

Operations

# PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

## Oversight roles and responsibilities specification

Number:	OPS-005.2
Version:	1
Purpose:	<p>This patient safety incident response plan is <i>part of the Patient Safety Incident Response Policy (OPS-005)</i> and sets out how Gloucestershire Health and Care NHS Foundation Trust (GHC) intends to <b>respond</b> to patient safety incidents over 12–18 months. The plan is not permanent: we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.</p> <p>The plan is underpinned by our Trust policies on incident reporting and investigation available to all staff via our organisation’s intranet (available to staff only).</p>
Consultation:	Engagement with key stakeholders within the Trust.
Approved by:	GHC Trust Board and Ratified by ICB
Date approved:	25 January 2024
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Date issued:	25 January 2024
<b>Review date:</b>	<b>01 October 2024</b>
Executive Lead:	Medical Director
Audience:	All GHC Employees
Dissemination:	Comms and published on the GHC intranet.

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## TABLE OF CONTENTS

1.0 INTRODUCTION	3
2.0 OVERSIGHT MINDSET	4
3.0 OVERSIGHT APPROACH	5
4.0 ORGANISATIONAL RESPONSIBILITIES	7
5.0 PROVIDERS OF NHS-FUNDED CARE	7
6.0 INTEGRATED CARE BOARD	12
7.0 NHS ENGLAND NATIONAL PATIENT SAFETY TEAM	18
8.0 CARE QUALITY COMMISSION	18
9.0 OTHER TYPES OF REVIEW AND/OR INVESTIGATION	19
10.0 IMPROVING INCIDENT RESPONSE THROUGH COLLABORATIVE EXTERNAL REVIEW	20
APPENDIX 1: RIIT incident response process	22

### **Please note:**

- Patient Safety Incident Response Policy (OPS-005)
- Patient Safety Incident Response Plan (OPS-005.1)

## 1.0 INTRODUCTION

The leadership and management functions of patient safety incident response framework (PSIRF) oversight are wider and more multifaceted compared with previous response approaches.

When working under PSIRF, Gloucestershire Health and Care NHS Foundation Trust (GHC) has sought to design the systems for oversight “in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures”.<sup>1</sup>

To achieve this, GHC has looked carefully not only at what we need to improve but also what we need to stop doing (e.g. panels to declare or review Serious Incident investigations).

Oversight of the patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. This will cease when the PSIRF becomes embedded within GHC.

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<sup>1</sup>[A framework for measuring and monitoring safety - The Health Foundation](#)

## **2.0 OVERSIGHT MINDSET**

The following 'mindset' principles should underpin the oversight of patient safety incident response.

### **2.1 Improvement is the focus**

PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

### **2.2 Blame restricts insight**

Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.

### **2.3 Learning from patient safety incidents is a proactive step towards improvement**

Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

### **2.4 Collaboration is key**

A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.

### **2.5 Psychological safety allows learning to occur**

Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.

### **2.6 Curiosity is powerful**

Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

### **3.0 OVERSIGHT APPROACH**

The following principles will be considered when designing and maintaining PSIRF oversight systems and processes.

#### **3.1 Use a variety of data**

GHC will avoid using single measures to learn from patient safety incidents. We will triangulate a mixture of qualitative and quantitative measures to get a clear understanding of the effectiveness of the patient safety incident response systems and processes in place.

Data can be outcome or process based and it is important to use both.

#### **3.2 Reduce the information-collection burden**

Oversight can often lead to excessively complex or burdensome data collection, form filling and report generation. This is not the intention of incident response oversight.

The focus should be on supporting our capacity to deliver healthcare safely, rather than on purely administrative activity.

#### **3.3 Oversight is not ‘one size fits all’**

Monitoring must be customised to local settings where appropriate; while some questions may need to be standardised, a ‘one size fits all’ approach does not exist.

**Tables 1 and 2**, which appear later in this document, outline potential oversight questions in more detail.

#### **3.4 Capture meaningful insight from patients, families, and staff**

Patients, families, and staff affected by patient safety incidents can provide some of the best and most pertinent warnings of poorly functioning patient safety incident response systems. Priority should be given to capturing meaningful patient-, family- and staff-centred metrics for learning and improvement (see also

[NHS England » Patient Safety Incident Response Framework and supporting guidance](#)

Organisations should ensure that Patient Safety Partners are involved in developing and delivering PSIRF oversight processes, and patient groups such as local Healthwatch will be involved to provide insight into the strength of patient safety incident response systems.

#### **3.5 Metrics require clarity and purpose**

The purpose of any safety metric collected for patient safety incident response oversight must be clear. All relevant stakeholders will understand what is being measured and how often.

