Queen Victoria Hospital
NHS Foundation Trust

Patient Safety Incident Response Policy

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FORMS AND DOCUMENTS LINKED or ADDED AS APPENDIX IN THIS POLICY	Rapid Response Review Patient Safety Incident Investigation (PSII) Report After Action Review (AAR)
DIRECTOR LEAD	Nicky Reeves, Chief Nurse
AUTHOR	Hilary Durrant, PSIRF Lead
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Version	Date Ratified	Brief summary of significant changes/ amendments	Author/ contributor

Contents

1. Introduction

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) in response to the NHS Patient Safety Strategy (2019) and sets out Queen Victoria Hospital NHS Trust (QVH) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues supportive oversight, focused on strengthening response systems and improvements.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient services and departments at QVH.

Responses 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.

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 exist for that purpose, and therefore outside of the scope of this policy, such as:

- Claim handling
- Coronial inquests
- Criminal investigations
- Human resources/ employee relations investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Complaints (except where a significant patient safety concern is highlighted)

For clarity, the principle aims of each of these processes above differ from those of a patient safety response and are outside the scope of this policy. Information can be shared with those leading other responses, but these processes should not influence the remit of a patient safety learning response.

3. Our patient safety culture

QVH is dedicated to work towards the move from a retribution approach to types of incidents, such as patient safety, to establishing a just culture within the organisation.

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety. QVH is dedicated to work towards ensuring a positive safety culture and to supporting staff who raise concerns, ensuring psychological safety.

Leaders across QVH are required to proactively embrace this approach and support from staff side colleagues will be instrumental in establishing the organisation transition to a just culture. This is being reflected in our training where we are focusing on system shortcomings rather than individuals. All learning response leads will complete Just Culture training and further training opportunities for all staff will be detailed in autumn 2024.

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families and carers to achieve learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are committed that patient safety incident investigations are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

It is recognised that sufficient protected time is central to patients, family and staff being at the heart of an investigation and a learning culture.

QVH encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Opportunities to speak up about concerns are available through the Freedom to Speak Up Guardian and anonymously though "*Tell Nicky*".

QVH is committed to developing a restorative and just culture in which to support the staff involved and those who are tasked with investigating.

4. Patient safety partners

At this time, QVH are not planning to develop this role. This will be reviewed as PSIRF is embedded in the organisation and formally reassessed in mid-2025 as to whether the role can be utilised. QVH will link with the Sussex PSP forum for opportunities to include the patient voice and with view for a comprehensive reassessment.

Patients and their next of kin will be invited to contribute to investigations with the support of a named liaison from the Risk, Safety and Patient Experience team. Where appropriate, advice and input will be sought from the existing patient support groups.

5. Addressing health inequalities

QVH recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

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

We will seek to utilise data and learning from investigations to identify actual and potential health inequalities. When constructing safety improvement actions in our patient safety learning responses we will consider inequalities and make recommendations which will aim to promote inclusivity.

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

QVH endorses a zero tolerance of racism, discrimination and unacceptable behaviours from and towards our patients, carers, families and our staff and aims to provide inclusive healthcare.

It is recognised that in addition to statutory requirements, some groups may be more likely to experience challenges in accessing care. The engagement of patients, family are pivotal in identifying some of these complex reasons which may include:

- access to transport
- access to child care
- language
- misinformation
- negative previous experiences
- fear and anxiety
- mental health
- literacy

Investigators will aim to identify whether health inequality factors may have contributed to the incident and will refer to the Health Inequalities Lead for advice with regards to safety actions inclusion.

This policy and protocol has been equality due regard assessed in accordance with the Trust's Equality Due Regard Assessment Guidance. Completed assessments are available upon request from gvh.edra@nhs.net.

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

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of effective patient safety incident responses that prioritise compassionate engagement and involvement of those affected by patient safety incidents (including patients, carers, 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.

We are committed to continuous improvement throughout the services we provide.

