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## 1. Purpose

- 1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out how Wrightington Wigan & Leigh Teaching Hospital NHS Foundation Trust (*the Trust*) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
- 1.2 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.
- 1.3 This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF which we can also align to our existing Trust values:
  - 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.
- 1.4 This policy should read in conjunction with the Trusts Patient Safety Incident Response Plan, this is a separate document that sets out how this policy will be implemented.

## 2. Scope

- 2.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.
- 2.2 Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.
- 2.3 There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy.
- Claims handling
  - Human resources investigations into employment concerns
  - Professional standards investigations
  - Information governance concerns
  - Estates and facilities concern
  - Financial investigations and audits
  - Safeguarding concerns
  - Coronial inquests and criminal investigations
  - Complaints (except where a significant patient safety concern is highlighted)
- 2.4 For clarity, the Trust considers these processes as separate from any patient safety investigation. 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. Our Patient Safety Culture

- 3.1 As a Trust, we have consistently worked over a number of years to move away from a retributational approach to types of incidents, such as patient safety and workforce, to establishing a restorative just culture within the organisation.
- 3.2 The Trust senior leaders have strongly embraced this work and with support from colleagues and patient safety leads both internally within the organisation and also externally the have been instrumental in establishing the organisational transition to a restorative just culture.
- 3.3 The main goals of creating a just culture when an incident has happened have been outlined as follows.
- Moral Engagement
  - Emotional Healing
  - Psychological Safety
  - Organisational Learning
  - Prevention
- 3.4 The PSIRF will enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.
- 3.5 We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.
- 3.6 To enhance our safety culture, we have safety huddles at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.
- 3.7 We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

## 4. Patient Safety Partners

- 4.1 The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England/Improvement to help improve patient safety across the NHS in the UK.
- 4.2 The Trust is excited to welcome PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.
- 4.3 This exciting new role across the NHS will evolve over time and at WWL the main purpose of the role is to be a voice for the individual patient and the community who utilise our services and ensure that patient safety is at the forefront of all that we do.
- 4.4 PSPs will communicate rational and objective feedback focused on ensuring that the patients safety is maintained and improved, this may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role evolves, we may ask PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.
- 4.5 The PSPs will be supported in their honorary role by the Patient Safety Specialist for the Trust who will provide expectations and guidance for the role.
- 4.6 PSPs will have regular scheduled reviews and regular one-to-one sessions with our Patient Safety Specialist and training needs will be agreed together based on the experience and knowledge of each PSP.
- 4.7 The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

## 5. Addressing Health Inequalities

- 5.1 The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.
- 5.2 The Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.
- 5.3 Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities, may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.
- 5.4 We will also address apparent health inequalities as part of our safety improvement work. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.
- 5.5 Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.
- 5.6 The Trust's commitment to transforming organisational culture to that of restorative justice has already been outlined. Further to this, the Trust has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. As part of this, discrimination of any kind including racism will be dealt with by using a 'Support, Educate, Challenge' approach. With explicit role modelling led by the Trust Board, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

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

- 6.1 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.
- 6.2 The Trust are firmly committed to continuously improving the care and services that we provide. We want to learn from any incident where the care does not go as planned or expected by the patient, their families, or carers to prevent recurrence.
- 6.3 We recognise and acknowledge the significant impact patient safety incidents can have on the individual patient, their families and carers.
- 6.4 Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.
- 6.5 In addition to meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.
- 6.6 As part of our new policy framework, we will be outlining procedures that support patients, families, and carers based on the Trusts existing Duty of Candour Policy. This will be underpinned by a network of Family Liaison Officers (FLOs) who are able to guide patients, families and carers through any investigation or learning review.
- 6.7 In addition, WWL have a Patient Relations Department (PRD). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PRD can provide support and advice to patients, families, carers, and friends. PRD is a free and confidential service and the PRD team act independently of clinical teams when managing patient and family concerns. The PRD service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PRD can help and support with the following:

- advice and information
- comments and suggestions
- compliments and thanks
- informal/formal complaints

If the PRD team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

Our PRD team can be contacted at the email address above or by post or telephone as follows:

*Patient Relations/PALS Department*

*T: 01942 773344 / 773343*

*Email: [patient.relations@wwl.nhs.uk](mailto:patient.relations@wwl.nhs.uk)*

*Wrightington, Wigan and Leigh NHS Foundation Trust*

*Royal Albert Edward Infirmary*

*Wigan Lane, Wigan. WN1 2NN*

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this. Please see list included at appendix A.

