Patient Safety and Incident Response Framework Policy	
Purpose	The purpose of this policy is to ensure that Dorking Healthcare has a robust system in place to report and learn from incidents as part of a continuous cycle of improvement
Applies to	All DHC staff and Independent Contractors
Date first implemented	
Author	Governance and Compliance Manager
Technical/clinical approval by	Medical Director
Executive approval date	07.03.2024
Review Frequency	Two years
Document Status: This is a controlled document. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from Teamnet.	

Consequential Amendments (made prior to full policy revision)		
Amendment date	**Nature of Amendment**	**Revised by**

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1. Aim

This Patient Safety Incident Response Policy (PSIRP) sets out how Dorking Healthcare (DHC) intends to respond to patient safety incidents (PSIs) reported by staff, patients, their carers and families over a period of 18 months after the approval of this document. It identifies how we will seek to learn from these events to continually improve the quality and safety of the care that we provide as part of our systematic program of improvement. The plan is flexible and supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the Patient Safety Incident Responses Framework (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
- supportive oversight focused on strengthening response system functioning and improvement.

2. Policy Scope

A PSI is any unexpected or unintended event that could have, or did, harm one or more patients receiving healthcare. PSIRP is a requirement of all organisations providing NHS-funded care. It will also apply to PSIs that occur within our private healthcare provision.
Responses covered in this policy will include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

Within our organisation, other types of response exist to deal with specific issues or concerns:

- Complaints Management
- Claims handling
- Human resources investigations into employment concerns
- Professional standards investigations
- Coroner inquests
- Criminal investigations

The principle aims of these responses differs from the aims of a patient safety response and are outside the scope of this plan.

3. Dorking Healthcare (DHC) Safety culture

DHC promotes a just and learning culture of openness, in which staff do not feel afraid of reporting adverse events or near misses or feel blamed when they are involved in an incident. In this way, learning can take place, and improvements can be made locally, which can be shared across other services.
DHC will ensure that incident reporting is not associated with blame or disciplinary action, except for the exceptions below.
DHC may only consider using disciplinary or legal action against individuals in untoward events when there is:

- Alleged gross or repeated misconduct
- Alleged professional malpractice or criminal behaviour
- An incident which results in a police investigation

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 '.Engaging and involving, patients, families and staff following a patient safety, incident' supporting guidance.
There is a responsibility as well as a statutory requirement under CQC Regulation 20, Duty of Candour, for all healthcare organisations to be open and transparent with patients and their families when things go wrong with treatment or care delivery.
DHC is open with patients and relatives when errors are made and ensures that the principles of Duty of Candour (DoC) are applied.

It is the responsibility of the Service Managers to ensure all Duty of Candour requirements See section' All other services we regulate' are met and that the accompanying evidence is uploaded to the relevant Radar record.

DHC recognises the significant impact being involved in a patient safety incident can have on staff. It will ensure staff receive the support they need to contribute positively to the review of the incident and continue working while this takes place.

DHC offers an Employee Assistance Programme, and further advice can be sought from Health and Wellbeing. Do remember that your managers, colleagues and peers can provide support too.

Local arrangements for supporting patients, families and carers will be tailored to their individual needs.

National sources of support include:

- National guidance for NHS trusts engaging with bereaved families
- NHS England » Learning from deaths: Information for families - explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.
- VoiceAbility | NHS complaints advocacy - can help navigate the NHS complaints system, attend meetings and review information given during the complaints process
- Parliamentary and Health Service Ombudsmen
- The Independent Sector Complaints Adjudication Service (ISCAS) - provides independent adjudication on complaints about ISCAS subscribers. ISCAS is a voluntary subscriber scheme for the vast majority of independent healthcare providers.
- Citizens Advice Bureau - provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

Patient Safety Partner(s)

As part of our commitment to working with members of the public, we aim to have a partner programme in place. This is where members of the public join our patient safety team to:

- Undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as other relevant training.
- Participate in investigation oversight meetings with the aim of helping us design safer systems of care and prioritise risk.
- Encourage patients, families and carers to play an active role in their safety through an open and transparent approach to managing their care pathway.

