Patient safety incident response policy

Document owner:	Head of Patient Safety and Learning			
Equality Impact Assessment Date:	01/05/2024		**Version No:** **Status:**	1.2 Ratified / Final
Publication Date:	April 2025		**Review Date:**	30/04/2028
APPROVAL INFORMATION:				
Assurance Group:	Clinical Governance Quality and Patient Safety Group		**Date Approved:**	14/07/2025
Ratification Group PDRG:	PDRG		**Date Approved:**	14/08/2025

Statement of changes made from previous version

Version	Date	Section & description
1.1	13/05/2025	Updated to reflect changes in governance processes
1.2	07/07/25	Section 3 added, oversight roles and responsibilities, and section 13, definitions

Contents

1. Purpose 3
2. Scope 4
3. Oversight, roles and responsibilities 5
4. Our patient safety culture 6
5. Assessing health inequalities 6
6. Patient safety partners 7
7. Engaging and involving patients, families and staff following a patient safety incident 7
8. Patient safety incident response planning 8
9. Resources and training to support patient safety incident response 9
10. Reviewing our patient safety incident response policy and plan 9
11. Responding to patient safety incidents 10
11.1 Patient safety incident reporting arrangements 10
11.2 Patient safety incident response decision-making 11
11.3 Responding to cross-system incidents/issues 12
11.4 Timeframes for learning responses 12
11.5 Safety action development and monitoring improvement 14
12. Complaints and appeals 15
13. Definitions 15
13. Appendix 1 16
14. Monitoring compliance with this policy 18

1. Purpose

This policy is an overarching policy for patient safety management in the Trust. This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Airedale NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

A patient safety incident is an unintended or unexpected event (or omission) which could have, or did, harm one or more patient's receiving healthcare.

This policy has been developed using the national NHS England template. The PSIRF replaces the Serious Incident Framework. The serious incident classification and its thresholds have been removed.

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

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key principles 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 here). This document sets out how this policy will be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust. This policy requires all staff to take responsibility for reporting any incident or adverse event or near miss that they become aware of and review them as detailed within this policy.

Responses under this policy follow a systems-based approach. The Trust acknowledges that patient safety incidents usually reflect a breakdown in systems within the organisation and that staff are trying to do their best to do their job safely and well. Although staff actions may contribute to an adverse incident there are often underlying causes affecting these actions. Consequently, the Trust is committed to exploring how these system failures occurred and how they can be improved using a range of learning response tools.

A patient safety incident is reviewed using this framework to understand the circumstances which led to it, for the purpose of learning and improvement. There is no remit to apportion blame, determine liability, preventability or cause of death. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. The processes listed below are therefore outside of the scope of this policy.

- Claims management
- Human resources investigation into employment concerns
- Professional standards investigations
- Coronial inquests and criminal investigations
- Complaints (except where a patient safety concern is identified)
- Other investigations by regulatory bodies such as the Health and Safety Executive

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.

3. Oversight, roles and responsibilities

Oversight of Patient Safety Incident Responses will be delivered through multiple approaches as they are wider and more multifaceted under the PSIRF. The approach focuses on engagement and empowerment and alignment with Trust governance arrangements. This will be delivered by reporting to the Trust board through Quality and Safety Committee with alignment to the national PSIRF oversight principles of:

- Focus on improvement
- Blame restricts insight
- Learning from patient safety incidents is a proactive step towards improvement
- Collaboration is key
- Psychological safety allows learning to occur
- Curiosity is powerful

This will be delivered by:

- Providing information on shared learning and improvement work in relation to patient safety.
- Detail the governance and reporting structures as well as the reporting process for staff to ensure openness and transparency in relation to patient safety incidents.
- The progress towards a just and learning culture ensuring that proportionate responses are maintained with compassionate engagement with those affected.

Alongside our local stakeholders of the Integrated Care Board and the Care Quality Commission, the Trust has specific organisational responsibilities. The Executive Director of Nursing is the Trust's designated executive lead for PSIRF. They are supported by all members of the executive team. Their responsibilities are to ensure the organisation meets the national patient safety standards as detailed by NHS England (May 2024).

