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East and North Hertfordshire Teaching NHS Trust

Patient Safety Incident Response Framework

About this document	
Document ID	123 **Version:** 03
Full review due before	01 August 2026
Document type	Policy
Version type	Full review of document - minor amendments
Usage & applicability	For use Trust wide by all roles at all sites

Summary

- The Patient Safety Incident Response Framework (PSIRF) is a core element of the NHS Patient Safety Strategy approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.

- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care. Robust delivery of PSIRF requires a degree of training to ensure that those conducting learning reviews – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.

- This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out East and North Herts NHS Trust's (the Trust) 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.

What you need to know about this version

Full review of document - minor amendments

This is a policy document in line with national guidelines. This document outlines the national framework for incident investigations and replaces investigation processes previously used at ENHT.

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Part 1 – Preliminary document information

1. Scope

This policy, written in line with current national guidelines, is specific to patient safety incident responses conducted for the purpose of learning and improvement across the Trust, through robust engagement with those involved in incidents.

Responses under this policy follow a systems-based human factors 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 and/or isolated component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', is stated as the cause of an incident.

Where other processes exist with a remit of determining liability or the apportion of blame, or cause of death, the principal aim would necessarily differ from a patient safety response. Such processes as listed below are therefore outside of the scope of this policy.

- claims handling
- human resources investigations into employment concerns
- professional standards investigations
- information governance concerns, with no implications to patient safety.
- estates and facilities concerns, (except where a significant patient safety concern is highlighted)
- financial investigations and audits
- safeguarding concerns, (except where a significant patient safety concern is highlighted)
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes are separate from any patient safety investigation. Information from a patient safety response process can be shared with staff/colleagues leading other types of responses, however, these processes should not in any way influence the remit of a patient safety incident response.

2. Purpose

The Patient Safety Incident Response Framework (PSIRF) is a core element of the NHS Patient Safety Strategy approach for the development and maintenance of mechanisms (systems and processes) for responding to patient safety incidents (PSIs) to maximise learning and improvement.

The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care. Robust delivery of the PSIRF requires a degree of training to ensure that those conducting learning reviews – as well as those providing oversight of the process – have the necessary and required level of knowledge, expertise and experience that supports effective robust investigations leading to Trust-wide learning and improvement.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out East and North Herts NHS Trust's (the Trust) 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, through robust engagement with those involved.

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

Our patient safety incident response policy is an overarching policy for patient safety management in our organisation. The policy includes details of relevant aspects of incident management in our organisation, including patient safety incident reporting and safety improvement monitoring.

This policy supports development and maintenance of an effective patient safety incident response process that integrates the four key aims of PSIRF which is aligned to East and North Hertfordshire NHS Trust values- Include, Respect and Improve:

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

This policy should be read in conjunction with our current [patient safety incident response plan], which details our current local and national safety priorities as well as the incident management standard operating procedure (SOP) which sets out how this policy will be implemented.

3. Definitions

Below is a list of abbreviations frequently used throughout the document.

Acronym	Meaning
AAR	After action review
AfC	Agenda for Change
DOC	Duty of Candour
	Divisional
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPO	Kaizen Promotion Office
LFPSE	Learning from patient safety events
MDT	Multi-disciplinary Team
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partner

QM	Quality Management
RJLC	restorative, just and learning culture
PSERP	Patient Safety Event Review Panel
SOP	Standard Operating Procedure
TEL	Technology Enhanced Learning
VMI	Virginia Mason Institute

4. Duties

Designation	Responsibilities
Chief Executive Officer (CEO)	Ensure ENHT systems and structures support delivery of high performing PSIRF safety standards
Chief Kaizen Officer	Ensure improvement capabilities accessible and sustainable
Medical Director	Accountable officer for PSIRF safety standards
Chief Nurse	Accountable officer for PSIRF safety standards
Chief Operating Officer	Ensure ENHT systems and management structures support delivery of high performing safety standards
Director of Quality	Deputy responsible officer for ensuring systems and structures support the delivery of high performing safety standards. Overseeing the publication of the PSIRF Plan.
Associate Medical Director PS	Deputy responsible officer for ensuring ENHT systems and structures support the delivery of high performing safety standards
Deputy Medical Director	Deputy professional officer for ensuring ENHT medical workforce deliver high performing safety standards
Chair Quality and Safety Committee	Responsible for overseeing and seeking assurance that systems and structures support the delivery of high performing PSIRF safety standards
Associate Director People	Responsible for ensuring capability building plans provide ENHT systems and workforce with requirements to meet PSIRF safety standards
AD Quality Governance	Responsible for ensuring compliance and assurance within systems and structures can be monitored against PSIRF safety standards
Head of Patient Safety, Learning and Legal services	Responsible for ensuring trust wide operational processes deliver PSIRF safety standards internally and externally to the trust, including the publication of the PSIRF Standard Operating Procedure.
Patient Safety Learning Response Leads	Responsible for ensuring all incidents have proportionate responses that meet PSIRF safety standards, including meaningful engagement of staff and patients involved in incidents.
Divisional Director(s) of Nursing / Midwifery and Quality	Divisional responsible officer for ensuring systems and structures support the delivery and oversight of high performing safety standards, including Duty of Candour and restorative responses.
Divisional Quality Managers	Responsible for ensuring operational compliance and assurance within care group systems and structures effectively meet PSIRF safety standards, including

	Duty of Candour and restorative responses.
Divisional Medical Director	Responsible for ensuring divisional systems and structures support the delivery and oversight of high performing safety standards.
Divisional Operations Director	Responsible for ensuring divisional systems and structures support the delivery and oversight high performing safety standards.
Care Group triumvirate	Responsible officers for ensuring systems and structures with care groups support the effective delivery and oversight of safety standards, including Duty of Candour and restorative responses.
Matron and operational managers	Responsible for ensuring operational services level systems and structures support the delivery and oversight of high performing safety standards
Ward manager/ other team leaders	Responsible for ensuring unit level systems and structures provide timely responses to incident reporting and provide immediate support when required to those involved.

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Management of complaints and concerns policy	63	☒ENHT | ☐Affiliated network | ☐National/ regional
Duty of Candour policy	131	☒ENHT | ☐Affiliated network | ☐National/ regional
Incident Management SOP	TBC	☒ENHT | ☐Affiliated network | ☐National/ regional
Risk Management Policy	148	☒ENHT | ☐Affiliated network | ☐National/ regional

6. Monitoring compliance

This document will be reviewed **annually** or as determined by changes in processes that supports the effective investigations of incidents and/or where any evidence or change in practice comes to light requiring an update to the document.

