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NHS
Bolton
NHS Foundation Trust

Patient Safety Incident Response Policy

November 2023

... for a better Bolton

Patient safety incident response policy

Effective date: 01 January 2024

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Version Control

Version	Type of change	Date	Revisions
1	New document	November 2023	-

Contents

Glossary

Definitions for technical terms and acronyms used within this document

PSI or Patient Safety Incident	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient
PSIRF	Patient Safety Incident Response Framework. The Framework supports the development and maintenance of an effective patient safety incident response system across the NHS
SEIPS	Systems Engineering Initiative for Patient Safety. A framework for understanding complex socio-technical systems. A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.
LRT	Learning response tool. A toll or method used to learn from an incident that uses a systems based approach to learning
AACD	Adult Acute Care Division
ASSD	Anaesthetic and Surgical Services Division
ICSD	Integrated Care Services Division
FCD	Family Care Division
NHS Greater Manchester (NHS GM)	NHS GM is the Integrated Care Board for Greater Manchester. A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
AIS	Accessible Information Standard. This directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care.
CQC	Care Quality Commission. The independent regulator of health and adult social care in England.
CNST	The Clinical Negligence Scheme for Trusts is a payment made to NHS Resolution who then handle all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995. There is a specific incentive scheme for maternity services that supports the delivery of

	safer maternity care through an incentive element to trust contributions to the CNST.
C.Diff / CDT	Clostridium Difficile or Clostridioides Difficile. A type of bacteria that can infect the bowel and cause diarrhoea. It commonly affects people who have been recently treated with antibiotics but can spread easily to others. CDT is a binary toxin frequently observed in Clostridium difficile strains associated with increased severity of C. difficile infection
NPSIPs	National Patient Safety Improvement Programmes. National priorities because of their potential to enable the most significant impact on patient safety.
PSII	Patient Safety Incident Investigation. An in-depth review of a single patient safety incident or cluster of events to understand what happened and how
LeDeR	LeDeR is a service improvement programme for people with a learning disability and autistic people. A LeDeR review looks at key episodes of health and social care a person received that may have been relevant to their overall health outcomes.
DHR	Domestic Homicide Review. A review into the circumstances around a death of your friend or family member following domestic abuse.
MHRA	Medicines and Healthcare products Regulatory Agency. MHRA regulates medicines, medical devices and blood components for transfusion in the UK.
ICO	Information Commissioner's Office. the UK's independent body set up to uphold information rights.
HTA	Human Tissue Authority. The independent regulator of organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. The HTA also give approval for organ and bone marrow donations from living people.
SWARM Huddle	A type of learning response tool designed to start as soon as possible after a patient safety incident occurs to identify learning. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk
MDT Reviews	A type of learning response tool. An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done.
After Action Reviews (AAR)	A type of learning response tool. A structured, facilitated discussion of an event, the outcome of

	which gives the individuals involved in the event understanding of why the outcome differed from the expected and the learning to assist improvement.

1. Purpose

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF). It sets out how Bolton NHS Foundation Trust will respond to patient safety incidents (PSI) to learn and improve patient safety.

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

1.3 This policy supports development and maintenance of an effective PSI response system. It integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

1.4 This policy also links with the Trust's Incident Reporting Policy, Being Open Policy, Risk Management Framework and Quality Improvement Strategy. These documents are available for staff on the Trust's intranet.

2. Scope

2.1 Responses under this policy follow a systems-based approach. The Trust will use the Systems Engineering Initiative in Patient Safety Framework (SEIPS). An overview of SEIPS is available in Appendix 1.

2.2 A systems based approach recognises that healthcare delivery requires many interactions between various components. It aims to understand how they all interact and influence outcomes. It focuses on wider system issues, not individuals.

2.3 The PSI response policy and plan do not include non-patient safety incidents. These could include information governance, health and safety or estates and facilities incidents. Agreed processes are in place for reporting and responding to non-patient safety incidents. Details are available in the Incident Reporting Policy.

2.4 The learning response methods described in this policy can support learning and improvement from other non-patient safety incidents. However, their use must comply with any wider requirements.

2.5 There is no remit to apportion blame or determine liability, preventability or cause of death in a patient safety incident learning response. Other processes exist for that purpose. These include:

- claims handling human resources investigations into employment concerns
- professional standards investigations
- coronial inquests
- criminal investigations

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

2.6 Other processes should not influence the remit of a PSI response. However, it is possible to share information from a PSI response with those leading other types of responses.

3. Our patient safety culture

3.1 All staff can report incidents via the Safeguard system on the intranet. This includes bank and agency staff. The incident reporting system must focus on what needs to change rather than punitive actions. Using the NHS Improvement 'Just Culture Guide' will support consistent, constructive and fair evaluation of the actions of staff involved in incidents.

3.2 Staff must feel supported to report incidents and raise safety concerns. This is fundamental to developing and supporting a positive safety culture. The Trust's Raising Concerns Policy sets out the process for staff members to raise concerns confidentially.

3.3 The Trust has already adopted the 'Just Culture Guide' as part of its learning response and investigation processes. We will continue to develop and embed a

restorative Just Culture approach at all levels of the organisation to ensure that learning focuses on wider systems and processes. See Table 1 (sidneydekker.com)

Table 1.

A **restorative just culture** asks: Who is hurt? What do they need? Whose obligation is that?	Accountability is *forward* looking. Together, you explore what needs to be done and who should do it.	An account is something you tell and learn from.
A **retributive just culture** asks: What rule is broken? How bad is the breach? What should the consequences be?	Accountability is *backward* looking, finding the person to blame and imposing proportional sanctions	An account is something you settle or pay.

3.4 The Trust's 2022 NHS Staff Survey results compare well when benchmarked against the other 124 Trusts in the same category (Acute and Acute & Community Trusts). Bolton scored better than the national average for all seven People Promise elements. However, results also highlighted some key areas for improvement including:

- Improving response rates
- Improving confidence levels that concerns will be addressed when they are raised.

The Trust has developed an overarching survey action plan. Each Division also an action plan tailored to their specific results and key areas of focus.

