The Rotherham NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: December 2024

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Contents

Introduction

The Patient Safety Incident Response Framework (PSIRF) was published in August 2022 and was first described in the NHS Patient Safety Strategy (2019). PSIRF is a replacement for the NHS Serious Incident Framework (SIF, 2015).

This document is the Patient Safety Incident Response Plan (PSIRP) has been effective from December 2024

PSIRF is a completely different approach from the preceding Serious Incident Framework (2015). PSIRF fundamentally shifts and changes how we as an organisation respond to patient safety incidents. It is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through a variety of response methods applied to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer “formal investigations” and to focus resource on areas where there is the greatest scope for learning and improvement. Patient Safety Incident Investigations (PSII) will be conducted using a systems-based approach by people that have been trained to do them and have allocated time. This plan and associated policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. Carrying out investigations for the right reasons can and does identify learning.

Since the implementation of PSIRF, TRFT now decides which patient safety incidents require more rigorous investigations and which are more suited to an alternative approach. Investigation timescales are also more flexible with the previous 60 days timeframe being replaced with individual PSII timescales agreed in consultation with the patient and/or family. There are a set of principles that we will work to but outside of that, we decide.

When asked “why do we investigate incidents?” the usual response is to learn, but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that.

Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will support our core ambition of working in partnership with patients to improve safety.

We recognise that changing culture is complex and we are committed to being an organisation with a positive safety culture where we continually learn and improve and where people feel safe to speak up.

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how The Rotherham NHS Foundation Trust (TRFT) will respond to patient safety incidents reported by staff and patients, their families and carers as part of the work to continually improve the quality and safety of the care we provide.

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The Rotherham NHS Foundation Trust (TRFT) is a combined acute and community Trust providing services at a number of sites across the borough, including:

- Rotherham Hospital
- Rotherham Community Health Centre (RCHC)
- Breathing Space
- Park Rehabilitation Centre (PRC)
- Kimberworth Place

The Trust is an Associate Teaching Hospital of the University of Sheffield.

TRFT has 4 Care Groups and corporate services which encompass:

- Care Group 1
- Care Group 2
- Care Group 3
- Care Group 4
- Corporate services

Care Group 1 consist of the following clinical services:

Urgent and Emergency Care (UECC)

- Accident & Emergency
- GP/Out of Hours Primary Care
- Paediatric UECC

Integrated Medicine

- General Medicine
- Specialist Medicine
- Healthcare for Older People (HCOP)
- Endoscopy

Care Group 2 consists of the following clinical services:

Surgery

- Anaesthetics and Theatres (including Critical Care)
- General Surgery, including breast surgery
- Orthopaedics
- Orthotics
- Ophthalmology
- Orthotics

- Specialist Surgery (including ENT and OMFS)
- Urology
- Rheumatology
- Sterile services

Care Group 3 consists of the following clinical services:

Family Health

- Obstetrics and Gynaecology
- Children and Young People's Services

Clinical Support Services

- Outpatients and Support Services
- Pharmacy
- Patient Access

Care Group 4 consists of the following clinical services:

Radiology

Therapies, Dietetics and Community Care

- Community Adult Services
- Therapy Services (Acute)
- Community Dental Services
- Nutrition and Dietetics

Corporate Services:

Corporate Operations
Corporate Functions
Estates and Facilities
Post Graduate Medical Education

Defining our patient safety incident profile

A key part of developing the PSIRP is understanding our patient safety profile and related activity. This allows us to plan appropriately and ensure we have the appropriate resource and systems and processes in place to deliver the plan.

In the three years prior to implementation there was over 26,000 patient safety incidents reported in TRFT, with 195 investigated as Serious Incidents. This approach did not always lead to the sustained learning and improvements hoped for and is time consuming for staff undertaking them, leaving little time for improvement activity.

Since moving to working under the new framework, the activity and type of patient safety responses has changed. Over the last 12 months there has been 355 patient safety incidents reported. The number of PSIIs were 36 +1 external. The utilisation of alternative methods of response has enabled early identification of opportunities for learning and implementing a more robust safety culture (table 2)

Table1: Patient Safety Incident Investigation Activity over the 3 year period 2020-2023

Patient Safety Activities	Activity	No. in last 3 years
National Priorities	Serious Incidents categorised as death	27
	Never Events	7
Local Patient Safety Priorities	Datix reported patient safety incidents	25,615
	Serious Incidents (not resulting in death)	166
	Internal 'red' investigations	127

