

Patient Safety Incident Response Policy and Plan

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1. Document summary

1.1 Why do we have this policy

- To keep patients safe
- To learn from mistakes and near misses
- To improve the quality of care
- To support patients, families and staff when incidents happen
- To make sure people are treated fairly and with respect

1.2 Learning not blame

The Trust uses the Patient Safety Incident Response Framework (PSIRF). This means:

- we try to understand what happened and why
- we look at systems, processes and environments, not just individual actions
- staff should feel safe to report concerns and incidents
- learning is more important than blaming people

The policy promotes a positive safety culture where staff, patients, families and carers feel able to raise concerns, report incidents and contribute to learning. It uses a restorative and just culture approach, recognising that incidents usually arise from a range of system factors rather than the actions of one individual. Staff are encouraged to report incidents, near misses and safety concerns openly and are provided with support when involved in investigations.

1.3 Involving patients and families

If a patient safety incident happens:

- patients, families and carers will be listened to
- they will receive updates
- they can ask questions
- they will be treated with kindness and compassion
- support will be available if needed

The policy recognises the importance of ensuring learning responses are accessible and inclusive, taking account of health inequalities and individual communication needs.

1.4 Reporting incidents

All patient safety incidents must be reported promptly through the Trust's incident reporting system. Incidents are reviewed to decide the most appropriate response, based on the opportunity for learning and any potential risks. Depending on the circumstances, responses may include local learning, a swarm huddle, after-action review, multidisciplinary review, thematic review or a Patient Safety Incident Investigation (PSII). The aim is always to understand what happened, identify contributory factors and develop meaningful improvements.

Learning from incidents must lead to practical actions that reduce risk and improve care. Safety actions are monitored through the Trust's governance arrangements to ensure improvements are implemented and remain effective. Learning may also contribute to wider safety improvement plans across services.

Key message: RDaSH wants a culture where people feel safe to speak up, incidents are reported openly, learning is shared, and improvements are made so patients receive safer care.

2. Introduction and aim

The Patient Safety Incident Response Framework (PSIRF) introduced a fundamental change in how the National Health Service responds to patient safety incidents. It replaces a focus on attributing blame with a systems-based approach that seeks to understand how and why incidents occur and what can be done to improve care and reduce future risk.

NHS England defines a patient safety incident as any unintended or unexpected event that could have, or did, result in harm to one or more patients receiving healthcare.

PSIRF provides a framework for responding to patient safety incidents in a way that is proportionate, compassionate and focused on learning. It supports organisations to identify the factors that contribute to incidents, understand how care is delivered within complex systems and develop meaningful improvements that strengthen patient safety.

At the trust, PSIRF is embedded within our wider approach to quality improvement, clinical governance and organisational learning and we are committed to fostering a culture that is open, fair and restorative, where staff, patients, families and carers are supported to contribute to learning and improvement following patient safety incidents.

Through the implementation of PSIRF, the Trust aims to strengthen patient safety, improve the quality of care and ensure learning is translated into meaningful and sustainable improvements across all services.

The purpose of the policy is to ensure that patient safety incidents are responded to in a way that promotes learning, supports improvement and strengthens the safety of services provided by the Trust. It establishes the principles, governance arrangements and processes used to guide patient safety incident responses and describes how learning will be identified, shared and translated into improvement.

The Trust acknowledges that safe and effective care relies upon strong partnerships between patients, families, carers, staff, volunteers, community organisations and partner agencies. Learning from patient safety incidents is therefore undertaken collaboratively wherever possible to maximise understanding and support improvement across services and systems.

This policy supports the four aims of PSIRF by ensuring:

- those affected by patient safety incidents are treated with compassion and are meaningfully involved in learning responses;
- a range of systems-based approaches are used to understand incidents and identify opportunities for improvement;
- responses to patient safety incidents are proportionate to the potential for learning and improvement; and
- governance arrangements provide effective oversight of learning, improvement and patient safety culture.

The Trust recognises that an effective patient safety system relies on a positive learning culture. Staff should feel able to raise concerns, report incidents and contribute to learning without fear of inappropriate blame. This culture is supported through effective leadership, psychological safety, transparent processes and a commitment to continuous improvement.

This policy should be read alongside the Trust's Patient Safety Incident Response Plan, which describes the patient safety priorities that will be the focus of learning responses and patient safety incident investigations during the life of the plan.

3. Procedure

Patient safety incident responses are based upon a systems approach. This approach recognises that healthcare is delivered within complex systems involving people, processes, environments, equipment, technology and organisational factors. These elements interact continually and influence the quality and safety of care provided.

Learning responses seek to understand how these system factors contributed to an incident rather than focusing solely on the actions of individual members of staff. The aim is to identify opportunities for improvement, strengthen safety and support sustainable learning across the organisation.

PSIRF processes are not intended to determine liability, disciplinary action, blame, negligence, professional misconduct, preventability or cause of death. Separate processes exist for those purposes and may operate alongside patient safety learning responses where required. These include:

- claims management processes
- employment investigations
- professional regulatory investigations
- coronial investigations and inquests
- criminal investigations
- information governance investigations
- safeguarding reviews (including PiPoT)
- domestic abuse death related reviews
- medical examiner reviews
- estates and facilities investigations
- financial investigations or audits

Information generated through patient safety learning responses may be shared with other investigations where appropriate and lawful to do so. However, the purpose and objectives of the patient safety learning response must remain focused on learning and improvement.

3.1 Our patient safety culture

The Trust is committed to creating and sustaining a culture where safety, learning and improvement are everyone's responsibility. This commitment is reflected within the Clinical and Organisational Strategy and underpins the approach taken to patient safety, governance and quality improvement across all services.

A positive patient safety culture is one in which staff, patients, families and carers feel able to raise concerns, report incidents, share experiences and contribute to learning without fear of unfair blame. Creating such a culture supports openness, transparency and continuous improvement and is essential to delivering safe, high-quality care.

The Trust adopts a restorative and just culture approach. This means that when incidents occur, the primary objective is to understand what happened, why it happened and what improvements are required to reduce future risk. Whilst individuals remain accountable for their professional responsibilities, learning responses focus on understanding the wider system factors that contributed to an incident.

The NHS England Being Fair approach may be used separately where there is a need to consider staff accountability and decision-making. However, it does not form part of routine patient safety incident investigations and must not interfere with the learning objectives of PSIRF.

The Trust actively encourages the reporting of patient safety incidents, near misses and safety concerns. Reporting provides opportunities to identify risks, understand emerging themes and develop improvements that enhance the safety and quality of care. Staff who wish to raise concerns are supported through established reporting arrangements and the Freedom to Speak Up process.

The Trust is equally committed to learning from excellence and promotes the recognition and sharing of examples of outstanding practice. Learning from what goes well supports continuous improvement and helps embed high standards of care across the organisation.

Patient safety learning is supported through a structured governance framework that includes daily incident review processes, patient safety huddles, Learning from Patient Safety Events meetings and the Patient Safety Operational Group. These arrangements provide opportunities to review incidents, identify themes, determine appropriate learning responses and oversee the implementation of improvement actions.

The Trust recognises that involvement in a patient safety incident can have a significant emotional impact on staff. Appropriate support will therefore be made available throughout learning responses and investigations. Sources of support

include line management, the Trauma Resilience Service, Freedom to Speak Up Guardians, Schwartz Rounds, chaplaincy services and other staff wellbeing resources.

The Patient Safety, Carer and Communities Team will provide advice, guidance and support to staff involved in patient safety learning responses and will help ensure that learning is shared effectively across services.

The Trust will continue to monitor patient safety culture through incident reporting, patient feedback, learning response outcomes, staff experience measures and staff survey results to support continuous organisational learning and improvement.

3.2 Patient Safety Partners

Patient Safety Partners (PSPs) play an important role in helping the Trust improve patient safety. Their involvement supports the aims of the National Patient Safety Strategy and ensures that the views and experiences of patients, carers and local communities contribute to the development, delivery and evaluation of patient safety arrangements.

Patient Safety Partners are members of the public who bring valuable lived experience of health and care services. They are not employees of the Trust but work alongside the Patient Safety, Carer and Communities Team to provide independent challenge, insight and support in relation to patient safety improvement.

Patient Safety Partners contribute to patient safety by:

- bringing the patient and carer perspective into discussions about safety and quality;
- contributing to the development and review of patient safety policies, procedures and guidance;
- supporting patient safety improvement programmes and learning responses;
- participating in governance and assurance processes where appropriate; and
- helping the Trust understand how its services and safety systems are experienced by patients and families.

The Trust is committed to supporting Patient Safety Partners to undertake their role effectively and will provide appropriate induction, development opportunities and ongoing support. Their contribution will be recognised as an important part of the Trust's approach to patient safety, learning and improvement.

