The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Patient Safety Incident Response Framework (PSIRF) Policy & Response Plan

Policy author	Assistant Director of Governance & Risk; Patient Safety Lead Nurse
Accountable Executive Lead	Chief Nurse; Executive Director of Governance
Approving body	Trust Board
Policy reference	POL-GOV-14

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – All Staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1 – All Staff

POLICY APPROVAL DATE:
July 2024

POLICY IMPLEMENTATION DATE:
July 2024

DATE POLICY TO BE REVIEWED:
July 2027

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1	November 2023	November 2023	November 2024	Policy implements new NHS England Patient Safety Incident Response Framework (PSIRF)
2	July 2024	July 2024	July 2027	Appendices added.

Patient Safety Incident Response Framework (PSIRF) Policy & Plan

KEY POINTS

1. PSIRF replaces the previous 'Serious Incident Framework' (2015).

2. Previous framework focused on when and how to investigate a serious incident - PSIRF focuses on **learning and improving**.

3. PSIRF is not a system upgrade or tweak. It is a whole system and cultural change to how we think about and respond to Patient Safety Incidents.

4. PSIRF is a contractual requirement under the NHS Standard Contract.

5. There are four key aims of PSIRF:

    - **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.**

6. **PSIRF Response Plan (see Appendix A) supplements the PSIRF Policy and provides the necessary detail on priority incidents and methods of investigation.**

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Patient Safety Incident Response Framework (PSIRF) Policy & Plan

APPENDICES

Patient Safety Incident Response Framework (PSIRF) Policy and Plan

1.0 INTRODUCTION

This policy, along with the accompanying response plan, supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

2.0 SCOPE

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT).

The Patient Safety Incident Response Framework (PSIRF, 2020) provides the NHS with guidance on how to respond to patient safety incidents; with no distinction between incidents and 'serious incidents' for the purpose of learning. As such, it is relevant to all bodies involved in providing; commissioning, supporting, overseeing, and regulating NHS-funded care.

Responses under this policy and the accompanying response plan follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principal aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Where there are legitimate concerns about individual and/or organisational accountability including criminal or civil proceedings, disciplinary procedures, employment law, or professional standards and organisational or professional regulators need to be involved, they must be informed, and their relevant protocols followed.

This policy applies to all permanent and temporary staff employed, or those working under contract for services or under service level agreement, within the Trust. The policy also describes the arrangements for the management of incidents where more than one provider is involved.

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

3.0 OTHER POLICIES TO WHICH THIS POLICY RELATES

This policy and the accompanying response plan relates to the following policies: -

- Duty of Candor and Being Open Policy
- Complaints and PALS Policy
- Risk Management Policy
- Performance & Capability Policy
- Disciplinary Policy
- Learning from Deaths Policy

4.0 OTHER POLICIES TO WHICH THIS POLICY SUPERCEEDS

This policy and the accompanying response plan replace the previous policies as listed below: -

- Serious Incident Reporting, Management, and Investigation Policy
- Incident Reporting & Management Policy

5.0 PRINCIPLES

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it.

Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

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

A patient safety incident or event is any unintended or unexpected incident or event which could have, or did, lead to harm for one or more patient's receiving healthcare, and can result in no harm or contribute to a fatal outcome. This policy requires all staff to take responsibility for reporting any incident or adverse event or near miss that they become aware of and review them as detailed within this policy and the accompanying plan.

The Trust acknowledges that adverse events usually reflect a breakdown in systems within the organisation and that people are trying to do their best to do their job safely and well. Experience shows that although staff actions may contribute to an adverse incident there are often underlying causes for these actions. Consequently, the Trust is committed to exploring how these system failures occurred and how they can be improved using a range of learning response tools.

The PSIRF advocates a coordinated 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.

6.0 ROLES AND RESPONSIBILITIES

Key staff and internal stakeholders/groups

All Staff

All staff are required to report and manage incidents in line with this policy. Where an incident occurs staff must take appropriate immediate remedial action at the time of an incident to prevent further harm to patients; staff; general public and Trust assets.

Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to identify, report, manage, investigate, and analyse patient safety incidents in order to learn lessons. The Chief Executive delegates responsibility to the Director of Governance.

Executive Director of Governance

The Director of Governance is responsible to the Trust Board and the Chief Executive in relation to patient safety incident management and the implementation of learning and improvement that stems from the investigation of patient safety events.

Executive Chief Nurse

The Executive Chief Nurse is responsible to the Trust Board and the Chief Executive and is the Executive Lead in relation to patient safety.

All Executive Directors

All Executive Directors have a role to encourage patient safety incident reporting, support patient safety incident responses and share lessons and themes from incidents across their areas of responsibility.

Assistant Director of Governance & Risk

The assistant Director of Governance & Risk, as well as the wider governance team, are responsible for: -

- Oversight of the development and management of the PSIRP within the Trust
- Developing strategies, designing, and implementing systems to raise awareness of and improvement of incident reporting, risk assessment, risk registers, investigation processes including training in learning response tools.
- Organisation wide trend analysis to identify cross cutting themes including the identification of health inequalities.
- Ensuring that learning from adverse events and incidents is shared across the Trust and where relevant the health system.
- Ensuring appropriate notification of incidents to relevant internal and external stakeholders, agencies, and regulatory bodies.
- Notifying the Chief Executive, Executive Directors, Non-Executive Directors and all other relevant stakeholders, of unexpected deaths or other serious incidents that may attract media attention.
- Providing appropriate advice and support to the Chief Nurse and Medical Director to enable the accurate identification, reporting and investigation of incidents.
- Ensuring an effective quality assurance process is in place to monitor the quality of investigations, associated reports, and action plans.

- Ensuring an effective tracking system is in place so that investigation and learning response data and progress against action plans can be monitored and reported on to the Trust Board and Sub Committees.
- Ensuring that evidence is collected and appropriately stored to validate the implementation of recommendations and actions arising from PSII's.
- Ensuring assurance evidence can be retrieved in a timely way when required by the Trust Board or other internal or external stakeholders, as appropriate.

Patient Safety Lead

The Trust's Patient Safety Lead is responsible for: -

- Oversight of the development and implementation of the PSIRF Plan and Policy within the Trust.
- Development and implementation of the Trust's Patient Safety Strategy and implementation of the NHS Patient Safety Strategy within the Trust.
- To ensure that the ROHNFT patient safety incident response system and investigations integrates the four key aims of PSIRF:

    1. Compassionate engagement and involvement of those effected by patient safety incidents.
    2. Application of a range of system-based approaches to learning from patient safety incidents
    3. Considered and proportionate responses to patient safety incidents and safety issues
    4. Supportive oversight focused on strengthening response system functioning and improvement.

- Oversight of quality and/or safety improvement workstreams, ensuring that these are logged appropriately and accessible to relevant staff and teams.
- Working with HR and other relevant stakeholders to ensure a just culture, systems thinking, and human factors awareness is embedded across the Trust.

Patient Safety Partner

The Patient Safety Partner (PSP) will be actively involved in the design of safer healthcare at all levels in the organisation.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

Divisional Triumvirate & Governance Team

The respective Divisional Triumvirates and the governance team are responsible within their areas and remit for: -

- Ensuring arrangements are in place at a ward or departmental level to enable appropriate and timely patient safety incident identification, reporting, management, and investigation for all areas within their responsibility.
- To inform the Governance team immediately of any serious incidents and ensure that an incident report is completed via the Trust's Local Incident Management System
- To make decisions on and undertake investigation into patient safety incidents by utilising and following the PSIRF Plan
- To produce a quality improvement plan outlining the required actions to be implemented to ensure lessons are learned.
- Sharing of any relevant patient safety incident response reports, quality improvement plans/action plans, and copies of any Duty of Candour correspondence with the patient / family.
- To feedback the outcome of patient safety incident responses to staff as appropriate.

- Governance team to provide assurance reports on patient safety incident responses to Divisional Management Board.
- Ensure that staff involved in patient safety incidents, or the management and investigation of patient safety incidents, receive appropriate support.
- Ensure that the patients, relatives or carers are informed about the incident in a timely manner in accordance with the Duty of Candour and document this discussion on the Trust's LIMS.
- To support and formally monitor, at Division meetings, progress against quality improvement plans/action plans produced as a result of patient safety incident investigations and responses.

Patient Safety Incident Investigators

Patent Safety Incident Investigators are responsible for conducting the types of patient Safety incident responses as set out in the PSIRF Plan and as decided upon by the divisional triumvirate under the governance processes outlined in this policy. They are responsible for: -

- Ensuring that they are competent to undertake the PSIIs assigned to them and if not or there is a conflict of interest, request it is reassigned.
- Developing clear terms of reference in conjunction with the Divisional Triumvirate, governance team, clinical teams, patients/relatives (those affected) and relevant Executive Directors
- Ensure that they undertake PSIIs in line with the national PSII standards.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.
- Identify those affected by patient safety incidents, both patients, families, carers and staff and support their needs, including signposting to support services and provide them with timely and accessible information and advice.
- Provide documentary evidence in support of the investigation findings and conclusions for safekeeping by the Patient Safety Team. This will include copies of evidence, statements and completed analysis tools. Following executive approval of the report, the report findings will be fed back to the Divisional Triumvirate and Governance Team.

Key Board and Committee Responsibilities

Board of Directors

The Board of Directors is responsible for ensuring that appropriate systems are in place to enable the organisation to deliver its objectives in relation to PSIRF. It delegates this responsibility to the Quality & Safety Committee.

