University Hospitals Dorset
NHS Foundation Trust

Policy for Patient Safety Incident Response Framework and LERN reporting

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Out of date policy documents must not be relied upon.

Title: PSIRF (LERNS)
Author: Head of Patient Safety and Risk
Version: 2.0
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Date of review: September 2027

A) EXECUTIVE SUMMARY POINTS
• Following the publication of the new Patient Safety Incident Response Framework (PSIRF) by NHS England it was necessary for University Hospitals Dorset (UHD) to review all procedures in relation to the management of all types of incidents including patient and staff safety Incidents.
• Alongside the Patient Safety Incident Response Plan this policy sets out the UHD approach to developing and maintaining effective systems and processes for responding to patient and staff safety incidents and issues for the purpose of learning and improving patient safety. Compliance with this policy enables the trust to meet the requirements of the Patient Safety Incident Response Framework (PSIRF).
• This policy replaces the LERN policy and the Serious Incident Policy

• Key points of the policy:
  • There are different forms to report different types of incidents.
  • Proportionate responses are required for all patient safety and staff safety incidents.
  • Compassionate engagement with patients and staff involved in patient safety incidents, including appropriate provision of support is key to our incident process.
  • Systems based responses are essential for patient and staff safety incidents, where current improvement work is not currently underway.
  • Learning and improvement are key, and we should be continuously looking for areas where we can improve
  • Supportive and collaborative oversight for both incident responses and our wide safety environment

B) ASSOCIATED DOCUMENTS
• Patient Safety Incident Response Plan
• Patient, Family and Staff Engagement and Support Framework
• Freedom to speak up policy
• Learning from Deaths Policy
• Risk Management Strategy
• Learning Response toolkits
• Framework for the strategic involvement of patient safety partners
• Health and Safety Policy

C) DOCUMENT DETAILS	
Author:	Natasha Sage and Jo Sims
Job title:	Head of Patient Safety and Risk
Directorate:	Corporate
Version no:	2.0
Equality impact assessment date:	12/09/2024
Target audience:	All Staff
Approving committee / group:	Quality Committee
Chairperson:	Cliff Shearman
Review Date:	29/10/2024

D) VERSION CONTROL

Date of Issue	Version No.	Date of Review	Nature of Change – (include section reference)	Approval Date	Approval Committee	Author
Dec 20	1	Dec 22	New policy for UHD	Dec 2020	Quality Committee	JH/ JS

June 23	1.1	Dec 23	Review date extended to Dec 23. Policy will then be replaced by a UHD Patient Safety Incident Response Plan and PSIRF policy in line with national requirements and timescales.	Dec 2023	Quality Committee	JS
Sep 24	2.0	Sep 26	Updated to reflect PSIRF terminology and framework	29/10/2024	Quality Committee	JS/NS

E) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	Dec 2022	JH, JS	QGG, QC
1.1	Dec 2023	JS	QC to note
2.0	Oct 2024	JS, TS	H&SG, CGG, TMG, QC

Contents

1 Introduction

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 improvement.

The PSIRF replaces the Serious Incident Framework (2015) and does not make a difference between "patient safety incidents" and "serious incidents". Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have- or did-harm one or more patients.

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

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

- compassionate engagement and involvement of those affected by patient safety incidents.
- applying system-based approaches so that we are able to learn 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 also be read in conjunction with our current Patient Safety Incident Response Plan, which is a separate document setting out how this policy will be implemented and explaining the processes involved.

This policy also covers reporting of incidents that are not 'Patient safety incidents' such as staff incidents and issues.

2 Policy Statement

This policy supports the requirements of the PSIRF and sets out University Hospitals Dorset's (UHD) approach to developing and maintaining effective systems and processes for responding to patient and staff safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF is a contractual requirement under the NHS standard contract and, as such, is mandatory for services provided under that contract including acute, ambulance, mental health, and community healthcare providers. This includes specialities within organisations such as maternity services and all specialised services.

The work of PSIRF uses a systems-based approach and therefore, there is no scope to attribute liability, blame or preventability/ cause of death in a response conducted for the purpose of learning and improvement.

The policy will support how UHD will work to the new Patient Safety Principles as outlined by the Patient Safety Commissioner. The principles outline a framework for decision making, planning and collaborative working with patients as partners in a just and learning culture and are for everyone working in the healthcare system.

This policy:

- sets out the general principles and processes how staff will respond to patient and staff safety incidents (from reporting incidents to reviewing and investigating them)
- highlights roles and responsibilities for all staff, individuals in specific roles and designated groups relating to recording, responding to and learning from patient safety incidents.
- informs of a range of systems- based learning response tools that can be used to identify learning following a patient or staff safety incident.

This policy is specific to responsibilities in relation to patient and staff safety incident responses conducted solely for the purpose of learning and improvement. The policy does **not** include learning responses conducted for the purposes of:

- insurance or legal claims handling
- human resources issues
- investigations into employment concerns
- professional standards investigations
- complaints handling
- Coroner's inquests, and
- Criminal investigations

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

This policy applies to all permanent and temporary employees, volunteers, agencies and agency staff working for and on behalf of the Trust. This includes staff whose role does not involve direct care delivery because staff in such roles may use or be involved with systems that support the delivery of safe care.

3. Definitions

Whilst there is no definition to cover every possible event, the following will assist.

3.1 LERN

A Learning Event Report Notification (LERN) is an electronic incident reporting form that is completed on the local risk management system (Datix) to record an incident and notifies relevant people within the organisation that an incident has occurred.

3.2 Incident

An incident may be a clinical or non-clinical event that has an unintended and/or unexpected outcome; an error or a circumstance that leads to, or could have led to, harm, loss or damage to a patient, member of staff, visitor/contractor or to Trust property or reputation. The harm may be physical or psychological.

3.3 Patient safety incident

A patient safety incident is any unintended or unexpected event (including omissions) in healthcare that could have or did harm one or more patients. This includes incidents related to direct care delivery and incidents relating to work systems that support care delivery. The incident may occur due to something that happened which should not have, or something that did not happen that should have and may or may not cause harm.

3.4 Compassionate Engagement

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

3.5 Just Culture

Just Culture is a concept that aims to create a culture of fairness, openness, and learning in the NHS. It is about supporting colleagues to be open about mistakes and to feel confident to speak up when things go wrong, rather than fearing blame. This allows valuable lessons to be learnt and helps to prevent the same mistakes being repeated. Just Culture also allows healthcare professionals to feel safe to report errors and “near misses” openly.

3.6 Work system

A work system includes elements that affect each other during a process for the purpose of delivering an intended outcome e.g., the delivery of safe and effective care with a good patient/family experience. A work system can include tools and technology, people, physical

environments, external environments (such as regulation, societal and economic environments) and organisational factors (such as structures, culture, training, work schedules, resource availability).

3.7 Near miss

A near miss is an incident that very nearly happened that could have resulted in harm but did not do so due to chance, corrective action and/or timely intervention.

3.8 Never Event

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been performed by healthcare providers.

The full list of Never Events can be found on the Department of Health website or on the Patient Safety intranet site (link following): 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

3.9 Incident leading to death thought more likely than not due to problems in care.

Where there is a probability that the care that was provided to a patient who has died may have contributed to the death of a patient. This may meet the Learning from Deaths criteria to undertake a patient safety incident investigation. More details are provided in the UHD Learning from Deaths (Mortality Review) Policy.

3.10 Patient Safety Incident Response Plan (PSIRP)

The Trust's Patient Safety Incident Response Plan (PSIRP) sets out the priorities for implementing PSIRF. It identifies the key patient safety risks that justify a learning response as part of planning a considered and proportionate approach required by PSIRF, as well as outlining learning responses for other types of incidents. The plan is to be refreshed every two years. The plan can be found on the intranet here: PSIRF (uhd.nhs.uk)

3.11 Learning Response

NHS England (NHSE) defines learning response as the methods in which an organisation can respond proportionately to recorded patient safety incidents for the purposes of learning and improvement.

There are four nationally recognised enhanced learning responses in PSIRF:

- a patient safety incident investigation (PSII)
- a swarm huddle(s)
- an after-action review
- a multi-disciplinary (MDT) review

3.12 Patient safety incident investigation (PSII)

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and/or potential for new learning to improve care and service. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes,

and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

3.13 **Swarm huddle**

Swarm huddles are one of the techniques that are used to identify learning from patient safety incidents and are designed to start as soon as possible after a patient safety incident occurs and prior to those involved have finished their shift. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.