Table 2: Patient Safety Incident Investigation Activity over the last 12 months

Patient Safety Activities	Activity	Number
National Priorities	PSIIs (Mandated Response)	7
	Never Events	1
Local Patient Safety Priorities	Datix reported patient safety incidents	355
	PSIIs (Trust Decision)	30
	After Action Review	42

Patient Safety Activities	Activity	Number
	MDT	3
	Cold Debrief	4

Stakeholder Engagement

To understand our patient safety concerns we consulted with a diverse range of stakeholders:

- Chief Nurse (Executive Lead)
- Medical Director
- Deputy Medical Director
- Deputy Chief Nurses
- Associate Medical Director- Patient Safety
- SYICB Lead
- Director of Corporate Affairs
- Legal Affairs
- Mortality
- Freedom to Speak up
- Patient Experience, Engagement & Involvement
- Project Management Office
- Communications team
- Human Resources & Equality, Diversity and Inclusion lead
- Education, Training & Development
- Head of Quality Improvement
- Heads of Nursing
- Care Group Directors
- General Managers
- Governance Leads
- Incident Reporting System Manager
- Local Maternity and Neonatal System (LMNS)
- Maternity and Neonatal Voice Partnership (NMVP)

At TRFT we understand the need to involve our patients and their families in our decision making. As we grow our patient panels, we aim to increase this involvement.

Defining our patient safety improvement profile

Notes

Describe how you identified and agreed your patient safety improvement profile.

Provide a consolidated list of all improvement and service transformation work with an impact on patient safety underway or planned across your organisation (this should describe relevant national, regional and locally driven improvement and service transformation programmes).

TRFT is committed to improving the quality of care for our patients. We have appointed a Head of Quality Improvement and aim to establish a Quality Improvement faculty, utilising the Quality Service Improvement and Redesign (QSIR) approach initially and now transitioned to Improvement Learning South Yorkshire, with an ambition to train 72 staff per year.

The Trust's patient safety improvement profile can be found on the Audit Management and Tracking system (AMaT). This database holds the Trusts audit programme as well as the Quality Improvement Plans.

Our patient safety incident response plan: national requirements

National event response requirements

In healthcare, there are a number of circumstances when the type of response is predetermined by a set criteria as set out in national policy or regulations. These responses may include review by or referral to another body or team depending on the nature of the event. TRFT will adhere to any national requirements as set out in Table 3 as a minimum requirement whilst acknowledging there will be PSIIs required outside of these criteria.

Table 3: Events requiring a specific type of response as set out in policies or regulations

Event	Action Required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII NHS England » National Guidance on Learning from Deaths)[5]	TRFT led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	TRFT led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk).	TRFT led PSII	The organisation in which the Never Event occurred
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Intrapartum stillbirth **Early Neonatal Deaths** **Potentially severe brain injury with grade 3 HIE** **Therapeutically cooled babies following birth.** **Maternal Deaths**	Refer to **Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) and NHS Resolution. (MBRRACE-UK also notified of maternal death for reporting purposes).**	MNSI (or SpHA)
All late fetal losses 22+0 to 23+6 weeks gestation. **All antepartum and intrapartum stillbirths.**	Reported via MBRRACE-UK, reviewed using the MDT, Perinatal Mortality Review Tool (PMRT).	MBRRACE-UK

Event	Action Required	Lead body for the response
Neonatal deaths from birth at 22+0 weeks gestation to 28 days after birth. **All post-neonatal deaths where the baby is born alive from 22+0 weeks gestation but dies after 28 weeks gestation**		
Off Pathway Births (for TRFT, any baby born before 26+6 weeks gestation in unit and not transferred out). **Term admissions into the NNU data**	**Refer to Local Maternity and Neonatal System (LMNS). MDT review required to then present at LMNS panel for thematic review and shared learning.**	TRFT / LMNS
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) TRFT led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of TRFT led learning response See: Guidance for managing incidents in NHS screening programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)	The organisation in which the event occurred
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the	PPO or IOPC

Event	Action Required	Lead body for the response
	relevant investigations Healthcare organisations must fully support these investigations where required to do so	
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

[5]Unless the death falls under another more specific category in Table A1, in which case that response must be followed.

Our patient safety incident response plan: local focus

Organisations are mandated to respond to incidents in accordance with nationally mandated responses. There is no mandate for a pre-determined response for any other incident type. TRFT will balance effort between learning through responding to incidents or exploring issues and improvement work with guidance from table 4. Safety action development will be based on the SEIPS Model / HFIX and application of the iFACES tool as per associated PSIRF policy. Our staff will be trained in the application of this method using the Safety Action Development Guide.