3.5 A range of workstreams are underway to support further development of a restorative Just Culture including:

- Staff can sign up to the Civility Saves Lives campaign.
- The Active Bystander project – This is a training programme that came about from work done by Medical, Dental and Public Health trainees in NW Region who formed an EDI Network- North West Trainee Equality, Diversity and Inclusion Allyship Network. It was led by Dr Naomi Fleming (Consultant Anaesthetist at Manchester Foundation Trust) and Mrs Clare Inkster (Consultant Ophthalmologist here at Bolton). The group provided peer support and shared lived experiences and the Active Bystander training grew from these discussions. The trainers have provided sessions at Bolton (2.5 hours) and facilitated Train the Trainer sessions (2 days). Discussions are now in progress to develop further rollout. This training is part of a bigger piece of work around behaviours and our culture. It aims to support staff to challenge poor behaviour and create a safe and inclusive work environment.

- Our Voice Change Programme - A schedule of listening events planned to engage and empower staff to make the changes and improvements that matter the most. Our Head of People Development is leading the programme. Following the events, the intention is to set up change teams, empowered driven and sponsored by the senior leadership team to deliver. These will be up and running by mid-November 2023. We will then agree clear measures of success for each theme and the overall programme.

4. Patient safety partners

4.1 Bolton NHS Foundation Trust recognises that Patient Safety Partners (PSPs) can support effective safety governance at all levels in the organisation. The benefits of PSP involvement include:

- Promoting openness and transparency
- Supporting the organisation to consider how processes appear and feel to patients
- Helping the organisation know what is important to patients
- Helping the organisation identify risk by hearing what feels unsafe to patients
- Supporting the prioritisation of risks that need to be addressed and subsequent improvement programmes
- Supporting the organisation in developing an action plan following an investigation so that actions address the needs of patients
- Helping the organisation to produce patient information that patients understand and can access.

4.2 The role of PSPs in Bolton is currently under development. The long-term aim is to have a pool of PSPs representative of the community we serve. PSPs will be involved in:

- Development of the organisation's PSI Response policy, profile and plan going forward
- Development of incident response processes including improved patient engagement and involvement
- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- Patient safety improvement projects
- Working with our board to consider how to improve safety
- Staff patient safety training
- PSI investigation oversight and review.

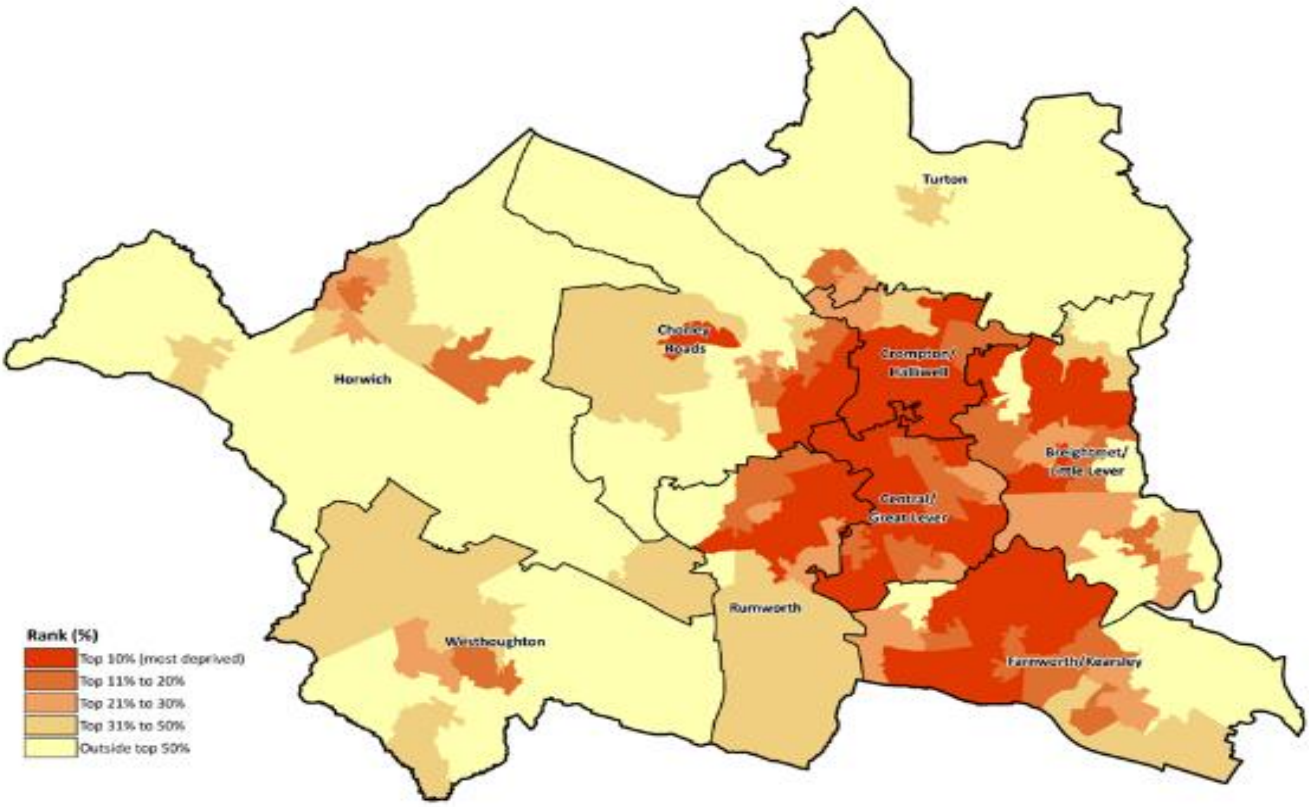
4.3 The first step in this process is to recruit two PSPs and this will be a priority area of focus for Q4 2023/24. As a result, PSPs will play a key role in the continued

development of this policy, our annual PSI Response Plan and the development of robust PSI response processes.

4.4 We have consulted with existing Trust patient representatives along with members of local Healthwatch during the development of this PSI Response Policy and Plan to ensure we take account of patients' views.

5. Addressing health inequalities

5.1 Bolton currently has a population of around 284,000. The Bolton Locality Plan estimates that it will grow to 300,000 by 2025. While the number of people in some age groups will reduce over this period, growth will be driven, in large part, by significant increases in the secondary school-age population and in the over 75s (a 19% increase in 11-15s and a 42% increase in the 75+ group).