Quality and Safety Committee

The Quality and Safety Committee is responsible for assuring the Board of Directors that:

- The Trust has a strong patient safety incident reporting culture in which patient safety incidents are promptly identified reported and investigated.
- PSIIs are being appropriately identified, managed, and investigated and any resulting actions and learning are being addressed and embedded.
- Trends in patient safety incidents are being reviewed and managed on a Trust-wide basis.
- Quality improvement and learning from patient safety incidents is being identified and implemented.
- In collaboration with the Divisions and the Governance Team, the Quality and Safety Committee will also ensure that divisions are: -
- Reporting, managing and investigating patient safety incidents in line with this policy and the accompanying plan.
- Ensuring implementation of recommendations and quality improvement plans from serious incident investigations.

They also have a role in the analysis of patient safety incident data, triangulating this information with other sources to identify trends and request assurance and improvement where required.

Executive Governance Meeting

The Executive Governance meeting is a forum for assurance and oversight as well as sign off on PSIIs and patient safety incidents and their responses that are deemed suitable for escalation to Executive Director level.

Key External Stakeholders

Birmingham and Solihull Integrated Care Board (BSOL ICB)

BSOL ICB will seek assurance on PSIIs and any other patient safety incident matters and provide scrutiny and oversight via regular monthly contracting and patient safety oversight meetings.

7.0 PROCEDURE

Our Patient Safety Culture

PSIRF heralds a significant cultural shift. Like all cultural shifts, it will not be easy and will take time. But the potential gains for patients and families, for staff and ultimately for safety are significant. There could be no bigger incentive.

At the ROHNFT, we are committed to working towards the move from a retribution approach to types of incidents, such as patient safety incidents, to establishing a just culture within the organisation. Leaders across the ROHNFT are required to proactively embrace this approach and support from staff side colleagues will be instrumental in supporting the organisation to a just culture.

The goals of a just culture include: -

- Moral engagement
- Fairness
- Reintegration of the practitioner
- Organisational Learning

Further information about the NHS Just Culture Guide can be found here: -

NHS England » A just culture guide

The PSIRF will enhance these by creating stronger links between patient safety events and learning for improvement.

Our safety culture within the ROHNFT continues to make progress: we have programmes of work in place to improve this, including: -

- A Just Culture Project Group.
- Development and implementation of safety data/dashboards.
- Human Factors and Civility and Respect Programmes.
- Focused work on Freedom to Speak Up and raising concerns.
- Leadership Development Programme.
- Equality and Diversity/Inclusion Agenda.
- Wellbeing Programme.

- Embedding of Values and Behaviours.
- Policy development and revisions
- Utilisation of resources to monitor improvement work across the organisation.
- Implementation of a lessons learned framework.

Patient Safety Partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS.

At the ROHNFT, we are excited to welcome PSPs, who will offer support alongside our people, patients, families, and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and offer great opportunities to share experiences and skills and provide an additional level of scrutiny.

This exciting new role will evolve over time with the main purpose of the role being to act as the voice for our patients and community who utilise our services, ensuring patient safety is at the forefront of all that we do.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

PSPs will be supported in their voluntary role by the Patient Safety Specialist who will provide expectations and guidance for the role. They will have regular reviews and training needs will be agreed together, based on the experience and knowledge of each partner.

The PSP role will be reviewed annually to ensure the role is aligned to the patient safety agenda as it continues to develop and expanded to ensure we are represented by the diverse communities we serve, including population groups who may sometimes experience challenges in accessing our services.

Addressing Health Inequalities

Health inequalities refers to the differences in care that people receive and the opportunities they have to lead healthy lives. Typically, in England health inequalities are often addressed across four types of factors: -

- Socio-economic factors, for example, income.
- Geography or location.
- Specific characteristics, including protected characteristics.
- Socially excluded groups, for example, people experiencing homelessness.

The PSIRF has been developed to provide a mechanism to help address inequalities in patient safety through the following:

- Its flexible approach makes it easier to address concerns specific to health inequalities, and it provides the opportunity to learn from PSIs that did not meet the definition of a ‘serious incident’.
- It prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans, and in the learning response process it describes.
- It gives guidance on engaging those with diverse needs.
- The framework endorses a system-based approach (instead of a ‘person focused’ approach).

This will support the development of a just culture and aims to reduce gaps in rates of disciplinary action between ethnic groups across the NHS workforce.

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way. The Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. This data can be captured via our Electronic Patient Records (EPR) and Ulysses incident reporting system.

In our response toolkit, we will directly address any features of an event which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to any population group, including all protected characteristics.

When constructing safety improvement actions in our patient safety learning responses we will consider inequalities. We will look to address health inequalities as part of our safety improvement work. In establishing our future policy and plan we will work to identify variations of inequality by using our population and patient safety data to ensure it is considered as part of the development process for the future.

Engagement of those involved (patients, families/carers, and our people) following a patient safety event, is crucial to our patient safety learning responses. We will ensure that we use available tools to include easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.

Information resources produced by the ROHNFT can be made available in alternative formats, such as easy read or large print and may be available in alternatives languages upon request. These requests can be made to our internal communications team.

ROHNFT endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our people, our patients, carers, and families.

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place.

It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The term engagement describes everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process. Organisations will need to provide this information to those affected. Any information should ideally contain:-

1. What a patient safety incident is.
2. What a learning response is, and what the different types of response are.
3. Definitions of key words and phrases.
4. Ways to involve those affected, and how they can prepare for this involvement.
5. Support resources (local and national).

Correspondence or information should be made available in both digital and physical formats, recognising that not everyone will have access to an electronic device. Special attention should be paid to how the information is presented, its tone, the reading age it is pitched at, its understandability by those whose first language is not English.

Patient Safety Incident Response Planning

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

The ROHNFT will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To fulfil this, we will proactively undertake planning of our current resources for patient safety learning responses and our existing safety improvement workstreams. Our Patient Safety Incident Response Plan (PSIRP) will detail how this will be achieved, alongside how we intend to meet both the National requirements and our ROHNFT local priorities for patient safety incident responses.

Resources and Training to Support Patient Safety Incident Response.

Training requirements for those involved in producing Patient Safety Incident Responses PSIRF oversight: -

Topic	Minimum duration	Content
Systems approach to learning from patient safety Incidents	2 days or 12 hours	● Introduction to complex systems, systems thinking and human factors ● Learning response methods: including interviewing, and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews ● Safety action development, measurement, and monitoring
Involving those affected by patient safety incidents in the learning process	1 day or 6 hours	● Duty of Candour ● Just Culture ● Being open and apologising ● Effective communication ● Effective involvement ● Sharing findings ● Signposting and support
Patient safety syllabus level 1: essentials for patient safety	E-Learning	● Listening to patients and raising concerns ● The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work

		● Avoiding inappropriate blame when things don't go well ● Creating a just culture that prioritises safety and is open to learning about risk and safety
Patient safety syllabus level 2: access to practice	E-Learning	● Introduction to systems thinking and risk expertise ● Human factors ● Safety culture
Continuing professional development	At least annually	● To stay up to date with best practice (for example through conferences, webinars.)

We will have governance arrangements in place to ensure patient safety learning responses are not led by ROHNFT staff who were involved in the patient safety event itself. Responsibility for patient safety learning responses from our locally agreed ROHNFT priorities sits with the Divisional governance teams and our Divisional Triumvirates.

Patient Safety Learning Responses (PSLRs) sitting outside of our priorities will be led by a suitable senior leader within the relevant service line. Patient Safety Incident Learning Response Leads will have an appropriate level of seniority to influence within the Trust; this may depend on the nature and complexity of the patient safety event and the learning response required.

The Trust's governance arrangements will ensure patient safety learning responses are not undertaken by staff working in isolation. The Divisional governance team and core governance team will support patient safety learning responses wherever possible and can provide advice on cross-system and cross-area working where this is required.

Our people affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All ROHNFT leaders will work within our just culture principles and utilise other teams to ensure our people are supported.

We will utilise both internal and (where necessary) external subject matter experts with relevant experience, knowledge, and skills.

Our Patient Safety Incident Response Plan

Our accompanying response plan sets out how the ROHNFT intends to respond to patient safety incidents over a period of 12 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.

The process to create our PSIRF response plan has been collaborative and has followed guidance and best practice prescribed by NHS England via their PSIRF guidance documents.

To define the ROHNFT patient safety risk and responses for 2023/24 the following stakeholders were involved*:-

- Staff – through the incidents reported on the ROHNFT Local Incident Management System
- Senior leaders across the divisions
- Partner organisations from across the Integrated Care System (ICS), through partnership working with the ICS patient safety and quality leads.

**The ROHNFT aims to incorporate wider patient perspective into future PSIRF planning through the introduction of Patient Safety Partners (PSPs). More information can be found on the National PSP programme on the NHS England website NHS England » Framework for involving patients in patient safety.*

The patient safety incident categories set out in our PSIRF Response Plan were identified through the following data sources:

- Trend analysis of five years of Ulysses incident data
- Thematic analysis of Ulysses incident data
- Key themes from complaints/PALS/claims/inquests
- Key themes from specialist safety and quality groups (e.g. falls, VTE and pressure ulcers)
- Output of stakeholder discussions

Responding to Patient Safety Incidents

Patient Safety Incident Reporting and Decision-Making Arrangements

The Trust is responsible for the safety of everyone who uses or works within its services and must ensure robust systems are in place to recognise, report, investigate and respond to patient safety incidents and to improving the quality of care to patients and the safety of staff and members of the public, through the consistent monitoring and review of incidents which result, or had the potential to result in harm, damage or other loss.