Table 4: Key objective of patient safety incident response activity

	Learning to inform improvement	**Improvement based on learning**	**Assessment to determine required response**
Circumstances in which to apply activity type	Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.	Where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.	For issues or incidents where it is not clear whether a learning response is required

All patient safety incidents matching the Trust profile will be responded to using the response method indicated below. Incidents will continue to be reported in an open and honest manner onto the Datix incident reporting system. Supportive oversight will be provided to all Care Groups through the Harm Free Care panel and Incident Response Meeting. Incidents where the following criteria is met will be brought to the Incident Response meeting for discussion, advice and guidance on proportionate response:

- Likelihood of reoccurrence and future harm – risk assessed approach
- Reoccurrence of the same incident type
- Where the contributory factors are not known or are not clear
- Where there is no current Quality improvement activity addressing the issue
- Any issues or incidents where it is not clear whether a learning response is required

In defining the Trust patient safety priorities, the views of our stakeholders were collated together with the quantitative and qualitative data sources. Consideration was also given to patient safety improvement projects already underway and the effectiveness of these and where there might be greatest opportunities for learning and improvement.

Criteria for defining top local patient safety risks.

Potential for harm – considering:

• People: physical, psychological, loss of trust (patients, family, carers)
• Service delivery: impact on quality and delivery of healthcare services; impact on capacity
• Public confidence: including media coverage Likelihood of occurrence – considering:
• Persistence of the risk
• Frequency
• Potential to escalate

The current local top ten patient safety risks for TRFT as identified via the analysis described above are presented in table 5 below.

Table 5

	Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
1	**Pressure Ulcers Including moisture lesion**	**Harm Free Care Panel**- Pressure Ulcer Investigation Tool which quarterly thematic analysis	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Harm Free Care Group review triangulation of Pressure Ulcers and incident data.
2	**Falls** Falls that lead to patient harm	**AAR** **Thematic Analysis** **PSII** should be considered if Table 4 principles are applicable	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Harm Free Care Group review triangulation of falls and incident data.
3	**Staffing Levels**	**Thematic Analysis**	Outcomes defined in the safe staffing plans
4	**Administration or Supply of Medication**	**Datix level investigation**	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.

	Patient safety incident type or issue	Planned response	Anticipated improvement route
		Thematic analysis for those incidents with recurring themes	Medicines operation group and committee. Local safety actions fed into the quality improvement strategy.
5	**Admissions**	**Datix level investigation** **Thematic analysis** for those incidents with recurring themes	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.
6	**Treatment and Procedure Incidents**	**AAR** **Thematic Analysis** **PSII** should be considered if Table 4 principles are applicable	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Quality Governance and Assurance Group, Patient Safety Committee. Local safety actions fed into the quality improvement strategy.
7	**Medical Device/Equipment**	**Datix level investigation** **AAR** **Thematic Analysis** **PSII** should be considered if Table 4 principles are applicable	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Medical Devices Group. Local safety actions fed into the quality improvement strategy.
8	**Discharge**	**Datix level investigation** **AAR** **Thematic analysis** for those incidents with recurring themes	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.
9	**Infection Control**	**Harm Free Care Panel**- PIR tool to be utilised. Quarterly	Safety Improvement Plan progression at regular group

	Patient safety incident type or issue	Planned response	Anticipated improvement route
		thematic analysis for if recurring themes identified	meetings – fed into quality improvement strategy. Harm Free Care Group review triangulation of Infection Control incident data.
10	**Prescribing Error**	**Datix level investigation** **AAR** **Thematic Analysis** **PSII** should be considered if Table 4 principles are applicable	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Quality Governance and Assurance Group, Patient Safety Committee. Local safety actions fed into the quality improvement strategy.

Locally Defined Responses

Table 6: Criteria for selecting risks for PSII response

Criteria	Considerations
Potential for learning and Improving	Increased knowledge: potential to generate new information, insights, or bridge a gap in current understanding. Likelihood of influencing: healthcare systems, professional practice, safety culture. Feasibility: practicality of conducting an appropriately rigorous PSII Value: extent of overlap with other improvement work; adequacy of past actions
Systemic risk	Complexity of interactions between different parts of the healthcare system

Based on the analysis and selection criteria described above, local priorities for PSII have been set by this organisation for the remainder of the year 2024/5.

Each PSII will be conducted separately, in full and to a high standard, by a team whose lead investigator is appropriately trained.

Table 7: Planned Patient Safety Incident Investigation responses for top local patient safety risks.