5.2 Greater Manchester has some of the poorest health outcomes in the UK. There is a significant gap between the wealthiest and poorest neighbourhoods. Bolton experiences higher-than-average early deaths from cardiovascular disease and cancer when compared with the rest of England. Life expectancy of those in areas that are more affluent is around nine years longer than in deprived communities. The healthy life expectancy in the most deprived communities in Bolton is 12 years below the England average. Our population has higher-than-average levels of alcohol-related harm, smoking-related deaths, deaths from drug misuse and higher rates of hospitalisation for self-harm.

5.3 Bolton has a diverse population, with 17.7% belonging to a non-white ethnic group. Census data shows that 20% of people assessed themselves as experiencing some form of long-term illness, health problem or disability that limits their daily activities or the work they can do. This is higher than the England and Wales figure of 18%.

5.4 Work to tackle health inequalities is complex. In the past year, the Trust's Health Inequalities Enabling Group has "*undertaken considerable work to analyse Trust data by ethnic group, deprivation, age and gender. They have used this information to understand any significant differences. For example, in waiting times. As a result, specialties can take account of any differences within recovery plans. It has also helped to identify that any differences found, are typically only present at one snapshot in time. Frequent monitoring has identified that differences at specialty level change and are more likely to do with gaps in recording of demographic details. For example, in the Waiting List Minimum data set, around 27% of patients are without a stated ethnicity*.

Several inequalities indicators are being developed for the FT Board of Directors report. This will enable better monitoring of health inequalities and ensure visibility. Lower level indicators will be included at a variety of other groups. The key aim is to ensure that health inequalities indicators are not seen as a separate entity. Instead, they are an integral part of routine reporting. Work is also ongoing across the locality to bring together a range of outcome indicators. This will also highlight any inequalities in the new and emerging governance structure" (Health Inequalities Annual Report, April 2023)

5.5 Going forward the work of this group will feed into the patient safety incident response plan updates. The patient safety specialist will also provide a patient safety update to the group every three months. Updates will focus on PSIRF to avoid silo working and ensure shared learning. The group has provided information where possible to assist with the development of this policy and the PSI Response Plan. However, gaps in monitoring data have been a significant barrier in drawing robust conclusions in relation to patient safety incident themes and health inequalities/affected groups.

5.6 Applying a more flexible approach and intelligent use of data can help identify any disproportionate risk to patients with specific characteristics. The monthly PSI report includes information related to locality and is presented to the Clinical Governance and Quality Committee. Information from this report has also been used in the development of this policy and the PSI Response Plan. Again, gaps in the completion of monitoring data for reported incidents has hindered further progress. We will undertake a review to understand how we can strengthen aspect of incident reporting.

5.7 We will use the tools recommended by NHS England to learn from patient safety incidents. These tools adopt a systems based approach. A system-based approach

looks at the components of a system and tries to understand how they influence each other. The aim is then to understand how they may contribute to patient safety. Examples of a component would be: person(s) involved and any specific characteristics, tasks, tools and technology, the environment and the wider organisation. The four main tools that the Trust will use to learn from patient safety incidents will be:

- SWARM Huddles
- After Action Reviews
- MDT Reviews
- Patient Safety Incident Investigations

5.8 This does not exclude the use of other learning response tools if they are more appropriate provided they fulfil the following criteria:

1. All learning responses must use a systems based approach
2. Involve those affected including patients, families and staff
3. Understand everyday work
4. Define areas for improvement – Develop safety actions – Monitor & adapt – Demonstrate improvement

This will be judged on a case-by-case basis.

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

6.1 Staff should read this section in conjunction with the Trust's Being Open policy. This is available on the Trust intranet.

6.2 The PSIRF recognises that supportive systems and processes must be in place to achieve learning and improvement following a patient safety incident. It supports the development of a response system that prioritises compassionate engagement and involvement of those affected (including patients, families and staff). This involves working with those affected to understand and answer any questions they have in relation to the incident and signpost them to support as required.

6.3 The term 'engagement' describes everything an organisation does to communicate with and involve people in a learning response. This may include the Duty of Candour notification or discussion. It also includes seeking the input of patients, families, and healthcare staff to develop a shared understanding of what happened (NHS England 2022).

6.4 The Trust recognises the importance of meaningful and compassionate engagement and involvement. We will achieve this by:

- Managers and Leaders showing their commitment to compassionate engagement and leadership through their words and actions. This includes fostering an open and just culture that recognises the impact of patient safety incidents on staff, as well as patients and families.
- Ensuring those responsible for leading on engagement are trained and competent in line with NHS England expectations.
- Working with PSPs, staff and people who use our services to design systems and processes that are inclusive and recognise individual needs.
- Providing those affected by a patient safety incident with clear information about the purpose of a learning response including what to expect from the process.
- Signposting those affected by a patient safety incident to relevant support services.
- Working with PSPs, staff and people who use our services to design and develop ways to engage and involve those affected, using feedback to improve.
- Providing open and honest feedback if processes and/or outcomes from a learning response do not meet the expectation of those affected.

6.5 The statutory Duty of Candour requirements are unaffected by PSIRF. The Trust will continue to uphold these in line with the organisation's Being Open Policy (available on the Trust intranet).

6.6 The lead clinician, Duty of Candour Lead or Family Liaison Officer may undertake engagement with families. In line with our Being Open policy, a Family Liaison Officer must be appointed within the Division to keep in contact with the family regarding updates about an investigation a minimum of every 3 weeks. We will continue with this process, ensuring anyone responsible for leading engagement with families has received appropriate training and is supported to maintain competence in line with the NHS England expected standards. This will form part of our Trust PSIRF Implementation Plan.

7. Patient safety incident response planning

7.1 PSIRF supports organisations to respond to patient safety incidents in a way that maximises learning and improvement. Under PSIRF, responses are not based on arbitrary and subjective definitions of harm. Nor does PSIRF define set thresholds. Beyond national requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve.

7.2 Resources and training to support patient safety incident response

7.2.1 At present, a clinician that has completed training usually undertakes the role and responsibilities of the PSI investigator. Aqua* provides the training over three days. Learning Objectives for the training are:

- Apply a systems approach to human factors
- Describe the principles of human factors
- Recognise methods of intelligence gathering
- Apply programme learning to develop investigation recommendations and write the report
- Develop investigation techniques and apply them to a case study example

**Aqua stands for the Advancing Quality Alliance. Aqua is an NHS health and care quality improvement organisation*

7.2.2 To date, 38 members of staff have completed this training. The Divisions allocate their investigations to one or two of these individuals on a case-by-case basis.