3.14 **After Action Review (AAR)**

An After-Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

3.15 **Multidisciplinary Team (MDT) review**

These support healthcare teams to:

- Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents).
- Agree, through open discussion, the key factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.
- Explore a safety theme, pathway, or process.
- Gain insight into 'work as done' in a healthcare system.

3.16 **Local risk management system (Datix)**

UHD's local risk management system at the time of writing this policy is called Datix. Datix is the system used for recording clinical and non-clinical incidents. Access to the Datix system is via the Trust's Intranet portal. Training on using the Datix system (how to record and respond to an incident) can also be found on the Intranet.

4. Consultation

The policy has been circulated to the PSIRF Oversight Group, Health and Safety Group and the Clinical Governance Group. Staff holding named job roles have also been consulted.

5. Procedures/Document Content

5.1 Compassionate engagement and involvement of those affected by patient safety incidents.

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.

Patients and their families will be supported throughout the PSII process by a Patient Safety Investigation and Liaison Lead. They will ensure that patients are able to contribute their experience and perspective to the investigation process.

The Trust Patient Safety Incident Response Plan (PSIRP) outlines our engagement process and describes how we support those involved in a patient safety learning response. The process is designed with flexibility to ensure that support is adapted to meet the circumstances of each individual affected. There are a range of supportive tools and resources identified in our PSIRP to support those affected and involved in patient safety investigation.

Alongside engagement and involvement, sits openness and transparency. The Trust has a statutory, contractual and regulatory duty to ensure that systems are in place to support a culture of openness, honesty and transparency.

5.11 **Statutory and Professional Duty of Candour**

Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether something has gone wrong or not.

The Trust recognises that timely involvement and communication with patients, their relatives or their carers is essential to improving safety and quality. The Trust is committed to ensuring there is open and honest communication between itself and patients and/or families/carers when a patient is harmed as a result of a patient safety incident.

Duty of Candour (DoC) involves apologising and explaining what happened to a patient who has been involved in care that has not gone as expected. DoC ensures that communication is open and honest this occurs as soon as possible following an incident. Promoting a culture of ‘Being Open’ is a prerequisite to improving patient safety and the quality of healthcare systems.

Saying sorry is:

- always the right thing to do.
- not an admission of liability

- acknowledges that something could have gone better.
- the first step to learning from what happened and preventing it recurring. (Reg 20 Duty of Candour accessed via Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)

This communication is known as 'Duty of Candour' and forms two parts:

- a legal/statutory duty on behalf of the Trust as a public organisation to communicate with patients and/or families/ carers following a notifiable patient safety incident and:
- a professional duty which is an individual duty that applies to all staff registered with a professional body.

Guidelines for staff on DoC following a patient safety incident are provided within the Duty of Candour Toolkit on the Quality & Safety page of the Intranet (Duty of Candour Section).

5.12 Just and Restorative Culture

The Trust aims to embed a 'Just and Learning culture' that facilitates continuous learning, creates psychological safety which supports staff to raise and address concerns, and focuses upon good practice that is shared and replicated within and beyond organisational boundaries.

The Trust is committed to promoting and improving the quality and safety of care and treatment all patients receive, as well as preserving the safety of its staff, visitors, and others. To achieve this, it is important to support and embed a positive reporting culture throughout the organisation to enable learning when things do not go as expected.

A safety conscious organisation is one which is receptive to adverse incidents so it can learn, develop, and change practice. We have embedded these principles into our procedures for the review of incidents.

In accordance with the Equality Act, 2010 and the Francis Report, 2013, this policy will support the Trust to ensure that learning responses and investigations are reviewed with fairness and transparency ensuring that all staff regardless of their protected characteristics are supported and listened to when raising a concern or reporting an incident relating to the quality of care and patient safety.

The Trust recognises the significant impact that being involved in a Patient Safety Incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. There is a range of support and information available across the Trust and can be found on the Thrive Wellbeing pages on the intranet.

All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining an After-Action Review or debrief meeting as part of a learning response or a conversation with

the patient safety incident investigation team. The UHD Just Culture framework and guidance is available on the UHD Intranet.

5.13 **Patient Safety Partners (PSP)**

Involving patients, their families and carers, and other lay people as safety improvement partners is a key strand of the National Patient Safety Strategy. The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in England. This new role has been created and will evolve over time at UHD with the main purpose of the role as being a voice for patients and the public to ensure safety is at the forefront of all that we do.

PSP involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Roles for PSPs can therefore include:

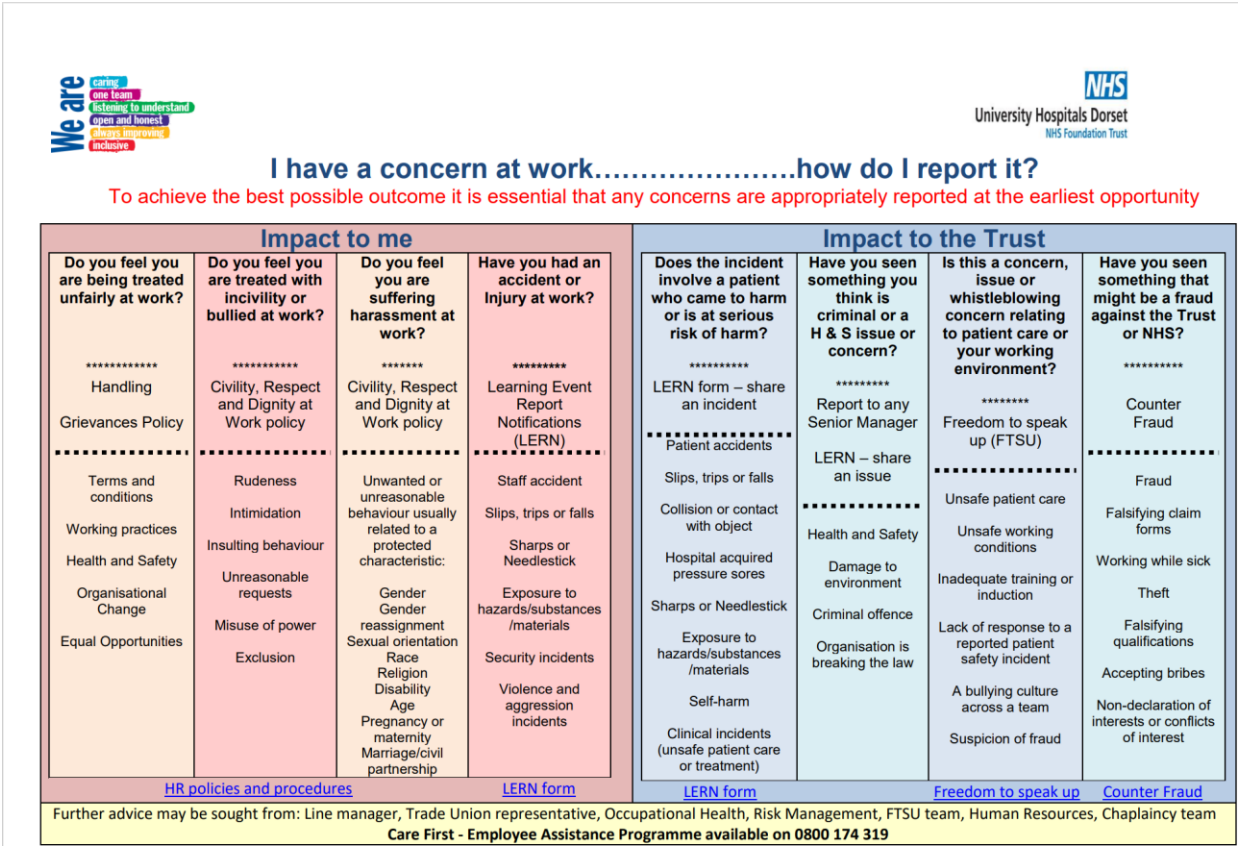
- membership of safety and quality committees whose responsibilities include the review and analysis of safety data.
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety.
- involvement in staff patient safety training
- participation in investigation oversight groups.