	Incident Type	Description	Response Type
1.	**Pressure Ulcers Including moisture lesion**	Pressure damage at Cat 3/4/SDTI and unstageable where there were missed opportunities	**Harm Free Care Panel**- Pressure Ulcer Investigation Tool which quarterly thematic analysis
2.	**Medication**	Relating to wrong dose, omitted / delayed / wrong / duplicate medication where a patient came to moderate harm or above. In particular related to critical medications	**PSII**
3.	**Delays in Care**	Delays to treat the deteriorating patient where moderate harm or above could have been avoided.	**PSII** **AAR**
4.	**Delays in Care**	Delays in diagnosis where a patient came to moderate harm or above and treatment plans had been significantly changed as a consequence	**PSII** **AAR**
5	**Significant maternity cases not fitting into any national reporting criteria.**	Any case where a baby or mother has suffered serious injury and or damage that does not fit the HSIB/MNSI or PMRT criteria, which has been caused by or suspected to have been caused by substandard care.	**PSII / AAR**
6	**Maternity specific cases falling into the treatment and procedural criteria.**	Post-Partum Haemorrhage Term admissions to the NNU Ruptured ectopic pregnancies Triage issues and complaints Preterm birth	**Thematic review plus or minus AAR**

Our Response Methods

PSIRF promotes a range of system-based approaches for learning from patient safety incidents. PSIRF requires us to respond proportionately and enables us to balance effort between learning through responding to incidents or exploring issues and improvement work'. National tools have been developed in a PSIRF Toolkit and the Trust will develop a training programme for staff to support the application of these methods. These tools apply the SEIPS framework (Systems Engineering Initiative for Patient Safety) to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement. The Trust will continue to evolve its Quality Improvement function and progress a seamless interface between safety actions and QI.

Learning response types	Description	Capacity to respond
Patient safety incident investigation (PSII)	A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. It is guided by the principle that people are well intentioned and strive to do the best they can. PSII's examine system factors such as the tools, technologies, environments, tasks and work processes involved.	Anticipated 15 PSII's meeting the criteria per year. The Trust may select up to an additional 6 PSII's per year
After Action Review (AAR)	A method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.	Anticipated 40 AAR's
Thematic Review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The 'top tips' document provides guidance on how to approach a thematic review.	Anticipated 6 Thematic Reviews
Multidisciplinary Team Review (MDT)	Supports teams to: identify learning from multiple patient safety incidents	Anticipated 8 MDTs

Learning response types	Description	Capacity to respond
	• agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process • gain insight into 'work as done' in a health and social care system	
Cold Debrief	Supports teams to: identify learning from multiple patient safety incidents • Discuss and debrief on the incident to ensure the experience of the staff are heard and understood • agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process • gain insight into 'work as done' in a health and social care system	Anticipated 8 cold debriefs

Timescales for PSII's

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified as meeting the PSII inclusion criteria.

Whilst there is no formal timescale PSIIs should ordinarily be completed within sixty days of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between The Rotherham NHS Trust and the patient/family/carer.

Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Learning from Incident Responses

Findings from PSIIs and other incident responses provide key insights and learning opportunities.

Findings will be translated into effective improvement design and implementation.

Quality Improvement Faculty and specialist working groups will oversee collation and execution of System Improvement Plans.

If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, these actions will be made as soon as possible.

All other recommendation development will consider collating findings across all or a subset of responses into a single risk.

Findings from each individual response linked to a specific risk will be collated to identify common contributory factors and any common associations upon which effective improvements can be designed. Recommendations and monitoring arrangements will be summarised in a System Improvement Plan.

Consideration will be given to the timeframe taken to complete a System Improvement Plan and the impact of extended timescales on those involved in the incident.
System Improvement Plans will be shared with those involved in the incident including patients, families, carers and staff.

Our anticipated response resource is as follows:

- 15 Patient Safety Incident Investigations (meeting national requirement)
- 6 Patient Safety Incident Investigations (Trust selected where a high level of risk is identified and contributory factors are unknown)
- 40 After Action Reviews
- 6 Thematic Reviews
- 8 MDTs
- 8 Cold Debriefs

As PSIRF is a new way of responding to incidents and uses new investigation models for in-depth investigations, this estimate will be reviewed as the Trust becomes more familiar with the response capacity requirements.

Roles and Responsibilities

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

All Staff

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the Quality Governance and Assurance Team pages of the Trust intranet.

Incident Reviewers

Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required. The reviewer(s) should have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training courses.