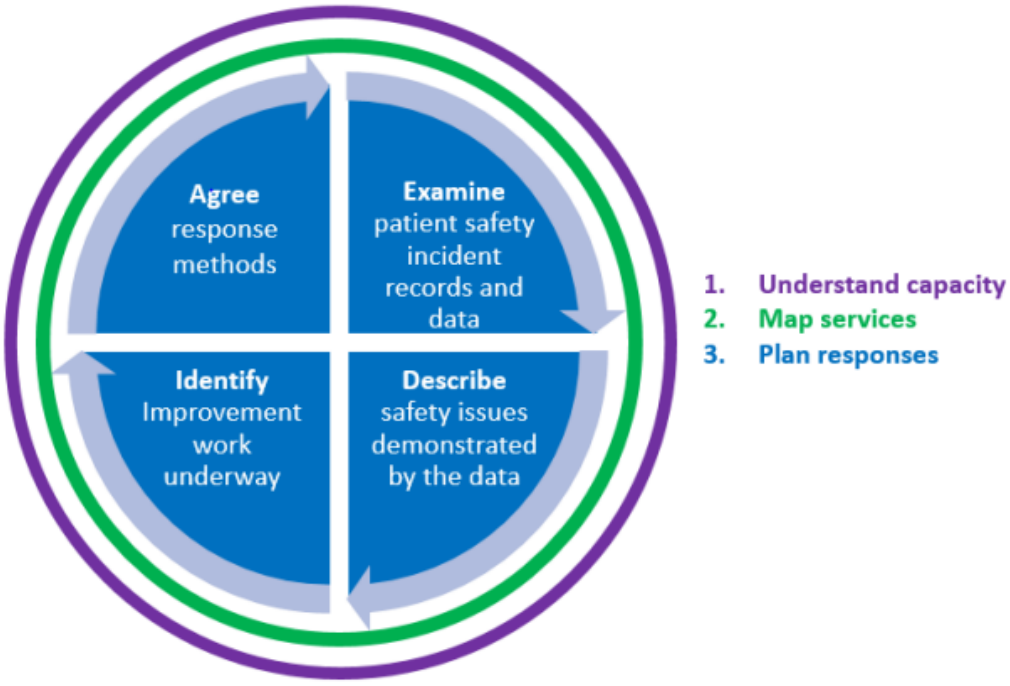
7.2.3 The Trust will continue with this process, ensuring anyone responsible for leading an investigation has the necessary dedicated time to do so and is supported to maintain competence in line with the NHS England expected standards. This will form part of our Trust PSIRF Implementation Plan.

7.2.4 This plan also includes the development of a support package for staff on how to use learning response tools as part of a wider rollout programme.

7.3 Our patient safety incident response plan

7.3.1 Our plan sets out how Bolton NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 months. Responding proportionately to balance learning and improvement efforts requires a thorough understanding of the local PSI profile and ongoing improvement work.

Figure 1. Patient safety incident response planning process (NHS England 2022)



7.3.2 We have developed our plan over a period of 12 months following review of information from a range of data sources including:

- Patient safety incidents reported via Safeguard 2020-2023
- Falls data 2021/2022 and 2022/2023
- Complaints data 2020-2023
- Claims data 2020-2023
- CNST Scorecard
- Pressure ulcer data 2021/2022 and 2022/2023
- Divisional review report of top 10 cause groups for incidents 2020-2023
- Quality Improvement Strategy
- Audits and NICE compliance
- Quality Improvement – local initiatives
- Learning from Deaths quarterly reports Q1-3 2022/23
- Integrated Performance Monitoring Reports Q1-3 2022/23
- Serious Incident investigation reports and action plans 2022-2023
- Divisional organisation and governance charts
- NHS Staff Survey 2022 Benchmarking Report and Breakdown Report

We have also engaged with multiple key stakeholders:

- Divisions via Divisional Governance meetings
- Family Care Division development session
- Monthly PSIRF Implementation Group meetings
- Bolton ICB (now NHS GM)
- Greater Manchester ICB (now NHS GM)
- Specialist nursing teams (Pressure ulcers, Enhanced care, Admiral nurse, learning disabilities)
- Staff experience manager
- Equality, diversity and inclusion programme manager
- BoSCA Lead
- North West Ambulance Service
- Greater Manchester Mental Health NHS Trust
- Healthwatch
- Patient representatives
- Director of Operations/Chair of the regional health inequalities enabling group
- Locality Systems Quality Group
- Divisional stakeholder workshop to stratify key themes

7.3.3 We undertook a service mapping exercise to ensure that the shape and structure of our plan reflects patient safety concerns for the range of services we offer.

7.3.4 Following collation and review of data, we were able to identify the top 15 most significant patient safety themes. By reviewing the current improvement work underway and engaging with stakeholders, we were able to narrow the list down to the top five patient safety themes.

7.3.5 To ensure this approach was consistent, measurable and comparable, we asked Divisions to rank the top 15 themes using the following matrix:

1. Are there any surprises?
2. Are there any themes you would add?
3. Using the matrix below give each theme a score from 1 to 5* (incl any themes you would add)
4. Rank the themes in order of priority/concern (1 being the highest priority)
5. Give each theme a total score

Level of harm**	Likelihood of harm**	Confidence in existing safety measures/ improvement work	Potential for new learning	Ranking	Total score

***Using the Trust matrix as per risk register*

7.3.6 We held a further workshop with key stakeholders from each Division across the Trust including relevant specialists. From this workshop, we were able narrow down the top five themes even further to identify specific areas. The Trust will focus PSI investigations on these areas in the next 12 months.

7.3.7 As part of the consultation process, we engaged with patient representatives and Healthwatch to gain feedback from people who use our services. We asked for their views on the top five themes and what they felt should be included in our plan.

7.3.8 There was a two-week stakeholder consultation period for the draft policy and plan in line with the Trust's procedural document development and management processes. We reviewed feedback and amended the draft documents accordingly. The final draft policy and plan were presented to Clinical Governance and Quality Committee and Quality Assurance Committee before finally being submitted to Trust Board for approval.