## 7. 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 will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

### 7.1 Resources and training to support patient safety incident response

- The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.
- The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.
- Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division. A learning response lead should be nominated by the Division and the individual should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the incident and response required, but learning responses are led by staff at Band 8a and above.
- The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional Governance leads including the designated member of the senior leadership team will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety team will support

learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

- Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work

within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

- The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

### Training

- The Trust has developed a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents. This is available on the e-learning platform for all staff Trust Wide to complete. Face to face training will also be provided for all new starters via the clinical and junior doctor induction programme.
- The NHSE Patient Safety Syllabus Levels one and two are These modules are available as eLearning via ESR access. It is expected that all staff (both clinical and non-clinical) will comply with the training as follows.

<b>Level 1 Essentials for Patient Safety</b>
All staff both clinical and non-clinical are expected to complete this module.
<b>Level 1 Essentials of patient safety for boards and senior leadership teams</b>
The Senior Leadership Team and all Trust Board members are expected to complete this module.
<b>Level 2 Access to Practice</b>
This is to be undertaken by all clinical staff at AFC Band 7 or above, with potential to support or lead patient safety incident management.

The above modules are all available by e-learning via the learning hub.

### **Learning Response Leads - Training and Competencies**

### Training

- Any Trust learning response should be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the Learning and Development Team as part of their general education governance processes.
  - Learning response leads must have complete Level one and two of the national patient safety syllabus.
  - Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.
- 
- To maintain expertise the Trust will undertake an annual networking event for all learning response leads. Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional Governance Team and Patient Safety.

### Competencies

As a Trust we expect that those staff leading learning responses are able to

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

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

### **Engagement and Involvement - Training and Competencies**

#### Training

- Engagement and Involvement Leads will be undertaken by those who have undergone a minimum of six hours training, this will include completion of the Duty of Candour Module on the Learning Hub. Records of such training will be maintained by the Learning and Development Team as part of their general education governance processes.

- Engagement leads must have complete Level one and two of the national patient safety syllabus.
- Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.
- To maintain expertise the Trust will undertake an annual networking event for all engagement leads.
- Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Governance teams.

### Competencies

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

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

### **Oversight Roles - Training and Competency**

#### Training

- All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.
- Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

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

### Competency

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

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

## 7.2 Our Patient Safety Incident Response Plan

Our plan sets out how WWL intends to respond to patient safety incidents over a period of 24 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.

A copy of our current plan can be found on the Trust Policy Library.

## 7.3 Reviewing our Patient Safety Incident Response Policy and Plan

- Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents.
- The Trust 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 24 months.

- Updated plans will be shared, 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), wider stakeholder engagement, CNST Scorecard data is used to agree targeted interventions aimed at improving patient safety (this is reflected in the Trusts Patient Safety Incident Response Plan).

## 8 Responding to Patient Safety Incidents

### 8.1 Patient safety incident reporting arrangements

- All staff are responsible for reporting any potential or actual patient safety incident on a Trust incident reporting system (Datix) and will record the level of harm they know has been experienced by the person affected (see Appendix B).
- Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (See Trust policy TW10-054 ). Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Division (see Patient safety incident response decision-making below).
- Divisions will highlight to the Patient Safety team any incident which appears to meet the requirement for reporting externally. A Patient Safety Review (PSR) will be presented at the Learning from Patient Safety Group Meeting. This will allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.
- The Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

### 8.2 Patient safety incident response decision-making

- The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan ([link to plan here](#)).

- PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.
- We have established a process for our response to incidents which allows for a clear ‘Ward to Board’ oversight of incident management and our PSIRF response.
- Divisions will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a rapid review due to possibly meeting the criteria as PSII or PSR or due to the potential for learning and improvement or an unexpected level of risk. Divisional Patient Safety Panels will consider any such incidents for further escalation to the Trust Patient Safety Panel.
- The Trust Patient Safety Panel will have delegated responsibility for the consideration of incidents for PSII or PSR and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.
- The Trust Executive Patient Safety Oversight Group will have overall oversight of such processes and will challenge decision making of the Patient Safety panels to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.
- Any incident highlighted will follow the process outlined below which can be seen in diagram form at Appendix C.

### Local level incidents

- Managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust guidance (see Policy No TW10-054).
- Divisional Patient Safety Panels may commission thematic reviews of such incidents to consider and understand potential emerging risks.

### Incidents with positive or unclear potential for PSII

- All staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Governance Teams. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety team as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to the Divisional and then Trust Patient Safety panels. A rapid review will be undertaken by the Division to inform decision making at the Divisional Patient Safety panel and onward escalation following this.
- Other incidents with unclear potential for PSII, must also be reported to the Patient Safety team. Decision making, regarding escalation to the Trust Patient Safety panel can be considered at the next possible Divisional Patient Safety panel. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.
- The Trust Patient Safety panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The panel will define terms of reference for a PSII to be undertaken. The panel will identify a lead investigator, a designate subject matter expert and will
- Additionally highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.
- Where an incident does not meet the requirement for PSII, the Trust Patient Safety panel may request a patient safety review (PSR) or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the panel's discretion in such circumstances to specify a particular tool is used to complete a PSR. The Trust Patient Safety panel will also indicate how immediate learning is to be shared.

### Incidents requiring possible patient safety review (PSR)

- All staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review response as soon as practicable after the event through Divisional escalation processes (including out of hours). A rapid review will be undertaken by the Division to inform decision making following this.
- The Divisional Patient Safety Panel will meet at the earliest opportunity to discuss the nature of the incident, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met.

- Where it is clear that a PSII is not required, the Divisional Patient Safety panel will consider any incident as having potential for PSR. The tool to be utilised for the review will be specified and a suitable member of the divisional team to undertake the review will be allocated. This will not be any staff involved in the incident or by those who directly manage the staff. The Division will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process.
- Divisional Safety panel arrangements will include the recording of safety action arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans.
- The Patient Safety Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety team will work with the Divisions to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

### Trust Executive Patient Safety Panel

- The Trust will establish and maintain a clinical Executive-led Patient Safety Group to oversee the operation and decision-making of the Trust Patient Safety panel and the incident responses it has delegated responsibility to commission. This will support the final sign off process for all PSII's. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

## 8.3 Responding to Cross-System Incidents/Issues

- The Trusts Patient Safety Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.
- The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.
- The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

## 8.4 Timeframes for Learning Responses

- Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.
- The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must 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 or require further checks to ensure they remain relevant.
- In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety panel.
- In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust

### Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

## 8.5 Safety action development and monitoring improvement

- The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.
- The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.
- Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way

with a flexible approach from Divisions and the support Patient Safety and Improvement Leads expertise.

### Safety Action Development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions.
- Define the context – this will allow agreement on the approach to be taken to safety action development.
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved.
- Prioritise safety actions to decide on testing for implementation.
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics.
- Safety actions will be clearly written and follow SMART principles and have a designated owner.