- There are links and alignment between patient safety and quality improvement systems and processes, and related clinical governance systems and processes, including complaints.
- Insight is shared between patient safety and quality improvement teams, and teams benefit from collective expertise.
- The patient safety incident response policy and **all** other relevant policies promote a just culture (e.g. they do not include automatic suspension or removal of business-as-usual activities from staff involved in patient safety incidents).
- Information governance agreements allow information sharing within and between relevant bodies to support effective communication during both incident response and improvement endeavours.
- Governance/reporting structures are clear to staff, patients, and the public, and encourage openness and transparency.
- The organisation's patient safety incident response policy is published on its website.

4. Our patient safety culture

A key aim within the Trust Quality and Safety strategy is to establish a culture that empowers our people to take appropriate decisions for their services and patients. This is underpinned by embedding a 'just and learning culture' which supports continuous learning and creates psychological safety.

Through the introduction of PSIRF and the learning review tools within it, staff will be more involved with patient safety incidents. Learning will take place in a timelier way with an expectation that all staff involved will contribute to the review. This will support an open culture where staff do not feel afraid to report adverse events or feel blamed if they have any involvement.

All staff with knowledge of the events being reviewed will be invited to participate in the learning review. This maybe through submitting written information, joining an After Action Review or through a conversation with the patient safety incident reviewer.

The involvement of staff will be to understand their recollection of the event and their views and options on how systems could be improved.

To achieve this, the Trust is committed to promoting and improving the quality and safety of care and treatment for all patients, their significant others and staff. It is important to embed a positive reporting culture throughout the organisation.

Alongside the opportunities to learn from incidents, the Trust is also committed to learning from excellence. This is achieved through excellence reporting and sharing at Trust and divisional Patient Safety and Learning Groups.

The Trust recognises the significant impact being involved in a patient safety incident can have on those involved. Key to this is compassionate engagement to ensure staff receive the support they need to positively contribute to the learning review. There is a range of support available including:

- The Patient Safety team
- Employee Health and Wellbeing team
- Freedom To Speak Up Guardian
- Professional nurse/midwifery advocates
- The Chaplaincy team

5. Assessing health inequalities

The Trust is committed to delivering its statutory obligations under the Equality Act (2010). This implementation of the PSIRF will include the assessment of health inequalities.

Through our learning responses we will address any factors which indicate health inequalities may have contributed to harm. Through analysis of our patient safety data we will review and monitor for any risks that are disproportionate to patients with protected characteristics.

The Trust will also encourage engagement with patients and families in patient safety responses, ensuring specific support is provided and barriers to participation are reduced.

6. Patient safety partners

The Patient Safety Partner (PSP) programme is a key element of the PSIRF. This is where members of the public with an interest or lived experiences of patient safety incidents within the NHS, support Trust improvement work.

The role of the PSP will be focused on:

- Proportionate responses to Patient Safety Incidents
- Supporting the delivery of patient safety responses as part of the wider patient safety team
- Provide their insight and input into patient safety quality improvement programmes
- Be an active member of the Patient Safety and Learning Group

PSPs will be supported to access patient safety syllabus education and provided with professional supervision from the Head of Patient Safety and Learning. The aim will be to use their experience and patient voice to compliment the Trust patient safety responses.

7. 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 patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

See NHS England's supporting guidance Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide

The Trust is committed to ensuring all patients and families are treated with respect and dignity following a patient safety incident. There is a responsibility, as well as a statutory requirement under the Duty of Candour Regulation to be open and transparent with patients and their families.

Where it is identified that a patient safety incident has caused moderate or severe physical or psychological harm, or resulted in a fatality, then the statutory Duty of Candour must be enacted.

The directorate will identify the appropriate person to deliver the Duty of Candour requirements. This person will be the point of contact for the patient and their family. It is the responsibility of this person, with support from the Risk and Governance lead to ensure all Duty of Candour requirements are met and accompanying evidence is recorded within the relevant Adverse Event Form in Ulysses. Further detail can be found in the Duty of Candour policy here.

