Ideally these should be undertaken in as timely a way as possible so that outcomes can be shared with team and commissioners.

Safety action development and monitoring improvement

Whether staff undertake a full review using the PSII template, or use one of the Learning Response Tools as mapped within our Plan, learning outcomes and improvement actions will be identified during the review process. These will be shared at all levels of the organisation, so that staff from Board to Ward level are made aware of how learning is translating into service improvement. Monitoring of improvement actions will occur at both hospital and corporate levels, through our existing governance and assurance meetings. Internal and external escalation processes will be led by our oversight leads at hospital and corporate level.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

- The Group Clinical Director will produce a quarterly organisation-wide safety improvement report which will summarise all of the organisations learning and improvement work;
- Hospital teams under the guidance of the Learning Response and Engagement Leads create individual safety improvement plans that focus on a specific service, pathway or locations;
- One Healthcare collectively reviews the output from learning responses to single incidents once it is felt that there is sufficient understanding of the underlying, interlinked system issues. This is done at both hospital and corporate levels as part of our existing governance and assurance committee meetings;

The decision to develop an improvement plan is based on the potential knowledge gained through the learning response process and opportunities for improvement. These improvement plans take account of key stakeholder views, including those of the patients and their families.

Oversight roles and responsibilities

Organisational level oversight

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. The Group Clinical Director/CNO will be the Corporate Oversight Lead for One Healthcare. This role ensures:

- the organisation meets national patient safety incident response standards
- the roles and responsibilities in relation to patient safety incident response are clearly described and understood by staff;
- activities should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality;
- learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame;
- that delivery of this new framework is not done working in isolation – it must be done collaboratively.
- creation of a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
- that PSIRF is central to overarching safety governance arrangements
- quality assurance of all PSII reports that come to the central team
- sharing of insights and information across the organisations to improve safety within the organisation
- creation of a reporting system that triangulates a mixture of qualitative and quantitative measures to get a clear understanding of the effectiveness of the patient safety incident response systems and processes in place, while using meaningful data from existing data streams.
- that staff all recognise that a 'one size fits all' approach does not exist.
- that where it is required – teams work collaboratively with the ICB and other providers to support co-ordination of cross-system learning responses when required.

Hospital level oversight will be the responsibility of the Hospital Director. This role is focused specifically on ensuring that oversight of implementation PSIRF across the hospital but to then oversee the operational delivery and monitoring of the new PSIRF processes. The Hospital Directors at each site will take on this operational oversight. They will need to:

- Liaise with their ICB specific PSIRF/Oversight leads, building a relationship and ensuring that requests for information, feedback on PSIRF implementation and operational delivery is provided as appropriate;
- Laise with local Coroners and Medical Examiners – when required, and supply requested information relating to specific patient deaths within the hospital;
- To have oversight of local patient safety incident related activity – liaising with the Learning Response and engagement Leads – providing support and advice where requested;
- Have a good understanding of the new requirements under PSIRF for NHS funded providers and have undertaken the required levels of training to act as an advisor to staff. To liaise with the Clinical Group Director as required as ensure the agreed organisational reporting requirements are met;

- Ensure that all local learning responses are quality assured and in liaison with the Group Clinical Director – to be involved in quality assurance of PSII responses;
- To understand and apply human factors and systems thinking principles.(part of mandated NHSE training syllabus)
- To constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- To recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g. inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).

One Healthcare has robust governance and assurance systems in place at both hospital and corporate level. Our patient safety reviews/ learning response activities will all be reported and monitored through these systems.

As part of these arrangements we already work closely with our commissioners, with our senior hospital teams having regular engagement meetings. As part of the ongoing monitoring of the effectiveness of our new patient safety arrangements we have agreed with our commissioners that we will be sharing certain Learning Response outputs with them. These will include all PSII reports once they have been assured through our local governance arrangements, together with the output of any thematic reviews we undertake. This will include updates on any Quality Improvement activity resulting from the learning identified during these events.

Complaints and appeals

Any concerns or complaints raised about a response to patient safety incidents from either patients and their families or our own staff will be taken seriously and managed in a way that upholds the principles of a 'Just Culture' and restorative healing.

Our patients have access to our formal complaints process should they want to formalise their concerns.

Patients and their families should in the first instance approach the Learning Response Lead who is leading the review of their individual incident. They can also approach the Director of Clinical Services for the hospital – who acts as the Engagement Lead for the site, to raise concerns at any time. If patients and their families want a more formal approach they can make use of our three-stage complaints process. Stage One of this process will involve a review of the complaint/concerns by the Hospital Director. Should this not adequately answer all concerns Stage Two of our process will involve a review by the Group Clinical Director. Should patient and their families remain dissatisfied following the Group Clinical Director's review, they can obtain external independent adjudication from the Independent Sector Complaints Adjudication Services (ISCAS).