Contribute to action plans following investigations, particularly around actions that address the needs of patients.

Addressing health inequalities

DHC has a key role in tackling health inequalities in partnership with our local partner agencies and services. Through our implementation of PSIRF, we will seek to use data and lessons from investigations to identify actual and potential health inequalities and make recommendations where found. Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs 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.

4. Defining our patient safety incident profile

Background and PSRs

There are many ways to respond to a PSI to learn and improve. PSRs identify areas for improvement, take immediate safety actions, and respond to any concerns raised by the affected patient, family, or carer.

Robust findings from investigations and reviews provide key insights and learning opportunities. Safety improvement plans bring together findings from learning responses to patient safety incidents and issues so that these can be developed into improvement design, implementation and quality improvement.

All safety actions are developed with relevant stakeholders, including those responsible for implementation. The implementation and effectiveness of all

safety actions are monitored, and a named individual is identified with responsibility for this.

Reports to the management board are shared through our governance structure and will include aggregated data on:

- Patient safety incident reporting and findings
- Audit and review results
- Progress against the Patient Safety Incident Response Plan
- Results from monitoring of improvement plans
- Results of surveys and/or feedback from patients/service users / families / carers on their experiences of our response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of our response to patient safety incidents

All incidents are recorded on Radar/Teamnet (Risk management system) and reviewed monthly. There are four broad categories of PSRs:

PSR TYPE	METHODS	OBJECTIVES
Incident recovery Immediate measures taken to: • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carer • Respond to concerns raised by staff • Determine the likelihood and severity of an identified risk	Immediate actions	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.
	Risk assessment	To assess the likelihood and severity of identified hazards so that risks can be determined, prioritised, and control measures applied
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'.
Team reviews Post-incident review as a team to:	Debrief	An unstructured, moderated discussion.

• Identify areas for improvement • Celebrate success • Understand the expectations and perspectives of all those involved • Agree actions • Enhance teamwork through communication and collaborative problem-solving		The simplest and most informal method is to gain understanding and insight soon after an incident (debriefs held immediately after an incident are known as 'hot' debriefs).
	Safety huddle	**Proactive**: a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive**: triggered by an event to assess what can be learned or done differently.
	After action review	A facilitated 'cold' structured debrief. The review is based around four questions: • What is expected to happen? • What happened? • Why was there a difference between what was expected and what happened? • What are the lessons that can be learnt?

Systematic reviews To determine: • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient	Case record/note review	To determine whether there were any problems with the care provided to the patient
		A systematic review of a series of case records to identify any problems in care. This can draw learning or conclusions that identify the actions needed to improve care within a setting or for a specific group of patients.
	Specialised reviews	For example, falls, or infection prevention control reviews.
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against expected outcomes and/or standards. Can be observational or include documentation review (or both).
	Survey	By collecting data from representative groups, this can aid the investigator to make informed decisions or draw conclusions.
	Appreciative Inquiry	This seeks to engage stakeholders in self-determined change.

5. Patient safety incident response framework planning

PSIRF supports organisations in responding 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, DHC will explore patient safety incidents relevant to our service and the populations that we serve where we identify potential for learning. Where required, we will collaborate, lead and/or participate in cross-organisational PSIIs where a need is identified, with support from the ICB.

Resources and training to support patient safety incident response

In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation, we will:

- Assign an appropriately trained member of the management board team to oversee delivery of the PSII standards and support the sign-off of all PSIIs.
- Provide the appropriate training for all management board members. *(See appendix 1: DHC PSIRF Training Plan)*
- Identify an appropriate training provider for training at all levels. *(See appendix 1: DHC PSIRF Training Plan)*
- Monitor training compliance through Radar.
- Provide access to training for current staff who provide the incident investigation oversight function.
- Provide access to updated training for existing investigators or investigation teams/staff in specific areas.
- Work with service managers to review the existing tools PSRs to ensure they reflect current practice.