The Trust encourages the principles of being open with all patients and their families regardless of the level of harm.

Support for staff following a Patient Safety Incident will be initially through their line manager. All staff can access services from the Employee Health and Wellbeing team here. The Patient Safety team are also available to provide support.

8. Patient safety incident response planning

The 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.

The Trust Patient Safety Incident response Plan (PSIRP) sets out how the Trust intends to respond to Patient Safety Incidents over the next 12 months. It was developed using incident, complaints, patient experience, mortality review, claim, inquest, peer review and staff survey data from 2020 to 2022.

The data was analysed and used to identify the Trust's highest safety risks to focus on a priorities for systems-based reviews. The PSIRP provides full details regarding:

- National requirements
- Triggers for an After Action Review
- Patient Safety Incident Investigation utilising Systems Engineering initiative for Patient Safety (SEIPS) Methodology

The PSIRP is flexible and allows consideration of the individual circumstances under which the Patient Safety Incident occurred and the needs of those affected. Our PSIRP is available here.

Further information from NHSE is also available Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide.

9. Resources and training to support patient safety incident response

The Trust is fully committed to implementing the PSIRF. The patient safety incident response standards have informed the resourcing, training and competency for those undertaking learning responses.

All systems based Patient Safety Incident Investigations (PSII) will have an identified lead investigator. They will be supported by a Risk and Governance lead and the Head of Patient Safety and Learning. Within this group will be an individual who has undertaken specific training in systems based investigations methodology.

After Action Reviews will be coordinated by the Divisional teams and will be facilitated by staff who have undergone specific training in facilitating After Actions Reviews. All training can be accessed via the Patient Safety Team.

10. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

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

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

11. Responding to patient safety incidents

11.1 Patient safety incident reporting arrangements

All staff have the responsibility to report patient safety incidents, this includes near misses. All incidents must be recorded on the Trusts Local Risk management System (Ulysses). This is done by completing an Adverse Event Form (AEF) see Adverse Event Reporting Procedure guidance.

The AEF form must be completed as close to the time the incident occurred as possible. It must contain all that is known about the incident at the time of reporting and should be factual information not opinion. Details of when the incident occurred and who was involved should be recorded in the relevant sections of the form.

The initial level of harm will be assigned with the information known at the time. Using the Learn From Patient Safety Events (LFPSE) harm guidance found here.

Any documents capturing staff members recollection of events (when necessary) should be attached the relevant AEF form.

In additional to internal reporting, certain categories of incidents also require reporting to external agencies. These are detailed below.

Incident type	Reportable to	Responsibility
Patient Safety Incidents including Never Events	The Learn From Patient Safety Events (LFPSE) service	Trust Patient Safety team
RIDDOR – reportable inquiries to staff sustained in the course of work. - An accident which results in more than 7 consecutive days away from work - Major injuries, e.g. fracture, amputation, loss of sight	Health and Safety Executive	Health and Safety Manager

- Diseases contracted in the course of work, e.g. hepatitis, tetanus		
Blood transfusion incidents meeting SHOT Definitions	Serious Hazards Of Transfusion (SHOT)	Blood Transfusion Nurse
Radiation incidents meeting the (IR(ME)R) reportable incident criteria	The Care Quality Commission	Radiology Professional Lead
Maternity incidents including early neonatal deaths and maternal deaths. Full criteria here	Maternity and Newborn Safety Investigations	Risk, Governance and Safety Lead for Women's and Children's services
Screening incidents. Guidance here	Screening QA Service and local public health commissioning teams, using the SIAF	Relevant screening teams
Incidents involving medical devices or defective medications, more guidance here	Medicines and Healthcare products Regulatory Agency (MHRA)	Quarantine any medicines and contact Pharmacy. For medical devices contact the Medical Devices Safety Officer.

11.2 Patient safety incident response decision-making

Any incidents initially rated as moderate harm or above, or that are a new emerging area of patient risk, must be escalated to the most senior person the ward, department or service.

