PATIENT SAFETY INCIDENT RESPONSE POLICY

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Approval	
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Document Control			
Version	**Date Approved**	**New, Update or Full Review**	**Summary of reasons for the changes**
1	17 February 2025	New	New Group-wide policy

Contents

Executive Summary

This policy sets out the approach of St George's Epsom and St Helier Hospital Group (gesh) 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. It supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of PSIRF:

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

Site Chief Nurse Officers (CNO) and Site Chief Medical Officers (CMO) have overall responsibility for ensuring that reporting and management of all incidents is undertaken in accordance with this policy. They are responsible for declaring and final approval off Patient Safety Incident response investigations (PSIIs).

Division Incident Review Groups (DIRG) are responsible for the monitoring, evaluation and scrutiny of the incident reporting within their Division.

The Central Incident Review Group (CIRG) / Incident Review Panel (IRP) is responsible for the monitoring, evaluation, and scrutiny of incident reporting within the Trust.

The Group Patient Safety Team will ensure the implementation of this policy and processes across gesh for the identification, reporting, investigation, performance management and evidencing of the incident management processes.

This policy should be read alongside the Trust's Patient Safety Incident Response Plan (PSIRP) which outlines the Trust's approach to various types of incidents, including Never Events, national and local priorities for investigation.

All gesh employees have the responsibility to report all incidents and to ensure they familiarise themselves and comply with this policy.

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach of St George's, Epsom and St Helier Hospital Group 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.

Our work is aligned to the National Patient Safety Strategy and its three strategic aims, which are at the forefront of our safety activity: insight, involvement and improvement. It is also aligned to the gesh quality and safety strategy that sets out our aspiration by 2028 to deliver outstanding care together:

- Strong governance: we will strengthen governance and oversight of quality and safety
- Better flow/shorter waits: we will improve flow through our services, so that patients get the right care, in the right place, more quickly
- A learning organisation: we will embed a culture of psychological safety, continuous improvement, learning from mistakes and learning from others

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

This policy should be read alongside each Trust's Patient Safety Incident Response Plan (PSIRP) which outlines the approach to various types of incidents including Never Events, national and local priorities

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

1. compassionate engagement and involvement of those affected by patient safety incidents
2. application of a range of system-based approaches to learning from patient safety incidents
3. considered and proportionate responses to patient safety incidents and safety issues

4. supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across gesh. Responses and improvements under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error,’ are stated as the cause of an incident, and improvement is designed at a system level.

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

System-based learning from a patient safety response can be shared with those leading other types of responses for the purposes of wider learning, but other processes as described above should not influence the remit of a patient safety incident response.

Roles and responsibilities

Group Chief Nursing Officer and Group Chief Medical Officer are the Executive leads who hold joint responsibility for effective monitoring and oversight of PSIRF across St George’s University Hospitals NHS Foundation Trust and Epsom and St Helier Hospitals and Health Group and are accountable to the Trust Board.

Director of Quality and Safety Governance is responsible for the strategic overview of the patient safety incident reporting framework and responsible for managing the Group Patient Safety Team, ensuring robust supervision arrangements are in place, linking operational and executive leads.

Site Chief Nursing Officer (CNO) has overall responsibility for ensuring that reporting and management of all incidents, including those involving nurses and Allied Health Professionals, is undertaken in accordance with this policy. The Site Chief Nurse, along with the site Chief Medical Officer, will be responsible for declaring and final approval of Patient Safety Incident Investigations (PSIIs). They are responsible for ensuring the Trust maintains adequate systems to support high quality learning from safety incidents, including training.

Site Chief Medical Officer (CMO) has overall responsibility for ensuring that reporting and management of all incidents, including those involving doctors, is undertaken in accordance with this policy. The Site CMO along with the site CNO will be responsible for declaring and final approval of Patient Safety Incident Investigations (PSIIs). They are responsible for ensuring the Trust maintains adequate systems to support high quality learning from safety incidents, including training.