3.3 Addressing inequalities

Reducing health inequalities is a strategic priority for the Trust and forms an integral part of the delivery of safe, effective and person-centred care. The Trust recognises that some individuals and communities experience poorer health outcomes, differences in access to services and increased exposure to patient safety risks.

Patient safety risks are not experienced equally across all population groups. Factors such as disability, age, ethnicity, sex, sexual orientation, gender reassignment,

religion or belief, socioeconomic circumstances and social exclusion can influence people's experience of care and their ability to participate in patient safety processes.

The Trust is committed to ensuring that patient safety incident responses are fair, inclusive and accessible. Consideration of health inequalities will be embedded throughout patient safety learning responses, investigations, safety improvement work and service development activities.

When responding to patient safety incidents, the Trust will:

- consider whether inequalities in access, treatment, communication or service delivery contributed to the incident or its outcome
- identify and understand any variation in patient safety outcomes across different population groups
- ensure people affected by incidents are able to participate fully in learning responses regardless of individual need or circumstance
- provide reasonable adjustments and accessible communication where required
- use patient safety information and population health intelligence to identify emerging inequalities and opportunities for improvement
- incorporate learning relating to health inequalities into quality improvement and service transformation programmes

The Trust will take account of the needs of individuals who may require additional support to participate in patient safety processes, including:

- people with learning disabilities
- autistic people
- people living with dementia
- people with sensory impairment or communication needs
- people who require interpreting or translation services
- people from ethnically diverse communities
- people experiencing social exclusion or disadvantage
- lesbian, gay, bisexual and transgender individuals

Recruitment and development of Patient Safety Partners will seek to reflect the diversity of the communities served by the Trust. Where gaps in representation are identified, targeted action will be considered to improve diversity and inclusion within this group.

The Trust will ensure that staff involved in patient safety learning responses have access to training, guidance and support to help them understand and address health inequalities as part of their role.

Learning from patient safety incidents will continue to inform the development and review of the Patient Safety Incident Response Plan, helping to ensure emerging inequalities and associated risks are identified and addressed.

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

Effective learning can only be achieved when those affected by a patient safety incident are treated with compassion, respect and openness, and are given meaningful opportunities to contribute to the learning process.

The Trust is committed to engaging patients, families, carers and staff following patient safety incidents in a way that is timely, person-centred and responsive to individual needs. Engagement will be proportionate to the circumstances of the incident and focused on supporting understanding, learning and improvement.

This approach aligns with the principles of PSIRF, the statutory Duty of Candour and the Trust's Being Open Policy. Patients, families and carers will be involved in learning responses unless there is a clearly documented reason why this would not be appropriate.

Engagement is not a single event. It is an ongoing process that begins as soon as possible following an incident and continues throughout the learning response. The purpose of engagement is to ensure people understand what has happened, are able to ask questions, contribute their perspective and access support where required.

3.4.1 Principles of engagement

The Trust will ensure that patients, families, carers and staff affected by a patient safety incident are:

- treated with dignity, compassion, courtesy and respect
- communicated with openly and honestly
- provided with information in a way that meets their individual needs
- given opportunities to share their experiences and perspectives
- supported to ask questions and receive timely responses
- offered appropriate emotional and practical support
- involved in learning responses wherever possible
- kept informed about progress and outcomes

Where a patient safety incident investigation is undertaken, those affected will have opportunities, where appropriate, to:

- contribute to the development of the terms of reference
- identify questions they would like the investigation to address
- discuss and agree realistic timescales
- receive updates regarding progress
- review and comment on draft findings where appropriate
- contribute to the development of improvement actions
- provide feedback on their experience of the learning response process

3.4.2 Four stages of engagement

The Trust adopts a structured approach to engagement which supports consistency whilst remaining flexible to individual needs.

Stage 1 Before Contact

Before making contact with those leading the response should:

- identifying the appropriate family member, carer or representative to act as the main point of contact
- consider any communication or accessibility needs
- identifying any support requirements
- understand the circumstances of the incident
- considering whether any other investigations or processes are taking place

Stage 2 Initial Contact

Initial contact should:

- introduce the purpose of the discussion;
- provide a sincere apology where appropriate;
- identify a named point of contact;
- explain what is known at that stage;
- discuss available support;
- explain the proposed learning response;
- answer immediate questions; and
- outline next steps and timescales.

Where a patient safety incident investigation is being undertaken, involvement preferences should be discussed at this stage.

Stage 3 Ongoing Engagement

Throughout the learning response, the Trust will:

- maintain regular communication;
- provide updates on progress;
- review any ongoing support needs;
- respond to questions and concerns;
- offer opportunities for involvement; and
- discuss emerging findings where appropriate.

For patient safety incident investigations, this may include discussion of terms of reference, review of draft findings and involvement in the development of safety actions.

Stage 4 Closing the Learning Response

Initial contact should:

- introduce the purpose of the discussion;
- provide a sincere apology where appropriate;
- identify a named point of contact;
- explain what is known at that stage;
- discuss available support;
- explain the proposed learning response;
- answer immediate questions; and
- outline next steps and timescales. [PSIRF poli...and plan | Word]

Where a patient safety incident investigation is being undertaken, involvement preferences should be discussed at this stage.

3.4.3 Support for Patients, Families and Carers

The Trust recognises that patient safety incidents can have a significant emotional impact on patients, families and carers. Appropriate support will therefore be offered throughout the learning response process.

Support may be provided directly by services or through signposting to external organisations, advocacy services or other sources of assistance where appropriate.

The Patient Advice and Liaison Service (PALS) is available to provide information, support and advice to patients, families and carers who have concerns about care or treatment received. PALS can assist with questions, comments, compliments, concerns and advice regarding formal complaints processes.

Where concerns cannot be resolved immediately, individuals will be provided with information about alternative sources of support and advice. Feedback regarding people's experience of learning responses will be used to support ongoing improvement of patient safety engagement processes.

3.4.4 Support for Staff Following a Patient Safety Incident

The Trust recognises that involvement in a patient safety incident can affect staff professionally and personally. Staff will therefore be supported throughout learning responses and investigations.

Managers are responsible for ensuring that staff involved in incidents are offered appropriate support, guidance and opportunities to participate in reflection and learning. This includes arrangements for debriefing, reflective discussions and learning events following significant incidents and investigations.

Where appropriate, staff will have access to support services including wellbeing services, the Trauma Resilience Service, Freedom to Speak Up Guardians, Schwartz Rounds, chaplaincy services and other resources available through the Trust.

Swarm huddles, post-incident reviews and learning events provide important opportunities for staff to reflect on incidents, contribute to understanding and support the development of improvements that strengthen patient safety across the organisation.

3.5 Patient safety Incident Response Planning

The Patient Safety Incident Response Framework (PSIRF) supports organisations to respond to patient safety incidents in a way that maximises learning and improvement. It promotes a flexible and proportionate approach which enables organisations to focus on the issues that present the greatest opportunity for learning and improvement, rather than responding solely on the basis of harm thresholds.

The Trust takes a considered and proportionate approach to patient safety incident response. Decisions regarding the most appropriate learning response are informed by the patient safety incident, the potential for learning, the needs of those affected and any wider organisational or system risks.

The Trust's Patient Safety Incident Response Plan (PSIRP) describes the patient safety priorities that have been identified through analysis of incident data, complaints, claims, mortality reviews, patient feedback and other sources of safety intelligence. The plan sets out where the Trust will focus its learning response resources and is reviewed regularly to ensure it reflects current patient safety risks and priorities.

3.6 Responding to patient incidents

All patient safety incidents must be managed in a way that supports immediate safety, fulfils statutory and regulatory responsibilities and enables learning and improvement.

The Trust uses a range of learning responses to understand what happened, identify contributory system factors and support continuous improvement. The response selected should always be proportionate to the circumstances of the incident and the opportunity for learning.

3.6.1 Patient Safety Incident Reporting Arrangements

All staff are responsible for reporting patient safety incidents, near misses and safety concerns using the Trust's incident reporting system as soon as reasonably practicable following an event. Wherever possible, incidents should be reported before the end of the working day and no later than 24 hours after becoming aware of the incident.

Incident reports must include an accurate description of what occurred and the actual or potential harm experienced by the person affected.

Where an incident results in, or has the potential to result in, significant physical or psychological harm, managers must be informed immediately and appropriate escalation processes followed. Outside normal working hours, incidents requiring urgent escalation must be reported to the on-call management team.

Never Events and other nationally reportable incidents must be escalated in accordance with national guidance and Trust reporting arrangements.