The senior manager (or most appropriate person) must:

- Ensure that an AEF has been completed.
- Ensure compassionate engagement and involvement of those affected by the incident.
- In line with the Trusts 'Being open' principles, explain to the patient and/or their relatives what has happened and what is known at the time. This **could** be the start of the Duty of candour process.
- Ensure staff and the patient, family or career are kept informed and support through the incident as necessary through an agreed single point of contact.
- Inform the triumvirate/Divisional Risk and Governance Manager.
- Review the incident within directorate in line with the LFPSE definitions of harm.
- At the weekly divisional safety/governance meeting review the incident to agree which pathway the incident will be managed through. See flowchart in Appendix 1.
- All incidents of moderate harm or above will be discussed at the weekly Quality Review Group to ensure Trust oversight.

If it is agreed the level of physical or psychological harm is moderate or above **and** the incident fulfils the criteria of a notifiable safety incident then the statutory Duty of Candour applies.

Clearly document in the AEF the rationale for the level of harm and if Duty of candour applies.

- The Division are responsible for using the guidance in Appendix 1 to support decision making regarding the proportionate learning response.
- Incidents identified as appropriate to be managed through the red pathway (see Appendix 1), must be brought by the relevant Divisional Triumvirate to a Patient Safety Incident Investigation (PSII) panel for discussion and approval. These panels are convened as and when required via the Head of Patient Safety and Learning.
- Divisions will be responsible for ongoing analysis of incident data through Power Bi dashboards to identify any themes or emerging risks. Appendix 1 can support with decision making in response to reported incidents.

11.3 Responding to cross-system incidents/issues

Where more than one organisation is involved in an incident requiring a formal and co-ordinated response, the Trust will work with the Integrated Care Board (ICB) who will support with the co-ordination of a cross system response.

The Trust is a member of the West Yorkshire Association of Acute Trusts (WYATT) shared learning group for learning from incidents. This forum provides the opportunity to share learning from incidents and develop shared safety actions where appropriate.

Where there are instances involving agencies which the Trust subcontracts to, they are required to support any Trust investigations or share learning from investigations they have undertaken. If any issues with engagement are identified this should be escalated the relevant Divisional triumvirate.

11.4 Timeframes for learning responses

Activity	Timescale	Details
Incident (Adverse Event Form) reporting	**As soon as possible** following the incident occurring. Maximum, within 24 hours of the incident occurring.	It is important to report as soon as possible so key facts are not lost and all relevant details can be added. Immediate actions can then be taken if needed.
Managers review of AEF's	Each morning review the AEF's for the previous day.	This will inform staff about any safety issues in their area and support escalation

		or immediate action where needed.
Divisional review of incidents of concern or where moderate harm is suspected or has occurred	Within a week of the incident occurring via huddles or governance review meetings.	This group discussion will ensure the most appropriate incident pathway is followed. AEF's are to be updated at this time with the final harm rating recorded and a summary of discussions. Duty of Candour will also be determined if incidents are identified as moderate harm or above and meet the criteria for a notifiable safety incident. Duty of candour lead to be identified at this point.
Duty of Candour	Face to face discussion and apology **as soon as possible.** Duty of candour letter within 10 days of the incident being reported. Sharing the outcome of the learning review (variable depending on the type of review undertaken).	**The AEF can be closed once the Duty of Candour letter has been attached.** The outcome of the learning review must be attached with details of when and who it was shared with. This can be added after the AEF has been closed. This is evidence of our compliance with the statutory Duty of Candour requirements so all sections in Ulysses MUST be completed.
After Action Review (AAR) agreed as next step from group review	AAR to be completed within 1 week or 2-4 weeks (see flowchart in appendix 1 for further guidance).	Complete the AAR tab within the AEF and add the relevant staff who will be leading the review. Incident lead to ensure the Risk and Governance lead for your area is aware of any AAR's that are taking place.
Patient Safety Incident Investigation (PSII)	Complete review and report template within 6 months, unless specific timeframe agreed with the patient/family.	National template to be used.
Closure of AEF's	As soon as possible but maximum within 30 days.	If the incident is being managed within another process, for example a conduct or capability process, this needs adding into the outcome (details not required) and the AEF can be closed.

