RM74 - PATIENT SAFETY INCIDENT

RESPONSE POLICY

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# Version Control, Review and Amendment Logs

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| New Policy |  | Update to the Patient safety response methodologies and relevant templates | To support the annual Patient Safety Profile development |

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# Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF). It sets out how Alder Hey Children’s NHS Foundation Trust (the Trust) will approach developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety.

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

This policy supports the development and maintenance of an effective patient safety incident response system 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 system functioning and improvement.

This policy should be read in conjunction with our current Patient Safety Incident Response Plan (PSIRP), which sets out how this policy is to be implemented.

# Scope

This policy is specific to patient safety incident responses conducted solely for learning and improvement across the Trust.

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 learning and improvement.

Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

# Our Patient Safety Culture

Safety culture is one of the two key foundations of Alder Hey’s and the wider [NHS’, Patient Safety Strategy](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/). We define a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

* Continuous learning and improvement of safety risks
* Supportive, psychologically safe teamwork
* Enabling and empowering speaking up by all.

There will be continued emphasis on improving safety culture and [engaging and involving patients, families and staff following a patient safety incident](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf) This supports the [Just culture guide](https://www.england.nhs.uk/patient-safety/a-just-culture-guide/) which encourages the treatment of staff involved in a patient safety incident in an open, consistent, constructive, and fair way.

We know that positive patient safety and healthy organisational culture are two sides of the same coin. A culture in which staff are valued, well supported, and engaged in their work leads to safe, high-quality care. We are exploring how a focus on staff safety can support patient safety. This means both psychological safety and physical safety, including considering staff [wellbeing](https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/), engagement, fatigue, burn-out, presenteeism, and the impact these can have on risks to patients and staff alike.

It does not matter whether a staff member is clinical or non-clinical; everyone has a right to feel safe from harm, and to feel safe about speaking up. It’s paramount that we move on from a more traditional focus on failure, to also learning from what goes well. In this way, and in the context of a psychologically safe culture, we can all hear more, learn more, and act together to improve patient care.

The Alder Hey staff voice can be viewed as an early warning system where leaders are allowed to understand in detail where improvements can be made and where best practice can be shared.

Psychological Safety, which is explicitly measured in the Staff Survey (and smaller, more safety focused derivatives of it), will therefore play a critical role in helping us to continuously improve. We will extrapolate our findings from the survey metrics to determine if we are sustaining our ongoing progress in improving our safety culture.

By embedding Psychological Safety across Alder Hey, with open discussion, and support from one another, we can take the next step to achieving a safer working environment for our staff and safer care for our patients.

# Patient Safety Partners

In 2025 at Alder Hey Children’s NHS Foundation Trust, we are excited to welcome Patient Safety Partners (PSP). These partners will work alongside our staff, patients, and their families or carers to help influence and improve safety across our services.

Our Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services.

The PSP’s will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety across the Trust and maximise opportunities to embed learning. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance, and challenge.

PSPs will be part of the Alder Hey family and will work alongside all staff, volunteers, and patients. They will attend quality and safety-focused meetings (face-to-face and online) and be intrinsically involved in patient safety and quality initiatives.

PSP role descriptions and a Patient Safety Partner Policy have been developed. PSP’s will be provided with the relevant training and support so that they can fulfil their role to their full potential and help ensure the best patient safety outcomes for all patients.

## 5.1 Addressing Health Inequalities.

Alder Hey Children’s NHS Foundation Trust is one of Europe’s biggest and busiest children’s Trust, caring for over 330,000 children, young people, and their families every year.

As a specialist provider of health care, Alder Hey has a key role to play in tackling health inequalities in partnership with local partner agencies and services. We continuously seek to utilise data gained from our incident reporting system and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these.

The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with children, young people, and their families following a patient safety investigation must also recognise the diverse needs of the communities that the Trust serves and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Alder Hey recognises that some groups of society can experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, transgender, pregnancy/maternity, and marriage/civil partnership. However, the Trust also acknowledges that other minority groups may also experience unfair treatment and discrimination.