GHC will consider the following criteria when defining safety measures (taken from [A framework for measuring and monitoring safety - The Health Foundation](#)

- Who is each safety measure developed for?
- How and in what context will the safety measure be used?
- Is it measuring what it claims to measure?
- Can this metric be used reliably to detect or demonstrate deterioration or improvement?
- What untoward consequences will this metric have?

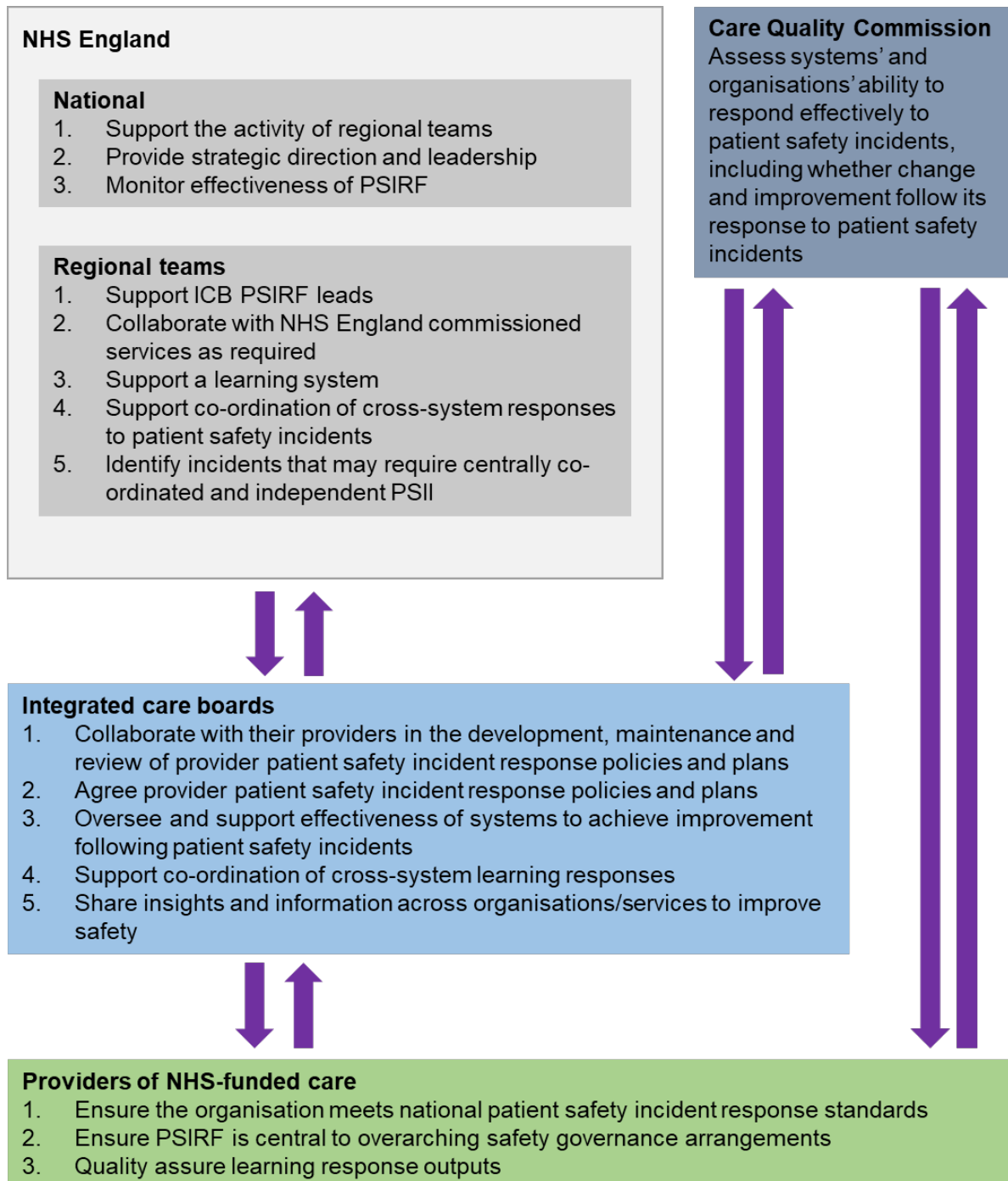
### 3.6 **Be aware of perverse incentives**

An approach that looks promising may, in practice, have a variety of unforeseen and unwanted consequences.

Monitoring can lead to gaming and 'box ticking' behaviour that misses the important purpose of incident response oversight.

## 4.0 ORGANISATIONAL RESPONSIBILITIES

This section describes the organisational responsibilities in relation to PSIRF oversight, an overview of which is shown in **Figure 1**.