Organisational learning and remedial action are central to a good patient safety incident response and the reporting of all incidents is a key factor in enabling this. Staff have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and its delivery of care.

Our aims and objectives are to: -

- Promote an open, honest, and fair approach to the identification, management and learning from patient safety incidents.
- Provide staff with an agreed method of reporting, investigation, and management of patient safety incidents in line with our PSIRF Response Plan and development of quality improvement plans.
- Enable collection and use of robust data to inform and promote organisational learning and improvement, providing appropriate assurance to internal and external stakeholders as required.
- Use patient safety incident responses to identify any deficiencies in care or service, learning from these findings through the development of safer practices and environments for the benefit of patients, staff and visitors.
- Establish a patient safety incident response and management framework which is proportionate to the incident being reported and fulfils statutory and contractual requirements in line with national best practice.
- Support openness and transparency and assure patients / their representatives that appropriate review, investigation and learning from patient safety incidents are embedded within the organisation.

The Trust's arrangements for the reporting of and management of patient safety incidents are set out below: -

Incident Reporting

All staff are required to report and manage patient safety incidents. Where a patient safety incident occurs, staff must take appropriate immediate remedial action at the time of an incident to prevent further harm to patients; staff; general public and Trust assets.

All patient safety incidents are reported by staff via our Local Incident Management System (LIMS), which is currently Ulysses. Through induction and mandatory training all staff receive training on how to report incidents and those members of staff specifically involved in the management and investigation of incidents are provided with further, more specialist training on how to utilise the system.

Divisional Triumvirate & Governance Arrangements

Each of the two Divisions within the Trust have delegated responsibility for the quality and safety of the clinical services that are within their remit.

The Divisional Governance groups/triumvirates, which hold a divisional governance meeting on a bi-weekly basis, are responsible for: -

- Ensuring appropriate and timely patient safety incident identification, reporting, management, and response arrangements are in place for all areas within their responsibility.
- Ensuring patient safety incident responses are conducted in line with the Trust's PSIRF Plan and take into consideration wider on-going or planned quality improvement projects or plans when making decisions on the necessity and/or type of response to patient safety incidents.
- Monitoring the implementation of recommendations from incident investigations and quality improvement plans relevant to their division.
- Escalating assurance/exceptions to appropriate Trust level Committees / individuals.

Reporting to the Learning From Patient Safety Events (LFPSE) service

The LFPSE service will eventually replace NRLS and StEIS.

Reporting to LFPSE will be the equivalent of reporting to NRLS and StEIS but once an organisation starts reporting to LFPSE, it only needs to make one incident report – that is, it no longer needs to report to NRLS and then also to StEIS.

Reporting to the National Reporting and Learning System (NRLS)

Until NRLS is replaced by the Learn From Patient Safety Events service (LFPSE), all patient safety incidents must continue to be reported to NRLS via the trust's local incident management system or via any other arrangements implemented via BSOL ICB.

Reporting to the Strategic Executive Information System (StEIS)

Until StEIS is replaced by the Learning From Patient Safety Events (LFPSE) service, all patient safety incidents must continue to be reported to StEIS via the trust's local incident management system and all patient safety incidents for which an independent or provider led PSII is to be undertaken must be reported to StEIS.

Once an independent PSII report is finalised and shared with the provider, the provider can complete the uploading of investigation findings to StEIS for sharing and learning purposes, ahead of closure of the incident.

Responding to Cross-System Incidents/Issues

The Trust will continue to follow current governance processes in regard to cross system patient safety incidents.

Where patient safety incidents involve other trusts, the governance team communicates and liaises with the other Trust's respective governance team to co-ordinate and facilitate timely investigation and feedback.

In addition, the Trust currently holds monthly joint governance meetings with University Hospital Birmingham NHS Foundation Trust and Birmingham Women's and Children's Hospital NHS Foundation Trust, which provides the forum for discussion of joint pathway patient safety incidents and operational risks and issues. Similar arrangements are currently being established with Robert Jones and Agnes Hunt NHS Foundation Trust.

Timeframes for Learning Responses

Response Type	Expected time to gather information	Expected timeframe to produce response report
Patient Safety Incident Investigation (PSII)	20 – 80 hours over several weeks.	3 months from date of incident, can be extended to up to 6 months in extenuating circumstances, to be agreed by divisional governance group.
After Action Review (AAR)	Likely to take 45 – 90 minutes.	Within 2-4 weeks of AAR.
Multidisciplinary Team (MDT) Review	Likely to take 2 – 3 hours.	Within 2-4 weeks of MDT Review.
Thematic Reviews	Dependent on complexity and data set to be reviewed.	Within 4 weeks of need for thematic analysis identified and investigator allocated.

Safety Action Development and Monitoring Improvement

Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. We must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited.

The process starts by identifying and agreeing those aspects of the work system where change could reduce risk and potential for harm (i.e., 'areas for improvement' or system issues). Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined.

The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutionising at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The process emphasises a collaborative approach throughout, including involvement of those beyond the 'immediate and obvious' professional groups and working closely with those with improvement expertise. Imposed solutions often fail to engage staff and lack sustainability as a result.

Work is ongoing to ensure our quality and safety improvement methodology is aligned to the PSIRF and that all improvement work is registered on one platform so that improvements required can be designed, implemented and monitored using an integrated approach of reducing risk and limit the potential for future harm.

Quality Improvement Plans

Quality improvement plans bring together findings from various responses to patient safety incidents and issues. The ROHNFT will have several wider quality and safety and continuous improvement plans in place, which will be adapted to respond to outcomes of improvement efforts and other influences such as national safety improvement programmes.

The ROHNFT Patient Safety Incident Response Plan has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning and improvement where improvement efforts have not been accompanied by reduction in risk or harm.

The Trust will implement a platform where all improvement plans and improvement work will be logged in one place to give an overview of where we were, what actions have been completed, what the impact of interventions and improvements has been and ongoing monitoring can continue to ensure that improvements are fully embedded.

Complaints and Appeals

All complaints and/or appeals relating to the Trust's response to patient safety incidents are to be communicated to our Patient Experience Team and managed in accordance with the Trust's Complaints and PALS policy.

The contact details for our Patient Experience Team can be accessed via the below link:-

https://roh.nhs.uk/patient-experience

8.0 CONSULTATION

Name of person / team / committee asked to provide feedback	Date request for feedback sent	Feedback received Y/N	Feedback incorporate d into policy Y/N
Trust Board	November 2023	Y	Y
Executive Team	October 2023	Y	Y
Quality and Safety Committee	October and November 2023	Y	Y
Divisional Triumvirates	October 2023	Y	Y
CSMs, CSSMs, CSLs, Associate Medical Directors, all clinical and operational managers/service leads/ department leads/heads of etc.	October 0223	Y	Y
BSOL ICB	November 2023	Y	Y
Local Trusts within BSOL System	October 2023	Y	Y

9.0 INCLUSION

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals (staff, patients and visitors) are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced and Equality Policy Statement to reflect this. All policies are assessed in accordance with the ROH Equality Impact Assessment Toolkit.

10.0 REVIEW

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change over time. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.
Updated plans will be published on our website, replacing the previous version.

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

11.0 REFERENCE DOCUMENTS AND BIBLIOGRPAHY

National guidance, issued to all Trusts by NHS England to support the implementation of PSIRF, has been used to inform the development of this policy and the accompanying plan. Please see the link to this guidance below:-

NHS England » Patient Safety Incident Response Framework

12.0 FURTHER ENQUIRIES

For further advice and information please contact the governance team on:-

Ext: 55292 or Ext: 55432

Or email:-

roh-tr.governance-mail@nhs.net

Appendix A

ROH Patient Safety Incident Response Framework (PSIRF) Response Plan

1. **INTRODUCTION**

This plan, along with the accompanying policy, supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

2. **SCOPE**

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it.

Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims: -

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

A patient safety incident or event is any unintended or unexpected incident or event which could have, or did, lead to harm for one or more patient's receiving healthcare, and can result in no harm or contribute to a fatal outcome. This policy requires all staff to take responsibility for reporting any incident or adverse event or near miss that they become aware of and review them as detailed within this policy and the accompanying plan.

The Trust acknowledges that adverse events usually reflect a breakdown in systems within the organisation and that people are trying to do their best to do their job safely and well. Experience shows that although staff actions may contribute to an adverse incident there are often underlying causes for these actions. Consequently, the Trust is committed to exploring how these system failures occurred and how they can be improved using a range of learning response tools.

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

This Patient Safety Incident Response Plan sets out how The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNHSFT) intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. The purpose is to continually improve the quality and safety of the care we provide.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them.

This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents, whilst allowing time to learn thematically from the other patient safety insights.