When considering our safety actions in response to any incident, we will consider if there are any inequalities, and this will be built into our governance and action planning process. We will use our reporting systems to monitor and identify any variations that identify any inequalities. By doing this we can identify any safety improvement work.

## 5.2 Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including our children, young people, their families, carers, 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 by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people’s needs not only helps alleviate the harm experienced but also helps avoid compounding the harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

Processes for engaging and involving those affected by patient safety incidents will be applied as follows:

* Apologies are meaningful. Apologising is a crucial part of the Duty of Candour.
* Approach is individualised.
* Timing is sensitive.
* Those affected are treated with respect and compassion.
* Guidance and clarity are provided. Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing.
* Those affected are heard. Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience.
* Approach is collaborative and open.
* Subjectivity is accepted.
* Strive for equity.

## 5.3 Involving Patients, Families and Patient Representatives

The Trust is committed to involving children, young people, their families, and carers following patient safety incidents, engaging them at the earliest opportunity and throughout the review process, to fulfil the duty of candour statutory and non-statutory requirements.

Further guidance for involving patients and families following a patient safety incident is available from NHSE [here](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf).

A network of staff acting as family liaison officers/ engagement leads within our Divisions will continue to guide children and young people their families and carers through any investigation or learning review.

Anyone with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their care team in the first instance.

We are committed to providing safe compassionate and joined-up care for all our children, young people and their families and continue to implement and achieve compliance with recommendations outlined in [Marthas Rule](https://demos.co.uk/wp-content/uploads/2023/08/Marthas-Rule_finalversion.pdf) .

In addition, Alder Hey Children’s NHS Foundation Trust has a patient advice and liaison service ([PALS](https://www.alderhey.nhs.uk/visiting/feedback/pals/)). Should the care team be unable to resolve the concern then PALS can provide support and advice to our children, young people their families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing concerns raised by our children, young people, and their family/carer or friends. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS, located in the Trusts Atrium near the Treehouse, is available from 9am to 5pm, Monday to Friday.

Or you can:

* Call [0151 252 5161](tel:0151%20252%205161)
* Write to PALS, Alder Hey Children’s NHS Foundation Trust, Eaton Road, Liverpool L12 2AP.

If the team are helping other families, they may not be able to answer the phone, and you may need to leave a voicemail, and they will return your call as soon as they are able to.

We also recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with our children, young people their families, and carers to signpost to their preferred source for this.

## 5.4 National Guidance for NHS Trusts

[Learning from deaths](https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/)

Child death support:

[Child Bereavement UK](https://www.childbereavementuk.org/)

[Lullaby Trust](https://www.lullabytrust.org.uk/bereavement-support/)

[Child Death Helpline](https://www.childdeathhelpline.org.uk/)

All sites offer support and practical guidance for those who have lost a child in infancy or at any age.

The [NHS Complaints Advocacy Service](https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy) can help navigate the NHS complaints system, attend meetings, and review information given during the complaints

[Healthwatch](https://www.healthwatch.co.uk/) are an independent statutory body who can provide information to help make a complaint, including sample letters.

Parliamentary and Health Service [Ombudsman](https://www.ombudsman.org.uk/) makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

[Citizens Advice Bureau](https://www.citizensadvice.org.uk/) provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

## 5.5 Involving Staff and Partner Agencies

Involvement of staff and partner agencies at the earliest opportunity and throughout a learning response is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout.

The Trust 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 continue working whilst this takes place.

Alder Hey Children’s NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles into our procedures for the review of incidents.

