Vision | Openness | Integrity | Compassion | Excellence

NHS Bolton NHS Foundation Trust

# Patient Safety Incident Response Policy

## Effective date: March, 2026

## Version Control

| Version | Type of change | Date | Revisions |
|---|---|---|---|
| 1 | New document | November 2023 | - |
| 2 | Full Review | January 2026 | Updated to align to current NHSE PSIRF requirements and Trust Patient Safety incident Response Plan |

# Contents

# Glossary

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|---|---|
| PSII | Patient Safety Incident Investigation |
| PSIRF | Patient Safety Incident Response Framework |
| PSIRP | Patient Safety Incident Response Plan |
| SEIPS | Systems Engineering Initiative for Patient Safety |
| PSPs | Patient Safety Partners |
| MNSI | Maternity and Newborn Safety Investigations |
| 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. |
| AAR | After Action Review |
| MDT | Multi disciplinary Team |
| NHS GM | NHS Greater Manchester |
| LMNS | Local Maternity and Neonatal Systems |
| GMEC | Greater Manchester and Eastern Cheshire Strategic Clinical Networks |

# Purpose

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

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

This policy supports development and maintenance of an effective patient safety incident response system. It integrates the four key aims by:

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

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

# Scope:

Responses following patient safety incidents follow a systems-based approach. The Trust will use the Systems Engineering Initiative in Patient Safety Framework (SEIPS).

This system based approach recognises that healthcare delivery requires many interactions between various components. It prompts to look for interactions rather than simple linear cause and effect relationships.

It aims to examine the different work system components of compassionateengagement and involvement, system based approaches to learning, considered and proportionate responses ans upportive oversight for system functioning and improvement. and their interactions focusing on wider system issues, not individuals.

The Patient Safety Incident Response Policy and Patient Safety Incident Response Framework do not include non-patient safety incidents. Non patient safety incident could include information governance, health and safety or estates and facilities incidents of which there are processes in place for reporting and responding to these. Details are available in the Trust Incident Reporting Policy.

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.

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 as listed below and are outside the scope of this policy.

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

# Our Safety Culture

All staff, substantive/NHSP or Locum, can report incidents via the Trust incident reporting and management system on the Trust intranet. The incident reporting system must focus on what needs to change rather than punitive actions.

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 'Freedom to Speak up- Raising Concerns' Policy sets out the process for staff members to raise concerns confidentially.

By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

The patient safety culture across the Trust is that of compassion, understanding and engagement of those affected by patient safety incidents. This includes patients, their families, and the Trust staff. The engagement lead role is vital in driving the improvements for patient and families; however, this approach will also be adopted by all staff.

Patient safety incidents are usually signs of underlying systemic issues that require wider, system-level action. Action singling out an individual is rarely appropriate.

As well as learning from incidents, the Trust is committed to learning from excellence by reporting what goes well and using those insights to make today's excellent care the standard care of the future.

# Patient Safety Partners

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 is sfundamental to the way we understand, learn and improve patient safety and includes:

- 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.

The Trust presently has one Patient Safety Partner in post. The long-term aim is to increase the number of PSP's to support Trust representation of the community we serve.

The role of the PSPs is to:

- Help make sure patient safety is at the forefront of all we do.
- Join membership of safety and quality committees.
- Have involvement in patient safety improvement projects.
- Work with the Trust Board to consider how to improve patient safety.
- Have involvement in staff patient safety training.
- Participate in investigation oversight groups.

# Addressing Health Inequalities

Addressing health inequalities is an organisational priority and will feature in a range of quality improvement and quality assurance processes.

This will include but not be limited to the continuous implementation of the Patient Safety Incident Response Framework.

Learning identified through patient safety responses under the Patient Safety Incident Response Framework has already identified improvements required regarding support for effective communication with patients who have additional requirements due to physical disabilities.