Any further activity to monitor to the use and compliance of the document at the Trust is documented below

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy, planning and oversight	Annual PSIRF plan shall be published every 12-18 months. Audit of adherence to standardised governance reporting of application of PSIRF learning responses, PSII learning reviews. PSIRF Improvement priorities shall be tracked through PSERP and Patient Safety Forum??	Director of Quality Head of Patient Safety, Learning and Legal services	Shared annually with Trust Board ICB & PLACE	
Compassionate engagement and involvement of those affected by patient safety incidents	Survey and other feedback methods shall be designed to be utilised through routine engagement processes with staff, patients and families Staff, patient and family stories shall be shared. Continuous monitoring of DOC application shall be visible via incident quality management reporting dashboard.	Head of Patient Safety, Learning and Legal services	Quality and Safety Committee Quarterly Trust Board Annually and as per PSii presentation	
Competency and capacity to apply of a range of system-based approaches to learning from patient safety incidents.	Measure compliance with essential national safety training modules Number of staff trained in PSIRF oversight roles. Number of staff capable to undertake Learning reviews (AAR, MDT Round tables, Debriefs) Number of staff trained in SEIPS model (PSII) Number of staff undertaking Msc Patient Safety		Quality and Safety Committee monthly People committee monthly Trust Board Annually	

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Considered and proportionate responses to patient safety incidents	A count of SEIPS learning response models deployed shall be measured monthly. Sample audit documented risk-based approach to decision making shall be captured through DSIRP and PSERP		Quality and Safety Committee monthly Patient Safety Oversight Panel -monthly Trust Board Annually	

This policy shall support the delivery of NHSE PSIRF Standards

Compliance with this policy shall be demonstrated through learning and improvement oversight structures through unit, service, care group and divisional learning and improving structures.

Evidence shall be provided to demonstrated compliance against the key standards

6.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, applies to all, regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

This evidence is in the form of an equality impact assessment (only if initial screening form below prompts a full EIA) – a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another based on:		Impact Yes/No	Comments
1	Age (younger people & children & older people)	No	
2	Gender (men & women)	No	
3	Race (include travellers)	No	

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another based on:		Impact Yes/No	Comments
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	No	
5	Religion/Belief	No	
6	Sexual Orientation (Gay, Lesbian, Bisexual)	No	
7	Gender Re-assignment	No	
8	Marriage & Civil Partnership	No	
9	Pregnancy & Maternity	No	
10	Is there any evidence that some groups maybe affected differently?	No	
11	Could this document have an impact on other groups not covered by a protected characteristic? (i.e.: low wage earners or carers)	No	
Any other comments: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.			
EIA screening form completed by: Director of Quality **Date completed**: 30/08/2023			

6.2. Dissemination and Access

This document is considered valid when viewed via the staff intranet for East & North Hertfordshire NHS Trust. If this document is printed (in hard copy), or saved at another location, users of this document must ensure they are using the same version that is on the intranet.

7. References

1. National patient Safety Strategy (2021) https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/
2. Patient safety Incident Response framework (2022) https://www.england.nhs.uk/patient-safety/incident-response-framework/
3. Equality Act (2010) https://www.legislation.gov.uk/ukpga/2010/15/contents
4. LFPSE https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/
5. Safety action development guide (2022), NHSE https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

8. Acknowledgements

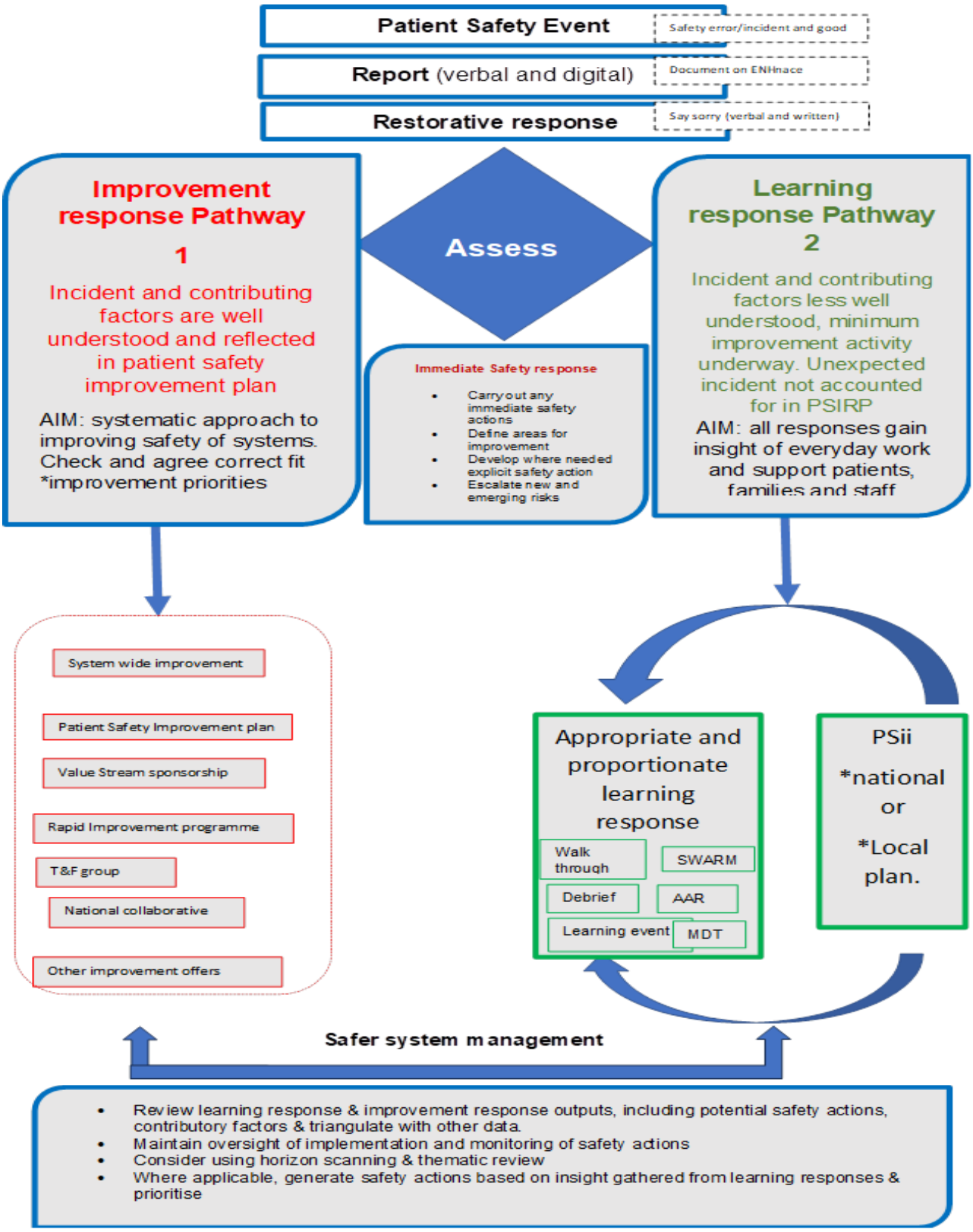
The development of this policy has been done through collaborative working from key staff members, particularly:

- Bridget Sanders, Medical Programme Director

- Dr Jon Bramall, Associate Medical Director, Patient Safety Specialist
- Rachel Bulloch, Patient Safety Pharmacist, Patient Safety Specialist
- Namdi Ngoka, Associate Director People Capability
- Michelle Anstiss, PSIRF project lead
- Margaret Mary Devaney, Director of Quality
- Sarah Simmons, Deputy head of Communication
- Chris Curtis, Patient Safety Partner
- Margaret Okojie, Associate Director of Quality Governance
- Rosie Connolly, Deputy Director of Quality Improvement & Patient Safety, Hertfordshire and West Essex ICB
- National and Regional Patient Safety Specialist networks
- NHSE Patient Safety Incident Response networks and platforms

Part 2 – Patient Safety Incident Response Framework

Flow chart



1. Our patient safety culture

East and North Hertfordshire NHS Trust in year one of implementing new processes and approaches to the manner, in which we manage and learn from patient safety incidents. Our ambition is to establish a restorative, just and learning culture (RJLC) within the organisation, one that promotes no blame, psychological safety and continuous quality improvement.