## 5.6 Corporate Teams

The Trust’s Patient Safety Team and Corporate Risk and Governance Team~~s~~ will advice, and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

## 5.7 Staff Advice and Liaison Service

[SALs](https://intranet.alderhey.nhs.uk/services/staff-advice-and-liaison-service/support-for-teams/) is an open access listening service available to all staff and learners at Alder Hey Children’s NHS Foundation Trust. The service has been developed and is delivered by Alder Hey staff for Alder Hey staff and is underpinned by the principles of person-centred compassionate care whereby staff are provided with the experience of being listened to, understood, empowered, and supported to take intelligent action.

## 5.8 Occupational Health service

The [Occupational Health Service](https://intranet.alderhey.nhs.uk/services/occupational-health-team-prevent/) for Alder Hey is provided by Optima Health , who have a dedicated team of Occupational Health professionals based on site on the interim site to help protect and promote the health and wellbeing of staff in the workplace.

## 5.9 Schwartz Rounds

Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience, or simply listen to their stories. Sessions are themed with invites to Trust wide Schwartz rounds distributed by the Communications Team.

## 5.10 Freedom to Speak Up

[Freedom to Speak Up](https://intranet.alderhey.nhs.uk/services/freedom-to-speak-up/) (FTSU) is an NHS England wide programme that supports you to identify issues and find ways to resolve them.

We know that an open and responsive raising concerns culture, where all our staff feel confident to speak up when things go wrong, is a huge part of what makes Alder Hey the caring organisation it is, every day. Freedom to Speak up Guardians can be contacted via [FTSU@alderhey.nhs.uk](mailto:FTSU@alderhey.nhs.uk)

## 5.11 Support from Patient Safety Incident Investigators

All staff with knowledge of the patient safety events being reviewed are encouraged to actively participate in the learning response.

Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

Staff in engagement roles will be trained in line with the PSIRF standards as outlined in section 8.1.

# 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.

By taking this approach we can focus on our resources, or groups of incidents that provide the greatest opportunities for learning and improving patient safety. Planning needs to consider other sources of information 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 the Trust plans should reflect:

* A thorough analysis of relevant organisational data
* Collaborative stakeholder engagement
* A clear rationale for the response to each identified patient safety incident type.

They will be:

* Updated as required and under emerging intelligence and improvement efforts.
* Published on the Trust external facing website.

## 6.1 Resources and Training to Support Patient Safety Incident Responses.

It is essential that Alder Hey Children’s NHS Foundation Trust ensures that it uses capacity and resources effectively to deliver the plan. The PSIR Plan provides the current level of resources required for Patient Safety Responses to be undertaken.

Currently, the Patient Safety Leadership Team, led executively by the Chief Nursing, AHP and Experience Officer and Chief Medical Officer have the following posts to support and facilitate the delivery and embedding of the PSIRF framework:

* Patient Safety Specialist
* Associate Director of Nursing Governance and Risk
* Medical Services Director
* Programme Manager

In addition, the following posts support the Patient Safety Leadership Team:

* Patient Safety Leads
* Governance and Risk Manager
* Divisional Governance Managers
* Head of Quality/Quality Hub
* Patient Safety Partners

There is a pool of trained staff, working in substantive clinical or governance roles, who can undertake comprehensive learning responses. Appropriate allocation of time to allow for the completion of learning responses will be given to trained staff.

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the [NHS England Patient Safety Incident Response Standards](https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/) to frame the resources and training required to allow for this to happen.

A learning response for a PSII will be led by the Patient Safety Leads who have an appropriate level of seniority and influence within the Trust. This is due to the nature and complexity of the incident and the response required.

The Patient Safety team will support learning responses wherever possible and can provide advice and participation in cross-system and cross-divisional working where this is required. The Cross System Management of Patient Safety Learning Responses flow chart can be found [here](https://alderheynhsuk-my.sharepoint.com/personal/sarah_craigie_alderhey_nhs_uk/Documents/Documents/PSII%20investigation%20tools/Cross%20System%20Management%20of%20Patient%20Safety%20Learning%20Responses%20Flowchart.pdf):

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All staff will work within our Just Culture principles. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise and advice.