**FIGURE 1** Organisational responsibilities for an effective governance structure.

## 5.0 PROVIDERS OF NHS-FUNDED CARE

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 their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

## 5.1 Appointment of a PSIRF Executive Lead

The Trust Board has identified a PSIRF Executive Lead to support the responsibilities outlined below. The Lead will provide direct leadership, advice, and support in complex/high-profile cases, and liaise with external bodies as required.

The Medical Director is a member of the Board and equipped (through training and professional development) with up-to-date safety skills, knowledge and experience as described in the

[B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf \(england.nhs.uk\)](#)

### PSIRF Executive Lead responsibilities

#### *1. Ensure the organisation meets national patient safety incident response standards*

The PSIRF Executive Lead, supported by the rest of the Board/leadership team, must oversee the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring they meet the expectations set out where relevant in the

[NHS England » Patient Safety Incident Response Framework and supporting guidance](#)

#### *2. Ensure PSIRF is central to overarching safety governance arrangements*

The Board or leadership team must have access to relevant information about their organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents.

It is the PSIRF Executive Lead's responsibility to ensure:

- patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the Board or leadership team's relevant subcommittee(s)
- roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

Mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement must form part of the overarching quality governance arrangements and be supported by clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement. The Board should monitor the balance of resources going into patient safety incident response versus improvement.

Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.



Updates to the policy and plan should be made as required as part of regular oversight processes. An overall review of the patient safety incident response policy and plan should be undertaken at least every four years alongside a review of all safety actions.

### 3. Quality assure learning response outputs

A final report will be produced for all individual PSII, and this reviewed and signed off as complete. Sign-off of provider-led PSII is the responsibility of the Board.

The PSIRF Executive Lead should be responsible for reviewing PSII reports in line with the [patient safety incident response standards](#) and signing them off as finalised. They may be supported by relevant colleagues as appropriate.

While a full report for submission to the Board/leadership team may not be produced for learning response methods other than PSII, PSIRF Executive Leads should monitor the quality of all response methods. A sampling approach will be adopted.

GHC have developed a process to ensure that all safety actions implemented in response to learning or wider safety improvement plan(s) are monitored, to check they are delivering the required improvement. Progress on individual actions are reviewed at appropriate intervals using relevant data, and an overall assessment of the delivery of all safety actions. (see [Guide to responding proportionately to patient safety incidents](#)).

## 5.2 Questions to guide local oversight of patient safety incident response

The questions in **Table 1**, grouped into subject areas based on the [patient safety incident response standards](#), can be used to guide the Board in overseeing patient safety incident responses. These support a formative (continuous) understanding of organisational safety, which is more meaningful than a summative (final) judgement.

**TABLE 1** Questions to guide provider Board oversight of patient safety incident management and improvement.

Oversight questions	
Engagement and involvement of those affected by patient safety incidents	<ul style="list-style-type: none"> <li>• How do we ensure those affected by patient safety incidents are engaged and involved in any learning response?</li> <li>• Does engagement include prompt and effective communication between those affected by a patient safety incident and our organisation?</li> <li>• Does engagement and involvement occur respectfully and according to individual needs?</li> <li>• How do we know how well our processes are working? What are the current barriers?</li> <li>• Are patients or staff with protected characteristics represented more often than others in any of our</li> </ul>

Oversight questions	
	incidents and responses? What are the organisational or cultural reasons behind this?
Policy, planning and governance	<ul style="list-style-type: none"> <li>• Does our patient safety incident response plan match the risks that feel tangible to us as an organisation?</li> <li>• Does emerging intelligence match our assumptions about the biggest risks in our plan?</li> </ul>
	<ul style="list-style-type: none"> <li>• Can we demonstrate wide collaboration and stakeholder involvement in the development and maintenance of our plan?</li> <li>• Does our plan demonstrate a thorough analysis of data and provide a clear rationale for the selection of patient safety incidents for further learning?</li> <li>• Is our ICB assisting cross-organisation working and information sharing?</li> <li>• How do we choose our response to a patient safety incident?</li> <li>• How do we support those who bring 'bad news' or surprises about organisational safety?</li> </ul>
Competence and capacity	<ul style="list-style-type: none"> <li>• Are we employing and continuously developing expertise in patient safety science for key roles?</li> <li>• Are our learning responses adequately resourced (including funding, time, equipment, and training)?</li> <li>• Are training and competence requirements met for learning response leads?</li> <li>• Do we have the competence within our teams to feel we can confidently have conversations with patients and families about patient safety incidents?</li> <li>• Does our ICB have its own continuous development plans in patient safety science training and competence to enable it to participate effectively?</li> <li>• Are our teams confident in having conversations with patients and families affected by an incident but where an individual?</li> </ul>
Proportionate responses	<ul style="list-style-type: none"> <li>• How are we triangulating insight from our responses to patient safety incidents?</li> <li>• Are we using recognised system-based methodologies for data collection and analysis?</li> <li>• Is external guidance/information used to inform patient safety responses and findings?</li> <li>• Do we have collaborative arrangements with our ICB to facilitate cross-system learning responses? This includes processes for recognising when support may be required and raising this with ICB colleagues.</li> </ul>
	<ul style="list-style-type: none"> <li>• Are learning responses completed in a timely manner in line with expectations of those affected?</li> </ul>