Division Incident Review Group: (DIRG): The group are responsible for the monitoring, evaluation and scrutiny of the incident reporting within their Division. In line with the terms of reference of the DIRG, the group will:

- Review incidents reported within their Division to establish if they meet the local or national criteria for a Patient Safety Incident Investigation (PSII), or establish the most appropriate learning response or local review based on the opportunity for learning and improvement.
- Ensure a considered and proportionate response to Patient Safety incidents in line with the Trust's Patient Safety Incident Response Plan.
- Ensure compassionate engagement and involvement of those affected by patient incidents, including meeting the needs of those involved to support an open and honest culture and ensure meaningful learning and improvements.
- Review the progress of PSIIs and learning responses instructed by their Division, as well as provide Divisional level approval once completed.
- Ensure the application of system based approaches to learning responses and understand the current areas for improvement within their Division to inform the relevant improvement plans.
- Provide a regular update to the Central Incident Review Group (CIRG) / Incident Review Panel (IRP) on incidents reviewed within the DIRG, incidents for escalation, progress with learning responses and associated actions, and any emerging safety themes.

Central Incident Review Group (CIRG) / Incident Review Panel (IRP): The Group is responsible for the monitoring, evaluation, and scrutiny of incident reporting within the Trust. In line with the terms of reference of the CIRG / IRP, the Group will:

- Review decision-making and actions taken at Division Incident Review Group (DIRG). Where CIRG / IRP does not agree with the decisions or actions taken, the CIRG / IRP will agree on the appropriate management, which will then be fed back to the DIRG for review and action.
- Seek assurance that incidents are being appropriately managed in line with the Trusts local Patient Safety Incident Response Plan (PSIRP) and policy.
- Ensure a considered and proportionate response to Patient Safety incidents in line with the Trust's Patient Safety Incident Response Plan (PSIRP).
- Provide oversight of incidents identified to meet the Local and National requirement for PSIIs.
- Review completed learning responses to assess content including compassionate engagement, robustness of the systems based learning response and recommendations.
- Review, approve and sign off Patient Safety Incident Investigation (PSII) reports ensuring they are robust and contribute to organisational learning.
- Provide oversight of progress against local incident response reviews, duty of candour, and CAS alerts.

Divisional Directors of Medicine, Nursing and Operations have the responsibility to ensure all incidents within their Divisions are acted upon in a timely manner and to the level commensurate with this policy and associated policies. They are responsible for compassionate engagement and involvement of those affected by incidents.

Group Patient Safety Team will ensure the implementation of this policy and processes across the organisation for the identification, reporting, investigation, performance management and evidencing of the incident management process.
The Group Patient Safety Team has responsibility to:

- Ensure that all relevant external agencies have been notified through the appropriate channels.
- Provide advice to any internal/external investigations on the incident management process.
- Provide specialist advice and expertise to staff involved in PSIRF learning responses.
- To monitor the progress of PSIRF learning responses across the group

- Retain original files of all PSII reports.
- Record/monitor PSII audit progress.
- Provide performance reports to all relevant committees, in line with their respective terms of reference.
- Monitor the timeframes within which incidents are identified and reported.
- Ensure Trust wide awareness of this policy
- Ensure the site specific Patient Safety Incident Response Plans (PSIRPs) are regularly reviewed

Divisional governance managers/quality leads. The Divisional Governance Team, which varies in description by site but is made of up specialist Quality Managers and clinical leads, will support the implementation of this policy and processes across their services for the identification, reporting, investigation, performance management and evidencing of the incident management process.

South West London Integrated Care Board (ICB)
gesh works closely with the local ICB and other national commissioning bodies as required. Representatives from the ICB sit on the Trusts' Central Incident Review Group (CIRG) / Incident Review Panel (IRP). Oversight and assurance arrangements are developed through joint planning and arrangements, incorporating the key principles of PSIRF.

Incident response policies and plans require relevant ICB sign off. In line with South West London Integrated Care Board's Patient Safety Incident Response Management policy, the ICB will collaborate with gesh in the development, maintenance, and review and agreement of Trust PSIRPs and policies.

In line with SWL ICB's Patient Safety Incident Response Management policy, the ICB will support with multi-agency/ cross provider/ cross system learning and/or lead a learning response, where required. The ICB will work collaboratively with providers to enable engagement and involvement of those affected by patient safety incidents and has set out a process that can be used in instances that involve multiple providers.

Patient Safety Specialists (at group and/or site level) have the responsibility to provide dynamic senior leadership, visibility, and expert support on patient safety.

Patient Safety Partners (at group and/or site level) bring the voice and needs of patients, families, carers, and the public into governance discussions in a way that provides appropriate challenge and fosters learning and change.

Learning response leads have the responsibility to carry out learning responses in line with the principles in this policy.