The patient safety partners will be supported by the lead for their area of interest. They will be provided with guidance and expectations on their role, and they will have regular scheduled reviews and any training they require will be based on their individual experience and knowledge.

5.14 **Freedom to Speak Up**

Anyone who works (or has worked) in the NHS or for an independent organisation that provides for NHS Services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Staff are encouraged to raise concerns initially (formally or informally) with their line manager (or lead clinician or clinical/educational supervisor). Where this is not appropriate staff can use any of the options set out below.



The Trust Freedom to Speak Up Guardians (F2SUG) can be contacted on Freedomtospeakup@uhd.nhs.uk

This is an important role, identified in the Freedom to Speak Up review, to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organization including the Chief Executive, or if necessary, outside the organisation. Staff can also contact:

5.2 Application of a range of system-based approaches to learning from patient safety incidents

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. There are no further national rules or thresholds to determine what method of response should be used to support learning and improvement for each type of incident.

This change will result in some moderate harm and greater incidents receiving less review than they would previously. Conversely, some low and no harm incidents will receive more review due to the fact they will represent greater opportunity for learning and improvement in systems where the issues are not well understood. However, all incidents must be reviewed to establish what happened and ensure appropriate actions have been taken to prevent

recurrence and to determine learning and/or improvement. Once a patient safety incident has been identified, the flow chart in **Appendix 1** sets out the decision-making process for the learning response.

The procedure aims to maximise learning and improvement, rather than basing responses on subjective definitions of harm, and links to UHDs PSIRP.

The PSIRP provides details of the governance and oversight process, to ensure learning and improvement is taking place across the organisation. It informs the decision-making process from the service area, through the Care Group Rapid Review. This is where incidents, events and areas of concern are initially raised and discussed to determine the method of learning response or investigation. Incidents and events are promptly escalated from the Care Group Rapid Review to the PSIRF Insight meeting after being identified and highlighted if the criteria is met.

Care Group Rapid Review- weekly.

The purpose of this meeting is to gain assurance that UHD is learning from the patient safety incidents. The group will:

- Review LERNS that have been triaged as Amber or Red and agree a learning response. This includes agreeing the type of learning response, the scope / Terms of Reference (TOR) of the response and lead for each response.
- Recognise immediate learning points and the actions required to ensure patient and staff safety.
- Agree the patient/family/staff liaison lead and duty of candour requirements for each incident.
- Agree timescales for each learning response.
- Refer appropriate incidents to the weekly PSIRF insight review meeting:
    - Incidents potentially meeting the Never Event criteria.
    - Deaths clinically assessed as more likely than not due to problems in care.
    - Death of a person detained under the Mental Health Act (1983-amended 2007) where there is reason to think that the death may be linked to problems in care.
    - Death of persons with learning disabilities.
    - Incidents of concern (triaged amber or red) which cross care groups.
    - Incidents of concern (triaged amber or red) that the care group wants the Insight meeting to consider for potential PSII.
    - If a patient safety theme has been identified that may require a thematic review
- Agree who will attend and present at the PSIRF insight review meeting.
- Commissioned learning responses will be reviewed and signed off at Care Group Rapid Review. Care Group directors are responsible for ensuring the quality of all learning responses, the sharing of associated learning, and implementation of any safety actions that arise from the learning responses.
- Agree learning to be shared via directorate and care group Risk and Governance meetings and any wider learning to be included in the care group report to the Clinical Governance Group
- Maintain an action log of agreed learning responses and monitor learning responses awaiting review.
- Review themes and trends of patient safety incidents reported within the care group.
- Monitor LERN review compliance.
- Monitor progress of LERN safety actions for the care group

- Monitor duty of candour compliance

PSIRF Insight Meeting- weekly

The purpose of this meeting is to review the collated evidence so far and make shared decisions relating to the learning response for:

- Incidents potentially meeting the Never Event criteria.
- Deaths clinically assessed as more likely than not due to problems in care.
- Death of a person detained under the Mental Health Act (1983-amended 2007) where there is reason to think that the death may be linked to problems in care.
- Death of persons with learning disabilities.
- Incidents of concern (triaged amber or red) which cross care groups.
- Incidents of concern (triaged amber or red) that Care Groups want the Insight meeting to consider for potential PSII.
- If a patient safety theme has been identified that may require a thematic review

PSIRF Oversight Meeting- monthly

The purpose of this meeting is to gain assurance that UHD is learning from the patient safety incidents that meet the criteria for nationally or locally defined priorities as described in the UHD PSIRP. The group will:

- Review progress of PSIIs (30- and 60-day review)
- Receive completed PSII investigations and agree final draft version before final sign off by Board.
- Monitor progress of safety actions
- Monitor learning responses awaiting review.
- Note completed learning responses for presentation/review.
- Monitor LERN review compliance.
- Monitor duty of candour compliance
- Highlight and report any Trustwide learning for presentation to Clinical Governance Group

UHD has a suite of tools and templates to enable systems-based learning, which can be found on the Intranet.

5.3 Considered and proportionate responses to patient safety incidents and safety issues

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that the Trust evaluates its capacity, resources and competency requirements to deliver our plan. The PSIRP provides specific details.

Whilst the Trust will be flexible and consider the specific circumstances in which each patient safety incident occurred, generally PSIIs will be completed if they either meet nationally set requirements, or the UHD Plan priorities and associated definition.

Following all patient safety incidents, consideration will be given around who needs to be informed of what has happened. The type of incident, level of harm and wider impact that the event may have upon the patient, their carer, the team and Trust will need to be considered.

The person in charge of the area will need to make an initial decision on how best to respond to what has happened. The focus initially will be supporting those involved but it is equally important that we ensure that any learning from the incident is identified and acted upon. For many of the incidents which happen, the response will be a debrief to discuss what has happened and offering support and follow up and documenting this. At the heart of our response is the wellbeing of people involved, with our response being proportionate to that which has happened.

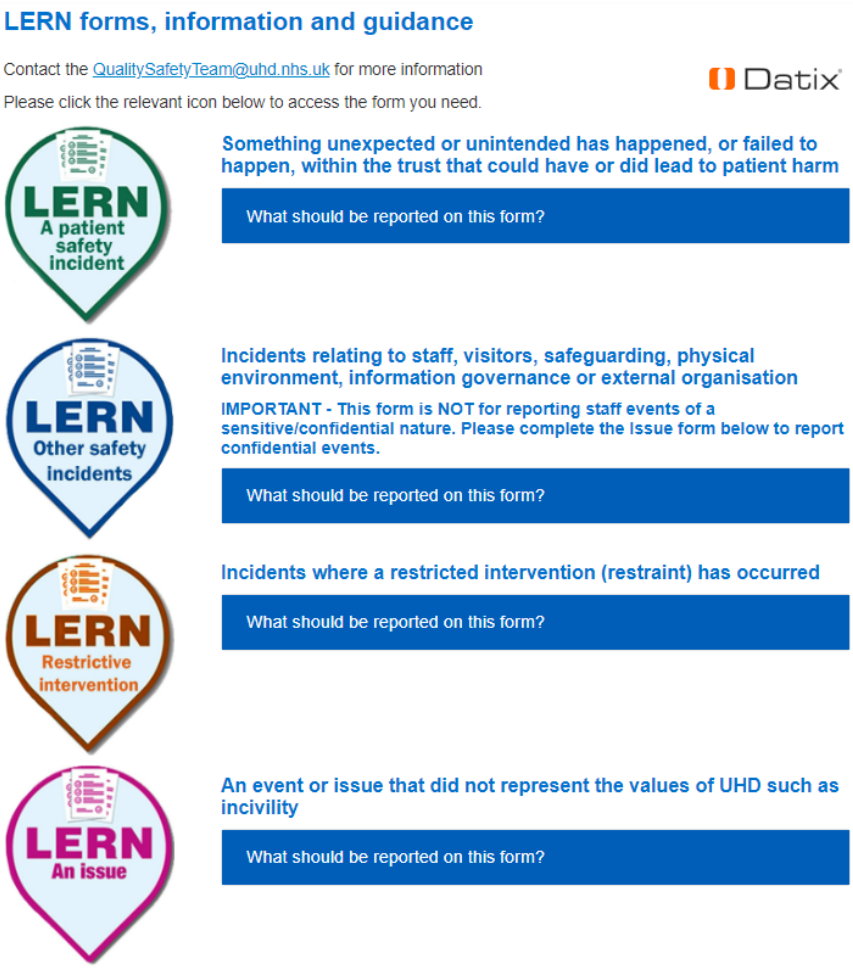
For those incidents which are identified as more significant in nature (triaged as Amber or Red), appropriate escalation will be required to the Care Group Rapid Review. The local team will also need to determine whether the incident requires a statutory response under the Duty of Candour requirements - all incidents which result in moderate harm or above to a patient. Incidents of this type will require some form of response and the person in charge of the area should consider discussing the response with their local manager so as to ensure that we can not only learn but respond in line with the statutory requirements.