Resource for proactive planning

DHC has identified the internal resources who will take on different roles per PSIRF plan requirements. The training is needed to meet the requirements and to:

- Enhance patient safety management and leadership support.
- Enhance skills to conduct alternative patient safety reviews.

- Enhance patient safety investigations with a lead and supporting investigator, subject matter experts, administrative support, patient and family liaison, and executive-level oversight and support.
- Enable each investigator to receive systems-based patient safety incident investigation training.

Our patient safety incident response plan

DHC patient safety incident response plan can be viewed at [*Link to plan will be inserted after ratification process*].
Our plan sets out how DHC intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.
The PSIRP is based on an analysis of themes and trends from all incidents (including Serious Incident investigations), complaints and concerns from 2021-2023, and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

As referred to above, our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we transition and evaluate our response to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date and as we engage with associated health partners to share experiences, adaptions, and learnings.

Updated plans will be located on the company intranet and available 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.

6. Responding to patient safety incidents

Patient safety incident reporting arrangements

Local reporting of patient safety incidents (PSIs)

All staff have the responsibility to report and escalate safety incidents and near misses. Where a patient safety incident is deemed to have occurred, a swarm huddle and debrief will be held, chaired by a senior member of the team, to discuss events that have taken place and confirm whether the incidents fulfil the PSII criteria.

National reporting of patient safety incidents (PSIs)

In line with the PSIRF, incidents previously defined as 'serious incidents' will be reported to the national 'STEIS' database and to the Learn From Patient Safety Events (LFPSE) service until such time as STEIS fully transitions into LFPSE.

Statutory Care Quality Commission notification requirements will be met by reporting incidents to the LFPSE and by the CQC provider portal.

Patient safety incident investigations (PSIIs) are distinct from PSRs and include a range of techniques, including interviews and observations. PSIIs will be carried out by the organisation, and some types of safety incidents have been identified as national priorities and require a specific response.

Incidents identified as requiring PSIIs by DHC or as listed in the National Priorities

National priorities are set by the PSIRF and other national initiatives for the period 2020 to 2021. These priorities require a PSII to be conducted by the organisation:

- Incidents meeting the Never Events Criteria 2018 or its replacement.
- Incidents that meet the learning from deaths criteria; e.g.:
  - deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care.

- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.
- death or long-term severe injury of a person in state care or detained under the Mental Health Act; e.g.: suicide, self-harm, assault resulting in the death or long-term severe injury.

National priorities to be referred to another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are as follows:

- Maternity and neonatal incidents meeting external agency referral criteria.
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes
- Deaths of patients in custody, in prison or on probation

Patient safety incident response decision-making

All incidents should be reported in line with DHC local policy and national requirements. Initially, if it is not clear whether the incident meets the criteria for a patient safety incident investigation (PSII), a meeting will be held between the medical director, governance and compliance manager, any relevant key role and the service/deputy manager. The purpose of the meeting is to review the assessment of the incident and establish if PSII is required.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning shall be applied to the decision-making in DHC PSIRP. If an incident is well understood or falls within our improvement

themes, no further investigation may be required, and DHC will direct resources at improvement in this area rather than a repeat investigation. All PSIIs will be reviewed at an Incident Review Group and recurrent themes outside the patient safety incident response plan will be tracked in these meetings.

Responding to cross-system incidents/issues

Where more than one organisation is involved in a patient safety incident, the organisation that identifies the incident is responsible for alerting relevant stakeholders to commence investigation and action. This should be one investigation if possible. If required, the ICB can help facilitate these discussions.

Timeframes for learning responses

Where a PSII is required, the investigation will start as soon as possible after the patient safety incident is identified. No specific timeframe is defined but PSIIs will ordinarily be completed within three months of their start date.

In exceptional circumstances, a longer timeframe may be required for the completion of a PSII, particularly if it examines a group of related patient safety incidents. In this case, any extended timeframe will be agreed upon between DHC and the patient, family, or carers.