3.6.1.1 Initial Response to an Incident

Following a patient safety incident, staff must take all reasonable steps to:

- ensure the immediate safety of patients, staff and visitors
- provide any necessary urgent care or treatment
- preserve equipment, records or environments that may be required for further review
- seek senior support where required
- comply with Duty of Candour requirements
- report the incident on the Trust incident management system
- participate in any immediate debrief, swarm huddle or information gathering activity

3.6.1.2 Reviewing an incident

Patient safety incidents are reviewed through daily incident monitoring arrangements and wider governance processes. The purpose of review is to determine the most appropriate response, identify any immediate risks and ensure learning opportunities are recognised.

Most incidents will be reviewed and managed locally. However, incidents presenting significant learning opportunities, system risks or concerns regarding quality and safety may require escalation to the Patient Safety Huddle, LFPSE Group or a Patient Safety Incident Investigation.

Incidents that may require immediate escalation include:

- deaths where problems in care are suspected
- inpatient deaths
- Never Events
- suspected homicides involving Trust service users
- incidents presenting significant reputational, organisational or system risk
- incidents meeting criteria within the Trust's Patient Safety Incident Response Plan

3.6.2 Patient Safety Incident Response Decision-Making

The Trust adopts a structured approach to selecting the most appropriate learning response. Decisions are informed by the nature of the incident, the potential for learning, previous learning in that area, organisational priorities and the needs of those affected.

The Patient Safety, Carer and Communities Team, supported by the Learning from Patient Safety Events Group, will determine whether a patient safety incident should be subject to:

- local learning
- a swarm huddle
- an after-action review
- a multidisciplinary review
- a thematic review
- a service-to-service review
- a patient safety incident investigation
- another proportionate response

Where incidents fall outside established priorities but present significant potential for learning or indicate emerging risks, the Deputy Chief Nurse, Head of Quality and Promises and relevant senior colleagues may commission an alternative learning response. Where there is a disagreement regarding a PSII decision, this will be reviewed by the Chief Nurse or the Medical Director.

3.6.2.1 Learning Response Process

All learning responses will:

- adopt a systems-based approach
- involve patients, families, carers and staff where appropriate
- seek to understand contributory factors

- identify opportunities for improvement
- consider wider organisational learning
- develop meaningful safety actions
- support the sharing of learning across services

Findings, learning and actions will be recorded on Trust systems and monitored through established governance processes.

3.6.2.2 Learning response methods

A **swarm huddle** is an immediate multidisciplinary discussion undertaken soon after an incident. Its purpose is to understand what happened, identify immediate learning and determine whether further review is required.

An **after-action review** brings together those involved to reflect on what happened, what was expected to happen, any differences between the two and any learning that can be identified.

Multidisciplinary Review and Thematic Analysis approaches are used when more detailed exploration is required or where patterns, trends or recurring themes have been identified. The purpose is to understand wider system issues and identify improvement opportunities across pathways, teams or services.

A **Patient Safety Incident Investigation** is a structured systems-based investigation undertaken by a trained patient safety investigator. It seeks to understand how and why an incident occurred, identify contributory factors and support sustainable improvement.

3.6.3 Responding to Cross-System Incidents or Issues

Where incidents involve more than one provider or system partner, the Trust will work collaboratively with relevant organisations and the Integrated Care Board to determine the most appropriate response.

The Trust will share information appropriately to support learning and will seek to avoid duplication of effort wherever possible. Joint learning responses may be undertaken where this offers the greatest opportunity for understanding and improvement.

3.6.4 Timeframes for Learning Responses

Learning responses should begin as soon as reasonably practicable following identification of an incident requiring review.

Patient Safety Incident Investigations should normally be completed within 50 working days unless exceptional circumstances apply. Timescales should be agreed with patients, families, carers and staff involved in the investigation wherever possible.

Where delays occur, those affected will be kept informed and revised timescales agreed. The need for timely learning and improvement must be balanced against the need to undertake a thorough and meaningful review.

Where incidents are subject to coronial proceedings, external investigations or other parallel processes, the Trust will continue to progress learning where appropriate whilst ensuring those processes are respected.

3.6.5 Safety Action Development and Monitoring Improvement

Understanding why an incident occurred is only one part of improving patient safety. Learning responses must also result in meaningful actions that reduce risk and strengthen systems of care.

Safety actions will be developed collaboratively with those responsible for delivering and sustaining improvement. The Trust will focus on addressing the system factors that contributed to incidents rather than relying solely on actions directed at individual behaviour.

Safety actions should:

- address identified system issues;
- be proportionate to the level of risk;
- support sustainable improvement;
- be evidence based where possible;
- be measurable; and
- align with ongoing improvement programmes where appropriate.

Safety actions will be developed using recognised improvement methodologies and should be Specific, Measurable, Achievable, Relevant and Time Bound (SMART).

3.6.5.1 Safety Action Development

When developing safety actions the Trust will:

- identify and define areas requiring improvement;
- understand the context in which risks occur;
- explore potential system changes;
- involve relevant stakeholders;
- prioritise actions based upon likely impact and feasibility;
- establish measures of success; and
- document responsibilities, timescales and monitoring arrangements.

Safety actions should be described clearly and written in a way that allows progress and effectiveness to be measured objectively.

3.6.5.2 Safety Action Monitoring

The Patient Safety, Carer and Communities Team will oversee monitoring arrangements for safety actions arising from learning responses and investigations.

Progress will be reported through the Trust's patient safety governance structure to provide assurance that actions have been implemented, remain effective and continue to contribute to improved patient safety outcomes.

3.6.6 Safety Improvement Plans

Safety improvement plans provide a structured method of bringing together learning from multiple incidents, investigations and learning responses. They support the coordinated delivery of improvement activity across services and pathways.

A safety improvement plan may be developed for a specific service, pathway, theme or organisation-wide patient safety priority. The approach taken will depend on the nature of the risks identified, available evidence and opportunities for improvement.

The Trust will use information from patient safety incidents, complaints, claims, mortality reviews, patient experience feedback, staff feedback and quality improvement activity to inform the development of safety improvement plans.

Safety improvement plans will be monitored through the Trust's governance arrangements to ensure learning is translated into sustainable improvements that reduce risk and improve patient outcomes.

3.6 Complaints and appeals

This section should be read in conjunction with the Trust's Listening and Responding to Concerns and Complaints Policy.

The Trust is committed to responding to concerns and complaints openly, fairly and in a timely manner. Patient safety learning responses and complaints processes serve different purposes but may be undertaken alongside one another where appropriate.

Patients, families, carers and staff will be supported to contribute to learning responses and investigations where appropriate. Participation in a learning response does not affect an individual's right to raise a complaint.

Where concerns raised through a learning response indicate that a complaint may be appropriate, information and support will be provided regarding available options.

Patients, families and carers can access support through the Patient Advice and Liaison Service (PALS) or the Trust Complaints Team. Staff who wish to raise concerns regarding patient safety may utilise the Freedom to Speak Up process.

3.6.1 Patient Advice and Liaison Service (PALS)

Patients, carers and families may seek advice, information or support from the Patient Advice and Liaison Service (PALS). PALS can provide:

- advice and information about Trust services
- support with concerns and informal complaints
- help to resolve issues locally where appropriate
- information about making a formal complaint
- signposting to additional support services

Patient advice and liaison service (PALS) at:

- Phone: 800 015 4334
- Email: rdash.pals@nhs.net

3.6.2 Formal Complaints

Where individuals wish to make a formal complaint, information regarding the Trust's complaints process will be provided. Staff should ensure that complainants are directed to the appropriate service and supported to access information about the process.

During normal office hours, Monday to Friday (excluding public bank holidays) at:

- Phone: 07967 793306
- Email: rdash.complaints@nhs.net

3.6.3 Staff Concerns

Staff who have concerns regarding patient safety, organisational responses or learning processes are encouraged to raise these through local management arrangements where appropriate. Independent support is also available through the trust's Freedom to Speak Up arrangements.

The trust values feedback from patients, families, carers and staff and will use concerns, complaints and compliments as important sources of organisational learning to improve the quality and safety of care.

Freedom to speak up guardian at:

- Phone: 07836 680975
- Email: rdash.fts@nhs.net

4. Responsibilities

The Trust is committed to maintaining effective governance arrangements that support learning, improvement and patient safety. Clear lines of accountability are required to ensure patient safety incidents are reported, reviewed appropriately, learned from and translated into meaningful improvements in care.

The Trust will work collaboratively with NHS providers, Integrated Care Boards (ICBs), regulators and other partner organisations to support the effective implementation of PSIRF and promote system-wide learning.

The Board remains ultimately accountable for ensuring that appropriate systems are in place to support the reporting, review, investigation and learning from patient safety incidents.

The Executive Director of Nursing and Facilities (Chief Nurse) is the Executive Lead for PSIRF and is supported by the Executive Medical Director as Executive Lead for Learning from Deaths arrangements.