A crucial step in the development of our RJLC patient safety culture has been the introduction of our new Trust values of “Include, Respect and Improve” and the expectation that all our people model locally agreed expected team behaviours.

As we imbed the PSIRF, we ensure that the following key elements are incorporated:

- leadership
- teamwork
- communication
- restorative, just and learning culture (RJLC)
- psychological safety
- promoting inclusion and diversity
- staff well-being
- civility and kindness initiative
- organisational and leadership development through a “healthy teams” approach

We continue to upskill staff to understand and support our restorative, just and learning culture ambitions, ensuring that our procedures and policies are suitable, and that line managers and senior clinicians are competent to support staff through the PSIRF appropriately.

Freedom to Speak Up: Our staff voice matters, and it is essential that every voice is heard. The Freedom to Speak Service complements and strengthens patient safety culture. The Freedom to Speak Up Guardian gives all staff a safe confidential space to discuss anything that gets in the way of providing great patient care. In addition to this, our Speak Up Champions will address any barriers to Speaking Up and help influence a positive and psychologically safe culture within their teams.

Our local Trust priorities include a common thread of communication and encouraging civility, so there we continue to learn and improve from these types of incidents.

We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at the identified learning and improvement whilst increasing transparency and openness amongst our staff in reporting of incidents. This will include identifying insight from when things have gone well and where things have not gone as planned.

To enhance our safety culture, we have introduced safety incident oversight huddles across Care Groups and Divisional governance structures which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

We will use the findings from our staff survey metrics based on specific patient and staff safety questions to assess if we are progressing in improving our safety culture, as well as using specifically designed patient safety culture questionnaires.

2. Patient safety partners

A patient safety partner is a role that is new and evolving. The purpose is for our service users, be they patients, carers or family members to use their lived experience to work with the Trust to improve our safety culture and systems as an equal member of the team.

A 'Patient Safety Partner' (PSP) is defined for the purposes of this policy as: a person that supports effective safety governance and improvement within an organisation by working in partnership with staff. They will be asked to provide a different perspective on patient safety which is not influenced by organisational bias or historical systems, resulting in a patient-centred approach to safer healthcare. This group of people will be a voice for patients and the community ensuring that patient safety is a priority for the organisation at all levels.

PSPs could be required to participate in any of the following activities:

- support the design of the patient safety plan and this policy in conjunction with the Patient Safety Specialist or delegated lead
- PSPs may work with the board and its members to consider how to improve safety
- PSPs may be involved in patient safety improvement projects
- PSPs may be asked to act as a mentor or 'buddy' for new PSPs joining the Trust
- PSPs may be asked to be involved in staff patient safety training
- PSPs may be asked to participate in investigation oversight groups

PSPs will be offered the following:

- Remuneration on a sessional basis.
- Ongoing support from the patient safety specialist.
- Opportunities for further training in relation to designated role identified in line with the requirements of the individual in conversation with a Patient Safety Specialist.
- A signed involvement agreement with the Trust, detailing mutually agreed commitments (reviewed on an annual basis alongside a grow together conversation to identify ongoing training and support needs).
- As this is a new and evolving role for the Trust, the Role Description is likely to adapt and change so duties will be subject to change (as specified within the Role Description). Early review in consultation with the PSP, Service Lines and the Patient Safety Specialist will be key to the success of the role.

3. Behaviours expected for patient safety responses

ENHT shall adopt a PSRIF mind set with partners that remains:

- Improvement focused – proposing where applicable to host system wide learning collaborative from ENHT.
- A 'just' and open mind set – sharing learning from errors and good practice and sharing compliance with DOC and actions taken from learning responses delivered.
- Curious and learning – proactively seek learning
- with system partners and support other partners to learn from ENHT, supporting system wide learning events and structures where able e.g. systems approach to AAR capabilities.

- Collaborate and share information with relevant stakeholders, including the ICB, CQC through existing regulatory partnership forums, and through PLACE, ICB, Regional and national quality and transformation structures, including local networks e.g. patient safety improvement networks, patient safety specialist networks, local maternity, and neonatal systems.

The PSIRF governance structure will be core to the wider Quality Governance Structure, across key drivers of learning and improving and seeking compliance and assurance of the PSIRF Standards.

Standard Operational Procedures shall be set to enable the reporting mechanism and oversight through divisional response panels and PSERP governance structure through core principles:

- Use a variety of data
- Reduce the information collection burden
- Oversight is not 'one size fits all'
- Capture meaningful insight from patients, families, and staff
- Metrics require clarity and purpose

4. Addressing health inequalities

Health inequalities can be defined as systematic, unfair and avoidable differences in health across the population, and between different groups in society. East and North Hertfordshire NHS Trust recognises that we, in collaboration with the Integrated Care Board, have a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate safety risk to patients from across the range of protected characteristics.

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

We will also address apparent health inequalities as part of our safety improvement work. In establishing our Patient Safety Incident Response plan, we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

5. 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 respond to any questions/queries they have in relation to the incident and signpost them to support as required.

The Trust is committed to co-production and to include patients, families and staff in learning responses, respect recognise and acknowledge their voice in the learning process and continuously improve the care, experience and service we provide. We will ensure that all accessible needs are met and that an individualised approach will be taken depending on individual's needs.

As a Trust we advocate being open and transparent with our patients, families, carers and staff alongside our statutory and regulatory Duty of Candour obligations. As part of our Duty of Candour process, we will be collaborative and open with all those affected and involved in a patient safety incident. The Trust recognises the importance of compassionate engagement in all our learning responses.

We will clearly outline procedures that support patients, families, carers and staff based on our existing Duty of Candour policy. These will include a leaflet for patients, guidance notes for staff and template letters. This will ensure that the 4 required steps of engagement are met; 1) before contact, 2) initial contact 3) continued contact and 4) closing contact.

The Trust will support and deliver an operational plan that provides a supportive and candid liaison relationship between all staff, families and carers and patients involved in patient safety incidents.

This liaison infrastructure shall guide patients, families and carers through the expectations of any learning review undertaken, ensuring that they can be involved in the learning process and be able to contribute to lessons learnt and/or seek support where required.

There may be occasions when other external responses are ongoing alongside a patient safety incident review. These may include litigation, an inquest, The Health Services Safety Investigations Body (HSSIB), The Maternity and Newborn Safety Investigation (MNSI) programme, police investigations or social services. In such instances, the patients, families, carers or staff should be made aware of these and provided with relevant contacts.

We recognise there are also other forms of support outside of the Trust that can help those affected by a patient safety incident and we will work with patients, families, carers and staff to signpost them accordingly. For example, bereavement charities, advocacy services and Healthwatch Hertfordshire.

Whilst we develop and strengthen our plans and guidance further, staff and patients/families involved in patient safety incidents will continue to be supported.

6. 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 Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising learning and improvement.

To fulfil this, we will align current resources for patient safety incident responses and safety improvement.