Ideally, no PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety.

Where external bodies' processes 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. See Appendix B for the timeframe for learning responses.

Safety action development and monitoring improvement

- Learning from patient safety incident responses and associated safety improvements are recorded on the DHC Radar/Teamnet systems.
- The Governance and Compliance manager and the service managers monitor recurrent themes. Any new reoccurring themes highlighted will be escalated to the Senior Management Board team by the DHC Medical Director.
- Quality improvement actions will be developed from feedback from all stakeholders involved in the patient safety investigation.
- The report will identify appropriate measures of effectiveness for each quality improvement action. These actions will be monitored and reviewed within specified time frames to evaluate their impact and determine whether they should be adapted, adopted, or abandoned.
- It is important that others can learn from improvement work to support more widespread learning and change. Learning from improvement is shared through team meetings, service reviews, and the quarterly 'Shared learning from incidents' bulletin.
- Learning will be shared with all PSII stakeholders through an agreed method of contact.
- Learning and actions associated with a PSII are additionally reported and monitored through the Clinical Quality and Performance Reviews with the main commissioning ICB.

Safety improvement plans

Safety improvement plans bring together findings from patient safety incidents and issues. DHC will:

- Set out its patient safety incident response plan over a period of 12 to 18 months which intends to learn and improve from safety incidents and inform improvement plans.
- Review the output from learning responses to single incidents at the monthly incident review meeting and the DHC-wide Governance meeting.
- Create safety improvement plans as required to tackle broad areas for improvement.
- Monitor and adapt the impact of the safety improvement plans at incident review meetings.
- There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning

responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

7. Roles and Responsibilities

All Staff

All staff have a responsibility to highlight any risk issues that warrant further investigation. Staff should be fully open and cooperative with any patient safety review process and are required to be aware of and comply with this patient safety incident response plan.

Service Managers/Deputy Service Managers

Those leading on engagement and involvement with persons affected by patient safety incidents are:

- 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 the review/Investigation of the incidents to help set expectations.

Patient safety incident investigators

Patient safety incident investigators will:

- 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 the latest national guidance and training.
- Provide liaison with patients and families subject to a patient safety incident investigation.

Learning Response Leads/Service Managers

Learning response leads are responsible for:

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

Oversight – Medical Director and Governance and Compliance Manager

Those in an oversight role must have knowledge of effective oversight and supporting processes, including:

- 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 (e.g. through conversations) and assess information from a wide range of sources.
- Constructively challenge the strength and feasibility of safety actions to improve system 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.

Governance and Compliance Manager and Service Managers

- Encourage the reporting of all patient safety incidents and ensure all staff in their 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 periodically review the PSIRF and the PSIRP to check that expectations are clearly understood.
- Provide protected time for training in patient safety disciplines.
- Provide protected time for participation in PSRs/PSIIs as required.
- Work with those affected by patient safety incidents to ensure they have access to the support they need.
- Support the development and delivery of actions in response to PSRs/PSIIs that relate to their area of responsibility.
- Review and update the Learning Response Review and Improvement Tool in line with any changes to the PSIRF tool.

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Commissioning ICB

- To be an active member of the DHC Clinical Quality and Effectiveness process and PSII review, providing support and oversight.
- Work in partnership with DHC to support cross-system investigations.
- Monitor, support and challenge DHC implementation of this policy and transition to PSIRF.
- Support continuous development and shared learning through local networks such as the Surrey Heartlands patient safety specialist network.

8. Complaints and Appeals

Complaints or appeals relating to DHC's response to a patient safety incident can be made using our formal complaints process.
Please refer to DHC's Complaints Policy for further information.
These can be accessed through the DHC website and Teamnet.

Concerns and complaints from members of staff can be made in accordance with policies as set out in DHC Staff Handbook and Freedom to Speak Up Policy.

9. PSIRF Training

PSIRF training requirements for DHC are identified in line with the PSIRF standards and the services DHC provides. DHC is using Radar (DHC internal risk management and compliance system) to monitor compliance, effectiveness and report on training.