The decision to undertake a patient safety incident investigation (PSII) will be made at the PSIRF Insight meeting and allocated to a Patient Safety Investigation and Liaison Lead. The PSIRF Insight meeting has the responsibility for commissioning and ensuring that the resources are available to undertake a patient safety incident investigation response. Once commissioned, the process to be followed can be found in **Appendix 3**. Incidents which meet the criteria for a PSII will be reported onto the Strategic Executive Information System (StEIS) or Learning from Patient Safety Events (LFPSE) on its implementation as per National requirements.

The Care Group Governance Managers will provide leadership within the Care Groups to staff undertaking learning responses as part of their day-to-day operational role within the Trust. They will ensure that response leads have a suitable level of seniority depending on the nature and complexity of the incident and response required. Oversight of patient safety responses will be undertaken by the Care Group Rapid Review meetings and the PSIRF Oversight meeting attended by Care Group Directors, Heads of Nursing and the Medical Director for Quality and Safety or Associate Medical Director for Quality, Governance and Risk.

5.31 **Reporting different types of incidents**

The type of incident to be reported, influences the form to be completed:



Green patient safety incident form. A patient safety incident is mandated to be reported via the NHSE Learn from Patient Safety Events (LFPSE) system. The green patient safety event LERN form is configured to report the incident directly to NHSE on submission. These incidents should be managed via the flow chart in **Appendix 1**.

Blue 'Other/Staff' safety incident form. This form is to report incidents relating to staff, visitors, estates, external organisations or anything else that does not meet the patient safety incident criteria.

Staff incidents are to be managed via the flow chart in **Appendix 2**

Orange Restrictive intervention form. This form is specific to when a restraint has been applied to a patient. If a patient and/or member of staff sustains harm during the restraint a patient safety incident form and/ or staff incident form should also be submitted. Restrictive intervention incidents are managed as per the flow chart in **Appendix 1**.

Pink Issues forms. This is a confidential form that only goes to the Head of Patient Safety and Risk and the Associate Director for Governance and Risk. On reading the content of an Issue, they will assign to the most appropriate person within the organisation to address the issues raised. There are regular meetings with the Freedom to Speak Up Guardian to discuss the themes raised within the Issues form for organisational learning.

General Principles of incident reporting

- All incidents will be reported via the online Datix/ LERN incident reporting system. This is a central Trust database of incidents, learning and actions that have been implemented as a result of their review. This system allows managers and senior staff members in departments to have oversight of all incidents in their area and enables them to record how they have reviewed and responded to the incident as well as how they have provided feedback to the staff who have raised their concerns. the system also allows senior managers and executives oversight of patient and staff safety incidents and is a vital source of data to identify areas of concern, opportunities for improvement as well as good practice to help inform the Trusts overall safety profile.
- All staff (including bank, agency, locum and volunteers) has the responsibility to report all patient and staff safety incidents and near misses via the Trust electronic incident management system, Datix.
- A record of the patient safety incident or near miss should be contemporaneously and objectively recorded in the patient's clinical records.
- There will be identified investigators/handlers for all reported incidents.
- Incident reports (LERNs) must be factual and must not include opinions – forms can be disclosed to a patient/claimant or their representatives if a challenge to the standard of care, or working conditions is made in the future.
- All incidents will be recorded with an initial level of harm grading and should contain enough detail in the description and action taken fields on Datix to determine this harm. Staff should use the NHSE policy guidance on recording patient safety incidents and levels of harm: NHS England » Policy guidance on recording patient safety events and levels of harm
- All incidents will undergo a level of investigation that is in line with the most proportionate learning response.
- All staff will be made aware of the importance of incident reporting and management, through induction and through a range of training programmes and learning materials.
- Training will be provided to managers and to staff members likely to be involved in incident investigation.
- In **ALL** cases, patients (and where appropriate, and with the patients consent their relatives / carers), will be informed of incidents that affect them as soon as is practicable and what action is being taken to address the issue.
- The statutory requirements, principles and concepts of 'Duty of Candour' will be applied when something in the care UHD has provided has gone wrong and caused significant harm.
- Staff involved in an incident will be provided with feedback on the investigation findings, learning and improvement.
- There is a clear distinction between incident investigation and disciplinary procedures. Identified staff performance or conduct issues do not fall with the remit of this policy and will be managed in accordance with relevant HR polices. No pre-existing information related to staff performance or conduct will be provided to an investigation panel/reviewer.

5.32 **Timescales for Reporting**

- Patient Safety and Staff Safety incidents must be reported immediately to the manager or senior person on the shift.
- A LERN (Datix) must be completed as soon as possible after identification of the incident or at least two working days of the incident occurrence or identification.
- The LERN should be triaged within 72 hours of reporting and ideally closed within 30 days of reporting unless investigation continues.
- Staff safety LERNs will be triaged by the Health and Safety team in their weekly rapid review meetings.

5.33 **Timeframes for patient safety incident learning responses**

Under the new PSIRF framework there are no national target timeframes for completion of PSIIs or other learning responses. Instead, realistic, achievable timescales should be discussed and agreed by all those involved in the incident and its review, including the patient, their families, carers, and advocates where appropriate. These discussions should consider the complexity of the incident being reviewed, if it is an individual incident being reviewed or a cluster of similar incidents, the availability of those that need to be involved, and the current workload of the team that will be completing the review.

Where a patient safety incident investigation (PSII) is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. The time frame for completion of an investigation will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. In exceptional circumstances, a longer timeframe may be required for completion. In this case, any extended timeframe should be agreed between the Trust and those affected. A balance must be drawn between conducting a thorough investigation with the impact of extending the timescale can have on those involved, and the risk that delayed findings may adversely have in affecting safety in the clinical environment.

Other forms of learning responses must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one month of their start date.

Expected time frames are:

Reflections	Within 72 hours of the incident
Debrief	Within 72 hours of the incident
Swarm huddle	Within 5 working days/ 1 week
Falls Information Tool	Within 5 working days/ 1 week
Pressure Ulcer Screening Tool	Within 2 weeks of identifying a cat 3 or 4
Timeline	Within 2 weeks
After Action Review	Within 20 days
Case Review	Within 1 month
MDT Review	Within 1 month
Thematic Review	Within 6 months
PSII	Within 6 months

5.33 **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013**

Certain incidents are reportable to the Health and Safety Executive (HSE) under the RIDDOR regulations. These may include:

- Accidents that result in an employee or self-employed person dying, suffering a major injury or being absent from work or unable to do normal work for more than seven days.
- Accidents which result in a person at work suffering an injury and being taken to a hospital for treatment or if the accident happens at a hospital, suffering a major injury.
- An employee suffering one of the specified work-related diseases:
- One of the specified “dangerous occurrences” (this may not necessarily result in an injury but has the potential to do significant harm).

All potential RIDDOR incidents will be reviewed as part of a formal RIDDOR review panel meeting. Once confirmed, the Health and Safety Team are responsible for reporting to the HSE.

5.34 **Responding to cross-system incidents/issues**

The Trust will work collaboratively with partner providers for any incident that requires a cross-system or partnership learning response. Colleagues from the Care Groups as well as Corporate and Executive Leaders may be involved in working and liaising with system partners regarding an incident that requires a learning response.

The Trust recognises the importance of timely engagement with partners and the importance of appropriate information sharing for the purpose of learning and improvement.

Where other department, specialty, service or external agency is involved, a multidisciplinary joint investigation will be considered to maximise the effectiveness and learning from the investigation. In this situation it will be agreed with the Integrated Care Board (ICB),NHS Dorset, who will take the lead role and what involvement and information each party requires via RASCI (Responsible, Accountable, Support, Consulted, Informed) methodology.