4.1 All staff

All staff have a responsibility to contribute to the delivery of safe care and to report patient safety incidents, near misses and safety concerns promptly.

Staff are expected to participate openly and constructively in patient safety learning responses and support the implementation of improvements arising from learning.

4.2 Managers

Managers are responsible for ensuring patient safety incidents are reported, reviewed and managed appropriately within their areas of responsibility and that staff receive appropriate support following incidents.

Managers must promote a learning culture and ensure that learning and improvement actions are implemented and monitored within their services.

4.3 Patient safety incident investigators

Patient Safety Incident Investigators are responsible for undertaking objective, systems-based investigations in accordance with agreed terms of reference and applicable national standards.

4.4 Patient safety, carer and communities team

The Patient Safety, Carer and Communities Team is responsible for:

- maintaining this policy and the Patient Safety Incident Response Plan
- supporting incident reporting, investigation and learning processes
- providing training, advice and guidance
- maintaining incident management systems
- monitoring implementation of safety actions and improvement plans
- undertaking quality assurance of learning responses
- producing patient safety reports for governance committees and groups

4.5 Specialist advisors

Specialist advisors provide expert advice and support in relation to patient safety incidents, investigations and improvement activity. This may include patient safety specialists, medicines safety leads, health and safety professionals, safeguarding specialists, infection prevention and control staff, information governance staff and other subject matter experts.

4.6 Accountable officer for controlled drugs

The Accountable Officer for Controlled Drugs is responsible for sharing information through local intelligence networks regarding controlled drug incidents, diversion concerns and associated patient safety risks in accordance with statutory requirements.

4.7 Care group directors of nursing and associate medical directors

Care Group Directors of Nursing and Associate Medical Directors are responsible for ensuring that:

- incidents are reported, reviewed and managed appropriately
- staff understand their responsibilities under this policy
- learning is shared within services and care groups
- identified risks are managed through the Trust risk management framework
- staff, patients and families receive appropriate support and communication

- Duty of Candour requirements are fulfilled
- staff receive appropriate training and development

4.8 Director of people and organisational development

The Director of Human Resources is responsible for ensuring staff wellbeing, occupational health and other support services are available to staff affected by patient safety incidents.

4.9 Mortality surveillance group

The Mortality Surveillance Group provides oversight of deaths reported through Trust systems and ensures learning arising from mortality reviews and structured judgement reviews is appropriately shared and acted upon in accordance with the Learning from Deaths Policy.

4.10 Learning from patient safety events group and patient safety operational group

The Learning from Patient Safety Events (LFPSE) Group is responsible for:

- reviewing significant patient safety incidents
- determining proportionate learning responses
- commissioning Patient Safety Incident Investigations where required
- overseeing the quality of learning responses

The Patient Safety Operational Group (PSOG) is responsible for:

- overseeing implementation of PSIRF across the Trust
- monitoring incident reporting arrangements
- ensuring learning is shared across services
- overseeing implementation of safety actions and improvement plans
- providing assurance regarding organisational learning and improvement

4.11 Quality and safety group

The Quality and Safety Group is responsible for:

- overseeing patient safety governance arrangements
- receiving assurance regarding the effectiveness of patient safety systems
- monitoring implementation of safety actions and improvement plans
- escalating concerns where appropriate

4.12 Chief nursing officer and chief medical officer

The Chief Nurse holds executive responsibility for the implementation of PSIRF, the Patient Safety Incident Response Policy and the Patient Safety Incident Response Plan.

The Executive Medical Director is responsible for executive oversight of Learning from Deaths arrangements and supports the Chief Nurse in ensuring effective patient safety governance.

5. Training

The Trust is committed to ensuring that staff have the knowledge and skills required to undertake their roles in relation to patient safety and PSIRF.

Training requirements will be determined according to role and responsibilities and will align with national patient safety education frameworks.

As a minimum, the Trust will ensure:

- all staff complete Patient Safety Essentials training as part of mandatory training requirements
- Board members and senior leaders complete training appropriate to their governance responsibilities
- staff involved in learning responses receive appropriate systems-based learning response training
- patient safety investigators complete recognised training in patient safety investigation methodologies

The Patient Safety, Carer and Communities Team will maintain guidance, resources and tools to support learning responses and investigations.

6. Monitoring Arrangements

The Learning from Patient Safety Events Group provides operational oversight of patient safety incident response arrangements across the Trust.

Monitoring arrangements are designed to provide assurance that:

- incidents are reported appropriately;
- learning responses are proportionate and completed to an appropriate standard;
- safety actions are implemented and monitored;
- learning is shared across services; and
- the Trust remains compliant with the principles and requirements of PSIRF.

Information relating to patient safety incidents, learning responses, safety actions and emerging themes will be reported through the Trust's governance framework to support organisational oversight and continuous improvement.

Governance and reporting arrangements are summarised within the flowchart contained within the appendices to this policy.

7. Related documents and references

- Patient Safety Incident Response Plan
- Freedom to Speak Up Policy
- Being Open Policy
- Learning from Deaths policy
- Listening and Responding to Concerns and Complaints Policy
- Risk management Policy

- Allegations against a person in position of trust policy
- Safeguarding adults policy
- Safeguarding children's policy

8. Appendices

8.1 Appendix 1 Patient safety incident response plan

The Patient Safety Incident Response Framework (PSIRF) is not an investigation framework: it does not require investigation as the sole approach to learning from patient safety event, nor does it prescribe which incident or event must be investigated. Instead, it sets out a systematic approach for developing and maintaining an effective patient safety incident response system. This system is underpinned by four core aims:

1. promoting compassionate engagement and meaningful involvement of those affected by patient safety events.
2. the application of a range of system-based approaches to learning from patient safety events.
3. considered and proportionate responses to patient safety events.
4. embedding a culture of continuous learning and improvement, and includes supportive oversight that strengthens our investigative and learning responses

This patient safety incident response approach sets out how Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) intends to respond to patient safety incidents over a period of 12 to 18 months. The approach will identify the priority focus areas, outline how this will develop a deeper understanding of underlying system issues and explain how this learning will be used to drive sustainable improvements in patient safety.

The approach is not a permanent rule that cannot be changed. It will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The whole plan will be reviewed every 12 months to ensure the work streams fully reflect the patient safety issues with the greatest potential for learning and improvement.

8.1.1 Our services

We operate services in more than 100 locations across Rotherham, Doncaster and North Lincolnshire. We employ over 3,700 staff and have more than 350 volunteers.

RDaSH is registered with the Care Quality Commission to provide the following services to our communities:

- adult mental health services
- older people's mental health services
- NHS Talking Therapies
- drug and alcohol services for adults (Doncaster)
- forensic services (Doncaster)

- adult physical health community services
- St Johns Hospice
- learning disability services
- children and young people's mental health services
- children and young people and families

More information about our trust and the services we provide can be found on our trust website service page.

8.1.2 Defining our patient safety incident profile

To define our profile, an evidence base that shows where our patient safety risks and harms were concentrated was required. To achieve this, we gathered the relevant intelligence from our key stakeholders (patients, carers and staff). The stakeholders involved identified, analysed, and subsequently defined our patient safety profile through:

- incidents reported
- complaints
- PALS feedback
- serious incidents and patient safety incident investigations
- safeguarding data
- medicines Management data
- freedom to speak up reports
- human resources
- clinical negligence claims
- inquests
- care group service improvement plan and risk registers
- key themes identified from the Quality Committee and supporting subgroups.
- data from quality surveillance processes: falls, tissue viability and mortality
- The trust's Clinical and Organisational Strategy 2023-2028 and 28 promises
- half day learning sessions on PSIRF
- PiPoT data

We put this data together and looked for the greatest opportunities for learning. We used this along with the national guidance to develop our patient safety priorities.

The trust's patient safety incident profile was further developed through review and analysis of the following organisational data:

incidents reported 2021 to 2022, 2022 to 2023 and 2022 to 2023

- complaints
- PALS
- serious incidents
- freedom to speak up reports
- human resources
- clinical negligence claims
- inquests
- key themes identified from the quality and safety group and supporting subgroups
- data from quality surveillance processes:

- falls
- tissue viability
- mortality

The trusts PIRSP includes the patient safety incidents identified through analysis of the organisational data that present the greatest opportunities for learning and subsequently improving the safety and quality of care our patients receive.

The trust has used the criteria below when defining our patient safety incident responses:

potential for significant harm or of significant psychological harm to patients

- potential for significant harm or of significant psychological harm to staff
- potential loss of trust in RDaSH services
- impact on quality and delivery of RDaSH services
- likelihood of occurrence including persistency of the risk, frequency and potential to escalate.

8.1.2.1 Patient safety priorities

- Claims.
- Complaints.
- Serious incident investigations.
- Incidents.
- Freedom to speak up.