We want to learn from any event where care does not go as planned or expected by staff, patients, their families, carers and other organisations. Encouraging involvement of patients and families in our response is crucial, particularly to support the improvement of the services we provide. This involves being open and honest whenever there is a concern about care/ treatment provided, or when a mistake has been made.

Alongside professional, regulatory and statutory requirements for Duty of Candour, QVH commits to being open and transparent because it's the right thing to do; regardless of the level of harm caused by an event. In-line with the PSIRF we will support those involved guiding staff, patients and their families through our patient safety learning responses to conclusion.

In addition, we have a Patient Advice and Liaison Service (PALS) for those with a concern or who are unhappy about their experience at QVH. This allows the QVH to review the concern, respond and make necessary improvements.

QVH loves to hear great things about our staff, our teams and the services we provide and we welcome compliments from our patients and their families. This is used to assist with learning from excellence.

Our teams at QVH can support with

- Raising a concern or complaint
- Sending a thank you or appreciation

Involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to be sure of an inclusive approach from the outset. Staff will continue to promote, support and encourage colleagues to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

7. 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 we can explore patient safety incidents relevant to their

context and the populations they serve rather than only those that meet a certain defined threshold/criteria.

QVH will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. Our Patient Safety Incident Response Plan (PSIRF Plan) will detail how this will be achieved alongside how we intend to meet both National requirements and our QVH Local Priorities for patient safety incident responses.

It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans will be:

- Updated as required and in accordance with emerging intelligence and improvement efforts
- Published on our external facing website

7.1 Resources and training to support patient safety incident response

QVH has committed to ensuring that we fully embed PSIRF and meet the national training requirements. We have utilised NHS England Patient Safety Response Standards, (2022) to provide resources and training required for this to happen.

We will ensure patient safety learning responses are not led by QVH staff who were involved in the patient safety event itself and that responses are not undertaken by staff working in isolation. The Patient Safety team will support patient safety learning responses, providing guidance and advice. Our colleagues affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All QVH leaders will work within our just culture principles and will utilise other teams to make sure support is provided.

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

Learning responses will be led by those with at least two days formal training and skills development in learning from patient safety incidents.

All staff will be required to complete eLearning for Health level 1 (Essentials of Patient Safety) and have access to level 2 (Access to Practice) of the patient safety syllabus.

Ad hoc Datix and incident management training will be provided to individuals and teams on request.

7.2 Our patient safety incident response plan

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

The PSIRF plan is based on a thorough analysis of themes and trends from all incidents from April 2020 to March 2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework),

mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients.

The priorities identified in the PSIRF plan will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

7.3 Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan annually to make sure 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 year.

Updated PSIRF plans will be published on QVH website, replacing the previous version.

For quality improvement 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

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

All staff are encouraged to and, responsible for, recording and reporting potential or actual patient safety events. The reporter will record the level of harm they believe to have been experienced by those affected.

Events and/or incidents that appear to meet requirements for reporting externally will be co-ordinated by the Patient Safety team. There will be occasions where events require the efforts of cross-system working with relevant partners, the ICB will support a collaborative approach with these arrangements if required.

8.2 Patient safety incident response decision-making

QVH will have arrangements in place to meet the requirement to review patient safety events under PSIRF. Some of these will require a mandatory response, others will require review or referral to another body and/or team; these are set out in the PSIRF plan.

PSIRF itself sets no further national rules of thresholds to determine what method of response should be used to support learning and improvement. In the development of a PSIRF plan, QVH has built our local priorities and developed response mechanisms.

The Clinical Governance Group (CGG) will hold overall oversight of such processes, permitting for challenge where required.

Never Events, as per national guidance, will be escalated as a board briefing and reported to the CQC and the ICB. A rapid response review will be completed and action taken as agreed by the triumvirate.

Incidents requiring, or potentially requiring, PSII

All staff (directly or through their line manager) must make sure all incidents resulting in harm are escalated as soon as practical. Duty of candour disclosure must take place according to QVH policy.