Contacts

Stage 1: Hospital Director	Jo Nolan – Hospital Director at One Ashford Hospital Jo.nolan@onehealthcare.co.uk Claire Armstrong – Hospital Director at One Hatfield Hospital Claire.armstrong@onehealthcare.co.uk
Stage 2: Group Clinical Director	Brenda Corby Brenda.corby@onehealthcare.co.uk
Stage 3: Independent Sector Complaints Adjudication Service NHS Patients	70 Fleet Street London EC4Y 1EU Telephone: 0207 536 6091 Email: info@iscas.org.uk The Parliamentary Health Service Ombudsman Millbank Tower, Millbank

	London SW1P 4QP Telephone: 0345 0154 033 www.ombudsman.org.uk/making-complain The Integrated Care Board's PALS team will also be made aware of any stage 2 or 3 complaint involving NHS Patients.

Our staff have access to our Freedom to Speak Up Guardian and Whistleblowing processes, but hope that high levels of staff engagement through the entire review/investigation process will resolve any concerns at the time.

REFERENCES

NHS Serious Incident Framework	https://www.england.nhs.uk/patient-safety/serious-incident-framework/
NHS England – Patient Safety Strategy	https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf
Patient Safety Incident Response Framework	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf
Engaging and involving patients, families and staff following a patient safety incident	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf
Guide to responding proportionately to patient safety incidents	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf
Oversight roles and responsibilities specification	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf
Patient safety incident response standards	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf
Patient Safety Incident Response Framework Preparation guide	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf
NHSE – PSIRF toolkit	https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/
NHS Just Culture Guide	https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf
SEIPS quick reference guide and work system explorer	https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf
PSII template	https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/
Learn together tools	https://learn-together.org.uk/
CQC Notifications	https://www.cqc.org.uk/guidance-providers/notifications

SUPPORTING DOCUMENTS

One Healthcare Patient Safety Incident Response Plan 2023/24	To be agreed by ICB
One Healthcare – Learning Response tools	• PSII template • Hot Debrief template • SBAR template • Swarm Huddle Template • AAR • SMT Debrief Tool • Round table Review Tool
Staff support/HR policies	Clinical staff – reporting to professional bodies Staff performance policy
Medical staff guidance	GP-MM-003- Group Policy- Practising Privileges
One Healthcare - Complaints	GP-Q&G-009 - Group Policy- Complaints and Compliments
One Healthcare - Duty of Candour	GP-CL-010 - Group Policy- Duty of Candour (Being Open)
One Healthcare - Incident Management	GP-CL-005 - Group Policy- Incident and Serious Incident Reporting and Management (Superseded by this new PSIRP)
One Healthcare – Safeguarding Adults	GP – CL-003 -Group Policy- Safeguarding Adults at Risk
One Healthcare – Dignity & Respect	GP-CL-001 - Group Policy- Privacy, Dignity and Respect
One Healthcare – Medical Staff performance	CG-MM-001-Group Policy- Medical Performance
One Healthcare IT Incident policy	CG-ITG-015 – IT Incident Response Policy

Initial Equality Impact Assessment

		Yes/No	Comment
1	Does the document/project affect any group less or more favourably than another on the basis of:		
	• Race	No	The ethos of PSIRF supports non-discrimination and equality of approach to all people
	• Ethnic Origins	No	
	• Nationality	No	
	• Gender or gender identified as	No	
	• Gender Reassignment	No	
	• Culture	No	
	• Pregnancy & Maternity	No	
	• Religion or Belief	No	
	• Sexual Orientation	No	
	• Marriage or Civil Partnership	No	
	• Age	No	

	• Disability – learning disabilities, physical disabilities, sensory impairment and mental health problems	No	
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified potential discrimination, are there exceptions valid, legal and/or justifiable?	No	
4	Is the impact of the document/project likely to be negative?	No	New way of thinking and cultural change required
5	If so can the impact be avoided?	N/A	
6	What alternative is there to achieving the document/project without impact?		Mandated
7	Can we reduce the impact by taking different action?		Staff will undertake the required training to successfully implement this new framework

Monitoring Compliance

Aspect of Compliance or Effectiveness	Monitoring Method	Responsibility	Frequency
Governance and assurance monitoring and reporting	Weekly monitoring of PSR/Learning responses	Quality and Risk Leads (via Datix)	Weekly
	Weekly review of Datix incidents	Hospital SMTs led by Hospital Directors	Weekly
	Local level reporting at Hospital Quality and Governance Committees	Directors of Clinical Services with support from Quality & Risk Leads	Bi-Monthly
	Corporate level Governance reporting	Directors of Clinical Services to include within monthly Clinical Board Reports which go to Cross Site Governance Committee for review	Monthly
	Board level reporting	Group Clinical Director to report to Clinical Assurance Board	Quarterly
	Tracked on Group Risk Register	Group Clinical Director	Bi-monthly reviews

Appendix 1 a - Guidance on National Priorities – where PSII template is mandated:

National priorities requiring a response

National priorities are set by the PSIRF and other national initiatives. These priorities require a PSII to be conducted by the organisation.