All Trust employees have the responsibility to report all incidents and to ensure they familiarise themselves and comply with this policy.

Our patient safety culture

gesh promotes a climate that encourages a Just Culture, ensuring that everyone is treated fairly, equally and given an opportunity to contribute to system based learning and improvement within patient safety. Patient safety incident responses are no blame and are conducted for the sole purpose of learning so that we can use this intelligence to design sustainable and effective system improvements to reduce risk and improve safety.

Within a Just Culture, it is assumed that most problems belong to the system and not an individual person or action. gesh expects staff to be open and honest, speak up and raise any concerns around safety, participate within a learning response and provide a meaningful apology to all those affected by an incident. We will avoid person focused or punitive safety actions for those involved in incidents, as this limits learning and slows the development of an effective commitment based safety culture.

We will work to develop a psychologically safe and open learning culture where gesh colleagues feel fully supported to report patient safety incidents, near misses, good practice and to raise any safety related concerns.

PSIRF puts compassionate engagement and involvement of all affected at the very centre of the learning and improvement processes. We will aim to meet the needs of staff members to ensure they are supported across gesh by our Health and Wellbeing policies, which are already embedded in our ways of working. These policies put the physical and mental health of staff at the centre of any involvement they have with patient safety processes.

More information on safety culture can be found in the links below:

NHS England » Safety culture: learning from best practice:

NHS England » A just culture guide

Patient Safety Partners

A clear priority for patient safety is to involve all the people concerned with an incident and this must include the patients, along with their families. This builds on our Duty of Candour process, giving a voice to all concerned.

gesh established the Patient Safety Partners (PSP) role in line with the NHS England guidance. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be part of our team.

The PSPs will participate in governance committee meetings with a focus on patient safety, risk, quality, and support and advise on activities, policies and procedures that will improve patient safety and help us deliver high quality care.

The PSPs will work alongside both medical and non-medical NHS staff to bring the voice and needs of patients, families, carers, and the public into those committees in a way that provides appropriate challenge and fosters learning and change.

PSPs will be supported in their role and will have regular one-to-one sessions with an identified Patient Safety Specialist and further training needs will be agreed together, based on the experience and knowledge of each PSP.

The gesh PSPs are also invited to be part of the South West London Integrated Care Board (SWL ICB) System Patient Safety Partners Network or Surrey Heartland PSP Network. These networks have agreed goals and priorities, providing a platform to share experiences and learn from each other to ensure the role is embedded well as mandated nationally.

The PSP placements will be reviewed to ensure the role is kept aligned to the patient safety agenda.

Addressing health inequalities

The NHS Patient Safety Strategy has made a commitment to address patient safety inequalities and local systems are being supported to do this. SWL ICB, in line with the Joint Forward Plan, aims to reduce health inequalities and deliver equitable care. SWL ICB will explore and respond to issues relating to health inequalities as part of the development and maintenance of their patient safety incident response plan (PSIRP) and use learning response tools that prompt consideration of inequalities, including when developing safety actions.

gesh also recognises the important role the NHS has in supporting all people who use health services. Ensuring access to services and making those services relevant to the needs of the local population, is central to the provision of fair and just care.

Both St George's, Epsom and St Helier Hospitals including Integrated Care are committed to complying with the statutory obligations enshrined in the Equality Act (2010) and will use data intelligently to help identify any disproportionate safety risk to patients with protected characteristics.

Through implementation of PSIRF at gesh, we will seek to collate and utilise data, including our learning responses, to identify actual and potential health inequalities and make recommendations on how to address them. Our population data will allow us to identify variations that could represent health inequalities. This will be used to support the development of future iterations of our patient safety incident response plans and this policy. To ensure that patients, along with their families and carers, are not excluded from any part of this process, gesh will ensure that tools such as translation services and interpretation services will be easily accessible and be made available. This will enable all those involved in a patient safety incident response to contribute fully.

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

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.

"Those affected" include staff and families in the broadest sense; that is the person or patient to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom in the incident occurred.

gesh welcomes the involvement of patients and families and is committed to engaging them in the investigation process. Often understanding the experience of the safety

incident from the perspective of the patient and their family provides a different and informative viewpoint that improves the learning opportunities that are gained by the investigation.

Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and will be supported to share their account.

This approach also dovetails with the Duty of Candour policy, a legal obligation as of 2014, requiring organisations to be open about safety concerns that have occurred. For further information on the Duty of Candour regulation please refer to the Duty of Candour Policy.