A Rapid Response review will be undertaken by the department, supported by the Patient Safety team for review within two working days by the triumvirate of Chief Nurse, Medical Director and Head of Patient Safety (or their nominated deputies). This panel will also identify lead investigators and subject matter expert(s) (who were not involved in the incident). Clear records will be maintained though this period using the Rapid Response template (*appendix 1*) detailing shared decision making.

PSII responses

The Patient Safety team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and to the CQC according to accepted reporting requirements.

The Patient Safety team will support and coordinate a panel review following guidance from the Rapid Response triumvirate. The panel will comprise three investigators, one of whom will be an identified lead. The report template (*appendix 2*) will be used.

As prescribed in NHS England Response Standards B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk), the lead investigator will have completed a minimum of 2.5 days training which will include:

- Human factors
- Learning response methods
- Safety action development
- Duty of Candour
- Just Culture
- After Action Review
- Continuing professional development

Panel input will be sought from expert leads as appropriate which may include (but is not limited to):

- Patient Experience
- Safeguarding
- Medical Devices
- Learning and Development
- Health and Safety
- Pharmacy
- Clinical support services

8.3 Responding to cross-system incidents/issues

The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

QVH will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive procedures to ensure that this is effectively managed.

QVH will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.4 Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement. One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team.

Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

Rapid Response Review

Rapid Response will be submitted for decision making at the soonest opportunity and within no more than two working days of the incident. A decision on level of investigation will be made by the Head of Patient Safety, Chief Nurse and Medical Director (or their nominated deputies) the following working day. Where more information is required to make a decision this will be clearly communicated and documented on the template.

PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and is expected to be completed within one to three months of their start date. No local PSII should take longer than six months.

Staff involved will be asked to provide a Recollection of Events (*appendix 4*). It should be noted that this will not be a substitute for a statement should one be required by the coroner or other external agencies.

The time frame for completion of a PSII will be agreed with those affected by the incident (patient, family, carer etc.) as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that protracted timescales can have on those involved in the incident and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Actions or changes may be required to be put in place for immediate effect and before completion of the PSII.

If responses are frequently taking more than six months, or exceeding timeframes set with those affected, then processes will be reviewed to understand how timeliness can be improved.

Timescales will be monitored through monthly specialty reports to make sure delays are identified early and support made available.

After Action Review (AAR)

A learning response in the form of an AAR must be completed for all reported incidents and started as soon as possible. It is expected that an AAR (*appendix 3*) will be completed within 20 days. It is recognised that there may be exceptional circumstances where this is not achievable and an extension should be sought with the Patient Safety team.

8.5 Safety action development and monitoring improvement

QVH recognises that any patient safety learning response will allow the circumstances of an incident or set of incidents to be understood and that this is only the beginning. To consistently reduce risk, safety actions are needed.

Investigators will identify safety actions for improvement. Safety actions will follow the SMART (Specific, Measurable, Achievable, Realistic and Time-bound) principles and thought must be given to monitoring and measures of success. Support and guidance for measuring success can be sought from the Audit team.

Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

The monitoring of completion and efficacy of safety actions will be through Business units and the CGG. The Patient Safety team will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

8.6 Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. QVH has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. The patient safety priorities were developed because the of the opportunity they offer for learning and improvement across areas where currently there is no existing plan or where previous improvement efforts have not resulted in a reduction in apparent risk or harm.

QVH will use the outcomes from existing patient safety incident reviews (SI RCA reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Safety improvement plans will be monitored through business unit governance meetings and the Clinical Governance Committee. Evidence of actions having been embedded may include audit with support from the audit team.