The Trust will work with the ICB and commissioning bodies to maintain robust procedures in the monitoring of learning processes and quality and safety improvements. Under PSIRF, commissioners will no longer be required to ‘sign-off’ investigation reports, instead they will seek assurances that improvements and priorities under PSIRF are progressing.

The ICB will be invited to routinely attend UHD PSIRF Oversight meetings.

Reporting to External Agencies

There is a requirement to report some incidents to other external agencies / bodies within prescribed timescales. These are outlined in **Appendix 4**.

5.4 Supportive oversight focused on strengthening response system functioning and improvement.

The main principle and purpose of PSIRF, is to focus on learning and improving patient safety. The PSIRF: Safety Action Development Guide describes the terms 'Areas for Improvement' and 'Safety Actions' as follows:

• **Areas for Improvement** - Identified areas where improvement is needed without defining how that improvement is to be achieved. Good areas for improvement provide an opportunity for a range of safety actions. Time should be spent considering how to improve the identified area, this can include multiple safety actions as a result. It is important to consider and clearly define the area for improvement to ensure safety actions are specific and effective.

• **Safety Actions** - Response to a clearly defined area for improvement, there can be multiple safety actions that form a wider safety improvement plan. To ensure that Safety actions are responsive to the improvement area, careful planning and brainstorming should take place.

Safety actions will be developed with the Departments/ Care Groups involved in the area that the incident occurred and be based on the recommendations of the investigators. The actions should be signed off by the Care Group and then monitored via the Care Group Rapid Review. All actions should be Specific, Measurable, Achievable, Relevant and Time-bound (SMART). Guidance from NHSE (PSIRF) for the development of actions is provided to investigators.

Areas for improvement and PSII and safety actions developed from investigations commissioned by the PSIRF insight group, will be monitored by the PSIRF Oversight meeting. The Trust has recognised that this is an area within the organisation that requires improvement in itself and understands the shift in the framework towards improving and developing further a learning culture within and across the organisation.

The outputs from the Oversight Meeting will inform the Patient Safety Report which will be shared and escalated through the Trust's Clinical Governance Group, Executive Committees, Trust Board and the ICB.

Whilst the Board is ultimately responsible for ensuring that the organisation effectively learns from incidents and implements improvements in accordance with this policy, all staff are responsible for working together to ensure learning from incidents and their associated action plans are shared across the Trust.

Learning from incidents is critical to the delivery of safe and effective services; to avoid repeating mistakes, organisations need to recognise and learn from them.

Learning from incident will be disseminated in a number of ways, including, but not limited to:

- Team meetings
- Safety Briefings/daily huddles
- 1:1 feedback
- Clinical Supervision

- Newsletters
- Directorate and Care Group governance meetings
- Care Group Rapid Review meetings
- PSIRF Oversight meetings
- Clinical Governance Group including 'Top Ten' monthly email circulation
- Synopsis summaries from investigations (added to the intranet)
- SBAR organisational wide learning (OWL) document for Trust Learning (Appendix 5)
- Learn at Lunch
- Core brief "You Said, We Did" articles.
- Medical grand round presentations (monthly)
- Ward/department/Directorate network forums e.g. Emergency department 'Basecamp'

6. Roles and Responsibilities

6.1 Chief Executive

The Chief Executive has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of health in respect of governance. This responsibility therefore includes ensuring that the Trust has in place an effective system for reporting, investigation and learning from incidents.

6.2 Board Directors

All Directors are responsible for:

- Acting as Board sponsors for Patient Safety Incident Investigations (PSII) under their responsibility.
- Bringing such reports to the attention of the Board of Directors and ensuring any Board approved action plans are implemented effectively.
- Ensuring that policies and procedures are implemented to enable the effective reporting, recording, management, investigation and monitoring of all LERNs within the area of responsibility.
- The management and analysis of information and implementation of relevant learning in their areas of responsibility.
- Working together to ensure learning from incidents and their associated action plans across the Trust.
- Ensuring that relevant incidents that pose a risk to service users, staff, visitors, contractors or to NHS Trust property or reputation are included on the Trust's Risk Register and that controls are applied to mitigate against these risks.

6.3 Chief Nursing Officer

The Chief Nursing Officer (CNO) is the Board of Directors Executive lead for risk management and is accountable and responsible for ensuring that policies and procedures are in place across the Trust to enable the effective reporting, recording, investigation, management and monitoring of all incidents to promote the culture of safety.

6.4 **Chief Medical Officer**

With the CNO the Chief Medical Officer (CMO) is jointly responsible for patient safety. This includes:

- Enacting processes to facilitate an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).
- Overseeing development and review of the trust's PSIRP and Policy.
- Ensuring there are enough resources to support the delivery of the PSIRP (including time, capacity, training needs and provision for staff support and patient and family engagement).
- Ensuring the trust complies with the national patient safety investigation standards.
- Ensuring that staff at all levels of the organisation have the training, skills, and relevant experience for their roles in patient safety incident management.
- Ensuring the incident reporting and investigation processes are effective for learning and improvement.
- Ensuring Board level scrutiny and oversight of Patient Safety Incident Investigations (PSIIs).

6.5 **Care Group Directors of Nursing, Medical Directors and Directors of Operations**

Are responsible for:

- Ensuring the care group procedures supports the management of patient and staff safety incidents in line with the trust's PSIRP and policy (including convening Care Group Rapid Review meetings to agree the level of response to all safety incidents reported in the care group).
- Ensuring the quality of all learning responses, the sharing of associated learning, and implementation of any safety actions that arise from the learning responses.
- Supporting lead investigators and investigation teams as required and appointing trained named contacts to support those affected.
- Ensuring patient and staff safety incident investigations are undertaken for all incidents that require this level of response.
- Establishing procedures to monitor/ review investigation progress and the delivery of all improvements.
- Supporting action plans, innovation, learning, and improvement work identified from patient and staff safety incident responses.

6.6 **Care Group Governance Managers**

Are responsible for:

- Supporting the Care Group and Directorate teams in ensuring that the Care Groups / Directorates review, manage, investigate and monitor learning from incidents.

- Leading Care Group coordination of patient and staff safety incident responses in line with the Trust PSIRF Plan and Policy
- Working closely with the Patient Safety Team and Health and Safety Team in supporting the timely and appropriate reporting, recording, investigating and co-ordinating of all incidents
- Monitoring responses, investigations, learning outcomes and improvement action plans.
- Ensuring that risks and trends from incidents are escalated through the risk management process.
- patient safety incident investigations and staff safety investigations are escalated in a timely fashion and will provide support and advice to lead investigators.
- Learning from incidents is included within the Care Group Quality, Safety and Risk Reporting so learning can be cascaded through the Quality and Safety processes within the Care Group/Directorates.

6.7 **Clinical Director/Directorate Managers/Matrons**

Are responsible for:

- Ensuring that all incidents for their directorate are reported and investigated within the timescales noted on this policy.
- Ensuring that a patient or staff safety response is undertaken for all reported incidents.
- Attending Care Group Rapid Review/ Patient Safety insight meetings to discuss and agree learning responses for reported incidents.
- Leading or supporting learning responses such as after action reviews as required
- Supporting and contributing to PSIIs and staff safety investigations as required
- Liaising with the patient safety team/ Health and Safety team to ensure those affected by a safety incident have access to the support they need.
- Adopting Just Culture principles
- Ensuring the output of learning responses are presented to Care Group Rapid Review meetings as required.
- Ensuring that action plans and risks highlighted from LERN investigations are discussed at the Directorate Governance meetings and issues placed on the Directorate Risk Register as appropriate.
- Disseminating learning identified from reported incidents and facilitating feedback to all relevant staff.
- Promoting a positive reporting culture

6.8 **Ward Leads/Clinical Leaders/Department Managers**

Are responsible for:

- Ensuring compliance with reporting and investigation of LERNs, identification and implementation of action plans and subsequent learning for all incidents within their area of responsibility.

- Facilitating huddles, hot debriefs, after action reviews and other suitable immediate learning responses to enable early safety reviews.
- Disseminating learning identified from reported incidents and facilitating feedback to all relevant staff.
- Supporting those involved in an incident and ensure access to any further wellbeing support is provided, including any local debriefing session.
- Adopting just culture principles
- Supporting and contributing to PSIIs as required
- Ensure all investigations and associated documentation is recorded on the LERN records on Datix.