We will identify insight from our patient safety incidents and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

7. Resources and training to support patient safety incident response

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required for all our staff including specific training for those involved in patient safety incidents.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant division. A learning response lead will be nominated by the division and the individual should have an appropriate level of skills and experience to competently lead the learning response required.

The Trust will ensure that learning responses are not undertaken by staff working in isolation. This will be overseen through clinical governance arrangements currently in management operational structures.

Those staff affected by patient safety incidents will be afforded the necessary restorative support and be given time to participate in learning responses and improvements.

All Trust managers will be supported to develop capabilities that enable the delivery of just culture principles in line with our Trust values.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response and improvement processes to provide expertise (e.g., clinical, or human factors review). The Trust has an improvement partnership with Virginia Mason Institute (VMI). This will deliver targeted and measurable capability programmes for staff to confidently drive improvements required.

Training

The Trust has implemented a suite of patient safety training packages to ensure that staff/colleagues are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows

- Level one
    - national – Health Education England patient safety syllabus module (Essentials for patient safety)
    - all staff, clinical and non-clinical are expected to undertake this on induction and to repeat every three years
    - these modules are available as eLearning via ENH Academy access
    - national – Health Education England patient safety syllabus module (Essentials of patient safety for boards/non-executive directors)
    - this module can be accessed directly from the ENH Academy platform
- Level two
    - national – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all medical staff and staff on Agenda for Change (AfC) bands 5 and above, with potential to support or lead patient safety incident management
    - this module is available as eLearning via the ENH Academy platform

Learning response leads training and competencies

- Training
    - Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the Learning and Development Technology Enhanced Learning (TEL) team as part of their general education governance processes.
    - Learning response leads must have completed Level one and two of the national patient safety syllabus.
    - Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.
    - To maintain expertise the Trust will undertake an annual networking event for all learning response leads.
    - Learning response leads will need to contribute to a minimum of two learning responses per year.
- Competencies

As a Trust we expect that those staff leading learning responses are able to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report format.

- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

Engagement and involvement training and competencies

- Training

  - Engagement and involvement with those affected by a patient safety incident will be undertaken by those who have undergone a minimum of six hours training, including Involving patients, families and staff in patient safety incidents (this covers areas such as the Duty of Candour training, challenges and complexity and dealing with conflict).
  - Records of such training will be maintained by the Learning and Development Technology Enhanced Learning (TEL) team as part of their general education governance processes.
  - Engagement leads must have complete Level one and two of the national patient safety syllabus.
  - Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.
  - To maintain expertise the Trust will undertake an annual networking event for all engagement leads.
  - Engagement leads will need to contribute to a minimum of two learning responses per year.

- Competencies

As a Trust we expect that those staff who are engagement leads to be able to:

  - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
  - Listen and hear the distress of others in a measured and supportive way.
  - Maintain clear records of information gathered and contact those affected.
  - Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
  - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight roles training and competencies

- Training

  - All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development Technology Enhanced Learning (TEL) team as part of their general education governance processes.
  - Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

- All those with an oversight role in relation to the PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency

As a Trust we expect staff with oversight roles to be able to

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report format.

Additional Learning for those involved in Patient Safety Responses

In addition to the above competences and training the Trust will provide the following additional support and learning to staff involved in our Patient Safety Incident Responses

1. Use of System Engineering Initiative for Patient Safety (SEIPS) framework in all learning responses
2. Human Factors training both theory and simulated learning
3. Training on the use and application of the agreed Trust learning response tools – Patient Safety Incident Investigations (PSII), Roundtable/Multi-disciplinary Team (MDT), After Action Reviews (AARs) and hot debriefs.
4. Duty of Candour, Psychological Safety and Just Culture learning
5. Facilitation skills training - theory and scenario based
6. Quality Improvement –theory and application

Training will be made available via ENH Academy online training and classroom-based events including opportunities for lab based and in-situ simulation.

8. Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Patient Safety Incident Response Plan] can be found on the intranet.

9. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12-18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 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 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.

10. Patient safety incident reporting arrangements

10.1. Safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident or good care event witnessed, on ENHance which is the Trust's Quality Management system. ENHance includes incident reporting. ENHance is aligned with 'Learning From Patient Safety Events' (LFPSE) and thus enables automated uploading to national systems, as appropriate, to support national learning. More information on LFPSE can be found here: https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/

As part of the incident reporting form, reporters are required to include detail of the level of physical harm and psychological harm that has been experienced by the person affected. The reporting form also provides the relevant prompt for when Duty of Candour applies to an incident and provides a section for the detail to be recorded. Being Open (Duty of Candour) Policy CSEC010 can be found on the intranet.

Local reporting

The nominated person in charge of clinical or non-clinical areas where a patient safety incident has occurred must be informed as soon as is viable from the time the incident occurred.

There must be clear identification of who shall report the incident in the reporting section of ENHance, this should be done as soon as is viable from the time the incident or good care event occurred/was identified.

Time frames for incident management

Incident stage	Timeframe	Evidence
Incident reporting	As soon as possible to incident occurring, within 24hrs	Reported LFPSE
Initial Learning review	Within 24-72 hrs of reporting	Daily incident

e.g. debrief, SWARM		oversight panel
Further learning response AAR, Debrief, MDT	20 working days (6 weeks) of reporting	Published report via governance oversight forum
PSii i.e. mandated or local priority	Within 88 working days (20 weeks) No more than 6 months	Published PSii
In exceptional circumstances a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).		

Ongoing review of incidents and good care reported

Staff in quality management (QM) and learning response and liaison roles must review the automatic 'daily incident report' on ENHance each day and should not rely on email notifications.

Divisional Directors of Nursing/Midwifery, as responsible officers within nominated divisions, will ensure daily review mechanisms are in place to ensure that reported patient safety incidents are responded to proportionately and in a timely manner.

The divisional clinical and quality governance teams will facilitate a safety incident response panel to provide oversight and review of incidents reported and the application of the safety response standards. This will ensure staff and patients/family's needs have been met and Duty of Candour has been applied, where appropriate.

The divisional response panel will also oversee the divisional safety action plan, stratified to unit and service level and seek high ranking evidence of assurance provided against each safety action.