7.3.9 We have developed a specific chapter within the plan for Families services. This is to ensure the plan reflects some of the specific nuances of these services.

7.3.10 The plan aims to support the Trust to use resources effectively and enhance opportunities for learning and improvement. However, it is not a permanent set of rules and can be changed if appropriate. As well as the plan, we will remain flexible and consider the specific circumstances in which patient safety incidents occur and the needs of those affected.

You can find our full plan here.

7.3.11 The Trust recognises there will always be a reactive element in responding to incidents. We will always consider a response for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement. Even if they fall outside the issues or specific incidents described in the Trust's plan.

7.4 Reviewing our patient safety incident response policy and plan

7.4.1 Our patient safety incident response plan is a 'living document' that we will amend and update as we use it. We will review the policy 12 months from sign off to ensure our focus remains up to date. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

7.4.2 We will publish updated plans on our website, replacing the previous version.

7.4.3 A rigorous planning exercise will be undertaken at least every four years and more frequently if appropriate (as agreed with our NHS GM) 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, PSI investigation reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data)
- wider stakeholder engagement

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

8.1.1 The Trust's Incident Reporting Policy clearly describes internal and external notifications requirements for the reporting of patient safety related incidents. A copy of this policy is available for staff on the Trust's intranet.

8.2 Patient safety incident response decision-making

8.2.1 Determining level of patient safety incident responses

(See Appendix 2 for full process flowchart and Appendix 3 for an overview of the PSII escalation and decision making process)

8.2.2 Staff should use the flowchart in Appendix 2 along with the definitions below to determine the appropriate level of response to a patient safety incident. Appendix 3 provides an overview of the PSI escalation and decision making process.

LEVEL 1
Patient Safety Incident Investigation = Meets national requirement or local PSI plan priority. Present to weekly PSI Investigation Review Group to identify Investigation Lead and Engagement Lead. If an incident does not meet these criteria but represents a significant concern and/or new/emerging risk then escalate incident to weekly PSI Review Group meeting.
Method: SEIPS methodology/National report template, Full involvement of those affected (including staff).
Outcome: Informs new and ongoing safety/quality improvement work.

LEVEL 2
Divisional Patient Safety Learning Response = Incidents where contributory factors are not fully understood, Limited ongoing safety/quality improvement work, concerns raised by patient/family/other, areas of increasing reporting/concerns.
Method: Learning response toolkit, Local patient safety response, Lead appointed by Division.
Outcome: informs organisational safety/quality improvement work or leads to development of local safety improvement plan.

LEVEL 3
Service/specialty incident review = Low/no harm incidents not identified as a PSI response plan priority/ limited concerns, moderate harm incidents where contributory factors are fully understood and are linked to improvement work.
Method: local service/speciality to have oversight/review. Duty of candour process should still be followed in line with Being Open policy.
Outcome: Service/specialty improvement actions identified, informs ongoing improvement work

Acknowledgements: With thanks to East Lancashire NHS Trust

8.2.3 Patient Safety Incident (PSI) Review Group

8.2.4 The PSI review group meets weekly to review any patient safety incidents that have been triaged as either:

i) A national reporting priority

ii) A local priority as per the Patient Safety Incident Response Plan

iii) Incidents that do not meet these criteria but do represent a significant concern/a new or emerging risk.

8.2.5 The group is responsible for:

- Identifying any immediate risks and/or actions in response to escalated incidents.
- Monitoring emerging risks and triangulating with other known intelligence from risks, complaints, inquests, structured judgement reviews etc. to inform any required investigations, learning responses or improvement work.
- Making an evidence based decision as to whether an incident meets the criteria for a PSI investigation or alternative patient safety learning response

- Keeping a clear record of decision making rationale
- Keeping a log of possible future local priorities.

8.2.6 The group will provide a quarterly update to the Clinical Governance and Quality Committee

8.2.7 Responding to broad patient safety issues

8.2.8 We will allocate resources on a case-by-case basis to support responses to emergent issues that are not in the PSI Response Plan. Where we already have a good understanding of an incident type, it may be better to direct resources at improvement work rather than repeat investigation (or other type of learning response). For example, there have been thorough investigations into previous incidents of this type and/or we are implementing national or local improvement plans and monitoring for effectiveness.

8.2.9 PSI response planning may identify risks or broader patient safety issues that could benefit from focused improvement efforts. In such instances, we will consider other methods such as a thematic review to inform the development of safety improvement plans. Alternatively, we may perform a 'horizon scan' where we identify or predict pathway issues regardless of whether an incident has occurred.

8.2.10 Assessment to determine if a learning response is required

8.2.11 If it is not clear where an incident 'fits' in relation to our plan (i.e. whether a learning response is required), we will perform an assessment to determine whether there were any problems in care that require further exploration and potentially action. This may take the form of a case note review, rapid review and/or structured judgement review. We will assess these incidents on a case-by-case basis.

8.3 Responding to cross-system incidents/issues

8.3.1 Work with NHS GM is ongoing to ensure an agreed process is in place to identify and report cross-system issues. This way, the organisation can initiate and/or support the relevant response as required at the most appropriate level of the system.

8.4 Timeframes for learning responses

8.4.1 We will undertake a learning response as soon as possible after the incident is identified in line with the process described in section 8.2.

8.4.2 We will agree learning response timeframes in discussion with those affected, particularly the patient(s) and/or their families/carer(s), where they wish to be involved in such discussions.

8.4.3 Depending on discussions with those involved, we will complete MDT reviews within one month and Patients Safety Incident Investigations within one to three months. PSI Investigations will take no longer than six months.

8.4.4 SWARM Huddles will be completed as close to the incident as possible (and no later than 5 working days)

8.4.5 After Action Reviews will be completed within 5 working days of an incident occurring (and no later than 10 working days).

8.4.6 Timeframes for any other learning responses must be agreed on a case-by-case basis in line with principles outlined in this policy.

8.5 Safety action development and monitoring improvement

8.5.1 We will develop safety actions following a learning response using a SMART* approach to allow monitoring.

8.5.2 Learning from improvement work will be shared at divisional or organisational level through established internal quality and safety processes. Learning will also inform quality improvement work reported through internal governance systems including via Quality Accounts monitoring and reporting.