8.1.3 Our patient safety incident response plan, national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. The table 1 sets out the local or national mandated requirements that are applicable to RDASH and the patient safety response that will be undertaken in these circumstances.

The Trust will respond to recommendations and safety actions from the learning responses identified below, both internal and from external agencies or organisations as required and feed safety actions into the trust quality improvement processes.

8.1.4 Our patient safety incident response plan, national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. The table 1 sets out the local or national mandated requirements that are applicable to RDASH and the patient safety response that will be undertaken in these circumstances.

The Trust will respond to recommendations and safety actions from the learning responses identified below, both internal and from external agencies or organisations as required and feed safety actions into the trust quality improvement processes.

8.1.4.1 Table 1 National requirements for patient safety incident response

Some events in healthcare require a specific type of response, as set out in national policies and regulations. These responses may include review by, or referral to,

another body or specialist team depending on the nature and circumstances of the event.

National priority patient safety incident types	Required response
Incidents meeting the never events criteria 2018, or its replacement	PSII locally led by RDASH Patient Safety, Carer and Communities team
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	PSII locally led by RDASH Patient Safety, Carer and Communities team
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	PSII locally led by Patient Safety, Carer and Communities team
Mental health-related homicides	Referral to the NHS England Regional Independent Investigation team (RIIT) for consideration of an independent PSII. Locally-led PSII may be required
Deaths under the state or in custody (for Example, police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the prison and probation ombudsman (PPO) or the independent office for policeconduct (IOPC) to carry out the relevant investigations healthcare organisations must fully support these investigations where required to do so
Deaths of persons with learning disabilities	Learning disability mortality structure judgement review in line with RDaSH learning from deaths policy. People with a learning disability and autistic people (LeDeR) referral process
Child death	Child death overview process locally-led PSII (or other response) may be required alongside the panel review, organisations should liaise with the panel
Domestic Homicide (DH)	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic abuse related death review (DARDR) are met, it uses local contacts and requests the establishment of a DARDR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DARDRs

National priority patient safety incident types

Required response

Safeguarding incidents in which babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse or violence. Adults (over 18 years old) are in receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse or violence

To be referred to RDASH Safeguarding team. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards

8.1.5 Locally agreed patient safety event priorities and learning responses

In line with our strategic objectives as a trust, we want to understand and resolve the issues which result in delay. This links to objective 3 and promise 14 of our clinical and organisational strategy.

Waiting for care to start can add additional stress and deterioration in health for people. Delays can cause difficulties in the wider care system and result in people not receiving the right care at the right time in the right place. To guide our understanding and our improvement work in this area, where we don't already understand the contributing factors, we will respond to the following patient safety incidents with a PSII:

- suspected suicide of a person waiting for an assessment longer than planned
- community Suspected Suicide where there have been three failed contacts with services
- incident involving a patient who has been identified as requiring a mental health admission and is awaiting a bed. Where the incident is likely directly linked to the mental health problem.

8.1.6 Inpatient services and alternatives to hospital admission

Our inpatient services are a critical but limited resource. Inpatient admissions and alternatives to inpatient services are used to support people when they are experiencing some of their most difficult times. We recognise there is pressure to move people through the service, due to the limited resources and high demand. It is imperative that we are providing evidence based safe and therapeutic care.

This is particularly important at points of transfer and discharge. Unsafe discharges potentially lead to poorer outcomes for people using our service and discharged patients are 32 times more likely than the general population to die by suicide.

To guide our understanding and our improvement work in this area, where we don't already understand the contributory factors involved, we will respond to the following patient safety incidents with a PSII:

- suspected suicide of an inpatient, including if the person is on leave

- suspected suicide of patient under the crisis home treatment and liaison service

This will include people who have been discharged from an inpatient or alternative to admission, within 30 days.

We will continue to be flexible and proportionate where required to find the most suitable learning response. To assist in discussions around choosing the most appropriate learning response, we have developed a 'PSIRF Policy Summary and Decision Guide' – please see Annex 1.

Where incidents involve care given by several agencies or trusts, and where system partners agree this is most appropriate, RDaSH will work collaboratively and undertake joint learning responses. Each party will follow their own sign off processes in the production of a single learning response and will work together with service users, their carers, families and advocates in a compassionate, engaging and joined up way.

8.1.7 Our approach to compassionate and meaningful engagement with patients and their families.

We always want to be open and honest with the people who use our service, their families and carers, if something in our care has not gone the way we had planned it to. As a trust we strive to be compassionate in the way that we engage with people, particularly if something has gone wrong. It is important that we always tell the people affected and say sorry where needed, if something has not gone as planned. If there has been a problem in care where we have made a mistake, it is especially important that we say sorry and that we engage with the people affected. If someone has been significantly harmed or there was a potential that they could have been, then we have a legal duty to be open and honest with patients. This is called duty of candour.

8.1.8 Our approach to compassionate engagement with our staff – 'Restorative Just Culture'.

We recognise that our work is complex and that there is inherent risk in everything we do. Sometimes things go wrong.

'A 'Restorative Just Culture' considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. Generally, in a Restorative Just Culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a Restorative Just Culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts '.

We aim to achieve a culture where the people doing the work feel able to talk freely about what happened without fear. This goes beyond "incidents" and is about our day-to-day work. Those closest to the work are uniquely placed to provide knowledge and information about the challenges of providing the care we aspire to. If

we develop a restorative just culture in which our workforce understands that they will be treated fairly and supported when things go wrong, this will help to strengthen psychological safety across our organisation. In turn, this will encourage open reporting of patient safety incident and concerns and supports the development of a strong learning culture. This approach echoes the ethos of PSIRF.

RDaSH aims to ensure everyone working within the trust feels safe and confident to speak up. We encourage our leaders to take the opportunity to learn and improve from those who speak up.

We want everyone working in the trust to feel safe and confident to speak up and all leaders to welcome this opportunity to learn and improve.

To support developing a 'Restorative Just Culture', RDaSH has invested in specific 'Restorative Just Culture' training for managers, clinical leaders, safety experts, staff side agencies and workforce support teams. This training was facilitated by Mersey Care, who are acknowledged as national experts in this field.

As a Trust we also have an active Freedom to Speak Up Guardian and champions service, who all work together in support of 'restorative just culture' principles. Please refer to our Trust Freedom To Speak Up processes in relation to this service:

<https://intranet.rdash.nhs.uk/wp-content/uploads/2024/05/FTSU-national-insert-Policy.pdf>

8.1.9 Recording and reporting incidents and learning

The recording of patient safety events is vital in supporting patient safety by providing opportunities for learning and improvement. Where we have a strong culture of reporting this underpins our ability to learn and make improvements.

From May 2025, RDaSH embedded a new electronic system (RADAR), designed to support healthcare organisations create a safer patient experience, through:

- timely reporting of incidents and complaints
- tracking progress of investigation
- consolidate learning response data and analysis of this data to create information
- highlighting trends and key areas for improvement
- enabling learning in how to prevent incidents and improve future outcomes through continuous improvements

8.1.10 Incident Response

There are a variety of approaches suggested for how we can learn from when patient safety incidents occur, RDASH intends to use all the available tools, and choose the most appropriate one for the incident concerned.

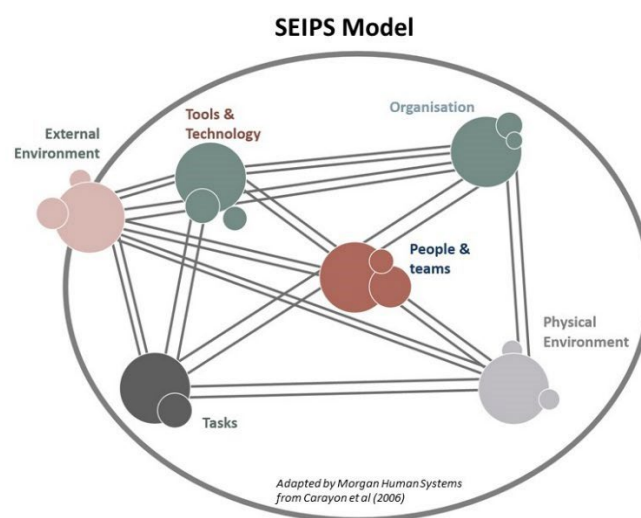
- **Swarm Huddle:** this learning response pulls everyone together quickly to support and identify any immediate learning. A is a good response when the incident is localised and the learning best drawn out by meeting with those immediately involved with the events. The SEIPS methodology must be used to review the events and describe the systemic factors at play.