9. Roles and responsibilities (Duties)

9.1 All staff

- Staff must make sure immediate actions are undertaken to manage the incident and identify actions needed to minimise the chances of recurrence
- All staff (including temporary workers) have a responsibility to highlight any safety concerns which may warrant further investigation: reporting incidents and near misses promptly
- Staff will be fully open and co-operative with any patient safety review process. Engaging in the investigation of incidents and providing information if, and when, required. This includes providing a full recollection of events if requested (*appendix 4*)
- Information regarding the reporting and management of incidents is provided for new staff at corporate induction and for existing staff is available on Qnet

9.2 Chief Executive has overall responsibility for effective patient management at QVH, including incident reporting and management. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

9.3 Board of Directors has delegated authority for incident reporting and management. The Board of Directors will be directly appraised of:

- New PSIIs
- Never Events
- Performance against agreed Key Performance Indicators as part of the agreed performance monitoring arrangements.
- Approve and monitor relevant key performance indicators

9.4 Senior Leadership team are responsible for ensuring that patient safety, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include:

- Addressing significant concerns/issues from incident investigation escalated by Lead Clinicians, Heads of Department or by local departmental / specialty meetings.
- Ensuring that actions from incident investigations are implemented within given timescales.
- Ensuring training and education in completed in their area of responsibility
- Ensure sufficient protected time to allow investigations to be completed in a timely manner
- Actively support and promote restorative just working culture
- Promoting and supporting Freedom to Speak up in line with the Raising Concerns (Whistle Blowing) Policy (2021)
- Ensuring that staff are adequately supported following an incident and as required during an investigation which may include signposting to Well-being.
- Responsible for overseeing implementation and embedding safety actions.

9.5 Chief Nurse is the Director designated with responsibility for governance and risk management and implementation of PSIRF. The Chief Nurse's key responsibilities in respect of incident reporting and management are:

- Notifying the Board of Directors of incidents reported as Never Events
- Notifying the Board of Directors of incidents considered as meeting the criterion of a PSII
- Presenting reports to public and private board which provide details of new cases, issues of concern, outcome, learning and assurance

- Joint decision making with the triumvirate (Medical Director and Head of Patient Safety), following submission of rapid response ensuring rationale is clear, documented and retrievable.

9.6 Medical Director is responsible for ensuring patient safety, including incident reporting and management is prioritised in their team. Key responsibilities include:

- Joint decision making with the triumvirate (Chief Nurse and Head of Patient Safety), following submission of rapid response ensuring rationale is clear, documented and retrievable.

9.7 Head of Patient Safety is responsible for ensuring the PSIRF plan and policy are maintained and implemented. Key responsibilities include:

- Ensuring sufficient support for investigation panel investigations
- Ensuring investigators are appropriately trained
- Joint decision making with the triumvirate (Chief Nurse and Medical Director), following submission of rapid response ensuring rationale is clear, documented and retrievable.
- Ensuring rapid escalation where timescales are not met

9.8 Patient Safety team is responsible for communicating and coordinating patient safety investigations at QVH. Key responsibilities include:

- Managing QVHs system for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, NHS England and the ICB.
- Supporting the review of incident trends and providing information and analysis on incident trends to assist responsible committees and individuals.
- Supporting the review of incidents reported as moderate, major or catastrophic harm to ensure statutory requirements for Duty of Candour are complied with.
- Reporting of all patient related incidents through the Learning from Patient Safety Events (LfPSE) via an online portal.
- Providing support and expert guidance during investigations.
- Providing/coordinating investigator training to relevant staff
- Ensuring staff involved in an investigation have support and are signposted to relevant resources

9.9 Investigators are responsible for:

- Raising conflicts of interest at the soonest opportunity
- Ensuring they have received the appropriate level of training
- Leading an investigation into the specific incident
- Producing a report using the Trust templates.
- Ensuring National and local practice is reflected within the investigation
- Ensuring that staff are adequately supported following an incident and as required during an investigation which may include signposting to Well-being.
- Investigators will not be responsible for following up, embedding and responding to safety actions as detailed

9.10 Managers are responsible for:

- Ensuring sufficient protected time to allow investigations to be completed in a timely manner
- Actively support and promote restorative just working culture
- Receiving all Datix reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident.