3. OUR SERVICES

The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) is registered with the Care Quality Commission to provide services in the following locations: -

- The Royal Orthopaedic Hospital
- College Green (Outpatient physiotherapy services)
- Lordswood Musculoskeletal Clinic
- ROH Community Health Hub
- The Royal Orthopaedics Community Scheme (delivering care in patients' homes)
- We provide a variety of services across the organisation in the following departments:
- Admissions and Day Case Unit (ADCU)
- In patient wards, including a private ward (109 beds - predominantly used by elective surgical patients)
- Main Outpatients Department
- Children and Young Persons Outpatient Department
- Theatres (14 theatres)
- Pre-Operative Assessment Unit (POAC)
- High Dependency Unit (HDU)
- Physiotherapists – inpatient, outpatient and hydrotherapy
- Orthotics

- Pain Management
- Imaging (X Ray and MRI)
- Discharge Lounge
- Safeguarding
- The Royal Orthopaedic Community Scheme
- We also have a variety of specialities which include:
- Foot and Ankle
- Hands and Forearms
- Hips
- Knees
- Musculoskeletal
- Shoulder and Elbow

- Spines
- Oncology
- Anaesthetics
- Critical Care
- Chronic Pain
- Perioperative Medicine
- Musculoskeletal Medicine
- Radiology

4. DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

The process to define our patient safety incident profile has been collaborative. To define the ROHNFT patient safety risk and responses for 2023/24 the following stakeholders were involved:

Staff – through the incidents reported on the ROHNFT Local Incident Management System (LIMS)

Senior leaders across the divisions.

ICS partner organisations through partnership working with the ICS patient safety and quality leads.

**The ROHNFT aims to incorporate wider patient perspective into future PSIRF planning through the introduction of Patient Safety Partners (PSP's).*

More information can be found on the National PSP programme on the NHS England website: -

NHS England » Framework for involving patients in patient safety

The ROHNFT patient safety risks were identified through the following data sources:

- Analysis of five years of ROH LIMS incident data
- Thematic analysis of ROH LIMS incident data
- Key themes from complaints/PALS/claims/inquests
- Key themes from specialist safety and quality committees (e.g. falls, VTE and pressure ulcers)

- Output of stakeholder discussions
- National priorities for investigation or referral to other bodies have been defined by NHS England, please see below for a full list of the current priorities and mandated response required.

5. DEFINING OUR PATINENT SAFETY IMPROVEMENT PROFILE

Throughout the ROHNFT improvement work is a key thread that is woven throughout all that we do. However, this improvement work is most often undertaken in silo, there is a lack of oversight of improvement work and a lack of assurances that improvements have been successful, meaningful, and fully embedded as "work as done". Work has commenced to ensure this oversight and assurance is visible and continuing.

There are many groups, networks and committee's that implement improvement works and these include, but are not limited to:

- The Falls and Dementia Working Group
- Cancer Board
- Safeguarding Committee

- Medical Device Assurance Group
- Divisional Management Boards
- Divisional Governance Groups
- Infection Prevention and Control Groups, including a Theatre Focus Group
- AQILA
- Resuscitation Group (responsible for National Managing Deterioration Safety Improvement Program (ManDetSIP))
- The Human Tissue Authority Group
- Specialty Meetings – ADCU, POAC, Theatres, RRT, HDU
- Harm Reviews
- Clinical Audit
- Venous Thromboembolism Group
- Blood Safety Group
- Nutrition and Hydration Steering Group
- Medication Safety Group (responsible for National Medicines Safety Improvement Programme (MH-SIP))
- Drugs and Therapeutics Committee

Work is ongoing to ensure our quality and safety improvement methodology is aligned to the PSIRF and that all improvement work is registered on one platform so that improvements required can be designed, implemented, and monitored using an integrated approach of reducing risk and limit the potential for future harm.

6. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS APPLICABLE TO ROHNFT

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria 2018 (or it's replacement)	Locally led Patient Safety Incident Investigation (PSII) & 72 hr Report	Create local organisational actions and feed these into the quality improvement strategy
Deaths thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR.	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan, Children in Care or a victim of wilful neglect. • People above the age of 16 experience domestic abuse. • Adults (over 18 years old) are in receipt of care and	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews, adult safeguarding reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding children's	Create local organisational actions and feed these into the quality improvement strategy

support needs from their local authority. • The incident relates to other forms of abuse and/or neglect where safeguarding has been identified as a factor.	partnership and local safeguarding adults boards.	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Create local organisational actions and feed these into the quality improvement strategy

A full list of the national incident response requirements is available on the NHS England website or by the following link:

B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (england.nhs.uk)

7. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL ROHFT FOCUS

In line with the Patient Safety Incident Response Framework the Trust will utilise 4 differing methods of investigating patient safety incidents. Please see Appendix B of the Patient Safety Incident Response Framework (PSIRF) Policy & Plan for further information on these response types.

Response Type	Report Template	Is report template mandatory?
Patient Safety Incident Investigation (PSII)	Patient Safety Incident Investigation (PSII) Report Template	Yes – recommended by NHSE
After Action Review (AAR)	AAR Response Template	No – other report templates can be used to summarise the learning identified e.g., Learning on One Page (LOOP)
Multidisciplinary Team (MDT) Review	MDT Response Template	No – other report templates can be used to summarise the learning identified e.g., LOOP
Thematic Reviews	Thematic Review Response Template	No – other report templates can be used to summarise findings and learning e.g., LOOP or a written report.

Patient Safety Incident Type	Patient safety incident issue	Planned response	Anticipated improvement route
Infection Prevention and Control (IPC)	• Surgical Site Infections • HCAI Outbreak • Bacteraemia • Clostridioides Difficile • Increase of Catheter related and UTI incidents	See 'Appendix C of the Patient Safety Incident Response Framework (PSIRF) Policy & Plan	• See 'Appendix C of the Patient Safety Incident Response Framework (PSIRF) Policy & Plan
Tissue Viability	Category 3 and 4 pressure sores (acquired	AAR	Create local safety actions and feed these into existing

	or deteriorated under ROHNFT care)		quality improvement workstreams: • Safety Huddles • Tissue Viability Mandatory Training
	All category pressure sores, acquired or deteriorated under ROHNFT care, in patients with darker skin tones	AAR	
	An increase of tissue viability related incidents	Thematic review	
Slips, Trips and falls	Where serious harm occurs as a result of the incident	Divisional Governance or Medication Safety Group to decide, either: • AAR • MDT	Create local safety actions and feed these into existing quality improvement workstreams: • Safety Huddles • Falls and Dementia Working Group
	An increase of slip, trip and fall related incidents	Thematic Review	
Venous Thrombo-embolism	Following completion of positive VTE questionnaire if there is any question over avoidability of VTE.	AAR	Create local safety actions and feed these into existing quality improvement workstreams: • Safety Huddles • VTE Advisory Group
	An increase in occurrence or severity of VTE related incidents.	Thematic Review	
Medication Error	Error in prescribing, dispensing or administering medication where moderate or severe harm has occurred (or near miss)	Divisional Governance or Medication Safety Group to decide, either: • MDT • AAR	Create local safety actions and feed these into existing quality improvement workstreams: • Medication Safety Group • Drugs and Therapeutic Committee • Safety Huddles
	An increase in occurrence or severity of medication related incidents	Thematic Review	
Clinical Assessment/Care	Incident led to moderate harm or above	Divisional Governance group to decide either: • AAR • MDT Review • PSII *depending on complexity of incident	Create local safety actions and feed these into existing quality improvement workstreams: • Clinical Quality Group • Safety Huddles • TBALD
	An increase in occurrence or severity of incidents	Thematic Review	
Deteriorating patient	Potential delay in diagnosis or care leading to moderate harm or above	Divisional governance to decide, either: • PSII • AAR • MDT review	Create local safety actions and feed these into existing quality improvement workstreams: • Deteriorating Patient Group • Resuscitation Committee

Emergency Transfers Out	All	Divisional governance to decide if response required, If required, then divisional governance to decide either: • PSII • AAR • MDT review	Create local safety actions and feed these into existing quality improvement workstreams: • Deteriorating Patient Group • Resuscitation Committee
New and emergent issues	All	Review by divisional governance group and response type to be decided.	Create local safety actions and feed these into quality improvement workstreams relevant to the incident type.

For any incident not listed above, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes, which may lead to new or supplement existing improvement work.

Appendix B

PSIRF INVESTIGATION METHODS

Patient Safety Incident Investigation (PSII)

What is it?	When would you use it?	Time required to complete.	Who leads it?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how.	When there has been serious harm to a patient or patients.	20 – 80 hours over several weeks.	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report.	People directly involved in the incident and senior clinicians.
	Strengths		**Weaknesses**	
	•It is a well-established approach which is widely recognised and valued by patients and their families. •PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified •Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements in each provider.		•Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed. •Outcomes are less system focused than other tools. •The quality of PSIIs varied before PSIRF mandated training for investigators. • Staff are only involved when they are interviewed, and this can feel very stressful.	

After Action Review (AAR)

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating	Led by a trained AAR Conductor -this could be anyone from within the MDT, local or remote to the participants	Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included

Strengths	Weaknesses
• The individuals learn for themselves what was happening and identify similarities and differences between themselves and others. • Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement. • It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety. • It is highly adaptable, suitable for a wide range of events. • Psychological safety is actively created and maintained throughout. • Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.	• Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority. • There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR. • Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

Multidisciplinary Team Review (MDT)

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
An in-depth process of review, with input from different disciplines, to identify learning from patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours	Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

Strengths	Weaknesses
• The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered. • Can be adapted to incorporate the systems engineering initiative for patient	• Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence. • Whilst participants will contribute and learn, it is not the specific purpose of the activity.

safety (SEIPS) framework to structure the review.	• It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available. • Resource intensive to undertake.