- **After Action Review (AAR):** a structured gathering of those involved in the incident together in a safe space to look at what happened, what should have happened, why there may have been a difference, and is there any learning. This should be carried out soon after the event and have the right people there to ensure the right people are involved in this wider meeting
- **MDT review (including thematic analysis):** a structured gathering with input from different disciplines, a similar process to that of a Swarm, however thoroughness is prioritised over speed. It may take some time to get everyone needed round the table, however in doing so a deeper dive into the system can be achieved. Useful where there are several teams involved or different agencies.
Analysing a patient safety theme or perceived pattern to identify issues and learning from multiple patient safety incidents. A few learning responses can be used to try to spot themes and trends.
- **PSII:** a full review. This is reserved for topics which are a priority as identified in the PSIRP. A national template must be used and the PSII must be undertaken by a person with the relevant level of PSIRF training. The SEIPS methodology is utilised to assist describing the system of work.
- **Service to Service:** a structured review process undertaken collaboratively between two or more services, teams, or organisations where an incident highlights interface issues, pathway gaps, or system-wide learning. This approach focuses on shared learning, coordination, and improvement across service boundaries.

8.1.11 Systems Engineering Initiative for Patient Safety (SEIPS)

Traditionally serious incident investigation and root cause analysis has focused on the actions or inactions of individuals. Whilst other elements of system learning may have been included, it has not been a central part of the approach.

To ensure that our learning is systems based under PSIRF, the trust will ensure that the SEIPS model is used, to help us make sense and describe our system of work. Using this model will ensure that all the system elements are considered within the learning responses and how they interact mapped out as the below diagram shows.



8.1.12 Learning from prevention of future deaths

If someone who is using our services dies, there are reliable processes in place to review our care and treatment for that person. Nationally this work is called learning from deaths in the NHS.

All deaths in England and Wales not investigated by a coroner must be independently reviewed by a senior medical doctor undertaking the role of medical examiner. They provide an independent scrutiny of what caused the death of the deceased and decide if the person's care before they died was appropriate. They will also decide if the coroner needs to be notified of the death. Often this will be the end of the process but if as part of this review we identify that the deceased person had a diagnosis of psychosis or an eating disorder at the time of their death, then we will do a more in-depth review. This is called a structured judgement review and involves a senior clinician reviewing the clinical records of the deceased person. The senior clinician will make judgements on the quality of the care and give appropriate feedback to services, which allows them to make improvements where required.

If a significant problem in someone's care is identified, then further learning will take place to understand the issues more fully. If the problems identified are thought to have contributed to the person's death, then a PSII will be completed.

8.1.13 Timeframes for investigations

We aim to engage with those affected by incidents at the earliest opportunity, in order to discuss and agree how long our investigation will take. In all cases investigations should be completed within 50 working days.

8.1.14 Core Governance

The trust has a process in place where incidents are reviewed with the Patient Safety, Carer and Communities Team, to ensure that there is oversight with the opportunity to escalate where required, and monitoring to ensure learning responses are being completed (see Appendix 2 and 3) There are patient safety huddles once per week where care services can raise issues with learning responses and seek guidance and assistance.

The main group to oversee patient safety at an operational level within the organisation is the Patient Safety Operational Group (PSOG), which meets monthly. This is both an oversight and learning group, which receives escalations from care groups and connects ward to board from a patient safety perspective. The learning from each care group's learning responses will be presented at PSOG. A subgroup of PSOG, is the learning from patient safety events (LFPSE) group. This group meets on a bi-weekly basis to review incidents of concern in a structured and systematic way. Its purpose is to ensure that incidents are appropriately analysed, that any immediate risks are identified and addressed, and learning is extracted from events to prevent reoccurrence. The group agrees a proportionate learning response for each incident, which may include local actions, wider dissemination of learning, changes to policy or practice, and escalation where necessary. This process supports continuous improvement in patient safety and helps in strengthening the organisational learning across all services. The group will refer to appendix two and

three to guide their decisions around proportionate learning responses, but the group has authority to indicate a learning response different from those suggested within the appendices if there is sufficient rationale. Any issues with learning responses, or significant exceptions to the expected learning responses will also be raised and monitored through LFPSE and PSOG.

There will be an out brief from each PSOG meeting to the quality and safety group to ensure oversight, governance, and shared organisational learning, this will be presented in the patient safety report that is sent to the Board Quality Committee bimonthly.

To Note:

*All Terms of Reference for a PSII are signed off by either the Chief Medical Officer or Executive Director of Nursing and Facilities (Chief Nurse) without exception.

**There is a specific requirement in terms of medical training, medical involvement, reporting and escalation, this process at RDaSH can be found in Appendix 5.

8.2 Appendix 2 Suggested learning responses – Death

Escalate to PSII where there is complexity or significant concern.

Use AAR for most learning where issues are understood.

Suggested learning response: Death (any complicating factors may increase the type of response needed, therefore this should be considered as a minimum)

Suggested responses generated through PSIRF decision-making frameworks do not replace professional judgement. Senior clinical judgement may override a suggested investigative response where clinically appropriate. Any such decision will be proportionate, clearly justified, and recorded in line with PSIRF governance requirements.

Mortality processes (apply to all deaths)

- Medical Examiner review
- Mortality review Group (MOG)

In addition, there are External Processes that need to be considered such as:

- coroner and or police
- CQC
- NHS England and or ICB
- LeDeR
- safeguarding

However, these processes run alongside and do not delay our PSIRF responses.

SWARM	After Action Review (AAR)	Multidisciplinary team (MDT) Review	PSII - internal	PSII - external
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Incident type	Area (typical – not restricted to)	PSII						Agencies to brief
		SWARM	AAR	MDT Review	Internal	External		
Expected Death in expected time (only where the local team feel there is a learning opportunity)	Community or inpatient	X						
Expected death with unexpected factors	Community or inpatient	X	X				If Inpatient – CQC	
Stillbirth or pregnancy loss	Community or inpatient	X			X if case meets national criteria or complex care issues.	X if case meets national criteria or complex care issues		
Death of a person with LD	Community or inpatient				X	x	LeDeR	
Unexpected death of a Child in community	Community				X		Safeguarding	
Death with drug and alcohol comorbidity	Community or Inpatient		x		X If care contributed or complexity identified	X If care contributed or complexity identified	If Inpatient – CQC	
Suspected Suicide	Community or Inpatient	X (For community suspected suicide: if system factors are not well understood then any of these responses would be appropriate)			X (if it is death of an inpatient or 3+ failed contacts with services)		If Inpatient – CQC and ICB	
Unexpected Inpatient Death	All RDaSH inpatient areas				X		CQC, ICB	
Unexpected community Death	Community		Either a SWARM or MDT X proceed to PSII if concerns are raised.					
Inpatient Homicide	Inpatient setting					X		
Community Homicide	Community service				X			
Death related to medication error	Community or Inpatient				X			

8.2.1 Suggested Learning Response Framework – Other considerations

This appendix outlines the organisation's Suggested Learning Response Framework aligned to PSIRF.

It provides guidance on the minimum expected learning response based on incident type, harm severity, and contextual factors.

Suggested responses do not replace professional judgement. Any deviation must be proportionate, justified, and documented.

8.2.1.1 The following learning responses may be applied:

- SWARM
- After Action Review (AAR)
- Multidisciplinary Team (MDT) Review
- Patient Safety Incident Investigation (PSII) – Internal
- Patient Safety Incident Investigation (PSII) – External.

8.2.1.2 Incident Categories, Harm Severity and Suggested Learning Response

Inappropriate Behaviour: Sexual Safety, incidents should be managed as follows:

- Low Severity
 - Verbal inappropriate behaviour; harassment
 - Suggested Learning Response:
- Moderate Severity
 - Sexual threats or unwanted touching
 - Suggested Learning Response: AAR or MDT Review
- Moderate to High Severity
 - Sexual assault; persistent harassment
 - Suggested Learning Response: MDT Review or PSII (Internal)
- High Severity
 - Rape; persistent threat
 - Suggested Learning Response: PSII (Internal or External depending on complexity)
- Severe and or Complex
 - Exposure, stalking, ongoing threatening behaviours
 - Suggested Learning Response: PSII (External likely required)

Police involvement, RIDDOR reporting, and POD team escalation must be considered for all high severity incidents.

Violence and Aggression: incidents should be managed as follows:

- Low Severity
 - Verbal aggression; harassment
 - Suggested Learning Response: SWARM
- Moderate Severity
 - Physical assault with minimal injury
 - Suggested Learning Response: AAR
- Moderate to High Severity
 - Assault requiring hospital treatment (non-permanent harm)

- Suggested Learning Response: MDT Review or PSII (Internal)
- High Severity
 - Attempted homicide or permanent injury
 - Suggested Learning Response: PSII (Internal or External)

Criminal investigation, RIDDOR reporting, and Health and Safety involvement must be undertaken where applicable.