Oversight questions	
Safety actions and improvement	<ul style="list-style-type: none"> <li>• How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it?</li> <li>• Do we have and use processes to share emergent intelligence and receive support from external partners (e.g. ICSs, regional and national NHS teams, royal colleges, professional associations, patient groups, charities etc)</li> <li>• How do we assess the sustainability of our safety actions and improvements?</li> </ul>

## Examples of use

Answers to the questions in **Table 2** may be obtained in numerous ways, including through conversations, observations, documentation and data review, and meetings.

The examples below guide their use; they are not an exhaustive list of potential uses.

### Document review

**Q:** Are we employing and continuously developing expertise in patient safety science for key roles?

The Board/leadership team may wish to review the job descriptions of key roles with responsibility for patient safety in their organisation. They may want to compare the essential and desirable requirements listed, and check whether these reflect the organisation's aspiration for safety maturity. The organisation may also wish to review the appraisal process for individuals, both those who are qualified and those working towards a qualification in safety, to ensure it reflects continuing professional development requirements and ambitions.

### Informal conversations

**Q:** *Are we employing and continuously developing expertise in patient safety science for key roles?*

The organisation may wish to understand how to support individuals who have a wealth of experience but no formal safety qualification. It may explore whether individuals wish to pursue a safety qualification and, if so, what the support needs would be.

**Q:** *How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it?*

The Board/leadership team may wish to speak to staff who are tasked with leading improvements within the organisation, to understand the current challenges they face. Such conversations need to be psychologically safe if the

challenges are to be openly and fully explored. The Board/leadership team may examine if the improvement plan is

achievable, likely to have the intended impact and aligns with the organisation's aspirations for safety improvement.

### Data review

*Q: How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it?*

In conjunction with key stakeholders (e.g. patient safety specialists, patient safety partners and, trust leadership), the Board/leadership team may wish to regularly review the progress of the planned implementation of improvements. The oversight of these improvements should not cease at sign-off or implementation and will need to consider sustainability of improvements and what this means for other planned changes.

## **6.0 INTEGRATED CARE BOARD**

The ICB has a responsibility to establish and maintain structures to support a coordinated approach to oversight of patient safety incident response in all the services within their system.

### **6.1 Appointment of an ICB Lead**

The ICB should appoint an appropriate lead(s) to support the responsibilities outlined below. This may be the person with overarching responsibility for quality or, more specifically, patient safety, e.g. an ICB patient safety specialist (see training requirements specified in [Patient safety incident response standards](#)).

Open questions to generate discussion and guide oversight of patient safety incident response by the ICB are listed in Table 2.

### **6.2 Responsibilities of the ICB Lead**

*1. Collaborate with GHC in the development, maintenance and review of provider patient safety incident response policies and plans*

The GHC policy describes how we intend to deliver an effective response to patient safety incidents. The ICB Lead works with GHC to develop and maintain its local patient safety incident response policy and plan, specifically to:

- review application of the national patient safety incident response standards
- establish roles, responsibilities, and processes for oversight within GHC and with the ICB
- establish mechanisms for escalation of incidents and risks that may require support or action at ICB level.

The GHC plan describes the methods it intends to use to respond to patient safety incidents for the purpose of learning and improvement. The ICB Lead works with GHC to develop its plans, specifically to:

- understand GHC's patient safety incident profile
- understand GHC's patient safety improvement profile of the provider
- support the selection of appropriate response methods for anticipated patient safety incidents based on an understanding of potential for new learning and ongoing safety improvement work.

The ICB Lead should be an integral collaborator in regular reviews of GHC's plans as specified in the [Guide to responding proportionately to patient safety incidents](#).

## *2. Agree provider patient safety incident response policies and plans*

ICBs are required to approve and sign off GHC's incident response policies and plans. ICB approval acknowledges the documents have been developed according to PSIRF guidance and meet (or demonstrate a plan to meet) the [patient safety incident response standards](#).

## *3. Oversee and support effectiveness of systems to achieve improvement following patient safety incidents*

ICB Lead(s) should collaborate with GHC to assess whether the systems and processes put in place to respond to patient safety incidents are effective for the purpose of learning and improvement.