		The AEF does not need to be kept open whilst learning reviews take place. The outcome of these can be added after they have been completed.

Further information is also available from NHS in their Guide to responding proportionately to patient safety incidents.

11.5 Safety action development and monitoring improvement

The following mechanisms are in place to develop, support and provide oversight of improvements and good practice identified from learning reviews:

- Safety actions and improvements from learning reviews (AAR's and PSII's) are identified by those involved in the review. The relevant teams will then agree these. They will be approved at the relevant divisional governance meeting.
- Safety actions from PSII's will also need final approval at the PSII panel chaired by the Executive medical Director and Chief Nurse.
- The safety actions and/or improvement plans from AAR's and PSII's will be recorded within the relevant Adverse Event Form in Ulysses where they will be assigned an action owner(s).
- Safety actions will be monitored through the relevant Divisional governance structures.
- Evidence of completed safety actions from PSII's will be presented at the Trust Clinical Governance, Quality and Patient Safety (CGQ&PS) meeting. The date for this will be agreed when the final report is approved at the PSII panel.
- Learning from these reviews will be shared from within Divisional meetings and through the PSIRF report presented at the monthly Trust CGQ&PS meeting.
- The Patient Safety Team will also support the cascading of information from learning reviews across the organisation through a range of media and attending staff forums.
- Where changes have led to measurable improvements these will be shared and adopted where relevant to other areas of the organisation and with peer organisations. This will be via the Patient Safety Specialist to the ICB Patient Safety Specialist Network and the West Yorkshire Associate of Acute Trusts (WYATT) shared learning group.

12. Complaints and appeals

Local and national arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are available via the Trust's Patient Advice and Liaison Service.

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a service provided by the Trust will be taken seriously and will be managed in a way that reflects the Trust's values.

The Trust encourages patients, families or carers to raise any concerns they may have at the time they occur by speaking to a member of staff. The Trust's complaints policy focuses specifically on those concerns or complaints that require management through the Patient Advice and Liaison Service and the Complaints Team.

13. Definitions

AAR – After Action Review. This is a non-hierarchical, facilitated structured discussion following an event. It enables teams to discuss what happened, why it happened, and to identify learning and improvements.

LFPSE – Learn From Patient Safety Event Service is a national system for the recording and analysis of patient safety events that occur within healthcare.