6.9 **Patient Safety Investigation and Liaison Lead**

Are responsible for:

- Undertaking patient safety investigations and investigation-related duties in line with latest national guidance and training.
- Ensuring investigations are undertaken in line with the patient safety investigation standards.
- Engaging and involving patients and their families involved in a patient safety incident investigation.
- Engaging and involving staff involved in a patient safety incident investigation
- Ensuring that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Presenting draft reports at PSIRF Oversight meeting
- Liaising with the Quality & Safety Team for support and progress updates

6.10 **All staff (includes volunteers, contractors, agency and temporary staff)**

All staff have a duty to report an incident as soon as it is reasonably practicable after the event. All UHD appointed staff should:

- Use the electronic reporting system (Datix) to report LERNs for incidents and issues.
- Be familiar with the PSIRF/LERN Policy and related procedures.
- Understand their responsibilities in relation to the trust's PSIRP
- Ensure that when an incident has occurred, the immediate safety and welfare of all those involved or affected, directly and indirectly is acted upon, and that they take any necessary actions to prevent harm.
- Report all incidents immediately to the person in charge of the team, department or building.
- Ensure a LERN is completed for all incidents they are directly involved in or witness.
- Inform their manager of any period of sickness absence, or if they are unable to perform their normal job, for more than seven days resulting from an accident or incident at work.
- Ensure all breaches in confidentiality and other information governance issues are reported as a LERN incident or issue.

- Know how to access help and support in relation to patient safety incident response process.

6.11 **Patient Safety Specialists**

The NHS England (NHSE) through the national Patient Safety Strategy for England creates a contractual responsibility to require NHS Trusts to have one or more named Patient Safety Specialists.

Patient Safety Specialists are individuals in healthcare organisations who have been specially trained and who are designated to provide dynamic senior patient safety leadership.

Patient Safety Specialists provide expert support to their organisation through direct access to their executive team, which facilitates the escalation of patient safety issues or concerns. They also play a key role in the development of a patient safety culture, safety systems and improvement activity. Further information on the role of Patient Safety Specialists and be found on the NHS England website.

6.12 **Patient Safety Team**

Are responsible for:

- Promoting the trust culture of open and honest reporting of a patient safety incident that may impact on the quality of patient care in accordance with trust policies on patient safety incident reporting and risk management.
- Overseeing patient safety activity within care groups and support them to meet the needs of the PSIRF process.
- Ensuring the principles of engaging with people affected by incidents are followed in line with the PSIRF standards.
- Promoting the use of a systems-based approach and quality improvement methodologies in responding to and identifying learning.
- Monitoring recommendations arising from all patient safety activity.
- Sharing information, learning and examples of good practice.
- Ensuring patient safety investigations are undertaken for all incidents that require this level of response (as directed by the trust's PSIRP).
- Developing and maintaining local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Ensuring the trust has procedures that support the management of patient safety incidents in line with the trust's PSIRP.
- Supporting and advising staff involved in the patient safety incident response.
- Escalating any concerns regarding themes, reports, policy compliance to the relevant Care Group/Directorate Senior Management Team to the Quality Committee, Trust Management Group and Board as appropriate.

6.13 **Health and Safety Team**

Are responsible for:

- Reviewing all staff safety incidents and investigating as required.
- Reporting all RIDDOR reportable incidents to the HSE.
- Promoting the trust culture of open and honest reporting of a staff safety incident and risk management.
- Promoting the use of a systems-based approach and quality improvement methodologies in responding to and identifying learning.
- Monitoring recommendations arising from all staff safety activity.
- Sharing information, learning and examples of good practice.
- Ensuring staff safety investigations are undertaken for all incidents that require this level of response.
- Ensuring the trust has procedures that support the management of staff safety incidents.
- Supporting and advising staff involved in any safety incidents.
- Escalating any concerns regarding themes, reports, policy compliance to the relevant Care Group/Directorate Senior Management Team and to the Health and Safety Group.

6.14 **Medication Safety Officer (MSO)**

One of the MSOs' key roles is to promote the safe use of medicines across their organisations and be the main experts in this area and include:

- being an active member of the National Medication Safety Network;
- managing medication incident reporting in the organisation and improving the reporting and learning from these.
- supporting learning responses by provision of expert specialist advice and participation in patient safety incident investigations and local learning responses
- working as a member of the medication safety committee - a multi-professional committee to support the safe use of medicines in the organisation.
- ensure incidents are reported to external bodies relevant to their scope of practice.

6.15 **Medical Devices Safety Officer (MDSO*)***

The principal role of the MDSO is to promote the safe use of medical devices across the Trust and provide expert advice. The MDSO acts as the essential link between the identification and implementation of local and national medical devices safety initiatives and the daily operations to improve the safety of medical devices.

The role of the MDSO includes:

- Membership of the National Medical Devices Safety Network.
- Monitoring the reporting and learning from medical device incidents.
- Supporting learning responses by provision of expert specialist advice and participation in patient safety incident investigations and local learning responses
- Attend the Trust Medical Devices Safety Group.

- Ensure the effective implementation of NHS England medical devices safety manufacturers' field safety notices.
  Ensure incidents are reported to external bodies relevant to their scope of practice.

6.16 **Local Security Management Specialist (LSMS)**

The LSMS is responsible for:

- Ensuring security incidents are recorded via the LERN system.
- Ensuring appropriate investigations of security incidents including assaults.
- Supporting learning responses by provision of expert specialist advice and participation in patient safety incident investigations and local learning responses
- Undertake thematic analysis of recorded incidents and other forms of quality intelligence related to their specialist area of expertise and provide reports to the Trusts Health & Safety Group.
- Provide feedback to victims of physical assault (and non-physical assaults where appropriate), stating the manner in which an incident will be dealt with, appraised of progress and any outcome of an investigation.
- Monitoring Police action in relation to violence and aggression conducted towards
- Trust staff.
- Recommending possible preventative action to be taken to minimise the risk of
- similar incidents from occurring.

6.17 **Fire Officer**

The Fire Officer is responsible for:

- The reporting of fire incidents in accordance with current practice
- Monitoring and mitigation of fire incidents
- Supporting learning responses by provision of expert specialist advice and participation in patient safety incident investigations and local learning responses

6.18 **Quality Committee**

The Quality Committee is established by and responsible to the Board of Directors. It provides assurance that the Trust has an effective framework within which it can work to improve and assure the quality and safety of services it provides.

The Trust Quality Committee will receive a monthly PSIR report.

6.19 **Clinical Governance Group**

The Clinical Governance Group is established by and responsible to the Quality Committee and Trust Management Board.

The Clinical Governance Group will receive a monthly PSIR report. The Clinical Governance Group will discuss LERN themes, action plans and shared learning from reported incidents.

The Clinical Governance Group will be the responsible group to monitor implementation of the UHD Patient Safety Incident Response Plan.

7. Training

We are committed to ensuring there are adequately trained and competent staff to conduct learning responses set out in our plan and policy

This has included:

- national level 1 and 2 training
- human factors training
- communication skills training
- Patient First training
- leadership training
- commissioning of external training

From early 2024 UHD will deliver in-house training and development for staff with specific investigation, improvement and/or oversight responsibilities under the PSIRP. Training and guidance documents can be found on the Intranet; Patient Safety (uhd.nhs.uk)

Table of training expectations:

Topic	Minimum duration	All Staff	Clinical Staff	Learning Response Leads/Managers	PSIRF Lead Roles	Oversight Roles
National Patient Safety Level 1: Essentials for Patient Safety	eLearning	✓	✓	✓	✓	✓
National Patient Safety Level 2: Access to Practice	eLearning		✓	✓	✓	✓
Involving those affected by Patient Safety Incidents	1 day / 6 hours			✓	✓	
Approach to Patient Safety Reviews	1 day / 6 hours (blended approach)			✓	✓	
Systems approach to	eLearning plus 2 days				✓	

learning from Patient Safety Incidents						
Oversight of Learning from Patient Safety Incidents	eLearning 6 hours					✓

HSSIB provides free training via their website which staff are encouraged to access for additional support, from system thinking training to investigative interviewing techniques and how to effectively engage and support those involved in investigations.