## 6.2 Training

All staff are aware of their responsibilities in reporting and responding to patient safety incidents.

The Trust has, following approval by Alder Hey Education Governance Committee, mandated the completion of [NHSE Patient Safety Training Syllabus](https://www.hee.nhs.uk/sites/default/files/documents/Curriculum%20Guidance%20for%20Delivering%20the%20NHS%20Patient%20Safety%20Syllabus.pdf) Level one – essentials for patient safety for all clinical and non-clinical staff within the Trust.

Furthermore, Level one – essentials of patient safety for board and senior leadership teams has been mandated to all executive members of the Trust.

Level one is a standalone module with currently no expiry/renewal date set for staff. This module is available as an eLearning package via ESR (Electronic Staff Record) access. The overall Trust compliance is monitored through the Integrated Performance Report.

Any future iterations, and national recommendations will be considered and implemented, as necessary.

## 6.3 Learning Response Leads Training and Competencies.

**Training**: Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

Records of such training will be maintained the Patient Safety Leadership Team.

Learning response leads must have completed Levels one and two of the national patient safety syllabus.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional risk and Governance teams and the Patient Safety team will support this.

**Competencies**: As a Trust we expect that those staff leading learning responses will:

* Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
* Summarise and present complex information in a clear and logical manner and in report form.
* Manage conflicting information from different internal and external sources.
* Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Divisional senior managers, Divisional risk and Governance teams and the Patient Safety Leadership team.

## 6.4 Engagement and Involvement Training and Competencies

**Training**: Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.

Records of such training will be maintained the Patient Safety Leadership Team.

Engagement leads must complete Level one and two of the national patient safety syllabus.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Risk and Governance leads.

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

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

## 6.5 Oversight Roles Training and Competencies

**Training**: All patient safety response oversight will be led/conducted by those who have had:

* One formal day (6 hours) training in oversight of learning from patient safety incidents.
* Level 1 (essentials of patient safety for boards and senior leadership teams)
* Level 2 (access to practice) of the patient safety syllabus.

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

Records of such training will be maintained by the Patient Safety Leadership Team.

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

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

# Our Patient Safety Incident Response Plan

Our plan sets out how Alder Hey Children’s NHS Foundation Trust intends to respond to patient safety incidents over a 12 month timeframe, noting that our 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 current plan is based on a thorough analysis of themes, patterns, and trends from:

* Patient safety incident reports (clinical and non-clinical)
* Top 10 incident cause groups
* Complaints and PALS themes
* Legal claims
* Staff survey results
* Mortality and in-patient death thematic reviews
* Trust-wide quality improvement workstreams

Additional resources reviewed included: Freedom to Speak Up reports, Annual Quality Accounts, Trust-wide Quality Round and Quality Assurance Round insight reports and presentations, Complaints and PALs reports, child deaths and mortality review reports, safeguarding data, risk data, and direct consultation with children, young people, and their families via open forums and through a range of children and young person’s forums that we have in place.

A copy of our current plan can be found at: <https://www.alderhey.nhs.uk/about/publications/patient-safety-incident-response-plan/>

## 7.1 Reviewing our Patient Safety Incident Response Policy and Plan.

Our patient safety incident response policy and plan are ‘living documents’ that will be appropriately amended and updated as we use it to respond to patient safety incidents.

The plan will be reviewed every 12 months to ensure our focus remains up to date; with ongoing improvement work, our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree on any changes made in the previous 12 months.

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

A rigorous planning exercise will be undertaken every 2 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

## 8.1 Safety Incident Reporting Arrangements

Patient safety incident reporting will follow the Trust Incident Reporting and Management Policy (see on [DMS](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal)). All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system InPhase and will record the level of harm they know has been experienced **by the person affected** [(Appendix A)](#_Appendix_B_–).