Thematic Review

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
A way of identifying patterns in data to help answer questions, show links or identify issues	Developing or revising an improvement plan; aggregating information from many sources of data; gathering insights into gaps/safety issues to direct further analysis; aggregating findings from multiple incidents to identify interlinked contributory factors; presenting summary data to show the impact of improvement work	Dependent on complexity and data sets to be reviewed - can be lengthy.	Led by an individual who understands how to conduct the review.	Those directly involved in the events and others connected to the patient pathway.

Strengths	Weaknesses
• As there is no single measure of safety – insights might come different forms - qualitative or quantitative; What is seen, heard and perceived is as important as hard data. Allows for exploration and triangulation of insights from different type of data and gives structure to this. • Allows for curiosity and a willingness to explore and being open to what the data is saying. • Allows for scoping of the questions(s) you want the review to answer, for example what factors contributed to this incident or safety theme? • Allows for collation and triangulation of data from different sources and transparency of evidence. • Allows the opportunity to seek out and include multiple perspectives that may bring out innovative ideas to find something you didn't know.	• Need to choose an approach to the analysis that best suits the question /theme – deductive or inductive. • Thematic analysis may be time consuming – requires immersion and resources. • Making assumptions too early can bias findings, be wary of drawing conclusions to soon and be open to the data. • Need to plan how the analysis will be written up to bring the findings to life – summarising is key, • Need to think about the analysis can lead to safety actions can lead to improvements

Appendix C

Midlands: Infection Prevention and Control Patient Safety Incident Response Framework Matrix

Version 1

Background

Following the rollout of the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023, the regional Assistant Director of Infection Prevention and Control (IPC) met with the Integrated Care Board (ICB) IPC leads, at their request, to discuss expectations and understanding of how this would be implemented across the Midlands region.

The matrix below was developed in consultation with the ICB IPC leads and was shared with all 11 ICB IPC teams, all provider organisations IPC and patient safety teams for consultation and feedback. Following this initial review, this document was shared with all providers across the Midlands region for further consultation and discussion. This version is the culmination of the consultation phases completed to date.

The plan is for this to be a Midlands wide framework and guidance, with the option to review and refine as we move forward. Engagement through providers into ICBs and then to region will continue through the ICB IPC forum, Acute Trust IPC forum and Community and Mental Health Trust IPC forum, with a full review of the document on a minimum of annually, using a short life working group.

Important Information

Organisations can go beyond the detail that is outlined within the document.

Each ICB and provider has slightly different governance processes so the terms within the table below are used in the generic sense noting that organisational internal meetings/governance structures maybe named differently. For example, IPC Committee, may be an assurance group in some organisations or a committee in others.

Alignment of IPC with the PSIRF does not impact or change current methods of mandatory reporting through the HCAI Data Capture System of key alert infections such as MRSA, *E. coli*, *Pseudomonas aeruginosa, Klebsiella*, MSSA bacteraemia's and *C. difficile*. There remains a zero tolerance for MRSA bacteraemia and thresholds in place for *C. difficile* and the Gram-Negative bacteraemia.

The PSIRF does not change national policy and regulatory requirements that mandate a particular response to certain safety events. For example, some patient safety incidents, such as Never Events and deaths thought more likely than not to be due to problems in care, that is, those meeting the Learning from Deaths criteria for investigation. These require a Patient Safety Incident Investigation (PSII).

PSIIs may also be triggered where there are shortcomings in care identified through the infection control review process or where intervention has been required to prevent deterioration.

Cases that involve community settings such as primary care, dental, general practice will require an ICB coordinated response to ensure that all information is made available for the review.

There may be occasions when ICB or regional teams require more in-depth investigations as part of system or regional thematic reviews into specific infections or groups of patients, these will be discussed, and agreed through system or regional meetings and will have terms of reference for the request and timeframes agreed, this remains within the principles of PSIRF.

Abbreviations and Definitions:

Mandatory reporting

This column relates to reporting to UKHSA either through Data Capture System (DCS) or through Notifications of Infectious Diseases (NOIDs) reporting systems. Please remember that Norovirus outbreaks are required to be reported through the Hospital Norovirus Outbreak Reporting System.

Duty of Candour

Formal regulatory duty of candour as outlined in Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 20 (CQC regulation 20).

Trusts/providers are still expected to be open and honest with patients, regardless of whether the legal/regulatory aspects of Duty of Candour are met, this is covered within the patient communication section of the table.

Incident Reporting System

This would be your internal incident reporting system, such as Datix, incident reporting system (IR1) Ulysses etc. The purpose of reporting IPC incidents through this way is to support with thematic reviews and provide evidence and assurance of actions and ensures local learning. Alternative systems can be utilised where they are able to draw themes and trends and feed into the patient safety approach within the organisation.

Infection Prevention and Control Review

Infection Prevention and Control reviews can be completed utilising a relevant process, such as after-action review, SWARM huddles, post event learning, structured judgement reviews, and SBAR approaches. This approach should be proportionate to the event and ensure learning is captured and reflect local processes and preferences.

Patient Safety Incident Investigations (PSII)

These Investigations will be automatically carried out where there are concerns raised following mortality review. Where significant concerns are noted during an Infection Control Review (ICR) cases will be discussed with the local Patient Safety Team for consideration into further investigation. PSII's will be reported via the agreed Trust governance processes, and a copy of any PSII is expected to be shared at the Provider IPC Committee/Assurance Group. Learning from these incidents should be shared across the system through whole health economy/system IPC meetings and consideration given to sharing learning at the System Quality Groups.

Where PSIIs are required to be led by ICBs, these will report through the ICB governance processes and through into the whole health economy/system IPC meetings and System Quality Groups.

Areas for improvement/actions

Where areas for improvement are identified either during Infection Control Review or Patient Safety Incident Investigations these will be documented on the IPC Patient Safety Incident Framework Response Improvement Plan or annual programme of work which will be monitored through the Trust or ICB IPC Committee/Assurance Group.

Severe or significant outbreak

Outbreaks are defined as two or more cases of infection linked in time and place, or a single case of a rare or high consequence infectious disease, or greater than expected rate of infection when compared with the background rate for the time/place where this has occurred. Communicable disease outbreak management: operational guidance - GOV.UK (www.gov.uk)

Severe or significant outbreaks would be considered when patients are linked across multiple bays or wards and prolonged outbreaks with ongoing transmission identified. This also includes outbreaks which impact on capacity and the ability to admit or discharge patients into the provider organisation. Immediate or continuing significant risk and public, political, or reputational interest should also be considered as severe or significant.

Hospital Onset Hospital Associated (HOHA)

These are cases are identified where the specimen was taken three or more days after the current admission, with the day of admission being day one.

Community Onset Hospital Associated (COHA)

These are cases are identified where the patient has been recently discharged from the same reporting Trust in the 28 days prior to the specimen, day one is the date of the specimen.
Community Onset Indeterminate Association (COIA)

These are cases are identified where the patient has been recently discharged from the same reporting Trust between 29 and 84 days prior to the specimen being taken, day one is the date of the specimen.

Community Onset Community Associated (COCA)

These are cases are identified where the patient has **not** been recently discharged from the same reporting Trust in the 84 days prior to the specimen being taken, day one is the date of the specimen.

Incident Management Team (IMT)

These meetings are convened to manage incidents and should be stood up as part of governance of incident management.

Outbreak Control team (OCT)

These meetings are convened to manage outbreaks and should be stood up as part of governance of outbreak management.

Notifications of Infectious Diseases (NOIDS)

Details can be found here: Notifiable diseases and causative organisms: how to report - GOV.UK (www.gov.uk)

National oversight Framework (NOF)

Details can be found here NHS England » NHS Oversight Framework

Data Capture System (DCS)

Details can be found here HCAI DCS: General Home Page (phe.org.uk)

Hospital Norovirus Outbreak Reporting System

Details can be found here: Norovirus Reporting (phe.gov.uk)

Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
Outbreak No HOHA/COHA Deaths.	N/A	Dependant on causative organism	Yes	Case by case	No	Patients advised of outbreak on declaration. Discussion/ disclosure to patients if admitting to an open/ongoing outbreak.	IPC Team to initiate outbreak meeting, reporting through IPC governance. Only if lessons learnt: • Clinical teams • IPC operational Group • Themes to IPC Committee	All outbreaks updated via Trust Sit rep to ICB, UKHSA and NHSE - Midlands If severe /significant outbreak an IMT expected with invite to ICB, UKHSA and NHSE - Midlands	Sitrep shared for operational support purposes. Assurances to be gained through IPC Committee Lessons learnt to be shared through system communication channels.
Outbreak HOHA/COHA Patient or Healthcare worker **Deaths (attributed to infection)**	N/A	Dependant on causative organism	Yes	Yes	Yes		Lessons learnt to: • Clinical teams • IPC operational Group • Themes to IPC Committee	Via Trust Sit rep to ICB, UKHSA and NHSE - Midlands IMT expected with invite to ICB, UKHSA and NHSE – Midlands	

Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
C. *difficile* Toxin positive	All cases	UKHSA HCAI DCS	Yes	Yes	Not routinely Yes – if meets threshold for DOC	CDI result to be communicated to the patient by clinician	Lessons learnt to: • Clinical teams • IPC operational Group • Themes to IPC Committee	PIIs/Outbreaks to be reported via Sit Rep to ICB, UKHSA and NHSE - Midlands GP to be informed of results, through pathology system or through discharge letters/discharge documentation if inpatient.	Thematic reviews of **community cases** where indicated can be led by ICBs and reported through system governance. Assurances to be gained through IPC Committee
Invasive Group A Strep	Healthcare Associated	Yes – notifiable to UKHSA (NOIDS) NOIDS	Yes	Yes	Not routinely Yes – if meets threshold for DOC	Result to be communicated to the patient by clinician	Only if lessons learnt: • Clinical teams • IPC/HCAI operational groups • IPC Committee	If outbreak or suspected outbreak – report to ICB, UKHSA and NHSE - Midlands If linked to care home, community healthcare setting as part of follow up actions	Assurances to be gained through IPC Committee
	Care home outbreak Primary care related outbreak		Using setting reporting systems	Yes			Community providers to follow incident reporting process with support from UKHSA and ICB		ICB to contribute to UKHSA outbreak/incident processes and follow up community cases where relevant.

Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
	All other		No	Not routinely. Cases followed up by UKHSA			Following UKHSA process for non-healthcare cases		N/A
Gram-Negative Bloodstream Infection (GNBSI)	HOHA and COHA	UKHSA HCAI DCS	Yes	Yes	Not routinely Yes – if meets threshold for DOC	Result communicated to patients	Only if lessons learnt: • Clinical teams • IPC/HCAI operational groups • IPC Committee	ICB via the NOF/DCS	Assurances to be gained through IPC Committee
	All other	**UKHSA HCAI DCS**	No	Thematic review desirable – ICB led decision		Results communicated to patients – clinical team/clinician	Only if lessons learnt: • Clinical teams • Themes to provider IPC Committee and system learning.	ICB via DCS GP to be informed of results, through pathology system or through discharge letters/discharge documentation if inpatient.	Thematic reviews of **community cases** where indicated can be led by ICBs and reported through system governance.

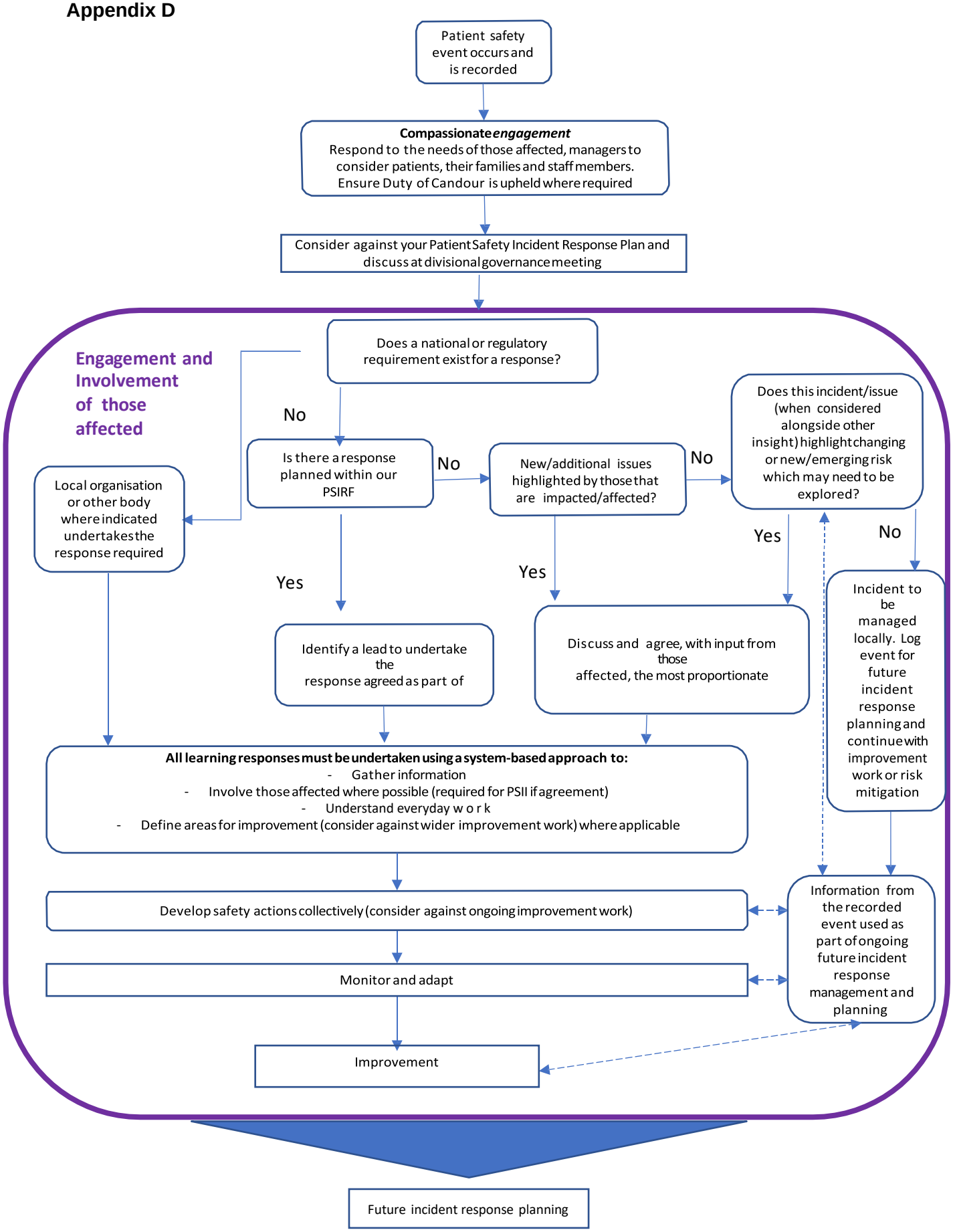
Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
MRSA Bacteraemia	HOHA COHA	UKHSA HCAI DCS	Yes	Yes	Not routinely Yes – if meets threshold for DOC	Result to be communicated to the patient by clinician	• Clinical teams • IPC/HCAI operational groups • IPC Committee	ICB via the NOF/DCS	Assurances to be gained through IPC Committee
	COIA COCA	UKHSA HCAI DCS	No				Only if lessons learnt: • Clinical teams • Themes to provider IPC Committee and system learning.	ICB via DCS GP to be informed of results, through pathology system or through discharge letters/discharge documentation if inpatient.	Thematic reviews of **community cases** where indicated can be led by ICBs and reported through system governance.
MSSA Bacteraemia	HOHA COHA	UKHSA HCAI DCS	Yes	Yes	Not routinely Yes – if meets threshold for DOC	Result to be communicated to the patient by clinician	Only if lessons learnt: • Clinical teams • IPC/HCAI operational groups • IPC Committee	ICB via DCS	Assurances to be gained through IPC Committee

Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
	COIA COCA	UKHSA HCAI DCS	No	Thematic review desirable – ICB led decision	No		Only if lessons learnt: • Clinical teams • Themes to provider IPC Committee and system learning.	ICB via DCS GP to be informed of results, through pathology system or through discharge letters/discharge documentation if inpatient.	Thematic reviews of **community cases** where indicated can be led by ICBs and reported through system governance.
High Consequence Infectious Disease (HCID)	N/A	UKHSA NHSE	Yes	Yes	Not routinely	Result to be communicated to the patient by clinician	IMT with ICB, UKHSA and NHSE - Midlands IPC Committee assurance report with review of HCID protocols Lessons learnt to: • Clinical teams • IPC/HCA	Reported to ICB, UKHSA and NHSE - Midlands	Immediate communication through system incident communication channels. Learning expected through System Oversight and Assurance Group (SOAG)

Legionella	Hospital/ healthcare exposure/ source for infection.	UKHSA	Yes	Yes	Not routinely Yes – if meets threshold for DOC	Result to be communicated to the patient by clinician	Lessons learnt to: • Clinical teams • Water Safety Group • IPC Assurance Committee	Reported to ICB, UKHSA and NHSE - Midlands	Assurances to be gained through IPC Committee

Incident	HCAI Attribution (HOHA /COHA)	Mandatory Reporting (UKHSA)	Incident Reporting System	Infection Control Review (ICR)	Regulatory Duty of Candour	Patient Communication	Internal (Provider) Governance	External reported governance processes	ICB governance
TB exposure	N/A	UKHSA	Yes, if healthcare related. i.e. patients exposed on a ward/health care. No if community case	Yes	Not routinely Yes – if meets threshold for DOC	Result to be communicated to the patient by clinician	Incident to be managed with an IMT Review with Clinical teams • IPC Committee	If healthcare exposure (i.e. HCW) - IMT to ICB, UKHSA and NHSE - Midlands GP to be informed of exposures through discharge letters/discharge documentation if inpatient. TB team notification and follow up	Assurances to be gained through IPC Committee

Appendix D


Patient safety event occurs and is recorded
Compassionate *engagement*
Respond to the needs of those affected, managers to consider patients, their families and staff members. Ensure Duty of Candour is upheld where required
Consider against your Patient Safety Incident Response Plan and discuss at divisional governance meeting
Engagement and Involvement of those affected
Does a national or regulatory requirement exist for a response?
No
Is there a response planned within our PSIRF
No
New/additional issues highlighted by those that are impacted/affected?
No
Does this incident/issue (when considered alongside other insight) highlight changing or new/emerging risk which may need to be explored?
Yes
No
Local organisation or other body where indicated undertakes the response required
Yes
Yes
Identify a lead to undertake the response agreed as part of
Discuss and agree, with input from those affected, the most proportionate
Incident to be managed locally. Log event for future incident response planning and continue with improvement work or risk mitigation
All learning responses must be undertaken using a system-based approach to:
- Gather information
- Involve those affected where possible (required for PSII if agreement)
- Understand everyday w o r k
- Define areas for improvement (consider against wider improvement work) where applicable
Develop safety actions collectively (consider against ongoing improvement work)
Monitor and adapt
Improvement
Information from the recorded event used as part of ongoing future incident response management and planning
Future incident response planning

Appendix E

Patient safety incident investigation (PSII) report

On completion of your final report, please ensure you have deleted all the blue information boxes and green text.