Health and Safety team offer Institution of Occupational Safety and Health (IOSH) approved UHD 'Managing Safely' course to support managers/supervisors in managing health and safety within their areas.

8. Monitoring Compliance and Effectiveness of the Document

Robust findings from PSIIs and reviews provide key insights and learning opportunities.

Findings must be translated into effective improvement design and implementation enabling the oversight to be shown.This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that any changes have measurably reduced risk of repeat incidents.

It is therefore proposed that programmed reports to the Board, Quality Committee and Clinical Governance Group will continue to include aggregated data on:

- patient safety incident reporting
- findings from PSIIs
- findings from patient safety reviews
- progress against the PSIRP
- results of surveys and/or feedback from patients, families, carers on their experience of the organisations response to patient safety incidents
- results of surveys and/or feedback from staff on their experience of the organisations response to patient safety incidents

9. Supporting Documents & References

This policy should be read alongside the Trust Patient Safety Incident Response Plan which outlines the Trust patient safety priorities and learning response framework. All PSIRF

related resources can be found on the Patient Safety intranet pages here: Patient Safety (uhd.nhs.uk).

NHSE Documentation: NHS England Patient Safety Incident Response Framework

10. Dissemination

Following approval, this document will be disseminated via the intranet (Patient Safety pages) to all UHD appointed staff.

A copy of the policy will also be made available on the UHD website and shared with the local Integrated Care Board (ICB), NHS Dorset.

11. Approval & Ratification

Policy is recommended to be approved by the Patient Safety Oversight group, Health and Safety Group, Clinical Governance Group, Trust Management Group, Quality Committee and Policies and Procedures Group

12. 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 18 to 24 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 time period.

Updated plans will be published on our Intranet and website, replacing the previous version.

A rigorous planning exercise will be undertaken on renew of each plan 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.

This policy will be reviewed every 3 years or following publication of new guidance from NHSE, changes to legislation or as a result of learning identified.

Revisions can be made in advance of the review date when the procedures within the plan require updating. Where the revisions are significant and the overall policy is changed the revised plan should be taken through the standard consultation, ratification and published on the intranet.

Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Clinical Governance Group and can be re-

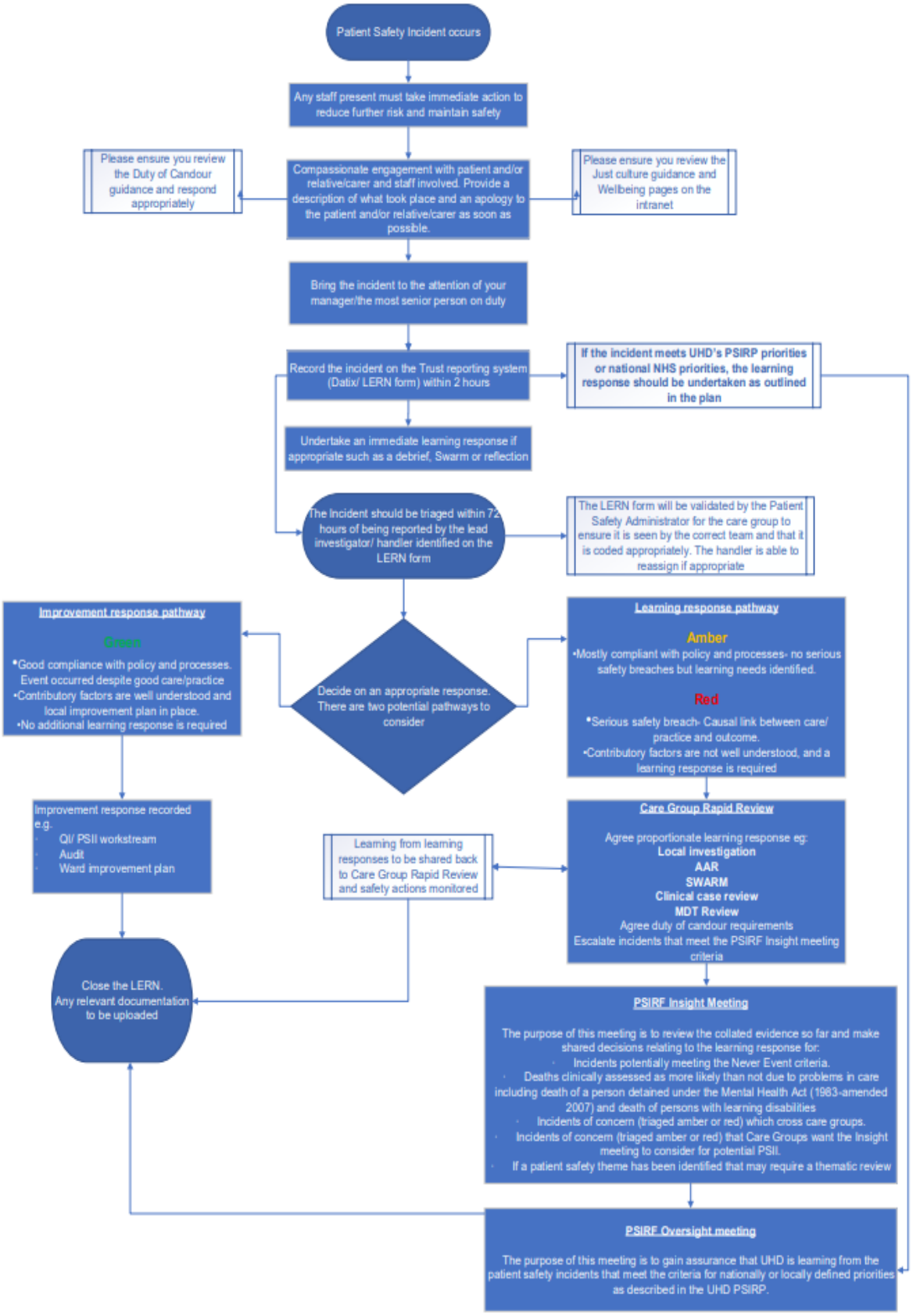
published on the intranet without having gone through the full consultation and ratification processes. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

13. Equality Impact Assessment

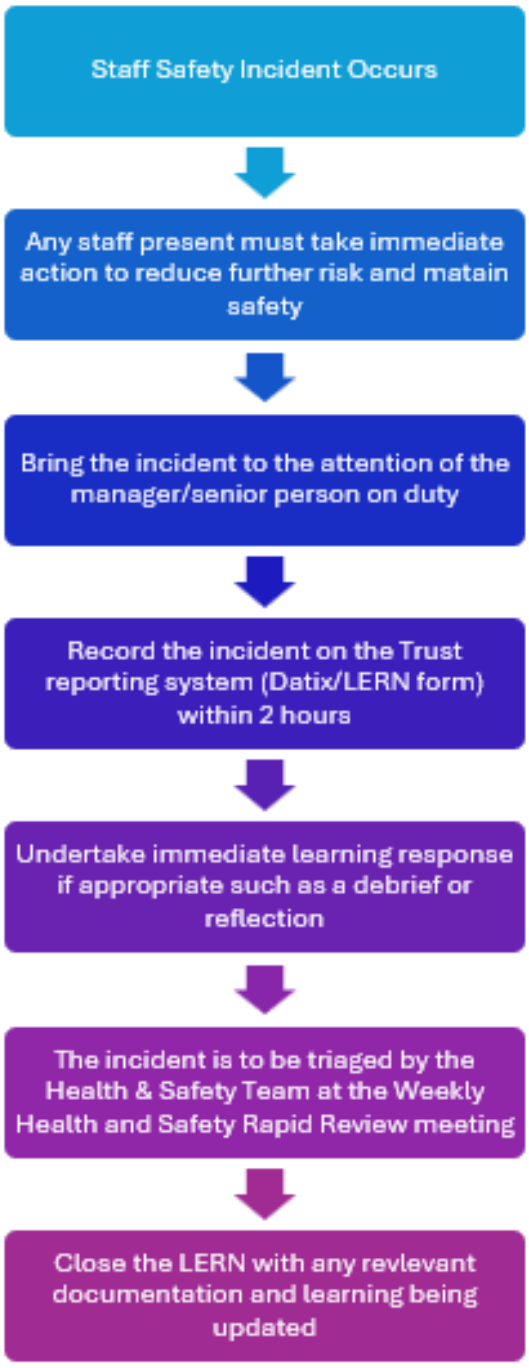
1. Title of document	PSIRF Policy	
2. Date of EIA	12/09/2024	
3. Date for review	12/09/2027	
4. Directorate/Specialty	Corporate Nursing	
5. Does the document/service affect one group less or more favorably than another on the basis of:		
	Yes/No	**Rationale**
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	
• Gender reassignment – the process of transitioning from one gender to another.	No	
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to parental leave in the context of employment. In the non-work context, protection against maternity discrimination is for 26 weeks (about 6 months) after giving birth, and this includes treating a woman or birthing person unfavorably because they are breastfeeding.	No	
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). A belief should affect your life choices or the way you live for it to be included in the definition.	No	
• Sex – a man or a woman.	No	

• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

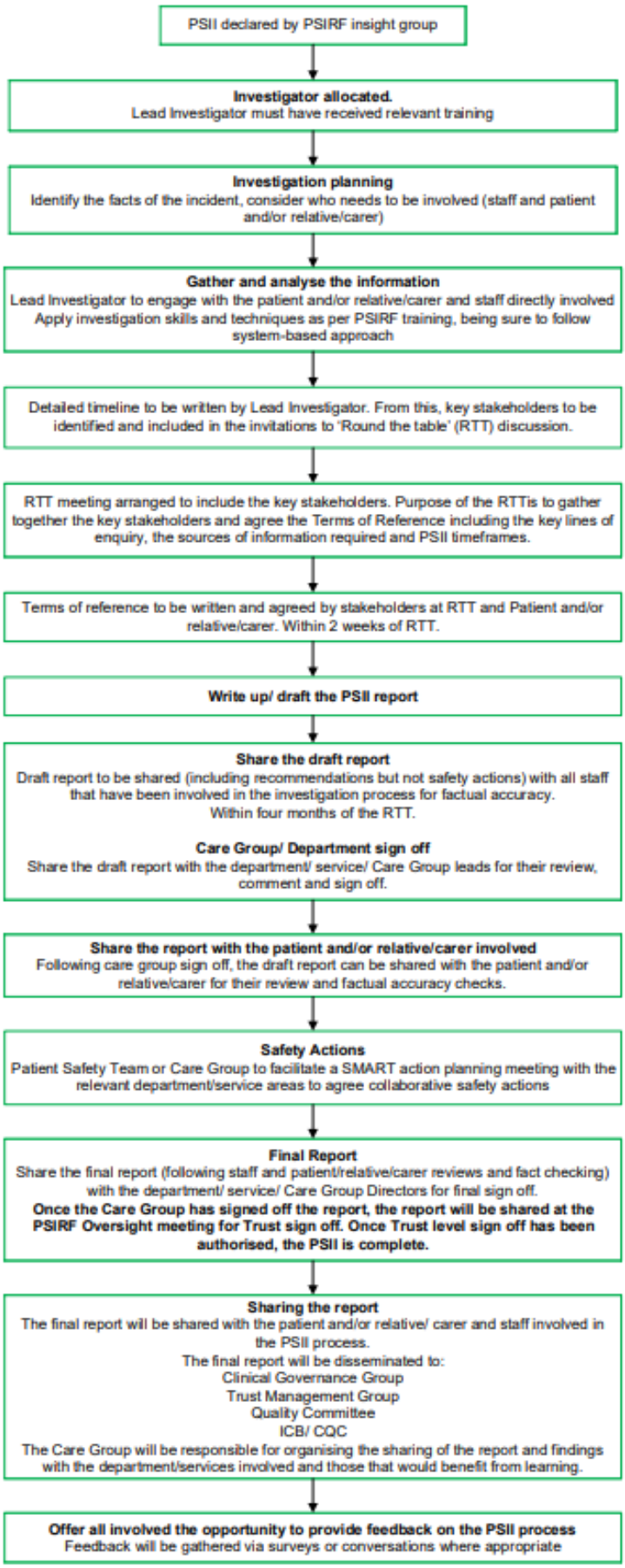
Appendix 1 - Flow chart for managing patient safety incidents.



Appendix 2 – Flow chart for managing staff safety incidents.



Appendix 3 – Flow chart for managing PSII



Appendix 4 - Reporting Incidents to External Agencies

External Agency	Type of Incident	Timescales for reporting	Reporting Officer
NHS England-Learn from Patient Safety Events (LFPSE)	All patient safety incidents are automatically uploaded to the new system LFPSE, which has replaced the National Reporting and Learning System (NRLS). NHS England use this data to provide a national picture of reported patient safety incidents.	Automatic	Reporter
Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR)	The Trust has an obligation to report serious work-place accidents, occupational diseases and specified dangerous occurrences to the Health and Safety Executive (HSE) in accordance to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). It is a legal requirement to report the following work-related incidents: • Death • Severe injuries • Over-seven day injuries – when an employee has an accident and the person is away from work or unable to work normal duties for more than seven days • Occupational Diseases i.e. work related dermatitis • Dangerous Occurrences i.e. exposure to Hepatitis C All incidents are to be reported via Datix and the Health and Safety Department must be informed whenever the above criteria is met	Within 10 days of a reportable incident	Quality and Safety Dept (Health and Safety)
NHS Dorset (ICB), Department of Health and CQC	PSIIs	2 working days (via STEIS or LFPSE)	Quality and Safety Dept
Other NHS Trusts	Incidents that involve care of patient by another Trust	2 working days from receipt of incident report	Quality and Risk Dept via LFPSE
Social Services (Child Protection)	Child Protection, Cause for concern cases	2 working days from receipt of incident report	Child Protection Lead
Social Services	Adult Protection, Cause for concern cases	2 working days from receipt of incident report	Adult Protection lead,
NHS Estates	Actual Fire or Suspected Arson Incidents	48 hours	Fire Officer
CQC IRMER	Ionising Radiation Incidents reporting under the 11 (Medical Exposure) Regs 2000 (IRMER)	Within 2 weeks of identifying incident	Radiology, Radiation Protection Adviser.

Medicines and Healthcare Regulatory Agency	Medical Devices Incident	5 working days from decision to report	Clinical Engineering, MDSO, Theatre manager or Quality and Safety Dept
MHRA	Medication (Serious Adverse Drug Reaction Incident)	5 working days from decision to report	Chief Pharmacist (or nominated lead), MSO
NHS Litigation Authority	Incidents that may give rise to potential Litigation.	5 working days after notification of claim	Head of Clinical Legal services
Information Commissioner	Serious breaches of Information Governance (Confidentiality Data Protection, Information Security)	24 hours	Information Governance Manager
Human Tissue Authority	The HTA must be notified of all incidents involving deceased patients that have occurred within the hospital. Notifications must be made using the HTA reportable incidents form on the HTA web portal and can only be completed by a Designated Individual (DI) or Person Designated.	5 working days of the incident being discovered	Pathology Quality Manager (HTA Designated Individual)
MNSI	Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England. Maternal deaths in England.	As soon as criteria identified	Maternity Risk and Governance Manager via online referral
Screening Incident Assessment Form (SIAF)	Any incident or near miss or suspected incident involving the NHS screening service must be reported to Public Health England (PHE) Screening Quality Assurance (QA) Service and Screening and Immunisation Teams who will agree a classification and provide timely recommendations on how it should be managed	As soon as criteria identified	Screening lead

Appendix 5- Organisational Wide Learning (OWL)

Circulation:

Medical Director, Deputies and Associates
Director of Nursing, Deputies and Associates
Care Group Directors of Nursing and Quality
Directors of Operations
Clinical Directors
Directorate Managers
Matrons
Governance Leads
Education Practitioners
Medication Safety Officer
Maternity Risk Manager
Medical Devices Safety Officer
Local Security Management Specialist
Subject Experts

Instruction to recipients:

for information, action and cascade as appropriate.

Responses will be filed and actioned as indicated.

NHS
University Hospitals Dorset
NHS Foundation Trust

Save lives, improve safety

Organisational Wide Learning
Look out for

Learning from a Patient Safety Event

DATE: AUGUST 2024

Situation
Background
Assessment
Recommendation
If you would like further information about this report, please contact: Patient Safety Team via patientsafetyteam@uhd.nhs.uk or on Ex 4014