Information on support available to staff can be found in the Policy for supporting staff at Difficult Times, available on the Intranet

We will continue to develop our processes to support staff who have been involved in an incident as we learn from staff feedback. Supporting guidance link: engaging and involving patients, families and staff following a patient safety incident:

Patient safety incident response planning

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

Our Patient Safety Incident Response Plans (PSIRPs) will reflect the following Patient Safety Incident Response Standards and will be published alongside this overarching policy framework. Each Trust PSIRP will:

- Demonstrate thorough analysis of relevant organisational data
- Demonstrate collaborative stakeholder engagement processes (informed by thorough service and stakeholder mapping activities to ensure all areas are involved and represented appropriately)
- Provide a clear rationale for the response to each identified patient safety incident type
- Be updated as required, and in accordance with emerging intelligence and improvement efforts.

- Be published on our external facing website.

Incident response policies and plans require relevant ICB sign off. In line with South West London Integrated Care Board's Patient Safety incident response management policy, the ICB will collaborate with gesh in the development, maintenance, and review and agreement of Trust PSIRPs and policies.

Resources and training to support patient safety incident response

gesh recognises that successful implementation of the patient safety incident response process requires sufficient and appropriate staff resource with access to relevant training to enable the delivery of high quality improvement.

It is the responsibility of the divisional triumvirates to ensure adequate resource is allocated within their divisions to support staff to conduct timely system-based safety debriefs, focus groups, learning responses, thematic review and improvement work. The divisional triumvirate will also be responsible for ensuring the quality of all learning responses and challenging disproportionate learning responses for example, where we already understand the safety themes, or single incident person-focused safety actions.

The divisional governance / quality managers and Group Patient Safety Team will work to support the patient safety incident responses at each site, for example by identifying learning response leads, reporting, and escalating any issues as appropriate.

It is the responsibility of the Senior Leadership Team and Group Patient Safety Team to ensure that appropriate training is identified and made available to staff across the group. This will be reviewed and monitored through the Patient Safety and Quality Group (PSQG)) and the Group Quality Committee in Common (QCiC).

Our patient safety incident response plan

Our patient safety incident response plans (PSIRP) set out how each gesh site intends to respond to patient safety incidents over a period of 12 to 18 months at each site. These plans are owned by the Chief Nursing Officer and Chief Medical Officer at each site and are supported by the corporate patient safety team. 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.

The PSIRP for each site is developed using data from several sources (including patient safety incidents, Serious Incidents and Never Events over a period of three years) by analysing our current systems and our historical incidents and identifying themes to inform our patient safety incident profile (our local priorities) and where we should apply our focus for improvement.

In line with PSIRF guidance we will take a proportionate approach and work towards focusing more resource and time towards improvement activity, as this benefits our patients and staff.

Reviewing our patient safety incident response policy and plans

Our patient safety incident response plans (PSIRPs) are 'living documents' that will be appropriately amended and updated as we use them to respond to patient safety incidents. We will review the PSIRPs every 12 to 18 months to ensure our focus remains up to date and reflects any emerging themes. With ongoing improvement work our patient safety incident profile is likely to change. The reviews will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

As described, the ICB is required to work with gesh on the ongoing development of plans, specifically to:

- Understand the patient safety incident profile of gesh
- Understand the patient safety improvement profile of gesh
- Support the selection of appropriate response methods for patient safety incidents based on an understanding of potential for new learning and ongoing safety improvement work.

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

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the relevant incident reporting procedures and PSIRPs at each Trust.

All staff (including contractors, agency, bank and voluntary workers) have a duty to report any incident or occurrence they consider to represent a threat to their own or others' health and safety in a timely manner, whether occurring on Trust premises or other 'sites' (where patients/users are under the care or management of a Trust team) or involve Trust employed staff carrying out their duties. We will continue to support staff to feel able and confident to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Certain incidents require external reporting to national bodies, such as the Care Quality Commission (CQC), Maternity and Newborn Safety Investigations programme (MNSI), Health and Safety Executive (HSE), and Medicines and Healthcare products Regulatory Agency (MHRA) as per the Trust's incident reporting policies. This will include escalation of appropriate incidents to the ICB, such as Never Events. The Group Patient Safety Team will continue to function as liaison with these external bodies to ensure effective communication via a single point of contact for the Group.