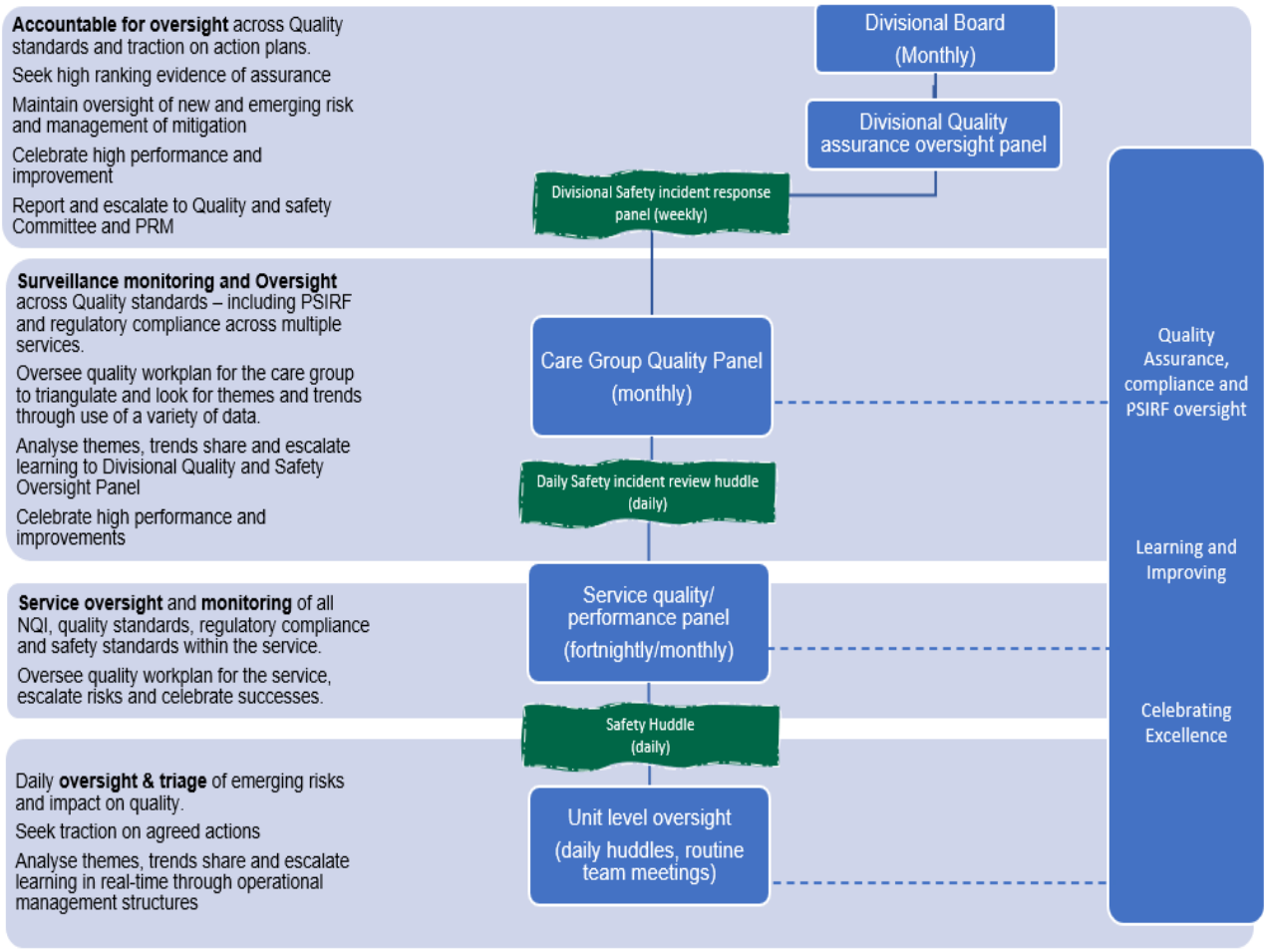
Reported incidents should be assessed at unit/area level, service/care group level, divisional level, hospital wide and system level for:

- assurance and evidence that the correct incident response has been applied and is proportionate.
- trends in reporting- looking for any hot spots, clusters (either geographically or subject similarity) and identify if normal and unwarranted variation present.
- any areas of poor/under reporting - should be explored to understand any potential reporting barriers.

The divisional response panel must ensure:

- A variety of data is interrogated to ascertain appropriate response to incidents reported.
- Information collection is relevant and required, and data has clarity and purpose.
- Application of different tools and methods that are appropriate for incident reported -not 'one size fits all'.
- Visibility of meaningful insight from patients, families, and staff

Divisional Safety Incident Response Governance Structures



A similar incident which may occur within a service/ discipline outside of the immediate remit of a prior investigation but falls within the scope of another subject matter expert shall be reported on ENHance and managed via/through an identified liaison for the local area with the relevant accountable service having oversight e.g. health and safety incidents will be managed through to the Health & Safety Executive, the Trust Health & Safety team will remain the liaison with HSE and the Health, Safety, Fire & Security Group would have oversight. This will enable the Trust to continue to meet all required reporting requirements and ensure oversight of relevant actions.

Sharing learning from reported incidents and good care

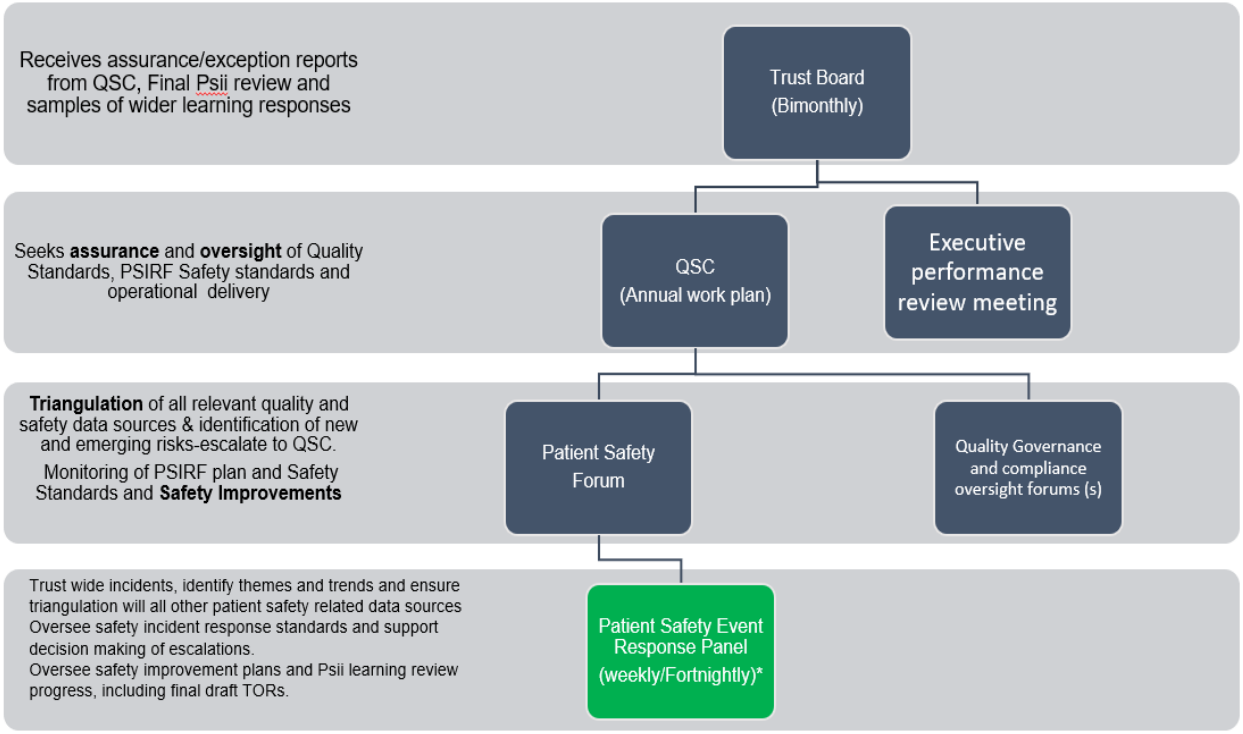
Learning from reported themes, trends, improvements and actions taken must be shared across services at ENHT.

A safety incident which appears to meet the requirement for reporting externally will be brought to PSERP for discussion and oversight. This will allow the Trust to work in a transparent and collaborative way with the ICB, or other key stakeholders as required.