ICBs should support safety improvement where GHC's systems and processes to respond to patient safety incidents are not leading to improvement. This may be through seeking support from colleagues in regional teams or linking with other organisations whose systems and processes are more developed.

## *4. Support co-ordination of cross-system learning responses*

Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service relating to the incident or issue. However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, the ICB should support the co-ordination of a cross-system response.

GHC should have a process to recognise incidents or issues that require a cross-system learning response. We will use judgement and seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system. Where there is insufficient capacity and/or capability, we will engage early with the ICB, which can identify the right person to support the coordination of a cross-system learning response.

The ICB Lead will liaise with relevant providers (and other ICBs if necessary) to 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. ICB Leads appointed to support cross system learning responses must have the required time and training (as described in the [Patient safety incident response standards](#)).

Providers and ICBs are expected to work together to establish and undertake cross system learning responses, but where issues arise, they will be supported by NHS England regional teams to ensure such responses are delivered as required (see NHS England responsibilities below).

GHC works with the ICB and regional teams to recognise and establish the infrastructure to support learning responses to cross-system incidents. This responsibility is outlined in our patient safety incident response policy.

Where required, an ICB can commission an investigation (or other learning response) that is independent of GHC. This may occur when:

- an organisation is too small (i.e., does not have the workforce) to provide an objective response and analysis
- an investigation independent of the provider is deemed necessary to ensure public confidence in the investigation integrity
- a multi-agency incident occurs, and no single provider is the clear lead for an investigation
- the incident(s) represent significant learning potential for the wider system (regional or national).

We recommend that advice is sought on accessing relevant procurement frameworks from the NHS England Regional Independent Investigation Team (RIIT). All multi-agency incidents and those representing significant learning potential for the wider system should be discussed with the RIIT. This includes all incidents of mental health related homicide. See Appendix B and the 'Responsibilities of NHS England regional teams' section below for further details.

#### *5. Share insights and information across organisations/services to improve safety*

The ICB should seek to identify and share areas of good practice in relation to patient safety incident response.

### **6.3 Questions to guide ICB oversight of provider patient safety incident response**

The questions in **Table 2**, grouped into subject areas based on the patient incident response standards, can be used to guide ICB oversight of GHC's patient safety incident response. They support a formative (continuous) understanding of organisational safety, which is more meaningful than a summative (final) judgement.

The oversight questions are:

- open – to stimulate discussion, rather than to be used to collect and collate answers for comparison (**it is not appropriate to request a report or set numerical targets against these questions**)
- to be used in conjunction with other existing sources (e.g. the national staff survey)
- to be asked as part of conversations with a wide range of stakeholders.

The intention is not that the ICB reviews all questions under one topic before moving on to the next one, rather that it works across a range of topics, focusing on those questions within a topic that feel most relevant to local circumstances.

**TABLE 2 Questions to guide ICB understanding the effectiveness of provider learning response systems.**

<b>Oversight questions</b>	
<b>Engagement and involvement of those affected by patient safety incidents</b>	<ul style="list-style-type: none"> <li>• What is the provider’s understanding of engagement and involvement?</li> <li>• What improvement work is ongoing to facilitate quality engagement and involvement? Is there evidence of continuous work in progress?</li> <li>• Is compassionate engagement equitable for all?</li> <li>• How extensive is the evidence of a just culture (e.g. does ‘blame’, or focusing on individual actions or omissions in investigations still occur)?</li> <li>• What do external data sources (e.g. NHS staff survey, GMC training survey, Health Education England (HEE) reviews) say about staff experience?</li> <li>• Is the organisation aware of its successes and challenges regarding staff support in response to incidents?</li> </ul>
<b>Policy, planning and governance</b>	<ul style="list-style-type: none"> <li>• Is the patient safety incident response plan being updated as required and in accordance with emerging intelligence and improvement efforts?</li> <li>• Does the patient safety incident response plan accurately address the known patient safety-related challenges for this organisation?</li> <li>• Is patient safety and improvement work across the organisation aligned?</li> </ul>
	<ul style="list-style-type: none"> <li>• Is work progressing to fulfil any gaps identified in meeting national patient safety incident response standards?</li> <li>• What learning is emerging through collaborative external (peer) review? How is this contributing to improvement?</li> <li>• What is the quality management process for the outputs of patient safety incident response (e.g. PSII reports)?</li> </ul>