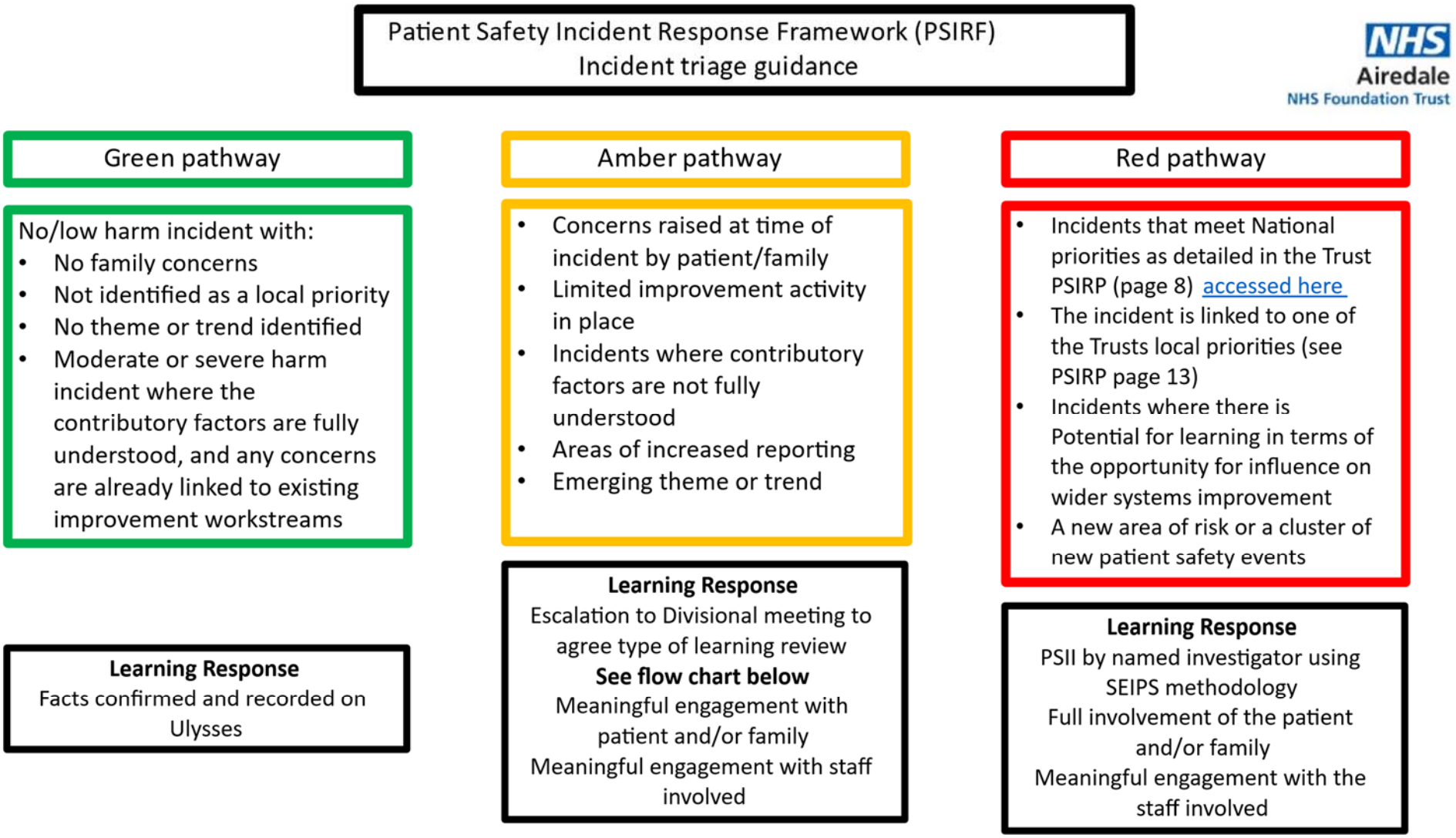
PSIRF – Patient Safety Incident Response Framework. This sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP – Patient Safety Incident Response Plan. This is the Trust's local plan which sets out how we will implement PSIRF.

PSII – Patient Safety Incident Investigation. A PSII is undertaken when an incident or near-miss indicates significant patient safety risk, and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Never Event - Patient safety incidents that are considered to be wholly preventable. Never Event Framework.

13. Appendix 1



Patient Safety Incident Response Framework (PSIRF)
Learning Response guidance – Amber pathway

Review of incident at Divisional/Directorate governance meeting/safety huddle to agree type of learning review

Learning review options

- After Action review
  - Type 1 - For a rapid evaluation of care or de-brief to be undertaken within 1 week of the incident occurring
  - Type 2 – Facilitated reflection after action review session for more complex, multidisciplinary reviews within 2-4 weeks of the incident occurring

  For both types of review the Trust After Action Review template is to be used
- Case note review
- Structured Judgement Review (SJR)

Learning and improvement pathway following the review

- Sharing locally for team learning
- Wider learning at Divisional and/or Trust Clinical Governance, Quality and Patient Safety Group
- Escalation to Patient Safety Incident Investigation panel if further investigation recommended from Divisional review

14. Monitoring compliance with this policy

Describe key metric	Target	How will metric be monitored?	Reporting committee	Frequency of review	Lead
Timeliness of Patient Safety Responses • AAR – within 4 weeks of reported incident • PSII – 6 months from date of decision at PSII panel	100% 100%	Captured within reporting to Divisional and Trust CGQ&PS meeting	Quality and Safety Committee	Monthly	Patient Safety Specialist
Training of response leads • PSII leads 2 day HSSIB training or equivalent • AAR leads AAR facilitator training (in-house)	100%	Reporting to Trust CGQ&PS meeting	Quality and Safety Committee	Quarterly	Patient Safety Specialist