Learning from reported incidents shall be shared through the Trust Patient Safety Event Panel (PERSP). This will ensure oversight of the Trust-wide patient safety and risk profile and alignment with patient safety improvement actions/priorities and PSIIs.

The Patient Safety Forum (PSF) will oversee a trust wide safety action plan and seek high ranking evidence of assurance provided against each safety action.

10.2. Organisational Safety Incident Response Structures



*alternating PSERP escalations and oversight

Where the Coroner has requested for further information or statements for the purposes of an inquest, the Claims and Inquests team will ensure any relevant patient safety incident learning is shared with the Coroner.

A strong operational process shall support cross-system learning with system partners through forums such as PLACE, Integrated Care Board oversight groups, regional quality system meeting and speciality forums e.g. End of Life, learning from deaths, and transformation groups.

11. Patient safety incident response decision-making

Incidents learning responses shall be overseen by the Trust's Patient Safety Learning Response leads.

Triangulation of information shall be used when agree proportionality of responses. Data is available online from the national surveys of staff and patients. These include inpatients, outpatients, maternity services and the staff survey. Each of these contains information about the safety of services. The staff survey contains questions relating to patient safety and from the results over time it is possible to assess views on workload pressures, job-related training

opportunities, violence, aggression and harassment, and the percentage of staff witnessing potentially harmful errors or near misses.

The Trust shall enable oversight of real time key quality metrics though a Quality Management System.

Safety cannot be seen in isolation from broader concerns about quality. Of necessity, safety is always only one consideration in a broader picture. Therefore, multiple factors potentially affect the safety and quality of care delivered to patients. The Trust Quality Assurance (QA) Framework should be used in alignment when considering responses to incidents. The QA Framework shall include:

Quality governance oversight: Work plan (work pattern agreed locally)	**Intelligence to be considered**
CQC Regulatory Fundamentals: • Complaints (Reg 16) • Duty of candour (Reg 20) • Staffing (Reg 18) • Good governance and policy compliance (Reg 17) • Premises and equipment (Reg 15) • Food and drink (Reg 14) • Dignity and respect (Reg 10)	Observations of care where the work is done, lived experience and feedback Themes and trends form staff feedback Patient, family and carer experience. Evidence of learning and improving form audits, incidents and complaints. Feedback, peer review information and actions, new risk escalations. Observations of care where the work is done, lived experience
Patient Safety Learning Response themes, actions and improvements – interpreting signs of repetitive themes, or judgment that new learning is required.	
Performance of nursing quality indicators and fundamentals of care: • Nutrition & Hydration risk assessment and action plans • Skin prevention risk assessment and action plans • Falls Risk assessment and action plans • IV care bundle risk assessment and action plans • Pain control assessed and actioned • Patient handling needs risk assessed and actioned • Reliability of observations and escalation • Catheter care and VIP mitigation • Core Competencies • Religious cultural needs documented and met • Staff supported to speak up • Hand Hygiene and IPC standards • Medication Safety • Patients able to discuss worries when asked • VTE Risk Assessment • Do patients feel involved in planning their care?	
Service level quality audit requirements – publish annually, gaps identified or risks evident?	
NICE/CAE and GIRFT action oversight – gaps/risks?	
Service specific standards and regulatory requirements e.g. JAG, HTA, RCP	

- analysis of trends in safety data – looking for variation within the system

- a review of other safety critical information such as staffing level, vacancy rates, risk management, key operational performance data sets, availability of equipment, environmental conditions and all aspects of feedback
- learning from mortality reviews
- evidence of high reliability in processes through audits and study of where work is done
- oversight of relevant regulatory compliance and other externally regulated requirements.

Where we recognise there are unknown aspects and more learning required a request shall be made to deploy recognised system-based methodologies for data collection and analysis e.g. Systems Engineering Initiative for Patient Safety reviews (SEIPS), AAR, debriefing, mapping current and future states, undertake baseline audits or survey.

Responses shall ensure prompt and effective communication between those affected by a patient safety incident through governance structures of local oversight incident response frameworks.

Where risk has been identified to be significant a proportionate response should be deployed.

- after action reviews and debriefs
- MDT roundtable learning review
- safety improvement initiatives
- area specific task and finish groups
- inform existing PSII learning reviews
- inform existing improvement programmes

12. Learning Responses from good or positive care

Learning from good or positive care will be reported on the Trust's Quality Management System, ENHance as a 'good care' event in line with LFPSE reporting. Information from this system will be analysed to understand themes and trends. The data will also be used to identify the service areas within which the good care is being identified and reported to ensure that the learning is appropriately captured and shared more widely.

13. Responding to cross-system incidents/issues

The Trust is committed to collaborative engagement with all those affected by and involved with patient safety incidents.

The Trust will work with other NHS Trusts, relevant system care providers and stakeholders and ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Where it is recognised that an incident requires a cross-system learning response, it will be escalated to the Trust PSERP from the divisional response panel, and/or escalations from external sources to the Trust.

Through collaborative partnership working the Trust will proactively seek out learning opportunities e.g. with other providers, GPs, the local authority, Police, Ambulance Service etc. and welcome joint learning through structured learning responses such as:

- AARs and debriefs
- MDT roundtable learning reviews

- safety improvement initiatives
- PSII learning reviews
- structured incident task and finish groups

ENHT safety incident response structures seek proactive strong partnership working with ICB Quality & Safety structures to ensure cross system learning reviews e.g. MDT roundtable discussions are collaborative and facilitated to achieve meaningful learning and engagement of improvement/ actions.

Where cross-system incidents themes and emerging risks occur, ENHT will consider an executive and board agreement for a proposal and consideration with the ICB and systems partners, for deployment of an ENHT hosted quality improvement breakthrough series collaborative across willing partner providers and system partners.

13.1. Timeframes for learning responses

Timescales for Patient Safety Incident Investigation (PSII)

Criteria for a PSII shall be clearly defined in the ENHT annual patient safety incident response plan.

Where a PSII is indicated, the investigation must be initiated immediately following PSERP acknowledgement that a PSII is required.

A PSII shall agree targeted milestones and trajectories at the beginning , agreed at the outset with the key stakeholders (including both those affected and those involved) as part of the setting of terms of reference.

The learning response lead shall ensure oversight of milestones through divisional learning and improving structures; and escalation via divisional response panel and PSERP. as required where milestones are at risk of not being met.

No PSII should take longer than six months.

The Trust recognises that every learning response will require various depths of application of the SEIPIS learning model. A PSII will require an extensive in-depth learning review and studying of systems where incidents have occurred, and a degree of flexibility of timescales will be required to ensure contributions of those involved and affected by the incident remain a priority and learning pace is compassionate and effective.

In exceptional circumstances a longer timeframe past 6 months may be required for completion of the PSII based on the individual, specific case e.g. where patient or family require more time to engage with the learning review. In such instances, any extended timeframe should be agreed between the interested parties and be noted at PSERP. In the spirit of the PSIRF, these timescales will not become routine targets, and the focus will remain on appropriate, impactful learning. However as per the above, having any extensions brought to the PSERP will allow for oversight of the timeliness of the process and if the PSIIs are frequently taking longer than anticipated, the process will be reviewed to understand the reasons why and how this can be improved.

14. Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the date when the incident is reported. No learning response should take longer than six months to complete.