<b>Oversight questions</b>	
	<ul style="list-style-type: none"> <li>• Does quality management involve key stakeholders (e.g. safety experts, patient safety partners, staff representatives)?</li> </ul>
<b>Competence and capacity</b>	<ul style="list-style-type: none"> <li>• Are oversight training and competence requirements met within the ICS?</li> <li>• Can the organisation describe its capacity to effectively deliver its patient safety incident response plan?</li> <li>• Is staff time protected or dedicated full-time roles in place for patient safety incident response?</li> <li>• Do the organisational stakeholders (e.g. patient safety partners, clinical teams, support staff) have continuous professional development opportunities to enable them to participate effectively?</li> <li>• Can the organisation describe where the capacity is to implement improvement based on patient safety incident response?</li> <li>• Are learning response leads empowered to act independently?</li> <li>• Is access to expertise and support provided?</li> </ul>
<b>Proportionate responses</b>	<ul style="list-style-type: none"> <li>• Is the organisation's leadership clear in communicating to teams that an individual learning response should not be conducted for every incident that results in moderate or more severe harm? And do leaders support teams where this policy is challenged?</li> <li>• Is there evidence that teams are attempting to conduct a learning response to every incident, and therefore resources are spread too thinly?</li> <li>• Are there opportunities for teams to learn from when things do and do not go well?</li> <li>• Is there evidence of filtering or censorship of findings or suggested improvements?</li> <li>• Is learning and improvement work adequately balanced? (i.e., balance of horizon scanning, thematic work, and individual learning responses)</li> </ul>
	<ul style="list-style-type: none"> <li>• Are learning responses completed in a timely manner in line with expectations of those affected?</li> </ul>
<b>Safety actions and improvement</b>	<ul style="list-style-type: none"> <li>• Is learning triangulated across the range of incident response methods used to inform improvement?</li> <li>• Can the organisation describe safety improvements in progress, what they aim to achieve and their interim successes and challenges?</li> </ul>



## Oversight questions

- What is the GHC Board doing to support local teams on challenges in patient safety?

### Examples of use

Answers to the questions in **Table 3** may be obtained in numerous ways, including through conversations, observations, documentation and data review, and meetings.

The examples below guide their use; they are not an exhaustive list of potential uses.

#### Review meeting

Q: Is compassionate engagement equitable for those affected?

The ICB Lead, with an individual or team from GHC, may wish to walk through how a patient group with a particular protected characteristic would experience engagement following an incident. They may also wish to understand what training the team have had in conducting the variety of engagement options available.

#### Informal conversations

Q: Is compassionate engagement equitable for those affected?

The ICB Lead may wish to speak to patients and families with a particular protected characteristic to understand their experience of engagement following a patient safety incident. They may ask GHC to identify a range of patients and families for the ICB to speak with. GHC may also gather feedback from conversations with patients and families to share with the ICB.

Q: Is the organisation clear in communicating to teams that an individual learning response should not be conducted for every incident that results in moderate or more severe harm?

The ICB Lead may wish to understand the pressures teams face to provide a learning response following an incident (e.g. from within the organisation and from coroners, patients, regulators, and professional bodies). It should help ensure that those in decision-making positions can determine which incidents will and which will not require an individual learning response. The ICB may wish to speak to different department leads and support those divisions that may be under pressure to investigate every incident.

#### Data review

Q: Is the organisation clear in communicating to teams that an individual learning response should not be conducted for every incident that results in moderate or more severe harm?

The ICB may wish to compare the volume of learning responses against GHC's patient safety incident response plan and determine if and where improvement plans are not being progressed because repeat response remains the focus.

## 7.0 NHS ENGLAND NATIONAL PATIENT SAFETY TEAM

National considerations to support monitoring of **PSIRF effectiveness** include reviewing:

- effectiveness and usability of PSIRF documentation, tools, templates, and guidance
- quality of training offered by suppliers on the [NHS training and development framework](#)
- the impact of PSIRF on patient safety incident reporting
- wider evaluation of the long-term outcomes of patient safety incident response systems including as well as advising on support and interventions to respond to issues relating to the effectiveness of patient safety incident response systems; long-term outcomes may include:
  - engagement and involvement of those affected
  - the quality of system-based learning responses
  - evidence of local system improvement in relation to patient safety incidents

## 8.0 CARE QUALITY COMMISSION

The assessment of GHC's leadership and safety by the Care Quality Commission (CQC) considers the Trust's ability to respond effectively to patient safety incidents, including whether change and improvement follow its response to patient safety incidents. CQC teams will apply the PSIRF and associated patient safety incident response standards as part of its assessment of the strength of an organisation's systems and processes for preparing for and responding to patient safety incidents.

CQC will expect to be informed (via the regional relationship lead) of high-profile and complex incidents as part of the co-ordinated response, as well as being provided with all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

CQC will assess how GHC can support the needs of those affected and take meaningful action in response to patient safety incidents. CQC also regulates Integrated Care Systems.

Where it specifically considers PSIRFs, the CQC review will consider how these meet the national patient safety incident response standards. CQC will assess, in partnership with the NHS England PSIRF team, the specific training requirements for those undertaking reviews of PSIRFs.