- Patient safety responses will continue to consider health inequalities through a variety of routes as listed below
- Targeted analysis of incident themes related to inequality
- Engagement with underserved or marginalised patient groups
- Using data to identify variation in access, outcomes, or experience
- Embedding equality considerations in all learning responses
- Working with partner organisations to address wider determinants of health
- Reviewing improvement actions to ensure they reduce—not widen—gap

These routes will also consider:

• Outcomes for patients across a range of specific characteristics to ensure any unwarranted variation is identified as an area for improvement for consideration through the use of the four PSIRF learning response tools:

- SWARM
- After Action Review
- Multidisciplinary Team review and
- Patient Safety Incident Investigations.

• We will provide tailored support to help all patients take part in patient safety learning, focusing on the unique insights each person can contribute and removing any barriers to their participation.

• During recruitment of PSPs consideration will be given to diversity and where gaps in partners with specific characteristics are identified, active recruitment will be led to ensure diversity in this key stakeholder group.

# Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

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.

All patients and families will be treated with respect, dignity, openness, and transparency at all times and including following a patient safety incident.

All patient safety incidents will be reported utilising the Trust incident reporting and management system.

Patients, and families as appropriate, will be provided with full details of the patient safety incident and offered support initially by the clinical team involved in their care. Further support for patients and their families following a patient safety incident will utilise the key role of a Divisional Engagement Lead.

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).*

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.

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).

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 through the Duty of Candour process. 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.

# Patient Safety Incident Response Planning

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.

# Resources and Training to Support Patient Safety Incident Response

At present, a Bolton NHS Trust staff member that has completed training usually undertakes the role and responsibilities of the PSI investigator.

Aqua* provides the training over two/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*

The Divisions must allocate their investigations to one or two of these individuals on a case-by-case basis.

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.

The Patient Safety Incident Responses will fall into four main categories:

• Swarm Huddle

• After Action Review (AAR) or a Mulltidisciplinary Review (MDT)

• Thematic Review

• Patient Safety Incident Investigation (PSII)

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.

# Our patient safety incident response plan

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 PSII profile and ongoing improvement work. This can be found on the Trust intranet.

- **Reviewing our patient safety incident response policy and plan**

  Our patient safety incident response plan is a 'living document' that we will amend and update as we use it. The policy will be reviewed in line with the Trust's procedural requirements—every three years or sooner if needed—to ensure it remains current and focused. We will publish updated policy and plan on our Trust internal and external website.

# Responding to Patient Safety Incidents

### Patient safety incident reporting arrangements

- 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.

### Patient safety incident response decision-making

Staff should use the flowchart in Appendix 1 along with the definitions below to determine the appropriate level of response to a patient safety incident.

| LEVEL 1 |
| --- |
| **Patient Safety Incident Investigation**: Meets national requirement or local PSII plan priority. If an incident does not meet these criteria but represents a significant concern and/or new/emerging risk then escalate incident to weekly Quality Divisional Governance Update 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**: In line with PSIRF, this includes low or no-harm incidents that are not prioritised in the PSII response plan or present limited concerns, as well as moderate-harm incidents where contributory factors are already well understood and linked to existing 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 |

## Quality Governance Divisional Weekly Update Meeting

The Quality Governance Divisional Update Group meets weekly to review any patient safety incidents that have been triaged as either:

- A national reporting priority
- A local priority as per the Patient Safety Incident Response Plan
- Incidents that do not meet these criteria but do represent a significant concern/a new or emerging risk.

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.

## Responding to broad patient safety issues

Resources will be allocated on a case-by-case basis to support responses to emergent issues that are not in the Patient Safety Incident 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.

Patient Safety Incident response planning may identify risks or broader patient safety issues that could benefit from focused improvement efforts. In such instances, other methods will be considered such as a thematic review to inform the development of safety improvement plans.

## Assessment to determine if a learning response is required

If it is not clear where an incident ‘fits’ in relation to our plan (i.e. whether a learning response is required), divisional governance teams 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. These incidents will be assessed on a case-by-case basis.