### Safety Action Monitoring

- Safety actions must continue to be monitored within the Divisions governance arrangements to ensure that any actions put in place remain impactful and sustainable.
- Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Learning from Experience Group (LEG)

## 8.6 Safety Improvement Plans

- Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as the national safety improvement programmes.
- The Trust patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

- The Trust will use the outcomes from existing patient safety incident reviews (SI RCA Investigation reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.
- Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through Divisional governance processes and reporting to the Strategic Patient Safety Group who may commission a safety improvement plan.
- Monitoring of progress regarding safety improvement plans will be overseen by reporting by the designated lead to the Learning from Experience Group (LEG) on a scheduled basis.

## 9 Oversight roles and responsibilities

### Principles of Oversight

- Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.
- The Trust followed the ‘mindset’ principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

### Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework. In order to meet these responsibilities, the Trust has designated the Executive Medical Director to support PSIRF as the executive lead.

#### 1. [Ensuring that the organisation meets the national patient safety standards](#)

The Executive Medical Director will oversee the development, review and approval of the Trust’s policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the Trust aspires to.

To achieve the development of the plan and policy the Trust will supported by internal resources within the Patient Safety team led by the Associate Director of Governance and Patient Safety who will report to the Executive Medical Director.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

## 2. Ensuring that PSIRF is central to overarching safety governance arrangements.

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality & Safety Committee and Learning from Patient Safety Events. Reporting to Quality & Safety Committee and Learning from Patient Safety Events. will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety..

The Learning from Experience Group (LEG) will provide assurance to the Quality & Safety Committee that PSIRF and related workstreams have been implemented to the highest standards. Divisions will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

The Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source any necessary training such as the Health Education England Patient Safety Syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development. alongside a review of all safety actions.

## 3. Quality assuring learning response outputs

The Trust will implement a central Patient Safety panel to ensure that PSIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

## 10 Complaints and Appeals

- Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.
- It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process
- The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.
- The first point of contact with the Trust is the Patient Relations Department (PRD):

***Patient Relations/PALS Department***

*T: 01942 773344 / 773343*

*Email: [patient.relations@wvl.nhs.uk](mailto:patient.relations@wvl.nhs.uk)*

*Wrightington, Wigan and Leigh NHS Foundation Trust*

*Royal Albert Edward Infirmary*

*Wigan Lane,*

*Wigan.*

*WN1 2NN*

- It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.
- The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.
- The Trust recognises that Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.
- Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

- If a concern cannot be resolved and the PRD are undertaking a formal review the complaints team will contact the complainant and they can be contacted directly 01942 773344 / 773343.

## Appendix A

### Reference links

**National guidance for NHS trusts engaging with bereaved families**

<https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf>

**Learning from Deaths – Information for families**

<https://www.england.nhs.uk/publication/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.

**Help is at Hand - for those bereaved by suicide**

<https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf>

Specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

**Mental Health Homicide Support**

<https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/>

For staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

**Child Death Support**

<https://www.childbereavementuk.org/grieving-for-a-child-of-any-age>

<https://www.lullabytrust.org.uk/bereavement-support/>

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

**Complaint's Advocacy**

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

**Healthwatch**

<https://www.healthwatch.co.uk/your-local-healthwatch/list>

Local Healthwatch contacts can be identified from the listing (arranged by council area) on the Healthwatch site

**Parliamentary and Health Service Ombudsman**

<https://www.ombudsman.org.uk/>

Makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

**Citizens Advice Bureau**

<https://www.citizensadvice.org.uk/> provides UK citizens with information about healthcare rights, including how to make a complaint about care received

## Appendix B

### Harm Level Definitions

Levels of harm were previously set out in the National Reporting and Learning Service (NRLS) guidance on reporting patient safety incidents. In summary harm is defined as follows