## 9.0 OTHER TYPES OF REVIEW AND/OR INVESTIGATION

Certain types of incident trigger mandated specific responses. PSIRF does not change existing requirements for these.

In some circumstances, learning responses under PSIRF will coincide with other responses, and when they do, co-operation and collaboration between partner agencies is essential to minimise duplication, uncertainty and/or confusion relating to the different processes, particularly for those affected.

Ideally, one investigation should be undertaken (by a team comprising representatives of relevant agencies) that meets the needs/requirements of all parties. In practice, this can be difficult to achieve because investigations have different aims/purposes, and none must be conflated to accommodate others. Where it is not possible to undertake a single investigation, duplication of effort should still be minimised, particularly with regards to communication with and requests made to those affected. In some circumstances, the NHS England RIIT can advise and/or support investigative work where multiple external agencies are involved (see Appendix B).

GHC's patient safety incident response policy sets out how the interface with the Trust-led response to patient safety incidents and other investigations will be managed.

### 9.1 Health Services Safety Investigations Branch (HSSIB)

The HSSIB undertakes national and maternity patient safety investigations.

### 9.2 Coroners

A coroner investigates unnatural or violent deaths, where the cause of death is unknown, or because the death took place in prison, police custody or another type of state detention, such as a mental health hospital. The investigation may include an inquest hearing. The coroner's role is to find out who died and how, when, and where they died.<sup>2</sup>

Organisations should establish good relationships with their coroner, involve them in patient safety incident response plan development and respond when they ask for information. PSIRF requires all deaths to be investigated **where the death is thought more likely than not to have been due to problems in care.**

In our work with the coroner, GHC will act as follows.

- We will ensure we comply with the Notification of Deaths regulations that require registered medical practitioners to notify the senior coroner of a death if one or more of the circumstances set out in the regulations applies, including where they "suspect" that the person's death was due to "undergoing any treatment or procedure of a medical or similar nature".

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<sup>2</sup> [A Guide to Coroner Services for Bereaved People \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672122/a-guide-to-coroner-services-for-bereaved-people.pdf)

- We will ensure we provide the coroner with any requested documents, such as PSII reports, learning from other response methods and any other relevant supporting materials. Where we have not generated a specific report, we will still gather information to respond to coroners' questions (this may not require an investigation). If the coroner suggests there may have been patient safety issues, we will should if an investigation or other response method would be appropriate.
- We will advise the coroner of any relevant documents we hold, even if these are not specifically requested.
- We will advise the coroner that the NHS omits person-identifiable information from local patient safety investigation reports to allow for wider sharing without inadvertently impacting on family members and NHS staff, or damaging safety culture with inappropriate blame. We will request that the coroner also has concern for the potential impact of any shared investigative supporting materials entering the public domain.
- We will ensure the remit of any learning response method under PSIRF focuses on learning and improvement and not other external requirements such as the coroner's role to make judgements about cause of death.

### 9.3 **Medical examiner system**

Medical examiners, supported by medical examiner officers, work to:

- listen to the bereaved, increasing transparency and offering them the opportunity to raise concerns about care
- improve the quality and accuracy of the Medical Certificate of Cause of Death
- ensure notification of deaths to the coroner, where appropriate.

Medical examiners do not carry out in-depth reviews, but when they identify concerns, they refer them to appropriate governance leads. This may include the Trust's Mortality Lead and/or PSIRF Lead. These leads will then ensure the death is considered for a response in line with the trust's learning from deaths policy and patient safety incident response plan. Where evidence, however identified, suggests problems in care were more likely than not to have led to the death occurring at the time that it did, a PSII must be undertaken.

## **10.0 IMPROVING INCIDENT RESPONSE THROUGH COLLABORATIVE EXTERNAL REVIEW**

An essential part of improving how organisations learn from patient safety incidents is external peer review of a sample of learning response reports that have been signed off by the Board/leadership team (or delegated Executive Lead). We specify the proportion of responses to be externally reviewed and note in our patient safety incident response policy how this will be facilitated.

Where possible, services with similar characteristics (including the population they serve) should partner with one another to review reports to support collaborative learning.

External review improves quality and reduces siloed approaches to learning that can embed unintentional bias. It can also anticipate future problems by reflecting on systems in place and any risks they carry. For example, from reviewing incident findings, areas for improvement and safety actions developed in other organisations, providers can review their own practice to ascertain if ‘this happens here’.