Duty of Candour Leads / Family Liaison Representative

• Responsible for ensuring the organisation's legal duty of candour is discharged for appropriate incidents.

• Identify those affected by patient safety incidents and their support needs by being the single point of contact.

• Provide them with timely and accessible information and advice.

• Facilitate their access to relevant support services.

• Obtain information from review/PSR teams to help set expectations.

• Work with the QGA team and other services to prepare and inform the development of different support services.

Care Group Clinical Triumvirates

Care Group Clinical Triumvirates have a responsibility to:

• Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information.

• Ensure that incidents are reported and managed in line with internal and external requirements.

• Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.

• Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.

• Provide protected time for participation in reviews/PSIIs.

• Work with QGA and others to ensure those affected by patient safety incidents have access to the support they need.
• Support development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).

Quality Governance and Assurance Team

The Patient Safety Incident Review group (PSIRG) will meet three times weekly to review incidents and ensure that PSIIs are undertaken for incidents that meet the agreed criteria for this level of response.

• Develop and maintain the local governance management systems and relevant incident reporting systems (including StEIS and LFPSE) to support the recording and sharing of patient safety incidents and monitoring of incident response processes.

• Lead the development and review of the organisation's PSIRP.

• Oversee procedures to monitor/review PSII progress and the delivery of improvements.

• Work with the Deputy Chief Nurse and Executive leads to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents.

• Support and advise staff involved in the patient safety incident response.

• Ensure staff members involved in the management of patient safety incidents have access to the requisite knowledge, skills and tools to undertake patient safety reviews to the required national standards.

Patient safety incident investigators

• Patient safety incident investigators will have been trained in systems-based PSII.

• Ensure that PSIIs are undertaken in-line with the national PSII standards.

• Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.

• Undertake PSIIs and PSII-related duties in line with latest national guidance and training.

Clinicians/Specialist Advisors

Incident reviewers may need to involve specialist advisors to assist in their review (e.g. Safeguarding, Health and Safety, Medical Physics, Pharmacy, Radiation Protection Advisor, Clinicians with experience in a particular medical or surgical technique). Patient safety reviewers are responsible for determining when specialist advice is required and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, review of recommendations.

Medical Examiner

The medical examiner's key role is to:

• provide greater safeguards for the public by ensuring proper scrutiny of all deaths • ensure the appropriate direction of deaths to the coroner

• provide an outstanding service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased

• improve the quality of death certification

• improve the quality of mortality data Whilst medical examiners are NHS employees, they have separate professional accountability and their independence, which is vital to the scrutiny they provide, is overseen by the national medical examiner.

Medical examiners scrutinise all deaths to:

• agree the proposed medical cause of death and ensure the overall accuracy of the medical certification of the cause of death

• identify problems in treatment or care and, as necessary, report to the trust's clinical governance process

• discuss the cause of death with the bereaved and listen to any concerns

• ensure the referral of deaths to the coroner as required by the law; this includes deaths where there are concerns that failure in care contributed to death or where the bereaved raise significant concerns about the care provided to their relative

• liaise with, and assist, the coroner with medical information

• educate and provide advice to other clinicians about death registration and the coronial process

Patient Safety Committee (PSC)

The Patient Safety Committee (PSC) has responsibility for reviewing completed report outputs and system improvement plans for effectiveness. The committee should feedback at each meeting on our progress against the PSIRP. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of PSC will seek assurances from the care groups that risks are being adequately addressed. Where there are remaining concerns these will be escalated to the Quality Committee.

Quality Committee (QC)

The Quality Committee has responsibility to seek and gain assurance that the actions and learning resulting from patient safety incident investigations are appropriate and timely and any challenges to implementation are escalated. The Committee should feedback at each meeting on our progress against this PSIRP.

Medical Director / Chief Nurse - Executive leads for supporting and overseeing implementation of the PSIRF

The Medical Director / Chief Nurse have delegated responsibility for:

1) ensuring that there are adequate arrangements in place for patient safety incident investigations and reviews

2) governance of these arrangements.

3) that there is adequate assurance to demonstrate learning is being shared and changes to practice as a result of patient safety incident investigations and reviews are implemented across the Trust.

Chief Executive

The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974). As part of this role the Chief Executive has overall responsibility for ensuring there are effective risk management systems and processes in the Trust to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff and visitors. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

Trust Board

The Trust Board has a responsibility to ensure that it receives assurance that this plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. This will be achieved through reporting processes as well as receiving assurance via the Quality Committee.

Flow chart for gudiance when considering how to response to a patient safety incident