Any incident in one of the national screening programmes hosted by gesh should be reported in line with guidance on Managing Safety Incidents in NHS Screening Programmes (Managing safety incidents in NHS screening programmes - GOV.UK)

Patient safety incident response decision-making

As explained above, reporting of incidents should continue in line with existing Trust policy and guidance. Each Trust also has governance and assurance systems to ensure oversight of incidents at both a divisional, site and group level.

Incidents will be reviewed on a regular basis in Division Incident Review Groups (DIRG). Incidents requiring a learning response, potential Never Events, any other incidents requiring Central Incident Review Group (CIRG) / Incident Review Panel (IRP) oversight will be escalated accordingly.

Site teams work with clinical and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have, caused significant harm (moderate, severe or death) so that Duty of Candour can be enacted. Level of harm is no longer a threshold that triggers a learning response, instead this decision is made in response to whether there is something new to learn about the system

- Identification of themes, trends, or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (e.g. CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g. Never Events, neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

Initial incident review will be used to determine if a learning response is required, whether improvement work is planned or already underway, or escalation is required. The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the gesh plan. This may often mean no further learning response is required, especially where the incident falls within one of the existing safety improvement plans.

Compassionate engagement and involvement processes with all affected will also be enacted as part of this initial review. Where there are other safety responses required, such as for the coroner, legal or HR processes, this will happen outside of the learning response.

The slide below shows the gesh Incident Review Process that will be followed.

The guide to responding proportionately to patient safety incidents outlines the different learning responses available under PSRIF, link available here: PSIRF.

A toolkit of learning response types is available from NHSE at:
https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

See appendix 2 for gesh Incident Decision Tree
See appendix 3 for National Learning Response Methods
See appendix 4 for gesh PSIRF Learning Response Reference Guide

Responding to cross-system incidents/issues

Any patient safety incidents that require cross system or partnership engagement are identified through CIRG/IRP and partnership colleagues are required to be fully engaged in investigations and learning activities.

In line with SWL ICB's Patient Safety Incident Response Management policy, the ICB will support with multi-agency/ cross provider/ cross system learning and/or lead a learning response, where required. The ICB will work collaboratively with providers to enable engagement and involvement of those affected by patient safety incidents and has set out a process that can be used in instances that involve multiple providers.

Timeframes for learning responses

Learning responses must start as soon as possible after a patient safety incident is identified, and usually completed in one to three months. Timescales must be set for all response methods.

When decisions are made regarding learning responses, the relevant templates and guidance will be issued for use by the Division, in conjunction with timescales within which learning responses should be completed and the sign off process.

It is important for responses to be timely to ensure all relevant information is captured as close to the incident as possible. This understanding of what happened must be proportionately balanced with the aim to understand the associated process of work system to enable learning for improvement.

A PSII is an in depth exploration of a work system that has been flagged up as an area of interest through an incident or incidents. The timeframe for completing a PSII will be agreed with those affected by the incident, provided they are willing and able to be involved in that decision, at the stage of setting the terms of reference for the PSII. PSIIs should be completed within a maximum of 6 months. There may be exceptional circumstances for which a longer investigation timeframe may be required, which should be agreed in conjunction with those affected and with the CIRG/IRP

Processes for the monitoring of timely completion of learning responses will be established and overseen by the DIRGs and CIRGs/IRP at each site.

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to seeking solutions at too early stage of the safety action development process and may lead to unintended consequences. "Learning response" methods enable us to understand the important and relevant work system factors and interactions between these, that can produce both wanted and unwanted safety and wellbeing outcomes. This valuable intelligence, along with other sources such as complaints, policy and work schedules will be themed and used to identify areas for improvement which are linked to our PSIRPs and group/site/divisional improvement plans.

To be proportionate with our resource we will move away from safety actions linked to single incidents and will instead use our new safety intelligence at local, divisional, Trust and Group level to more effectively direct our improvement priorities. Staff and service users will be involved in the design of effective, achievable, and sustainable safety actions that have a clear and measurable benefit.

The safety actions from learning responses should follow the SMART (specific, measurable, achievable, realistic, time-bound) principles and provide detail on how they will be monitored and measured. Further guidance on this can be found in NHSE resources at:https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Site divisional teams will monitor and maintain an overview of safety actions developed following patient safety incidents. This will be overseen at the Central Incident Review Group (CIRG) / Incident Review Panel (IRP) level and will form part of assurance reporting to the Quality Committee in Common.