**SMART = Specific. Measurable. Achievable. Relevant. Time specific*

8.6 Safety improvement plans

8.6.1 A variety of safety improvement plans will be adopted based on context (local, organisational, system), other ongoing safety actions and sphere of influence (control, influence, escalate). Approaches will include:

- Organisation-wide safety improvement plan summarising improvement work
- Individual safety improvement plans that focus on a specific service, pathway or location
- Safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).
- Thematic safety improvement plan following review of learning responses from single incidents where there is sufficient understanding of the interlinked, underlying system issues/repeated themes.

8.6.2 There are no thresholds for when to develop a safety improvement plan. For example, after completing a certain number of learning responses. We will use knowledge gained through the learning response process and other relevant data to decide when a safety improvement plan is required.

8.6.3 To support alignment of safety improvement efforts across the Trust, Quality Improvement and Patient Safety sit centrally in the Trust's Governance Team. This ensures that the highest risks and themes are key quality improvement priorities. In

turn, patient safety will mutually inform the deliverables of the quality improvement strategy (and vice versa). There is evidence of this in the work of Trust wide collaborative work on key aspects of harm free care such as pressure ulcers, falls and infection prevention and control.

9. Oversight roles and responsibilities

9.1 The Trust Board

9.1.1The trust board (or those with delegated responsibility, including members of board quality sub-committees), is responsible and accountable for effective patient safety incident management in the organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations where required.

9.1.2 The 'oversight mindset' principles described in the *Oversight Roles and Responsibilities Guidance* (NHS England, 2022) underpin our approach to oversight. However, further work is required to embed and sustain these principles throughout the organisation.

9.2 Executive Lead for Patient Safety and PSIRF Implementation

9.2.1 The Chief Nurse and Medical Director hold delegated executive responsibility for quality and patient safety, with the Chief Nurse designated as Executive PSIRF lead. In line with NHS England Oversight Roles and Responsibilities guidance, are responsible for:

- Ensuring the organisation meets national Patient Safety Incident Response Standards.
- Ensuring PSIRF is central to overarching safety governance arrangements
- Quality assuring learning response outputs

9.2.2 To support the Board and its Executive Leads in fulfilling the requirements of PSIRF, a gap analysis of the incident response standards has highlighted areas for development and strengthening as follows:

- Rollout of this policy and the PSI Response Plan will support staff to understand the roles and responsibilities in relation to PSI response. We will provide further training in the PSIRF approach and supporting methodologies.
- Learning responses, particularly PSI investigations, are currently undertaken by staff as part of their existing job role. The Trust will continue to use appropriately trained staff to complete investigations with support from experts/clinicians/staff where possible. However, we will also ensure anyone responsible for leading an investigation has the necessary dedicated time to

do so and is supported to maintain competence in line with the NHS England expected standards.

- Similarly, we will ensure anyone responsible for leading engagement with families has received appropriate training and is supported to maintain competence in line with the NHS England expected standards.
- Mechanisms are in place to support staff affected by patient safety incidents and enable them to take part in learning responses but our approach is inconsistent. We will develop a standard support package for staff.
- Staff knowledge and application of the different learning response tools is inconsistent and training is variable. In addition to general PSIRF training, we will provide a series of workshops and troubleshooting clinics as part of the PSI response plan and policy rollout.
- Whilst subject matter experts with relevant knowledge and skills are involved throughout the learning response process, there is no consistent approach. Involvement of subject matter experts is usually limited to those with specific clinical knowledge as opposed to broader patient safety/human factors expertise. Rollout of the National Patient Safety Syllabus and dedicated human factors training will raise awareness of these areas.
- All learning response leads will have to complete level one (essentials of patient safety) and level two (access to practice) of the patient safety syllabus as part of their mandatory training. At present, completion of this training is voluntary and is therefore not in line with the expected standards.
- In line with expected standards, we must ensure that 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.

9.2.3 A Trust PSIRF Implementation action plan will support rollout of this policy and our PSI Response Plan. The plan identifies the actions required to develop and embed PSIRF principles and was submitted to the Board for approval along with this policy and the PSI Response Plan. Completion of this action plan will be monitored via quarterly Patient Safety Specialist updates to Clinical Governance and Quality Committee.

9.3 Integrated Care Boards

9.3.1 The Trust will work in collaboration with NHS GM to develop, maintain and review this policy and our PSI Response Plan.

9.3.2 We will also work closely with NHS GM, LMNS, GMEC plus any other networks/groups identified through the ongoing development of the plan to support cross-system learning responses, effectiveness of systems and achieve improvement following a patient safety incident.

9.4 Care Quality Commission and Other Regulatory Bodies

9.4.1 The Trust will continue to inform the CQC of high profile and complex incidents, as well as complying with all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

10. Complaints and appeals

10.1 As described in section 6, the Trust recognises the importance of compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). As such, we will assign an engagement lead as part of the PSI response process. Their role is to liaise with the patient and/or their representative, families and staff and:

- Provide those affected with clear information about the purpose of a learning response and what to expect from the process.
- Ensure those affected by a patient safety incident are signposted to relevant support services as needed.
- Adopt a flexible approach to the individual and changing needs of those affected. Ensure those affected are listened to, share their experience, have the opportunity to ask questions and inform the terms of reference of a learning response.

10.2 Those affected by a patient safety incident should raise any complaints or concerns regarding the PSI response process with the Engagement Lead initially where possible.

10.3 However, if attempts to resolve any issues are unsuccessful or if a patient wishes to make a formal complaint, patients can do so via the Trust's complaints process.