Notes on the PSII template
This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips
A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible.
- explain or avoid technical language.
- use lists where appropriate.
- keep sentences short.

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

Distribution list

List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position

Appendix F

Guidance for After Action Review (AAR) Facilitators

- AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is important to disseminate learning widely so that good practice can be shared, and others can learn from mistakes.
- Try to include as many people as possible who were involved in the activity or event so that a wide range of viewpoints can be explored. A prerequisite of an AAR is that everyone feels able to contribute without fear of blame or retribution. **AARs are about learning, not holding people to account or apportioning blame.**
- Ensure that participants are aware of the questions that will be asked and are supported to have time to prepare for the meeting.
- The discussion tends to last a maximum of one hour. The facilitator will guide the group through a series of questions:
    - What happened that we want to learn from?

Creating a common understanding of the activity or event under review.

    - What was the intended outcome/What was meant to have happened?
    - What actually happened?
    - What went well? Why?

Reflecting on the successes and failures:

    - What are the identified areas for improvement?

- Next steps, agree as a group on any actions that need to be taken, including how you are going to share the learning more widely.
- AAR Facilitators must be familiar with the SEIPS (System Engineering Initiative for Patient Safety). A quick reference guide and work system explorer is available on this link:

B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf (england.nhs.uk)

AFTER ACTION REVIEW REPORT TEMPLATE

Background:

1. **Patient Safety Incident Number:**
2. **Patient Safety Incident Date:**
3. **Date of After-Action Review:**
4. **Participants:**

NAME	JOB TITLE	ROLE IN TEAM
		Facilitator

5. **What was the intended outcome/What was meant to have happened?**

6.

What actually happened?

7. **What went well? Why?**

(What were the successful steps taken towards achieving your objective?)

Successes		How to Ensure Success in the Future

8. What are the identified areas for improvement?

(Consider the SEIPS framework – Technology and Tools, Job Tasks, External Influences, Person Factors, Organisational Factors, Physical Environment)

Areas for Improvement	SEIPS Category

Areas for Improvement Action Plan: [Insert Incident Number Here]

Monitoring body (Internal and/or External):	
Reason for action plan:	
Date of action plan approval:	
Operational Lead:	
Frequency of review:	
Date of last review:	
Expected completion of action plan:	

REF	ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	Tools and Technology (Delete if no area for improvement identified)						
1.1	*[Action]*						
1.2	*[Action]*						
2	Job Tasks (Delete if no area for improvement identified)						
2.1	*[Action]*						
2.2	*[Action]*						
3	External Influences (Delete if no area for improvement identified)						
3.1	*[Action]*						
3.2	*[Action]*						
4	Person Factors (Consider individuals confidentiality) (Delete if no area for improvement identified)						
4.1	*[Action]*						
4.2	*[Action]*						
5	Organisational Factors (Delete if no area for improvement identified)						
5.1	*[Action]*						
5.2	*[Action]*						
6	Physical Environment (Delete if no area for improvement identified)						
6.1	*[Action]*						

6.2	*[Action]*						
7	**Shared Learning (Mandatory)**						
7.1	*Duty of Candour – Sharing findings with Patient and/or family* *(This MUST include an offer to share investigation findings via a face-to-face meeting)*						
7.2	*Dissemination of findings/sharing and learning:* *Sharing of Report with Directorate Leads and HOD* *Sharing of Report at Surgical/Anaesthetic Audit* *Discussion of learning at relevant meetings and Safety Huddles*						

Key to initials of leads.

Initials	Name	Job Title

Status Key

5	Complete	**4**	On track	**3**	Some delay – expect to be completed as planned	**2**	Significant delay – unlikely to be completed as planned	**1**	Not yet commenced	**0**	Objective Revised

Appendix G

MDT Template (to be completed)

Appendix H

Serious Incident – 72 Hour Update Report			
STEIS Reference		**Date of Incident**	
		Date Incident Reported on Datix	
STEIS Category		**Date Reported**	

Information Required	***Response***
Incident Summary (to be copied from STEIS entry):	
Have any other relevant parties been notified of the incident, e.g. Police, CQC, Safeguarding Professionals, Information Commissioner, Health and Safety Executive, Coroner etc.? ***If yes – please provide details of who has been informed***	
Are you aware of any media interest in relation to this incident? ***If yes – please provide details***	
Have you identified any action that are required to ensure the safety of staff, patients or the public? ***If yes – please provide details of actions being taken***	
Does information gathered so far highlight any concerns or issues which will require exploration or joint investigation with other providers? ***If yes – please provide details of how this is being taken forward***	
Has any other significant information which will have a bearing on the investigation come to light since this incident was reported to STEIS? ***If yes – please provide details***	

What 'Duty of Candour / Being Open' arrangements have been made with the patient / family affected?	

Please return this form to nhsbsolicb.patientsafety@nhs.net within 72hrs of logging the incident on STEIS

Appendix I

Learning On One Page (LOOP)

Date:
Area:
Author:

Division: **Ulysses ID:**

Brief Description of the incident	Actions taken	Good practice
[Description / Executive Summary from RCA report, Complaint, or litigation]	*[Include immediate and subsequent actions taken]*	*[Note any practices or processes found to have been used that promoted and supported safe and effective care being delivered]*

What didn't go well?	Areas for improvement	Any key themes?
[Note any gaps or weaknesses in care delivery processes that were contributory factors in the incident]	*[What are the further actions now to be taken in order to learn from the incident and ensure the risk of recurrence is reduced or eliminated?]*	*[What were the main areas of care delivery or processes that were relevant in this case?]*

Appendix J

PSIRF Implementation Action Plan (Quality Priority 1)

	Reason for action plan:	Implementation of PSIRF
	Executive Sponsor:	Nicola Brockie, Chief Nurse Simon Grainger Lloyd, Director of Governance.
	Operational Lead:	Rebecca Hipwood, Patient Safety Specialist Adam Roberts, Assistant Director of Governance and Risk.
	Expected completion of action plan:	31/05/2024

REF		ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1		SIGN OFF OF ROH PSIRF POLICY AND PLAN (INTERNAL)						
1.1		*Draft Plan and Policy to be shared with internal stakeholders, including Executive Directors, Quality and Safety Committee and Trust Board.*	NB/SGL	RH/AR	13/10/2023	NA	Sent out to all internal stakeholders via email.	
1.2		*Feedback and comments from internal stakeholders to be incorporated into Draft Policy and Plan.*	NB/SGL	RH/AR	26/10/2023			
1.3		*Final Draft Policy and Plan to be shared with Trust Board.*	NB/SGL	RH/AR	27/10/2023			

1.4		*Draft Policy and Plan to be signed off at Trust Board.*	NB/SGL	RH/AR	01/11/2023			
1.5		*PSIF Plan and Policy transferred into standard Trust template*	SGL	AR	12.03.204	N/A	Policy and Plan transferred into standard format, templates and flowcharts added as appendices, IPC PSIRF Plan included, and wording of policy and plan amended to reflect recent queries and clarifications. Revised Policy submitted to Exec Governance Meeting on 12.03.2024 for review	
2		**SIGN OFF OF ROH PSIRF POLICY AND PLAN (EXTERNAL)**						
2.1		*Draft Plan and Policy to be shared with BSOL ICB.*	NB/SGL	RH/AR	13/10/2023	NA	Sent to BSOL via email.	
2.2		*Peer to peer review of draft Policy and Plan*	ES/SGL	RH/AR	23/10/2023	NA	Attendance confirmed: • Emma Steele • Simon Grainger Lloyd • Adam Roberts • Rebecca Hipwood • Matthew Revell	
2.3		*Final Draft Version of PSIRF Plan and Policy to be submitted to BSOL for final Sign off*	NB/SGL	RH/AR	27/10/2023			
2.4		*ICB approval*	NB/SGL	RH/AR	03/11/2023			
3		**TRUSTWIDE COMMUNICATION**						
3.1		*A meeting is to be attended by PSIRF leads and ROH comms team to discuss communication strategies. Further actions will arise following this meeting.*	SGL	AR/RH	26/10/2023		AR & RH discussed Engagement Plan with Comms Team. Dedicated PSIRF intranet page set up. 3 layers of detail: - 1. General info for all staff	