Safety improvement plans

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

- Support divisions to develop and implement local safety improvement plans
- Create an organisation-wide safety improvement plan summarising improvement work
- Create individual site safety improvement plans that focus on a specific service, pathway, or location

- Collectively review system-based learning from learning responses when it is felt that there is sufficient understanding of the underlying, interlinked system issues, with a view to theme and find areas for improvement
- Create a safety improvement plan to tackle broad areas for improvement (ie overarching system issues in collaboration with the ICB/system partners where appropriate.)

SWL ICB suggest the following key lines of enquiry when reviewing safety actions and improvement, aligned to the PSIRF standards framework:

- Is learning triangulated across the range of incident response methods, used to inform improvement?
- Can the organisation describe safety improvement in progress, what they aim to achieve, and their interim successes and challenges?
- What is the provider board doing to support local teams on challenges in patient safety improvement?

Oversight of safety improvement plans will be through existing site and Trust governance processes i.e. Patient Safety and Quality Group (PSQG), gesh Quality Group and Quality Committee in Common (QCiC).

Oversight roles and responsibilities

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Leads are the Group Chief Nursing Officer and Group Chief Medical Officer who hold joint responsibility for effective monitoring and oversight of PSIRF. Oversight role and responsibilities will be in line with the National specification available on this link:

B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

gesh recognises and is committed to close working, in partnership, with South West London ICB and other commissioning bodies as required. Representatives from the ICB actively participate in Central Incident Review Group / Incident Review Panel meetings. Oversight and assurance arrangements will be developed through joint planning, and arrangements must incorporate the following key principles:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

SWL ICB's approach to oversight is outlined in their Patient Safety Incident Response Management policy (see Appendix 5). The ICB is required to collaborate with its providers to assess whether the systems and processes put in place to respond to patient safety incidents for the purpose of learning and improvement are effective. The ICB is also required to support safety improvement where a provider's systems and processes to respond to patient safety incidents are not leading to improvement. This may be through seeking support from colleagues in regional teams or linking with other organisations whose systems and processes are more developed.

Complaints and appeals

Any complaints relating to this guidance, its application or implementation, can initially be raised informally with the Trust Patient Safety Team. They will aim to resolve any concerns as appropriate.

Formal complaints from patients or families should be submitted to the complaints departments at St George's Hospital and for Epsom and St Helier Hospital Group, as per the complaints process.