## Responding to cross-system incidents/issues

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.

## Timeframes for learning responses

We will undertake a learning response as soon as possible after the incident is identified in line with the process described in 'patient safety incident response decision-making' section .

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.

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.

**SWARM** Huddles will be completed as close to the incident as possible or within a reasonable timeframe decided by the Divisional Governance teams of where the incident occurred.

**After Action Reviews** will be completed within or within a reasonable timeframe decided by the Divisional Governance teams of where the incident occurred.

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

## Safety action development and monitoring improvement

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

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*

### Safety improvement plans

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.

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.

To support alignment of safety improvement efforts across the Trust, Quality Improvement and Patient Safety sit centrally in the Trust's Quality 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).

## Complaints & Appeals

The Trust is focused on quality improvement and supporting those affected by patient safety incidents, therefore it is expected that all actions to support a proportionate and thorough investigation following a patient safety event will be delivered.

This process should be fully inclusive of the considerations for those affected by the incident, however where patients and or families / friends do not feel the response to the patient safety incident has been appropriate or that they have not been supported appropriately via the Engagement Lead process a right to raise a concern or complaint will remain.

All people affected by a patient safety incident who wish to raise a concern or complaint can do so via the Patient Experience Team email address complaints@boltonft.nhs.uk or PALS@boltonft.nhs.uk

# Oversight roles and responsibilities

## The Trust Board

The 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.

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 continue to embed and sustain these principles throughout the organisation.

### Executive Lead for Patient Safety

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

**Director of Quality Governance** will support the Chief Nurse with all elements of their portfolio in relation to Patient Safety. The Director of Quality Governance has overall responsibility as the lead manager for the Trust's patient safety function and will provide strategic direction in relation to the implementation of this policy and the Patient Safety Incident Response Plan. They will also ensure that all staff who work within the Quality Governance department structure and within the remit of supporting this policy and patient safety incident response plan have clearly defined roles and responsibilities included within their specific job descriptions.

**Assistant Director of Quality Governance** will support the Director of Quality Governance with all elements of their portfolio and provide senior day to-day leadership in relation to patient safety which includes ensuring the successful implementation of this policy and Patient Safety Incident Response Plan.

**Head of Quality Governance & Patient Safety Specialist:** will operationally manage the patient safety function within the Trust. This includes ensuring an appropriate system is in place for staff to report, manage and investigate patient safety events. They will be responsible for maintaining this policy.

**Divisional Governance Teams** will have responsibility for adhering to, championing and supporting the implementation of this policy within the remits of their identified portfolios. They will ensure emerging themes and trends are escalated as and when appropriate. Respond to patient safety events appropriately and proportionately and ensure any learning identified as part of any patient safety activity is assessed, discussed at Divisional level for oversight and shared through established routes as appropriate.

**Family Liaison and Engagement Lead:** Family Liaison and Engagement Leads are responsible for ensuring appropriate support is offered to the patient/family/carers. They will confirm any questions of concern the family/patient/carer would like to include as part of the key lines of enquiry of an investigation. They will act as the link person for the patient/carer/family and ensure they are given the opportunity to provide relevant information that may inform the outcome of the investigation and linking in with the Patient Safety Incident Investigation Lead.

**Patient Safety Partners** will play an essential role by ensuring the voice of patients, families and carers is heard at all levels within the organisation in relation to patient safety activity.

**Patient Safety and Risk Team** will support the Head of Quality Governance & Patient Safety Specialist with the implementation of this document.

**All other staff** across the organisation are responsible for ensuring any patient safety event is reported into the Trust Incident reporting system at the earliest opportunity. All staff will also be required to refer and adhere to this plan.

## Integrated Care Boards

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

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.

## Care Quality Commission and Other Regulatory Bodies

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.