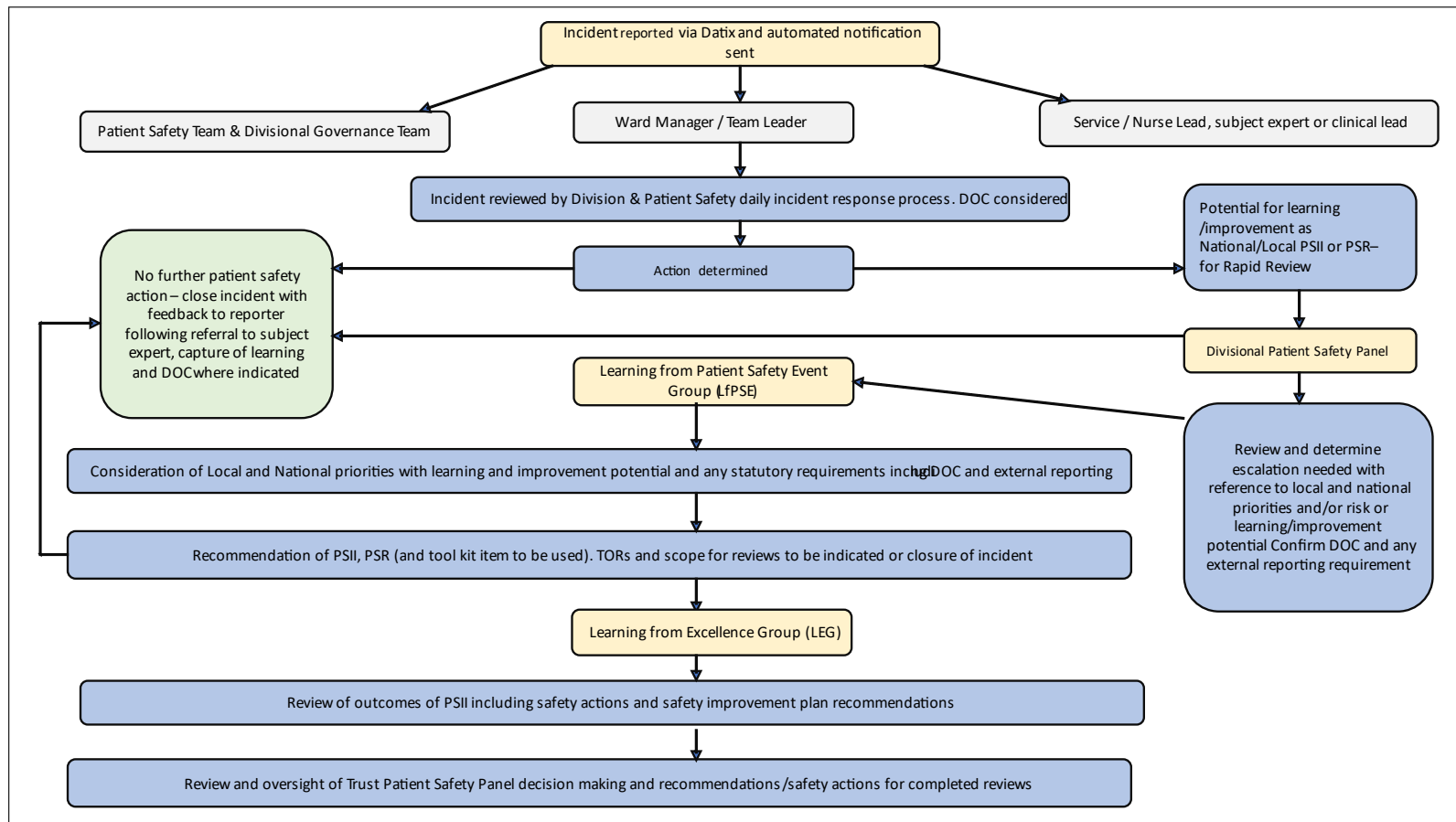
- **No Harm:** this has two sub-categories:

<b>No harm (Impact prevented)</b>	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.
<b>No harm (impact not prevented)</b>	Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the

- **Low Harm:** Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.
- **Moderate Harm:** Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.
- **Severe Harm:** Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.
- **Death:** Any unexpected or unintended incident that directly resulted in the death of one or more persons.

## Appendix C

### Incident Investigation Flowchart





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