These reports will be automatically uploaded to the national database (Learning from Patient Safety Events-LFPSE) to support national learning. Locally, support is available on how to report an incident via the Trust intranet or via the Risk and Governance team at [governanceandqualityassurance@alderhey.nhs.uk](mailto:governanceandqualityassurance@alderhey.nhs.uk)

Reporting of serious incidents (SIs) to the Strategic Executive Information System (StEIS) will eventually be superseded by LfPSE (Learn from Patient Safety Events). However, to reduce complexity during the continued transition period and to maintain data flows it has been agreed nationally that organisations will continue to use StEIS to record any incidents that are subject to PSII. A new incident type has been added to StEIS that allows organisations to record incidents that are responded to using PSII.

Daily Divisional incident review mechanisms are currently in place to ensure that patient safety incidents can be responded to proportionately and in a timely manner. This includes consideration and prompting to service teams where [Duty of Candour](https://alderheynhsuk.sharepoint.com/:w:/r/sites/ClinicalGuidancePortal/_layouts/15/Doc.aspx?sourcedoc=%7B291362A5-5A35-4191-B5DE-5809885B2B5A%7D&file=Duty%20of%20Candour%20Policy%20-%20RM47.docx&action=default&mobileredirect=true&DefaultItemOpen=1) applies.

Whilst the statutory obligation for the Trust to complete Duty of Candour (DoC) for moderate harm and above remains, under PSIRF, the timescale for DoC to be completed within 10 days has been removed: however, Alder Hey will continue to adhere to the 10-day timescale to ensure compliance with DoC legislation.

Most incidents will only require local review within the Divisions/services, but in line with our approved governance process ([Appendix B](#_Appendix_A_–)), all incidents reported as moderate physical and/or psychological harm or above, plus any patient safety incident where it is felt that the opportunity for learning and improvement is significant, will be presented by the relevant Division and reviewed collectively at the weekly Patient Safety Incident Response Investigation (PSIRI) Panel to determine the appropriate learning response required (PSII or PSR). Divisions will also escalate any identified trends, clusters, or patient safety risks that cannot be actioned, plus any incident that appears to meet the criteria to be reported eternally to the weekly PSIRI panel.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents. Any PSII undertaken by our organisation will use the national PSII template ([Appendix C](#_PSII_report_Template)).

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome. There are five broad categories of PSRs agreed upon with stakeholders to be utilised at Alder Hey Children’s NHS Foundation Trust ([Appendix C](#_Appendix_C_–))

* Initial Review
* Situation, Background Assessment, Recommendation, Decision (SBARD) review
* After Action Review (AAR)
* Thematic Review
* Multi-disciplinary team (MDT) review

Our approved governance process allows the Trust to work transparently and collaboratively with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if a supportive co-ordination of a cross-system learning response is required.

## 8.2 Patient Safety Incident Response Decision-Making

In line with our approved PSRIF governance arrangements, the Trust has arrangements in place to allow it to meet the requirements for the review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIR Plan.

The Trust has established governance and assurance systems in place to ensure oversight of patient safety incidents at both Divisional and Trust-wide level allowing for a clear ‘Ward to Board’ oversight of incident management and our PSIRF response.

Corporate and Divisional Governance teams will continue to work collaboratively 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)
* 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 (Care Quality Commission) concerns)
* Identification of any incidents requiring external reporting or scrutiny (e.g. – Never Events, Neonatal deaths, RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations))
* Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures.

This data will be reviewed regularly against the identified priorities in the PSIR Plan to determine whether any shift in focus is required, which will be agreed by the Patient Safety Board and Safety Quality Assurance Committee if required.

The process for completion of a Patient Safety Incident Review, currently identified as an Initial Review, to determine further investigation or escalation required will remain with other tools as outlined in [section 8.1](#_7.1_Safety_incident) and available in [Appendix C](#_Appendix_C_–).

The principles of proportionality and a focus on incidents that provide the greatest learning opportunity for learning will be central to this decision-making under the Trust’s PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP and this will be considered on a case-by-case basis with justification where necessary.