11. References

Patient Safety Incident Response Framework, NHS England 2022: NHS England » Patient Safety Incident Response Framework

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients 2019: Report template - NHSI website (england.nhs.uk)

Bolton Locality Plan, Bolton Council, 2016: Local plan – Bolton Council

Our Strategy: For a Better Bolton 2019-2024, Bolton NHS Foundation Trust, 2019: Our strategy - Bolton NHS FT (boltonft.nhs.uk)

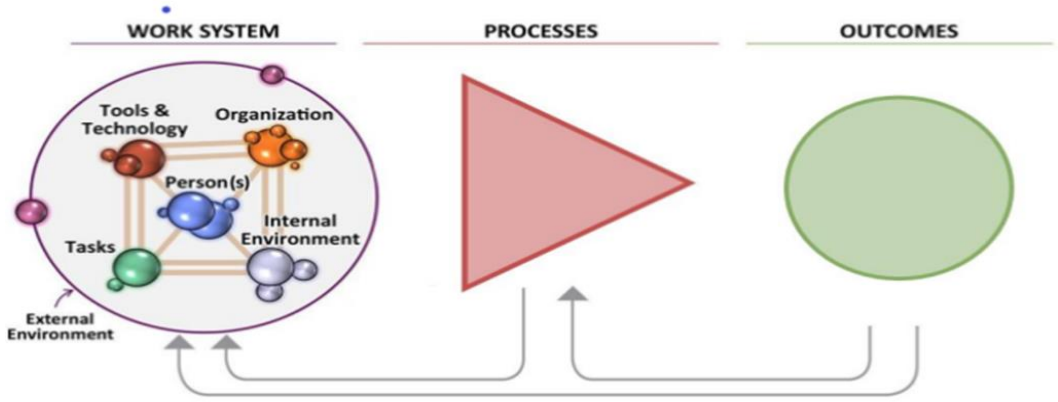
Bolton NHS Foundation Trust: Our Quality Account 2022/23: Bolton-NHS-Foundation-Trust-Quality-Account-2022-23.pdf (boltonft.nhs.uk)

Restorative Just Culture: Home - Sidney Dekker

Appendix 1 Systems Engineering Initiative for Patient Safety (SEIPS) Overview

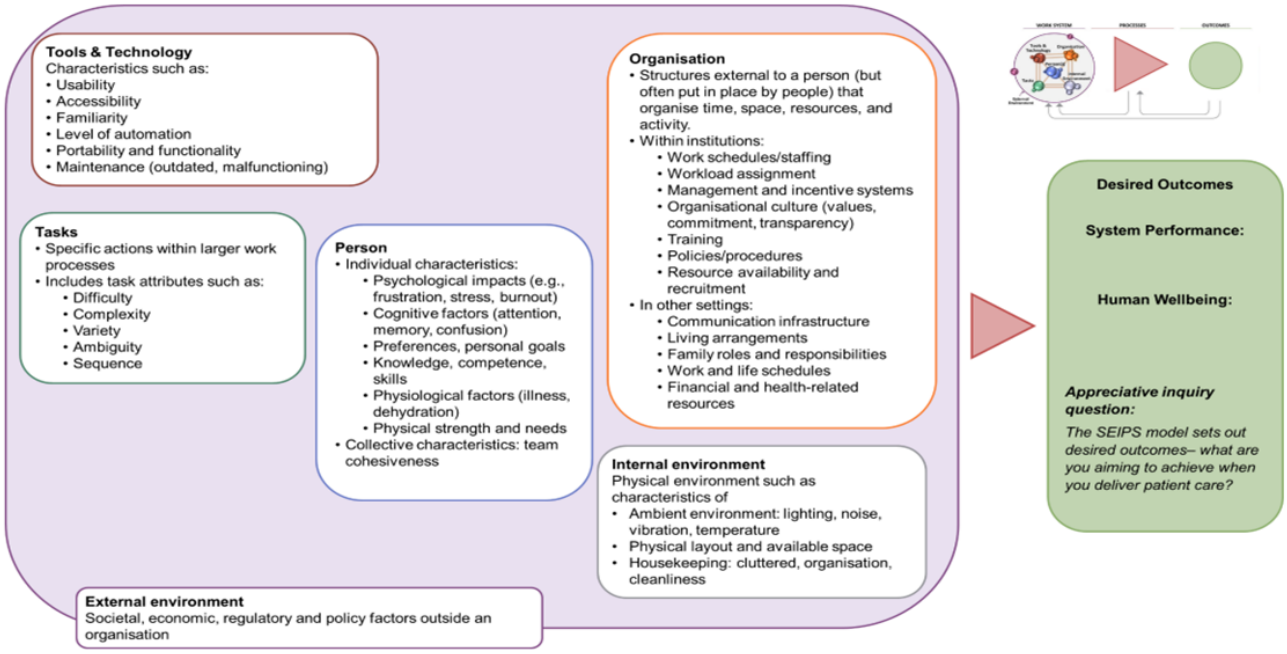
SEIPS is a Framework for understanding complex socio-technical systems. The figure below shows how a work system (or socio-technical system) can influence processes ('work done') which in turn shapes outcomes.