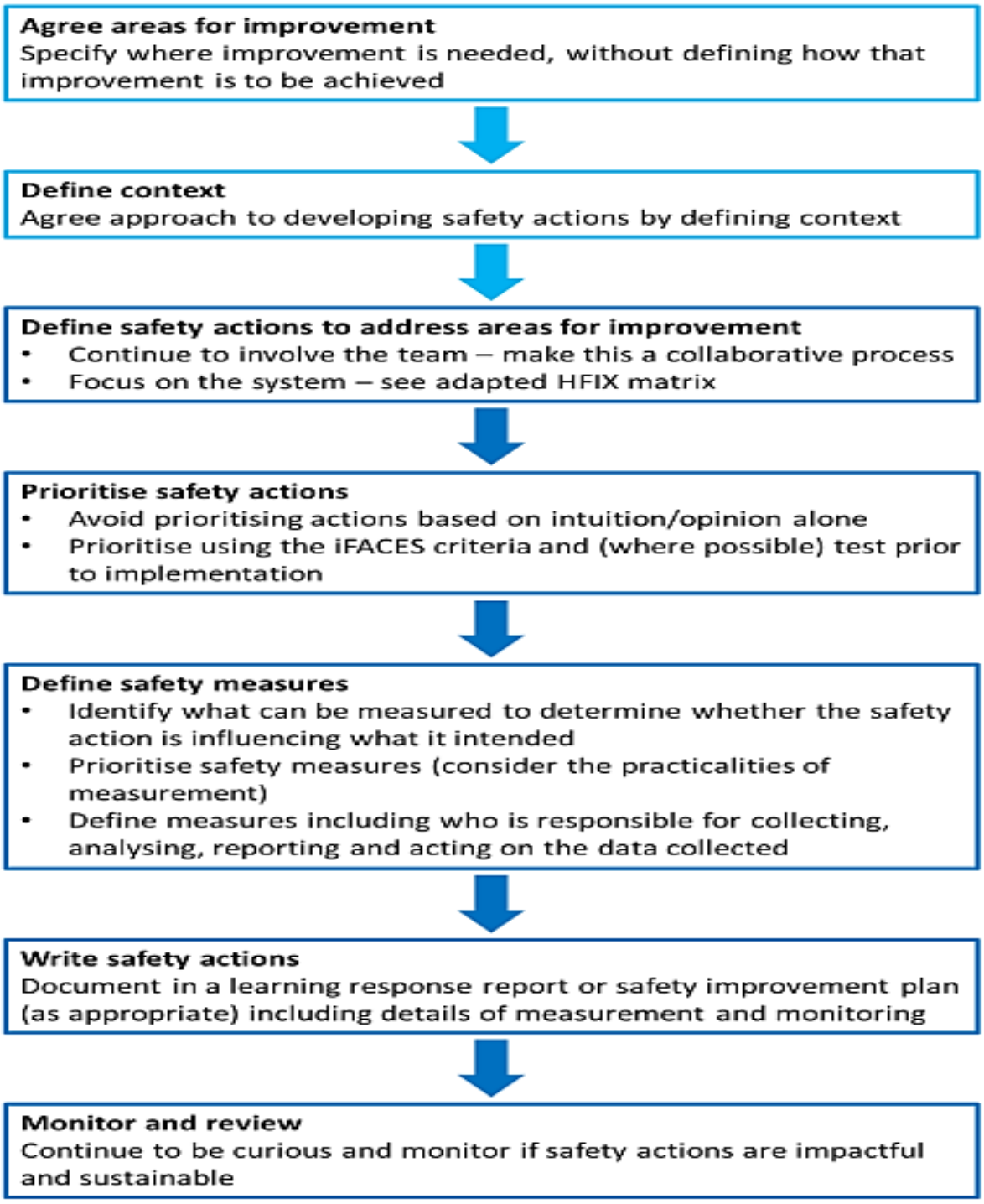
15. Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or other learning review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, credible safety actions are needed. These actions need to be delivered through demonstrating high ranking evidence of assurance.

The Trust will have systems and processes in place across unit, service and divisional structures that support the design, implementation and monitoring of safety actions using an integrated approach to reduce risk and limit the potential for future harm.

Learning responses should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on identified factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from key stakeholders e.g. estates, IPC, safeguarding, digital, therapy teams, porters etc.

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



A risk-based approach to appropriate response should be done through oversight and triangulation of key information such as:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions
2. Define the context – this will allow agreement on the approach to be taken for safety action development
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
4. Prioritise safety actions to decide on testing for implementation

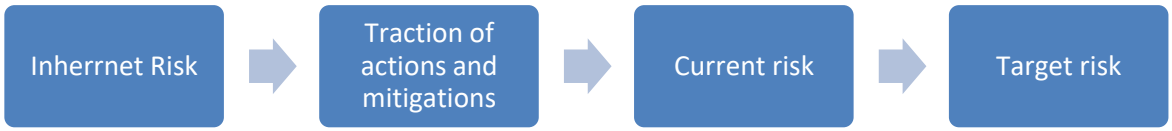
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
6. Safety actions will be clearly written and follow 'Specific, Learning-Oriented, Impactful, and Measurable' (SLIM) principles and must have a designated owner.

Safety Action Monitoring

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable.

This monitoring and traction of actions shall be done in alignment with a divisional audit plan.

Actions shall be monitored in the context of ongoing dynamic assessment of risk within the system, tracking mitigations and progress of risk trend.



The Trust PSF review all safety actions bi-annually.

16. ENHT Patient Safety Incident Response Framework: Improvement response pathway

PSIRF improvement priorities shall be identified and published through the Trust PSIRF plan annually.

Ongoing development of PSIRF improvement priorities shall be in response to continuous review of output from learning responses of incidents, and sufficient understanding of the underlying interlinked system issues, ongoing dynamic risk management, and recognition of where a structured improvement response is required.

PSIRF improvement priorities can be delivered to benefit individual safety improvement plans that focus on a specific service, pathway or location.

17. Governance of patient safety improvement plans

Patient safety organisational wide improvement priorities shall be agreed through PSERP.

Service specific improvement priorities shall be agreed through Divisional governance structures.

All PSIRF improvement priorities shall be cohesive, structured and formed from thematic analysis and stratification of intelligence outputs from continuous learning responses (SEIPS analysis).

All PSIRF improvement plans shall consider the trust single model for improvement design through, focusing the whole organisation on working together to enhance value from the perspective of the patient, improve quality and safety of service delivery, and embed a sustainable culture of continuous improvement.

Safety improvement priorities will be addressed through combining subject matter experts and patient/family members.

Reporting and recording of PSIRF improvements will be driven by the studying of 'where work is done', setting measurable objectives, clarity of expected benefits, share expected resource requirements, explain expected risks and associated measures for improvement, and follow standardised reporting templates.

All PSIRF improvement efforts shall strive to lead approaches that empower and engage staff to improve their processes and services and adopt tools and techniques advocated through ENH Production System.

18. Oversight roles and responsibilities

18.1. System oversight

ENHT will work in partnership with ICB, regional and national networks to facilitate delivery of the PSIRF Standards.

This will be done through collaborative partnership working with systems partners and wider healthcare providers where value can be gained to support learning and improving following incidents.