## 8.3 Responding to Cross-System Incidents / Issues.

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and actions. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The Cross System Management of Patient Safety Learning Response can be found [here](https://alderheynhsuk-my.sharepoint.com/personal/sarah_craigie_alderhey_nhs_uk/Documents/Documents/PSII%20investigation%20tools/Cross%20System%20Management%20of%20Patient%20Safety%20Learning%20Responses%20Flowchart.pdf). The PSIRI Panel and Corporate Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust via the following email address: [governanceandqualityassurance@alderhey.nhs.uk](mailto:governanceandqualityassurance@alderhey.nhs.uk)

The ICS (Integrated Care Systems) should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

We will also continue to collaborate with our paediatric peers to share any-cross paediatric patient safety themes and trends for learning purposes.

## 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. Our PSIR Plan provides more detail on the types of learning response most appropriate to the circumstances of the incident reported.

**Timeframes by Response type:**

|  |  |  |
| --- | --- | --- |
| **Response type** | **Start date** | **End date** |
| **PSR:** Initial Review | Within 7 calendar days of the incident being reported | Within 7 calendar days of initial review start date |
| **PSR:** MDT Review/ SBARD Review/ AAR/ Thematic Review | Within 7 calendar days of the PSR being commissioned | Within 1 calendar month of the learning response being commissioned |
| **PSII** | Within 7 calendar days of the PSII being commissioned | Within three calendar months of their start date (with no local PSII taking longer than six months) |

**PSIIs:** The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion of PSIIs within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In some incidences, longer timeframes may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

**PSRs:** In some incidences, longer timeframes may be required for completion of the PSR. In this case, any extended timeframe should be agreed between the Trust and those affected.

Amendments to Response timeframes should be approved via the Patient Safety Incident Response Investigation (PSIRI) Panel and minuted for audit and assurance purposes.

## 8.5 Safety Action Development and Monitoring Improvement.

PSIRF moves away from the identification of ‘recommendations’ and shifts its focus to describing ‘areas for improvement.’

The Trust will use the process for development of safety actions as outlined in the [NHS England safety action development guide](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf) as follows:

* Agree areas for improvement.
* Define the context.
* Define safety actions to address areas of improvement.
* Prioritise safety actions.
* Define safety measures to demonstrate improvement.

Safety actions will be written following the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and have a named designated owner.

Completion and effectiveness of safety actions will continue to be monitored through established organisational and divisional governance processes. Divisional reporting on the progress with safety actions will be made to Patient Safety Board (PSB) and were applicable Safety Quality and Assurance Committee.

The Corporate Governance and Risk Team will maintain an overview across the organisation to identify themes, patterns, and trends via the Aggregated Analysis Report reported to PSB on a bi annual basis.

Areas for improvement will be identified via the PSB. In collaboration with our Brilliant Basics quality improvement team, service or teams will be supported using our A3 Quality Improvement methodology to identify and embed learning and improvement following a patient safety investigation to improving patient safety outcomes.

## 8.6 Safety Improvement Plans

As referred to throughout the policy, the Trust has developed a plan that clarifies what our improvement priorities are. The PSIR Plan details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The Trust has several overarching safety quality improvements plans already in place including individual safety improvement plans that focus on specific services.

Where overarching system issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan may be developed. These will be identified through the weekly Divisional Patient Safety Meetings and weekly Patient Safety Incident Response Investigation (PSIRI) panel. Monitoring of progress will be overseen by the PSB with oversight and reporting to Safety Quality and Assurance Committee (SQAC).

## 8.7 Oversight Roles and Responsibilities

Responsibility for oversight of the PSIRF sits with the Trust Board as outlined in the [Oversight roles and responsibilities specification](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf). At Alder Hey, the Executive Medical Director and Chief Nursing, AHP and Experience Officer, have joint responsibility for the effective monitoring and oversight of PSIRF.