Figure 1. Overview of the SEIPS framework



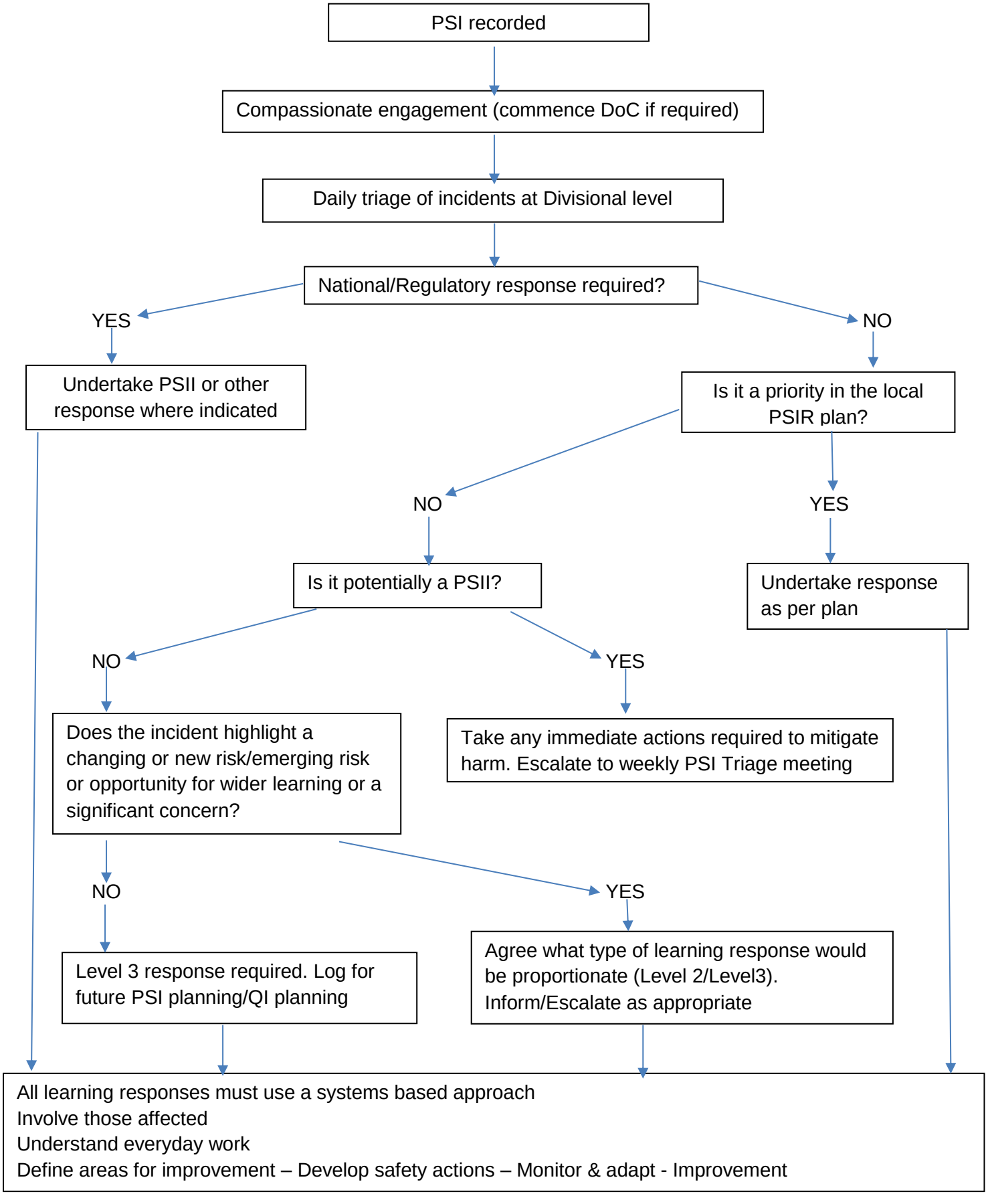
People cannot be separated from the work system; their deliberate placement at the centre emphasises that design should support – not replace or compensate – people. A 'work system' consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s).

Figure 2. Overview of the SEIPS work system

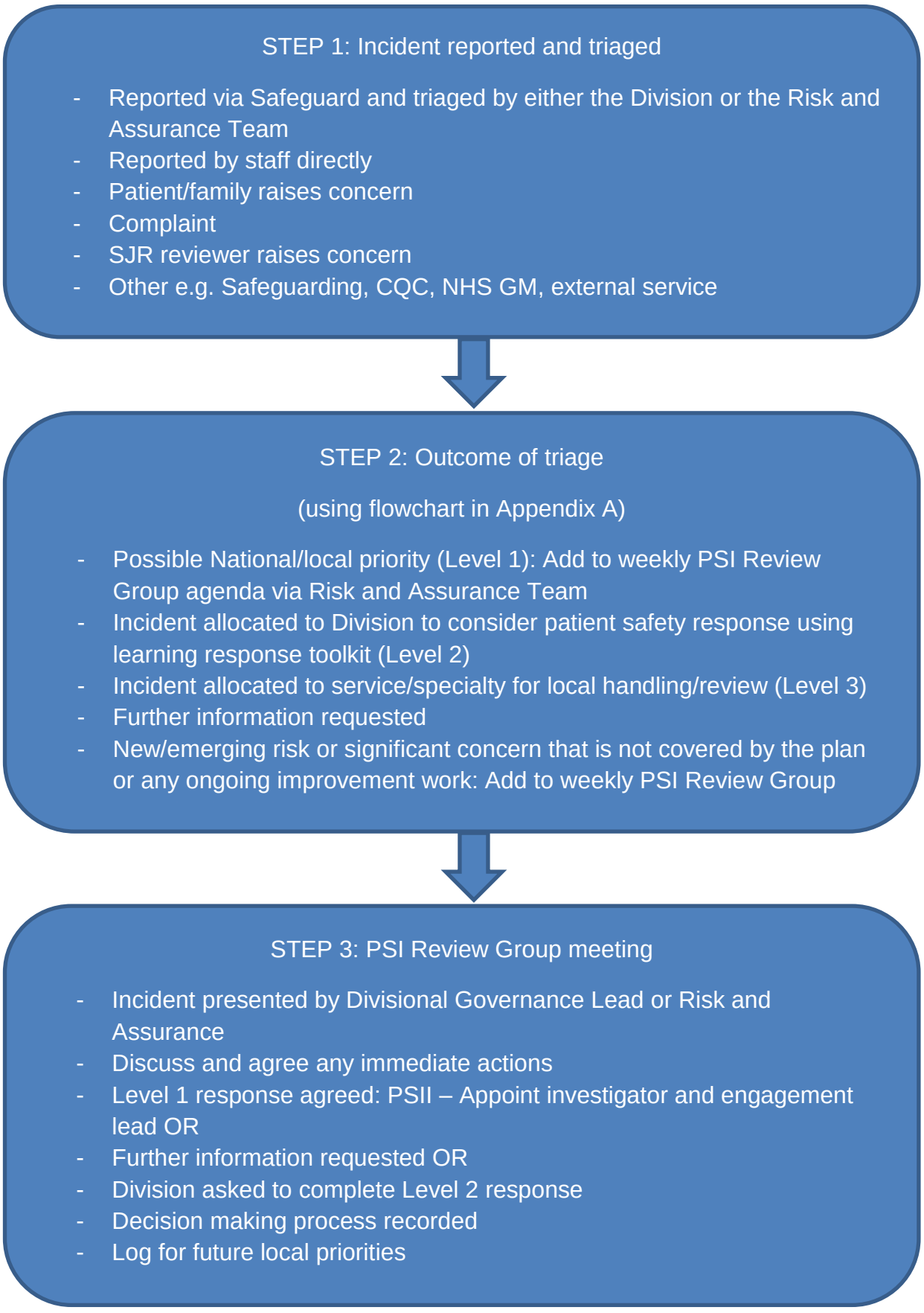


NHS England has produced guidance along with a 'works system' blank template to record findings and learning. Copies of both documents can be found in the Learning Resources Toolkit on the Trust Intranet.

Appendix 2 Determining the level of patient safety incident response required



Appendix 3 PSI Escalation and Decision Making Process



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