Other Inappropriate Behaviours: incidents should be managed as follows:

- Low Severity
 - Discriminatory language or racism
 - Suggested Learning Response: SWARM or AAR
- Moderate Severity
 - Vandalism or damage to equipment
 - Suggested Learning Response: AAR or MDT Review
- High Severity
 - Significant property damage
 - Suggested Learning Response: MDT Review or PSII.

Police and Health and Safety involvement should be considered for high severity incidents.

Prescribing Incidents: incidents should be managed as follows:

- Low Severity
 - Recording error
 - Suggested Learning Response: SWARM
- Moderate Severity
 - Dose error with minimal side effects
 - Suggested Learning Response: AAR
- Moderate to High Severity
 - Dose error requiring treatment
 - Suggested Learning Response: MDT Review
- High Severity
 - Severe or permanent harm
 - Suggested Learning Response: PSII (Internal or External depending on severity and complexity)

All relevant incidents must be reported via the MHRA Yellow Card Scheme.

Medication Administration: incidents should be managed as follows:

- Low Severity
 - Wrong time or administration without valid prescription
 - Suggested Learning Response: SWARM
- Moderate Severity
 - Wrong patient, low harm
 - Suggested Learning Response: AAR
- Moderate to High Severity
 - Wrong patient, moderate harm
 - Suggested Learning Response: MDT Review

- High Severity
 - Severe or permanent harm
 - Suggested Learning Response: PSII (Internal or External)

Trust-specific processes must be followed for insulin-related errors.

Other Medication-Related Incidents: incidents should be managed as follows:

- Medication Theft
 - Suggested Learning Response: AAR or MDT Review (PSII if systemic issues identified)
- Needlestick Injury
 - Suggested Learning Response: SWARM or AAR (escalate depending on harm severity)
- Adverse Drug Reaction
 - Suggested Learning Response: AAR or MDT Review
- Overdose or Non-Prescribed Medication Use
 - Suggested Learning Response: MDT Review or PSII (dependent on severity and intent)
- Inability to Access Medication
 - Suggested Learning Response: AAR or MDT Review

Reporting to the MHRA Yellow Card Scheme is required where appropriate.

8.2.2 Additional Considerations

Inpatient Self-Harm: suggested responses:

- Low harm, appropriately managed
 - SWARM or AAR
- Increased severity, recurrence, or complexity
 - MDT Review or PSII

Escalation should consider:

- severity
- recurrence
- complexity of need
- adequacy of risk management systems

Inpatient substance misuse: suggested responses:

- Low harm, appropriately managed
 - SWARM or AAR
- Increased severity, recurrence, or complexity
 - MDT Review or PSII

Escalation should consider:

- severity
- recurrence
- complexity of need
- adequacy of risk management systems

8.2.4 Escalation Principles

Escalation to MDT Review or PSII should occur where:

- harm severity increases
- incidents are repeated
- there is increased complexity
- there is uncertainty regarding system effectiveness
- known risks are not being adequately managed

8.2.5 Governance and Documentation

All decisions must:

- be clearly documented
- include rationale for the selected learning response
- demonstrate application of PSIRF principles
- be proportionate and defensible.

8.2.6 Suggested Learning Response Framework

Suggested responses generated through PSIRF decision-making frameworks do not replace professional judgement. Senior clinical judgement may override a suggested investigative response where clinically appropriate. Any such decision will be proportionate, clearly justified, and recorded in line with PSIRF governance requirements.

SWARM	After Action Review (AAR)	Multidisciplinary team (MDT) Review	PSII - internal	PSII - external
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		Physical Harm (examples)			Psychological Harm (examples)			Comments and persons involved
Inappropriate Behaviour								
Sexual Safety	Verbal	Sexual threat and Touch	Sexual Assault	Rape	Harassment	Threat and behaviours such as exposure	Persistent Threat	Criminal Investigation, RIDDOR, POD Team
Violence and Aggression	Verbal	Physical assault with minimal injury, requiring first aid	Physical Assault requiring hospital treatment. Injury is non-permanent	Attempted homicide or injury resulting in permanent damage or injury	Harassment	Threat of harm	Persistent Threat accompanied with behaviours such as stalking or following	Criminal Investigation, RIDDOR, Health and Safety Team
Other inappropriate behaviours	Discriminatory Language or Racism	Vandalising, Throwing and or damaging equipment	Significant damage to personal or Trust property					Police contact, Health and Safety Team involvement
Prescribing	Recording error	Dose error (form, dose, rate, timing) too low or high, minimal side effect	Dose error – moderate side effects experienced requiring treatment	Dose error – severe side effects or permanent	Side effects			Reporting via the 'Yellow Card' BNF or NICE scheme – includes VAPE
Administration	Wrong time administered or medication given without current prescription	Drug administered to wrong patient – low harm	Drug administered to wrong patient – moderate harm	Dose error – severe side effects or permanent				Please note specific trust process for reporting insulin errors
Other medication	Medication theft (including police report)	Needlestick (injury may vary)	Adverse drug reactions	Overdose or nonprescribed medication	Unable to gain medication			MHRA Reporting “Yellow Card”

Other factors to consider								
Where an inpatient involves self-harm	Where harm is low and managed.		Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty about the adequacy of system responses to known risks."	Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty		Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty	Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty about the adequacy of system responses to known risks."	
Where an inpatient involved substance misuse	Where harm is low and managed.		Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty	Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty		Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty	Escalation to MDT review or PSII will depend on the severity of harm, recurrence, complexity of need, and the extent to which there is uncertainty	
Missing Person								
Patient (informal)	Leave ward without discussion	Leave ward, resulting in self-injury						Family or significant other notification
Patient (detained)	Returned – had leave but the leave breached the prescribed S17 time	Absconding from inpatient ward – may be connected to any of these harm categories and MDT review should follow including family						Mental Health Act reporting and family notification
Staff	Not returned at time agreed from visit							Counter fraud may be a consideration

		Physical Harm (examples)			Psychological Harm (examples)			Comments and persons involved
Patient Care and Treatment								
Pressure Sore	Risk identified without the ability to adhere to safety advice	Reddening to the skin, physical assessment and mobility assessment		(Grade 3+) - Moderate to severe (AAR or SWARM)	There may be a number of psychological side effects related to a pressure sore (i.e. social isolation, embarrassment related to odour); these should be assessed on an individual basis.			
Falls (inpatient only)	Slip or trip with no injury	Slip or trip with mild harm	Slips, trips or falls resulting in moderate or severe harm	Slips, trips or falls resulting in death	There may be several psychological side effects related to a fall; (i.e. shame, PTSD) these should be assessed on an individual basis.			NAIF report if an inpatient
VTE	Assessment identifies issues but no physical need	Assessment identifies issues, but physical complications seen due to lack of adherence to guidance re proactive intervention, may fall into any of these harm categories. Also, may be suitable for AAR, MDT Review or SWARM dependant on level of harm and context.						Consider specific VTE policy and assessment requirements
Other Examples								
Data Breach	Information governance will advice upon the questions in SWARM				There may be a number of psychological side effects related to a data breach (i.e. fear of sensitive information been known; safeguarding issues etc); these should be assessed on an individual basis.			Data Protection; Information Commissioner
Mental Health Act Breach	i.e. second opinion not completed in time frame							Mental Health Act Office, CQC in some circumstance
Infection control – hospital acquired infection or outbreak	See related policy or process within the infection control manual							Infection control team, Health and Safety. National reporting.

8.3 Appendix 3 PSII Process Flow Process

The process below provides a guided timeline for Patient Safety Incident Investigations (PSII).

Day 0 is the day the event is declared a PSII, either by the nature of the incident and being one of the trusts priorities or following review at the LFPSE group.