							2. Info for managers/staff involved in governance process. 3. Info for PSIRF investigators Detailed info for sections 2 and 3 to be developed.	
4		**EDUCATION AND TRAINING**						
4.1		*PSII Incident investigators to be identified.*	NB/SGL	AR	January 2024		It has been identified that Divisional leaders (triumvirate) and/or sufficiently senior colleagues with relevant knowledge and experience within division (CSL, CSM, Matron, consultant etc) will be required to undertake Patient Safety Incident Investigations.	
4.2		*PSII, AAR and MDT Incident investigators to attend PSIRF investigation training courses.*			December 2023	HSSIB Training becomes booked up within minutes of being published online. Awaiting further information regarding BSOL training provision. Risk that the Trust will not have adequate numbers of trained investigators by the launch date of PSIRF. Mitigations are that HON's and PSS have completed training via HSSIB and that PSS will work alongside untrained investigators in the short	AR currently scoping suitable providers. Seeking info on costs and availability. Aim to provide training by end of May 2024	

						term until training has been completed by all required investigators.		
4.3		*Provision of guidance and support to Divisional Governance Group in implementation of the ROHNFT Patient Safety Incident Response Plan*	SGL	RH/AR	Ongoing		PSIRF Leads to attend Divisional Governance Meetings to provide support, guidance and reassurance on the implementation of the PSIRF Plan. This will aid decision making within the meetings.	
4.4		*Provision of Ward and Department Manager training on the implementation of PSIRF.*	NB	RH		RH on annual leave for Novembers WADM meeting so this will be delayed until December 2023. Mitigated by action 4.5	RH to attend WADM Meeting to discuss implementation of PSIRF, system thinking and human factors when completing local level investigations into incidents.	
4.5		*Providing Ward and Department Managers ongoing support and guidance on the implementation of PSIRF.*	NB & SGL	RH & AR	December 2024		RH to meet with ward and department managers on a one-to-one basis to discuss PSIRF, systems thinking and human factors etc when completing local level investigations into incidents. RH to ensure ward and department managers know to reach out as and when required when further support or guidance is required. AR met with Theatres Matron and Managers AR attended Operational Management Board to discuss PSIRF. AR met with Div 1 HoN and attended Div 1 Governance meeting to provide context and	

							explanation of principles and purpose of PSIRF. AR to meet with Div 2 HoN and attend Div 2 governance meeting to do similar. RH attended Council of Governors RH & SB attended a PSIRF stand prior to AGM. RH attended AQILA	
5		**IMPROVEMENT WORK**						
5.1		*Consolidated list to be created of improvement work that is in progress across the Trust.*	NB	RH & CH	June 2024		QI Nurse and PSS Nurse led work that is currently underway. Focus on scoping and then using AMAT to register QI projects. Discussions also held on this process at Continuous Improvement Triage Group.	
5.2		*Create/obtain a list of all staff who have undertaken QSIR training to ensure each area of the Trust has staff that are able to implement the QSIR methodology in designing and implementing improvements.*	NB	RH	31/12/2023		Allocated to corporate nursing business student.	
5.3		*Meet with Audit Lead to discuss AmaT and its suitability for logging improvement work.*	SGL	AR	28.11.2023		Discussed potential use of AmaT to register, record and report on QI projects and/or PSIRF incident action plans. System has modules that would appear to be able to perform this work for us. Assistant Dir of Gov and Clinical Governance Lead have been set up on AmaT	

							system as super users to allow monitoring of QI projects. Need to review audits and projects already registered. Need to undertake more detailed system use training	
5.4		*Process map how learning from patient safety events will feed into improvement workstreams, how effectiveness of improvements will be monitored, and upward assurance reports provided.*	SGL	RH & CH	March 2024		Next phase of utilising AmaT for QI & PSIRF work. RH and CU to work with transformation team to process map.	
6		**CLEANSING OF ULYSSES**						
6.1		*Remove 'Serious Incident Framework' templates and documents from Ulysses*	SGL	AR	March 2024			
6.2		*Transition to LFPSE*	SGL	AR	April 2024	Delays with system provider	Waiting for access code from NHSE so we can begin testing LFPSE prior to go live. Several Trusts in system and BSOL ICB have not gone 'live' with LFPSE.	
6.3		*Review questionnaires and RCA forms within Ulysses to ensure they are aligned with PSIRF, ensure removal of references to RCA's.*	SGL	AR, RH & SB	March 2024	Technical difficulties and delays with amending current forms. Resistance to changes within divisions/speciality teams	Amendment of previous specialty (VTE, TV for e.g.) RCA questionnaires so they are more akin to triage forms used for initial assessment of these incidents to determine whether further investigation required. HoN Div 1 currently trialling amended VTE triage template, TV lead to also trial PU template prior to roll out	
7.		**Duty of Candour**						

7.1		*Amend DoC process to better ensure PSIRF priority of compassionate engagement with patients is embedded in our process.*	SGL	AR & SB	March 2024		Revised process currently being drafted, and flowchart created before being circulated for comment and feedback.	

Key to initials of leads

NB	Nicola Brockie – Chief Nurse
SGL	Simon Grainger Lloyd – Director of Governance
RH	Rebecca Hipwood – Patient Safety Specialist
AR	Adam Roberts – Assistant Director of Governance and Risk
ES	Emma Steele – Deputy Chief Nurse
SB	Sally Breecher - Clinical Governance Lead
CU	Chidiebere Ukaegbu – Quality Improvement Nurse

Status key:	5	Complete	4	On track	3	*Some delay – expect to completed as planned*	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised	

Appendix K

The Initial Equality Impact Assessment (EIA) is a quick and easy screening process. It should:

1. Identify those policies which require a full EIA by looking at:

   - Negative, positive or no impact on any of the protected characteristics.
   - Opportunity to promote equality for the protected characteristics.
   - Data/feedback to prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed.

Corporate Services
Division or Corporate area:

Governance
Speciality/Service Area

Simon Grainger-Lloyd, Executive Director of Governance
Executive Lead (enter name and designation):

Patient Safety Incident Response Framework (PSIRF) Policy & Plan

Title of Policy:

Q1) What is the aim of your Policy?

Learning and improvement following patient safety incidents.

Q2) State to which Trust strategic objective this Policy relates:

Objective 1 – Our Care: Aim to be rated outstanding by the CQC within 5 years.

Q3) Who benefits from your Policy?

All patients

Q4) Do you have any feedback data that influences, affects, or shapes this, Policy?

Yes	No
☐ Please complete below.	☐ Please go to question 5

What is your source of feedback?

- Monitoring Data

☐ Previous EIAs
☐ National Reports
☐ Internal Audits
☐ Patient Surveys
☒ Complaints / Incidents / Claims / Litigation
☐ Focus Groups

☐ Equality & Diversity Training
☐ Other (please state)

What does this source of feedback reveal?

Always opportunity for learning and improvement of patient safety

Q5) Thinking about each group below does or could the Policy have a negative impact on members of the protected characteristics below?

Protected Characteristic	Yes	No	Unclear
Age	☐	☒	☐
Disability	☐	☒	☐
Race	☐	☒	☐
Sex	☐	☒	☐
Gender Reassignment	☐	☒	☐
Sexual Orientation	☐	☒	☐

Religion or belief	☐	☒	☐
Pregnancy & Maternity	☐	☒	☐
Marriage & Civil Partnership	☐	☒	☐
Other socially excluded groups	☐	☒	☐

If the answer is “yes” or “Unclear” please complete a full EIA

Q6) Who was involved in the EIA and how?

Policy Authors
How were they involved? ☐ Surveys ☐ Team Meeting ☐ Group Review ☒ Other Please specify: Authors are persons within the Trust responsible for the implementation of the national patient safety framework to which the policy relates and are therefore the experts on the matter and best placed to assess the possible equality impact.

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	☒	yes	☐

Q7a) If ‘No’ Explain why you have made this decision?

National patient safety framework that is implemented under this policy applies to all patients regardless of protected characteristic. Application of the policy is based on whether a patient has suffered harm.

Q7b) If ‘yes’ explain the negative impact – you may need to complete a full EIA.

If a negative impact has been identified, please continue to undertaking a full impact assessment. If no negative impact has been identified, please submit your Initial Equality Impact Assessment to roh-tr.governance@nhs.net

Justification Statement:
As member of ROH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated

against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	Adam Roberts
Designation:	Assistant Director of Governance & Risk
Date:	07/03/2024
Contact number:	Ext: 55216

This EIA has been approved:

Name:	Simon Grainger-Lloyd
Designation:	Executive Director of Governance
Date:	07/03/2024
Contact number:	Ext: 55853

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Equality Impact Assessment

Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Equality Impact Assessment form. This will involve you questioning aspects of a proposed/existing policy, guideline or strategy and forecasting the likely effect on different groups.

Step 1) What is the impact?

1. Why have you carried out this Full Equality Impact Assessment?

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination or anyone else who will be impacted on by your policy, guideline or strategy.

Step 2) What are the differences?

2a) Identify the Equality group(s) that will be affected by the impact and state what the differences are:

Protected Characteristic	Negative / Potential Negative Impact	Positive / Potential Positive Impact	How is the Equality group identified affected in a different way to others as a result of the policy, guideline or strategy?
Age	☐	☐	
Disability	☐	☐	
Race	☐	☐	
Sex	☐	☐	
Gender Reassignment	☐	☐	
Sexual Orientation	☐	☐	
Religion or Belief	☐	☐	
Pregnancy & Maternity	☐	☐	
Marriage & Civil Partnership	☐	☐	
Other socially excluded groups	☐	☐	

2b) If this EIA indicates that there is insufficient evidence to judge whether there is differential impact please state why below.

Step 3) Consultation

3a) With whom have you consulted on your policy and when did the consultation take place?

3b) As a result of the consultation are there any further changes to the policy needed?

Step 4) Plan to address negative impact

4a) Please complete your action plan using the table below. Detail how you are going to address the negative impact, stating the timescales involved.

Protected Characteristic	Negative Impact	Action Required	Cost Implications	Expected Outcome	Lead (name and job title)	Timescale (specify dates)

Completed by:

Name:	
Designation:	
Date:	
Contact number:	

This EIA has been approved by:

Name:	
Designation:	
Date:	
Contact number:	