In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Assign an appropriately trained member of the management board team to oversee delivery of the PSII standards and support the sign-off of all PSIIs. DHC Medical Director will carry out this responsibility.
- Provide the appropriate training for all management board members. ***(See Appendix A)***
- Identify an appropriate training provider for training at all levels. ***(See Appendix A)***
- Monitor training compliance through Radar
- Provide access to training for current staff who provide the incident investigation oversight function
- Provide access to updated training for existing investigators or investigation teams/staff in specific areas.
- Work with service managers to review the existing tools PSRs to ensure they reflect current practice.

Appendix A DHC PSIRF Training

PSIRF Role	Competence and Training Requirements	Role	Courses required by NHSE (patient safety syllabus)	Provider
All staff		Clinical	• Level 1: Essentials for patient safety (e learning) • Level 2: Access to practice (e learning) 1 • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1 – Understandi	E Learning for Health

			ng	
All staff		Non-clinical	• Level 1: Essentials for patient safety (e learning) • Level 2: Access to practice (e learning) 1 • Level 2: Patient safety in the management and administrative sector • Human Factors / Ergonomics (Safety Science) for	E Learning for Health

			Patient Safety Level 1 – Understanding	
Engagement & Involvement Leads	• Engagement leads to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections. In addition: • 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. • Engagement leads undertake	These should be people leading on engagement and involvement with those affected by patient safety incidents such as but not limited to: • Services Manager • Deputy Service Manager • Governance Manager	• Involving those affected by a patient safety incident - 6 hours (face to face)	E Learning for Health Procure training from a NHS Training & Procurement Framework In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards *From October 2023 HSIB intend to have a commercial model for all PSIRF and non- PSIRF training where they hope to offer additional training at a charge to the Independent Sector.

	continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise. • Engagement leads contribute to a minimum of two learning responses per year			
Learning Response Leads	• Learning Response Leads to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections **In addition:** •Learning responses are led by those with at least two	**These should be people leading any system-based learning response such as but not limited to:** • Chief Operating Officer • Governan	HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)	E Learning for Health HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)

	days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response. •Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise. • Learning response leads contribute to a minimum of two learning responses per year	ce and Compliance Manager • Services Manager		

Oversight	Those with an oversight role on a provider board or leadership team to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections
	In addition:
	• All patient safety incident response oversight is led/conducted by those with:
	  • at least two days' formal training and skills developm ent in learning from patient safety incidents AND
	  • One day training in oversight of
		These should be people leading in system oversight roles as outlined in the NHSE Roles & Responsibilities guide (i.e. provider board PSIRF lead(s)) and must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development such as but not limited to:
		• Chief
			• HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)
			• Oversight learning from patient safety incidents – 6 hours (face to face)
				E Learning for Health
				HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)
				Oversight learning from patient safety incidents
				• Procure training from a NHS Training & Procurement Framework
				• In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards
				*From October 2023 HSIB intend to have a commercial model for all PSIRF and non- PSIRF training where they hope to offer additional training at a charge to the Independent Sector

	learning from patient safety incidents. • All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.	Operating Officer • Governance and Compliance Manager • Services Manager		
Board & Senior Leadership			• Level 1: Essentials of patient safety for boards and senior leadership teams (e learning) • Level 2: Access to	E Learning for Health

			practice (e learning) 2 • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1 – Understanding	