As designated Trust Executive Patient Safety Leads, the Chief Nursing, AHP and Experience Office and Chief Medical Officer will:

* Delegate all incidences reported as moderate harm or above to the PSIRI panel for review and agreement of action as per agreed Trust PSRIF process.
* Delegate authority for the approval of downgrading of any moderate harm incident following divisional review of rapid review findings to the PSIRI panel.
* Receive a weekly tracker from PSIRI of all incidences received by PSIRI panel, including the decisions made for each incident presented plus any areas/incidences for escalation.
* Receive all completed PSIIs for oversight and approval for presentation to SQAC and sign off at Trust Board.

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

It should be noted that similarly the ICB’s role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to ‘declare’ an SI (Serious Incident) and have individual patient safety responses ‘signed off’ by commissioners.

However, the ICB may wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB.

# Mortality Issues

Our Trust has an established monthly Hospital Mortality Review Group (HMRG) to provide oversight of compliance with the mortality review process and will provide the Trust with the assurance that causes, and contributory factors of the inpatient deaths of all children and young people including neonates have been reviewed, considered, and are appropriately responded to in an open and transparent manner.

If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trust’s safeguarding team for investigation in line with statutory and operational guidance.

Our Safeguarding team will liaise with CDOP as locally led PSII may be required and respond to recommendations from external parties for learning purposes.

If a PSII is undertaken regarding a death that will be reviewed by a coroner, the coroner will receive the PSII report. If a different learning response is undertaken, the output from the response will also be shared with the coroner.

Any neonatal death will be referred to Maternity and Newborn Safety Investigation Programme for independent patient safety incident investigation <https://www.mnsi.org.uk/>

All perinatal deaths will be referred to MBRRACE and any relevant recommendations and/or actions from external referred agency will feed into our local neonate partnership (LNP) Board (if relevant) and PSB to be considered as part of QI process.

# Complaints and Appeals.

The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust. When this occurs, they may wish to raise a local concern, an informal PALS concern or a formal complaint and the Trust has a duty to listen to their concerns, investigate them fully in a timely and responsive manner, provide a full and appropriate response, and seek a resolution.

Formal complaints from children, young people or families can be lodged through the Trust’s complaints procedure. The management of complaints as an Organisation can be reviewed in the [Complaints and Concerns Policy.](https://alderheynhsuk.sharepoint.com/:w:/r/sites/ClinicalGuidancePortal/_layouts/15/Doc.aspx?sourcedoc=%7B6C48DB5A-2738-4F48-9870-A1EDA9F52FE9%7D&file=Complaints%20and%20Concerns%20Policy%20-%20RM6.docx&action=default&mobileredirect=true&DefaultItemOpen=1)

Any complaints relating to this policy, or its implementation can be raised informally with the Corporate Governance team, initially, who will aim to resolve any concerns as appropriate.

# Appendices

See [DMS](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal) for documents.

(If you are not a Trust staff member and wish to receive access, please contact: [patientsafety@alderhey.nhs.uk](mailto:patientsafety@alderhey.nhs.uk))