There are three categories of national priorities requiring local PSII:

- incidents that meet the criteria set in the Never Events list (2018);
- incidents that meet Learning from Death criteria;
- and Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Further detail is provided below.

Incidents that meet the criteria set in the Never Events list 2018

Patient safety incidents that are 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.

Incidents that meet the 'Learning from Deaths' criteria;

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Examples include:

- deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Examples include suicide, self-harm or assault resulting in the death or long term severe injury of a person in state care or detained under the Mental Health Act.

National priorities to be referred to another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are as follows, further details are provided below:

- Maternity and neonatal incidents
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities

- Safeguarding incidents
- Incidents in screening programmes

Maternity and neonatal incidents:

- Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- All perinatal and maternal deaths must be referred to MBRRACE

Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge

These must be discussed with the relevant NHS England and NHS Improvement regional independent Investigation team (RIIT)

Child deaths

For further information, see: Child death review statutory and operational guidance

Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities

Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

Incidents in screening programmes

For further information see: incidents in screening programmes

Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

Deaths of patients in custody, in prison or on probation

Where healthcare is/was NHS funded and delivered through an NHS contract, incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

Appendix 1b – The Patient Safety Incident Investigation Template (Mandated) – See as separate document

Appendix 1c – Patient Safety Review (Concise) – See as separate document

Appendix 2 – One Healthcare Learning Response Toolbox. – See separate document.

Appendix 3 - National Institute for Health and Care research (NIHR) co-designed guidance booklets

Appendix 4 – Independent Sector PSIF Training Requirements

Appendix 4 - Independent Provider PSIRF Training requirements (NHSE)

PSIRF Role	Competence & Training	Requirements Role	Courses required by NHSE (patient safety syllabus)	Provider Options
Engagement & Involvement Leads	• Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus. (See row for 'all staff') <u>In addition:</u> • Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process. • Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise. • Engagement leads contribute to a minimum of two learning responses per year.	These should be people leading on engagement/involvement with those affected by patient safety incidents such as but not limited to: • Director of Clinical Services	Involving those affected by a patient safety incident - 6 hours (face to face)	• Procure training from a NHS Training & Procurement Framework • Training offered through ICB • In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards • From October 2023 HSIB intend to have a commercial model for all PSIRF and nonPSIRF training where they hope to offer additional training at a charge to the Independent Sector.
Learning Response Leads	Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus. (See row for 'all staff') <u>In addition:</u> • Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and	These should be people leading any system-based learning response such as but not limited to: • Quality and Risk Leads	Systems approach to learning from patient safety incidents – 2 days (face to face)	• HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector) • Procure training from a NHS Training & Procurement Framework • PSIRF Role Competence & Training Requirements Role

	experience of patient safety incident response. • Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise. • Learning response leads contribute to a minimum of two learning responses per year			Courses required by NHSE (patient safety syllabus) • In house training can be offered by staff meeting requirements of 5.1 in PSIRF standard • Training arranged via ICB from valid training provider
Oversight	Those with an oversight role on a provider board or leadership team (e.g. an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus. (See rows for 'all staff' and 'board and senior leadership') <u>In addition:</u> • All patient safety incident response oversight is led/conducted by those with: ➢ at least two days' formal training and skills development in learning from patient safety incidents AND ➢ one day training in oversight of learning from patient safety incidents. • All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and	These should be people leading in system oversight roles as outlined in the NHSE Roles & Responsibilities guide (i.e. provider board PSIRF lead(s)) and must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development such as but not limited to: • PSIRF Executive Lead/ Group Clinical Director • Hospital Directors • Patient Safety Partners	Systems approach to learning from patient safety incidents – 2 days (face to face) Oversight learning from patient safety incidents – 6 hours (face to face)	Systems approach to learning from patient safety incidents • See options listed for 'Learning response Leads' above Oversight learning from patient safety incidents • Procure training from a NHS Training & Procurement Framework • In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards *From October 2023 HSIB intend to have a commercial model for all PSIRF and non-PSIRF raining where they hope to offer additional training at a charge to the Independent Sector

	network with peers at least annually to build and maintain their expertise.			
Note • HSIB welcome the Independent Sector on to their Level 2 programme. This is free of charge to the Independent Sector. HSIB have just received CPD accreditation for this programme so the April 2023 cohort will have CPD points attached to it. • From October 2023 HSIB intend to have a commercial model for all PSIRF and non-PSIRF training where additional training will be on offer at a charge to the Independent Sector.				
All staff			Level 1: Essentials for patient safety (e learning) Level 2: Access to practice (e learning)	• E Learning for Health https://www.hee.nhs.uk/our-work/patient-safety
Board & Senior Leadership		Corporate and Hospital senior teams	Level 1: Essentials for patient safety (e learning) Level 2: Access to practice (e learning)	• E Learning for Health https://www.hee.nhs.uk/our-work/patient-safety