Appendix B Timeframe for learning responses

Activity	Timescale	Details
Incident Reporting	As soon as possible following the incident occurring – maximum within the same working day	It is vital to ensure a rapid incident report so that all relevant detail can be entered, and key facts are not lost.
Risk assessment	1 working day	To ensure that the most appropriate incident management pathway used and where relevant a proportionate learning response is selected.
Incident Review	2 working days	To ensure that immediate safety actions can be taken to mitigate risk to patients, staff and the public
Closure of low and no-harm incidents	14 days	Closure of low and no harm incidents
Information gathering for potential PSII or PSR	Within five working days following the incident being reported	To ensure that the service undertakes an initial review and that immediate actions have been taken to minimise risk to patient safety
Patient Safety Review (PSR)	Complete review using agreed learning response method and provide an approved report within 30 working days	To provide an of assurance that a thorough review has taken place and actions have been taken to minimise risk to patient safety
Actions agreed to be completed following PSR	All evidence for each action within 60 working	To ensure that all actions have been undertaken to provide assurance to patients, relatives and Board that

	days of completion and approval of report.	areas have improved practice and quality of care to maintain patient safety
Patient Safety Incident Investigation (PSII)	Complete investigation and provide an approved report within 3 months and no longer than 6 months	Nationally agreed in alignment with PSIRF, timescales are to be agreed upon with the patient/family. Safety recommendations will inform new or ongoing Quality Improvement or Transformation programmes and will be monitored via these established governance routes.

Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
AAR	After Action review
Accident	An unexpected event without apparent or deliberate cause that causes injury or damage
IRG	Incident Review Group
CQC	Care Quality Commission
Radar /Teamnet	Risk management databases, central recording system of incidents, complaints, actions, safety alerts, audits and Risk Register
External body	An organisation that has an official advisory or regulatory role that has been mandated to regulate the corporate and professional activities of Dorking Healthcare.
HSE	Health and Safety Executive
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
Incident	An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or psychological distress to a patient, staff, visitors or members of the public
LFPSE	Learning from Patient Safety Events (LFPSE) service. A national database for the direct recording of incidents as they are reported. It collects data from all NHS funded providers. The

Term	Definition
	Integrated Care Board (ICB), NHS England and Care Quality Commission (CQC) have access to this database. This will eventually replace the National Reporting and Learning System (NRLS).
Near Miss	Any event that could have caused harm to patients, staff or the reputation of the organisation had it been allowed to reach its natural conclusion.
Never Event	Never Events are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. A core list of never events is issued by NHS England.
Non-patient Safety Incident	Any unintended or unexpected incident which could have or did lead to harm or an undesired effect which was not as a direct result of patient intervention or the patients' clinical presentation.
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm or one or more patients receiving NHS-funded care.
PSII	Patient Safety Incident Investigation. Some incidents are classified as Patient Safety Incident Investigations (PSII). This is an incident identified and investigated through a systematic process that includes systems-based analysis. The objective is to identify what happened, where, when, how, to whom and why. Using observation, listening and discussion for determining contributory/causal/ human factors and design recommendations/ improvements which address the underlying interconnected, system-based contributory and causal factors of patient safety incidents. PSII's are identified on an on-going basis based on the identification of areas of most significant risk, along with those categories for which a PSII is nationally mandated. DHC's Patient Safety Incident Response Plan (PSIRP) on the website, identifies those incidents requiring a PSII.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan. To support local improvement, DHC must determine which categories of incidents are priorities locally and require a Patient Safety Incident Investigation (PSII). In line with the PSIRF, DHC will do this by reviewing past incident data (from the last three to five years where available) to identify those incidents representing the most significant risks. This list must be set out in the PSIRP, reviewed and refreshed every 12 to 18 months adapted as new risks emerge or diminish locally

Term	Definition
PSP	Patient Safety Partner
PSR also known as a learning response	Patient Safety Response. Patient safety incidents which do not require PSII but may benefit from a different type of review to gain further insight or address queries from the patient, family, carers or staff. Different review techniques can be adopted, depending on the intended aim and required outcome.
Q.I	Quality Improvement
Risk	An uncertain event or set of events which, should it occur, will have an effect on the achievement of objectives. It is measured in terms of likelihood and consequences.
StEIS	Strategic Executive Information System. A national database for the recording of incidents. The ICB, NHS England and the Care Quality Commission also have access to StEIS. This system will be phased out when all providers have transitioned to Learning from Patient Safety Events (LFPSE) service.