- Supporting and facilitating the opportunity for learning within the business unit, department and across QVH
- Managers will be responsible for following up, embedding and responding to safety actions as detailed.
- Ensuring that staff are adequately supported following an incident and as required during an investigation which may include signposting to Well-being.
- Promoting and supporting Freedom to Speak up in line with the Raising Concerns (Whistle Blowing) Policy (2021)

9.11 Human Resource team are responsible for;

- identifying relevant policies and the inclusion and promotion of Just Culture ensuring it is embedded in practice.
- To work collaboratively with the Patient Safety team to ensure access to Wellbeing services are accessible

9.12 ICB;

- NHS Sussex to be involved in and review, from an improvement opportunities lens, a minimum of two learning responses with a system focus per financial year. The learning response to be selected by the provider and can range from an AAR, thematic review or PSII. This will enable the ICB to fulfil its oversight and assurance function and support in reviewing the process and learning. This will also facilitate the sharing of learning across Sussex as well as regionally and nationally via NHSE.
- The PSIRP to be reviewed with NHS Sussex bi-monthly for the first six months of implementation to use a "plan, study, do, act (PDSA) approach" to understand any changes that may be required, learning identified and improvement s to be realised. To be reviewed with the ICB quarterly thereafter.

10. Complaints and appeals

QVH Is committed to high quality care for all as a core principal of our vision and purpose. We will ensure that patients and their representatives can seek advice, provide feedback or make a complaint about the services we commission or the policies we have developed and implemented. When dealing with complaints we aim to adhere to NHS England's organisation value's principles and follow the 'Good Practice Standards for NHS Complaints Handling' (Sept 2013) outlined by the Patients Association.

Any concerns or complaints raised about services provided by QVH will be taken seriously and will be managed in a way that reflects our values.

QVH encourages patients, their family and friends to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff. Our complaints policy focuses specifically on those concerns or complaints that require management through the Patient Advice and Liaison Service (PALS).

The QVH Handling Complaints and Concerns Policy (2022) sets out the principles and processes involved when any person wishes to raise a concern or complaint. This includes the need for the Trust to provide an apology where appropriate and an opportunity for learning when complaints are responded to, where this is relevant.

10.1 Monitoring outcomes of PSIIs

Updated reports will be provided for CGG, Quality and Safety Committee and the Board review and assurance.

The reports will include aggregated data including:

- Patient safety incident reporting
- Findings from PSIIs
- Learning to be shared and how this will be delivered
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents

10.2 Procedures to support staff affected by PSIIs

QVH is committed to a culture which promotes openness, honesty and that focuses on improving practice rather than on individual deficiencies and blame. It is recognised that fear of disciplinary action may deter staff from reporting incidents and investigations must be viewed as an opportunity to learn rather than punish.

Disciplinary proceedings will only result in exceptional circumstances, for example where there has been a breach of the law, gross negligence or professional misconduct.

QVH advocates a fair and just system where staff are held to account for their actions and behaviours, without being unduly blamed. Every effort will be made to ensure that reported incidents are managed and investigated positively as a way of improving safety through learning.

The principles of the NHS Just Culture Guide ensures the fair, open and transparent treatment of staff who are involved in patient safety incidents. We will embed these principles in to our procedures for the review of incidents.

QVH recognises the significant impact 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 to be able to continue working whilst this takes place. All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response.

Opportunities to support staff affected by PSIIs investigation, include joining a debrief meeting or a one-to-one conversation with the incident review team.

Access to support can be found:

- The Patient Safety team will advise and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.
- The Freedom To Speak Up Guardian provides a confidential service for staff if they have concerns about the organisation's response to a patient safety incident.
- *Second Victim* is a website resource for healthcare staff and managers involved in patient safety incidents.
- Ensure appropriate action is taken to deliver divisional KPI relating to incident reporting and management.