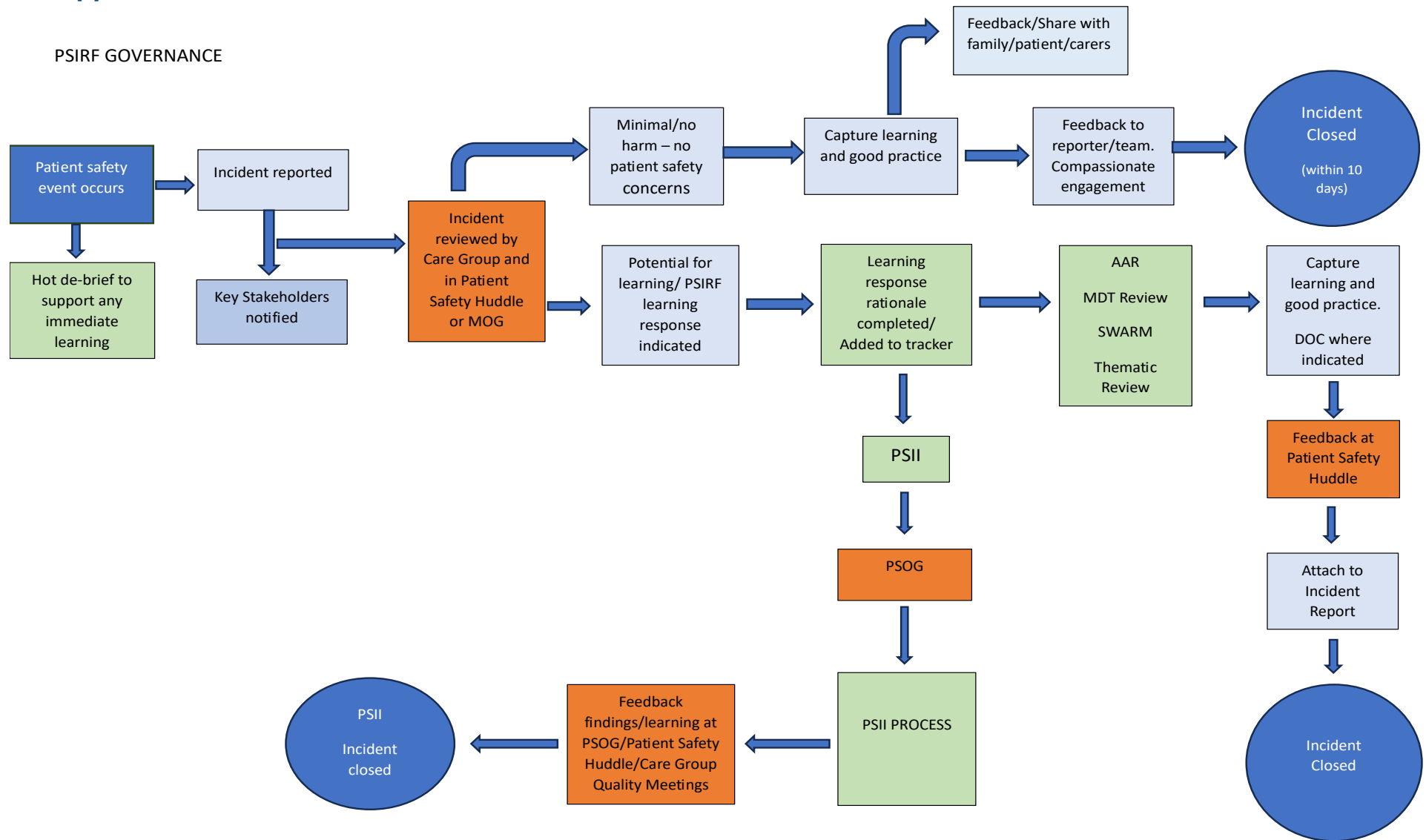
Timescales are in working days excluding weekends and public holidays.
Timescales may be broad due to the differing length of time it may take to investigate.

There may be some investigations that take longer than outlined below depending on the preferences and wishes of the family and or patient.

Investigation Timeframe	In Working Days
A PSII is indicated as meeting criteria outlined in PSIRF plan/agreed at LFPSE Panel	Day 0
The PSCCT to allocate a lead investigator	Day 0
The PSCCT notify the care group SLT This will include the identified lead investigator contact that will work with the care group.	Day 0-1
The lead investigator will contact the family/patient to introduce self and talk through the process and arrange first face to face (or preferred option) meeting to agree timescales and preferences. Share the learning together guide (Family/carers involvement will be threaded throughout the process according to their wishes and preferences)	Day 1-4
The lead investigator will scope the incident time window and review the patient record	Day 1-4
The lead investigator will hold a meeting with the care group identified team to establish terms of reference and scope of investigation. (to be determined with care group) The PSCCT will coordinate and arrange the required meetings within the PSII process at this point with relevant professionals – this to avoid any delays in meeting schedules. Key elements with application of the SEIPS methodology to review findings, key learning points and improvement planning.	Day 4-8
ToR with IR1 to be approved at LFPSE panel (but MUST also have CMO and CNO sign off).	By day 10
Establish an interview schedule for the investigation ensuring family/patient are first to be involved. Interview schedule to be shared with PSCCT lead and team.	By day 10

Investigation Timeframe	In Working Days
The Lead Investigator conducts interviews and present version 1 draft report and share with PSCCT lead. (version 1 needs to have been edited and formatted appropriately).	By day 20
The PSCCT lead will review, edit and feedback on version 1.	By day 25
The lead investigator will send version 1 draft to the clinical services involved for comment and will then work with the care group representatives and relevant clinicians/specialist services to formulate/review the key findings/learning/improvement planning. (Expected return within 5 days)	By day 30 By day 35
The lead investigator will complete draft version 2, with improvement plan and send to the PSCCT lead for sign off. (Expected return within 2 working days (as of 15.07.26) LI will need 2 working days to review feedback and make any amendments	By day 32 By day 36
The PSCCT lead will send draft version 3 to the Care Group SLT for review/sign off. (Expected return within 5 working days).	By Day 37 By Day 42
8.8888The PSCCT lead and Head of Quality and Promises to QA version 4 (Expected return within 3 working days)	By day 40 By day 45
Nominated appropriate person(s) (depending on the individual case) will meet with family/patient/carer to go through the report for further input and family/patient/sign off.	By day 45
The Deputy Director of Nursing will send draft version 5 to the Chief Nursing Officer and/or the Chief Medical Officer for Trust sign off. Any PSII of a never event is to be signed off by the CEO (Expected return within 5 working days).	By day 50 By day 55
The PSII and the learning will be presented at the PSOG meeting by the Care Group.	Next available PSOG.
The final report (ONE VERSION) will be shared with family, Care Groups (to circulate with focus on learning/improvements), Coroners (if required), MOG.	Following PSOG.
Learning Brief to be completed and shared	Following PSOG

8.4 Appendix 4 PSIRF Governance



8.5 Appendix 5 Process for identifying PGDiT involvement in significant event to PGME team



- The matrix of training posts and residents placed within RDASH will be shared with the Patient Safety, Carer and Community Team and Coroner Liaison Services. The lists will be updated whenever changes occur to ensure information is accurate.
- Actions following identifying PGDiT involvement in a significant event to ensure compliance with requirements of NHSE Y&H requirements and support for PGDiT throughout this process are set out in accompanying 'Actions on PGDiT Involvement in Significant Event' SOP.

8.5 Appendix 6 RADAR Risk rating Chart

Consequence

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Injury (Physical & Mental) to anyone	Minor injury (not requiring first aid)	Minor injury or illness (first aid treatment needed)	Reportable to external agencies/statutory bodies (e.g. RIDDOR, HSE, NPSA, Police, MHRA Contractor, CQC)	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience no injury	Unsatisfactory patient experience and or involving first aid treatment readily resolvable	Mismanagement of patient care requiring more than first aid treatment and is likely to take more than one month to recover (breach of working practices)	Serious mismanagement of patient care (major permanent harm) (breach of working practices)	Totally unsatisfactory patient care (breach of working practices)
Complaint or Claim Potential	Locally resolved complaint	Justifiable complaint peripheral to clinical care / management	Justifiable complaint involving lack of appropriate care / management. Claim below excess	Multiple justifiable complaints. Claim above excess	Multiple claims or single major claim

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Objectives or Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget or schedule slippage. Minor reduction in quality or scope	5 - 10% over budget or schedule slippage. Reduction in scope or quality requiring client approval	10 - 25% over budget or schedule slippage. Does not meet secondary objective(s)	> 25% over budget or schedule slippage. Does not meet primary objective(s)
Service or Business Interruption	Loss or interruption < 1 hour	Loss or interruption >1 hour and < 8 hours	Loss or interruption > 8 hours and < 24 hours	Loss or interruption > 24 hours and < 1 week	Loss or interruption > 1 week
Human Resources or Organisational Development	Short term low staffing level temporarily reduces service quality < 1 day	Ongoing low staffing level reduces service quality	Late delivery of key objective or service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Uncertain delivery of key objective or service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training	Non delivery of key objective or service due to lack of staff. Very high turnover. Critical error due to insufficient training
Financial	Small loss < £100	Loss > 0.1% of budget or > £100 and < £1,000	Loss > 0.25% of budget or > £1,000 and < £5,000	Loss > 0.5% of budget or > £5,000 and < £10,000	Loss > 1% of budget or > £10,000
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards. Reportable to associated external / statutory agencies	Enforcement action. Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with standards	Prosecution. Zero rating. Severely critical reports.
Adverse Publicity / Reputation	Rumours	Local Media interest (short term)	Local Media interest (long term)	National Media interest < 3 days. Local MP concern	National Media interest > 3 days. National MP concern (questions in the House)

Likelihood

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not