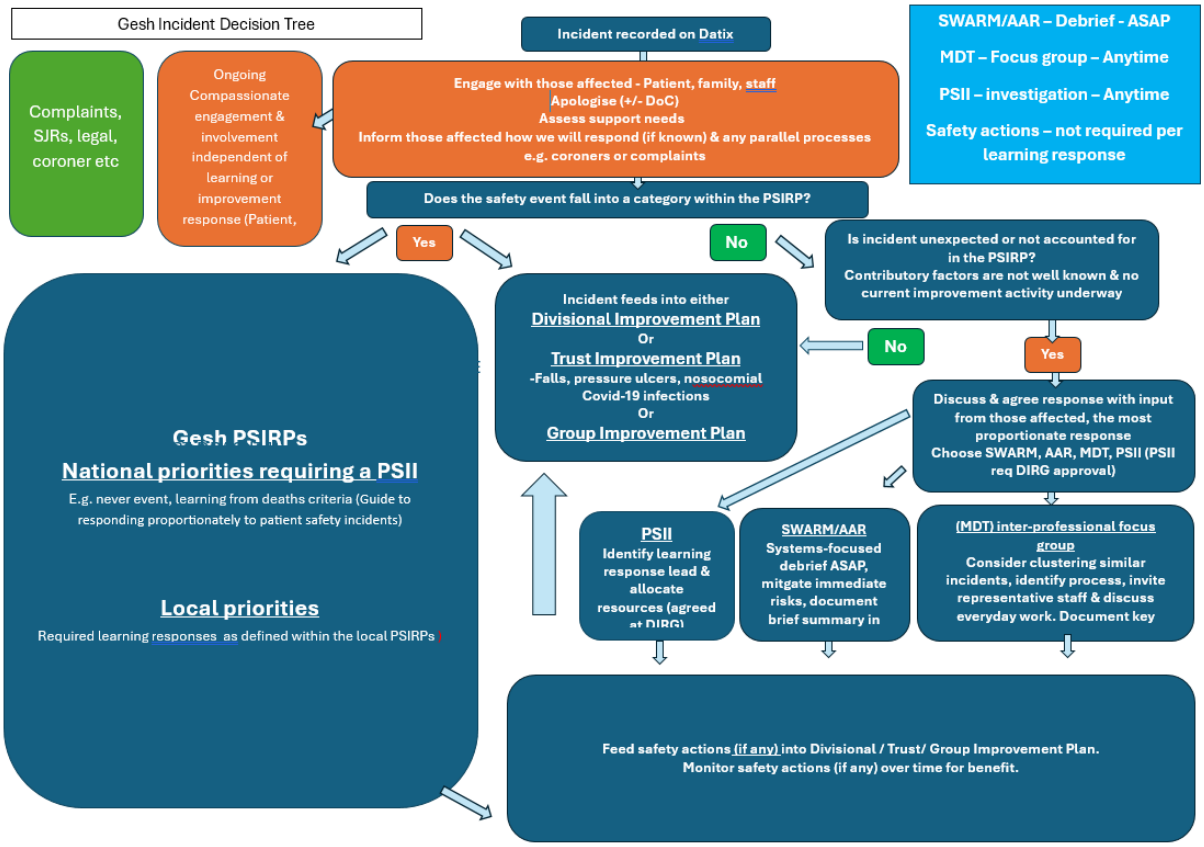
Associated documentation

NHS England Patient Safety Response Framework Guidance
SGH Patient Safety Incident Response Plan (PSIRP)
ESTH Patient Safety Incident Response Plan (PSIRP)
Duty of Candour Policy
Adverse Incident Reporting Policy
Policy for supporting staff at Difficult Times

Appendix 1 – Glossary

AAR	After Action Review: A structured system based debrief that helps teams understand what happened, why and does this happen often, so we can learn and improve
Compassionate Engagement	Describes a process that we enact to meet the physical psychological and emotional needs of all affected. This process may be short or long term dependant on the nature of the incident
Duty of Candour	It is the professional responsibility to be open and honest with patients and families when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This includes saying sorry and taking action to put things right where possible.
Engagement Lead	Is anyone who leads on engaging with and involving those affected by a patient safety incident. This may be a person leading a learning response or a family liaison officer (or similar).
Just Culture	A system of shared accountability in which organisations are accountable for the systems they have designed and for responding to the behaviours of their employees in a fair and just manner.
Learning Response	Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as multidisciplinary team debriefs, huddles and after-action reviews.
MDT	Multidisciplinary team review. An interprofessional focus group that involves a representative workforce that carry out the process or theme of interest.
Never Event	Never Event - Patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
Patient Safety Incident	An unintended or unexpected incident that could have led or did lead to harm one or more patients in our care.
PSII	Patient Safety Incident Investigation - A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
Safety Culture	It is an organisational culture that places a high level of importance on safety beliefs, values, and attitudes—and these are shared by the majority of people within the company or workplace. It can be characterised as 'the way we do things around here'.
SEIPS	Systems Engineering Initiative for Patient Safety replaces the contributory factors classification framework. This is made up of six factors or elements that when considered together cover all elements of a ‘system.’ All the national PSIRF tools are based on SEIPS.
SWARM	Swarm based huddle - Bringing together a diverse team of healthcare Professionals to rapidly assess, communicate and coordinate actions immediately after an incident.