# References

Patient Safety Incident Response Framework, NHS England 2022
The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients 2019
Bolton NHS Foundation Trust Quality Account 2024/2025
Bolton NHS Foundation Trust Our Trust Strategy 2024-2029
Patient Incident Response Plan
Incident Reporting Policy
Being Open Policy
Risk Management Policy and

## Appendix 1: Determining the level of patient safety incident response required

### PSII Recorded

### Compassionate Engagement

- Commence Duty of Candour (DoC) if required.

### Daily Triage of Incidents at Divisional Level

### National/Regulatory Response Required?

- If **YES** → Undertake PSII or other response where indicated.
- If **NO** → Continue to next decision point.

### Is it a priority in the local PSIR plan?

- If **YES** → Undertake response as per plan.
- If **NO** → Consider if potentially a PSII.

### Is it potentially a PSII?

- Take any immediate action to mitigate harm.
- Escalate to weekly PSI triage meeting.

### Does the incident highlight a changing/new risk, opportunity for wider learning, or significant concern?

- If **YES** → Level 3 response required; log for future PSI/QI planning.
- If **NO** → Agree proportionate Level 2/Level 3 response and inform/escalate as appropriate.

### All learning responses must include:

- Use a systems-based approach.
- Involve those affected.
- Understand everyday work.
- Define areas for improvement.
- Develop safety actions.
- Monitor, adapt, and improve.

## Appendix 2: PSII Process – Two-Page Quick Guide

**1. Incident Identified**
Incident occurs and is logged on Safegaurd
Initial review completed by the Division

**2. Escalation Decision**
If appropriate, completed PSII review tool (Appendix 3) escalated to Director / Assistant Director of Quality Governance/Head of Quality Governance & Patient Safety Specilaist and Patient Safety & Risk Team.

**3. PSII Criteria Decision (within 2 days)**
PSII Review tool reviewed by Director / Assistant Director of Quality Governance or Executive Team Division

**4A. If NOT PSII**
Alternative review considered (AAR / MDT)
Any review to be completed within 6 weeks as minimum timeframe
Incident updated/closed on the Trust incident reporting and management system

**4B. If PSII**
PS&R Team updates Trust incident reporting and management system and STEIS (same day)
PSII Review Panel arranged within 5–7 days.
If Chair not available withinin that timeframe must be arranged for the next available date/time.
Review panel organizer must ensure all on the agreed distribution list are invited.
Review panel organizer must also check with relevant division if other staff are required to attend and forward invite to them.

**5. Investigation & Report**
Named investigator issued PSII template
Draft report submitted on or before the timeframes provided or extension requested to Director of Quality Governace
Draft review by Director / Assistant Director of Quality Governance or Executive Team
Division and sent back to division if amendments required.

**6. Patient Safety & Risk Team**
PSII Sign off Panel to be arranged within 10 working days of the 60 day PSII deadline.
If Chair not available withinin that timeframe must be arranged for the next available date/time.
Review panel organizer must ensure all on the agreed distribution list are invited.
Review panel organizer must also check with relevant division if other staff are required to attend and forward invite to them

**7. Executive Review & Sign-Off**
Medical Director / Chief Nurse review
Sign-Off Panel held
If amendments required, complete within 5 days

**7. Closure & Learning**
Actions agreed and uploaded to the Trust incident reporting and management system
STEIS updated
Report shared with family as agreed
Incident closed

## Appendix 3: PATIENT SAFETY INCIDENT INVESTIGATION – PROCESS CHART

**Initial review of incidents undertaken by division**

If deemed appropriate –incident details esclated to Director of Quality Governace/Assistant Director or Quality Governance for review using PSII review tool (*Appendix 3*)

PSII reviewed by Director of Quality Governance/Assistant Director of Quality Governance/Executive team – decision made within 2 days

**Incident does not meet PSII criteria**
division informed same day

Division decide if any other means of review is required if learning is identified - i.e AAR or MDT.