## **Appendix A** – PSIRF Harm Grading Guidance

## **Appendix B** – PSIRF Governance Process

## **Appendix C**:

### PSIRF Tools - Initial Review Template

### PSIRF Tools - SBARD Template

### PSIRF Tools – AAR (Individual) Template

### PSIRF Tools- AAR (Team) Template

### PSIRF Tools - Thematic Review Guide

### PSIRF Tools - MDT Review template

### PSIRF Tools - PSII Report Template

### PSIRF Tools - Terms of Reference for Investigation

### PSIRF Tools- Account of Involvement Template

### PSIRF Tools – Memory capture Template

### PSIRF Tools - SEIPS Worksheet and Guide

### PSIRF Tools – Incident Timeline

## **Appendix D:**

### Acute Life-Threatening Event (ALTE) and Sudden Unexpected Death in Childhood (SUDiC) Management Process

|  |  |
| --- | --- |
| Initial Equality Impact Assessment (EIA) Form | |
| This section must be completed at the development stage i.e. before approval or ratification.For further support please refer to the Equality Impact Assessment (EIA) Policy on [DMS](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal/SitePages/Home_Portal.aspx). | |
| **Part 1** | |
| **Name and Job Title of Responsible Person(s):** Jackie Rooney, Associate Director of Nursing Governance and Risk | **Contact Number:** jackie.rooney@alderhey.nhs.uk |
| **Department(s)**: Corporate | **Date of Assessment**: 27/01/2025 |
| **Name of the policy / procedure being assessed:** Patient Safety Incident Response Policy | |
| **Is the policy new or existing?**  New  Existing | |
| **Who will be affected by the policy** (*please tick all that apply*)?  Staff  Patients  Visitors  Public | |
| **How will these groups / key stakeholders be consulted with?** Key stakeholders have been consulted with as part of the development and insight of the local Patient Safety Incident Plan process | |
| **What is the main purpose of the policy?** A key element and requirement of the national implementation of PSIRF | |
| **What are the benefits of the policy and how will these be measured?** Based on our local patient safety profile | |
| **Is the policy associated with any other policies, procedures, guidelines, projects or services?** Yes  No  *If yes, please give brief details:* Patient Safety Incident Response Plan and Patient Safety Strategy | |
| **What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?**  *Please use the* ***Equality Relevance*** *guidance (see on* [*DMS*](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal/SitePages/Home_Portal.aspx)*) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).*  *Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)* | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Protected Characteristic** | **Tick either positive, negative or no impact** | | | **Reasons to support your decision and evidence sought** | **Mitigation / adjustments already put in place** |
| **Positive Impact *(benefit)*** | **Negative**  ***(disadvantage***  ***or potential disadvantage)*** | **No Impact** |
| Age |  |  |  |  |  |
| Sex |  |  |  |  |  |
| Race |  |  |  |  |  |
| Religion or belief |  |  |  |  |  |
| Disability |  |  |  |  |  |
| Sexual orientation |  |  |  |  |  |
| Pregnancy and maternity |  |  |  |  |  |
| Gender reassignment |  |  |  |  |  |
| Marriage and civil partnership |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |
| If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)  Click or tap here to enter text. | | | | | |
| **Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998?** Yes  No  *See* ***Equality Relevance*** *guidance (on* [*DMS*](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal/SitePages/Home_Portal.aspx)*) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)* | | | | | |

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| --- | --- | --- | --- |
| **If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form** on [DMS](https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal/SitePages/Home_Portal.aspx). | | | |
| **Action** | **Lead** | **Timescale** | **Review Date** |
| N/A | N/A | N/A | N/A |

|  |  |
| --- | --- |
| **Declaration** | |
| **I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:** | Tick one box |
| **Continue** – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken |  |
| **Justify and continue** – EIA has identified an adverse impact but it is felt the policy cannot be amended.  ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***. |  |
| **Make Changes** – EIA has identified a need amend the policy in order to remove barriers or to better promote equality  ***You must ensure the policy has been amended before it can be ratified.*** |  |
| **Stop** – EIA has shown actual or potential unlawful discrimination and the policy has been removed |  |
| Name: Jackie Rooney Date: 27/01/2025 | |

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| --- | --- | --- |
| **Approval & Ratification** | | |
| **Policy Author:** | Name: Jackie Rooney | Job title: Associate Director of Nursing Governance and Risk |
| **Approval Committee:** | Patient Safety Board | Date approved: 30/01/2025 |
| **Ratification Committee:** | SQAC | Date ratified: 15/11/2023 |
| **Person to Review Equality Analysis:** | Name: Jackie Rooney | Review Date: 02/02/2026 |
| **Comments:** |  | |