Appendix 2 – gesh Incident Decision Tree



Appendix 3 - National Learning Response Methods

Table 3: National learning response methods

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

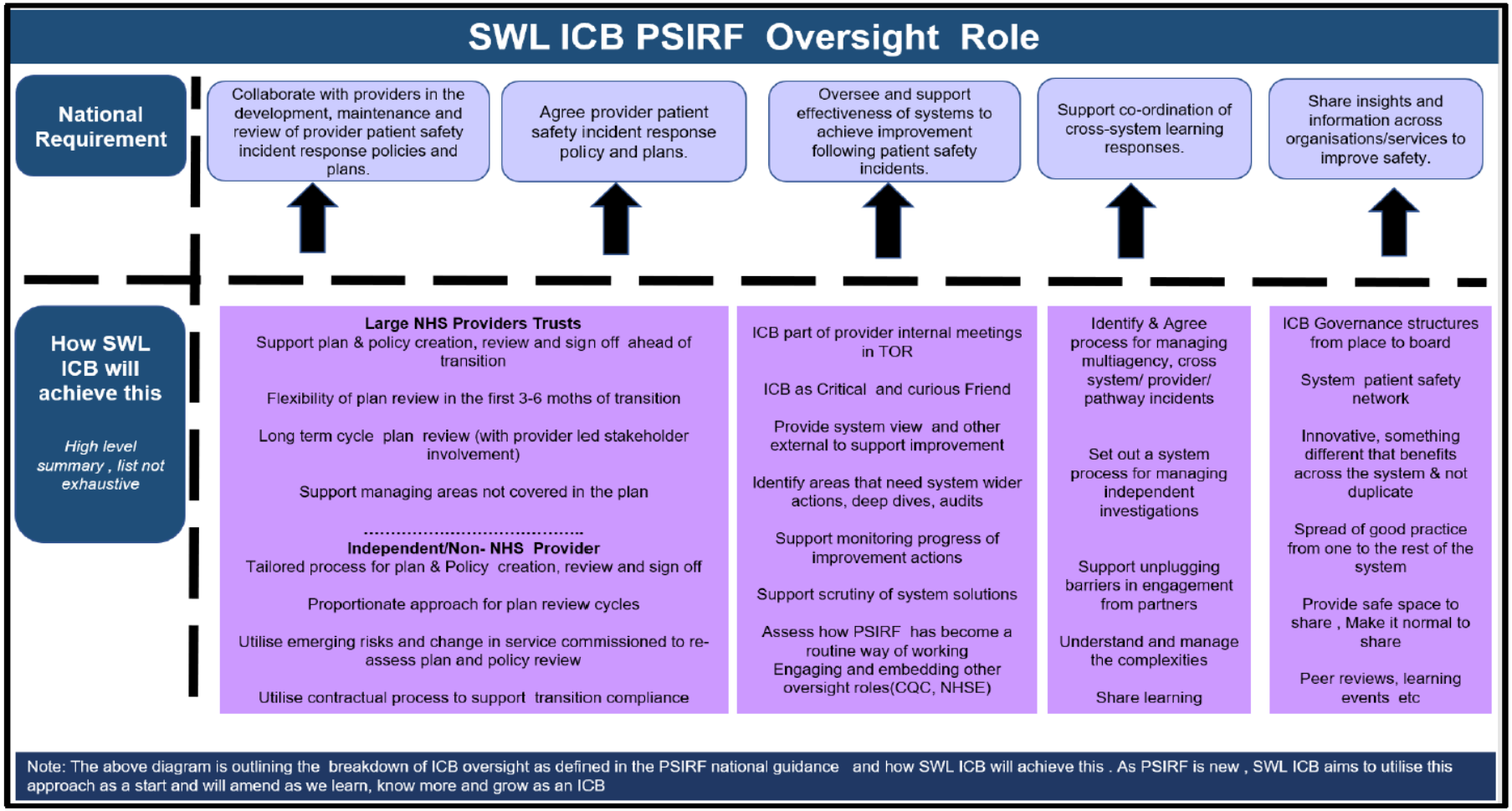
Appendix 4 – gesh PSIRF Learning Response Reference Guide

Learning Response	When to use	Time required to complete	Who is involved
After Action Review	After any activity or event where there is something new to learn	Approx. 45-90 minutes	Those directly involved in the event and others connected to the event or the patient pathway.
MDT review	Following multiple similar incidents (including incidents where multiple patients were harmed or where there are similar types of incidents) When time has passed since the incidents occurred or staff not available for other learning response types	Approx. 2-3 hours	Those directly involved in these events, plus subject matter experts and senior clinicians.
PSII (patient safety incident investigation)	PSIIs are the highest level of investigation and are mandated for certain types of incidents. They will be led by trained staff and should include an engagement lead and subject matter expert. They are investigated using a systems-based approach.	Timeframes for PSIIs will be decided upon by the terms of reference. These can take up to 6 months.	Those directly involved in the event, led by someone independent to the event, plus subject matter experts and senior clinicians.
SWARM	As soon as possible after a patient safety incident occurs	No more than 30 minutes	Those directly involved in the incident.

Appendix 5 – SWL ICB PSIRF Oversight Role

NHS South West London
Integrated Care Board

17.1. Appendix A (i): SWL ICB PSIRF Oversight Role



17.2. Appendix A(ii): SWL ICB PSIRF Oversight Role-Structures for System Oversight, Supporting Learning & Improvement