11. Freedom of information

Any information that belongs to the Trust may be subject to disclosure under the Freedom of Information Act 2000. This act allows anyone, anywhere to ask for information held by the Trust to be disclosed (subject to limited exemptions). Further information is available in the Freedom of Information Act Trust Procedure which can be viewed on the Trust Intranet.

12. Review

This policy will be reviewed in three years' time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

13. References

NHS England » Patient Safety Incident Response Framework

NHS England » Revised Never Events policy and framework

NHS England » A just culture guide

14. Appendices

Appendix 1 Rapid Response Review
Appendix 2 Patient Safety Incident Investigation (PSII) Report
Appendix 3 After Action Review (AAR)
Appendix 4 Recollection of Events

Rapid Response Review

Patient name							
hospital number		Ward/department		Incident date		reference number	
Incident summary							
Completed by		Date completed		Staff involved in Rapid Response Review			

Part 1: timeline of events

Date & time	Event	Details (what happened)	Additional information (including what should have happened)	Comments / queries to be followed up

Part 2

What went well?	
What didn't go so well?	

Part 3: initial findings

1.	
2.	
3.	
4.	
5.	
6.	

Part 4: grading

Grade & level of investigation to be followed including: • lead investigator • support • submission group & date	
Agreed by & date (Head of Risk or deputy)	
Agreed by & date (Chief Nurse or deputy)	
Agreed by & date (Medical Director or deputy)	

Appendix 2

Queen Victoria Hospital NHS Foundation Trust

Patient safety incident investigation (PSII) report

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

Notes on the PSII template

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

General writing tips

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

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

Appendix 2

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

Distribution list

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

Name	Position

Appendix 2

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

Appendix 2

A note of acknowledgement

Notes on writing a note of acknowledgement

In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc.) who gave time and shared their thoughts.

You could consider referring to the patient by name or as ‘the patient’ according to their wishes.

Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Appendix 2

Executive summary

Notes on writing the executive summary

To be completed only after the main report has been written.

Incident overview

Notes on writing the incident overview for the executive summary

Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary

Add a brief overview of the main findings here (potentially in bullet point form) including what went well

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs.

Contents

To update this contents table, click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

Appendix 2

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – eg by day or by contact with different services on the care pathway.

It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’.

Appendix 2

Investigation approach

Investigation team

Role	Initials	Job title
Investigation commissioner/convenor:		
Investigation lead:		

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Appendix 2

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Appendix 2

Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

Consider potential health inequalities and their impact.

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (e.g. refer to other ongoing improvement work, development of a safety improvement plan).

The final summary should also include what went well and how those actions can influence work in the future.

Appendix 2

Safety action summary table

Area for improvement: [e.g. r*eview of test results*]								
	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency *(e.g. daily, monthly)*	Responsibility for monitoring/ oversight *(e.g. specific group/ individual, etc.)*	Planned review date *(e.g. annually)*
1.								
2.								
…								

Area for Improvement: [e.g. *nurse-to-nurse handover*]								
	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency *(egg daily, monthly)*	Responsibility for monitoring/ oversight *(e.g. specific group/ individual, etc.)*	Planned review date *(e.g. annually)*
1.								
…								

Appendices

Notes on appendices

Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

References

Notes on references

Include references to national and local policy/procedure/guidance, and other data sources as required.

Appendix 3

After Action Review (AAR)

Incident number	
Incident description	
Incident date & time	
AAR date & time	
AAR facilitator	
Attendees	

What should have happened?	
What actually happened?	
Why was there a difference?	
What can be learned?	

Summary	
Key learning points	
Actions arising as a result of learning & name of person following up	

Appendix 4

Recollection of events

Please could you let us know what happened & what your role was. The aim is to understand the circumstances leading to the incident & to identify improvements.
It isn't a memory test so please feel free to refer to medical records, policies or other documents. Thank you

Name	
Job title	
Date	

What happened?
What was your role?
What went well?
Would you do anything differently next time?
What can be learned by the department/QVH?
Is there anything else you want to add? Please include comments & concerns
Who else was present?