## APPENDIX 1: RIIT incident response process

Where the Regional Independent Investigation Team agree a PSII should be managed at a regional level, they will:

- commission and manage the investigation in line with the national procurement framework, [patient safety incident response standards](#) and independent PSII operating procedures
- determine the terms of reference for the PSII and ensure that the patient safety incident response standards are followed
- manage the interface with other statutory investigations (e.g. domestic homicide reviews, special case reviews, safeguarding adult reviews), and work with other bodies to support a collaborative approach
- ensure agreement with internal and external stakeholders, including the police, probation, local authorities, Health and Safety Executive, local safeguarding Boards and/or other agencies, as required, regarding:
  - timing of investigations
  - sharing of information and confidentiality issues
- involvement, support and communication with families, carers, staff and the media; the standards outlined in [Engaging and involving patients, families and staff following a patient safety incident](#) must be upheld
  - completion and sign-off of the PSII report
  - PSII report publication strategy (including assessment of the impact of publishing sensitive, confidential, and identifiable information; see below)
  - arrangements for the ongoing monitoring and/or escalation of actions and delivery of improvement
  - dissemination of learning and subsequent improvement efforts.

### Publication of sensitive and confidential information in independent patient safety investigation reports

Independent PSII reports must be shared with internal and external stakeholders, including the affected individuals and families, and should be written in a clear and accessible way as described in the [Patient safety incident response standards](#). Where possible, independent PSII reports will be published in full.

The impact of publishing an independent PSII report can have on those affected must be carefully considered, especially when individuals may be identifiable.

Where a patient, the family of a deceased patient or another affected person does not consent to publication, their rights must be balanced against the wider public interest when deciding whether to publish. If publication could prevent a similar patient safety incident, the wider public interest could outweigh the rights of individuals to privacy. However, this right for both individual and family life, provided under Article 8 of the European Convention on Human Rights (ECHR), must be considered.

Where risks to individuals outweigh the wider public interest, other approaches can be considered, such as publishing a summary report of the investigation and/or thematic work, or system improvement plans relating to similar incident types/issues.

A contemporaneous written record of the factors considered in the decision to publish sensitive material or not must be retained.

### **Responsibility for openness, Duty of Candour and responding to immediate risk**

Regardless of whether an independent PSII is required, the organisation identifying the incident is expected to be open with those affected, explaining what has happened, listening to any questions and/or concerns, and explaining what will happen next. Any immediate risks to the patient(s) or others and actions that may be required to mitigate those risk must be considered.

The requirement to comply with Duty of Candour regulations is unchanged: that is, the patient/family/carers must be informed of any notifiable patient safety incident and follow all the requirements of the Duty of Candour. In cases of mental health-related homicide, this will be both the patient and their family, and the victim's family. While legal obligations associated with Duty of Candour apply to those in receipt of care, the moral obligation to be open, honest, supportive, and inclusive must be upheld for all affected. Further information is included within [Engaging and involving patients, families and staff following a patient safety incident](#).

### **Reporting to the Learn from Patient Safety Events service (LFPSE)**

The LFPSE service replaces the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS). Reporting to LFPSE is the equivalent of reporting to NRLS and StEIS, but once an organisation starts reporting to LFPSE, it only needs to make one incident report – that is, it no longer needs to report to NRLS or StEIS.

### **Implications of the Human Rights Act**

The Human Rights Act 1998, which gives the European Convention on Human Rights (ECHR) effect in the UK, may impact investigations carried out in relation to patient safety incidents.

Article 2 has been interpreted in the case law of UK courts and the European Court of Human Rights as imposing both positive and procedural (investigative) obligations on the State: the state must never arbitrarily take someone's life and must also safeguard the lives of those in its care. In addition, the state must carry out an effective investigation when an individual dies following the state's failure to protect the right to life, or the use of force by government officials.<sup>3</sup>

Not all incidents being investigated under PSIRF will trigger a duty for the investigation to be Article 2 compliant. The duty does not, for example, arise for every death in hospital, but it almost always will where there is an unexpected death in custody

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<sup>3</sup>[Guide on Article 2 - Right to life \(coe.int\)](#)

(including those detained under the Mental Health Act 1983) and where real concerns exist that there were failings in care. It may also arise because of the control of, and responsibility assumed for the individual, so Article 2 could apply to the death of an informal psychiatric patient. However, every case will depend on its circumstances and legal advice should be sought.

Any duty to carry out an Article 2 compliant investigation covers the span of investigations following an incident and is not restricted to an investigation under the PSIRF in isolation. Normally, a coroner's inquest will ensure Article 2 compliance either for its own purposes or for an investigation under PSIRF and/or civil or criminal proceedings. An investigation under PSIRF may contribute towards the coroner's inquest as part of the State's overall response to its Article 2 obligations. Again, legal advice may be needed to determine the scope of and proper procedures for any investigation under PSIRF that involves significant Article 2 issues.