To be completed within 6 weeks

Incident updated/closed on Trust incident reporting and management system by division following competion of any actions

**Incident meets PSII criteria**
division informed same day

PS&R team to arrange a PSII review panel meeting within 5-7 days

PS&R team – Trsust Incident reporting and management system updated /STEIS reported that incident meets PSII criteria

Following review panel the psii investigation tool template emailed to named investigator deadlines for submission of draft report to ps&r team within 1 day of review panel

**Sign off panel to be booked**

Division to submit draft PSII report to PS&R team following approval within their divisional teams by given submission date. If report not ready for submission within timeframes an extension request proforma must be submitted (*Appendix 3*)

Draft PSII report to be reviewed by Quality Director of Governance/Assistant Director of Quality Goverance within 3 days of receipt

**REPORT NOT APPROVED**

Returned to division to amend/update & re-submit to PS&R team within 2 working days

**REPORT APPROVED.**

To be forwarded to Medical Director/Chief Nurse for final review/approval

Draft PSII report reviewed by Exec team to be sent back to division if any comments and returned minimum 2 days before sign off panel. If not received in time sign off panel to be rescheduled

PS&R team rearrange a sign off panel meeting if required

(combine papers to attach to diary invite)

**PSII SIGN OFF PANEL TAKES PLACE.**

Report not approved – amendments required to be completed within 5 days for either virtual approval or teams sign off panel as decided by the chair.

If report is not received PS&R team escalate to Director of Quality Governance, Assistant Director of Quality Governance to then escalate to the division

Report and action plans agreed/approved by Executive team

Actions uploaded to Trust incident reporting and management system – by PS&R team

Division inform action owners of actions

Steis updated by PS&R Team

Approved report shared with family by division or chief nurse as agreed

## Appendix 4: Patient Safety Incident Investigation (PSII)

### Formal Extension Request

**To Note:**

- Any extension request must be received at the earliest opportunity and no later than 5 working days before submission date.
- The extension request must only be made from a DND, DMD or DDO.

| | |
|---|---|
| Incident Number | |
| Date incident occurred | |
| Date of PSII Review Panel | |
| Date of planned PSII sign off panel | |
| 60 day Deadline Date | |

| | |
|---|---|
| Name of Investigation Lead | |
| Name of Investigation Support | |

| **Category of PSII declared** | **Tick relevant category (✓)** |
|---|---|
| Never Event | |
| Death thought more likely than not due to problems in care | |
| Mental health-related homicide | |
| Death of a patient detained under the Mental Health Act thought more than likely due to problems in care | |
| Child Death | |
| Death of a person with Learning Disability | |
| Cancer patient or management of patient with pre-malignant condition lost to follow up. | |
| Discharge/Transfers of care (patients 75+) failure to provide adequate information. | |
| VTE Failure to reassess within 24 hours and/or subsequent reassessment following changes to a patient's condition. | |

| | |
|---|---|
| Medication administration – missed critical medication in ED or community with failure to escalate. | |
| Neonatal unexpected admission, identification and management of sepsis | |

| |
|---|
| I am formally requesting an extension for this PSII which was due submission on **(add submission date)** for a new submission date **(add timeframe including date).**<br><br>The reason for this request is **(add reason why)** |

| | |
|---|---|
| **PSII report is required at inquest** | Yes / No *# delete as appropriate* |
| Date of Inquest | |
| | |
| **PSII report is required to inform a complaint response** | Yes / No *# delete as appropriate* |
| Date report required | |

| **Patient/Relative/NOK** |
|---|
| Provide details of how and when the Patient/Relative/NOK (*# delete as appropriate)* will be updated that the original deadline will not be met. |

| | |
|---|---|
| **Date requested:** | |
| **Requested by:** | |
| **Division:** | |

| | |
|---|---|
| **Approved by Director Of Quality Governance** | Yes / No *#delete as appropriate* |
| **Date request approved:** | |