Dependencies

- Trust Quality Accounts and Quality Contract agreement
- PSIRF Annual plan
- Trust audit programmes, particularly key NICE guidelines pertaining to safety priorities and Nursing fundamentals, Pathways to Excellence Accreditation programme
- Commissioning for quality and innovation programmes (CQUIN)
- Patients experience surveys
- Staff experience surveys
- Pre and postgraduate training
- PLACE based improvement priorities
- Trust objectives
- Internal performance reviews

Key Stakeholders

- ENHT patients, parents, carers and residents
- Patient safety partners (PSPs)
- ENHT staff: specifically including Divisional Directors, Senior management, Clinical Directors forum, Matrons forum, Consultants.
- Local GPs
- Local acute, specialist, mental health and community provider organisations
- EAST Ambulance Service
- Local patient, public and voluntary groups
- Kaizen promotion Office
- ICB and special commissioning groups
- NHS England
- NHSR
- Local and national Patient Safety Speciality networks

Performance Measures and Success Criteria

- Quantitative and qualitative data described below will be collected retrospectively from year each year to plan PSIRF priorities for the next year and measured within year against quality standards:

    - Hospital standardised mortality rate (HSMR)
    - cardiac arrest rate
    - unexpected admission to critical care rate
    - never event prevalence
    - reporting of zero-harm or near-miss incidents (should increase)
    - reporting of moderate and significant harm incidents (should decrease)
    - improved staff survey results in relation to patient safety culture
    - patient safety culture survey
    - patient experience survey results
    - number of improvement initiatives with tangible patient co-design.

19. Complaints and appeals

On occasion it is recognised by the Trust that patients, families and carers will be dissatisfied with aspects of the care and services that have been provided by the Trust. A fair, sensitive and accurate response to patient, families and carers complaints is one of the ways of improving the quality of care within the Trust. We strive to create an environment and culture in which patients know it is acceptable to raise a complaint or concern or offer feedback about our services.

It is essential for all to understand that complaints and concerns are two separate processes and not all concerns would be escalated to a complaint. The Trust is committed to responding promptly to all concerns and complaints in an open, honest and sensitive way; ensuring that they are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner.

The Patient Advise and Liaison Service (PALS) would be the first point of contact and can support the resolution of concerns. PALS aim to provide a fast and appropriate access to help, advice and information to those users of our services who require assistance or support. It may also be more appropriate to deal with and resolve in a more immediate and timely manner if this is with the agreement of the person raising the concern.

A formal complaint requires an in-depth, formal investigation and response due to complexity or nature of content, by a person independent to the immediate service. Patients, carers and their representatives experience of our services can be from a different perspective and can provide a valuable insight and enable the Trust to implement changes from lessons learnt as part of the organisation's commitment to continuous quality improvement.

We will endeavour to ensure that:

- there is a culture of openness and transparency, that information and processes are accessible and understood by all those involved in a complaint
- complaints are managed and investigated with a consistent approach
- complaints are investigated and responded to sympathetically and in an appropriate negotiated timeframe

- responses should provide a level of detail relative to the seriousness of the complaint
- complainants are provided with support and guidance throughout the complaints process
- the care of a patient is not negatively impacted on because of a complaint
- matters are put right wherever possible, and an apology offered
- there is learning from complaints resulting in better practice

The Trust is strongly committed to the organisational learning, and recognises that whatever the circumstances, and however regrettable these may be, each complaint provides opportunities for organisational learning to occur. Sometimes, the complaint has Trust wide, or cross service implications. The learning for such complaints will be ensured by Quality and Safety Committee and Patient and Carer Experience Group.

The Trust policy for [Managing complaints and concerns CP 306] can be found on the intranet.

Part 3 – Appendices

Not applicable

Part 4 - Document record

As per policy **97 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001.**

Document info	Doc ID: 123, Version – 03 Patient Safety Incident Response Framework This version is using TMP 001 – 01 April 2023
Document type	**Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Mount Vernon Cancer Centre, ☐Other: **Input your selection here:** **For use Trust wide by all roles at all sites**
Review cycle	☐ Every 3 years (standard) ☒Annual review ☐ Other: **01 August 2026**
Version type	SELECT ONE ☐New document – full consultation and endorsements ☐Full review of document - various amendments/ complete re-write ☒Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **Full review of document - minor amendments**
Keywords	Patient safety, Incident
Version author/owner	Director of Quality ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☒Corporate/Directorate
Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☐ **Forms** - This document contains forms in use at the Trust ☒ None of the above

Consultation & review

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust **policies** require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document. If the initial EIA screening in Part 1, section 6.1 determines a full EIA is required, visit the Equality, Diversity & Inclusion intranet section for next steps, which could take **3 to 4 weeks to receive approval.** EIA approval (supplied via email): Click or tap to enter a date.
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation:
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☒No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: TPC requires sign off on the final file and will be the final approver in the Record of agreement.

Trust stakeholder	Action required by author
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☒No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Nursing, Midwifery, AHP Quality Committee and/or ☐The appropriate training team e.g. Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☒No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☒No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement.
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust

Trust stakeholder	Action required by author
	wide or locally within the Trust. ☒No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1** **Divisions (clinical areas)**: Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical

Trust stakeholder	Action required by author
	director is apprised at that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record. **Step 2** In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (i.e. date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document. A minimum of one stakeholder must be listed. Please delete unused rows.

Document stakeholders

Document stakeholder	Date	Activity type
Michelle Anstiss, Interim Associate Director of Governance ☒**Internal*** ☐**External****	01/11/2024 ☒Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Dr Jon Bramall, Associate Medical Director Patient Safety specialist ☒**Internal*** ☐**External****	13/05/2025 ☒Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Lucinda Berry, Legal and governance lead ☒**Internal*** ☐**External****	13/05/2025 ☒Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Chris Curtis, patient safety partner ☐**Internal*** ☒**External****	13/05/2025 ☒Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☒At least one of the above in the consultation list is a formal endorser in the Record of agreement. NOTE: An endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Other consultation and stakeholder actions required

Not applicable.

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **97 - Trust policies and procedural documents**.

DOC ID & title	123, Version: 03 - Patient Safety Incident Response Framework
Due date of next full review	01 August 2026
Document type	Policy
Version type	Full review of document - minor amendments
Applicability	For use Trust wide by all roles at all sites
Version author	Director of Quality
Legacy ID	CP 310

Endorsement	Record of formal agreement this version is fit for use at the Trust by **Patient Safety Forum** is supplied in the meeting held on 13/05/2025
Approval	Upon considering the above endorsements, the approver* Margaret Mary Devaney, Director of Quality agrees this document is fit for use at the Trust. Confirmation of this agreement in PSF meeting minutes/ meeting action log under item, held on **13/5/2025**.
Trust endorsement	Record of formal agreement this version is fit for use at the Trust by **Policy Compliance Group** at meeting held on **14/08/2025**.
Governance checks	Policy Officer – Policy Documents Management, 14/08/2025

*Types of approvers (as per policy 97):

- A member of senior leadership or divisional triumvirate, a Trust committee/group or Trust function stakeholder (including name, role, dept) can approve a fully reviewed and endorsed document.
    - The Trust delegation of standards cites specific policies that require board approval.
- A head of service, or stakeholder or committee chairperson (usually endorser listed at the last full review) can approve an interim update of a document.
- A head of service or department can approve documents for local use only (for all version types).
- All policies require “Trust endorsement” from the Policy Compliance Group.